Provider Handbook

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SECTION 1: INTRODUCTION

Purpose of Provider Handbook

Community Care, Inc.'s (Community Care) Provider Handbook serves as a reference tool for information pertaining to the programs and services offered by Community Care including, but not limited to: Model of Care, Contact information, Member information/benefits, Quality Improvement, Member rights/responsibilities, Provider billing responsibilities, and policies, procedures, regulations and guidelines established by the Centers for Medicare and Medicaid Services (CMS), the Wisconsin Department of Health Services (DHS) and Community Care, Inc. which govern our Provider Network.

Providers should use this Handbook in conjunction with their contract with Community Care. The contract and this handbook reference other requirements for which both the provider and Community Care are responsible. Websites to be referenced include:

- Community Care, Inc. www.communitycareinc.org
- Centers for Medicare and Medicaid Services www.cms.gov
- Wisconsin Department of Health Services www.dhs.wisconsin.gov

Updates and Revisions to Handbook

You can always find the most current version on our web site, www.communitycareinc.org.

SECTION 2: OVERVIEW

What is Community Care, Inc.
Community Care is a private, non-profit organization which integrates health, home and community services to meet the wider range of help seniors and adults with disabilities need. Since 1977, Community Care, Inc. has provided services allowing people to continue living in their own homes and communities.

Community Care, Inc. Mission
Our mission is to develop and demonstrate innovative, flexible, community-based approaches to care for at-risk adults, in order to optimize their quality of life and optimize the allocation of community resources. We believe providing quality care can enable our members to live in their own communities with greater independence.

Community Care, Inc. Core Values
The core values serve as the foundation to guide both the development of the organization's mission and the identification of appropriate behavior and activities in the fulfillment of the mission.

Respect - We treat our members and staff as individuals with compassion, sensitivity, dignity and equality.

Member Centered - Our interdisciplinary teams place the interests of our members at the forefront of our decision-making.

Diversity - We embrace diversity in our members, staff and business interactions operating culturally competent programs.

Quality of Life - We support our members in remaining functionally independent for as long as possible by meeting their health and social needs.

Quality of Care - We respond to the needs of our members while promoting excellent health, wellness and safety striving for a high level of member satisfaction.

Innovation & Creativity - We expand existing programs, develop new ones and provide technical assistance service to encourage replication of successful approaches to long- term care.

Community Focused - We support individuals living as active members of their communities outside of institutions even through the end of life.

Cost Effective - We are prudent stewards fiscally accountable with public funds.

Teamwork & Collaboration - Our staff is entrusted to work together in the best way possible to meet the needs of those we serve.

Integrity - We believe in being open, honest and fair in our interactions with our members, their families, other agencies, contractors, volunteers and our employees. We strive for an atmosphere of mutual trust and respect in our work.

SECTION 3: PROGRAMS AND ELIGIBLITY

Community Care Programs
The hallmark of Community Care's approach to care is to use interdisciplinary teams to deliver care to adults with disabilities and seniors in their homes and communities. A single team sees members through assessments and care delivery and coordination, and the result is members enjoying comprehensive, continuous care addressing their changing needs.

Community Care, Inc. offers this approach to care through three programs:

PACE (Program of All-inclusive Care for the Elderly)
PACE, or Program of All-Inclusive Care for the Elderly, demonstrates an innovative and proven way to provide members with high quality care and positive outcomes. The PACE program through Community Care offers long-term care services, health and medical care services (primary and acute care), and prescription medications to eligible individuals. PACE coordinates all services through an Interdisciplinary Team and often administers those services through an adult day health center. In the PACE program, members see a Community Care staff doctor or a PACE community-based physician.

- Be at least 55 years old
- Live in Milwaukee, Waukesha, Racine or Kenosha County
- Be eligible for Medicaid and/or Medicare or choose to Private Pay

FAMILY CARE PARTNERSHIP
The Family Care Partnership program features the same components as the PACE model, except it allows members to keep their current doctor, if he or she is in our network of contracted physicians, while receiving the benefits of this special program. Individuals enrolling in the Family Care Partnership Program receive all-inclusive health care while continuing to live in the community. Each member is assigned to an Interdisciplinary Team, a group of professionals including a Partnership doctor, a nurse practitioner, a registered nurse and a social worker.

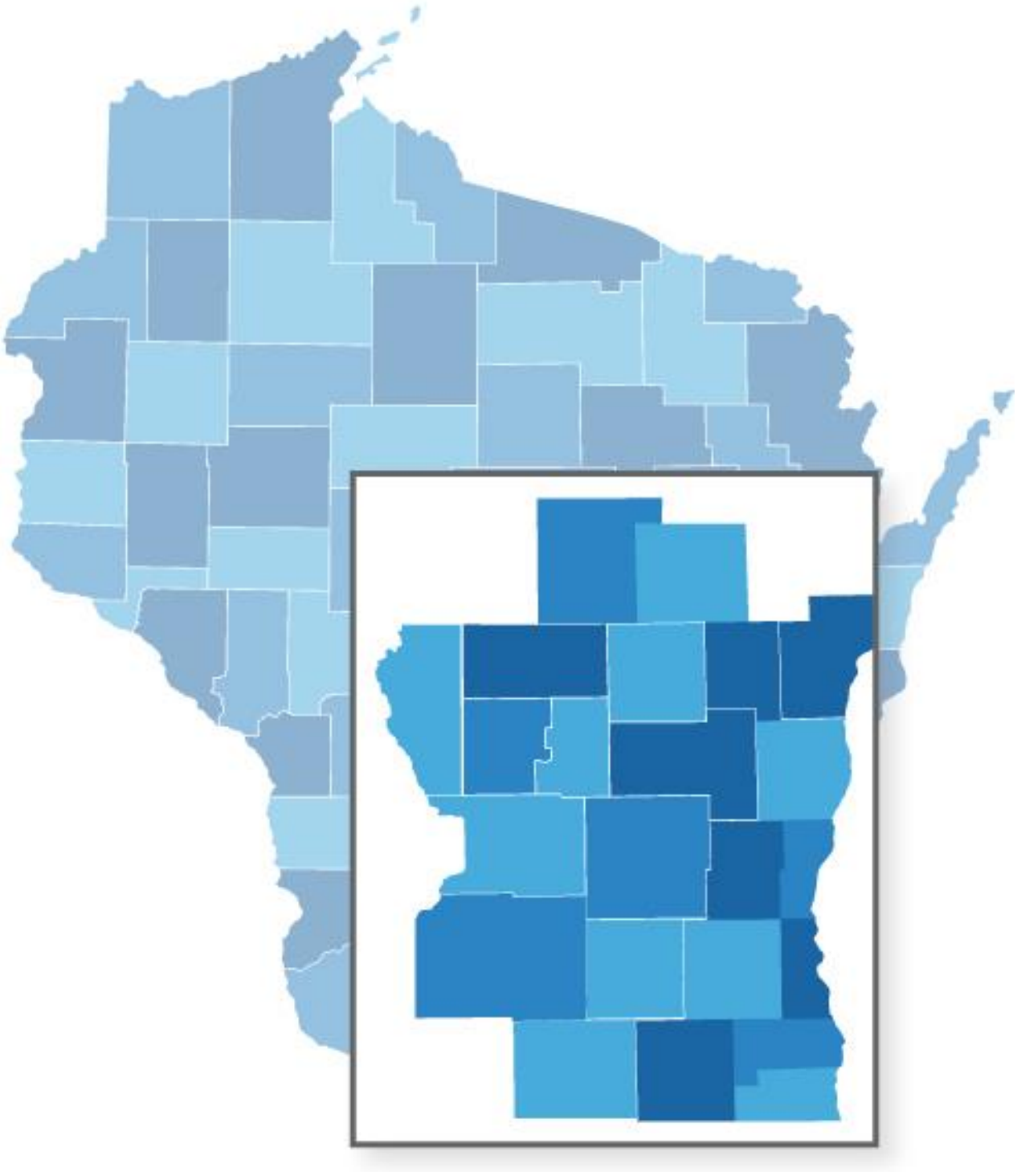
- Be at least 18 years old
- Live in Calumet, Kenosha, Outagamie, Ozaukee, Racine, Washington, Waupaca, or Waukesha County
- Be eligible for Medicaid

FAMILY CARE
The Family Care program members receive services where they live. Each of our Family Care members has support from an IDT made up of a nurse and a care manager. The members themselves remain responsible for their own medical services, including choosing their own physicians, while Family Care coordinates, manages, and funds the long-term care services.

- Be at least 18 years old
- Live in Adams, Columbia, Calumet, Dane, Dodge, Fond du Lac, Kenosha, Green Lake, Jefferson, Manitowoc, Marquette, Milwaukee, Outagamie, Ozaukee, Racine, Sheboygan, Walworth, Washington, Waukesha, Waushara, Waupaca or Winnebago County.
- Be eligible for Medicaid

Enrollment into Community Care, Inc.'s PACE, Family Care Partnership or Family Care programs is conducted through the county's Aging and Disability Resource Center.

Where is Community Care, Inc.?



Community Care offers Family Care, Family Care Partnership and PACE services in Wisconsin.
For county specific programs please visit our website and select the county you are interested in at:
https://www.communitycareinc.org/contact/locations

SECTION 4: CONTACT INFORMATION AND LOCATIONS

Provider Hotline
The Provider Hotline is staffed Monday through Friday, 8:00 AM to 4:30 PM (Central Time), and can be reached at 1-866-937-2783. We offer the ability to contact our Claims Department under Option number 1 or our Provider Management Department under option number 2. At other times, you can leave a detailed message and your call will be returned within two (2) business days.

Member Authorizations
If you need a service authorization or have a member-related question or concern, your first contact should always be the member's care team. Please see below for telephone numbers of regional PACE, Family Care and Family Care Partnership offices. Regular business hours are Monday through Friday, 8:00 AM to 4:30 PM. After business hours, you can reach the on-call care team on evenings, weekends and holidays by calling 1-866-992-6600.

Claim Submissions
For any questions or concerns regarding Claim Submission, please contact the Provider Hotline Monday through Friday, 8:00 AM to 4:30 PM (Central Time), at 1-866-937-2783 option 1.

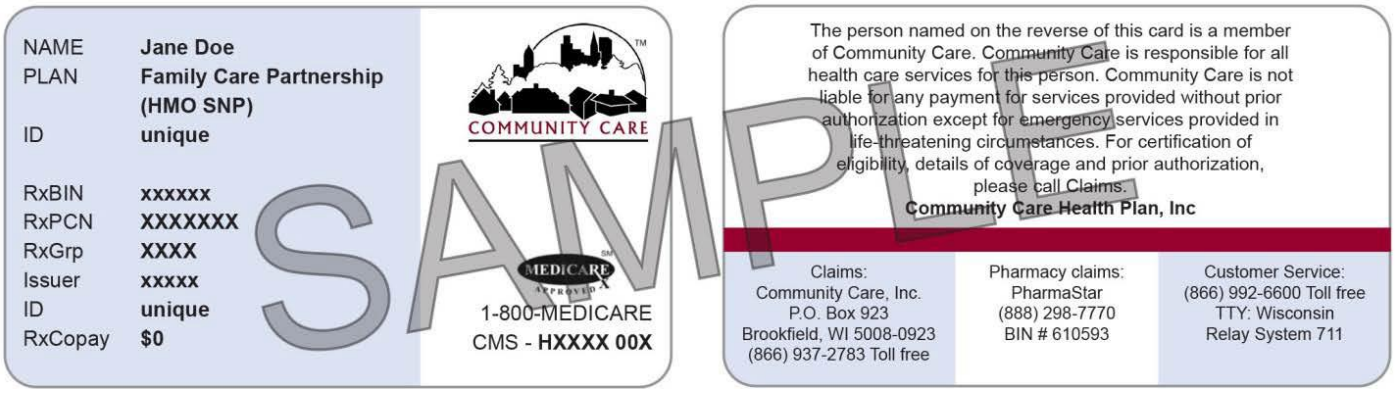
Regional Offices and Contacts
Community Care offers long-term care services in 23 Wisconsin counties. Select your county through our website link: **https://www.communitycareinc.org/contact/locations** for more information regarding the local office address, telephone number, programs offered, and enrollment.

SECTION 5: MEMBER INFORMATION

Member Identification Cards

Family Care Partnership and PACE members are issued identification cards from Community Care, Inc. Eligibility can also be verified by calling the Community Care Provider Hotline 866-937-2783, option 1.

Partnership Identification Card Example



PACE Identification Card Example

Family Care members are issued an identification card called a Forward Health Card by the State of Wisconsin. There is no Community Care-issued identification card for Family Care members. Eligibility can also be verified by calling the Community Care Provider Hotline 866-937-2783, option 1.

Forward Health Card Example

Member Disenrollment

Community Care members who request to disenroll from the PACE, Family Care and Family Care Partnership Programs may do so at any time. The IDT will refer the member to the Aging and Disability Resource Center (ADRC) for Options Counseling and potential disenrollment. At no time, shall the provider or the IDT encourage or counsel a member to disenroll from the program. All member-requested disenrollment's are initiated and processed by the local ADRC.

SECTION 6: PROGRAM BENEFITS

Community Care

1/2025

PACE/Partnership Programs (benefit package includes all 4 columns)

Family Care Program
(benefit package includes first 2 columns (at NH LOC))

- Adult day care
- Assistive technology
- Care management
- Competitive Integrated Employment Exploration
- Consultative clinical and therapeutic services for caregivers
- Communication Assistance
- Consumer directed supports (self-directed supports) broker
- Consumer education and training
- Counseling and therapeutic resources
- Environmental accessibility adaptations (home modifications)
- Financial management services
- Health and Wellness
- Daily living skills training
- Day habilitation
- Home delivered meals
- Housing counseling
- Personal emergency response system
- Prevocational services
- Relocation services
- Remote Monitoring and Support
- Residential services:
  - 1-2 bed adult family home (AFH)
  - 3-4 bed adult family home (AFH)
  - Community-based residential facilities (CBRF)
  - Residential care apartment complexes (RCAC)
- Respite
- Self-directed personal care
- Skilled nursing services RN/LPN
- Specialized medical equipment and supplies
- Supported employment – individual employment support
- Supported employment - small group employment support
- Supportive home care (SHC)
- Training services for unpaid caregivers
- Transportation – community & other
- Vehicle Modifications
- Vocational futures planning and support (VFPS)
- AODA day treatment (excluding hospital-based or physician provided)
- AODA services (not inpatient nor physician provided)
- Case Management
- Community support program (excluding physician provided)
- Disposable medical supplies
- Durable medical equipment (excluding hearing aids, prosthetics' and family planning supplies)
- Home Health services
- Mental Health Day Treatment
- Mental Health Services, (excluding inpatient or physician provided)
- Medicare deductible and coinsurance amounts (dual eligible only)
- Nursing Home stays (nursing home, institution for mental disease (IMD) and ICF-IID. IMD only covered under age 21 or over age 64)
- Nursing (including intermittent and private duty)
- Occupational Therapy (in all settings except for inpatient hospital)
- Personal Care
- Physical Therapy (in all settings except for inpatient hospital) – includes cardiac rehab
- Respiratory care
- Speech and Language Pathology Services (excluding inpatient hospital)
- Transportation: (excluding ambulance)

Please see Member Handbook, or DHS/ MCO Contract for services covered in Family Care at the Non NH LOC

Medicaid Card Services Acute and Primary

- Physician services
- Laboratory and x-ray services
- Inpatient hospital services
- Outpatient hospital services
- EPSDT (under 21)
- School based services
- Family planning
- Federally-qualified health center services
- Clinic Services
- Rural health clinic services
- Health center ambulatory services
- Nursing facility
- Certified professional midwife services
- Certified nurse practitioner services
- Behavioral Treatment Services
- Medical supplies and equipment
- Home Health Care
- Prescribed drugs
- Diagnostic, screening, preventive and rehabilitation services
- Psychotherapy rehabilitation services
- Dental services, dentures
- Physical, occupational and speech therapies
- Private duty nursing
- Prosthetic devices
- eyeglasses
- TB –related services
- Respiratory Care
- Inpatient mental health
- Chiropractic services
- Podiatry services
- Outpatient mental health
- Outpatient substance abuse
- Outpatient surgery
- Ambulance services
- Emergency care
- Urgent care
- Hearing services
- Vision services

Medicare Card Services

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

- Ambulance services
- Ambulatory surgical centers
- Anesthesia
- Blood
- Bone mass measurement
- Durable medical equipment, supplies and prosthetics
- Cardiac rehab
- Diabetes supplies
- Diagnostic tests, x-rays and lab services
- Physician services
- Emergency and urgent care services
- Home health care in certain situations
- Hospice care
- Inpatient hospital care
- Inpatient mental health care
- Outpatient mental health care
- Outpatient hospital services, including outpatient surgery
- Limited skilled nursing facility care
- Physical/speech/occupational therapy
- Prescription drugs, including drugs covered under Medicare Part A, Part B, and Part D
- Substance abuse treatment (outpatient)

Self-Direct Supports

Self-Directed Support (SDS) is an option for all members in PACE, Family Care and Family Care Partnership Programs. SDS offers a wide range of choices to members so they can maximize choice and control over their services and support. A member may arrange for, manage and monitor his or her benefit directly, or with assistance of another person. Community Care offers opportunities for members to direct one, some, or all of the services available to them in the benefit package, not including residential or case management services.

If a member chooses SDS, the Interdisciplinary Team will:

- Explain the variety of choices available
- Work with the member to assess their needs
- Determine the amount of resources available
- Monitor member available resources

More information is available at http://www.iselfdirect.org/.

Cost Sharing

Most covered services in PACE, Family Care and Family Care Partnership Programs are provided with no member co-payment, coinsurance, or deductible. The only exception is the Medicare Part D co-pay for the covered drugs and supplies of dually eligible Family Care Partnership members. Providers are prohibited from balance-billing PACE, Family Care and Family Care Partnership members for covered services.

Prescriptions/Formulary

A formulary is a list of covered drugs selected by Community Care in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. Community Care will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a Community Care network pharmacy, and other plan rules are followed. If Community Care makes any formulary change which limits a members' ability to fill their prescriptions, Community Care will notify the effected member before the change is made. For more information on how to fill prescriptions, please review the Evidence of Coverage (EOC), linked below:

Partnership Formulary
https://www.communitycareinc.org/docs/default-source/member-handbooks/partnership-handbook.pdf?sfvrsn=4ee35fb7_1

PACE Formulary
https://www.communitycareinc.org/docs/default-source/member-handbooks/pace-member-handbook.pdf?sfvrsn=89c47eba_1

Service Authorization

Community Care has a Provider Authorization Requirement Document. All questions related to the need for a prior authorization can be found here:
https://www.communitycareinc.org/docs/default-source/providers/prior-authorization-requirement.pdf?sfvrsn=951fecb9_7

Authorization Provider Portal

This is a portal for Community Care providers to view and electronically "sign" their authorizations.
https://www.communitycareinc.org/providers/current-providers/authorization-provider-portal

Resource Allocation Decision (RAD) Method

The Interdisciplinary Team (IDT) takes great care in evaluating the care needs of the members enrolled in Community Care programs. Prior to approving allocation of services and resources, the team carefully considers the needs of the member, and resources available to them.

Community Care is responsible for supporting long-term care outcomes, but also must consider cost when planning care and choosing providers to meet each eligible member's needs. The IDT will use a process called the Resource Allocation Decision (RAD) method. The RAD is a step- by-step tool the IDT and member use to find the most effective and efficient ways to meet the needs and support the member goals. The RAD is a series of questions, which help explore what is needed and the options available to support those outcomes. This may include how friends, family or other community and volunteer organizations may be available to help. The member is always included in this discussion.

All long-term care services must be approved BEFORE the eligible member receives them. Community Care is not required to pay for services received without our prior approval. If you feel a service which is not already approved may be needed for our member, please make contact with the member's assigned IDT.

Enhanced Services or Items

"Enhanced" services or items are services or items a Member or Member's family voluntarily chooses to purchase at fair market value, which are either: (a) not included in the benefit and not covered by Medicaid, or (b) additional services included in the benefit that are not necessary to achieve member outcomes as documented in the Member Centered Plan. Enhanced services may be purchased by the member only when the MCO's procedures for ensuring the purchase is voluntary are followed and documented in the member's case record. The Provider must have approval from the MCO before providing or charging for Enhanced Services or Items. The member or his/her family has the right, at any time, to revoke the consent for payment.

Usage of Network Providers

Community Care has an established provider network to meet long-term care outcomes of members. Members understand they are to utilize Community Care network providers to get covered services. Provider shall provide services in accordance with the services authorized by Community Care through the member's IDT.

Usage of Out-of-Network Providers

Out-of-network (OON) providers may be used in limited cases and require notification to member's IDT as soon as possible after services are rendered. Hospitals contracted with Community Care are required to notify the member's IDT when a member is admitted to the hospital.

Examples include:

- Emergency services
- Urgently needed care when our network is not available
- Out of service area dialysis

Licensed Health Care Providers Advising and Advocating

Community Care may not prohibit, or otherwise restrict, a licensed health care provider acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient including any of the following:

- The member's health status, medical care, or treatment options, including any alternative treatment;
- Any information the member needs to decide among all relevant treatment options;
- The risks, benefits, and consequences of treatment or non-treatment; or the member's right to participate in decisions regarding his or her health care

Benefit Exclusions

Some services are excluded from coverage under the Family Care and Family Care Partnership Programs. For information and questions on service exclusions, please contact the member's IDT. In addition, Community Care may also deny coverage if:

- The service is not medically necessary;
- The service is not a covered benefit; or
- The member is not enrolled in Community Care's PACE, Family Care or Family Care Partnership program at the time the services are provided.

Durable Medical Equipment Upgrade Process

Community Care Inc. (CCI) acknowledges at times that CCI dual eligible members will qualify for a specific piece of equipment through primary insurance. There are times when CCI member(s) need upgraded equipment that they do not qualify for through primary insurance. In this event, the CCI care team works with the provider for best solution for the member(s). In those instances, the provider is to bill primary insurance for the equipment that the member qualifies for and the provider is to bill CCI for the co-insurance for that equipment after primary insurance pays. In the event that the CCI care team is approving upgraded equipment CCI will authorize primary for the E1399 upgrade and pay the difference between the HCPC code allowable.

For example if member qualifies for an E0260 semi-electric hospital bed but care team states member needs a E0265 full electric hospital bed, CCI would authorize and pay the E1399 upgrade based on the difference between the allowable of E0260 and E0265.

SECTION 7: PROVIDER NETWORK

Provider Network Overview

Community Care ensures members have access to quality providers who have agreed to a number of member protections and other legal requirements in the provider contract. The Community Care Provider Directory contains a listing of our network providers to provide and manage care for our members. Community Care is committed to ensuring our provider network is adequate to meet the needs of our members. We are equally committed to ensuring our providers demonstrate competency and quality in the provision of service to our members. You may view the Provider Directory online at: https://www.communitycareinc.org/members/provider-directories

Access Standards

All Community Care members have the right to receive timely access to medically necessary health care services. Community Care's Quality Improvement (QI) Committee approves member access standards and reviews network provider compliance with the standards on an annual basis. Community Care members with life-threatening emergencies have immediate access to care without prior authorization from Community Care, and may receive emergency care from participating or Out-of-Network Providers at hospitals within or outside of Community Care's service area.

How to Become a Network Provider

If a potential provider is interested in joining the Community Care Provider Network, our applications are available at: https://www.communitycareinc.org/providers/potential-providers/join-network Submission of an application does not guarantee an offer to contract. You can also utilize the Provider Hotline or email contractinquiries@communitycareinc.org with any questions.

Community Care considers requests for contracting based on the following criteria:

- Proposed services are in the Family Care and Family Care Partnership and PACE benefit package
- Community Care needs additional providers for the proposed services in order to meet member capacity or choice
- The proposed provider's mission and vision complement PACE, Family Care and Family Care Partnership Programs and the Community Care mission
- The provider meets applicable licensing and/or certification standards applicable to the services to be provided
- The provider is willing and able to sign and adhere to all components of a contract with Community Care including, but not limited to:
    - Agree to Community Care rate
    - Follow contractual requirements related to authorizations and billing
    - Maintain ongoing communications with Community Care staff
    - Meet or exceed quality assurance expectations set by Community Care
- Community Care ensures the integrity of our network providers through credentialing, on-site quality visits, utilization review and ongoing quality initiatives.

Current Providers

If you are a current Community Care contracted provider and you are interested in adding services to your existing contract, please call the Provider Hotline 866-937-2783.

Room and Board in Residential Facilities
Room and Board payments must be covered by member's available funds. For members residing in a Certified or Licensed residential setting [which may be an Adult Family Home (AFH), Community Based Residential Facility (CBRF), or a Residential Care Apartment Complex (RCAC)], as part of the member's approved service plan, Community Care will pay the provider one single rate inclusive of services and Room and Board. Community Care will bill the member for the member's Room and Board Obligation.

Care and Supervision in Residential Facilities Clarifications
The per diem will apply to the date of admission and all full days of residence, but not to the day of discharge. Community Care will not pay for Care and Supervision during a member's temporary absence from the facility if the member is placed in another Medicaid/Medicare funded facility during the absence (i.e. hospital or nursing home). Community Care will pay for up to 14 consecutive days of Care and Supervision during the temporary absence only when 1) the absence is part of the member's care plan, 2) the absence does not require the member or Community Care to fund concurrent expenses for Care and Supervision, and 3) the member is not placed in another Medicaid/Medicare funded facility. Community Care will pay for Room and Board (under a Room Retainer procedure code) during periods of temporary absences unless the member is residing in a setting (during the absence) which requires payment for Room and Board. The provider may not require members or their family/guardian to pay a fee in order to keep the bed open for the member.

Nondiscrimination in Provider Selection and Contracting
Community Care, Inc. does not discriminate in terms of participation, reimbursement or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

Nondiscrimination in Employment
The services provided for our PACE, Family Care and Family Care Partnership members include federal and state funds. For any work performed in connection with these programs, Community Care and its providers (and their subcontractors) are required to comply with federal and state laws regarding equal opportunity and nondiscrimination in employment and service delivery.

Prohibition of Interference with Health Care Professionals' Advice to Members
Community Care respects the patient/provider relationship and does not restrict or prohibit a health care professional, acting within the lawful scope of their practice, from providing advice to a patient who is a member of a Community Care, Inc. program.

Member Right to Refuse Services and Second Opinions
Community Care may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of an member who is his/her patient, including any of the following:

- For the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
- For any information the member needs in order to decide among all relevant treatment options;
- For the risks, benefits, and consequences of treatment or non-treatment;
- For the member's right to participate in decisions regarding his/her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

The MCO, consistent with the scope of the MCO's benefit package, must provide for a second opinion from a qualified health care professional within the network. The MCO shall arrange for the member to obtain a second opinion outside the network, at no cost to the member, if the MCO does not have a health professional qualified to provide a second opinion. (FCP/PACE)

Member Privacy

Community Care requires its providers to be committed to using and disclosing Protected Health Information (PHI) in compliance with the Privacy Rule (45 C.F.R. Parts 160 and 164) under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This commitment includes password protection or encryption of any external email communication containing PHI. Only the member can give permission to transmit PHI through unprotected email communication. Because of the risk of inappropriate disclosure, Community Care does not want providers to email PHI to us. If it becomes absolutely necessary, all PHI must be in a password protected attachment to the email message and the password must be sent in a separate email. Do not put PHI in the body of the email unless the email is encrypted.

Credentialing of Health Care Providers

Community Care's credentialing process enables us to contract with qualified health care providers and to meet the requirements of our contracts with the Centers for Medicare & Medicaid Services (CMS) and the Wisconsin Department of Health Services (DHS). The credentialing process ensures that providers are properly educated, trained, and accessible to Community Care's members.

Although Community Care delegates some credentialing activities to recognized credentialing programs, Community Care always retains the right and the obligation to accept or reject the recommendations of our credentialing delegates. Community Care reviews these credentialing programs annually, and performs in depth reviews every three (**3**) years. Community Care may not contract with or use any providers, including their employees and subcontractors, who are excluded from participation in any federal or state health care programs.

Information acquired through the credentialing and re-credentialing processes is considered confidential, and Community Care staff and credentialing delegates who have access to the files are responsible for ensuring the information remains confidential, except as otherwise provided by law. Community Care may deny or restrict participation, terminate participation, or take other action in accordance with the provider's written agreement with Community Care and our credentialing policies and procedures.

SECTION 8: NETWORK PROVIDER REQUIREMENTS AND EXPECTATIONS

CCI's network of providers have signed contracts and agreed to adhere to all components of the contract including:

Provider Responsibilities

- All providers are required to have a Medicaid ID, prior to January 1, 2026, for each service/location in order to provide services and receive payment from Family Care, Family Care Partnership, Program of All-Inclusive Care for the Elderly (PACE), and IRIS (Include, Respect, I Self-Direct).
  Providers are responsible for maintaining their Medicaid ID(s) and keeping them active. Failure to have an active Medicaid ID(s) will result in disruption of payment and potential termination of contract.
  More information related to this requirement and how to obtain a Medicaid ID can be found at:
  https://www.forwardhealth.wi.gov/WIPortal/cms/public/ltc/provider_enrollment.htm
- Provider is expected to understand and adhere to the contract provisions at all times.
- Provider is required to provide compliance and fraud, waste and abuse training for all staff and annually document training in staff files. Providers can click the link below to review training resources. (additional information is included in Section 9 of this handbook)https://www.cms.gov/training-education/medicare-learning-network/resources-training
- Provider acknowledges that Community Care, Inc. will not pay for any goods or services provided by an individual (i.e. employee) or entity which has been excluded from participation in government programs, and will recover any payments previously made for goods or services provided by an excluded individual or entity. Community Care, Inc. will not make payment to an individual – directly or indirectly – or entity while that individual or entity is under a government imposed payment suspension. Provider will immediately notify Community Care, Inc. of any exclusion or suspension, including a payment suspension, involving the provider's operation.
- Provider understands that the US Department of Justice may impose civil monetary penalties (CMP) on anyone who hires an excluded individual or entity.
- Providers are encouraged to regularly check employees and other associated individuals and entities (e.g., vendors, volunteers, board members, etc.) to verify that exclusions have not been imposed. Government exclusion databases can be found at https://exclusions.oig.hhs.gov/.
- Prior to rendering any services to Community Care program members, a service authorization is needed to specify the authorized services in accordance with the member's service plan. If an authorization has not been received, the provider is expected to contact the member's IDT to obtain a copy.
- Written notice of any change in the type, scope or location of delivery of services shall be provided to Community Care, Inc. at least ninety (90) days prior to the effective date of the change.
- Provider must only bill for services actually provided. Submitting claims for services that were not provided, even if authorized, is illegal (fraud).
- Provider shall send written notice to Community Care, Inc. within **five (5) days** of any legal, governmental or other action initiated against Provider.
- Suspension of Payments - Per the *Accountable Care Act*, 42 CFR 455.2 and 455.23, Community Care withholds the right to suspend payments to Provider pending investigation of an allegation of fraud.
- Overpayments - Provider must do all of the following when it has received any overpayment from Community Care:
  1. Report the overpayment to Community Care when identified
  2. Return the overpayment to Community Care within sixty (60) calendar days of the date on which the overpayment was identified
  3. Notify Community Care in writing of the reason for the overpayment

- Provider shall notify Community Care, Inc.'s Provider Management Department at contractinquiries@communitycareinc.org of any changes in address, telephone number, or other contact information, such as email address or contract administrator name.
- Community Care expects providers to demonstrate sensitivity to cultural diversity and to honor members' beliefs. Providers are expected to foster staff attitudes and interpersonal communication styles that respect members' cultural backgrounds.
- Provider must ensure staff members have access to the following documents for continuity of care and communication with members' Interdisciplinary Teams and other Community Care departments.
- Providers who provide services that relate to our Medicare Parts C and D contracts must be in compliance with our First Tier, Downstream and Related Entities (FDR) Compliance Program. More information on this program can be found here: https://www.communitycareinc.org/providers/current-providers/compliance-privacy

  More information regarding this section can be found here:
  - Communication Requirements
  - Member Rights Preservation
  - Restrictive Measures
  - Practice Guidelines
  - Model of Care
  - Influencing the Exercise of Participant Freedom of Choice
  - Fraud, Waste and Abuse
  - Member Grievance and Appeal Information
  - *http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html*

Proof of Insurance

Community 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 Community Care, Inc. as a certificate holder on the Certificate of Insurance.

Inspection of Records and Record Keeping

All Network Providers must maintain and upon request furnish to Community Care all information requested by Community Care related to the quality and quantity of services provided through their contract. This includes written documentation of care and services provided, including dates of services, time records, invoices, contracts, vouchers or other official documentation evidencing in proper detail the nature and propriety of the services provided.

Provider agrees to provide representatives of Community Care, as well as duly authorized agents or representatives of DHS or their designees, and the Federal Department of Health and Human services access to its physical premises, equipment, books, contracts, records, and computer or other electronic systems in accordance with Article XIII.H. in the DHS-MCO Contract. This includes the right to inspect, evaluate, and audit any pertinent information for minimum of ten (10) years after termination of services as specified in this Contract or from the date of completion of any audit, whichever is later for Family Care-funded services and for a minimum of ten (10) years after termination of services as specified in your CCI Contract or from the date of completion of any audit, whichever is later for Family Care Partnership and PACE-funded services.

Request to Amend Provider Contract

Requests to amend a contract should be made in writing and can be sent to Provider Management via:

- email at ContractInquiries@communitycareinc.org
- mail to Community Care, Inc., Attn: Provider Management Department, 1801 Dolphin Drive, Waukesha, WI 53186
- fax to 262-446-6707

Termination of Provider Contract

Consistent with Community Care, Inc.'s contract with CMS and DHS and the requirements of its provider contracts, Community Care reserves the right to terminate, suspend or not renew a contract with any network provider, or to terminate or suspend any of provider's subcontractors, as the case may be. Providers may terminate their contracts with Community Care as specified in the contract.

Provider Advisory Committee

The Provider Advisory Committee consists of providers representing a variety of service categories throughout Community Care, Inc. service areas. The purpose of the group is to provide the following:

- Serve as a communication channel between the Community Care, Inc. Board of Directors and the subcontracted member service organizations and agencies to ensure a smooth flow of appropriate financial, quality, utilization and satisfaction information in all directions
- Secure provider input in program management of long-term managed care services
- Assist Community Care, Inc. in providing managed care programs which support member outcomes in a financially prudent way that ensures good stewardship of public funds
- Assist providers in understanding how to work successfully in a managed care system environment
- Create a public and transparent process where questions and concerns are openly expressed and addressed and where effective problem solving can occur

SECTION 9: COMPLIANCE

Corporate Compliance

The government expects Community Care and all our contractors and providers to follow all laws, rules, regulations, and contract requirements and conduct business in an ethical manner. This means:

- Providers will always act in the best interests of our program members, including the protection of members' rights.
- Providers will avoid conflicts of interest. Where potential conflicts exist, providers are expected to disclose the conflict to Community Care and work with us to successfully resolve it.
- Providers will treat members with dignity, respect and fairness. Members will not be discriminated against based on race, color, religion, gender, sexual orientation, age, disability, or any other protected characteristic.
- Providers will protect the confidentiality of member information and any confidential information of Community Care.
- Providers will obey all laws, rules, regulations, and contract requirements.
- Providers will report any known or suspected instances of unethical or illegal behavior, and will not retaliate against any staff member who in good faith reports any such concern.

Providers are expected to have written policies and procedures that guide staff in complying with regulatory and contractual requirements. Staff should also be trained annually on compliance and fraud, waste and abuse. Community Care may ask for copies of these training records.

Providers are expected to check the government sanction and exclusion databases to ensure that they, their employees, and their subcontractors are not excluded from participating in government programs. There are companies that provide monitoring service or you can monitor by going to the government site https://exclusions.oig.hhs.gov/. Providers need to keep documentation their monitoring activity. Community Care may ask for this documentation as proof the monitoring is being performed.

Fraud, Waste, Abuse

Community Care, Inc. is required to report to DHS all suspected fraud, waste or abuse (FWA).

- **Fraud** – is defined as an intentional deception, false statement or misrepresentation made by an individual with knowledge that the deception could result in unauthorized benefit to that individual or another person. Claims submitted for services not provided are considered fraudulent.
- **Waste** – is defined as failing to control costs or using Medicare or Medicaid funds to pay for services that are not determined to be necessary.
- **Abuse** – is defined as practices that are inconsistent with professional standards of care; medical necessity; or sound fiscal, business or medical practices. The primary difference between fraud and abuse is "intent". Poor recordkeeping, lack of understanding of care responsibilities or reporting obligations may result in an investigation for abuse.

FWA can occur at any point and by anyone involved in the care of program members. Members may also be involved in FWA activities, including:

- Misrepresentation of medical conditions to obtain additional or unnecessary services, supplies, equipment, or medications
- Failure to disclose information that may affect eligibility

If you suspect that fraud, waste or abuse is occurring, please contact:

- Compliance Hotline 262-207-9440
- Compliance Inquiries Webs

All contacts will be treated confidentially.

Link to CMS training related to Fraud, Waste and Abuse:

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining

Protected Health Information (HIPAA) Requirements

Based on the services you provide on behalf of Community Care, Inc. you may be provided with protected health information (PHI). This information includes all medical and care-related services you provide. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) you are responsible to keep this information secure. Information must not be left out where anyone can read it, including paper records and emails, and should be protected against theft.

The law also requires you to only share PHI with the member's consent in all but a limited number of situations. Any loss, theft, misuse, or accidental disclosure of PHI must be reported to Community Care's Compliance Department, and may also need to be reported to the government under the breach notification requirements.

There are government resources available to assist you to understand your obligations. They can be found at:

- http://www.hhs.gov/ocr/privacy/index.html

Please contact our Provider Management Department or Compliance Department if you have questions or concerns about HIPAA.

Gifts and Entertainment

In order to avoid even the appearance of improper conduct, Community Care, Inc. requests that providers do not offer gifts to our staff members. Please do not extend to our staff invitations to sporting and other entertainment events, since acceptance may be perceived to have an influence on the decisions made by our employees. It is our hope that this policy will eliminate real or imagined bias by our staff regarding selection of providers for member services.

Providers should also be careful when giving gifts to members, since a gift may be perceived to influence a member's decisions regarding providers or services. The Office of the Inspector General permits inexpensive gifts (other than cash or cash equivalents) or services that have a retail value of no more than $15 individually, and no more than $75 in the aggregate annually per individual.

SECTION 10: MEMBER CARE PLAN REVIEW AND SIGNATURES

Providers of essential services are required to use the Member Centered Plan portal to electronically sign Member Care Plans. Essential services are defined in the State of Wisconsin contract as:

1) Adult Day Care Services

2) Day Habilitation Services

3) Daily Living Skills Training

4) Prevocational Services

5) Adult residential care (adult family homes, community-based residential facilities, residential care apartment complexes)

6) Respite

7) Skilled nursing services RN/LPN

8) Supported employment (individual and small group employment support)

9) Supportive home care (excluding routine chore services)

Procedure codes: 0240, 0241, 0242, 0243, 0670, S5100, S5101, S5102, S5105, S5125, S5126, S5135, S5136, S9123, S9125, T1001, T1005, T1502, T2013, T2014, T2015, T2018, T2019, T2020, T2021, G0299, G0300 & 99600.

Community Care has created a Member Care Plan Portal to make it easier for providers to sign the Member Care Plan. This Portal can be accessed at: https://mcpportal.communitycareinc.org.

SECTION 11: ELECTRONIC VISIT VERIFICATION

Electronic Visit Verification, known as EVV, is a federally mandated initiative that is designed to mitigate fraudulent billing and neglect of vulnerable persons by caregivers. The 21st Century Cures Act mandates that all states implement EVV.

EVV data is collected by the State of Wisconsin's EVV provider (Sandata). This data is sent by to Community Care on a regular basis. This data is then matched with claim data prior to claim processing. Claims that do not have a corresponding EVV visit will be denied.

EVV is required for all Family Care and Family Care Partnership members. It is *NOT* required for PACE members.

When searching for Community Care members within the Sandata system, please select the correct member's program. If the correct program is not chosen, results will not be accurate. **The Program name will show as CCIFC for Family care members or CCIFCP for Partnership members.** CCI PACE members will not show in the system as they are except from the EVV requirements.

Services Require EVV

Service
T1019: Personal care services; per 15 minutes
T1020: Personal care services; per day
S5125: Supportive home care; per 15 minutes
S5126: Supportive home care; per day
99509: Nurse supervisory visit; Home visit for assistance with activities of daily living and personal care; per visit
92507: Treatment of speech, language, voice, communication, and/or auditory processing disorder; per visit
97139: Unlisted therapeutic procedure – Occupational therapy; per visit
97799: Unlisted physical medicine/rehabilitation service or procedure – Physical therapy; per visit
99504: Home visit for mechanical ventilation care; per hour
99600: Unlisted home visit service or procedure; per visit
S9123: Non-vent private duty nursing care in the home – by registered nurse; per hour
S9124: Non-vent private duty nursing care in the home – by licensed practical nurse; per hour
T1001: Nursing assessment/evaluation; per visit
T1021: Home health aide or certified nurse assistant; per visit
T1502: Administration of oral, intramuscular and/or subcutaneous medication by health care agency/ professional; per visit

Please follow the following link for the most recent CCI information on EVV: EVV Information

Additional information and contact information from the State of Wisconsin can be found at:

Wisconsin EVV Customer Care: (833) 931-2035 M-F 7am to 6pm

Email: VDXC.ContactEVV@wisconsin.gov

EVV webpage: https://www.dhs.wisconsin.gov/evv/index.htm

EVV Resource Page: https://www.dhs.wisconsin.gov/evv/training.htm

SECTION 12: CLAIM SUBMISSION AND PAYMENT

Claim Submission Overview
Never Billed Community Care Before? - Visit our website https://www.communitycareinc.org/providers/current-providers/billing-claim-submission and complete our Billing Registration Form.

Residential Services & Supportive Home Care – Community Care has created a Claim Submission Portal located at: https://claimsportal.communitycareinc.org:444/

For any questions regarding our Claim Submission Portal site, please contact your Account Rep.

Medical Services including Skilled Nursing Facilities – You can bill electronically through a clearing house.

Community Care Payer ID information:
- Family Care: 60995
- Family Care Partnership or PACE: 39126

Provider Payment Inquiries
For questions concerning claim status, adjustments, or requests for a claim review; please contact our Provider Hotline: 1 866-937-2783 option 1.

Payment of Claims
Community Care shall process all Clean Claims within thirty (**30**) calendar days of receipt. A Clean Claim means one which can be processed without obtaining additional information from the provider of the service or from a third party. It does not include a claim from a provider who is known to be under investigation for fraud or abuse, a claim under review for medical necessity, or a claim for which there is no authorization or the claim does not match the services authorized via the authorization.

All information on the service authorization must be accurate before performing services, especially:
- Dates of Service: Provider must verify that the service authorization covers the date span of the expected service period.
- Units of Service: Provider must verify that the number of units authorized is equal to the number of units expected during the service period.
- Service Code/HCPCS/Revenue Code: Provider must verify that the service code authorized is the same as the expected service to be provide.

Clean Claims
Providers are responsible for submitting a clean claim for each member served in order to receive payment. A clean claim is free from errors and contains all of the following:

Member Information:
- Member full name
- Social Security Number (SSN) and/or Master Client Index (MCI) number
- Date of birth

Service Authorization Information:

- Authorization number (each claim form must contain ONLY ONE authorization number)
- Date(s) of service (date range or individual days)
- Service/HCPCS/Revenue code/Modifier (if applicable)
- Number of units (number of days in service period or units of provided service)
- Unit rate/Billed amount

Provider Information:

- Provider name
- Provider address
- Provider number (TIN/EIN/SSN)
- National Provider Identifier (NPI) – highly recommended

Coordination of Payment for Out Of Network Providers

CCI will coordinate payment with non-network providers for out-of-network services authorized by the IDT, as well as emergency or court ordered services obtained out-of-network. CCI will ensure that cost to the member is no greater than it would be if the services were provided within the Network.

Coordination of Benefits (COB)

Coordination of Benefits (COB) will apply. Review your contract to determine the maximum amount of payment you will receive.

Provider Claims Appeal Process

The Claims Appeal Process is outlined within your contract.

Section 13: QUALITY IMPROVEMENT

Quality Improvement (QI) Program

Community Care, Inc. strives to provide services of the highest quality with a direct focus on meeting the needs of members. The purpose of CCI's Quality Program is to provide the necessary focus and structure to identify, monitor, and evaluate clinical and service improvement opportunities for all the members CCI serves. The Quality Program is carried out with collaboration among physicians, providers, healthcare professionals, community stakeholders and other CCI staff who directly or indirectly influence the delivery of care and service provided to all members enrolled in CCI's programs. The Quality Program is an evolving one that is responsive to the changing needs of our members and standards established by the medical community and regulatory agencies.

Target Group for Improvement or Monitoring

- Members
    - Comprehensive Internal File Reviews
    - Satisfaction Surveys
    - Long Term Care Functional Screens
    - Incident Management System
    - Appeal and Grievance Resolution
    - Utilization Management
    - Prevention & Wellness
- Care Teams
    - Enrichment Opportunities
    - Trainings
- Providers
    - Access to services
    - Trainings

Community Care's Quality Improvement Projects:

- DHS and CMS required
- CCI identified opportunities for improvement based upon monitoring activities, data analysis, and newly identified and/or evidence based approaches

Community Care encourages its network providers to communicate feedback on how we can continue with our strong tradition of delivering quality care. You can always find the most current version of Community Care, Inc.'s Quality Plan on our web site, www.communitycareinc.org.

Providers can communicate with Community Care through:

- Our Provider Hotline at 866-937-2783
- Our email at contractinquiries@communitycareinc.org
- A phone call to the Quality Improvement Department at: (414) 231-4000 or (866) 992-6600 or email at: qualityprojects@communitycareinc.org
- A letter to the Quality Improvement Department at:

  Community Care, Inc.
  Attn: Quality Improvement Dept.
  205 Bishops Way
  Brookfield, WI 53005