Scope of Service

# Adult Day Care

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

Family Care Partnership: Attachment to 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 |
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| 1.1 | **Adult Day Care** services are the provision of services for part of a day in a non-residential group setting to adults who need an enriched social or health-supportive experience or who need assistance with activities of daily living, supervision, and/or protection.<br>Services may include personal care and supervision, light meals, medical care, and transportation to and from the adult day care center site.<br><br>Services must be provided in a non-institutional community-based setting and the MCO staff must specify the number of hours of service in the member's member-centered plan.<br><br>**Transportation** between the member's place of residence and the adult day care center may be provided as a component of adult day care services. The cost of this transportation is included in the rate paid to providers of adult day care services.<br><br>**Meals** provided as part of adult day care may not constitute a "full nutritional regimen" (3 meals per day).<br><br>Adult Day Care Centers must be certified under Wis. Admin. Code DHS 105.14 and HCBS compliant per 42 CFR 441.301(c)(4). |
| **2.0** | **Service Description/Requirements** |
| 2.1 | **Adult Day Care** services are services that may include but are not limited to:<br>• Supervision and safety monitoring<br>• Meals<br>• Personal care assistance (including bathing or showering)<br>• Medication administration and assistance<br>• Socialization<br>• Range of motion exercises<br>• General exercise<br>• Accessing and using community resources<br>• Recreation and leisure activities<br>• Use of adaptive aids/assistive devices |

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| 2.2 | **Assisted Bathing or Showering Services**, if provided, must be in a safe and appropriately equipped facility located in the Adult Day Care center. |
| 2.3 | **Leisure Time and Community Activities,** Adult Day Care provider will make available age-appropriate activities that are consistent with the outcomes, needs, desires, and abilities of the member. The cost of this transportation is included in the rate paid to providers of adult day care services. |
| 2.4 | **Transportation** between the member's place of residence and the adult day care center **may** be provided as a component of adult day care services. |
| 2.5 | Adequate space shall be provided for dining, group and individual activities, rest, and privacy. |
| 2.6 | **Nutrition:**<br>• The Adult Day Center shall arrange for or provide a meal to each participant who is at the Adult Day Center for 5 or more hours. Meals shall provide at least one-third of an adult's daily nutritional requirements.<br>• The Adult Day Center shall document the food served at each meal and maintain the documentation on file for at least 6 months.<br>• A nutritious snack shall be made available consistent with each participant's dietary needs. |
| 2.7 | All settings and locations must meet all Home and Community-Based Services (HCBS) rules and be determined compliant prior to being eligible to provide services under the Family Care waiver program.<br>• Compliance is needed for facility and community-based settings unless the community-based setting is 100% in the community. Community based means the participants are never at an actual setting OR that they only meet at the setting in the AM, then proceed to other places in the community for the rest of the day. They may or may not return to the setting to get picked up to go home, but the setting itself cannot provide services and support to any client.<br>• Additionally, compliance is specific to the approved location, any planned move to another location (address) needs to be prior approved by DHS and determined HCBS compliant. To ensure we are able to fund members receiving services through the new location, a copy of the letter of determination will need to be shared and the contract updated.<br><br>All nonresidential settings must meet conditions that ensure specific rights of people receiving HCBS in those settings, including the following qualifications:<br>• Is integrated in, and supports full access to, the greater community.<br>• Provides opportunities to seek employment, work in competitive integrated settings, engage in community life, and control personal resources.<br>• Ensures that individuals receive services in, and access to, the greater community to the same degree of access as individuals not receiving HCBS. |

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<li>Is selected by the individual from among multiple setting options, including non-disability specific settings.</li>
<li>Ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint.</li>
<li>Optimizes individual initiative, autonomy, and independence in making life choices, including but not limited to, daily activities, physical environment, and with whom to interact.</li>
<li>Facilitates individual choice regarding services and supports, and who provides them.</li>
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Exceptions or modifications to an HCBS Settings Rule requirement may be necessary to mitigate risks to a member's health and safety. Exceptions to these requirements can be allowed through the Person-Centered Planning process and must be included as part of the MCP and the provider Individual Service Plan (ISP). CMS refers to these as Modification of Rights (MOR) Plan. Consideration and planning for a modification of rights must include the member, Legal Decision Maker (LDM) when indicated, IDT, and the provider.
For more specific information regarding HCBS requirements use this link: HCBS Settings Rule: Compliance for Nonresidential Services Providers | Wisconsin Department of Health Services
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<tr><td>3.0</td><td>Unit of Service</td></tr>
<tr><td>3.1</td><td>One day of attendance is defined as four or more hours. The rate must include prorated costs of assessment for service, case planning, absenteeism factor and all other fees. Services provided for less than 4 hours per day where the payment amount totals greater than the rate for Service Code S5101 will be reimbursed at Service Code S5101. Services provided for more than 4 hours per day will be reimbursed at Service Code S5102</td></tr>
<tr><td>3.2</td><td>Provider must bill using appropriate procedure codes and modifiers.
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<tr><th>Service Code</th><th>Modifier</th><th>Service Description</th><th>Unit of Service</th></tr>
<tr><td>S5100</td><td>N/A</td><td>Adult Day Care</td><td>Per 15 minutes</td></tr>
<tr><td>S5101</td><td>N/A</td><td>Adult Day Care</td><td>Per half day (less than 4 hours)</td></tr>
<tr><td>S5102</td><td>N/A</td><td>Adult Day Care</td><td>Per day (4 hours or more)</td></tr>
<tr><td>S5105</td><td>N/A</td><td>Services not included in program fee, i.e., Bath or Shower</td><td>Each</td></tr>
<tr><td>T2003</td><td>N/A</td><td>Transportation</td><td>Per trip</td></tr>
<tr><td>T2004</td><td>N/A</td><td>Transportation</td><td>Per trip</td></tr>
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<tr><td>3.3</td><td>Minimum Referral Units<br>There is no minimum for referral units; however, Providers may decline referrals at their own discretion if they are unable to cover the timeframe based on current staffing.<br><br>Referrals will only be made based on member need. The IDT will not increase units to meet a Provider's desired number of referral units.</td></tr>
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| 4.0 | Documentation of Service |
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| 4.1 | Provider must respond to the IDT within two (2) business days to accept or decline a referral. Provider must work with IDT to ensure services begin on the planned date and time. If the planned start date is delayed, Provider shall immediately notify the IDT to ensure the needs of the Enrollee are met. |
| 4.2 | IDT must prior authorize all services prior to being rendered by Provider. Notification of authorization to Provider shall include expected start date, duration of authorization, units authorized and any expected outcomes, if applicable. |
| 4.3 | The Provider must retain copies of the authorization notification. |
| 4.4 | The IDT shall issue a new authorization notification to Provider when the tasks assigned, amount, frequency, or duration of the service changes. |
| 4.5 | The Provider must retain the following documentation and make available for review by *i*Care upon request:<br>• Proof that Provider meets the required standards for applicable staff qualification, training, and programming.<br>• Policy and procedure for verification of criminal and caregiver background checks, and certification/licensing as required.<br>• Evidence of completed criminal and caregiver background checks and certification/licensing as required.<br>• Policy and procedure related to supervision methods by the provider agency including frequency, intensity, and any changes in supervision.<br>• 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.<br>• Employee time sheets/visit records which support billing to MCO. |
| 4.6 | Information regarding authorization and claims processes are available at:<br>**Family Care:** Providers/Claims and Billing at www.inclusa.org<br>**Family Care Partnership:** Provider/Claims section and Provider/Prior Authorization section at www.icarehealthplan.org |
| **5.0** | **Staff Qualifications and Training** |
| 5.1 | **Caregiver Background Checks –** Caregiver and Criminal Background checks must be completed in compliance with Wisconsin DHS Admin. Code Chapter 12 and 13. Provider must maintain and make available for review documentation that caregiver and criminal background checks have been completed timely for all staff. |
| 5.2 | Provider must comply with all training requirements as outlined in their licensing/certification standards. If training standards are not specified, Provider must ensure that staff are fully trained to complete the assigned tasks. |
| 5.3 | It is desirable that a licensed practical nurse (LPN) or a registered nurse (RN) be available to monitor the health conditions of day care Enrollee. |
| 5.4 | Services provided by anyone under the age of 18 shall comply with Child Labor Laws. |

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| 5.5 | The provider agency must ensure that staff have received training as outlined in the Adult Day Care Certification Standards. |
| 5.6 | Provider must orient and train their staff on the Family Care and Family Care Partnership Programs. Support materials can be found at:<br>**Family Care:** www.inclusa.org<br>**Family Care Partnership:** www.icarehealthplan.org |
| 5.7 | The Provider must ensure that staff have received training on the following subjects pertaining to the individuals served:<br>• Policy, procedures, and expectations may include the following:<br>  ○ Enrollee rights and responsibilities<br>  ○ Provider rights and responsibilities<br>  ○ Record keeping and reporting<br>  ○ Arranging backup services if the caregiver is unable to make a scheduled visit<br>  ○ Other information deemed necessary and appropriate<br>• 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.<br>• 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.<br>• Recognizing abuse and neglect and reporting requirements<br>• Interpersonal and communication skills and appropriate attitudes for working effectively with Enrollees and with IDT.<br>• Confidentiality laws and rules<br>• Practices that honor diverse cultural and ethnic differences<br>• Procedures for following Family Care and Family Care Partnership required processes for handling complaints and grievances (see Section 7.3). |
| **6.0** | **Supervision and Staff Adequacy** |
| 6.1 | Adult Day Care provider shall maintain and provide adequate staffing to meet the needs of Enrollees referred by MCO and accepted by Adult Day Center provider. |
| 6.2 | Supervision of planned activities should be provided by a degreed recreational therapist, occupational therapist, certified occupational therapy assistant, or an individual experienced in working with specialized populations. |
| 6.3 | Provider must ensure:<br>• Staff are supervised and assessed to assure they are working effectively and collaboratively with Enrollees by conducting adequate on-site supervision and review.<br>• Performance issues with staff are addressed promptly and IDT is kept informed about significant issues that affect the Enrollee.<br>• Supervisory staff are involved in assessment, goal planning and tracking, and supervision for Enrollees.<br>• 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. |

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| 7.2 | The Provider shall report to the IDT whenever:<br>• There is a change in service provider<br>• There is a change in the Enrollee's needs or abilities<br>• The Enrollee or provider is not available for scheduled services (within 24 hours unless an alternate date is scheduled between provider and Enrollee) |
| 7.3 | Provider shall notify IDT of formal complaints or grievances received from Enrollees within 48 hours of receipt. Written notification of completed complaint investigations must be submitted to the IDT. |
| 7.4 | Provider must notify the Enrollee and IDT when the contracted service is unable to be rendered such as closing for inclement weather or widespread illness outbreak. |
| 7.5 | The IDT must be notified in a timely manner if the Provider, through its experience in providing services to the Enrollee, believes that the Enrollee's needs have changed, and a modification of the service level is indicated. ***i*Care will not pay for services that have not been authorized.** |
| 7.6 | Provider shall follow up with the Enrollee or IDT to determine the reason for an unplanned Enrollee absence. |
| 7.7 | **Member Incidents:** Provider must communicate and report all incidents involving an *i*Care Enrollee to the IDT– the Care Coach or the Field Care Manager Nurse within **24 hours** via phone, fax, or email.<br><br>If the reporter is unable to reach someone from the care team, they may leave a message reporting detail of an incident that has been resolved and did not result in serious harm or injury to the Enrollee.<br><br>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.<br><br>**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**.**<br><br>**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.<br><br>All reported incidents will be entered into the MCO Incident Management System and reported to DHS in accordance with MCO contract requirements. Providers may be asked to provide any additional information or details necessary to complete the investigation of reported incidents. The provider will inform the MCO when notifying their regulatory authority of incidents. A copy of the report may be submitted as a form of notification.<br><br>Incident reporting resources and training are available at:<br>• **Family Care**: Providers section of the Inclusa website at www.inclusa.org<br>• **Family Care Partnership**: For Providers/Education/Resources section of the *i*Care website at www.iCarehealthplan.org |

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| 7.8 | The Provider agency shall give at least 30 days' advance notice to the IDT when it is unable to provide authorized services to an individual Enrollee. The Provider agency shall be responsible to provide authorized services during this time period.<br><br>The IDT or designated staff person will notify the provider agency when services are to be discontinued. The IDT will make every effort to notify the provider at least 30 days in advance. |
| **8.0** | **Quality Program** |
| 8.1 | *i*Care quality assurance activities are a systematic, measured approach to ensuring and recognizing a specified standard or level of care expected of subcontracted providers. These methodologies are established to review and inspect subcontracted provider performance and compliance.<br>It is the responsibility of providers and provider agencies to maintain the regulatory and contractual standards as outlined in this section. *i*Care will monitor compliance with these standards to ensure the services purchased are of the highest quality. |
| 8.2 | **Quality Performance Indicators**<br>• Legal/Regulatory Compliance- evidenced by regulatory review with no deficiencies, type of deficiency and/or effective and timely response to Statement of Deficiency<br>• Education/Training of staff- Effective training of staff 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.<br>• Performance record of contracted activities-<br>  ○ tracking of number, frequency, and outcomes of Member Incident Reports related to provider performance<br>  ○ tracking of successful service provision (Enrollee achieving goals/outcomes, increased Enrollee independence and community participation, etc.)<br>• Contract Compliance- formal or informal review and identification of compliance with MCO contract terms, provider service expectation terms, applicable policies/procedures for contracted providers<br>• 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**<br>• **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<br>• **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<br>• **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<br>• **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<br><br>*i*Care is committed to interfacing with providers to collaboratively and proactively discuss issues identified with processes and assist with implementing improvements and reviewing the impact of the changes as a partner in the mission to serve Enrollees. |