INDEPENDENT CARE HEALTH PLAN

QUALITY, CHOICE, RESULTS

FCP PROVIDER REFERENCE MANUAL

CONTENTS

I. INTRODUCTION

This manual is intended to serve as a reference for provider information and guidelines applicable to the Independent Care Health Plan (*i*Care or Independent Care) Family Care Partnership (FCP) plan, especially information and guidelines for *i*Care's network of Long Term Care (LTC) service providers (also known as Home and Community Based (HCB) service providers or long-term services and supports (LTSS) providers. Throughout this document the term LTC will be used.) For Medicare and Medicaid covered services to FCP members and for information applicable to *i*Care's Medicare SNP, Medicaid SSI, and BadgerCare Plus health plans please reference the Provider Reference Manual found on the *i*Care provider website: https://www.icarehealthplan.org/Provider.htm. The *i*Care website offers additional information regarding *i*Care's Family Care Partnership Plan, Medicare SNP, Medicaid, SSI, and BadgerCare Plus Plans.

A. MISSION STATEMENT

The mission of Independent Care Health Plan is to secure the wellness of person with complex medical and behavioral conditions, respecting their dignity and the values of caring stakeholders.

B. COMPANY INFORMATION

Independent Care has a unique history, originating from a non-profit human service provider supported by a major for-profit national health insurer. This unusual blend of competencies supports member confidence in *i*Care's mission to respond to complex health needs of persons who otherwise go unserved. *i*Care also has unique members, many with complex health care needs and who are disabled and poor.

Independent Care began as a research and demonstration project sponsored by the Health Care Financing Administration (now Centers for Medicare and Medicaid Services or CMS) that integrated managed health care and social services for adults with disabilities. Formed in 1992, *i*Care was jointly created by Milwaukee Center for Independence (MCFI) and a local health insurer, Wisconsin Health Organization (which was later acquired by Humana). The two distinct organizations resolved to create a program with improved quality and access to care for individuals covered by Medicaid through Social Security Supplemental Security Income.

In 2003, Independent Care Health Plan was reincorporated as a Wisconsin-licensed HMO insurance corporation, creating an insurer that is operationally and financially independent from its owners. Since its beginning in 1992, *i*Care has grown from a small federal demonstration project with a new care model into one of Wisconsin's largest health insurers for adults with disabilities and into one of the nation's best working examples of how integrated care can occur and benefit members with complex care needs.

C. WHAT IS FAMILY CARE PARTNERSHIP?

The Family Care Partnership (FCP) Program is a comprehensive program of services for frail elders and adults with developmental or physical disabilities in Wisconsin. The program integrates health and long-term support services, and includes home and community-based services, physician services and medical care. Services are delivered in the participant's home or a setting of his or her choice. Member choice is a cornerstone of the FCP Program. Independent Care and its providers make every effort to honor member preferences of how, when, and where services are delivered. Another key component of the FCP Program is team-based care management. Under this arrangement, an Interdisciplinary Care Team (IDT) develops a care plan to coordinate all service delivery.

The goals of the FCP Program are to:

- Increase the ability of people to live in the community and participate in decisions regarding their own health care.
- Reduce fragmentation and inefficiency in the existing health care delivery system.
- Improve quality of health care and service delivery while containing costs.

Independent Care participates in the Wisconsin Family Care initiative through a FCP program which integrates primary and acute services with LTC services. All FCP members have a nursing home level of need. FCP services are provided in the community, therefore, in lieu of nursing home placement. Fifty-five percent of FCP members are dually eligible for both Medicare and Medicaid coverage. LTC services are accessed through contracted arrangements with services reimbursed by *i*Care. The goal of the program is to make nursing home placement unnecessary by providing all required supports in the community. Independent Care's FCP program offers a member-centered care model, where the member is part of a team (the IDT) of professionals that includes a Nurse Practitioner (NP), a Registered Nurse (RNCM), a Social Services Care Manager (CM) and other professionals as appropriate. The IDT develops a care plan to coordinate all service delivery.

In keeping with the values of modern healthcare reforms, *i*Care's care management model provides members with a person-centric approach to healthcare. Many *i*Care members report multiple medical co-morbidities that are further complicated by extensive social and behavioral needs. This "whole-person" model recognizes that in serving individuals with complex needs, *i*Care must also address social and behavioral issues while treating medical conditions. Through this integrated care management model, *i*Care works to identify and coordinate the service needs of *i*Care members.

Independent Care treats its members with dignity and respect. We take pride in the diversity of our membership and consider cultural specific concerns when rendering services. *i*Care values its providers who share the *i*Care mission and commitment to serving individuals with special needs.

D. MODEL OF CARE/INTERDISCIPLINARY CARE TEAM (IDT)

In our member-centric model of care management, the member is at the center of each IDT. Every *i*Care FCP member is assigned an IDT and provided with the name and direct contact number of all team members. The composition of the team varies based upon the assessed needs of the individual member. At a minimum, each FCP member's IDT consists of an individual with a social services background (CM) and a registered nurse (RNCM) and a Nurse Practitioner (NP). Additional staff and other professionals are incorporated into the IDT as appropriate. For those members who have been appointed guardians, the guardian is also a member of the IDT.

The IDT completes a comprehensive assessment of members' needs, abilities, preferences, and values. The assessment identifies a member's perception of his/her current health status, knowledge of disease processes and adherence to treatment recommendations. Guided by the assessment, the IDT develops and implements an evidence based, individualized member-centered plan (MCP) based upon member defined outcomes. This helps members take ownership for their health and guides what the IDT staff and members work on together. A key component of the MCP is for the IDT staff to work with the member in determining if the member's goals/outcomes are met or not met. If the goal/outcome are not met the IDT will reassess the current MCP and determine alternative actions. The outcomes of these alternative actions will also be assessed, and the cycle will repeat at minimum every 6 months or with a significant change of condition, as needed. The MCP provides staff with a focused approach to member education and future follow up contacts. The member-centered care plan is updated at least every six months and with changes in condition, utilization, or risk level.

The IDT will discuss a variety of strategies to address the clinical, functional, and personal outcomes that are listed in the MCP for the member. Some of these may include paid services that are covered under the *i*Care FCP plan. The IDT will utilize the Resource Allocation Decision-making (RAD) process developed by the State of Wisconsin to determine cost-effective strategies to make use of available resources and services to meet a particular outcome.

The IDT assures that members receive coordinated services to help them maintain their independence and remain active in the community. Members participate in team decision making, including working in collaboration with the member's primary care provider for all medical and LTC services. FCP services support the member's best possible functioning in the least restrictive setting. The member-centric approach emphasizes services provided in the location desired by the member by the providers desired by the member and embodies the member's choice, autonomy, and independence.

*i*Care's care management model is rooted in the premise that coordination of services relative to the entire spectrum of medical, behavioral, and social needs is necessary to optimize the well-being of the FCP member. Medical factors contribute to co-morbidity and compete for prioritization in application of care management efforts. Chronic disease progression is more often advanced and complicated by the presence of multiple chronic diseases, limiting the usefulness of traditional single-disease management programs. Behavior change underlies the success or failure of medical management efforts. The

lack of basic financial resources and social supports can undermine the most heroic of medical management efforts. Therefore, the combination of medical and social service/behavioral science expertise on the IDT maximizes the benefit for the FCP member.

This model of care management is supported by an advanced care management electronic record with referenceable standards of care. *i*Care's care management solution has predictive and claims tracking capability, enabling the IDT staff to review the past 24 months of encounter information. IDT staff can see clearly where the member touches the healthcare system, the frequency of use, and the regularity of that contact. One of the principle aims of the model of care management is for the member to establish a reliable and steady relationship with a primary care resource. Another aim of the care management models is for the members to grow in the ability to care for their own health needs as an active agent. Impoverished and disabling conditions present significant challenges to accomplish these aims. A further description of the Model of Care for each *i*Care plan is available as a webinar on the *i*Care Provider Website (https://www.icarehealthplan.org/Education/Providers.htm). Please use the educational webinars annually for any new staff and to refresh your knowledge of the Model of Care for your practice.

II. GENERAL PROVIDER NETWORK INFORMATION

A. ACCESS AND CAPACITY STANDARDS

It is *i*Care's goal to offer members a provider network with adequate geographic coverage, adequate capacity for timely provision all services in the benefit package and to provide members a choice of providers. Capacity of the provider network and adequacy of the provider network is routinely monitored by *i*Care to assure that this goal is met.

Providers must offer hour of operation that are not less than the hours of operation offered to other MCO members or Medicaid FFS members.

Providers are prohibited from creating barriers to access care by imposing requirement that are inconsistent with the provision of services necessary to achieve MCP outcomes. Access standards for acute and primary services can be found in the Provider Reference Manual at https://www.icarehealthplan.org/Providers/

B. CONFIDENTIALITY

*i*Care is a covered entity under the Health Insurance Portability and Accountability Act of 1996 as amended (HIPAA) and complies with all applicable state and federal confidentiality and privacy laws and regulations (See 45 CFR § 160.103). Under HIPAA, a covered entity may disclose protected health information to another covered entity without informed consent if the disclosure is for the purposes of the healthcare operations activities of the entity that receives the information, and if each entity has or had a relationship with the individual who is the subject of the information being requested. (See 45 CFR § 164.506(c) (4)). Case management, Care Coordination and

conducting quality assessment and improvement activities, including outcomes evaluation are healthcare operations activities under HIPAA (See 45 CFR § 164.501). Wisconsin law also permits access to patient healthcare records without informed consent of the patient if the releases are for the purposes of healthcare operations as defined by HIPAA (see Wis. Stats. § 146.82).

C. CULTURAL COMPETENCY and NON-DISCRIMINATION

Providers are prohibited from discriminating against any *i*Care member on the basis of race, color, national origin, age, disability status, gender identity, or sex. Providers serving *i*Care members are required to be sensitive to cultural diversity including members with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. Providers are required to foster in their staff attitudes and interpersonal communication styles which respect members' individual needs related to their diversity. Provider must agree to comply with all non-discrimination requirements and all applicable affirmative action and civil rights compliance laws and regulations as applicable. For more information please see https://www.dhs.wisconsin.gov/civilrights/index.htm.

D. NOTICE OF CHANGE

Providers shall notify *i*Care of changes in information related to the provider's practice. Send all provider demographic changes to netdev@icarehealthplan.org. A form for submission of this information is available at the *i*Care Provider website: https://www.icarehealthplan.org/Provider.htm.

Notification is required for:

- Addition of a provider
- Provider retirement or termination
- New location
- Closing of a location
- Any change in NPI number
- Any change in Tax Identification number (TIN) (submit with revised and corresponding W9)
- Any billing service change
- Any billing address change
- Change in licensure or certification
- Any sanctions imposed by a governmental agency
- Any Criminal investigations

E. CONTACT INFORMATION

MAIN NUMBER: 414-223-4847 or 1-800-777-4376
Please see individual department phone and fax numbers and email addresses below.

Customer Service
Monday through Friday- 8:00 -5:00
Member Local: 414-223-4847
Out of area: 1-800-777-4376

Provider Services
Local: 414-231-1029
Out of Area: 1-877-333-6820
Email: providerservices@icarehealthplan.org

Interdisciplinary Team
414-223-4847
Provide the member's name and DOB to be connected to the IDT CM
After hours Care Manager On call can be reached at this number.

Member Rights Specialist
414-231-1076
Fax: 414-231-1090

Pharmacy
1-800-910-4743 or 877-333-6820

Provider Contracting
Email: Netdev@icarehealthplan.org
Fax: 414-272-5618

III. MEMBER ELIGIBILITY

To participate in the *i*Care FCP Program, the member must be eligible for Medicaid and be certified at the Medicaid nursing home level of care. The program also serves people who are eligible for both Medicaid and Medicare. Participation in the program is voluntary. Individuals interested in learning more about their options for long-term care, including applying for Family Care Partnership, should contact their local Aging and Disability Resource Center (ADRC). ADRC services are available to everyone, whether or not they are eligible for Family Care or other Medicaid programs.

A. *i*CARE FCP PLAN ELIGIBILITY CRITERIA

To enroll in the *i*Care Family Care Partnership Plan, the recipient must:

- Be a resident of Dane, Kenosha, Milwaukee, Racine, (or beginning in 2019, Sauk) Counties.
- Be a person with physical or developmental disabilities (18 years of age or older) OR a frail elderly adult over 60 years of age.
- Be eligible for full Wisconsin Medicaid.
- Have long term care services needs as determined by the State of Wisconsin Long- Term Care Functional Screen.
- Not have End Stage Renal Disease (exceptions apply).

To be eligible for the *i*Care Medicare plan under Family Care Partnership, the member must meet the following criteria:

- If Medicare eligible, must have active coverage in Part A and Part B.
- Cannot have End Stage Renal Disease (some exceptions may apply).

It is imperative the provider verify eligibility each time services are provided. For various reasons, Medicaid eligibility can change at any time.

- Eligibility is administered by the State of Wisconsin.
- The State of Wisconsin issues all Medicaid members a Forward Health ID card. The front of the ForwardHealth card displays the recipient's name, Medicaid ID number, and a unique 16- digit card number.
- *i*Care issues the FCP member an *i*Care ID card includes both Medicare and Medicaid ID numbers (if member is eligible for both) and pharmacy information.

Providers can access immediate and real-time eligibility, Medicaid date and *i*Care designation using a point of service device or special computer software allowing access to the Eligibility Verification System (EVS).
https://www.forwardhealth.wi.gov/WIPortal/Default.aspx

Providers may also verify a member's Medicaid eligibility status by calling 1-800-947-9627.

B. *i*CARE FAMILY CARE PARTNERSHIP ID CARD

*i*Care issues the member an ID Card with both Medicare and Medicaid identification numbers and pharmacy information.

In an emergency, call 911 immediately. Please call Customer Service at the number below as soon as possible after an emergency hospital admission. All services performed by non-network providers, except emergency services, require prior authorization.

Customer Service: 1-800-777-4376 (TTY: 1-800-947-3529)
Voice: 1-800-947-6644, 7 days-a-week, 8:00 a.m. - 8:00 p.m.

www.icare-wi.org

Submit claims to:
Independent Care Health Plan
PO Box 224255
Dallas, TX 75222-4255

IV. MEMBER BENEFITS

The attached chart (Exhibit 2) lists LTC services along with the Medicaid and Medicare services available to members in the *i*Care FCP plan. This document is also available at https://www.dhs.wisconsin.gov/publications/p0/p00570.pdf. More information regarding benefits is available at Forward Health https://www.forwardhealth.wi.gov/WIPortal/Default.aspx or by calling *i*Care Customer Service (414-223-4847).

For a complete listing of benefits of the FCP program, please reference the Summary of Benefits and Evidence of Coverage at http://www.icarehealthplan.org/Plans/FCP/Benefits.aspx

A. ACUTE/PRIMARY SERVICES

Please reference the *i*Care Provider Reference Manual for information regarding acute and primary Medicaid services and Medicare services, including the process to follow for services that require authorization. The *i*Care Provider Reference Manual is found on the *i*Care provider website: https://www.icarehealthplan.org/Providers/

B. LONG TERM CARE SERVICES

All LTC services must be reviewed and authorized by the IDT. To receive authorization for LTC services, please contact the member's CM. Service authorizations are provided by the IDT to the provider prior to the start date of designated services by the provider. When prior written authorization is not practicable, verbal authorization is provided for the service and written authorization issued later.

LTC services will be provided to *i*Care FCP members through our network of providers. All LTC services must be authorized through the IDT. Prior to delivery of a service to an *i*Care FCP member, the provider must obtain a Service Authorization from the member's IDT staff at *i*Care outlining the specific services and rates of reimbursement.

Members, guardians, or providers can request new services or extensions of existing services from the member's IDT staff. The IDT will consider all requests for service and will approve or deny the request using the RAD method. A written Service Authorization for each service will be sent to the provider.

C. SERVICE AUTHORIZATION

The IDT needs the following information to consider a Service Authorization request:

- Member name
- Description of services to be provided and HCPCS code (5-digit code)
- Units and frequency of service
- Dates of service

- Service location

Providers are requested to notify the IDT as soon as possible in an emergency situation. The IDT will work to authorize necessary services. For emergencies after-hours, please contact *i*Care at 414-223-4847 to reach the Care Manager on call.

Questions regarding authorizations should be addressed to the member's CM. Contact information for the CM and other IDT staff is on the Service Authorization Letter. To obtain the name and telephone number of a member's CM, contact *i*Care Customer Service at 414-223-4847.

D. SUPPORTIVE HOME CARE

Providers of supportive home care or in-home respite care services shall comply with the Managed Care Organization Training and Documentation Standards for Supportive Home Care and in-Home Respite at the following link: https://www.dhs.wisconsin.gov/publications/p01602.pdf

Supportive home care providers requesting a Service Authorization for S5125 or S5126 must meet Electronic Visit Verification (EVV) requirements as outlined in ForwardHealth Policy published on the ForwardHealth website in accordance with Section 12006(a) of the federal 21st Century Cures Act.

*i*Care does not require EVV for live-in workers, however:

- The Supportive home care agency must supply a completed Electronic Visit Verification Live-In Worker Identification form, F-02717 at the time of the service request submission for all live-in workers.
- Supportive home care agencies must verify live-in workers' permanent residency based on the ForwardHealth criteria for live-in workers at least annually.
- The agency is required to retain all documentation supporting the determination of live-in worker status according to the record retention requirements as set forth in the Long Term Care Services Agreement. Supporting documentation must be submitted to *i*Care upon request.

Once a service authorization request for a live-in worker is approved, claims for services provided by a live-in worker must include the modifier KX. Using the modifier KX will prevent the claim from denying due to lack of EVV data.

E. RESIDENTIAL CARE SERVICES

A registry of FCP contracted residential providers for room availability is maintained by *i*Care. For new availability, complete the *i*Care Residential Availability Form (http://www.icarehealthplan.org/forms/ProviderForms.aspx) and e-mail it to the attention of: Community Resource Specialist-Family Care Partnership at

icareresidentialopenings@icarehealthplan.org

Residential care services providers are prohibited from distributing marketing/outreach activities or materials to general public that claim Family Care, Partnership or PACE programs will pay for an individual to continue to receive services from the provider after the member's private financial resources have been exhausted.

Residential care providers must report to *i*Care that a member has been or will be involuntarily discharged.

For residential providers that charge room and board, *i*Care has set the board at 20% of the charges.

F. TRANSPORTATION

Transportation is a covered benefit under the *i*Care FCP program. This includes transportation as specified in the member's plan for waiver and community activities and resources to support the member's long-term outcomes, medical appointments, and *i*Care sponsored programs. As with all LTC services in the FCP program, all transportation must be authorized by the IDT team before the transportation takes place. Transportation can be in the form of bus, taxi, van, or specialized medical vehicle service (SMV).

Transportation, when authorized by the IDT staff, will be for the member and may include a person that accompanies the member, if necessary, for their health and safety. Please keep the following rules in mind for transportation:

- When appointments occur on Monday, the notice must be given on the previous Friday.
- For a taxi ride, a minimum of one (1) business day advance notice should be given.
- For van or SMV transportation, a minimum of three (3) to five (5) business days advance notice is preferred.
- Members are responsible for contacting the taxi, van, and SMV provider to confirm or cancel the ride.
- SMV requires a physician certification which identifies medical necessity.
- Certification is required for recipients who are legally blind or disabled to the extent that they cannot safely use private vehicles or mass transit services.

G. LANGUAGE ACCESS

Under Title VI of the U.S. Civil Rights Law, all healthcare programs and activities that receive federal financial assistance from the U.S. Department of Health and Human Services (e.g., hospitals, healthcare clinics, physician's practices, community health centers, nursing homes, and rehabilitation centers) are required to take reasonable steps

to provide meaningful access to each individual with limited English proficiency served or likely to be encountered in its health programs and activities. Reasonable steps may include the provision of language assistance services such as oral language assistance or written translations. Facilities must offer a qualified interpreter when oral interpretation is a reasonable step to provide an individual with meaningful access. Where language services are required, the service must be provided free of charge and in a timely manner. Entities may not require an individual to provide his or her own interpreter.

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 send a request for interpreter services to the Provider Service Mailbox at callcenters@icarehealthplan.org or call 414-231-1029 (or toll free: 1-877-333-6820) and include the following information:

- Name of member
- *i*Care 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 (callcenters@icarehealthplan.org). *i*Care will in turn provide a 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.

The Translator/Interpreter Payment form is sent to the agency by *i*Care Provider Service. The interpreter takes this form to the appointment and requests the form be completed by the healthcare provider. Essential information must include the date, time of the service and name (printed and signed) of staff and interpreter/translator agency completing the form. The interpreter/translator agency submits the invoice(s) and signed payment form to *i*Care:

Independent Care Health Plan
Attention: Accounts Payable
1555 N. RiverCenter Dr. Suite 206
Milwaukee, WI 53212

If an America Sign Language interpreter is needed, please send the request five (5) to seven (7) business days prior to the appointment. For other languages, please make

requests at least three (3) business days prior to the appointment. Please notify *i*Care Customer Service of any cancellation twenty-four (24) hours prior to the appointment or as soon as possible.

V. QUALITY IMPROVEMENT

Independent Care Health Plan's Quality Improvement (QI) Program provides structure and processes that enable *i*Care to carry out its mission and commitment to ongoing improvements: to secure the wellness of persons with complex medical and behavioral conditions, respecting their dignity and the values of caring stakeholders. It is through this commitment of continuous quality improvement that we are able to produce favorable health outcomes for our members.

The QI Program is integrated throughout *i*Care's functional areas with each department accountable for reviewing procedures, systems, quality, cost and outcomes related to their areas of responsibility. The QI Program ensures each department meets regulatory requirements, achieves business objectives and adds value to the services for our members and providers. The QI Program works diligently with *i*Care's network of providers ensuring the highest level of quality for our members. Our expectation is that through a collaborative effort, favorable outcomes are continuously achieved.

A. QI PROGRAM SCOPE

- Annual Quality Improvement Studies
- Credentialing and Re-credentialing
- Delegation Oversight
- Member and Provider Satisfaction
- Network Adequacy and Access to care
- Provider Quality Management
- Quality and Safety of Care and Services
- Quality Site Visits
- Utilization Management

B. GOALS OF THE QI PROGRAM

- Develop and maintain an integrated QI Program that provides structure for promoting and achieving excellence in all areas through continuous quality improvement.
- Use an ongoing, systematic approach to monitor, evaluate, and improve the quality, appropriateness, availability and accessibility of medical care and services to *i*Care members.
- Monitor the quality of care and services provided to *i*Care members by participating providers, medical groups, organizational providers, behavioral health providers and delegated entities.

- Allocate resources necessary to assist in quality improvement initiatives, medical groups organizational providers, behavioral health providers and delegated entities.
- Identify opportunities for improvement of the health status of our members through development and implementation of health promotion, preventive education programs and appropriate referrals.

C. CMS 5 STAR PROGRAM

Independent Care is committed to CMS standards through HEDIS (Healthcare Effectiveness Data and Information Set), Consumer Assessment of Health Providers and Systems (CAHPS), Health Outcome Survey (HOS), the Department of Health Services (DHS) and Pay-for-Performance (P4P) indicators. *i*Care strives to provide medically necessary healthcare that is efficient, effective, safe, accessible, and accountable. Both the CAHPS and HOS ask Medicare members to report and evaluate their experiences with their healthcare providers. It is important that *i*Care's team of professionals, along with the provider community, seek to improve the health outcomes of our members. It is also important to stay in communication with our members ensuring their needs are met.

CMS contracted with the National Committee for Quality Assurance (NCQA) to develop a strategy to evaluating the quality of care provided by Special Needs Plans. This strategy relies on a phased approach, beginning with defining and assessing desirable structural characteristics, followed by assessing processes and, eventually, outcomes. The evaluation approach includes several types of assessments:

- HEDIS measures
- CAHPS measures
- HOS measures
- CMS specific measures
- DHS Pay-for-Performance measures
- Measures that evaluate structure and process requirements through submission of documentation

D. FOCUS OF QUALITY MEASURES

- Preventive care
- Up-to-date treatments for acute episodes of illness
- Chronic disease care
- Appropriate medication treatment

E. CAREGIVER BACKGROUND CHECKS

All *i*Care contracted providers are required to comply with all applicable requirements of

Wis. Stat. § 50.065 and Wis. Admin. Code §§ DHS 12 and 13 relating to caregiver background checks. Providers are required to provide documentation of compliance with these requirements to *i*Care at the point of applying for network provider status and periodically thereafter to validate continuing compliance.

*i*Care reserves the right to decline to contract with, or to terminate the contract of any provider who cannot document that it is in compliance with the requirements of Wis. Stat. § 50.065 and Wis. Admin. Code §§ DHS 12 and 13. The results of caregiver background checks shall be made available by the provider to *i*Care members consistent with the requirement of Wis. Admin. Code §§ 12 and 13.

F. PREVENTIVE HEALTH AND CLINICAL PRACTICE GUIDELINES

A set of preventive health guidelines that are recognized in the medical community to help prevent or delay serious health problems has been adopted by *i*Care. The selected Clinical Practice Guidelines (CPGs) were created by national medical associations and/or health organizations 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. The CPGs guide decisions and provide criteria regarding diagnosis, management, and treatment in specific areas of healthcare based on published evidenced-based medical literature. The CPGs reflect current evidence in the literature for large groups of individuals with specific health diagnoses; at all times, a licensed and boarded practitioner is encouraged to practice patient-centered care, developing care plans with each individual patient's needs and conditions in mind, utilizing medical justifications for exceptions when deviating from the CPGs, based on the provider's expertise and clinical judgment and patient specific situations.

*i*Care's Clinical Practice Guidelines address the following conditions:

- Osteoporosis Management in Women who had a Fracture
- Diabetes Care – Eye Exam
- Diabetes Care – Kidney Disease Monitoring
- Diabetes Care – Blood Sugar Controlled
- HTN - Controlling Blood Pressure
- Rheumatoid Arthritis Management
- Reducing the Risk of Falling
- Behavioral Health
- Depression
- Improving Bladder Control
- Care of older adults – pain assessments
- Asthma

- Cancer screening
- Breast
- Colon

Clinical Practice Guidelines that have been adopted by *i*Care are available at the *i*Care Provider Web page at https://www.icarehealthplan.org/Providers/. *i*Care expects all clinical providers to access the Clinical Practice Guidelines to enrich the quality of clinical care provided to our members by contracted clinical providers.

G. REPORTABLE INCIDENTS CATEGORIES

Providers must report critical incidents and adverse events to *i*Care. The provider must submit the critical incident within 24 hours of the incident to *i*Care for review. Incidents should be reported to the care manager (CM)of the *i*Care member.

Reportable Member Incidents includes the following suffered by or caused by a Member:

Neglect: As defined in §46.90(1)(f), Wis. Stats., to mean the failure of a caregiver, as evidenced by an act, omission, or course of conduct, to endeavor to secure or maintain adequate care, services, or supervision for an individual, including food, clothing, shelter, or physical or mental health care, and creating significant risk or danger to the individual's physical or mental health. "Neglect" does not include a decision that is made to not seek medical care for an individual, if that decision is consistent with the individual's previously executed declaration or do−not−resuscitate order under Ch. 154, Wis. Stats., a power of attorney for health care under Ch. 155, Wis. Stats., or as otherwise authorized by law.

Self-Neglect: As defined in § 46.90(1)(g), Wis. Stats., means a significant danger to an individual's physical or mental health because the individual is responsible for his/her own care but fails to obtain adequate care, including food, shelter, clothing, or medical or dental care.

Financial Exploitation: As defined in Wis. Stats. § 46.90 (1) (ed) includes any of the following acts:

- Fraud, enticement or coercion;
- Theft;
- Misconduct by a fiscal agent;
- Identity theft;
- Unauthorized use of the identity of a company or agency;
- Forgery; or
- Unauthorized use of financial transaction cards including credit, debit, ATM, and

similar cards.

Abuse, Physical: As defined in Wis. Stats. § 46.90 (1) (fg) intentional or reckless infliction of physical pain or injury, illness, or any impairment of physical condition.

Abuse, Sexual: Wis. Stats. §46.90 (l)(gd) a violation of criminal assault law, Wis. Stats. §§ 940.225 (1), (2), (3), or (3m).

Abuse, Emotional: As defined in Wis. Stats. §46.90 (1)(cm) language or behavior that serves no legitimate purpose and is intended to be intimidating, humiliating, threatening, frightening, or otherwise harassing, and that does or reasonably could intimidate, humiliate, threaten, frighten, or otherwise harass the individual to whom the conduct or language is directed.

Abuse, Treatment Without Consent: Administration of medication to an individual who has not provided informed consent or the performance of psychosurgery, electroconvulsive therapy, or experimental research on an individual who has not provided informed consent, with the knowledge that no lawful authority exists for the administration or performance.

Abuse, Unreasonable Confinement or Restraint: The intentional and unreasonable confinement of an individual from his or her living area, use on an individual of physically restraining devices, or the provision of unnecessary or excessive medication to an individual, but does not include the use of these methods or devices in entities regulated by the department if the methods or devices are employed in conformance with state and federal standards governing confinement or restraint.

Any Unplanned or Unapproved Use of Restraints (or restrictive measures): restraint types include: mechanical supports, mechanical restraints, medical restraints, medical procedure restraint, restraints allowing healing, restraints for protection. Also – chemical restraints (use of as-needed (prn) medications for controlling acute or episodic behavior.

Any Unplanned or Unapproved Use of Isolation/seclusion: The intentional and unreasonable confinement of an individual from his or her living area, use on an individual of physically restraining devices, or the provision of unnecessary or excessive medication to an individual, but does not include the use of these methods or devices in entities regulated by the department if the methods or devices are employed in conformance with state and federal standards governing confinement or restraint.

Falls: Unless there is evidence to indicate otherwise, a fall, with or without injury, has occurred when a member is found on the ground/floor or a member reports a fall. A fall is an unintentional occurrence (not as a result of being pushed down) and may be an assisted or unassisted fall; may include rolling off a low bed onto a mat. An unintentional change in condition due to a sudden medical condition is not a fall

(because treatment for a medical condition is different than treatment for a fall).

Death: Deaths under the following categories are considered a reportable incident:

- Neglect
- Self-neglect
- Financial exploitation
- Abuse
- Accident
- Restraint
- Isolation/seclusion
- Suicide
- Psychotropic medication
- Medication error
- Fall(s)
- Unexplained, unusual, or suspicious circumstances
- Missing person
- Other
- Deaths from a known diagnosed disease, health condition, or similar situation are not considered an incident but still need to be reported to the Client.

Missing Person: Any instance when a member visually and physically wanders away or leaves a home or a community setting for any length of time without prior arrangement or permission.

Any Unplanned or Unapproved Involvement of Law Enforcement and/or Criminal Justice System: Any time law enforcement personnel are called to the CBRF, AFH, RCAC, or other community setting as a result of an incident that jeopardizes the health, safety, or welfare of residents(member) or employees/other persons.

Medication Errors:

- errors in medication time;
- omission;
- wrong medication;
- wrong dose;
- wrong person;
- wrong route of administration; or
- wrong technique

H. RESTRICTIVE MEASURES

Provider agrees to submit a request for restrictive measures involving any one or more

members prior to submission to *i*Care. Independent Care will contact the State once *i*Care and the provider agree to the measures. The use of isolation, seclusion, and restrictive measures in licensed facilities in WI is regulated by the DHS. Providers may find information on restrictive measures at https://www.dhs.wisconsin.gov/waivermanual/appndx-r1.pdf

In emergency situations, the provider must contact the *i*Care IDT team as soon as possible after the incident; the day of the incident if possible, or within 24 hours of the incident.

Provider must adhere to regulatory requirements and *i*Care standards relative to restrictive measures including any type of restraint, isolation, seclusion, protective equipment, or medical restraint as required Wis. Stat. 51.61(1)(i) and Wis. Admin Code DHS 94.10.

I. 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 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.

Medical records and other documentation may be requested and reviewed as part of the quality concern and grievance processes. The provider agrees to make records available to members and his/her legal decision makers with ten (10) business days of the records request if the records are maintained on site and sixty (60) calendar days if maintained off site. Provider further agrees to forward records to *i*Care pursuant to grievance and appeals within 15 business day of *i*Care's request or immediately, if the appeal is expedited. If requested, copies of medical records are reimbursed as specified in your *i*Care Provider Agreement.

J. ACCESS AND AUDIT

Pursuant to the requirements of 42 CFR §§ 438.3(h) and 438.230 and the provisions of *i*Care's DHS and CMS Contracts, *i*Care, the State of Wisconsin, CMS, the Secretary of United States Department of Health and Human Services (DHHS), the DHHS Inspector General, and/or the Comptroller General of the United States, or any of their duly authorized representatives, have the right to audit, evaluate and inspect any books,

records, contracts, computer or other electronic systems, premises, physical facilities and equipment of Providers that pertain to any aspect of the services and activities performed, or determination of amounts payable. Providers must make such items available for audit, evaluation and inspection. The right to audit exists through ten (10) years from the final date of the DHS or CMS contract period or from the date of completion of any audit, whichever is later. If the State, CMS or the DHHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, they may inspect, evaluate and audit a Provider at any time.

K. MEMBER GRIEVANCES AND APPEALS

Please refer to detailed member Grievance and Appeal information, including required timeframes, which can be found on the *i*Care website, by member plan type.

An A***dverse Benefit Determination*** includes any of the following:

- The denial or limited authorization of a requested service that falls within the Family Care Partnership benefit package, including the type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit.
- The reduction, suspension, or termination of a previously authorized service, unless the service was only authorized for a limited amount of tim or duration and that amount or duration has been completed.
- The denial, in whole or in part, of payment for a service that falls within the Family Care Partnership benefit package.
- The failure to provide services and support items included in the member's member centered plan in a timely manner.
- The failure of *i*Care to act within the required timeframes for resolution of grievances or appeals.
- The development of a member-centered plan that is unacceptable to the member because any of the following apply:
    - The plan is contrary to a member's wishes insofar as it requires the member to live in a place that is unacceptable to the member.
    - The plan does not provide sufficient care, treatment or support to meet the member's needs and support the member's identified outcomes.
    - The plan requires the member to accept care, treatment or support items that are unnecessarily restrictive or unwanted by the member.
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities

An ***Appeal*** means a review by iCare of an adverse benefit determination. Members can request a Fair Hearing with the Wisconsin Division of Hearings and Appeals if they are dissatisfied with the outcome of an appeal to *i*Care.

A ***Grievance*** is an expression of dissatisfaction about any matter other than an adverse benefit determination.

An ***Authorized Representative*** is an individual appointed by the member, including a provider or estate representative, who may serve as an authorized representative with documented consent of the member. Authorized representatives may file an appeal or grievance on behalf of the member.

Members can receive assistance in filing a grievance or appeal from the *i*Care Member Rights Specialist. The *i*Care Member Rights Specialist can be reached at: (414) 231-1076.

Family Care Partnership members can also get free help from an independent ombudsman. The following agencies advocate for Family Care Partnership members:

For members age 18 to 59:

Disability Rights Wisconsin
Toll Free: 800-928-8778
TTY: 711

For members age 60 and older:

Wisconsin Board on Aging and Long Term Care
Toll Free: 800-815-0015
TTY: 711

VI. CLAIMS PROCESSING OVERVIEW

One of *i*Care's main goals is to facilitate the processing of provider claims in an efficient, accurate, and timely manner. This section includes guidelines to ensure a payment system that is beneficial to both *i*Care and its providers.

*i*Care claims are processed by the TriZetto Group, A Cognizant company, at its Dallas, Texas location. The TriZetto Group uses an automated claims processing system called QNXT.

All claims for LTC services should be submitted on **either** the *i*Care LTC Residential Services Claim Form or the *i*Care LTC Professional Services Claim Form. The documents, as fillable forms, are found at the *i*Care Website (http://www.icarehealthplan.org/Providers/ClaimsProcessing.aspx) Claim completion requirements can be found on page 2 of both forms.

A. PROVIDER PORTAL

https://www.icarehealthplan.org/Provider/Provider_Portal.htm
The *i*Care Provider Portal provider information about service authorizations and claims information for the *i*Care's members you serve. A PIN letter containing a unique PIN number for each provider is provided by *i*Care and is required to access the Provider Portal. Request a PIN number by emailing the completed Portal Access Request Form to netdev@icarehealthplan.org. The Portal Access Request Form is found at https://www.icarehealthplan.org/Provider/Provider_Portal.htm

A PIN letter containing your unique PIN number will be provided by *i*Care. If you have not received your PIN Letter, please contact *i*Care at netdev@icarehealthplan.org to obtain your unique PIN Number. Providers can create multiple user names utilizing the same PIN Number.

The *i*Care Portal User Guide provides step by step instructions for registration and outlines portal functions and is found at https://www.icarehealthplan.org/Provider/Provider_Portal.htm. If you have any questions, please contact ProviderOutreach@icarehealthplan.org.

B. CLAIM SUBMISSION

The *i*Care LTC claims forms are mailed to:

_i_Care Family Care Partnership Long Term Care Services
Independent Care Health Plan
PO Box 224255
Dallas, Texas 75222-4255

LTC Professional Services Claim can be submitted via the *i*Care Provider Portal. Please reference the Portal Guide, page 27. The *i*Care Portal User Guide is found at https://www.icarehealthplan.org/Provider/Provider_Portal.htm.

If you are providing services that fall under the scope of *i*Care's primary and acute care network submit the services for payment using the CMS 1500 or UB-04 claim forms. Please refer to the Provider Reference Manual and the *i*Care website for more information. http://www.icarehealthplan.org/Providers/ .

C. CORRECTED CLAIMS

Mark the claim as "Corrected Claim". Corrected claims will not be accepted via fax. For proper processing label claims submitted with corrected or additional information as a "Corrected Claim". The corrected claim address is:

Long Term Care Claims:
Independent Care Health
Plan PO Box 224255
Dallas, Texas 75222-4255

D. CLAIMS FILING LIMITS

The contracts between providers and *i*Care have specific claims filing limit information. All claims for LTC services rendered for *i*Care Family Care Partnership, must be submitted according to the terms of the contract. Timely filing limits of 120 days from the date of service apply to initial claims submissions, resubmissions and corrected claims, and unless specified in your agreement. Claims which contain multiple dates of service on one Claim will be treated as follows dependent upon the type of Claim/service being billed: i) for Home and Community-Based Waiver Services and facility inpatient services, the latest date of service represented on the Claim will be the date used to determine timely filing for the entire Claim; ii) for professional Claims and facility outpatient Claims, each date of service represented on the Claim (Claim line) will be assessed individually for timeliness.

E. CHECKING CLAIM STATUS

Claim status can be found at the *i*Care Provider Portal
https://ichcwsregion3.tzghosting.net/tzg/cws/registration/registrationLogin.jsp

Providers may also direct calls to Customer Service regarding status of a claim or email Provider Services at providerservices@icarehealthplan.org

F. EXPLANATION OF PAYMENT/REMITTANCE

Providers receive an Explanation of Payment (EOP) including each claim submitted to *i*Care. The Remittance Education Package explains the EOP and can be located at http://www.icarehealthplan.org/Providers/ClaimsProcessing.aspx

The EOPs can also be found in the Provider Portal. Please note there is a charge of $25.00 for duplicate copies of the EOPs. Direct questions to Customer Service.

G. BILLING MEMBERS

According to federal regulations, providers cannot hold a Medicaid member responsible for any commercial or Medicare cost-sharing amount such as coinsurance, copayment or deductible. Therefore, a provider may not collect payment from a Medicaid *i*Care member, or authorized person acting on behalf of the *i*Care member for cost-sharing payments required by other health insurance sources. The provider can collect only the

Medicaid copayment amount from the member.

Medicaid certified providers cannot charge a Medicaid member for services covered by Medicaid. Providers are responsible for checking ForwardHealth to review eligibility prior to providing services. Wisconsin law prohibits providers who are Medicaid certified from billing or collecting payment from a Medicaid eligible individual for services that are covered by Medicaid in lieu of properly billing the patient's Medicaid coverage for the service (Wis. Admin. Code. §DHS 106.04(3)). Providers can have their Medicaid certification terminated or suspended by the state for billing or collecting payment from a Medicaid covered individual in violation with Wis. Admin. Code § DHS 106.06 (21).

The Social Security Act, Section 1128B. (d)(1), [42 U.S.C. 1320a-7b], also provides that Medicaid certified providers may not bill Medicaid eligible members for medically necessary covered services. Any provider who knowingly and willfully bills a member for a Medicaid covered service may be guilty of a felony as defined in Section 1128B. (d)(1) [42 U.S.C.1320a-7b] of the Social Security Act.

H. REFUNDS

If at some point it is necessary for the provider to send a refund to *i*Care, please make the checks payable to *i*Care. Include the following information:

- A complete explanation of why the money is being refunded
- Member name
- Member identification number for the related claim
- Date of Service
- Service rendered
- Copy of the EOP containing the payment being refunded

I. CLAIM ERRORS, REVIEW/REOPENING AND RECONSIDERATION/APPEALS

Quality is a top priority and *i*Care strives to process submitted claims in a timely and accurate manner. Claims processing and submission errors do occur and *i*Care's goal is to accurately resolve the situation as quickly as possible.

Medicaid Covered Services

Appeal: formal request for review of an action (e.g., the denial, in whole or in part of payment for a service). For provider appeals, an application or proceeding for review when a provider does not agree with the claim reconsideration decision. For example: a claim is denied by *i*Care for untimely claim filing. The provider must appeal the denial action to *i*Care; an internal review by *i*Care is required.

Reconsideration of a Claim: a request to review a claim or a portion of a claim that a provider feels was incorrectly paid or denied because of processing errors.

Resubmission of a Claim: a claim or a portion of a claim that was denied and that is resubmitted through the claims process with changed or added information. Providers contracted within *i*Care's network, as well as non-contracted providers may request reconsideration from *i*Care if the payment or denial determination on a claim is questionable. Providers must submit the reconsideration request in writing within sixty (60) calendar days of the initial claim payment or denial notice. Independent Care has forty-five (45) calendar days from the date of receipt of the request to respond in writing to the provider.

If a provider does not agree with the results of the reconsideration, or if *i*Care fails to respond to the provider's request for reconsideration within forty-five (45) days, both contracted and non-contracted providers may file a formal appeal with *i*Care. Requests for an appeal must be submitted in writing within sixty (60) calendar days of the date the provider is notified of the initial claim payment or denial notice, the decision on the reconsideration, or the end of the forty-five (45) day period for a reconsideration response (if no response was received) as applicable. Independent Care has forty-five (45) calendar days from the date of receipt of the request for an appeal to respond in writing to the provider. Requests for a reconsideration or appeal must be sent to *i*Care as follows:

Reconsiderations:
Independent Care Health Plan
P.O. Box 660346
Dallas, TX 75266-0346

Appeals:
Independent Care Health Plan
Appeal Department
1555 N. RiverCenter Dr., Suite 206
Milwaukee, WI 53212

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:

Email: DHSLTCProviderAppeals@dhs.wisconsin.gov

Fax: (608) 266-5629

Or

Mail: Provider Appeals Investigator

Division of Medicaid Services
1 West Wilson Street, Room 518
P.O. Box 309
Madison, WI 53701-0309

Medicare Covered Services

A provider who is contracted within *i*Care's network may request a reopening from *i*Care if the provider disagrees with *i*Care's payment or denial determination on a claim. A provider must submit the reopening request in writing within sixty (60) calendar days of the initial Claim payment or denial notice. Independent Care has sixty (60) calendar days from the date of receipt of the request to respond in writing to provider. Requests for a reopening must be sent to *i*Care as follows:

Reopening's:
Independent Care Health Plan
P.O. Box 660346
Dallas, TX 75266-0346

Providers who are not contracted within *i*Care's network may request a reopening as set forth above. In addition, providers may file an appeal with *i*Care if the reopening process does not resolve their concerns. Non-contracted provider requests for an appeal must be submitted in writing within sixty (60) calendar days of the date the provider is notified of the initial claim payment or denial notice, the decision on the reopening, or the end of the sixty (60) day period for a reopening response (if no response was received) as applicable. Independent Care has sixty (60) calendar days from the date of receipt of the request for an appeal to respond in writing to the provider. Requests for an appeal must be sent to *i*Care as follows:

Appeals:
Independent Care Health Plan
Appeal Department
1555 N. RiverCenter Dr., Suite 206
Milwaukee, WI 53212

If a non-contracted 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 a CMS Qualified Independent Contractor (QIC). Providers are required to first exhaust all appeal rights with *i*Care before appealing to the QIC. All appeals to the QIC must be submitted in writing to the QIC within one hundred and eighty (180) calendar days of *i*Care's final decision or failure to respond to the provider, as follows:

Maximus Federal Services

Medicare Managed Care Reconsideration Project
3750 Monroe Avenue, Suite 702
Pittsford New York 14534-1302

Further information on all of the above processes, and the required forms can be found on the provider-claims processing tab of the *i*Care website: http://www.icarehealthplan.org.

Overpayments

In accordance with the requirements of 42 U.S.C. § 1320a-7k(d) and its implementing regulations, Providers must report any overpayments to *i*Care when identified, return any overpayments to *i*Care within sixty (60) days of the date that the overpayment was identified and notify *i*Care in writing of the reason for the overpayment (explanation of why the payment is being refunded).

VII. MEMBER RIGHTS

Independent Care recognizes each member as an individual and emphasize each member's capabilities. Independent Care staff and affiliated providers shall demonstrate dignity and respect in all of their interactions with members and take members' rights into account when furnishing services to members, including but not limited to:

1. Being treated with respect and with due consideration for his/her dignity and privacy.
2. Receiving information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
3. Participating in decisions regarding health and long-term care, including the right to refuse treatment and the right to request a second opinion.
4. Being free from any form of restraint or seclusion used as a means of coercion discipline, convenience, or retaliation.
5. Being able to request and receive a copy of his/her medical records, and to request that they be amended or corrected, as specified in 45 C.F.R. § 164.

Further Members have the right to all of the following:

1. Freedom from unlawful discrimination in applying for or receiving the benefit.
2. Accuracy and confidentiality of member information.
3. Prompt eligibility, entitlement and cost-sharing decisions and assistance.
4. Access to personal, program and service system information.
5. Choice to enroll in an MCO, if eligible, and to disenroll at any time.
6. Information about and access to all services of the Department, Resource Centers and MCOs to the extent that the member is eligible for such services.
7. Support in understanding member rights and responsibilities related to Family Care, Partnership or PACE.

8. Support from *i*Care in all of the following:
    a. Self-identifying outcomes and long-term care needs.
    b. Securing information regarding all services and supports potentially available to the member through the benefit.
    c. Actively participating in planning individualized services and making reasonable service and provider choices for supporting identified outcomes.
    d. Identifying, eliminating or monitoring and managing situations where a conflict of interest may exist due to a person or entity having an interest in, or the potential to benefit from, a particular decision, outcome or expenditure.
9. Services identified in the member's member-centered plan.
10. Support in the exercise of any rights and available grievance and appeal procedures beyond those specified elsewhere in this article.
11. Exercise rights, and to be assured that the exercise of those rights does not adversely affect the way *i*Care or its providers or any state agency treat the member.

Members have the right to file appeals or grievances and assure that such action will not adversely affect the way that the Provider treats the member. Provider agrees to cooperate and not interfere with the members' appeals, grievances and fair hearings procedures and investigations and timeframes.

VIII. PROVIDER RIGHTS AND RESPONSIBILITIES

A. PROVIDER RIGHTS

Provider may bill *i*Care for Family Care Partnership, Medicare, and Medicaid covered services.

Providers may bill a member for non-covered services only if the provider informs the member prior to performing the service that the member is responsible for payment because Medicare or Medicaid does not cover the service. Providers must obtain a written statement in advance verifying that the member has accepted liability for the specific service. The standard release form signed by the member at the time of the services is not sufficient. A written and signed acknowledgment from the member must specifically state the admissions, services or procedures that are not covered by Medicare or Medicaid and that the member is accepting liability for payment.

Providers acting within the lawful scope of practice may advise or advocate for patients. Independent Care may not prohibit, or otherwise restrict, a healthcare professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient, for the following:

- The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

- Any information the member needs in order to decide among all relevant treatment options.
- The risks, benefits, and consequences of treatment or non-treatment.
- The member's right to participate in decisions regarding his or her healthcare, including the right to refuse treatment, and to express preferences about future treatment decisions.

Providers may file an appeal or grievance on behalf of the member, provided the member's written consent. Independent Care informs providers and subcontractors, in writing at the time the contract is finalized, of the toll-free number for members to file oral grievances and appeals and their right to appeal a denied/reduced payment or payment recoupment after audit or Utilization Management review (42 CFR s. 438.414). The toll-free number is 800-777-4376. For additional information, please also reference the Wisconsin BadgerCare Plus or Medicaid SSI HMO Ombuds brochure at the *i*Care website: https://www.icarehealthplan.org/Provider.htmor http://www.medicare.gov/claims-and-appeals/medicare-rights/get-help/ombudsman.html and attached.

B. PROVIDER RESPONSIBILITIES

Providers are required to obtain member eligibility information. Possession of a ForwardHealth ID Card or Medicare Part A and/or Part B card does not guarantee eligibility. To determine enrollment for the current date (since a member's enrollment status may change) and to discover any limitations to the member's coverage, providers are expected to verify member eligibility at every visit. Enrollment verification provided by ForwardHealth allows the provider to verify member's enrollment in a ForwardHealth program(s), the MCO enrollment, Medicare or other commercial health insurance coverage and any exemption from copayment for BadgerCare members. Providers can access the Wisconsin Enrollment Verification System (EVS) through the ForwardHealth Portal, WiCall, and commercial enrollment verification vendors or by calling ForwardHealth Provider Services: 800-947-9627.

Provider must accept *i*Care reimbursement as payment in full except in cases where coordination of benefits applies. Providers are required to bill *i*Care for covered services provided to a member during periods of retroactive eligibility when notified that a member has obtained such eligibility.

State and federal law prohibits providers from charging a Medicaid member for services covered by Medicaid. Providers are responsible for checking ForwardHealth to review eligibility prior to providing services. Any provider who knowingly and willfully bills a member for a Medicaid covered service may also be guilty of a felony, as defined in Section 1128B. (d)(1) [42 U.S.C.1320a-7b] of the Social Security Act. *i*Care is required to report violations of this act.

Provider shall not bill an *i*Care member for medically necessary services covered by Family Care, Medicare, or Medicaid that are provided during the member's period of *i*Care enrollment.

Provider shall not bill an *i*Care member for co-payments and/or premiums for medically necessary services covered by Family Care, Medicare, or Medicaid and provided during the member's period of *i*Care enrollment.

Provider agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of services in the benefit package that are necessary to achieve outcomes.

Providers shall document in the member's medical records whether or not the member has executed an advance directive. Provider shall not discriminate in the provision of care or otherwise discriminate against a member based on whether or not the member has executed an advance directive. Provider shall ensure compliance with requirements of Wisconsin law (whether statutory or recognized by the courts of Wisconsin) respecting advance directives.

With respect to the services provided to *i*Care members, providers must observe and comply with all applicable federal and state laws, rules or regulations in effect at the time services are provided, including health data and information privacy and security requirements and any other standards and regulations as may be adopted or promulgated under Health Insurance Portability and Accountability Act of 1996 as amended (HIPAA) or state laws.

Providers are prohibited from discriminating against *i*Care members. Provider's hours of operation must not discriminate against *i*Care members. Provider agrees to comply with all non-discrimination requirements and all applicable affirmative action and civil rights compliance laws and regulations. Reference https://www.dhs.wisconsin.gov/civil-rights/index.htm.

Providers and subcontractors to providers are required to cooperate with any member-related investigation conducted by *i*Care, DHS, DHHS, CMS, law enforcement, or any other legally authorized investigative entity. This includes submitting information when requested that is related to the member incident.

All LTC services must be prior-authorized through the IDT. Prior to delivery of a service to an *i*Care FCP member, the provider must obtain a Service Authorization from the IDT staff at *i*Care outlining the specific services and rates of reimbursement.

All appeals and reconsiderations should be dated and submitted to *i*Care within sixty (60) days of receipt of the *i*Care Explanation of Payment.

Note: For Medicaid appeals the provider may seek a final determination from the Department of Health and Family Services (DHFS) if *i*Care has not responded in writing within 45 days from receipt of the receipt of the request for reconsideration. The provider will accept the DHFS determination regarding appeals of disputed claim (s).

Providers shall comply with Electronic Visit Verification (EVV) requirements established by DHS for supportive home care (Section IV. D.) and personal care services funded by Medicaid. Prior authorization and EVV requirements for personal care services are outlined in the *i*Care Provider Reference Manual, found on the *i*Care provider website: https://www.icarehealthplan.org/Providers/.

Provider may not require a member to receive a service via interactive telehealth or remotely if in person service is available.

C. PROVIDER MINIMUM INSURANCE COVERAGE REQUIREMENTS

Providers are required to have in effect and maintain, at a minimum, the insurance coverage as set forth in the chart below.

Provider Type	General Liability	Auto Liability	Worker's Compensation
Supportive Home Care	General Liability Per Occurrence $1,000,000 Aggregate $3,000,000	Combined Single Limit $1,000,000	Per Occurrence $100,000 Aggregate $500,000
AFH 1-2 Bed	General Liability Per Occurrence $1,000,000 Aggregate $2,000,000	Combined Single Limit $1,000,000	Per Occurrence $100,000 Aggregate $500,000
AFH 3-4 Bed	General Liability Per Occurrence $1,000,000 Aggregate $2,000,000	Combined Single Limit $1,000,000	Per Occurrence $100,000 Aggregate $500,000
CBRF >8 Bed	General Liability Per Occurrence $1,000,000 Aggregate $2,000,000	Combined Single Limit $1,000,000	Per Occurrence $100,000 Aggregate $500,000
CBRF <8 Bed	General Liability Per Occurrence $1,000,000 Aggregate $2,000,000	Combined Single Limit $1,000,000	Per Occurrence $100,000 Aggregate $500,000
Fiscal Agency	General Liability Per Occurrence $1,000,000 Aggregate $2,000,000	N/A	N/A
Day Program	General Liability Per Occurrence $1,000,000 Aggregate $2,000,000	Combined Single Limit $1,000,000	Per Occurrence $100,000 Aggregate $500,000
Employment Programs	General Liability Per Occurrence $1,000,000	Combined Single Limit $1,000,000	Per Occurrence $100,000

	Aggregate $2,000,000		Aggregate $500,000
Other providers including home and community-based service providers not otherwise noted above.	General Liability Per Occurrence $1,000,000 Aggregate $2,000,000	Combined Single Limit $1,000,000	Per Occurrence $100,000 Aggregate $500,000
Primary and acute care providers must meet Wisconsin Statutory requirements for professional liability coverage.			

Please contact your insurance agent to obtain a Certificate of Insurance with *i*Care Health Plan (1555 River Center Drive, Suite 206, Milwaukee, WI 53212) as the certificate holder.

Proof of Insurance
*i*Care requires all Network Providers to procure and maintain comprehensive policies of property and casualty insurance including general and professional liability insurance, and workers compensation, if the Provider is acting as an employer as defined in Wis. Stat. § 102.04. Provider will provide certificates of insurance within thirty (30) calendar days of a renewal of any property or casualty policy annually. Provider will list *i*Care Health Plan as a certificate holder on the Certificate of Insurance.

IX. PROHIBITED MARKETING/OUTREACH PRACTICES

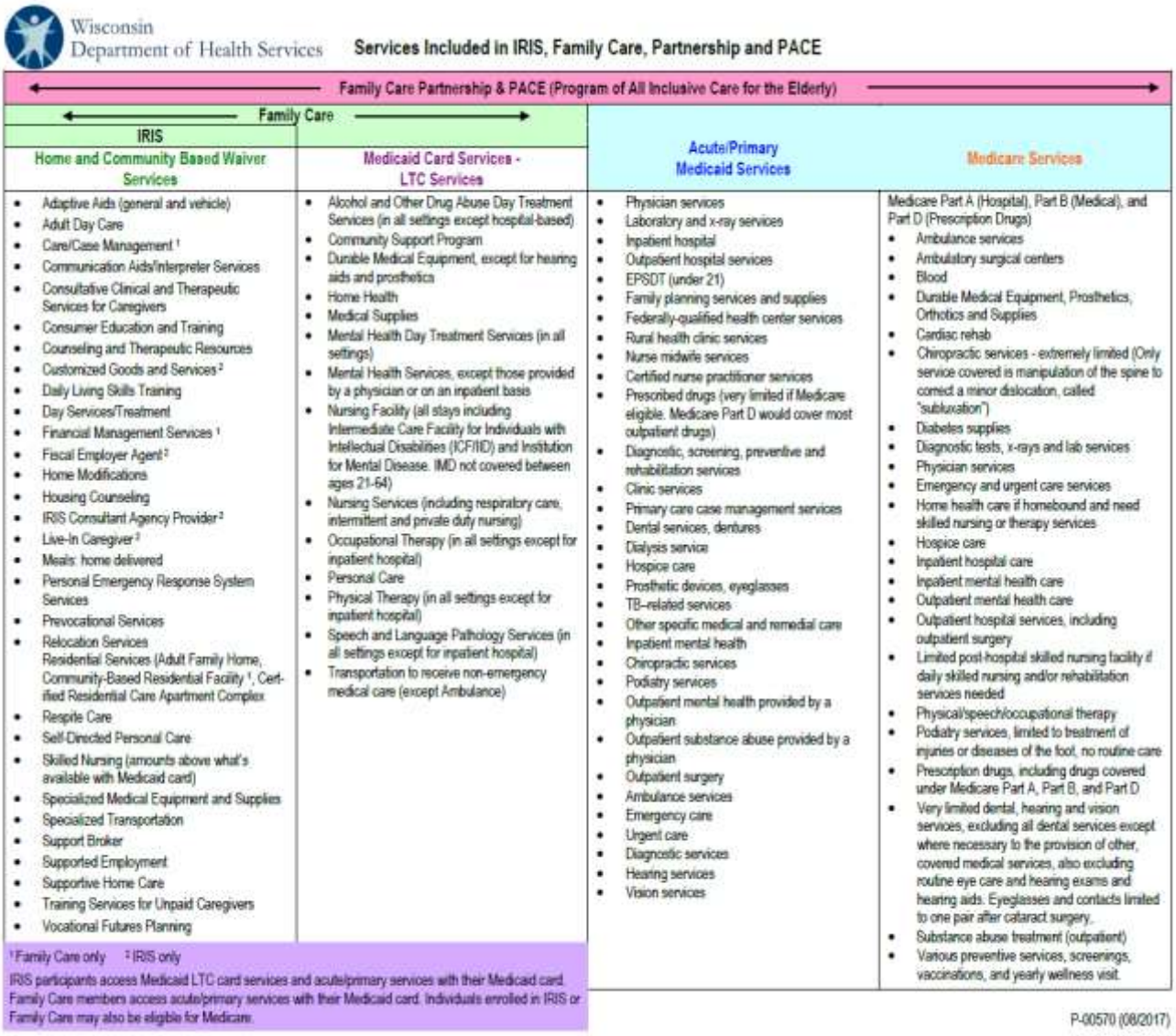
Provider agrees that *i*Care may, in its sole discretion and without Provider's approval, prepare, distribute materials and furnish information generally describing Providers or its Participating Providers and may furnish information on Provider's qualification. The following marketing/outreach practices are prohibited:

1. Practices that are discriminatory.
2. Practices that seek to influence enrollment in conjunction with the sale or offering of any other insurance product.
3. Direct and indirect cold calls, either door-to-door, email, telephone, text or other cold call marketing activity.
4. Offer of material or financial gain to potential members as an inducement to enroll.
5. Activities and materials that could mislead, confuse or defraud members or potential members or otherwise misrepresent *i*Care, its marketing representatives, DHS, or CMS. Statements that would be considered inaccurate, false, or misleading include, but are not limited to any assertion or statement (whether written or oral) that:
    a. The recipient must enroll in *i*Care in order to obtain benefits or in order to not lose benefits.
    b. *i*Care is endorsed by CMS, the federal or state government, or other similar entity.
6. Practices that are reasonably expected to have the effect of denying or discouraging enrollment.
7. Practices to influence the recipient to either not enroll in or to disenroll from another insurance plan.

EXHIBIT

Exhibit 1: Services Included in IRIS, Family Care, Partnership and PACE

EXHIBIT 1



Wisconsin Department of Health Services

Services Included in IRIS, Family Care, Partnership and PACE

Family Care Partnership & PACE (Program of All Inclusive Care for the Elderly)

Family Care

IRIS

Home and Community Based Waiver Services

- Adaptive Aids (general and vehicle)
- Adult Day Care
- Care/Case Management [1]
- Communication Aids/Interpreter Services
- Consultative Clinical and Therapeutic Services for Caregivers
- Consumer Education and Training
- Counseling and Therapeutic Resources
- Customized Goods and Services [2]
- Daily Living Skills Training
- Day Services/Treatment
- Financial Management Services [1]
- Fiscal Employer Agent [2]
- Home Modifications
- Housing Counseling
- IRIS Consultant Agency Provider [2]
- Live-In Caregiver [2]
- Meals: home delivered
- Personal Emergency Response System Services
- Prevocational Services
- Relocation Services
  Residential Services (Adult Family Home, Community-Based Residential Facility [1], Certified Residential Care Apartment Complex
- Respite Care
- Self-Directed Personal Care
- Skilled Nursing (amounts above what's available with Medicaid card)
- Specialized Medical Equipment and Supplies
- Specialized Transportation
- Support Broker
- Supported Employment
- Supportive Home Care
- Training Services for Unpaid Caregivers
- Vocational Futures Planning

Medicaid Card Services - LTC Services

- Alcohol and Other Drug Abuse Day Treatment Services (in all settings except hospital-based)
- Community Support Program
- Durable Medical Equipment, except for hearing aids and prosthetics
- Home Health
- Medical Supplies
- Mental Health Day Treatment Services (in all settings)
- Mental Health Services, except those provided by a physician or on an inpatient basis
- Nursing Facility (all stays including Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) and Institution for Mental Disease. IMD not covered between ages 21-64)
- Nursing Services (including respiratory care, intermittent and private duty nursing)
- Occupational Therapy (in all settings except for inpatient hospital)
- Personal Care
- Physical Therapy (in all settings except for inpatient hospital)
- Speech and Language Pathology Services (in all settings except for inpatient hospital)
- Transportation to receive non-emergency medical care (except Ambulance)

[1] Family Care only [2] IRIS only

IRIS participants access Medicaid LTC card services and acute/primary services with their Medicaid card. Family Care members access acute/primary services with their Medicaid card. Individuals enrolled in IRIS or Family Care may also be eligible for Medicare.

Acute/Primary Medicaid Services

- Physician services
- Laboratory and x-ray services
- Inpatient hospital
- Outpatient hospital services
- EPSDT (under 21)
- Family planning services and supplies
- Federally-qualified health center services
- Rural health clinic services
- Nurse midwife services
- Certified nurse practitioner services
- Prescribed drugs (very limited if Medicare eligible. Medicare Part D would cover most outpatient drugs)
- Diagnostic, screening, preventive and rehabilitation services
- Clinic services
- Primary care case management services
- Dental services, dentures
- Dialysis service
- Hospice care
- Prosthetic devices, eyeglasses
- TB-related services
- Other specific medical and remedial care
- Inpatient mental health
- Chiropractic services
- Podiatry services
- Outpatient mental health provided by a physician
- Outpatient substance abuse provided by a physician
- Outpatient surgery
- Ambulance services
- Emergency care
- Urgent care
- Diagnostic services
- Hearing services
- Vision services

Medicare Services

Medicare Part A (Hospital), Part B (Medical), and Part D (Prescription Drugs)

- Ambulance services
- Ambulatory surgical centers
- Blood
- Durable Medical Equipment, Prosthetics, Orthotics and Supplies
- Cardiac rehab
- Chiropractic services - extremely limited (Only service covered is manipulation of the spine to correct a minor dislocation, called "subluxation")
- Diabetes supplies
- Diagnostic tests, x-rays and lab services
- Physician services
- Emergency and urgent care services
- Home health care if homebound and need skilled nursing or therapy services
- Hospice care
- Inpatient hospital care
- Inpatient mental health care
- Outpatient mental health care
- Outpatient hospital services, including outpatient surgery
- Limited post-hospital skilled nursing facility if daily skilled nursing and/or rehabilitation services needed
- Physical/speech/occupational therapy
- Podiatry services, limited to treatment of injuries or diseases of the foot, no routine care
- Prescription drugs, including drugs covered under Medicare Part A, Part B, and Part D
- Very limited dental, hearing and vision services, excluding all dental services except where necessary to the provision of other, covered medical services, also excluding routine eye care and hearing exams and hearing aids. Eyeglasses and contacts limited to one pair after cataract surgery.
- Substance abuse treatment (outpatient)
- Various preventive services, screenings, vaccinations, and yearly wellness visit.

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