

Scope of Service

Financial Management Services

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

Family Care Partnership: Attachment to Description of Long-Term Care Provider Services and Payment
Family Care Only (If applicable): Appendix N to Subcontract Agreement

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

1.0	Definitions
1.1	Service Definition Financial management services assist members and their families in managing service dollars or their personal finances to prevent institutionalization. This service includes a person or agency paying service providers after the member or legal decision maker authorizes payment to be made for services included in the member's approved self-directed supports plan. This service includes facilitation of the employment of staff by the member or legal decision-maker by a financial management services provider or fiscal intermediary performing as the member's agent such employer responsibilities as processing payroll, withholding federal, state and local tax, and making tax payments to appropriate tax authorities; and performing fiscal accounting and making expenditures reports to the member or family and state authorities as indicated in the individual's self-directed supports plan and budget for services. Financial management services are purchased directly by the MCO and made available to the member to ensure that appropriate compensation is paid to providers. Additionally, this service includes the provision of assistance to members who are unable to manage their own personal funds. This service includes assistance to the member to effectively budget personal funds to ensure sufficient resources are available for housing, board, and other essential costs. This service includes paying bills authorized by the member or the member's legal decision maker and keeping an account of disbursements. Excludes payments to court-appointed guardians or court-appointed protective payees if the court has directed them to perform any of these functions. Excludes payment for the cost of room and board.
2.0	Service Description/ Requirements
2.1	A financial management services provider must meet the following requirements: • Is an agency, unit of an agency or individual that is bonded and qualified to provide financial services related to the scope of the services being provided, which may include self-directed supports; • Has training and experience in accounting or bookkeeping; and • Has a system in place that recognizes the authorization of payment by the participant or legal decision maker, that promptly issues payment as authorized and that documents budget authority and summarizes payments in a manner that can be readily understood by the participant or legal decision maker.

2.2	Provider will work with Enrollee to determine current needs for day-to-day living (food, clothing, and housing) and use that information to develop and monitor a monthly budget.		
2.3	Provider will ensure that bills are paid promptly, and that Enrollee receives “personal needs” funds in a timely manner.		
2.4	Provider must meet all responsibilities and duties as outlined by the Social Security Administration in GN 00502.114 Representative Payee Responsibilities and Duties <u>SSA - POMS: GN 00502.114 - Representative Payee Responsibilities and Duties - 05/23/2023</u>		
3.0	Unit of Service		
3.1	Representative Payee: This service shall be billed at a set monthly rate per member. The rate shall not exceed Social Security Guidelines.		
3.2	Provider must bill using appropriate procedure codes and modifiers.		
	Service Code	Modifier	Service Description
	T2025		Financial Management, Rep Payee
			Unit of Service
			Each; per month
3.3	The Organizational Representative Payee cannot collect a fee for this service from the MCO if they are receiving compensation for the service from another source such as the court, guardianship fees, the Social Security Administration, or if they did not perform any payee services in the month.		
3.4	Remote Waiver Services and Interactive Telehealth Provider must include modifier 95 when submitting claims for services that are delivered remotely or through telehealth.		
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	Provider must meet with Enrollee within seven (7) business days from the date of referral and as needed on an on-going basis to discuss Enrollee financial matters.		
4.3	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.		
4.4	The Provider must retain copies of the authorization notification.		
4.5	The IDT shall issue a new authorization notification to Provider when the tasks assigned, amount, frequency, or duration of the service changes.		

4.6	The Provider must retain the following documentation and make available for review by iCare upon request: • Proof that Provider meets the required standards for applicable staff qualification, training, and programming. • Policy and procedure for verification of criminal, caregiver and licensing background checks as required. • Evidence of completed criminal, caregiver and licensing background checks as required. • Policy and procedure related to supervision methods by the provider agency including frequency, intensity, and any changes in supervision. • Policy and procedure for responding to complaints, inappropriate practices or matters qualifying as Enrollee-related incidents. The policy and procedure should also cover expectation of work rules, work ethics and reporting variances to the program supervisor. • Employee time sheets/visit records which support billing to MCO. • The Provider shall maintain written records (retain a written receipt) for each instance that cash is provided to the Enrollee. The receipt shall include the date, dollar amount and the signature of both the representative payee and the Enrollee. • The Provider shall maintain written records of all payments and correspondence received from payer sources, including Social Security, SSI, Railroad Retirement, etc. • The Provider shall maintain records of all bank statements, cancelled checks, receipts for rent, utilities and major purchases made for the Enrollee.
4.7	Information regarding authorization and claims processes are available at: Family Care: Providers/Claims and Billing at www.inclusa.org Family Care Partnership: Provider/Claims section and Provider/Prior Authorization section at www.icarehealthplan.org
5.0	Staff Qualifications and Training
5.1	Caregiver Background Checks – Caregiver and Criminal Background checks must be completed in compliance with Wisconsin DHS Admin. Code Chapter 12 and 13. Provider must maintain and make available for review documentation that caregiver and criminal background checks have been completed timely for all staff. This requirement is only applicable for staff that will have in-person direct contact with members.
5.2	The agency must ensure that the direct service staff is qualified by having education and/or experience in financial services, including training and experience in accounting and bookkeeping. Provider staff that handle Enrollee funds must be bonded and insured for an amount sufficient to protect both the Enrollee and the MCO.
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 7.6).
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 shall have policies and procedures in place to protect the Enrollee and MCO from misuse or misappropriation of funds by Provider staff or employees. Provider shall make these policies and procedures available to MCO upon request.
6.3	Provider must ensure: • Staff are supervised and assessed to assure they are working effectively and collaboratively with Enrollees by conducting adequate on-site supervision and review. • Performance issues with staff are addressed promptly and IDT is kept informed about significant issues that affect the Enrollee. • Supervisory staff are involved in assessment, goal planning and tracking, and supervision for Enrollees. • Provider staff are working collaboratively and communicating effectively with MCO staff
7.0	Communication and Reporting Requirements
7.1	It is the responsibility of the Provider to ensure the MCO has the most accurate and updated contact information to facilitate accurate and timely communication.
7.2	Provider must provide a toll-free telephone number of other accessible communication method for Enrollee to contact the Organizational Representative Payee organization directly without cost to the member. Provider must be willing to meet face to face with Enrollee as needed.
7.3	Provider will report changes or events to the Social Security Administration as documented in A Guide for Representative Payees A Guide for Representative Payees (ssa.gov)

7.4	Provider will promptly report to Enrollee's care manager regarding any changes or events that could affect Enrollee's eligibility for benefits including situations where Enrollee balance will exceed \$2,000.
7.5	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)
7.6	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.
7.7	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.
7.8	The IDT must be notified in a timely manner if the Provider, through its experience in providing services to the Enrollee, believes that the Enrollee's needs have changed, and a modification of the service level is indicated. iCare will not pay for services that have not been authorized.
7.9	Provider must maintain accurate records regarding the inflow and outflow of all funds. Records should include copies of monthly statements, processed bills, and cancelled checks (if available).
7.10	Member Incidents Provider must communicate and report all incidents involving an iCare Enrollee to the IDT– the Care Coach or the Field Care Manager Nurse within 24 hours via phone, fax, or email. If the reporter is unable to reach someone from the care team, they may leave a message reporting details of an incident that has been resolved and did not result in serious harm or injury to the Enrollee. If the incident is not yet resolved or resulted in serious harm or injury to the Enrollee, the provider must attempt to contact the IDT via phone. Family Care: If unable to contact IDT, call 1-877-622-6700 and ask to speak to a Care Management Support Manager to immediately make a report. If a manager is unavailable, the provider will speak with the receptionist to be redirected or leave a message. Family Care Partnership: If unable to contact IDT, call 1-800-777-4376 and ask to speak to a Care Management Support Manager to immediately make a report. If a manager is unavailable, the provider will speak with the receptionist and ask to be redirected or leave a message. All reported incidents will be entered into the MCO Incident Management System and reported to DHS in accordance with MCO contract requirements. Providers may be asked to provide any additional information or details necessary to complete the investigation of reported incidents. The provider will inform the MCO when notifying their regulatory authority of incidents. Incident reporting resources and training are available at: Family Care: Providers section of the Includa website at www.includa.org Family Care Partnership: For Providers/Education/Resources section of the iCare website at www.iCarehealthplan.org

7.11	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	iCare 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. iCare will monitor compliance with these standards to ensure the services purchased are of the highest quality.
8.2	Quality Performance Indicators • Legal/Regulatory Compliance- evidenced by regulatory review with no deficiencies, type of deficiency and/or effective and timely response to Statement of Deficiency • Education/Training of staff- Effective training of staff Enrollees in all aspects of their job, including handling emergency situations. Established procedures for appraising staff performance and for effectively modifying poor performance where it exists. • Performance record of contracted activities- ○ tracking of number, frequency, and outcomes of Member Incident Reports related to provider performance ○ tracking of successful service provision (Enrollee achieving goals/outcomes, increased Enrollee independence and community participation, etc.) • Contract Compliance- formal or informal review and identification of compliance with MCO contract terms, provider service expectation terms, applicable policies/procedures for contracted providers • Availability and Responsiveness- related to referrals or updates to services, reporting and communication activities with MCO staff.
8.3	Expectations of Providers and MCO for Quality Assurance Activities • Collaboration: working in a goal oriented, professional, and team-based approach with MCO representatives to identify core issues to quality concerns, strategies to improve, and implementing those strategies • Responsiveness: actions taken upon request and in a timely manner to resolve and improve identified issues. This may include submitted documents to MCO, responding to calls, emails, or other inquiries, keeping MCO designated staff informed of progress, barriers, and milestones achieved during quality improvement activities • Systems perspective to improvement: approaching a quality concern, trend, or significant incident with the purpose of creating overall improvements that will not only resolve the issue at hand, but improve service and operations as a whole • Enrollee-centered solutions to issues: relentlessly striving to implement solutions with the focus on keeping services Enrollee-centered and achieving the goals and outcomes identified for persons served iCare 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.