

# PACE PROGRAM

Community Care Program of All-Inclusive Care for the Elderly

# *Member Handbook & Enrollment Agreement*

MILWAUKEE, KENOSHA, RACINE  
& WAUKESHA COUNTIES

For help or information, please call Customer Service or visit our website at [www.communitycareinc.org](http://www.communitycareinc.org). Call toll free: 1-866-992-6600.

TTY users call the Wisconsin Relay System at 711



Community Care Health Plan, Inc. • 205 Bishops Way • Brookfield, WI 53005

**Enrollment Agreement and Member Handbook  
For Community Care's Program of All-Inclusive Care for the Elderly (PACE)  
(Community Care)**

This Enrollment Agreement provides an explanation of your benefits, rights and responsibilities. You will learn how to get the health care, long-term care and prescription drugs you need as a member of Community Care PACE.

**This is an important document. Please keep it in a safe place.**

**English**

ATTENTION: If you speak English, language assistance services are available to you free of charge. Call 1-866-992-6600 (TTY: 711).

**Spanish**

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas están disponibles sin cargo, llame al 1-866-992-6600 (TTY: 711).

**Hmong**

CEEB TOOM: Yog koj hais lus Hmoob, kev pab rau lwm yam lus muaj rau koj dawb xwb. Hu 1-866-992-6600 (TTY:711).

**Chinese**

注意：如果您说中文，您可获得免费的语言协助服务。请致电 1-866-992-6600 (TTY 文字电话: 711)。

**Serbo-Croatian**

PAŽNJA: Ako govorite srpsko-hrvatski imate pravo na besplatnu jezičnu pomoć. Nazovite 1-866-992-6600 (telefon za gluhe: 711).

**Arabic**

تنبيه: إذا كنتم تتحدثون العربية، تتوفر لكم مساعدة لغوية مجانية. اتصلوا بالرقم 1-866-992-6600 (هاتف نصي: 711).

**Community Care:**

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - o Qualified sign language interpreters
  - o Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - o Qualified interpreters
  - o Information written in other languages

If you need these services, contact your care team toll free at 1-866-992-6600.

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## Chapter 1. Important phone numbers and resources

General phone number: 1-866-992-6600

TTY: Call the Wisconsin Relay System at 711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

You can call these numbers 24 hours a day, 7 days a week. Calls to these numbers are free.

Corporate Office:  
205 Bishops Way  
Brookfield, WI 53005  
Office hours: 8:00 a.m. – 4:30 p.m., Monday – Friday  
Website: [www.communitycareinc.org](http://www.communitycareinc.org)

### Contacting Customer Service

Contact your Interdisciplinary Team (IDT) or Customer Service for assistance at the numbers listed above. We will be happy to help you. Customer Service also has free language interpreter services available for non-English speakers.

**If you are experiencing a life-threatening emergency, call 911.**

### Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for people with limited incomes and resources.

If you have questions about assistance from Medicaid, contact the Wisconsin Department of Health Services.

<b>Wisconsin Department of Health Services (DHS)</b>	
<b>CALL</b>	1-800-362-3002
<b>WEBSITE</b>	<a href="http://www.dhs.wisconsin.gov/Medicaid">www.dhs.wisconsin.gov/Medicaid</a>

### Ombudsman Programs

Ombudsmen investigate reported concerns and help members resolve issues. The Board on Aging and Long Term Care provides ombudsman services to potential and current members age 60 and older. Disability Rights Wisconsin provides ombudsman services to potential and current

PACE members under age 60. Both ombudsmen programs can help you file a grievance or appeal with our plan.

<b>Disability Rights Wisconsin</b> - Ombudsmen from this agency provide assistance to individuals <b>under age 60</b> .	
<b>CALL</b>	General: (608) 267-0214 Fax: (608) 267-0368 Milwaukee Toll-Free: 1-800-708-3034
<b>TTY</b>	TTY: 1-888-758-6049
<b>WRITE</b>	131 W. Wilson Street, Suite 700 Madison, WI 53703
<b>WEBSITE</b>	<a href="http://www.disabilityrightswi.org/programs/fcop">www.disabilityrightswi.org/programs/fcop</a> (See Website for contact information for other locations.)

<b>Wisconsin Board on Aging and Long Term Care</b> - Ombudsmen from this agency provide assistance to individuals <b>age 60 and older</b> .	
<b>CALL</b>	1-800-815-0015
<b>WRITE</b>	1402 Pankratz Street, Suite 111 Madison WI 53704-4001
<b>WEBSITE</b>	<a href="http://longtermcare.wi.gov">http://longtermcare.wi.gov</a>

**PACE Interdisciplinary Team (IDT) Contact Information**

Each Community Care PACE member has access to a PACE site within our service area. You may contact your PACE IDT at the numbers below.

County	PACE Site Address	City State Zip	Phone
<b>Waukesha</b>	1801 Dolphin Dr.	Waukesha, WI 53166	262-953-8550
<b>Milwaukee</b>	3220 West Vliet St.	Milwaukee, WI 53208	414-231-4000
<b>Racine</b>	3220 West Vliet St.	Milwaukee, WI 53208	414-231-4000
	1801 Dolphin Dr.	Waukesha, WI 53166	262-953-8550
<b>Kenosha</b>	3220 West Vliet St.	Milwaukee, WI 53208	414-231-4000
	1801 Dolphin Dr.	Waukesha, WI 53166	262-953-8550

In addition, Community Care PACE has the following Alternative Care Settings (ACS):

- United Community Center (UCC)  
 1028 South 9<sup>th</sup> Street  
 Milwaukee, WI 53204  
 The services that are provided at the UCC day center include social services, personal care services, recreation therapy and meals.



- Community Care Layton Clinic  
 1555 S. Layton Blvd.  
 Milwaukee WI 53215  
 The services that are provided at the Layton Clinic include physician and nursing services, restorative therapies, nutrition counseling, dental services and behavioral health treatment and counseling.
- PACE Clinic at Siena Center  
 5635 Erie Street  
 Racine, WI 53402  
 262-670-5950

Your IDT can give you more information about Community Care’s Alternative Care Centers.

**You can get assistance from Aging and Disability Resource Centers (ADRC)**

ADRCs provide a place to get information and assistance on all aspects of life related to aging or living with a disability, including all available programs and services. ADRCs can provide services at the Center, via telephone or through a home visit, whichever is more convenient to you. The ADRC is responsible for enrollment and disenrollment from the PACE Program. Visit [www.dhs.wisconsin.gov/LTCare/adrc](http://www.dhs.wisconsin.gov/LTCare/adrc) for more information about ADRCs.

You can contact your local ADRC as listed below.

County	Phone Number	TTY/TDD
Kenosha County ADRC	262-605-6646	Call the Wisconsin Relay System at 711
Milwaukee County ARC <sup>1</sup>	414-286-6874	414-289-8591
Milwaukee County DRC <sup>2</sup>	414-289-6660	414-289-8559
Racine County ADRC	262-638-6800	Call the Wisconsin Relay System at 711
Waukesha County ADRC	262-548-7848	Call the Wisconsin Relay System at 711

<sup>1</sup> For individuals age 60 and older

<sup>2</sup> For individuals under age 60

## Chapter 2. Introduction to the Program of All-Inclusive Care for the Elderly (PACE)

### Welcome to Community Care PACE

Welcome to Community Care, a Managed Care Organization (MCO) that operates the Program of All-Inclusive Care for the Elderly (also known as PACE.)

This *Enrollment Agreement & Member Handbook* booklet tells you how to get your Medicare and Wisconsin Medicaid, if applicable, health and long-term care and prescription drugs through Community Care PACE.

When you enroll, you agree to accept all services from our PACE plan. Community Care will provide the same benefits you would receive from Medicare and Medicaid plus many more.

This Enrollment Agreement will give you the information you need to:

- Understand the basics of PACE.
- Become familiar with the medical care, long-term care and prescription drug services in the PACE Program Benefits
- Understand your rights and responsibilities.
- Know what you pay as a member
- File a grievance or appeal if you have a problem or concern.

In general, the words “you” and “your” in this document refer to *you*, the *Member*. “You” and “your” may also mean your authorized representative, such as a legal guardian or activated health care power of attorney.

The word “services” in this document generally refers to all the medical care, long-term care, supplies and equipment and prescription drugs our plan covers. See Chapter 4 for a list of covered services.

Chapter 10 at the end of this document contains definitions of important words. These definitions can help you understand the words and phrases frequently used in this handbook.

### Your Membership Card

One of the first things you will get when you join PACE is a membership card. When you are a member of our program, **you must show your membership card whenever you get services.** You must also use this card to get prescription drugs at network pharmacies.

If your membership card is damaged, lost, or stolen, call Customer Service at 1-866-992-6600, and we will send you a new card.

Here's a sample membership card to show you what yours will look like:



## Who can be a member of Community Care PACE?

It is your choice whether to enroll in Community Care PACE. Membership is voluntary.

To be eligible for PACE you **must** be:

- At least fifty-five years of age;
- A resident of Community Care's PACE Service Area which is Milwaukee, Kenosha, Racine and Waukesha Counties; and
- Functionally eligible as determined via the Wisconsin Adult Long-term Care Functional Screen.

You must remain a resident of Milwaukee, Kenosha, Racine or Waukesha County to stay a member of Community Care PACE.

- For PACE you may have:
  - Medicaid, or
  - Both Medicaid and Medicare, or
  - Medicare and able to pay the monthly premium for Medicaid and Part D Services, or
  - Neither Medicare or Medicaid and able to pay the monthly premium for Medicare, Medicaid and Part D services.
- If you are eligible for Medicare, you must enroll in Medicare to remain eligible for PACE.
- If you are eligible for Medicare, you must be enrolled in and remain enrolled in all the parts of Medicare for which you are eligible (Part A, Part B, and Part D) and obtain all Medicare services from Community Care PACE.
- If you are eligible for Medicare, but do not enroll, you will be disenrolled from PACE. If you are eligible for Medicare and you do not currently have Medicare because you feel you can't afford it, contact your Income Maintenance Agency. They may help you find a program to help pay for your Medicare premiums.

- You cannot disenroll from Community Care PACE at a Social Security Office.

**SPECIAL NOTE:**

Some plan members must pay a premium for Medicare Part A, and all plan members must pay a premium for Medicare Part B to remain a member of the plan.

If you have Medicaid, you may qualify for assistance in paying for these premiums. Contact your county's Income Maintenance Agency for more information.

If you plan to move out of the service area, you must notify your IDT. If you move outside of our service area, you can no longer be a member of Community Care PACE. Your IDT will work with you to transition you to a program in your new service area.

## How can the PACE program help me?

Services are individually tailored to meet your needs. A main goal of PACE is to ensure that people are safe and supported at home. When people live in their own home or in their family's home, they have more power over their lives. When you join PACE, we will talk with you about services that can help you live at home.

We want you to live as independently as possible for as long as possible. We will encourage you to do as much for yourself as possible. We will help you make informed health choices. We will make sure you get the care you need to be healthy and safe.

## Who will help me?

When you become a PACE member, you will work with a team of professionals from Community Care. This is your Interdisciplinary Team (IDT). Your IDT includes YOU and:

- Anyone you want to be on your IDT, including family members or friends
- Primary Care Provider which could be a PACE physician, community-based physician, nurse practitioner (NP) or physician assistant
- Registered Nurse
- Social Worker/Care Manager
- Occupational Therapist
- Physical Therapist
- Recreational therapist or activity coordinator
- Dietician
- PACE Center Manager
- Home Care Coordinator
- Personal Care Attendant or his/her representative
- Driver or his/her representative

Although all of these roles must be represented on the IDT, one individual may fill two (2) roles.

Your IDT plans and authorizes your care across all settings. You will work with your IDT to make decisions about your health and lifestyle. Together you will make the best possible choices to support you.

You are a central part of your IDT, and you should be involved in every part of planning your care. Let your IDT know if you need any assistance taking part in the process.

The job of your IDT is to work with you to:

- Identify your strengths, resources, needs and preferences.
- Develop a care plan that includes the help you need and continues to work for you.
- Ensure that the services PACE provides meet your needs and that they are cost-effective.
- Make sure the services in your care plan are actually provided to you.

Your IDT is responsible for your initial assessment, periodic reassessments, your care plan and coordinating the 24-hour care you may require. Community Care is responsible for providing care that meets your needs across all care settings, 24 hours a day, every day of the year and must create and use a written plan to ensure that care is appropriately provided.

Community Care encourages family members, friends and other people that are important to you to be involved in your care. PACE does not replace the help you get from your family, friends or others in the community. We will work with you to build on these important relationships. We can also help find resources in your community that can assist you.

## How does PACE work?

When you enroll in PACE, you and your IDT will do an **assessment** of your needs, strengths and preferences. You and your IDT will also identify which services will meet your needs. Your IDT will develop a care plan that will help you move toward the outcomes that you and your IDT identify during the assessment process.

You will receive your health care, long-term care services, and prescription drugs through Community Care providers. When you join PACE, we will give you a list of providers who have agreed to work with us. You and your IDT will work together to choose providers that best support your needs. These “formal supports” must have a contract with Community Care. If you are unhappy with any provider, you have the right to request a new provider, but you must talk with your IDT first. Your IDT needs to authorize all services you receive.

Community Care is responsible for meeting the health and long-term care needs of ALL of our members. By working together, we can make sure PACE remains available to other people who need our services.

## **What is Self-Direction by Member Preferred Caregiver**

You can choose the Self-Direction by Member Preferred Caregiver option if you want to manage some of your **long-term care services**. It is an option you can use if you want to have more responsibility and be more involved in the direction of your own care. (You may also hear Self-Direction by Member Preferred Caregiver referred to as Self-Directed Supports or SDS.) If you are interested, please ask your IDT for more information about the benefits and limitations of Self-Direction by Member Preferred Caregiver.

## Chapter 3. Things to know about getting your medical care, long-term care and prescription drugs

### What are “network providers” and “covered services?”

Here are some definitions to help you understand how you get care and services in PACE:

- “**Providers**” are doctors, pharmacists, and other health care professionals licensed by the state to provide medical services. The term “providers” also includes hospitals, health care facilities and long-term care agencies that provide things like home delivered meals or rides.
- “**Network providers**” are the doctors and other health care professionals, medical groups, hospitals, pharmacists, and other health care facilities that have an agreement with us to accept our payment as payment in full. We have arranged for these providers to deliver covered services that have been authorized to members in our plan. The providers in our network generally bill us directly for care they give you. When you see a network provider, you usually pay nothing for covered services. Network pharmacies have agreed to fill covered prescriptions for our plan.
- “**Covered services**” include all the medical care, long-term care services, supplies and equipment our plan covers. Long-term care consists of services to meet your daily needs such as assistance with eating, bathing, supportive home care, residential care and case management. Prescription drugs are also “covered services”. See Chapter 4 for a complete list of covered services.
- “**Provider Directory**” is a list of all of Community Care’s contracted network providers for PACE.

### How are services selected and authorized?

Your IDT must approve all services **BEFORE** you receive them. **Community Care is not required to pay for services you receive without our prior approval. If you arrange for services yourself without your IDT’s approval, you may have to pay for them.**

Your IDT will use the **Resource Allocation Decision (RAD)** process as a guide in making decisions about some long-term care services. The RAD is a step-by-step tool you and your IDT may use to find the most effective and efficient ways to meet your needs and support your outcomes.

#### Your care plan will include:

- Your physical health needs and your ability to perform certain tasks and activities (such as eating and dressing).
- Your strengths and preferences.
- The services you will receive.

- Who will provide each service.
- The things you are going to do yourself or with help from family, friends, or other resources in your community.

Your IDT will ask you to sign your care plan showing that you agree and are satisfied with the plan. You will get a copy of your signed plan.

Your IDT will make sure services are provided as quickly as your health requires considering your medical, physical, emotional and social needs.

Your IDT will be in contact with you on a regular basis. We want to be sure you are healthy and safe. If your needs change, let your IDT know. Community Care can provide more or less service based on your changing needs. We will always be there to support you.

## **Requesting Services and the Service Determination Request Process**

### **What is a Service Determination Request?**

A service determination request (SDR) takes place when you ask:

- To start a new service; or
- To change a service you are receiving; or
- To continue a service that your Interdisciplinary Team (IDT) thinks should be discontinued or reduced.

Requests to begin, change or continue a service before your initial care plan is completed are **not** service determination requests.

You, your authorized representative or your caregiver may request a service determination. Your caregiver is the natural or unpaid support you have identified and consider your caregiver. The request may be oral or written. You can ask any member of your IDT for a service determination.

### **What happens when you make a Service Determination Request?**

Staff must bring the Service Determination Request to the team as quickly as your health condition requires but no later than three (3) calendar days from when you made the request. The IDT will review and talk about your request and decide whether to approve, deny or partially deny it. The IDT may require a reassessment to help them determine if they should approve the request.

The IDT must notify you of their decision as quickly as your health condition requires but no later than three (3) calendar days from the date the request was presented to the team. The IDT may extend the time up to five (5) additional calendar days to review your SDR and notify you of their decision. If the IDT extends the time to make a decision, they will notify you in writing within 24 hours after deciding to take more time. The notice will explain why they need more time.



If the IDT decides to approve your request, they will notify you orally or in writing. The notice will explain the conditions of the approval.

If the IDT decides to deny or partially deny your request, they must notify you of the decision both orally and in writing. The notice will explain the reason(s) for the denial, inform you of your right to appeal the decision and describe the appeal processes.

If your IDT fails to respond to your Service Determination Request in the required time, Community Care will consider the failure to be an adverse decision and automatically process your request as an appeal. A Member Rights Specialist will notify you that an appeal is in process and explain how you can participate in the appeal process.

If you have questions about requesting a service, please contact a member of your IDT.

### **Important rules for getting your care and services.**

Community Care will generally cover your care and services as long as:

- 1.) The services are included in your care plan and are approved by your IDT.
- 2.) The care you receive is included in the PACE Program Benefits. (This information is in Chapter 4.)
- 3.) The care you receive is considered medically necessary. “Medically necessary” means that you need the services, supplies or drugs for the prevention, diagnosis or treatment of your medical condition and the care meets accepted standards of medical practice.
- 4.) You must receive your care from a network provider. In most cases, we will not cover services you get from an out-of-network provider, except for emergency services or urgently needed care.
- 5.) PACE will be your sole service provider.
- 6.) Community Care PACE guarantees access to services but not to a specific provider.

### **How do I use the provider network?**

As a Community Care PACE member, all of your medical and long-term care services are provided and arranged by your IDT. Our provider network is intended to give you a choice of providers whenever possible. After your IDT approves your services, you and your IDT will choose from the providers in Community Care’s provider network. Community Care PACE, Medicaid or Medicare will not pay if you get services from non-contracted providers **without prior authorization** (with the exception of urgent care and emergency services).

There might be times when you want to switch providers. Contact your IDT if you want to change from one provider to another in the network. **If you change providers without talking to your IDT and getting approval first, you may be responsible for the cost of the service.**

The list of the providers we routinely use is on our website at [www.communitycareinc.org](http://www.communitycareinc.org). We call this the Provider Directory. Contact your IDT for help reviewing the Provider Directory and selecting a provider.

## **What is a Primary Care Provider (PCP)?**

Your PCP is the PACE physician, community-based physician, nurse practitioner (NP) or physician assistant who is part of your IDT and who provides your routine or basic medical care. Your PCP collaborates with the rest of your IDT and any needed specialists to manage your health care and to manage your health care and coordinate the other covered services you get as a PACE member.

## **How do I choose a PCP?**

As a PACE member, you must have a Community Care PCP or a community-based PCP who has a contract with Community Care PACE. Your IDT can help you choose a PCP. If there is a particular specialist or hospital that you want to use, be sure your PCP makes referrals to that specialist or uses that hospital.

## **How do I change my PCP?**

You may change your PCP for any reason, at any time. Call your IDT to change your PCP. They will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will check to be sure that the PCP you want is accepting new patients. Your IDT will tell you when the change to your new PCP will take effect.

## **How to get care from specialists and other network providers**

A specialist is a doctor who provides health care services for a specific disease or part of the body. Your IDT will arrange and authorize the health care you get from a specialist.

## **What if a network provider leaves our plan?**

Sometimes a physician, clinic, hospital or other network provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of our plan. We will let you know if your provider leaves our plan and help you choose another provider so you can continue getting the covered services in your care plan.

## The plan's List of Covered Drugs (Formulary)

The plan has a *List of Covered Drugs (Formulary)*. We call it the “Drug List” for short. It tells which prescription and over-the-counter drugs we cover. A team of doctors and pharmacists help us select the drugs on this list. The list must meet requirements set by Medicare and Medicaid.

The Drug List also tells you if there are any rules that restrict coverage for your drugs. To get the most complete and current information about which drugs are covered, you can go to our website at [www.communitycareinc.org](http://www.communitycareinc.org) or call your IDT.

## Getting care if you have a medical emergency

**If you have a life-threatening emergency, call 911.**

*You do NOT need to contact your IDT or get prior authorization in an emergency.*

A “**life-threatening emergency**” is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent serious harm to your health or to your ability to regain maximum function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Call the number on the back of your membership card.

## What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over. We will try to arrange for network providers to take over your care as soon as your medical condition and circumstances allow.

Whenever possible, you must use our network providers when you are in the plan's service area and you have an urgent need for care.

### **What is “urgently needed care?”**

“Urgently needed care” is a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care.

In most situations, if you are in the plan's service area, we will cover urgently needed care *only* if you get this care from a network provider and follow the other rules described earlier in this chapter.

When you are outside the service area and cannot get care from a network provider, contact your IDT. Our plan often covers urgently needed care that you get from any provider in this situation.

**Our plan does not cover urgently needed care or any other care you receive outside of the United States or its territories.**

## Chapter 4. PACE benefits and coverage

### What services are provided?

This chapter focuses on what services our plan covers. The PACE program provides health care, long-term care and prescription drug services. The services we provide are called the PACE Program Benefits.

You and your IDT may use the Resource Allocation Decision (RAD) process to help develop your care plan. Although the PACE Program Benefits are available to all members, it does not mean that you can get a service that is listed just because you are a PACE member. You will get the services that your IDT has approved in your care plan and which are necessary to assure your health and safety.

**Your IDT must authorize most of the services listed as PACE benefits. If you get services that are not authorized, you may have to pay for them yourself.**

The services our plan does not cover are listed at the end of this chapter.

Talk with your IDT if you have any questions about covered services.

### PACE benefits and coverage

PACE benefits for all members, regardless of enrollment in Medicare or Medicaid, include the following:

- All Medicare-covered services.
- All Medicaid-covered services, as specified by the Wisconsin Department of Health Services.
- Other services determined necessary by your IDT to improve and maintain your overall health status.

Medicare and Medicaid benefit limitations and conditions relating to amount, duration, scope of services, deductibles, copayments, coinsurance, or other cost-sharing do not apply.

Your IDT decides whether to approve or deny services. These decisions must be based on an evaluation of your medical, physical, emotional and social needs and the current clinical practice guidelines and professional standards of care that apply.

While you are enrolled in Community Care PACE, you must receive all Medicare and Medicaid benefits from Community Care PACE.

The services listed below are available if they are:

- Medically necessary

- Pre-approved by your IDT
- Stated in your care plan

You pay nothing when you receive these covered services from network providers.

Because you are a member of Community Care PACE, if you have Medicaid and Medicare, your Medicare deductible and coinsurance amounts are paid on your behalf.

### ***Outpatient Health Services***

- General medical and specialist care including a woman's health specialist as requested.
- Nursing care.
- Social services.
- Prescribed medications and pharmacy services when prescribed by a PACE contracted physician or PACE nurse practitioner and dispensed by a Community Care PACE contracted pharmacy.
- Physical, occupational, speech and respiratory therapies.
- Laboratory tests, X-ray and other diagnostic tests.
- Vision care, including examinations and treatment.
- Hearing services, including evaluation, hearing aids, repairs, and regular care.
- Podiatry services, including routine foot care.
- Psychiatric care including evaluation, consultation, diagnosis, and treatment.
- Artificial limbs, disposable medical supplies, and durable medical equipment (such as hospital beds, wheelchairs, and walkers).
- Nutritional counseling and special diet assistance.
- Alcohol and other drug treatment.
- Chiropractic services.

### ***Inpatient Hospital Care***

- Semi-private room and meals.
- General medical and nursing services.
- Medical and surgical care, intensive care, and coronary care units as necessary.
- Laboratory tests, X-rays and other diagnostic procedures.
- Receiving blood or plasma.
- Prescribed drugs and medicine.
- Use of oxygen.
- Physical, occupational, speech and respiratory therapies.
- Psychiatric care.
- Social services and planning for discharge from the hospital.
- Alcohol and other drug treatment.

### ***Nursing Home Care***

- Semi-private room and meals.
- Doctor and nursing services.

- Custodial care.
- Personal care and assistance.
- Prescribed drugs and medicines.
- Physical, occupational, and speech therapies.
- Social services and planning for discharge.
- Medical supplies and appliances.

### ***Dental Care***

Our first priority for dental care is to treat pain and acute infections. Our second priority is to maintain dental functioning. Dental care is provided according to the need and appropriateness as determined by your IDT and the dentist. Additional dental services may include:

- Diagnostic services.
- Preventive services.
- Restorative dentistry.
- Prosthetic appliances.
- Oral surgery.

### ***End of Life Care***

As your health conditions change, the goals of your care may change from treatment-focused to comfort-focused. The goals will include quality of life, symptom management and staying in your own residence as long as possible. If you need end of life care, you may choose to have that care provided by your IDT.

**If you enroll in the Medicare hospice program, while you are a Community Care PACE member, it is considered a voluntary disenrollment from our program. Once you have enrolled in the Medicare hospice program, you will be disenrolled from PACE and lose all services and benefits provided by Community Care PACE.**

### ***Medicaid Benefits***

Listed below are the Wisconsin Medicaid benefits covered by Community Care. All members of Community Care are eligible to receive the following long-term care services:

- Adaptive aids
- Adult day care services
- Assistive Technology / Communication aids
- Care/case management
- Consultative clinical and therapeutic services for caregivers
- Consumer education and training services
- Counseling and therapeutic services
- Environmental accessibility adaptations / Home modifications
  - Individual employment support
  - Small group employment support

- Vocational futures planning and support
- Home delivered meals
- Housing counseling
- Personal Emergency Response Systems
- Relocation services
- Residential Care
  - Adult family homes of 1-2 beds
  - Adult family homes of 3-4 beds
  - Community-based residential facilities (CBRF)
  - Residential care apartment complexes (RCAC)
- Respite care
- Self-directed personal care services
- Self-directed Supports (SDS)
- Skilled Nursing services RN/LPN
- Specialized medical equipment and supplies
- Support broker
- Supportive home care
- Training services for unpaid caregivers
- Transportation (specialized transportation)
  - Community transportation
  - Other transportation

### **Benefits *not* covered by the plan (exclusions)**

This section tells you what kinds of benefits are excluded. “Excluded” means that our plan doesn’t cover these benefits.

Neither Community Care, Medicare nor Medicaid will pay for the excluded benefits. Even if you receive the services at an emergency facility, the excluded services are still not covered. In addition to any exclusions described anywhere else in this handbook, the following items and services are not covered:

- Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary, covered under Medicaid and if applicable, Medicare.
- In an inpatient facility (hospital or nursing home), private room and private duty nursing, except when it is considered medically necessary.



- Personal items in your room at a hospital, a skilled nursing facility, or other residential facility, such as a telephone or a television, unless specifically authorized by your IDT as part of your care plan.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, which does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.
- Reversal of sterilization procedures, sex change operations
- Naturopath services (uses natural or alternative treatments).
- Services furnished outside of the United States or its territories, except emergency medical care that meets very specific requirements.
- Services or supports that are not necessary to support your outcomes.
- Normal living expenses like rent or mortgage payments, food, utilities, entertainment, clothing, furniture, household supplies and insurance.
- Room and board in residential housing.

## Chapter 5. Understanding who pays for services

### Will I pay for any services?

You are not required to pay for any covered services that are PACE Program Benefits and which are approved as part of your care plan and as long as you follow the plan's rules for getting your care. You are responsible for paying the full cost of services that are not covered by our plan, because they:

- Are not covered services in the PACE Program Benefits, or
- Were obtained without authorization.

If you have questions about whether we will pay for any medical care, long-term care services, or prescription drugs, you have the right to ask us about coverage before you receive the service, item, or drug. If we say we will not cover the requested service, item, or drug, you have the right to appeal our decision.

There are other types of expenses you may have to pay for each month in order to remain eligible for PACE:

- Cost share
- Room and board
- Premium Payments

Cost share and room and board are two different things. It is possible that you will have to pay for both.

### Cost share

Some members may have to pay a monthly amount to remain eligible for Medicaid. This monthly payment is known as **cost share** and is also called post eligibility treatment of income. Your cost share is determined by the Income Maintenance Agency based on your income and must be paid to maintain eligibility for Medicaid.

If you have a cost share, you will receive a bill from Community Care every month. Although you mail your payment to Community Care, the Income Maintenance agency determines the amount you must pay each month.

The amount of your cost share will be reviewed once a year or anytime your income changes. **You are required to report all income and asset changes to your IDT and the Income Maintenance agency within ten days of the change.** Assets include, but are not limited to, motor vehicles, cash, checking and savings accounts and cash value of life insurance.

Failure to pay your monthly cost share or make satisfactory arrangements to pay it after a 30-day grace period may result in loss of eligibility for Medicaid, and you might be disenrolled from

PACE, unless you become a private pay PACE member. If you think your cost share is incorrect, you can file an appeal with the Wisconsin Division of Hearings and Appeals (DHA).

If you have questions about cost share, contact your IDT.

## Room and board

You will be responsible to pay for room and board (rent and food) costs if you are living in or moving to a residential care setting. Residential care settings include adult family homes (AFHs), community based residential facilities (CBRFs), residential care apartment complexes (RCACs) and nursing homes.

Community Care will pay for the care and supervision portion of your services. You will be required to pay the room and board (rent and food) portion of the cost. We will tell you how much your room and board will cost, and we will send you a bill each month.

If you have questions about room and board, or cannot make a payment, contact your IDT. Your IDT may be able to help you find a facility that meets your needs at a more affordable rate.

## Monthly Premium Payments

You may or may not have to pay a monthly premium. Your premium payment each month will depend on your eligibility for Medicare and Medicaid.

### If you are eligible for:

- **MEDICARE AND MEDICAID or MEDICAID ONLY**  
If you are eligible for both Medicare and Medicaid, or Medicaid only, you will make no monthly premium payment to Community Care PACE, and you will continue to receive all PACE services, including prescription drugs.
- **MEDICARE ONLY**  
If you have Medicare and are not eligible for Medicaid, then you will pay a monthly premium to Community Care PACE.

Because this premium does not include the cost of Medicare prescription drug coverage, you will be responsible for an additional monthly premium for Medicare prescription drug coverage.

- **PRIVATE PAY** (Not eligible for Medicare or Medicaid)  
If you are not eligible for either Medicare or Medicaid, then you will pay a monthly premium to Community Care PACE for both the Medicare and Medicaid services.  
Because this premium does not include the cost of Medicare prescription drug coverage, you will be responsible for an additional monthly premium for Medicare prescription drug coverage.

If you have questions about premium payments, contact your IDT for assistance.

## How do I make a payment?

You can pay by check or money order. Send payments to:

Community Care, Inc.  
Attention: AR Department  
205 Bishops Way  
Brookfield, WI 53005

Automatic withdrawal from your bank account may also be available. Ask your IDT for details.

## What if I get a bill for services?

You do not have to pay for services that your IDT authorizes as part of your care plan. If you receive a bill from a provider, do not pay it. Instead, contact your IDT so they can try to resolve the issue.

If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for the service or drug. Instead, we will send you a letter that explains the reasons why we are not paying the bill and your rights to appeal that decision.

## Does PACE pay for residential services or nursing homes?

An important goal of Community Care PACE is to help members live as independently as possible. All people should be able to live at home with the support they need, participating in communities that value their contributions. Many PACE long-term care services can be provided at home and living at home is usually the most cost-effective option.

The PACE Program Benefits include residential care services and nursing home stays. However, moving from home to a care facility or nursing home should be a “last resort.”

Your IDT will authorize residential care or nursing home stays only when:

- Your health and safety cannot be assured in your home; or
- Moving into a facility is the most cost-effective option for supporting your long-term care outcomes.

If you are living in your own home and you and your IDT agree that you should no longer live there, you will decide about residential services together. **Your IDT must authorize all residential services.** You must work with your IDT on these decisions to make sure Community Care will pay for the services. Your IDT will continue to work with you while you are in a residential facility or nursing home.

**You will be required to pay the “room and board” (rent and food) portion of the facility’s cost.**

### **What is estate recovery? How does it apply to me?**

If you are already on Medicaid and a member of Community Care, the estate recovery rules apply to you. Medicaid estate recovery applies to all Medicaid services you receive whether they are provided by Community Care or through other programs.

Through estate recovery, the State of Wisconsin seeks to be paid back for the cost of all Medicaid long-term care services. Recovery is made by filing claims on estates. The State of Wisconsin will not try to be paid back from your estate when your spouse or child with a disability is still alive. Recovery will happen after their death. The State of Wisconsin uses the recovered money to care for others in need.

For more information about estate recovery, ask your IDT. Information about the Medicaid Estate Recovery Program is also available through the resources listed below:

Phone: Toll-free: 1-800-362-3002  
TTY: 711 or 1-800-947-3529

Visit: <https://www.dhs.wisconsin.gov/medicaid/erp.htm>

Or write to: DHS - Estate Recovery Program  
P.O. Box 309  
Madison, WI 53701-0309

## Chapter 6. Your rights

### Your Rights in the Community Care Program of All-Inclusive Care for the Elderly

The Program of All-inclusive Care for the Elderly, also called PACE, is a special program that combines your medical and long-term care services in a community setting.

When you join a PACE program, you have certain rights and protections. Community Care PACE must fully explain and provide your rights to you or someone acting on your behalf in a way you can understand. These rights will be explained to you before you join Community Care PACE, at the time you join Community Care PACE and any other time your needs require you to have this information explained to you again so you can make an informed choice about your care.

To be eligible, you must

- Be age 55 or older.
- Live in the service area of Community Care PACE.
- Be certified as eligible for nursing home care by the Wisconsin Department of Health Services (DHS).
- Be able to live safely in the community at the time of enrollment with Community Care PACE services

The goals of Community Care PACE are:

- To maximize the independence, dignity, and respect of PACE members;
- To help make PACE members more independent and improve their quality of life;
- To provide coordinated quality health care to PACE members;
- To keep PACE members living safely in their homes and communities as long as possible;
- To help support and keep PACE members together with their family.

At Community Care PACE, we are dedicated to providing you with quality health care services so that you may remain as independent as possible. Our staff seeks to affirm the dignity and worth of each member by assuring the following rights:

#### **You have the right to be treated with respect.**

You have the right to be treated with dignity and respect at all times, to have all of your care kept private and confidential, and to get compassionate, considerate care. You have the right:

- To get all of your health care in a safe, clean environment and in an accessible manner.
- To be free from harm. This includes excessive medication, physical or mental abuse, neglect, physical punishment, being placed by yourself against your will, and any physical or chemical restraint that is used on you for discipline or convenience of staff and that you do not need to treat your medical symptoms or to prevent injury.
- To be encouraged to use your rights in the Community Care PACE program.
- To get help, if you need it, to use the Medicare and Medicaid complaint and appeal processes, and your civil and other legal rights.

- To be encouraged and helped in talking to Community Care PACE staff about changes in policy and services you think should be made.
- To use a telephone while at the Community Care PACE Center.
- To not have to do work or services for Community Care PACE.

### **You have a right to protection against discrimination.**

Discrimination is against the law. Every company or agency that works with Medicare and Medicaid must obey the law. They cannot discriminate against you because of your:

- Race
- Ethnicity
- National Origin
- Religion
- Age
- Sex
- Mental or physical disability
- Sexual Orientation
- Source of payment for your health care (For example, Medicare or Medicaid)

If you think you have been discriminated against for any of these reasons, contact a staff member at Community Care to help you resolve your problem.

If you have any questions, you can call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

### **You have a right to information and assistance.**

You have the right to get accurate, easy-to-understand information and to have someone help you make informed health care decisions. You have the right:

- To contact 1-800-MEDICARE for information and assistance, including to make a complaint related to the quality of care or the delivery of a service.
- To have someone help you if you have a language or communication barrier so you can understand all information given to you.
- To have Community Care PACE interpret the information into your preferred language in a culturally competent manner, if your first language is not English and you can't speak English well enough to understand the information being given to you.
- To get marketing materials and Community Care PACE member rights in English and in any other frequently used language in your community. You can also get these materials in Braille, if necessary.
- To have the enrollment agreement fully explained to you in a manner understood by you.
- To get a written copy of your rights from Community Care PACE. Community Care must also post these rights in a public place in the PACE center where it is easy to see them.
- To be fully informed, in writing, of the services offered by Community Care PACE. This includes telling you which services are provided by contractors instead of the Community Care PACE staff. You must be given this information before you join, at the time you join, and when you need to make a choice about what services to receive.
- To look at, or get help to look at, the results of the most recent review of Community Care PACE.

Federal and State agencies review all PACE programs. You also have a right to review how Community Care PACE plans to correct any problems that are found at inspection.

### **You have a right to a choice of providers.**

You have the right to choose a health care provider within the Community Care PACE program's network and to get quality health care. Women have the right to get services from a qualified women's health care specialist for routine or preventive women's health care services.

You have the right to have reasonable and timely access to specialists as indicated by your health condition and consistent with current clinical practice guidelines.

### **You have a right to access emergency services.**

You have the right to get emergency services when and where you need them without Community Care PACE program's approval. A medical emergency is when you think your health is in serious danger—when every second counts. You may have a bad injury, sudden illness or an illness quickly getting much worse. You can get emergency care anywhere in the United States.

### **You have a right to participate in treatment decisions.**

You have the right to fully participate in all decisions related to your health care. If you cannot fully participate in your treatment decisions or you want to have someone you trust help you, you have the right to choose that person to act on your behalf. You have the right:

- To have all treatment options explained to you in a language you understand, to be fully informed of your health status and how well you are doing, and to make health care decisions. This includes the right not to get treatment or take medications. If you choose not to get treatment, you must be told how this will affect your health.
- To have the Community Care PACE program help you create an advance directive, if you choose. An advance directive is a written document that says how you want medical decisions to be made in case you cannot speak for yourself. You should give it to the person who will carry out your instructions and make health care decisions for you.
- To participate in making and carrying out your plan of care. You can ask for your plan of care to be reviewed at any time.
- To be given advance notice, in writing, of any plan to move you to another treatment setting and the reason you are being moved.
- You have a right to receive necessary care in all settings including placement in a long-term care facility when Community Care can no longer provide the services necessary to keep you safely in the community.

### **You have a right to have your health information kept private.**

- You have the right to talk with health care providers in private and to have your personal health care information kept private and confidential, including health data that is collected and kept electronically, as protected under State and Federal laws.
- You have the right to look at and receive copies of your medical records and request



amendments.

- You have the right to be assured that your written consent will be obtained for the release of information to persons not otherwise authorized under law to receive it.
- You have the right to provide written consent that limits the degree of information and the persons to whom information may be given.

There is a patient privacy rule that gives you more access to your own medical records and more control over how your personal health information is used. If you have any questions about this privacy rule, call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800- 537-7697.

### **You have a right to file a complaint.**

You have a right to complain about the services you receive or that you need and don't receive, the quality of your care, or any other concerns or problems you have with your PACE program. You have the right to a fair and timely process for resolving concerns with your PACE program. You have the right:

- To a full explanation of the complaint process.
- To be encouraged and helped to freely explain your complaints to Community Care PACE staff and outside representatives of your choice. You must not be harmed in any way for telling someone your concerns. This includes being punished, threatened, or discriminated against.
- To appeal any treatment decision by the Community Care PACE program, staff, or contractors.

### **You have a right to leave the program.**

If, for any reason, you do not feel that the Community Care PACE program is what you want, you have the right to leave the program at any time and have such disenrollment be effective the first day of the month following the date the Community Care PACE organization receives your notice of voluntary disenrollment.

### **Additional Help**

If you have complaints about your PACE program, think your rights have been violated, or want to talk with someone outside your PACE program about your concerns, call 1-800-MEDICARE or 1-800-633-4227 to get the name and phone number of someone in your State Administering Agency which is the Department of Health Services in Wisconsin.

In addition to the rights listed above you also have the following rights:

### **The right to be free from physical or mental abuse, neglect, corporal punishment, and financial exploitation.**

- **Abuse** can be physical, emotional, financial or sexual. Abuse can also be if someone gives you a treatment such as medication, or experimental research without your informed consent.
- **Neglect** is when a caregiver fails to provide care, services, or supervision which creates significant risk of danger to the **individual**. Self-neglect is when an individual who is responsible for his or her own care fails to obtain adequate care, including food, shelter, clothing, or medical or dental care.

- **Financial exploitation** can be fraud, enticement or coercion, theft, misconduct by a fiscal agent, identity theft, forgery, or unauthorized **use** of financial transaction cards including credit, debit, ATM and similar cards.

What can you do if you are experiencing abuse, neglect, or financial exploitation? Your IDT is available to talk with you about these issues. They can help you with reporting or securing services for safety. You should always call 911 in an emergency.

If you feel that you or someone you know is a victim of abuse, neglect, or financial exploitation, you can contact Adult Protective Services. Adult Protective Services help protect the safety of seniors and adults-at-risk who have experienced abuse, neglect or exploitation. They also help when a person is unable to look after his or her own safety due to a health condition or disability.

You may call the following numbers to report incidents of witnessed or suspected abuse:

Milwaukee County DRC (under age 60)  
414-289-6660  
TTY Call the Wisconsin Relay System at 711  
[InfoMilwDRC@milwcnty.com](mailto:InfoMilwDRC@milwcnty.com)

Milwaukee County ARC (over age 60)  
414-289-6874  
TTY Call the Wisconsin Relay System at 711  
[aging\\_webinfo@milwaukeecounty.com](mailto:aging_webinfo@milwaukeecounty.com)

Racine County ADRC  
262-833-8777  
TTY Call the Wisconsin Relay System at 711  
[adrc@racinecounty.com](mailto:adrc@racinecounty.com)

Waukesha County ADRC  
262-548-7848  
TTY Call the Wisconsin Relay System at 711  
[adrc@waukeshacounty.gov](mailto:adrc@waukeshacounty.gov)

Kenosha County ADRC  
262-605-6646  
TTY Call the Wisconsin Relay System at 711  
[adrc@kenoshacounty.com](mailto:adrc@kenoshacounty.com)

You may contact the numbers listed above 24 hours a day, 7 days a week

The right to be free from any form of restraint or seclusion or excessive medication **used as a means of coercion, discipline, convenience or retaliation.**

## Chapter 7. Your responsibilities

Things you need to do as a member of Community Care are listed below. If you have any questions, please contact your IDT. We're here to help.

### Your Responsibilities

As a member of Community Care, you have:

- The responsibility to participate in the development of your care plan as a Team member.
- The responsibility to help your team or other providers by giving them information, asking questions and following through on your care.
- The responsibility to use providers that are part of the Community Care network unless you and your Team decide otherwise and except in cases of emergency.
- The responsibility to be familiar with your covered services, the rules you must follow to get covered services and be responsible for your actions if you refuse treatment or do not follow instructions.
- The responsibility to notify Community Care if your move or change your phone number.
- The responsibility to treat your Team, home care staff and providers with dignity and respect and accept services without regard to the provider's race, color, religion, age, gender, sexual orientation, health, ethnicity, creed (beliefs), or national origin.
- The responsibility to pay any monthly costs on time such as cost share, spend down or room and board.
- The responsibility to complete your annual review for Medicaid eligibility.
- The responsibility to tell us about private insurance coverage you may have and any other health insurance coverage.
- The responsibility to take care of the durable medical equipment we have provided to you.
- The responsibility to report fraud or abuse on the part of providers or Community Care employees and not to engage in any fraudulent activity or abuse your benefits.

If you suspect anyone of misuse of public assistance funds, including PACE, you can call the fraud hotline or file a report online at:

**Report Public Assistance Fraud**

1-877-865-3432 (toll-free) or visit  
[www.reportfraud.wisconsin.gov](http://www.reportfraud.wisconsin.gov)

Do not engage in any fraudulent activity or abuse benefits. This may include:

- Misrepresenting your level of disability
- Misrepresenting income and asset level
- Misrepresenting residency
- Selling medical equipment or supplies provided to you by Community Care.

Any fraudulent activity may result in disenrollment from PACE or possible criminal prosecution.

- Tell us how we are doing. From time to time, we may ask if you are willing to participate in member interviews, satisfactions surveys, or other quality review activities. Your responses and comments will help us identify our strengths as well as the areas we need to improve. Please let us know if you would like to know the results of any surveys. We would be happy to share that information with you.

## Chapter 8. Grievances and appeals

### Introduction

We are committed to providing quality service to our members, but there may be a time when you have a concern. If you are unhappy with your care or services, talk with your IDT first. Talking with your IDT is usually the easiest and fastest way to address your concerns.

You can also call a Member Rights Specialist. The Member Rights Specialist can tell you about your rights, try to informally resolve your concerns and help you file a grievance or appeal. The Member Rights Specialist can work with you throughout the entire grievance or appeal process to try to find a solution.

**For assistance with the grievance or appeal processes contact  
Community Care's Member Rights Specialist at:**

Community Care  
Member Rights Specialist  
205 Bishops Way  
Brookfield, WI 53005  
Toll-free: 1-866-992-6600  
TTY: call the Wisconsin Relay System at 711

This handbook tells you about all the ways you can file a grievance or an appeal, which can be confusing. You don't have to know or understand all the information in this chapter because people are available to help you.

### Copies of your records

You can get a free copy of your records if you think you need them to help you with your grievance or appeal. To request copies, contact your IDT.

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You will not get into trouble if you complain or disagree with your IDT.  
If you file a grievance or appeal with Community Care, our providers or the  
State of Wisconsin, you will not be treated differently.  
We want you to be satisfied with your care.

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## Grievances

### What is a grievance?

A grievance is when you are not satisfied with Community Care, one of our providers or have concerns about the quality of your care or services. For example, you might want to file a grievance if:

- You feel your IDT doesn't listen to you.
- You have trouble getting appointments with a provider.
- You are unhappy with the quality of care you have received.

### What is the deadline to file a grievance?

Medicaid grievances can be filed at any time. Medicare grievances must be filed within **60 calendar days of the event**.

### What are my options?

If you want to file a grievance, you must start by filing a grievance with Community Care.

### File your grievance with Community Care

**You must file your grievance with Community Care first and complete the Community Care grievance process.**

**Contact us promptly – either by phone or in writing. Usually, contacting your Team is the first step.** Many times your concerns can be resolved informally. If we are unable to solve your concerns, you can file a grievance with Community Care by calling or writing to us.

**If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us**

**Contact a Community Care Member Rights Specialist** who can help you understand the grievance process and may assist you submit a grievance. You can also ask the Member Rights Specialist to put your verbal grievance in writing.

#### **To contact the Member Rights Specialist:**

- Call Toll-free: 1-866-992-6600 and ask for extension 79325
- TTY/TDD call the Wisconsin Relay System at 711.
- Write: 205 Bishops Way, Brookfield, WI 53005

Community Care must provide you with a written decision on your grievance as quickly as your health condition requires but no later than ninety (90) calendar days after the date we received your grievance. This timeframe may be extended by up to fourteen (14) calendar days, up to a total of one hundred and four (104) calendar days, if you request the extension or Community Care needs more information and the delay is in your interest. Community Care will notify you in writing if we request an extension. Community Care will make every effort to resolve your grievance within thirty (30) calendar days.

### What happens next?

If you file a grievance with Community Care, we will send you a letter within five business days to let you know we received your grievance. Then, Community Care staff who are not on your IDT will try to help informally address your concerns or come up with a solution that satisfies both Community Care and you. **If we are not able to come up with a solution**, our Grievance and Appeal Committee will review your grievance and issue a decision. The Committee will give you a chance to explain your concerns.

The Committee is comprised of:

- a. Individuals who were not involved in any previous level of review or decision making. A subordinate of an individual who was involved in a previous level of review or decision making may not be included in the PACE organization grievance and appeal committee;
- b. Individuals who do not have a stake in the outcome of the grievance.
- c. At least one member or guardian, or one person or guardian of a person, who meets the functional eligibility for one of the target populations served by the MCO. This person must be free from conflict of interest regarding his/her participation in the committee;
- d. Individuals who, if deciding any of the following, are health care professionals possessing the appropriate clinical expertise, as determined by the Wisconsin Department of Health Services (DHS), in treating the member's condition or disease:
  - A grievance regarding denial of expedited resolution of an appeal.
  - A grievance or appeal that involves clinical issues.
- e. Individuals who will take into account all comments, documents, records, and other information submitted by the member or the member's legal representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

The Committee is made up of Community Care representatives who meet the qualifications listed above and at least one "consumer". The consumer is a person who also receives services from us or represents someone who does. We train this person on how to protect the privacy of others while serving on the Committee.

- We will let you know when the Committee plans to meet to review your grievance.
- The meeting is confidential. You can ask that the consumer not be on the Committee if you are concerned about privacy or have other concerns.
- You have the right to appear in person. You can bring an advocate, friend or family member with you.
- The Committee will give you a chance to explain your concerns. You may provide information to the Committee.
- Your IDT or other Community Care staff will likely be at the meeting.
- The Committee will send you a written notice of the decision.

### **What if I disagree with the Grievance and Appeal Committee's decision?**

If you disagree with Community Care's response on your grievance, or if Community Care fails to timely respond to your grievance, you can ask for a review by the Wisconsin Department of Health Services (DHS).

### **Ask the Wisconsin Department of Health Services (DHS) to review your grievance.**

DHS is the Medicaid agency that is in charge of the PACE program. You must exhaust Community Care's grievance process first. If you are dissatisfied with Community Care's decision regarding your grievance, you may request a DHS review.

**To ask for a DHS review, call or e-mail:**

DHS PACE Grievances  
Toll-free: 1-888-203-8338  
E-mail: [dhsfamcare@wisconsin.gov](mailto:dhsfamcare@wisconsin.gov)

DHS works with an outside organization called MetaStar to review grievances.

MetaStar is an independent organization that is hired by DHS. This organization is not connected with our plan and is not a government agency. This organization is a company chosen by DHS to handle the job of reviewing Medicaid grievances. DHS oversees its work. **Before asking DHS to have MetaStar review your grievance, you must file your grievance with Community Care and complete the Community Care grievance process.**

You must request a review of your grievance by DHS and MetaStar within forty-five (45) calendar days from the date you received Community Care's written decision on your grievance or, if Community Care fails to provide you with a written decision on your grievance within the required amount of time, within forty-five calendar days from the date Community Care's time frame to review your grievance expires.

MetaStar will reply in writing to let you know they received your request to review your grievance.

MetaStar will review the facts surrounding your grievance.

MetaStar has thirty (30) calendar from the date of receipt it receives your request to review your grievance and issue a written, **binding** decision.

If MetaStar determines that it needs more time to issue a decision, it will send you a written notice explaining:

- The reason they need additional time.
- The amount of additional time needed.
- Your right to deny the MetaStar request for an extension (more time).



- **If you deny the MetaStar request for an extension, Community Care’s decision on your grievance is the final decision.**

MetaStar will send you and Community Care its written, binding decision within seven (7) calendar days of completing the review of your grievance.

### **Analyzing Grievance Information**

Community Care maintains, aggregates and analyzes PACE grievance information and uses this information in the Community Care quality improvement program.

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## **Appeals**

### **What is an appeal?**

An appeal is a request for a review of a decision made by Community Care. You can file an appeal regarding Community Care’s non-coverage of or nonpayment for, a service including denials, reductions or termination of services. You can file an appeal if your IDT denies, reduces or ends a service or suspends a covered service.

If you want someone to help you file an appeal, please call a Community Care Member Rights Specialist. The Member Rights Specialist can help you file an appeal and suggest others who might also be willing to help.

Community Care must handle your request to begin, end, modify or continue a service before we can treat your issue as an appeal.

### **Are You Eligible for Medicare or Medicaid?**

When you submit an appeal, you can use one of two processes. The processes that are available to you will depend on whether you are eligible for Medicaid, Medicare or both.

If you are only eligible for Medicaid, you will always use the Medicaid appeal process, which is described below. If you are eligible for both Medicaid and Medicare, you can choose the appeal process you wish to follow. You can also choose the appeal process you wish to follow if you are only eligible for Medicare, and you pay a private pay premium. Both the Medicaid and Medicare appeal processes are described in this chapter.

If you are eligible for both Medicare and Medicaid, you have the right to external review by either the Independent Review Entity (IRE) or the State Fair Hearing process. You may request external review after you have completed the Community Care appeal process, and the decision is fully or partially adverse. Adverse means that Community Care fully or partially denied your appeal.

For help in filing an appeal, talk with your IDT or call the Member Rights Specialist at 1-866-

992-6600. TTY call the Wisconsin Relay System at 711. We can help you decide which process to use.

## Medicaid Appeal Process

### When can I file a Medicaid Appeal?

You have the right to file an appeal in the following types of situations:

- 1.) You can file an appeal if Community Care:
  - Plans to stop, suspend or reduce an authorized service you are currently getting.
  - Decides to deny a service you requested
  - Decides not to pay for a Medicaid service.

If we take one of the actions listed above, we must send you a “Notice of Adverse Benefit Determination.” The Notice of Adverse Benefit Determination includes the date we plan to stop, suspend or reduce your services and explains the appeal process.

- 2.) You can file an appeal if:
  - You do not like your care plan because it:
    - Doesn’t support you to live in the place where you want to live.
    - Doesn’t provide enough care, treatment, or support to meet your needs and identified outcomes.
    - Requires you to accept care, treatment or support items you don’t want or you believe are unnecessarily restrictive.

In these situations, Community Care will send you a Notice of Adverse Benefit Determination which explains your appeal rights.

- 3.) You can also file an appeal related to decisions about your Medicaid eligibility.
  - If the Income Maintenance agency decides you are no longer financially eligible for Medicaid, you will receive a written notice from them.
  - You, your legal decision maker or anyone acting on your behalf with your written permission, may request a State Fair Hearing regarding loss of financial eligibility or calculation of cost share.
  - **Filing an appeal with the Division of Hearings and Appeals is the only way to challenge decisions related to financial eligibility and calculation of cost share.**
  - **You cannot appeal a loss of financial eligibility with Community Care.**

### What is the deadline to file an appeal?

**You must file your Medicaid appeal no later than sixty (60) calendar days after you receive the Notice of Adverse Benefit Determination.** (For example, if you get a notice in the mail on August 1, you must file your appeal on or before October 1.)

If you receive a notification of your appeal rights, you should read the notice carefully. You can always call a Member Rights Specialist for assistance.

### What are my options?

If you want to file a Medicaid appeal, you must start by filing your appeal with Community Care.

You can file a request for a fair hearing **after** receiving an appeal decision from Community Care.

If you want **both** Community Care and the Department of Hearings and Appeals (DHA) to review your issue, you must file your appeal with Community Care **before** you file the appeal with DHA.

**An appeal with DHA is the final level of a Medicaid appeal.**

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### Continuing Your Services During Your Appeal

If you have Medicaid, Community Care must continue to provide the service until the final decision is made if the following conditions are met:

- (1) Community Care decides to stop, suspend, or reduce services you are currently receiving, and
- (2) You ask for the service to continue and understand that you may have to pay for the services being appealed if the decision is not in your favor.

If you want your services to continue, you must:

- Postmark or fax your appeal **on or before** the date Community Care plans to stop, suspend or reduce your services; **AND**
  - Ask that your services continue throughout the course of your appeal; **AND**
  - State that you understand you may have to pay Community Care back for the services you got during the appeal process if the decision is not in your favor.
- 

### Filing your appeal with Community Care

To file a standard appeal with Community Care you can:

- **Call Community Care.** If you file your appeal by calling us, we will ask you to send in a written request. If you want, our Member Rights Specialist can help you put your appeal in writing.
- **Mail or fax a request form** which you can find online at:  
[www.dhs.wisconsin.gov/familycare/mcoappeal.htm](http://www.dhs.wisconsin.gov/familycare/mcoappeal.htm).

- **Write your request in a letter or on a piece of paper** and email or mail it to the address below.

**To file an appeal with Community Care, contact us at:**

Member Rights Specialist  
Community Care, Inc.  
205 Bishops Way.  
Brookfield, WI 53005  
1-866-992-6600  
Member Rights Phone Number: 262-207-9325  
TTY: Call the Wisconsin Relay System at 711  
[MemberRights@communitycareinc.org](mailto:MemberRights@communitycareinc.org)  
Fax: 262-827-4044-

**What happens next?**

All appeals of a written denial of coverage or payment will be prepared and processed in a timely manner as required by the PACE regulations.

If you file an appeal with Community Care, we will send you a letter within five business days to let you know we received your appeal. Then, we will try to help informally address your concerns or come up with a solution that satisfies both you and Community Care. If we are not able to come up with a solution or if you do not want to work with Community Care staff to informally address your concerns, our Grievance and Appeal Committee will meet to review your appeal.

- We will let you know when the Committee plans to meet to review your appeal.
- The Committee is made up of Community Care representatives and at least one consumer. The consumer is a person who also receives services from us (or represents someone who does). We train this person on how to protect the privacy of others while serving on the Committee. Sometimes other people who specialize in the area of your appeal might be part of the Committee.
- The Committee includes an individual who is appropriately credentialed in the field(s) or discipline(s) related to the appeal.
- The Committee will make sure that services are provided consistent with the PACE benefits and service delivery requirements.
- Decisions must be made consistent with regulatory requirements.
- Certain Medicare and/or Medicaid limitations and conditions regarding benefits do not apply.
- The Committee's decision will not be made by anyone involved in making the original decision or who has a stake in the outcome of the appeal.
- The meeting is confidential. You can ask that the consumer not be on the Committee if you are concerned about privacy or have other concerns.
- You have the right to appear in person. You can bring an advocate, friend, family member, or witnesses with you.

- You and all parties involved in the appeal must be given a reasonable opportunity to present evidence related to the appeal in writing as well as in person.
- Your IDT or other Community Care staff will likely be at the meeting.
- The Committee will give you a chance to explain why you disagree with your IDT's decision. You or your representative can present information, bring witnesses, or describe your concerns to help the Committee understand your point of view.

After the Committee hears your appeal, Community Care will send you a decision letter within thirty (30) calendar days after we first got your appeal. If the decision is made in your favor, Community Care must furnish the disputed service as quickly as your health condition requires.

All decisions on appeals will be provided in writing. If the decision on an appeal is in your favor, Community Care PACE will provide the disputed service as quickly as your health condition requires. If the decision on an appeal is not in your favor, Community Care PACE will notify you at the same time that DHS and CMS are notified.

If you are not notified of the decision on your request for service in a timely manner or your IDT does not furnish the services needed to implement a revised care plan in the required period of time, it is considered an unfavorable decision. Your request will automatically be processed as an appeal. A Member Rights Specialist will notify you that an appeal is in process and explain how you can participate in the appeal process.

### **Speeding up your appeal**

Community Care has thirty (30) calendar days to decide your appeal. If you think waiting that long could seriously harm your health or your ability to regain maximum function, you can ask us to speed up your appeal. We call this an "expedited appeal." If you ask for a fast appeal, we will decide if your health requires it. We will let you know as soon as possible if we will expedite your appeal. You can request an expedited appeal in the same ways as described for a standard appeal.

In an expedited appeal, you will get a decision on your appeal no later than 72 hours after receipt of your request. However, Community Care may extend the 72-hour timeline by up to fourteen (14) calendar days if you request the extension or if Community Care justifies the need for additional information to the Wisconsin Department of Health Services and the delay is in your best interest. If you have additional evidence you want us to consider, you will need to submit it quickly.

### **What if I disagree with the Grievance and Appeal Committee's decision?**

If you disagree with Community Care's decision on your Medicaid appeal, you can request a State Fair Hearing with the Division of Hearings and Appeals (DHA). You must do so within ninety (90) calendar days from the date of the Grievance and Appeal Committee's decision. You can file an appeal with DHA if Community Care does not issue an appeal decision in a timely manner.

## State Fair Hearings

### Filing your appeal with the Wisconsin Division of Hearings and Appeals (DHA)

If you file an appeal with the Wisconsin Division of Hearings and Appeals (DHA), you will have a State Fair Hearing with an independent Administrative Law Judge. Administrative Law Judges do not have any connection to Community Care. You can find more information about State Fair Hearings online at <http://dha.state.wi.us/home/HrgInfo.htm> or ask a Member Rights Specialist.

### How do I request a State Fair Hearing?

To ask for a State Fair Hearing, you can either:

- **Send a request form.** You can get a copy from a Community Care Member Rights Specialist or download the form at [www.dhs.wisconsin.gov/forms/f0/f00236.doc](http://www.dhs.wisconsin.gov/forms/f0/f00236.doc).
- OR**
- **Mail a letter.** Include your name and contact information and explain what you are appealing. If you received a Notice of Adverse Benefit Determination or other notification of your appeal rights, it's a good idea to include a copy of that notice with your request for a State Fair Hearing. Do not send your original copy.

The Member Rights Specialist or an advocate can help you put your appeal in writing. To contact an advocate, see the end of this chapter.

#### **To request a State Fair Hearing**

Send the completed request form or a letter asking for a hearing to:

PACE Request for Fair Hearing  
c/o Wisconsin Division of Hearings and Appeals  
P.O. Box 7875  
Madison, WI 53707-7875  
(Or fax your request to 608-264-9885)

### What is the deadline to file an appeal with DHA?

You must file your appeal within ninety (90) calendar days after you receive the notice of Community Care's decision on your appeal.

### What happens next?

- After you send in your request for a State Fair Hearing, DHA will mail you a notice with the date, time and location of your hearing.
- The hearing will be at an office in your county or may be done by telephone.
- An Administrative Law Judge will run the hearing.
- You have the right to participate in the hearing. You can bring an advocate, friend or family member, or witnesses with you.
- Your IDT or other Community Care staff will be present at the hearing to explain their decision.

- You will have a chance to explain why you disagree with your IDT's decision. You or your representative can present information, bring witnesses, or describe your concerns to help the Judge understand your point of view.
- The Administrative Law Judge must issue a decision within 90 days of the date you filed a request for the hearing.

### **What can I do if I disagree with the Administrative Law Judge's decision?**

If you disagree with Administrative Law Judge's decision, you have two options.

- 1.) Ask for a re-hearing. If you want DHA to reconsider its decision, you must ask within 20 days from the date of the Judge's decision. The Administrative Law Judge will only grant a re-hearing if:
  - You can show that a serious mistake in the facts or the law happened, or
  - You have new evidence that you were unable to obtain and present at the first hearing.
- 2.) Take your case to circuit court. If you want to take your case to court, you must file your petition within 30 days from the date of the Judge's decision.

## **Medicare Appeal Process**

If you are eligible for Medicare and Community Care plans to stop or reduce an authorized service you are getting, has denied a service you requested or denies payment for a service you received, you have the right to submit a Medicare appeal to Community Care.

If your appeal involves a Medicare-covered benefit, you must go through the Community Care PACE appeal process before your appeal can go to an outside organization for review.

To submit your appeal to Community Care please send your request to:

Member Rights Specialist

Community Care, Inc.

205 Bishops way

Brookfield, WI 53005

Toll-Free: 1-866-992-6600

TTY: Call the Wisconsin Relay System at 711

Your appeal can be submitted orally or in writing.

If you are eligible for both Medicare and Medicaid and are dissatisfied with Community Care's decision on your appeal, you have the right to external review by the Independent Review Entity or the State Fair Hearing process. A Member Rights Specialist can help you decide which on to choose, if both are applicable.

## Denial of Medicare Services

If your IDT denies your request for a service, you may submit an appeal to Community Care. You must request a standard appeal or an expedited appeal within 60 days of the day Community Care notifies you that your request has been denied. You may submit your appeal by yourself or ask your IDT for help. You may also get help from a Community Care Member Rights Specialist. Please see the section below for more suggestions about getting help filing an appeal.

- Standard Appeal Process for Denial of Medicare Services

If you request a standard appeal, Community Care must notify you in writing of its decision as quickly as your health condition requires but no later than 30 calendar days from the time that Community Care received your appeal. If we deny your appeal, you can request a review of our decision by the Medicare Independent Review Entity (IRE). **C2C is the IRE for Medicare Part D appeals. MAXIMUS is the IRE for all other Medicare appeals.**

MAXIMUS and C2C are Independent Review Organizations hired by Medicare. The letter which explains that we denied your appeal tells you how to submit your appeal to MAXIMUS or C2C for review.

MAXIMUS and C2C are not connected to Community Care and are not government agencies. Medicare chose MAXIMUS and C2C to independently review appeal decisions made by organizations like Community Care.

If Community Care fails to respond to your appeal in the required time, you may also submit an appeal to MAXIMUS or C2C.

If Community Care agrees to provide the service you requested, we must authorize or provide the service as quickly as your health requires, but no later than 30 calendar days from the time you submitted your appeal. If your IDT fails to authorize or provide the service you requested in the required timeframe, Community Care will consider the failure to be an adverse decision and automatically process your request as an appeal. A member rights specialist will notify you that an appeal is in process and explain how you can participate in the appeal process.

If we fail to do so, you may submit an appeal to MAXIMUS or C2C.

Community Care must continue to furnish you with all other required services that are unrelated to your appeal during the appeal process.



- Expedited Appeal Request for Denial of Medicare Services

For situations in which you believe that your life, health, or ability to regain maximum function would be seriously jeopardized, without the service in dispute, Community Care will respond to the appeal as quickly as your health condition requires, but no later than 72 hours after it receives the appeal.

1. When you request an expedited appeal, Community Care will review your appeal and decide whether it should be handled through the expedited process. If we decide it does not qualify as an expedited appeal, we notify you that we will handle it through the standard appeal process. You may submit a grievance about Community Care's decision not to expedite your appeal.

When we expedite your appeal, we will review your appeal very quickly and respond to your appeal as quickly as your health condition requires but no later than 72 hours after receiving your appeal.

If we deny your expedited appeal, you can request a review of our decision by MAXIMUS or C2C.

If Community Care agrees to provide the service you requested, we must authorize or provide the service within 72 hours or as quickly as your health requires. If we fail to do so, you can appeal to MAXIMUS or C2C.

2. Extending the Expedited Review Timeframe

Community Care may extend the 72-hour timeframe by up to 11 calendar days for a total of no more than 14 calendar days if:

- You or your representative request an extension; or
- Community Care determines there is a need for additional time, the delay is in your best interest and justifies the extension to the Wisconsin Department of Health Services (DHS).

All appeals of a written denial of coverage or payment will be prepared and processed in a timely manner as required by the PACE regulations.

If you file an appeal with Community Care, we will send you a letter within five business days to let you know we received your appeal. Then, we will try to help informally address your concerns or come up with a solution that satisfies both you and Community Care. If we are not able to come up with a solution or if you do not want to work with Community Care staff to informally address your concerns, our Grievance and Appeal Committee will meet to review your appeal.

- We will let you know when the Committee plans to meet to review your appeal. The Committee is made up of Community Care representatives and at least one consumer. The consumer is a person who also receives services from us (or represents

- someone who does). We train this person on how to protect the privacy of others while serving on the Committee.
- The Committee will include an individual who is independently and appropriately credentialed in the field(s) or discipline(s) related to the appeal.
  - The Committee will ensure that services must be provided consistent with the PACE benefits and service delivery requirements.
  - Decisions must be made consistent with regulatory requirements.
  - Certain Medicare and/or Medicaid limitations and conditions regarding benefits do not apply.
  - The Committee's decision will not be made by anyone involved in making the original decision or who has a stake in the outcome of the appeal.
  - The meeting is confidential. You can ask that the consumer not be on the Committee if you are concerned about privacy or have other concerns.
  - You have the right to appear in person. You can bring an advocate, friend, family member, or witnesses with you.
  - You and all parties involved in the appeal must be given a reasonable opportunity to present evidence related to the appeal in writing as well as in person.
  - Your IDT or other Community Care staff will likely be at the meeting.
  - The Committee will give you a chance to explain why you disagree with your IDT's decision. You or your representative can present information, bring witnesses, or describe your concerns to help the Committee understand your point of view.

After the Committee hears your appeal, Community Care will send you a decision letter within thirty (30) calendar days after we first got your appeal.

All decisions on appeals will be provided in writing. If the decision on an appeal is in your favor, Community Care PACE will provide the disputed service as quickly as your health condition. If the decision on an appeal is not in your favor, the decision will also be communicated to you orally. Community Care PACE will notify you at the same time that DHS and CMS are notified.

### **Additional appeal rights under Medicare or Medicaid**

A Member Rights Specialist will help you choose whether to pursue a Medicare or Medicaid appeal, if both are applicable,

### **Reduction of Medicare Services**

If Community Care wants to reduce the amount or frequency of an approved service you are presently receiving, we must provide you with written notice at least 10 days in advance of the date on which services are to be reduced or terminated.

You may only appeal a reduction of a previously approved service. It is not a reduction in service if you have received all of the services that were authorized. In such cases, members who wish to receive additional services must submit a new request for these

services. This request will be subject to the rules for any new request for service.

If Community Care notifies you that it plans to reduce a service as described above, you may submit an appeal to Community Care.

You may request an expedited review of your appeal if you feel that your health will be seriously harmed if you do not receive a rapid decision. (See the discussion of expedited appeals above.)

You have up to 60 days from the date of the written notice to request an appeal. If you do not request an expedited appeal, Community Care PACE must respond as quickly as your health requires, but not more than 30 days from the time you request the appeal.

Under Medicare rules, Community Care does not have to continue to provide the reduced services while your appeal is being processed. However, if you submit your request for an appeal within 10 calendar days of receiving your written notice or prior to the date that the reduction is to begin (whichever comes first), Community Care must continue to provide the service until you have completed the appeal process (including appeals to MAXIMUS or C2C).

If Community Care denies your appeal, you can request a review of our decision by MAXIMUS or C2C.

### **Denial of Payment for Medicare Services**

Except for emergency care, Community Care will only pay for services that are approved by your IDT. If Community Care receives a bill for services that were not approved by us, we will refuse payment. We will notify you immediately, and you have the right to request an appeal when this happens. The appeal process is the same as for a standard appeal for denial of services. You must request an appeal no later than 60 calendar days after we notify you that we have refused payment.

Community Care must respond to your appeal no later than 30 calendar days from the time that you submit your appeal request. If Community Care agrees to pay for the services, we must make payment no more than 60 calendar days after you requested an appeal.

If Community Care does not notify you of the decision on your request for payment in the required time frame, it is considered an unfavorable decision. Your request will automatically be processed as an appeal. A Member Rights Specialist will notify you that an appeal is in process and explain how you can participate in the appeal process.

If Community Care denies your request for payment, you can request a review of our decision by MAXIMUS or C2C.

## How to ask for a coverage decision or file an appeal for a Medicare Part D prescription drug

PACE members follow the same Medicare process for Medicare Part D coverage determinations and appeals as previously described in this chapter.

Your benefits as a member of our plan include coverage for many prescription drugs. Medicare calls these outpatient prescription drugs “Part D drugs.” You can get these drugs as long as they are included in our plan’s *List of Covered Drugs* (“*Formulary*” or “*Drug List*” for short) and they are medically necessary for you, as determined by your primary care provider or other provider.

A coverage determination is a decision your IDT makes about your Part D benefits and coverage.

Here are examples of coverage determinations you can ask us to make about your Part D drugs:

- You can ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan’s Drug List
  - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
- You can ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan’s Drug List, but we require you to get approval from us before we will cover it for you.)
- You can ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

## How does Community Care handle your Medicare appeal?

If you file an appeal with Community Care, we will send you a letter within five business days to let you know we received your appeal. Then, we will try to help to informally address your concerns or come up with a solution that satisfies both Community Care and you. If we are not able to come up with a solution or if you do not want to work with Community Care staff to address your concerns, our Grievance and Appeal Committee will meet to review your appeal.

- The grievance and appeal committee is made up of:
  - Individuals who were not involved in any previous level of review or decision making.
  - Individuals who do not have a stake in the outcome of the appeal.
  - Individuals who are not subordinates of an individual who was involved in a previous level of review or decision making.
  - Community Care representatives and at least one “consumer”. The consumer is a person who also receives services from us or represents someone who does. We train this person on how to protect the privacy of others while serving on the Committee. Sometimes other people who specialize in the area of your grievance might be part of the Committee.
  - Individuals who will take into account all information you or your representative submit **regardless of whether this information was submitted or considered when the original decision was made.** Individuals who will respect your privacy and have been trained in maintaining confidentiality.

- The meeting is confidential. You can ask that the consumer not be on the Committee if you are concerned about privacy or have other concerns.
  - You have the right to appear in person. You can bring an advocate, friend, family member, or witnesses with you.
  - Your IDT or other Community Care staff will likely be at the meeting.
  - The Committee will give you a chance to explain why you disagree with your IDT's decision. You or your representative can present information, bring witnesses, or describe your concerns to help the Committee understand your point of view.
  - The Committee will give you a chance to explain why you disagree with your IDT's decision. You or your representative can present information, bring witnesses, or describe your concerns to help the Committee understand your point of view.
- After the Committee hears your appeal, Community Care will send you a decision letter within 30 calendar days after we first got your appeal.
- a. If the Community Care Grievance and Appeal Committee's decision is not in your favor or Community Care fails to provide a decision on an appeal within the required time period, you can request a review of the decision by the Medicare Independent Review Entity (IRE). C2C is the IRE for Medicare Part D appeals. MAXIMUS is the IRE for all other Medicare appeals.
  - b. You can contact MAXIMUS at 1-585-348-3300 or on the internet at <http://www.medicareappeal.com>.
  - c. You can contact C2C at 1-833-919-0198 or on the internet at <https://PartDAppeals.C2Cinc.com>.

If you are eligible for both Medicare and Medicaid, you have the right to external review by the Independent Review Entity or the State Fair Hearing process.

## Who can help me with my grievance or appeal?

You can contact a Community Care Member Rights Specialist any time you need help with a grievance or appeal, or have questions about your rights. You can ask anyone you want to act as an advocate for you, including family members, friends, an attorney, or any other person willing to help.

Below are some additional places you can contact for assistance.

### **Ombudsman Programs**

Regional ombudsmen programs are available to help all PACE members with grievances and appeals. They can respond to your concerns in a timely fashion. Both ombudsmen programs will typically use informal negotiations to resolve your issues without a hearing.

**Wisconsin Board on Aging and Long Term Care**

Ombudsmen from this agency provide advocacy to PACE members **age 60 and older**.

Board on Aging and Long Term Care  
1402 Pankratz Street, Suite 111  
Madison, WI 53704-4001  
Toll-free: 1-800-815-0015  
Fax: 608-246-7001  
<http://longtermcare.state.wi.us>

**Disability Rights Wisconsin (DRW)**

Ombudsmen from this agency provide advocacy to PACE members **under age 60**.

Disability Rights Wisconsin  
131 W. Wilson St., Suite 700  
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## Chapter 9. Ending your membership in Community Care

You can choose to end your membership in Community Care PACE at any time. We cannot advise or encourage you to disenroll from PACE due to your health condition. You might leave our plan because you have decided that you *want* to leave. However, there are some situations when your membership will end even if that wasn't your choice.

If you are leaving our plan, you must continue to get your care and drugs through our plan until your membership ends.

Whether your disenrollment is voluntary or involuntary, Community Care will do its best to help transition your care to whatever Medicare or Medicaid program you have chosen.

### **IMPORTANT**

If you enroll in any other Medicare or Medicaid plan or optional benefit while you are a Community Care PACE member, including a Medicare Advantage plan, another Medicare Part D Plan or the Medicare hospice program, it is considered a voluntary disenrollment from our program. Once you have enrolled in any of these plans, you will be disenrolled from PACE and lose all services and benefits provided by Community Care PACE.

If you are a Medicaid-only or private pay PACE member and you become eligible for Medicare, you will be disenrolled if you choose to get Medicare coverage from anywhere other than Community Care PACE.

### **Voluntary Disenrollment**

You may choose to disenroll from PACE for any reason. Voluntary disenrollment is effective on the first day of the month following the date Community Care PACE receives notice of your voluntary disenrollment. Please discuss the timing of your disenrollment with your IDT.

If you are eligible for Medicare at the time of disenrollment, you may go back to Original Medicare or another Medicare health plan. If you switch to Original Medicare and do not enroll in a Medicare prescription drug plan, you will not have coverage for prescription drugs. If you go 63 days or more in a row without Part D or other "creditable" prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare prescription drug plan later. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.)

If you are eligible for Medicaid at the time of disenrollment, you may continue to be covered by Medicaid. However, if you were not enrolled in Medicaid when you enrolled in PACE, you will have to apply to find out if you are eligible for Medicaid.

### **If you want to end your membership in PACE**

To end your membership, contact the Aging and Disability Resource Center (ADRC) in your area. The ADRC can also answer any questions you have about ending your membership. In addition, notify your IDT if you decide to disenroll. Please note that you cannot disenroll from Community Care PACE at a Social Security Office.

You can end your membership in Community Care PACE at any time.

### **Loss of PACE Eligibility**

**Community Care must report the things listed below to the Income Maintenance agency. An Income Maintenance worker will determine if you are still eligible for PACE. If they determine you are no longer eligible, they will end your membership in PACE.**

- You fail to pay the required monthly premium and are unable to pay or make satisfactory arrangements to pay the premium owed to Community Care, after a 30-day grace period,
- You fail to pay or make arrangements to pay any applicable Medicaid spend down liability or any amount due under the post-eligibility treatment of income process, after a 30-day grace period,
- You are no longer functionally eligible as determined by the Wisconsin Adult Long-Term Care Functional Screen.
- You permanently move out of Community Care's service area. If you plan to move within Wisconsin but outside of the PACE service area, your IDT may be able to ease the transition and help you find services in your new residence, so it is a good idea to let them know if you plan to move.
- You are in jail or prison.
- You are admitted to an Institute for Mental Disease (IMD) and the service was not authorized by Community Care PACE.



- You make any of the choices below that will result in the loss of eligibility:
  - You choose a primary care provider who is not in the Community Care provider network.
  - You choose to disenroll from, or if you are newly Medicare eligible, choose not to enroll in, any part(s) of Medicare for which you are eligible.
  - You choose to disenroll from, or if you are newly Medicare eligible, choose not to enroll in Community Care PACE.
  - You choose to enroll in any other Medicare or Medicaid prepayment plan or optional benefit, including the hospice benefit.

**Your membership CANNOT be ended for any reason related to your health or because you filed a grievance or appeal.**

**You have the right to file an appeal if you are disenrolled from PACE and your membership in Community Care ends.** You will get a notice from the Income Maintenance agency that tells you the reason for ending your membership. This notice will have the words “About Your Benefits” on the first page. The notice will explain how you can file an appeal.

## Chapter 10. Definitions of important words

**Abuse** – The physical, mental, or sexual abuse of an individual. Abuse also includes treatment without consent and unreasonable confinement or restraint. See Chapter 6 for full descriptions of the types of abuse.

**Administrative Law Judge** – An official who conducts a State Fair Hearing to resolve a dispute between a member and the member’s Managed Care Organization (MCO). See Chapter 8 for information about State Fair Hearings.

**Advance Directive** – A written statement of a person’s wishes about medical treatment used to make sure medical staff carry out those wishes should the person be unable to communicate their wishes. There are different types of advance directives and different names for them. “Living will, power of attorney for health care and do-not-resuscitate (DNR) order” are examples of advance directives. See Chapter 6 for more information on advance directives.

**Advocate** – Someone who helps members make sure the MCO is addressing their needs and outcomes. An advocate may help a member work with the MCO to informally resolve disputes and may also represent a member who decides to file an appeal or grievance. An advocate might be a family member, friend, attorney, ombudsman, or any other person willing to represent a member.

**Aging and Disability Resource Center (ADRC)** – Service centers that provide information and assistance on all aspects of life related to aging or living with a disability. The ADRC is responsible for handling enrollment and disenrollment in the PACE program. In Milwaukee County, there is an Aging Resource Center (ARC) for people 60 years and older and a Disability Resource Center (DRC) for people who are younger than 60.

**Appeal** – A request for review of a decision. Members can file an appeal regarding Community Care’s non-coverage of or nonpayment for, a service including denials, reductions or termination of services. Examples of this would be when the IDT decides to: stop, suspend a Medicaid-covered service or reduce a service the member is currently receiving, deny a service the member requests, or not pay for a covered service. Other types of appeals and the process for filing an appeal are in Chapter 8. An appeal will automatically be filed if the IDT does not make a timely decision on a service you request.

**Assets** – Assets include, but are not limited to, motor vehicles, cash, checking and savings accounts, certificates of deposit, money market accounts, and cash value of life insurance. The amount of assets a person has is used in part to determine eligibility for Medicaid.

**Authorized Representative** – A person who has the legal authority to make decisions for a member. An authorized representative may be court appointed, a person designated as the member’s power of attorney for health care or a person’s guardian.

**Care Plan** – An ongoing plan that documents the member’s personal experience and long-term care outcomes, needs, preferences, and strengths. The plan identifies the services the member receives from family or friends, and identifies authorized services the MCO will provide. The member is central to the care plan process. The IDT and member meet regularly to review the member’s care plan.

**Choice** – The PACE program supports a member’s choice when receiving services. Choice means members have a say in how and when care is provided. Choice also means members are responsible for helping their IDT identify services that are cost-effective. Members can also choose to direct one or more of their long-term care services by using the Member Preferred Caregiver option.

**Cost Share** – A monthly amount that some members may have to contribute toward the cost of their services. Cost share is based on income and is determined by the Income Maintenance agency. Individuals must pay their cost share every month to remain eligible for Medicaid. See Chapter 5 for information about cost share and spend down.

**Cost-Effective** – The option that effectively supports the member’s identified long-term care outcome at a reasonable cost and effort. The member and the IDT use the Resource Allocation Decision (RAD) method to determine ways to support the member’s long-term care outcomes. Then the member and the IDT look at the options and choose the most cost-effective (not necessarily the cheapest) way to support the member’s outcomes.

**Department of Health Services (DHS)** – The State of Wisconsin agency that runs Wisconsin’s Medicaid programs, including PACE.

**DHS Review** – A review of a member’s grievance by the Department of Health Services (DHS). DHS contracts with an outside organization called MetaStar to review member grievances. After completing the review, MetaStar issues a written, binding decision. See Chapter 8 for information about DHS reviews.

**Disenroll/Disenrollment** – The process of ending a person’s membership in PACE. A member can choose to disenroll from PACE at any time. The MCO has to disenroll a member in certain situations. For example, the MCO would disenroll a member if he or she loses eligibility for Medicaid or permanently moves out of the service area. Chapter 9 explains the disenrollment process in PACE.

**Division of Hearings and Appeals (DHA)** – The State of Wisconsin agency that hears Medicaid appeals for PACE. Administrative Law Judges in this Division conduct State Fair Hearings when a member files an appeal. This Division is independent of the MCO and DHS. See Chapter 8 for information about State Fair Hearings.

**Enroll/Enrollment** – Enrollment in PACE is voluntary. To enroll, individuals should contact their local Aging and Disability Resource Center (ADRC). The ADRC determines whether an individual is functionally eligible for PACE. The Income Maintenance agency also determines whether an individual is financially eligible for Medicaid. If the individual is eligible for PACE and wants to enroll, he or she must complete and sign an enrollment form.

**Estate Recovery** – The process where the State of Wisconsin seeks repayment for costs of Medicaid services when the individual receives Medicaid-funded long-term care. The State recovers money from an individual’s estate after the person and his or her spouse dies. The money recovered goes back to the Medicaid program to be used to care for other Medicaid recipients. See Chapter 6 for more information about estate recovery.

**Expedited Appeal** – A process that members can use to speed up their appeal. Members can ask the MCO to expedite their appeal if they think waiting the standard amount of time could seriously harm their health or ability to perform daily activities. See Chapter 8 for information about expedited appeals.

**Financial Eligibility** – Financial eligibility means eligibility for Medicaid. The Income Maintenance agency looks at a person’s income and assets to determine whether he or she is eligible for Medicaid.

**Functional Eligibility** – The Wisconsin Long Term Care Functional Screen determines whether a person is functionally eligible for PACE. The Functional Screen collects information on an individual’s health condition and need for help in such things as bathing, getting dressed and using the bathroom.

**Grievance** –An expression of dissatisfaction about care or services or other general matters. Subjects for grievances include quality of care, relationships between the member and his or her IDT and member rights. Chapter 8 explains grievances, including the process for filing a grievance.

**Guardian** –A person responsible for making decisions for someone who is not able to make decisions about his or her own life. The court may appoint a guardian for an individual if needed.

**Income Maintenance Agency** (*formerly known as Economic Support Agency*) – The government agency that determines an individual’s financial eligibility for Medicaid, and other public benefits.

**Interdisciplinary Team (IDT)** – Every PACE member is assigned an IDT. The PACE IDT includes a Primary Care Provider, Registered Nurse, Masters Prepared Social Worker, Recreational Therapist, Occupational Therapist, Physical Therapist, Dietician, Home Care Coordinator, Personal Care Attendant Representative, PACE Center Manager, Transportation Representative and the member.

The member is a central part of his or her IDT. Members can choose anyone else they want involved on their IDT, such as a family member or friend. The IDT works with members to assess needs, identify outcomes and create care plans. The team authorizes, coordinates and monitors services.

**Long-Term Care (LTC)** – A variety of services that people may need as a result of a disability, getting older, or having a chronic illness that limits their ability to do the things they need to do throughout their day. This includes such things as bathing, getting dressed, making meals, and going to work. Long-term care can be provided at home, in the community or in various types of facilities, including nursing homes and assisted living facilities.

**Long-Term Care Outcome** – A situation, condition or circumstance, that a member of the IDT identifies that maximizes a member’s highest level of independence. During the assessment, the IDT works with the member to assess their physical health needs and ability to perform daily activities. The IDT uses this information to determine a member’s long-term care outcomes. The MCO authorizes services based on long-term care outcomes.

Outcomes also include clinical and functional outcomes. A clinical outcome relates to a member's physical, mental or emotional health. An example of a clinical outcome is being able to breathe easier. A functional outcome relates to a member's ability to do certain tasks. An example of a functional outcome is being able to walk down stairs.

**Managed Care Organization (MCO)** – The agency that operates the PACE program.

**Medicaid** – A medical and long-term care program operated by the Wisconsin Department of Health Services. Medicaid is also known as “Medical Assistance,” “MA,” and “Title 19.”

**Medical Care (acute and primary)** – Medical or health care is the diagnosis, treatment, and prevention of chronic disease, illness, injury, and other physical and mental impairments. It includes the delivery of acute care (i.e., short-term care provided in a hospital or emergency room), primary care (i.e., care provided by a physician), and other levels of care that are a part of the continuum of care within the health care system.

**Medicare** – The Federal health insurance program for people age 65 or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or kidney transplant). Medicare covers hospitalizations, physician services, and prescription drugs.

**Member** – A person who meets functional eligibility criteria and enrolls in PACE.

**Member Preferred Caregiver** – The Member Preferred Caregiver option is a way for members to arrange, purchase and direct their long-term care services. Members have greater responsibility, flexibility and control over service delivery. With the Member Preferred Caregiver option, members can choose to control their own budget for long-term care services, and may have control over their providers including hiring, training, supervising, and firing their own direct care workers. Members can choose to self-direct all or some of their long-term care services.

**Member Rights Specialist** – An MCO employee who helps and supports members in understanding their rights and responsibilities. The Member Rights Specialist also helps members understand the grievance and appeal processes and can assist members who wish to file a grievance or appeal. See Chapter 8 for information about grievances and appeals.

**MetaStar** – The agency contracted by the Wisconsin Department of Health Services (DHS) to review grievances, when requested by members, and conduct independent quality reviews of MCOs. See Chapter 8 for information about DHS reviews.

**Notice of Adverse Benefit Determination** – A written notice from the MCO explaining a specific change in service and the reason(s) for the change. The MCO must send the member a Notice of Adverse Benefit Determination if the MCO denies a member's request for a new service, refuses to pay for a service, or plans to stop, suspend or reduce a member's service. See Chapter 8 for more information about appeals.

**Notification of Appeal Rights** – A written notice sent to members explaining their options for filing an appeal. MCOs must send a notification of appeal rights to members if the MCO

didn't provide services in a timely way or didn't meet the deadlines for handling an appeal. Other situations when MCOs send this notice include times when members didn't like their care plan because it didn't support their outcomes or requires members to accept care they didn't want. Income Maintenance agencies send members a notification of appeal rights when members lose financial or functional eligibility for PACE. See Chapter 8 for more information about appeals.

**Nursing Home Level of Care** – Members who are at this level of care have needs that are significant enough that they are eligible to receive services in a nursing home. A very broad set of services is available at this level of care. A person must be at a nursing home level of care to be eligible for PACE.

**Ombudsman** – A person who investigates reported concerns and helps members resolve issues. Disability Rights Wisconsin provides ombudsman services to potential and current PACE members under age 60. The Board on Aging and Long Term Care provides ombudsman services to potential and current members age 60 and older. Contact information for these agencies can be found in Chapter 1 and Chapter 8.

**Personal Outcomes** – The goals the member has for his or her life. One person's outcome might be being healthy enough to enjoy visits with her grandchildren, while another person might want to be able to be independent enough to live in his own apartment. See Chapter 3 for a list of personal outcome areas.

**Pharmacy Network** – A network pharmacy is a pharmacy where members can get their prescription drugs. We call them "network pharmacies" because they contract with our plan. In most cases, we will pay for prescriptions only if you have them filled at one of our network pharmacies.

**Power of Attorney for Health Care** – A legal document people can use to authorize someone to make specific health care decisions on their behalf in case they ever become unable to make those decisions on their own.

**Prior Authorization (Prior Approval)** – The IDT must authorize services before a member receives them (except in an emergency). If a member gets a service, or goes to a provider outside of the network, the MCO may not pay for the service.

**Program Benefits** – Services that are available to PACE members. The PACE benefits include all Medicare covered services, all Medicaid covered services and other services that the IDT determines are necessary to improve or maintain the member's health. These include, but are not limited to, medical care, prescription drugs, hospital care, personal care, home health, transportation, medical supplies, and nursing care. The services a member receives must be pre-authorized by the member's IDT and listed in the member's care plan. See Chapter 4 for more information about PACE Program Benefits.

**Provider Network** – Agencies and individuals the MCO contracts with to provide services. Providers include physicians, hospitals, home health agencies, assisted living care facilities, and nursing homes. The IDT must authorize the member's services before the member can choose a provider from the directory. See Chapter 3 for information about the MCO's provider network.

**Residential Services** – Residential care settings include adult family homes (AFHs), community based residential facilities (CBRFs), residential care apartment complexes (RCACs), and nursing homes. The member’s IDT must authorize all residential services.

**Resource Allocation Decision (RAD) Method** – A tool a member and his or her IDT use to help find the most effective and efficient ways to meet the member’s needs and support his or her outcomes.

**Room and Board** – The portion of the cost of living in a residential care setting related to rent and food costs. Members are responsible for paying their room and board expenses. See Chapter 5 for information about room and board.

**Service** – All Medicare-covered services, all Medicaid-covered services and other services determined necessary by the IDT to maintain and improve the member’s overall health, including items and drugs.

**Service Area** – The geographic area where a member must reside in order to enroll and remain enrolled in Community Care PACE.

**State Fair Hearing** – A hearing held by an Administrative Law Judge who works for the Wisconsin Division of Hearing and Appeals. Members may file a request for a State Fair Hearing when they want to appeal a decision made by their IDT. Members may also ask for a State Fair Hearing if they filed an appeal with their MCO and were unhappy with the MCO’s decision. Notices of Adverse Benefit Determination and notifications of appeal rights give members information on how to file a request for a State Fair Hearing. See Chapter 8 for information about State Fair Hearings.

## Chapter 11. Home and Community-Based Waiver Service Definitions

<b>Home and Community-Based Waiver Service Definitions</b> Full definitions available upon request
<p><b>Adaptive Aids</b> are controls or appliances that enable people to increase their abilities to perform activities of daily living or control the environment in which they live (including patient lifts, control switches, etc.). Adaptive aids are also services that help people to access, participate and function in their community. This includes vehicle modifications (such as van lifts, hand controls), and may include the initial purchase of a service dog and routine veterinary costs for a service dog. (Excludes food and non-routine veterinary care for service dogs.)</p>
<p><b>Adult Day Care Services</b> 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. Services may include personal care and supervision, light meals, medical care, and transportation to and from the day care site.</p>
<p><b>Assistive Technology/Communication Aids</b> means an item, piece of equipment or product system that increases, maintains or improves the functional ability of members at home, work and in the community. Services include devices or services that assist members to hear, speak or see, such as communication systems, hearing aids, speech aids, interpreters and electronic technology (tablets, mobile devices, software).</p>
<p><b>Care Management Services</b> (also known as case management or service coordination) are provided by an IDT. The member is the center of the IDT. The IDT consists of, at minimum, a registered nurse and a care manager, and may also include other professionals as appropriate to the needs of the member and family or other natural supports requested by the member. Services include assessment, care planning, service authorization and monitoring the member's health and well-being.</p>
<p><b>Consultative Clinical and Therapeutic Services</b> assist unpaid caregivers and paid support staff in carrying out the member's treatment or support plan. Services include assessments, development of home treatment plans, support plans, intervention plans, training and technical assistance to carry out the plans. Services also include training for caregivers and staff that serve members with complex needs (beyond routine care).</p>
<p><b>Consumer Education and Training</b> are services designed to help a person with a disability develop self-advocacy skills, support self-determination, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services. These services include education and training for members, their caregivers and legal representatives. Covered expenses may include enrollment fees, books and other educational materials, and transportation to training courses, conferences and other similar events.</p>
<p><b>Counseling and Therapeutic Services</b> are services to treat personal, social, physical, medical, behavioral, emotional, cognitive, mental health, or alcohol or other drug abuse disorders. Services may include assistance in adjusting to aging and disability, assistance with interpersonal relationships, recreational therapies, art therapy, nutritional counseling, medical counseling, weight counseling and grief counseling.</p>



**Daily Living Skills Training** teaches members and their natural supports the skills involved in performing activities of daily living, including skills to increase the member's independence and participation in community life. Examples include teaching money management, home care maintenance, food preparation, mobility training, self-care skills and the skills necessary for accessing and using community resources.

**Day Services** is the provision of regularly scheduled activities in a non-residential setting (day center) to enhance social development and to develop skills in performing activities of daily living and community living.

**Financial Management Services** assist members and their families to manage service dollars or manage their personal finances. This service includes a person or agency paying service providers after the member authorizes payment for services included in the member's self-directed support plan. Fiscal Management Services also includes helping members with budgeting personal funds to ensure resources are available for housing and other essential costs.

**Home Delivered Meals** (sometimes called "meals on wheels") include the costs associated with the purchase and planning of food, supplies, equipment, labor and transportation to deliver one or two meals a day to members who are unable to prepare or obtain nourishing meals without assistance.

**Home Modifications** are the provision of services and items to assess the need for, arrange for and provide modifications or improvements to a member's living quarters in order to provide accessibility or increase safety. Home modifications may include materials and services such as ramps, stair lifts, wheelchair lifts, kitchen/bathroom modifications, specialized accessibility/safety adaptations and voice-activated, light activated, motion activated and electronic devices that increase the member's self-reliance and capacity to function independently.

**Housing Counseling** is a service that helps members to obtain housing in the community, where ownership or rental of housing is separate from service provision. Housing counseling includes exploring home ownership and rental options, identifying financial resources, identifying preferences of location and type of housing, identifying accessibility and modification needs and locating available housing.

**Member Preferred Caregiver services** are services to assist members with activities of daily living and housekeeping services members need to live in the community. Activities of daily living include help with bathing, eating, dressing, managing medications, oral, hair and skin care, meal preparation, bill paying, mobility, toileting, transferring and using transportation. The member selects an individual to provide his or her services, pursuant to a physician's order and following his or her member-centered plan .

**Personal Emergency Response System** is a service that provides a direct communications link (by phone or other electronic system) between someone living in the community and health professionals to obtain immediate assistance in the event of a physical, emotional or environmental emergency.

**Prevocational Services** involve learning and work experiences where a member can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated, community settings. These services develop and teach general skills which include the ability to communicate effectively with supervisors, co-workers and customers, generally accepted community workplace conduct and dress, ability to follow directions, ability to attend to tasks, workplace problem solving skills, general workplace safety and mobility training. Prevocational services are designed to create a path to integrated community-based employment for which a person is paid at or above the minimum wage, but not less than the usual wage and level of benefits paid for the same or similar work performed by people without disabilities.

**Relocation Services** are services and items a member would need in order to move from an institution or a family home to an independent living arrangement in the community. Relocation services may include payment for moving the member's personal belongings, payment for general cleaning and household organization services, payment of a security deposit, payment of utility connection costs and telephone installation charges, the purchase of necessary furniture, telephones, cooking/serving utensils, basic cleaning equipment, household supplies, bathroom and bedroom furnishings and kitchen appliances.

**Residential Care: 1-2 Bed Adult Family Home** is a place in which the operator provides care, treatment, support, or services above the level of room and board for up to two adults. Services typically include supportive home care, personal care and supervision. Services may also include transportation and recreational/social activities, behavior and social support and daily living skills training.

**Residential Care: 3-4 Bed Adult Family Home** is a place where 3-4 adults who are not related to the licensee reside and receive care, treatment or services above the level of room and board, and may include up to seven hours per week of nursing care per resident. Services typically include supportive home care, personal care and supervision. Services may also include behavior and social support, daily living skills training and transportation.

**Residential Care: Community-Based Residential Facility (CBRF)** is a homelike setting where five or more adults who are not related to the operator or administrator reside and receive care, treatment, support, supervision, training, transportation, and up to three hours per week of nursing care per resident.

**Residential Care: Residential Care Apartment Complex (RCAC)** is a homelike, community-based setting where five or more adults reside in their own living units that are separate and distinct from each other. Services include supportive services (laundry, house cleaning), personal care, nursing services (wound care, medication management) and assistance in the event of an emergency.

**Respite Care Services** are services provided on a short-term basis to relieve the member's family or other primary caregiver(s) from daily stress and care demands. Respite care may be provided in the member's home, a residential facility, a hospital or a nursing home.

**Skilled Nursing** are medically necessary skilled nursing services that may only be provided by an advanced practice nurse, a registered nurse (RN) or a licensed practical nurse (LPN) working under the supervision of a registered nurse. Skilled nursing includes observation and recording of symptoms and reactions, general nursing procedures and techniques, and may include periodic assessment of the member's medical condition and ongoing monitoring of a member's complex or fragile medical condition.

**Specialized Medical Equipment and Supplies** are those items necessary to maintain the member's health, manage a medical or physical condition, improve functioning or enhance independence. Allowable items may include incontinence supplies, wound dressing, orthotics, enteral nutrition (tube feeding) products, certain over the counter medications, medically necessary prescribed skin conditioning lotions/lubricants, prescribed Vitamin D, multi-vitamin or calcium supplements, and IV supplies.

**Support Broker** is a person the member chooses to assist him or her in planning, obtaining and directing member preferred caregiver which may be called self-directed support (SDS).

**Supported Employment Services** (individual and small group employment support services) help members who, because of their disabilities, need on-going support to obtain and maintain competitive employment in an integrated community work setting. The outcome of this service is sustained paid employment at or above minimum wage in an integrated setting in the general workforce, in a job that meets personal and career goals.

- Individual employment services are individualized and may include vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, meeting with prospective employers, job analysis, job coaching and training, transportation, career advancement services or support to achieve self-employment.
- Small group employment services are services and training provided in a business, industry or community setting for groups of two to eight workers with disabilities. Examples include mobile crews and other business-based workgroups employing small groups of workers with disabilities in employment in the community. Services may include vocational/job-related discovery or assessment, person-centered employment planning, job placement, job development, meeting with prospective employers, job analysis, training and systemic instruction, job coaching and training, transportation, career advancement services or support to achieve self-employment.

**Supportive Home Care (SHC)** includes services that directly assist members with daily living activities and personal needs to ensure adequate functioning in their home and community. Services may include help with dressing, bathing, managing medications, eating, toileting, grooming, mobility, bill paying, using transportation and household chores.

**Training Services for Unpaid Caregivers** assist the people who provide unpaid care, training, companionship, supervision or other support to a member. Training includes instruction about treatment regimens and other services included in the member's care plan, use of equipment specified in the service plan, and guidance, as necessary, to safely maintain the member in the community.

**Transportation (specialized transportation) – Community and Other Transportation**

- Community transportation services help members gain access to community services, activities and resources. Services may include tickets or fare cards, as well as transportation of members and their attendants to destinations. Excludes emergency (ambulance) transportation.
- Other transportation services help self-directing members to receive non-emergency, Medicaid-covered medical services. Services may include tickets or fare cards, reimbursement for mileage as well as transportation of members and their attendants to destinations. Excludes non-medical transportation, which is provided under community transportation-see above. Excludes emergency (ambulance) transportation.

**Vocational Futures Planning and Support** is a person-centered, team-based employment planning and support service that provides assistance for members to obtain, maintain or advance in employment or self-employment. This service may include the development of an employment plan, work incentive benefits analysis and support, resource team coordination, career exploration and employment goal validation, job seeking support and job follow-up and long-term support.

## Chapter 12. Notice of privacy practices

### Notice of Privacy Practices

Community Care, Inc. / Community Care Health Plan, Inc.  
(Community Care)  
205 Bishops Way  
Brookfield, WI 53005  
[www.communitycareinc.org](http://www.communitycareinc.org)

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal law that requires that all medical records and other individually identifiable health information used or disclosed by Community Care in any form, are kept properly confidential. HIPAA gives you significant rights to understand and control how your health information is used.

As required by HIPAA, this notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

#### **Your Rights**

**When it comes to your health information, you have certain rights.** This section explains your rights and some of Community Care’s responsibilities to help you. You have the right to:

#### **Get a copy of health and claims records**

- You can ask to see or get a copy of the health and claims records and other health information we have about you.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### **Ask us to correct health and claims records**

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We are not required to agree to the change you have requested and may say “no” to your request, but we’ll tell you why in writing within 60 days.

#### **Request confidential communications**

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not honor your request.

#### **Ask us to limit what we use or share**

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

#### **Get a list of those with whom we’ve shared information**

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

#### **Get a copy of this privacy notice**

You can ask for a copy of this notice at any time. We will provide you with a paper copy promptly.

#### **Choose someone to act for you**

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

#### **File a complaint if you feel your rights are violated**

- You can complain if you feel we have violated your rights by contacting us. Our contact information can be found at the end of this notice.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **[www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)**.
- We will not retaliate against you for filing a complaint.

#### **Your Choices**

**For certain health information, you can tell us your choices about what we share.**

If you have a clear preference for how we share your information in the situations

described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

*If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*

## **Our Uses and Disclosures**

### **How do we typically use or share your health information?**

We typically use or share your health information in the following ways:

#### **To help manage the health care treatment you receive**

- We can use your health information and share it with professionals who are treating you. Treatment means providing, coordinating, or managing your health care and related services.

*Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*

#### **To run our organization**

- We can use and disclose your information to operate our organization and contact you when necessary. This includes the business aspects of running our health plan, such as conducting quality assessment and improvement activities, auditing, budgeting and customer service.

*Example: We use health information about you to develop better services for you.*

#### **To pay for your health services**

- We can use and disclose your health information as we pay for your health services. Payment means such activities as reimbursing providers for services, confirming eligibility, billing or collection activities and utilization review.
- Example: We process a claim and pay a provider for an office visit.

### **How else can we use or share your health information?**

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

### **Help with public health and safety issues**

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

### **Do research**

We can use or share your information for health research if you give us written permission or if all references to your individually identifiable information have been removed.

### **Comply with the law**

- We can share information about you if state or federal laws require it, including sharing your information with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

### **Respond to organ and tissue donation requests and work with a medical examiner or funeral director**

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

### **Address workers' compensation, law enforcement, and other government requests**

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

### **Respond to lawsuits and legal actions**

We can share health information about you in response to a court or administrative order, or in response to a subpoena.



### **Our Responsibilities**

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you give us written permission. You may change your mind at any time. Let us know in writing if you change your mind.
- We will not sell your health information.
- We will not share your psychiatric, substance abuse and HIV-related information without your written permission except when permitted by law.
- We will abide by all applicable state and federal laws. There may be state and federal laws that have more requirements than HIPAA on how we use and disclose your health information. If there are specific, more restrictive requirements, even for some of the purposes listed above, we may not disclose your health information without your written permission.

For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

### **Changes to the Terms of this Notice**

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our web site. We will provide you with a copy of the revised notice within 60 days of the change.

This notice is effective as of November, 2013.

Please contact us for more information:

Compliance Officer  
Community Care, Inc. / Community Care Health Plan, Inc.  
205 Bishops Way  
Brookfield, WI 53005  
414-231-4000  
compliancehotline@communitycareinc.org  
Compliance Hotline: 800-826-6762

## **Chapter 13. Community Care PACE Enrollment Agreement Form**

I have received an Enrollment Agreement and Member Handbook from Community Care, which includes a description of benefits available, including all Medicare and Medicaid services, and how services can be obtained.

I have received a list of current providers. I understand that I may request additional providers for the network, including a primary care physician at enrollment time.

I understand that my PACE IDT and physician will authorize services. If I wish to obtain services outside the PACE network, I must obtain prior approval from Community Care or I will be financially responsible.

I have received information on grievance and appeal procedures.

I have received a copy of the Member Bill of Rights, and they were discussed at enrollment. I understand my rights and responsibilities.

I understand I may contact 1-800-MEDICARE for information and assistance including to make a complaint relate to the quality of care of the delivery of a services.

I have received a copy of Community Care’s Notice of Privacy Practices.

I have been asked whether I have advance directives or if I would like to discuss advance directives further with a Community IDT member.

I have received information on how to obtain emergency services and urgent care and I understand that I am not financially responsible for any emergency or out of area urgent care.

I understand I have the right to reasonable and timely access to specialists as indicated by my health condition and consistent with current clinical practice guidelines.

I understand I have a right to receive necessary care in all settings including placement in a long-term care facility when Community Care can no longer provide the services necessary to keep me safely in the community.

I understand that I may voluntarily disenroll from the Community care program at any time. I understand that my disenrollment will be effective on the first day of the month following the date Community Care receives my notice of voluntary disenrollment.

I understand that I may not enroll or disenroll in Community Care PACE at a Social Security Office.

I understand that if I am eligible for both Medicare and Medicaid, I am not liable for any premiums but may be liable for any cost share amounts that I must pay to retain financial eligibility for Wisconsin Medicaid.

I understand that I may be contacted for on-going quality assurance by Community Care staff or someone outside of the program authorized to do quality assurance. I understand that my participation is voluntary.

I authorize the disclosure and exchange of information between Community Care and state and federal oversight agencies and their authorized representatives.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Community Care is a private, non-profit organization that integrates health care and well-being services to provide the wider range of help that seniors and adults with disabilities need. In business since 1977, our services allow people to continue living independently, in their own homes and communities.

*Community Care has a contract with the Wisconsin Department of Health Services and is a certified care management organization.*



Community Care Health Plan, Inc. • 205 Bishops Way • Brookfield, WI 53005  
[www.communitycareinc.org](http://www.communitycareinc.org) • Telephone: 414-231-4000 • Toll-free: 866-992-6600  
TTY users call the Wisconsin Relay System at 711