



Family Care Partnership Program Member Handbook

IMPORTANT:

If you are covered by Medicare, see your Evidence of Coverage for information about your benefits.

Ask your care team for a copy of the Evidence of Coverage or view it on our website:
www.communitycareinc.org.



For help or information:

www.communitycareinc.org

Call toll free: 866-992-6600

TTY, the Wisconsin Relay System at 711

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

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

Community Care

- Provides free aids and services to people with disabilities, such as:
 - Sign language interpreters
 - Written information in large print, audio, accessible electronic formats, and other formats
- Provides free language services to people whose primary language is not English, such as
 - Interpreters
 - Information written in other languages

If you need these services, contact Community Care at 1-866-992-6600.

Community Care complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, gender, age, national origin, or disability.

Table of Contents

Chapter 1. Important phone numbers and resources	4
Chapter 2. Introduction to Family Care Partnership.....	14
Welcome to Community Care	14
Your membership cards	15
How can the Partnership program help me?.....	15
Who will help me?	16
What does it mean to be a member?	17
Who can be a member of Community Care?.....	17
How do I become a member?	18
How does Partnership work?	18
What should be in my care plan?	20
How does Partnership help me manage my services?	20
What are self-directed supports (SDS)?.....	21
Chapter 3. What to know about getting services	22
How are services selected and authorized?.....	22
What if my needs change?	23
Important rules for getting your care and services.....	23
How do I use the provider network?.....	24
Why do I need to know which providers are part of our network?	24
What is a primary care provider (PCP)?	25
How do I change my PCP?	25

What kinds of medical care can I get without prior approval from my care team?.....25

How do I get care from specialists and other network providers?.....26

What if a specialist or another network provider leaves the plan?26

How do I get my prescription drugs?.....26

How do I get care if I have a medical emergency?.....26

What is covered if I have a medical emergency?27

What if it wasn't a medical emergency?.....27

What is "urgently needed care?".....28

What if I am *in* the plan's service area when I have an urgent need for care?28

What if I am *outside* the plan's service area when I have an urgent need for care?.....28

How do I get help after normal business hours?.....28

What if I need care while I am out of the area?28

Chapter 4. The Partnership benefit package.....30

 What Medicaid services are provided?.....30

 Partnership Medicaid benefit package31

Chapter 5. Understanding who pays for services and coordination of your benefits.....34

 Will I pay for any services?34

 How do I make a payment?36

 What if I get a bill for services?.....36

 Does Partnership pay for residential services or nursing homes?.....36

 How are my other insurance benefits coordinated?37

 What is estate recovery? How does it apply to me?38

Chapter 6. Your rights39

Chapter 7. Your responsibilities43

Chapter 8. Grievances and Appeals46

 Introduction.....46

 Grievances.....48

 Appeals52

 State fair hearing.....57

 Who can help me with my grievance or appeal?59

Chapter 9. Ending your membership in Community Care61

APPENDICES.....63

 1. Definitions of important words..... 63

 2. Home and Community-Based Waiver Services 69

 3. Notice of Privacy Practices..... 86

Chapter 1. Important phone numbers and resources

Corporate office:

Community Care Health Plan, Inc. (Community Care)
205 Bishops Way
Brookfield, WI 53005
Office hours: 8:00 a.m. to 4:30 p.m. Monday – Friday

How to contact Community Care Customer Service

For help with claims, billing, or member card questions, call or write to your care team or contact Community Care Customer Service. We're here to help.

Customer service contacts	
Call	866-992-6600 You can call from 8 a.m. to 4:30 p.m., Monday–Friday. For help after hours, on weekends, and holidays, call 866-992-6600. Free language interpreter services are available for non-English speakers.
TTY	711 (Wisconsin Relay)
Write	205 Bishops Way Brookfield, WI 53005
Website	www.communitycareinc.org

If you are having an emergency, call 911.

How to contact us about a coverage decision for your medical care, long-term care services, or prescription drugs

A coverage decision is a decision we make about your benefits and coverage. It could also be about the amount we will pay for your medical care, long-term care services, or prescription drugs.

You can call us if you have questions about coverage decisions.

Coverage decision contacts	
Call	866-992-6600 You can call from 8 a.m. to 4:30 p.m., Monday–Friday. For help after hours, on weekends, and holidays, call 866-992-6600. Free language interpreter services are available for non-English speakers.
TTY	711 (Wisconsin Relay)
Write	205 Bishops Way Brookfield, WI 53005
Website	www.communitycareinc.org

How to contact ForwardHealth to ask about a coverage decision for prescription drugs if you do not have Medicare

If you do not have Medicare, you will get your prescription drugs from Wisconsin Medicaid. You'll use your ForwardHealth card.

ForwardHealth Member Services	
Call	800-362-3002 Free language interpreter services are available for non-English speakers.
Website	www.dhs.wisconsin.gov/forwardhealth/resources.htm

How to contact us to make a *complaint* about your medical care or long-term care services

You can make a complaint about us or our providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. This type of complaint is called a grievance. See Chapter 8 for more information.

Contacts for complaints about medical care or long-term care services	
Call	866-992-6600 You can call from 8 a.m. to 4:30 p.m., Monday–Friday. For help after hours, on weekends, and holidays, call 866-992-6600. Free language interpreter services are available for non-English speakers.
TTY	711 (Wisconsin Relay)
Write	205 Bishops Way Brookfield, WI 53005
Email	MemberRights@communitycareinc.org
Website	www.communitycareinc.org

How to contact us to make an *appeal* about your medical care or long-term care services

An appeal is a formal way of asking us to review and change a coverage decision we made. See Chapter 8 for more information on making an appeal about your medical care, long-term care services, or prescription drugs.

Contacts for appeals for medical care or long-term care services	
Call	866-992-6600 You can call from 8 a.m. to 4:30 p.m., Monday–Friday. For help after hours, on weekends, and holidays, call 866-992-6600. Free language interpreter services are available for non-English speakers.
TTY	711 (Wisconsin Relay)
Write	205 Bishops Way Brookfield, WI 53092
Email	MemberRights@communitycareinc.org
Website	www.communitycareinc.org

Where to send a request asking us for reimbursement or to pay a bill for medical care or long-term care services you have received

See Chapter 5 for more information about asking us to reimburse you or to pay a bill from a provider.

Please note: If you send us a payment request and we deny any part of it, you can appeal our decision. See Chapter 8 for more information.

Payment request contacts	
Call	866-992-6600 You can call from 8 a.m. to 4:30 p.m., Monday–Friday. For help after hours, on weekends, and holidays, call 866-992-6600. Free language interpreter services are available for non-English speakers.
TTY	711 (Wisconsin Relay)
Write	205 Bishops Way Brookfield, WI 53092
Website	www.communitycareinc.org

Social Security

The United States Social Security Administration (SSA) determines eligibility for Social Security benefits. To apply for Social Security, call SSA or visit your local Social Security Office. SSA also oversees Medicare.

Social Security Administration	
Call	800-772-1213 Available 8 a.m. to 7 p.m. Central Time, Monday–Friday. <ul style="list-style-type: none">You can use the automated phone services to get recorded information 24 hours a day. You can also do simple tasks, like get your account status, find the address of your local Social Security office, or request a new social security card.
TTY	800-325-0778
Website	www.ssa.gov

Medicaid

Medicaid government program that helps people get health care, long-term care, and services for health and well-being.

If you have questions about Medicaid, contact ForwardHealth Member Services.

ForwardHealth Member Services contacts	
Call	800-362-3002
Email	memberservices@wisconsin.gov
Website	www.dhs.wisconsin.gov/medicaid

All Medicaid applicants and members can use ACCESS. ACCESS is a website (www.access.wi.gov) that you can use to:

- See which programs can help you
- Apply for benefits
- Check your benefits
- Report changes
- Renew your benefits
- Get a new ForwardHealth Card

You can call ForwardHealth Member Services at 800-362-3002 to get:

- General information about Medicaid
- A new ForwardHealth Card

You can contact your local county or tribal agency to:

- Ask questions about enrollment rules for BadgerCare Plus, Medicaid, or FoodShare.
- Find out if your application was approved or why it was denied.
- Report changes to your information (for example, a change in address, a job, or health care).
- Send proof of eligibility.

To get the address and phone number of your agency, call 800-362-3002 or visit www.dhs.wisconsin.gov/forwardhealth/imagency.

If you suspect anyone of misuse of public assistance funds, call the fraud hotline or file a report online

To report public assistance fraud at the state level, call 877-865-3432 (toll free) or visit www.reportfraud.wisconsin.gov. You may remain anonymous.

Ombudsman programs

An ombudsman is an advocate for people in long-term care programs who get long-term care services. They can help address questions and concerns. They can also help you understand your rights.

The organization to contact depends on your age.

Disability Rights Wisconsin Ombudsmen from this agency help people under age 60 .	
Call	General: 800-928-8778 Fax: 833-635-1968
TTY	888-758-6049
Write	1502 West Broadway, Suite 201 Madison, WI 53713
Email	info@drwi.org
Website	disabilityrightswi.org/program/family-care-and-iris-ombudsman-program (See website for contact information for other locations.)

Wisconsin Board on Aging and Long Term Care Ombudsmen from this agency help people age 60 and older .	
Call	800-815-0015
Write	1402 Pankratz Street, Suite 111 Madison WI 53704-4001
Email	BOALTC@wisconsin.gov
Website	https://longtermcare.wi.gov

How to contact the Railroad Retirement Board

The Railroad Retirement Board is a federal agency that oversees benefit programs for railroad workers and their families. Contact them with questions about your benefits from the Railroad Retirement Board.

Railroad Retirement Board contacts	
Call	877-772-5772
TTY	312-751-4701 This number requires special telephone equipment and is only for people who have difficulty hearing or speaking.
Website	www.rrb.gov

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

ADRCs and Tribal Resource Centers serve the public and offer information. They help with issues that affect older adults, people with disabilities, and their families. ADRCs and Tribal Resource Centers make it easy to learn about resources near you.

ADRCs and Tribal Resource Centers:

- Share information about programs and services in your area.
- Help people understand their long-term care options.
- Help people apply for programs and benefits.
- Help people find ways to pay for long-term care.

You can connect with your local ADRC or Tribal Resource Center:

- By telephone.
- In person at the ADRC or Tribal Resource Center.
- Through a home visit.

Visit www.dhs.wisconsin.gov/adrc for more information about ADRCs.

You can contact your local ADRC and Tribal Resource Center as listed below.

County	Phone Number	TTY/TDD
Calumet County ADRC	920-849-1451	Call the Wisconsin Relay System at 711
Kenosha County ADRC	262-605-6646	Call the Wisconsin Relay System at 711
Milwaukee County ADRC	414-289-6874	Call the Wisconsin Relay System at 711
Racine County ADRC	262-638-6800	Call the Wisconsin Relay System at 711

Outagamie County ADRC	920-832-5178	Call the Wisconsin Relay System at 711
Ozaukee County ADRC	262-284-8120	Call the Wisconsin Relay System at 711
Washington County ADRC	262-335-4497	Call the Wisconsin Relay System at 711
Waukesha County ADRC	262-548-7848	Call the Wisconsin Relay System at 711
Waupaca County ADRC	715-258-6400	Call the Wisconsin Relay System at 711

FoodShare Wisconsin

FoodShare helps people with limited money buy the food they need for good health. People all over Wisconsin get help from FoodShare. The program helps people of all ages who have low income jobs, live on a small or fixed income, have lost their jobs, or have a disability and can't work.

FoodShare Wisconsin	
Call	QUEST Card Service at 877-415-5164 <ul style="list-style-type: none"> • Get general information about your QUEST card. • Report that you did not get a QUEST card. • Report a lost, stolen, or damaged QUEST card. • Get your current account balance.
TTY	711 (Wisconsin Relay)
Website	www.dhs.wisconsin.gov/foodshare

Chapter 2. Introduction to Family Care Partnership

Welcome to Community Care

Welcome to Community Care, a managed care organization (MCO) that runs the Family Care Partnership program (also known as Partnership). Partnership is a Medicaid program that helps older adults and adults with physical, developmental, or intellectual disabilities. It mixes health and long-term support services in home and community settings.

This handbook will give you the information you need to:

/

- Become familiar with the medical care and long-term care services in the benefit package.
- See which services Partnership covers.
- Know your rights and responsibilities.
- File a grievance or appeal if you have a problem or concern.

Contact your care team if you want help reviewing this handbook. Their contact information is below.

Partnership Care Team Contact Information

Calumet County 1848 N. Casaloma Dr. Appleton, WI 54913 920-441-5075	Outagamie County 1848 N. Casaloma Appleton, WI 54913 920-441-5075	Washington County 910 E. Paradise Drive West Bend, WI 53095 262- 338-5933
Milwaukee County 3220 W. Vliet St. Milwaukee, WI 53208 414-231- 4000	Ozaukee County 910 E. Paradise Dr. West Bend, WI 53095 262- 338-5933	Waukesha County 1801 Dolphin Drive Waukesha, WI 53186 262-953-8500
	Racine and Kenosha Counties 6216 Washington Avenue Suite 200 Racine, WI 53406 262-633-4800	Waupaca County 102 Grand Seasons Drive Waupaca, WI 54981 715-256-3435

The words “you” and “your” in this handbook refer to **you**, the **member**. “You” and “your” may also mean your legal decision maker. This could be a legal guardian or activated power of attorney.

The end of this document (page 63) has definitions of important words. They can help you understand the words and phrases in this handbook.

Your membership cards

You will get a ForwardHealth card from Wisconsin Medicaid. You will need your ForwardHealth card to get your prescription drugs. If your ForwardHealth card is damaged, lost, or stolen, call ForwardHealth Member Services at 800-362-3002 right away to ask for a new card.

When you join Partnership, you will get a Partnership membership card. **You must show your membership card whenever you get services.**

Always carry your Partnership member card with you. Show it every time you get care. You may have problems getting health care or long-term care services if you don't have your card with you. If you get services using a different insurance card, **you may have to pay the full cost yourself.**

If your Partnership membership card is damaged, lost, or stolen, contact your team. Here is a sample Partnership membership card.



How can the Partnership program help me?

A main goal of Partnership is to ensure that you are safe and supported at home. When you live in your own home or in your family's home, you have more power over your life. You can decide when to do certain things, such as when to wake up and eat meals, and how to plan your day.

When you join Partnership, we will talk with you about what services will help you live as independently as possible. This might include:

- Help with bathing, transportation, housekeeping, and home delivered meals
- Building a wheelchair ramp or using a medical alert system

Partnership:

- Can help with quality of life.
- Helps you live in your own home or apartment, among family and friends.
- Involves you in decisions about your care and services.
- Maximizes your independence.

- Medical care, including laboratory tests and dental care (see Chapter 4 for a list of covered services)

We will make sure you get the care you need to be healthy and safe. We will also help you maintain ties with your family, friends, and community.

If you are a young adult preparing to move out on your own, Community Care can help you be more independent. For example, we can help you develop the skills you need to find a job or learn how to make your own meals.

Who will help me?

As a Partnership member, you will work with a team of professionals from Community Care. This is your care team. You are a central part of your care team and **you should be involved in every part** of planning your care.

Your care team will include **you** and:

- A nurse practitioner
- A registered nurse
- A care manager
- Other professionals, depending on your needs. This could be your doctor, an occupational or physical therapist, or a mental health specialist
- Anyone you want to be involved, including family members or friends

Your care team plans and oversees your care across all settings, from your home to the hospital.

Your care team's job is to work with you to:

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

Let your care team know if you need help taking part in the process.

Community Care wants your family, friends, and others who are important to you to be involved in your care. Partnership 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 find resources in your community that can help you. This might include libraries, senior centers, and churches.

We can also help find ways to strengthen your support network. For example, if the people who help you need a break, we can provide respite services. Respite is a temporary break for your caregivers so they can relax and stay healthy.

What does it mean to be a member?

As a Partnership member, you and your care team will make the best possible choices for your health and lifestyle.

You will get health care and long-term care services from Community Care providers. When you join Partnership, we will give you a list of providers who work with us. You and your care team will work together to choose providers who best support your needs.

Community Care believes our members should have personal choice when getting services. Choice means having a say in how and when you get care. It also means you are responsible for helping your care team find the most cost-effective ways to support you.

Community Care needs to meet the health and long-term care needs of **all** our members. We can only do that if everyone has care plans that work, are reasonable, and are cost-effective. Together, we can make sure Partnership is available to other people who need our services.

Who can be a member of Community Care?

It is your choice to enroll in Community Care. You must:

- Be at least 18 years old.
- Be a frail elder or an adult with a disability.
- Be eligible for Medicaid.
- Be functionally eligible for Partnership. The Long Term Care Functional Screen (www.dhs.wisconsin.gov/functionalscreen) helps confirm eligibility.
- Have a long-term care condition that will last more than 90 days.
- Live in a county that offers Partnership.

Partnership serves members who qualify for both Medicaid and Medicare.

Our service area includes these counties in Wisconsin:

Calumet, Kenosha, Milwaukee, Outagamie, Ozaukee, Racine, Washington, Waukesha
and Waupaca Counties

If you plan to move out of the service area, you must notify your care team. If you move outside of our service area, you may not be able to stay enrolled with Community Care's Partnership program.

Requirements to stay enrolled

Once you're a member, you must continue to meet financial and functional eligibility requirements to stay enrolled.

- **Financial eligibility** means eligibility for Medicaid (also known as Medical Assistance, MA, or Title 19). The county or tribal agency looks at your income and assets to see if you are eligible for Medicaid. If you have income or assets above a certain level, you may be not financially eligible for Medicaid, and you may have a monthly payment to remain eligible for the Partnership program. Your county or tribal agency determines your cost share amount. The county or tribal agency will review your financial eligibility and cost share at least once a year.
- **Functional eligibility** relates to your health. It measures your need for help with things like bathing, getting dressed, and using the bathroom. The ADRC will tell you if you are functionally eligible for Partnership. Your care team will review your functional eligibility at least once a year.

How do I become a member?

If you are not already a member but want to become a member of Community Care, please call or visit the ADRC in your area. The address and phone number of your local ADRC is on pages 12-13.

The ADRC will help figure out what services you might need. They also make sure you are functionally eligible for Partnership. They will give you information about other available programs. They can also help you choose the resource or program that might be right for you.

When you enroll, the ADRC will ask you to:

- Provide information about your health and needs.
- Provide information about your income and assets.
- Sign a "Release of Information" form for your medical records.
- Complete and sign an enrollment form.

You will also speak with a county or tribal agency worker. This person will determine if you meet financial eligibility for the Partnership program.

How does Partnership work?

When you enroll in Partnership, you and your care team will look at your needs, strengths, and preferences. You'll tell your care team about the kind of life you want to live and the support you need. This gives your care team a clear understanding of what is important to you.

Identify my personal experience outcomes

During the assessment, your care team will help you identify your personal experience outcomes. These are the goals you have for your own life. They include:

- Input on:
 - Where to live, and with who
 - Needed supports and services
 - Your daily routines

- Personal experience—having:
 - Interaction with family and friends
 - A job or other meaningful activities
 - Community involvement
 - Stability
 - Respect and fairness
 - Privacy

- Health and safety—being:
 - Healthy
 - Safe
 - Free from abuse and neglect

Only you can tell your care team what is important to you. **You** define what these outcome statements mean to you and your life. For example, you might want to:

- Be healthy enough to enjoy visits with grandchildren.
- Have a paid job.
- Be independent enough to live in your own apartment.

You have a right to expect your care team to work with you to identify your personal experience outcomes. Before Community Care buys services for you, your care team has to decide which services:

- Support your needs best
- Are the most cost-effective

This does not mean Community Care will always provide services to help you achieve your outcomes. **The things you do for yourself and the help you get from your family, friends, and others will still be very important in the plan to support your outcomes.**

Identify my long-term care outcomes

During the assessment, you and your care team will identify your **long-term care outcomes**. This helps you and your care team know which services will meet your long-term care needs.

Long-term care outcomes are things Partnership can help you achieve to have the kind of life you want. For example,

- Being able to get your daily needs met.
- Getting what you need to stay safe, healthy, and as independent as possible.

Having these things will let you focus on the people and activities most important to you. For example, getting help to dress or take a bath may also help you feel well enough to go to work or visit family and friends.

Your care team will develop a care plan that will help you achieve your long-term care outcomes.

What should be in my care plan?

Your care plan will include:

- Your physical health needs and your ability to do certain tasks and activities (such as eating and dressing).
- Your strengths and preferences.
- Your personal experience and long-term care outcomes.
- The services you will receive.
- Who will provide you with each service.
- The things you are going to do yourself or with help from family, friends, or other resources in your community.

Your care team will ask you to sign your care plan, which shows that you took part in creating it. You will get a copy of your signed plan. If you are not happy with your plan, you can file a grievance or appeal. (See Chapter 8 for more information.)

Your care team will contact you often to talk about how you are doing. They will also check if your services are helping you. Your care team must meet with you in person regularly. Your care team may meet with you more often if there is a need for more visits.

How does Partnership help me manage my services?

Community Care strives to respect the choices of our members. For example:

- Living arrangement, daily routine, and support services are examples of outcomes Partnership supports. You will say what is important to you in these outcome areas. You will work with your care team to find reasonable ways to support your outcomes. If you do not think your care plan offers supports for your outcomes that work for you, you can file a grievance or appeal.

- If you ask, we will consider using a provider we do not usually use.
- For providers that come to your home or provide intimate personal care, we will, at your request, purchase services from any qualified provider you choose. This includes a family member. **The provider must meet our requirements, accept our rates, and sign a contract with** Community Care.
- You have a right to change to a different care team up to two times in a year. You do not have to say why you want a different care team. Community Care may not always be able to meet your request or give you the specific care team you want.
- You may choose to self-direct some of your services.

What are self-directed supports (SDS)?

You can choose the self-directed supports (SDS) option if you want to manage some of your long-term care services. Choosing SDS means you will have more say in how you get your long-term care services. It also means you choose who your direct care providers are. It allows you to have more responsibility and be more involved in the direction of your own services.

With SDS, you have control over and responsibility for your own budget for services. You may also have control over your providers. This includes hiring, training, supervising, and firing your own direct care workers.

SDS is often used for in-home care. You can also use it outside of the home for services such as transportation and personal care at your job. You are not able to self-direct all of your services. For example, you cannot self-direct residential care services or medical care such as lab tests or x-rays. Your care team can tell you which services you can self-direct.

You can choose how much you want to take part in SDS. It is not “all or none.” You can choose to direct one or more of your services. For example, you could choose to self-direct services that help you stay in your home or help you find and keep a job. Then you could work with your care team to manage services aimed at other outcomes in your care plan.

If you choose SDS, you will work with your care team to determine a budget for services. The budget is based on your care plan. You will decide on services within that budget. You can do this yourself, or with the help of another person you choose.

If you are interested in SDS, please ask your care team for more information. They can explain the benefits and limitations of SDS.

Chapter 3. What to know about getting services

How are services selected and authorized?

In most cases, your care team must approve services **before** you get them. Community Care **usually will not pay for services you get without prior approval. If you get services yourself without your care team’s approval, you may have to pay for them.** Please talk with your care team if you need a service that is not already approved and in your care plan.

Note: If you are thinking about moving to an assisted living facility or nursing home, please see Chapter 5. Community Care will only authorize residential services in certain situations.

Community Care supports your outcomes, but we also have to consider **cost when planning your care and choosing providers to meet your needs.**

To do this, your care team will use the Resource Allocation and Decision (RAD) process. It is a guide in making decisions about services.

About the Resource Allocation Decision process

The RAD is a tool you and your care team will use to find the best ways to meet your needs and outcomes.

Cost-effectiveness is an important part of the RAD process. It means best supporting your outcomes at a reasonable cost and effort. For example, if two different providers offer the services you need, Community Care will purchase the more appropriate service.

You have the right to know and understand all your options. This includes how much things cost. Your responsibility is to talk with your care team about these options. You can then make decisions together. This includes asking questions and sharing your opinions.

During the RAD process, you and your care team will talk about the services you need. You’ll also explore the options that can help you meet your outcomes. This includes talking about how friends, family, or others can help. Many times, you can reach one or more of your outcomes without a lot of help from Community Care because family, friends, or others can help you. Community Care purchases services that your own supports don’t provide.

Our goal is to support the people in your life who are already helping you. These “natural supports” keep people that are important to you in your day-to-day life. Building on, instead of replacing, the help you get from your family and friends strengthens these important relationships. It also helps Community Care pay for services where and when you need them.

At the end of the RAD process, you and your care team will talk about how you can have more control in your life. You'll also talk about self-directing your services. For more information about self-directing your services, see page 21.

Your care team will find service providers to help you. These providers must have a contract with Community Care. See page 24 for information about using our providers.

If you are unhappy with any provider, you have the right to request a new provider, but you must talk with your care team first. Your care team must approve all services you get.

What if my needs change?

Your services may change over time as your health and life situation change. For example, you may need less services if your physical health gets better. If you have more needs, we will make sure you get the help you need to stay safe, healthy, and as independent as possible. One of our goals is to provide the right service, in the right amount, and in the right place.

If your needs change, let your care team know. Community Care can get you more or less services based on your changing needs. We are here to support you.

Important rules for getting your care and services

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

- 1.) The services support your outcomes.
- 2.) The services are the most cost-effective way to support your outcomes.
- 3.) The services are included in your care plan and approved by your care team.
- 4.) The care you receive is included in the Partnership benefit package. (See Chapter 4)
- 5.) The care you receive is medically necessary. This includes health and long-term care services or supplies that meet accepted standards and are needed to diagnose or treat an illness, injury, condition, disease, or its symptoms.
- 6.) Your primary care provider (PCP) is part of our network. If you are an American Indian or Alaska Native, you can see an Indian Health Care Provider outside of our network.
- 7.) The care you receive is from a network provider. In **most** cases, we will not cover services you get from a non-network provider.

There are some exceptions to this rule:

- The Partnership program covers emergency care or urgently needed care that you get from a non-network provider.
- You can get care from a non-network provider if:
 - You need medical care that our plan covers.
 - The providers in our network cannot provide this care or are too far from where you live.

Your care team must approve this care before you get it.

- If you are an American Indian or Alaska Native, you can get covered services from an Indian Health Care Provider outside of our network.

How do I use the provider network?

You and your care team will choose your providers from our “provider network.” Our list of providers is on our website at www.communitycareinc.org. We update it at least every 30 days. It is available in different formats and languages. If you want a paper copy of the Provider Network Directory, ask your care team for a copy.

The provider directory lets you know what each of our providers has to offer. For example, providers who have staff that speak a certain language or providers who understand a certain ethnic culture or religious belief. Your care team can also tell you if the provider’s office is accessible.

There might be times when you want to switch providers. Contact your care team if you want to change from one provider to another in the network. **Talk to your care team and get approval before you change providers. Otherwise, you may have to pay for the cost of the service.**

Why do I need to know which providers are part of our network?

It is important to know the providers in our network. While you are a member of our plan, you must use network providers to get your medical care and long-term care services.

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

You do NOT need to contact your care team or get prior approval in an emergency.

What is a primary care provider (PCP)?

Your PCP is the provider who works with your care team and our plan to oversee your health care. When you become a member of Partnership, you must choose a network provider to be your PCP. If you are an American Indian or Alaska Native, you can choose to see an Indian Health Care Provider outside of our network.

Talk with your care team about choosing and getting care from your PCP. You will see your PCP for most of your routine health care needs.

You may choose a PCP by using the provider network list. You can also get help from Customer Service or your care team. PCPs do not always accept new patients. You may keep your current PCP if the provider is part of our network. You can tell us your choice of PCP by calling your care team. If there is a certain specialist or hospital you want to use, be sure to ask if 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.

To change your PCP, call your care team. When you call, be sure to tell your care team if you are seeing specialists or getting other covered services that needed your PCP's approval. (This might be things like home health services and durable medical equipment.) Your care team will tell you when the change to your new PCP will take effect.

What kinds of medical care can I get without prior approval from my care team?

You can get these services without prior approval from your care team:

- Routine women's health care, as long as you get it from a network provider. This includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams.
- Flu shots **and** pneumonia vaccinations as long as you get them from a network provider.
- **Emergency services** from network providers or from non-network providers.
- Urgently needed care from in-network providers.
- Urgently needed care from non-network providers. This only applies when you cannot access network providers. For example, when you are away from home and outside of the plan's service area.
- Family planning services.

How do I 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. There are many kinds of specialists. Here are a few examples:

- Oncologists, who care for people with cancer.
- Cardiologists, who care for people with heart conditions.
- Orthopedists, who care for people with certain bone, joint, or muscle conditions.

Contact your care team if you need care from a specialist. You may need to get prior approval from your care team.

What if a specialist or another network provider leaves the plan?

Sometimes a specialist, clinic, hospital, or other 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. If your provider leaves our plan, we will let you know. We'll then help you choose another provider so you can keep getting covered services.

How do I get my prescription drugs?

If you have Medicare, Community Care will cover your prescription drugs. The pharmacies in our network are listed at: www.communitycareinc.org.

If you do not have Medicare, Wisconsin Medicaid covers your prescription drugs. You must go to a pharmacy that accepts Medicaid. You can ask your pharmacy if they accept Medicaid. You can also search for pharmacies online at <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Public/DirectorySearch.aspx>.

If you are not sure if you have Medicare, please ask your care team for help.

How do I get care if I have a medical emergency?

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

You do NOT need to contact your care team or get prior approval in an emergency.

An emergency means you believe your health is in serious danger. An emergency could be a sudden illness, suspected heart attack or stroke, a broken bone, or a severe asthma attack.

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.
- **Please make sure our plan knows 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 Partnership membership card.

What is covered if I have a medical emergency?

You may get emergency medical care whenever you need it. You can get it anywhere in the United States or its territories. Our plan covers ambulance services when getting to the emergency room in any other way could endanger your health. For more information, see the Benefits Chart in Chapter 4.

If you have an emergency, we will talk with the doctors who are giving you emergency care. This is so we can help manage and follow up on your care. The doctors who are giving you emergency care will decide when you are stable and the medical emergency is over.

After the emergency is over, you may need follow-up care. Follow-up care helps make sure your condition stays stable. If you get your emergency care from a non-network provider, we will transfer your care to network providers as soon as your medical condition allows.

You must use our network providers when you are in the plan's service area and you have an urgent need for care, if possible. (For more information about the plan's service area, see Chapter 2.)

What if it wasn't a medical emergency?

It can be hard to know if you have a medical emergency. For example, you might go in for emergency care thinking that your health is in serious danger. Then, the doctor says it was not a medical emergency after all.

As long as you reasonably thought your health was in serious danger, we will cover your care.

If the doctor has said that it was **not** an emergency, we will only cover follow-up care if you get it in **one of these two ways**:

- You go to a network provider to get the follow-up care.
- The follow-up care you get is considered "urgently needed care" and you follow the rules for getting this urgent care. (For more information about this, see below.)

What is “urgently needed care?”

“Urgently needed care” is:

- Not an emergency.
- An unexpected medical illness, injury, or condition.
- Something that requires medical care right away.

The unexpected condition could be a flare-up of a known condition you have that you weren’t expecting. For example, a flare-up of a chronic skin condition.

What if I am *in* the plan’s service area when I have an urgent need for care?

If you are in the plan’s service area, we will usually cover urgently needed care **only** if you go to a network provider. You must also follow the other rules described earlier in this chapter.

If you cannot access network providers, we will cover urgently needed care that you get from a non-network provider.

What if I am *outside* the plan’s service area when I have an urgent need for care?

We will cover urgently needed care from a non-network provider when you are outside the service area and cannot get care from a network provider.

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

How do I get help after normal business hours?

Call 866-992-6600, TTY 711 if you have an urgent need or questions about urgently needed care that cannot wait until the next business day. Staff are available 24 hours a day, seven days a week. The on-call staff can approve needed services to continue until the next business day. Your care team will follow up with you to decide if the services should continue.

What if I need care while I am out of the area?

Tell your care team about your plans as soon as possible. You’ll need to tell them if you are going to be out of Community Care service area and you want to keep getting services while you are gone. (For more information about the plan’s service area, see Chapter 2.)

Community Care will work with the county or tribal agency to find out if your plans will change your county residence.

- If the county or tribal agency tells you that you will **not be a resident** of a county served by Community Care, contact the ADRC in the county you'll be in. The ADRC can tell you about the programs in that county.
- If you will **still be a resident**, Community Care will work with you to plan for your care. This includes a cost-effective way to support your needs and keep you healthy and safe while you are gone.

Community Care may find that it cannot develop a cost-effective plan that meets your needs while you are out of our service area. If this happens, we can ask the state to disenroll you from the program. If the state disenrolls you, you will be able to challenge this decision with the appeal process. (See Chapter 8 for more information.)

Community Care does not pay for care if you permanently move out of the service area. **If you are planning a permanent move, contact your care team as soon as possible.** Your team can help you plan for medical care in your new area.

Chapter 4. The Partnership benefit package

What Medicaid services are provided?

Partnership provides health care and long-term care services. The list of services we provide is called the “Partnership benefit package.”

If you have Medicare, see your Evidence of Coverage for the full Partnership benefit package. This section only discusses the Medicaid benefits you can get.

You and your care team will use the Resource Allocation Decision (RAD) process to decide on services. This will help find the most cost-effective care plan for you. Keep in mind you can only get services you need to support your outcomes and to keep you healthy and safe. Just because a service is in the benefit package, doesn’t mean you can get it.

Please note that:

- Some members may have to pay a cost share. See Chapter 5 for more information.
- Community Care will only cover residential services and nursing homes stays in certain situations. See Chapter 5 for more information.
- You can only self-direct certain services in the benefit package. Ask your care team if you would like more information.

Your care team must approve all services before you get them.

The services listed below are available if they are:

- Needed to support your outcomes
- Pre-approved by your care team
- Stated in your care plan

You can get services in person or through “telehealth.”

“Telehealth” is a way of getting services in a live, two-way video call or telephone (audio). Community Care covers telehealth services that your provider can deliver at the same quality as in-person services. This could be doctor office visits, mental health or substance abuse services, dental consultations, and more. Some services you cannot get using telehealth. This includes services where the provider needs to touch or examine you.

Both you and your provider must agree to a telehealth visit. You always have the right to refuse a telehealth visit and do an in-person visit instead. Your Partnership benefits and care will not be impacted if you refuse telehealth services. If your provider only offers telehealth visits and you want to do in-person, they can refer you to a different provider.

Community Care and Wisconsin Medicaid providers must follow privacy and security laws when providing services over telehealth.

See the services our plan does not cover at the end of this chapter.

Talk with your care team if you have questions about covered services.

Partnership Medicaid benefit package

Your care team must approve most of the services in this list. If you get services without approval, you may have to pay for them yourself.

Partnership covers the following services:

- Alcohol and other drug abuse (AODA) services
- Audiology
- Adaptive aids
- Adult day care services
- Assistive technology/communication aids
- Care/case management
- Chiropractic
- Consultative clinical and therapeutic services for caregivers
- Consumer education and training services
- Counseling and therapeutic services
- Dental services
- Diagnostic testing services
- Dialysis services
- Drugs
- Durable medical equipment and medical supplies
- Environmental accessibility adaptations/home modifications
- Financial management services
- Habilitation services:
 - Daily living skills training
 - Day habilitation services
 - Prevocational services
- Home care services (home health, nursing, and personal care)
- Home delivered meals
- Hospice care services
- Hospital services
- Housing counseling
- Medicare deductible and coinsurance
- Mental health services
- Nursing home services

- Personal emergency response systems
- Physician services
- Podiatry services
- Respiratory care for ventilator-assisted recipients
- Supported employment
 - Individual employment support
 - Small group employment support
- Relocation services
- Residential 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
- Therapy (physical therapy, occupational therapy and speech and language pathology services)
- Training services for unpaid caregivers
- Transportation, emergency services
- Transportation, non-emergency specialized transportation
 - Community transportation
 - Other transportation
- Vision care services
- Vocational futures planning and support

Prescription drugs

If you do not have Medicare, you will get your prescription drugs from Wisconsin Medicaid. You will need to show the pharmacy your ForwardHealth card.

Services available through ForwardHealth

The following services are **not in the Partnership benefit package**, but you can get them using your ForwardHealth card:

- Behavioral treatment services
- Comprehensive community services
- Community recovery services
- Prenatal care coordination
- School-based services

- Medication therapy management
- Tuberculosis-related services

Services *not* covered

Partnership does not cover the following items and services:

- Services that your care team hasn't approved or are not included in your care plan.
- Services or supports that are not needed to support your outcomes.
- Normal living expenses like rent or mortgage payments, food, utilities, entertainment, clothing, furniture, household supplies, and insurance.
- Personal items in your room at an assisted living facility or a nursing home, such as a telephone or a television.
- Room and board in residential housing.
- Guardianship fees.

Chapter 5. Understanding who pays for services and coordination of your benefits

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Will I pay for any services?

You are not required to pay for any covered services in the Partnership benefit package that:

- Are identified in your care plan
- You follow the plan's rules for getting (see Chapter 3 for the rules you must follow)

You are responsible for paying the full cost of services that are not covered by our plan, if they:

- Are not covered services in the benefit package
- Were obtained without prior approval

You have the right to ask us if we will pay for a service before you get it. If we say we will not cover the service, you have the right to appeal our decision.

You may have to pay the following each month:

- Cost share
- Room and board

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

Cost share

Some members have to make a monthly payment. This monthly payment is a **cost share**. Cost share is based on a member's income and certain expenses. Certain expenses may lower a cost share. Your care team can explain the types of expenses that may reduce a cost share and receipts you should keep.

If you have a cost share, you will get a bill from Community Care every month. You mail your payment to Community Care. The county or tribal agency decides the amount you must pay each month.

The amount of cost share will be looked at once a year, or when your income changes. **You must report all income and asset changes to your care team and the county or tribal agency within 10 days of the change.** Assets include things like cars, checking and savings accounts, and cash value of life insurance.

If you don't pay your monthly cost share, you may lose eligibility for Partnership. If you think your cost share is wrong, you can file an appeal with the Wisconsin Division of Hearings and Appeals. (See Chapter 8.)

If you have questions about your cost share, contact your care team].

Cost share reduction

If you are not able to pay your monthly cost share because of necessary living expenses, you may be able to lower your cost share. Necessary living expenses include:

- Mortgage payments
- Rent
- Home or renter's insurance
- Property taxes
- Utilities
- Food
- Clothing
- Hygiene items
- The cost of operating and maintaining a vehicle

To request a reduction of your cost share, you must fill out the “Application for Reduction of Cost Share.” Your care team can give you an application. You can also get it online at www.dhs.wisconsin.gov/library/collection/f-01827.

Along with the application, you will need to submit proof of your monthly income, your monthly expenses, and the cost share amount you pay to Community Care each month. The application tells you what kind of proof you'll need. It also gives examples of the types of documents you will need to provide.

If you need help with the application, you can get free help from an Ombudsman. Find contact information for the Partnership Ombudsman program in Chapter 1.

Room and board

You will pay for room and board (rent and food) costs if you are living in an adult family home, community-based residential facility, or residential care apartment complex.

Community Care will pay for care and supervision services. 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 care team. Your care team may be able to help you find a facility that meets your needs at a more affordable rate.

How do I make a payment?

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

Community Care
205 Bishops Way
Brookfield, WI 53005

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

What if I get a bill for services?

You do not have to pay for services that your care team approves as part of your care plan. If you receive a bill from a provider, do not pay it. Instead, contact your care team so they can help.

If we decide that the service is **not** covered, or you did **not** follow all the rules, we will not pay for the service. We will send you a letter that explains why we are not paying for the service. The letter will also explain your right to appeal that decision.

Does Partnership pay for residential services or nursing homes?

An important goal of Community Care Partnership is to help you live as independently as possible. All people—including people who are older or have disabilities—should be able to live at home with the support they need. They should also be able to take part in communities that value them.

Studies and surveys show that most people want to live in their own home or apartment, among family and friends. Many Partnership long-term care services can be provided at home. Living at home is usually the most cost-effective option.

The Partnership benefit package includes residential care services and nursing home stays. However, moving from home to a care facility or nursing home should be a “last resort.”

Your care team will approve residential care or nursing home stays only when:

- You can't stay healthy and safe in your home
- Your long-term care outcomes aren't cost-effective in your home
- Your long-term care outcomes are most cost-effective in a facility

You may not be able to stay at or move to the facility you want. That facility may not have a contract with Community Care or may not be willing to accept the rate we pay. Community Care cannot force providers to accept our rates.

If you and your care team agree that you should no longer live in your own home, you will decide about residential services together.

You and your care team are responsible for finding the most cost-effective residential options. They must be in Community Care's provider network. Your care team will continue to work with you while you are in a residential facility or nursing home.

Your care team must approve all residential services. You should not select a residential provider on your own. You must work with your care team to make sure Community Care will pay for these services.

You must pay the rent and food portion of the facility's cost. These costs are "room and board" expenses.

How are my other insurance benefits coordinated?

When you enroll in Community Care, we will ask if you have insurance other than Medicaid. (Medicaid is also known as known as Medical Assistance, MA, or Title 19.) Other insurance could include Veterans benefits (VA), pension plan health coverage, and private health insurance.

It is important to give us information about other insurance you have. **If you choose not to use your other insurance, we may refuse to pay for services they would have covered.**

Other insurance must be billed first before Medicaid and Partnership pays for services.

Community Care expects members to:

- Tell us you have other insurance.
- Tell us if there are changes to your other insurance.
- Tell us if you receive a payment from an insurance company. You may have to repay Community Care. How you handle these payments may affect your eligibility for Partnership.

Medicare

You must enroll in the Partnership Medicare plan if you have Medicare.

If you are eligible for Medicare but don't have it because you feel you cannot afford it, talk to your care team. Your care team may be able to find a program that will help you pay Medicare premiums.

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

Medicaid estate recovery applies to all Medicaid services you get from Community Care.

Through estate recovery, the state works to recover money from the assets of members and their dependents who no longer need it. The money helps pay for long-term care services for others in need.

Funds come from your or your spouse's estate after both of you have died.

Recovery is made by filing claims on estates. The state will not try to recover funds from your estate when your spouse or child with a disability is still alive. Recovery will happen after their death.

For more information about estate recovery, ask your care team. Information is also available through the resources listed below:

Toll-free: 800-362-3002
TTY: 711 or 800-947-3529
Website: www.dhs.wisconsin.gov/medicaid/erp.htm

Chapter 6. Your rights

We must honor your rights as a member of Community Care.

- 1.) **We must provide information in a way that works for you.** Contact your care team to get information from us in a way that works for you.
- 2.) **We must treat you with dignity, respect, and fairness at all times.** You have the right:
 - To get compassionate, considerate care from Community Care staff and providers.
 - To get your care in a safe, clean space.
 - To not have to do work or perform services for Community Care.
 - To be encouraged and helped in talking to Community Care staff about changes you think should be made. This could be policy changes or different services.
 - To be encouraged to exercise your rights as a member of Community Care.
 - To be free from discrimination. Community Care must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, mental or physical disability, religion, gender, gender identity, sexual orientation, health, ethnicity, creed (beliefs), age, national origin, or source of payment.
 - To be free from any form of restraint or seclusion used to coerce, discipline, be convenient, or retaliate. This means you have the right to be free from being restrained or forced to be alone to make you behave in a certain way, to punish you, or because someone finds it useful.
 - To be free from abuse, neglect, and financial exploitation.
 - **Abuse** can be physical, emotional, financial, or sexual. Abuse can also be if someone gives you 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 someone who handles their own care fails to get 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 I do if I am abused, neglected, or financially exploited? Your care team can talk with you about abuse, neglect, or financial exploitation. They can help you report issues or get services for safety. You should always call 911 in an emergency.

Contact Adult Protective Services if you feel that you or someone you know is a victim of abuse, neglect, or financial exploitation. Adult Protective Services help protect the safety of seniors and adults who have experienced abuse, neglect, or exploitation. They also help when a person is not able to look after their own safety due to a health condition or disability.

Call these numbers to report abuse you see or suspect:

Calumet County ADRC 920-832-4646 adrc@co.calumet.wi.us	Ozaukee County ADRC 262-284-8120 866-537-4261 (toll free) aging@co.ozaukee.wi.us
Kenosha County ADRC 262-605-6646 800-472-8008 (toll free) 262-605-6663 (TTY) adrc@co.kenosha.wi.us	Racine County ADRC 262-833-8777 866-219-1043 (toll free) (Call the WI Relay System at 711 (TTY)) adrc@goracine.org
Milwaukee County ADRC 414-289-6874 TTY: Call the WI Relay System at 711 aging_webinfo@milwaukeecounty.com	Washington County ADRC 262-335-4497 877-306-3030 (toll free) webage@co.washington.wi.us
Outagamie County ADRC 920-832-4646 866-739-2371 (toll free) adrc@co.outagamie.wi.us	Waukesha County ADRC 262-548-7848 866-677-2372 (toll free) adrc@waukeshacounty.gov
Waupaca County ADRC 920-832-4646 866-739-2372 (toll free) adrc@co.waupaca.wi.us	

You can call these numbers 24 hours a day, seven days a week.

- 3.) **We must make sure you can access covered services when you need them.** As a member of Community Care, you have a right to get services in your care plan when you need them. Your care team will arrange for your covered services. Your team will also work with your health care providers. These could be doctors, dentists, and podiatrists.

Ask your care team for help choosing your providers.

As a member of Community Care, you have the right to choose a primary care provider (PCP) in the provider network to get many of your services. Call Community Care to learn which doctors are taking on new patients. If you think you are not getting services within a reasonable amount of time, talk to your care team. You may also refer to Chapter 8, which explains what you can do.

- 4.) **We must protect the privacy of your personal health information.** Call your care team if you have questions or concerns about the privacy of your information. See Appendix 3 for Community Care’s Notice of Privacy Practices.
- 5.) **We must give you access to your medical records.** Ask your care team if you want a copy of your records. You have the right to ask Community Care to change or correct your records.
- 6.) **We must give you information about Community Care, our network of providers, and services you can get.** Please contact your care team if you want this information or go to our website at www.communitycareinc.org,
- 7.) **We must support your right to make decisions about your care.**
 - You have a right to know about all of your choices. This means you have the right to be told about all available options, what they cost, and if they are covered by Partnership. You can also suggest other services or supports that you think would meet your needs.
 - You have the right to be told about any risks involved in your care.
 - You have the right to say “no” to any recommended care or services.
 - You have the right to get second medical opinions.
 - You have the right to give instructions about what you want done if you are not able to make decisions for yourself. Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen in these situations. If you want, you can develop an “**advance directive**.” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples. Contact your care team if you want to know more about advance directives.
- 8.) **You have the right to get your Partnership services in places that let you be a true part of the community you live in.** This is your right under the federal home and community-based services settings rule. The rule applies to where you live and places

outside of your home where you get services during the day. Community Care has to make sure you get your Partnership services in places that connect you to your community. They must also support your independence. This means places that allow you to

- Live where you want to live.
- Take part in community life.
- Find and take part in work in the same way as other people in your community.
- Control your schedule.
- Access and control your money.
- Decide who to see and when to see them.
- Maintain your privacy.

Contact your care team if you have concerns about the places where you get services.

- 9.) **You have the right to file a grievance or appeal if you are not happy with your care or services.** Chapter 8 has information about what you can do if you want to file a grievance or appeal.

Chapter 7. Your responsibilities

Things you need to do as a member of Community Care are listed below. Contact your care team with questions. We are here to help.

- 1.) Know about the services in the Partnership benefit package. This includes understanding what you need to do to get your services. See Chapters 3 and 4 for more information.
- 2.) Take part in creating and updating your care plan.
- 3.) Take part in the Resource Allocation Decision (RAD) process. This includes finding the most cost-effective ways to meet your needs and outcomes.
- 4.) Talk with your care team about ways your friends, family, or other community and volunteer organizations can support you. Also talk about how you can do more for yourself.
- 5.) Follow the care plan that you and your care team agreed to.
- 6.) Tell your doctors and other providers that you are in Partnership. This helps them work with you and your care team to be a part of your care plan.
- 7.) Be responsible for your actions if you refuse treatment or do not follow the instructions from your care team or providers.
- 8.) Use the providers that are part of Community Care unless you and your care team decide otherwise.
- 9.) Show your Partnership membership card whenever you get medical care. It is important to show your membership card so providers know to bill Partnership.
- 10.) Show your ForwardHealth card whenever you get prescriptions drugs. It is important to show your ForwardHealth card so providers know who to bill.
- 11.) Follow Community Care's rules for getting care after hours.
- 12.) Tell us if you move to a new address or change your phone number.
- 13.) Let us know when if you are planning a temporary stay or move out of the service area.
- 14.) Provide Community Care with the right information about your health care needs, finances, and preferences. Tell us right away about any changes in your status. This includes signing a "release of information" form. We use this when we need information from someone else.

- 15.) Treat your care team, home care staff, and providers with dignity and respect.
- 16.) Accept services without regard to the provider's race, color, religion, age, gender, sexual orientation, health, ethnicity, creed (beliefs), or national origin.
- 17.) Pay any monthly costs on time. This includes any cost share or room and board charges you may have. Let your care team know right away if you have problems with your payment.
- 18.) Complete an “**Annual Renewal**” for Medicaid eligibility. The county or tribal agency uses the annual renewal to see if you are financially eligibility. The renewal is to make sure you still meet program requirements. You will get a letter the month before your renewal is due. This letter will tell you how to do your renewal.

If you do not complete your renewal by the due date, you will lose your Medicaid and Partnership coverage. There will be a gap or delay in your benefits. Contact your care team if you need help or have questions about the annual renewal.

- 19.) Use your private insurance benefits, when appropriate. If you have any other health insurance coverage, tell Community Care and the county or tribal agency. Let your care team know right away if you enroll in Medicare or think you may be eligible for Medicare.
- 20.) Take care of any durable medical equipment (DME) Community Care gives you. This includes items like wheelchairs and hospital beds.
- 21.) Report fraud or abuse by providers or Community Care employees.

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

Report Public Assistance Fraud

877-865-3432 (toll-free) or visit

www.reportfraud.wisconsin.gov

- 22.) 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 supplied by Community Care

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

- 23.) Help your care team, doctors, and other providers help you. Give them information, ask questions, share concerns, and follow through on your care.
- 24.) Call your care team for help if you have questions or concerns.
- 25.) Tell us how we are doing. From time to time, we may ask if you want to take part in member interviews, satisfactions surveys, or other things that look at quality of care. Your responses help us see our strengths and find what we need to improve. Let us know if you want to see the results of any surveys. We are happy to share that information with you.

Chapter 8. Grievances and Appeals



This chapter is for members who **only have Medicaid**. If you have **Medicare**, see the Evidence of Coverage (EOC) booklet. The EOC includes information for members who have both **Medicaid AND Medicare**.

Introduction

We are committed to providing quality service to our members. There may be a time when you have a concern. As a member, you have the right to file a grievance or appeal a decision made by Community Care. You also have a right to a prompt and fair review.

If you are unhappy with your care or services, you should talk with your care team first. Talking with your team is usually the easiest and fastest way to address your concerns. If you do not want to talk with your care team, you can call our member rights specialist. The member rights specialist can tell you about your rights, try to informally solve your concerns, and help you file a grievance or appeal. They can work with you during the entire grievance and appeal process to try to find a workable solution.

**For help with the grievance and appeal process, contact
Community Care's member rights specialist:**

Community Care Member Rights Specialist
205 Bishops Way
Brookfield, WI 53005
Toll free: 866-992-6600
Member Rights Specialist Phone: 262-207-9325
TTY: 711
Contact Hours: 8 a.m. to 4:30 p.m., Monday–Friday
Email: MemberRights@communitycareinc.org
Website: www.communitycareinc.org

If you are not able to solve your concerns with your care team or our member rights specialist, there are other ways to address your concerns. Each way has different rules, procedures, and deadlines.

This handbook tells you how to file a grievance or appeal. It can seem confusing because each option has different deadlines. Note: When this handbook refers to “days,” it means any day of the year, including holidays. When this handbook refers to “business days,” it means Monday through Friday, not including holidays. You do not have to know or understand all the information in this chapter because people are available to help you.

If you have a concern that you do not know how to solve, ask your care team or Community Care’s member rights specialist. There are Ombudsman programs available to help all members with grievances and appeals. See the end of this chapter for their contact information. You can also ask an advocate such as a family member, friend, or attorney for help. Our member rights specialist may be able to help you find other places that can help you too.

Working with other insurance

There are rules if you have other insurance and want to file a grievance or appeal. You may consider filing your grievance or appeal with the other insurance first.

When you have other insurance (like employer group health coverage), there are rules that decide whether our plan or your other insurance pays first. This is called “**coordination of benefits.**” It involves coordinating the benefits you get from our plan with any other benefits you get.

The insurance that pays first is called the “primary payer.” It pays up to the limits of its coverage. The one that pays second is called the “secondary payer.” It only pays if there are costs left over by the primary coverage. The secondary payer may not pay all the leftover costs. They only pay after the other insurance plan has paid.

If your other insurance covers a service, Medicaid never pays first. Medicaid always pays last.

Copy of your case file

You have a right to a free copy of the information in your case file related to your grievance or appeal. Information means all documents, medical records, and other materials about to your grievance or appeal. This includes any new or extra information that Community Care gathers during your grievance or appeal. To request a copy of your case file, contact your care team.

You will not get into trouble if you complain or disagree with your care team or providers.

You will not be treated differently if you file a grievance or appeal with Community Care, our providers, or the State of Wisconsin.
We want you to be happy with your care.

Grievances

What is a grievance?

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

- Your personal care worker arrives late a lot.
- You feel your care team does not listen to you.
- You have trouble getting appointments with a provider.
- You are not happy with the products your provider uses, such as incontinence products.

Who can file a grievance?

Any of the following people can file a grievance:

- You
- Your legal decision maker. For example, a legal guardian or activated power of attorney for health care.
- A person or organization you chose as your authorized representative for Medicaid purposes
- Any person with your written permission. For example, a family member, friend, or provider.

What is the deadline to file a grievance?

You can file a grievance at any time.

1. Start by filing a grievance with Community Care. See Grievance option 1 below.
2. If you don't agree with Community Care's decision about your grievance, you can ask for a review by the Wisconsin Department of Health Services (DHS). See Grievance option 2, on the next page.

1. File your grievance with Community Care

Community Care wants you to be happy with your care and services. Our member rights specialist can work with you and your care team to try to resolve your concerns informally. A lot of the time we can take care of your concerns without going further. However, if we are not able to solve your concerns, you can file a grievance with Community Care Partnership by calling or writing to us at:

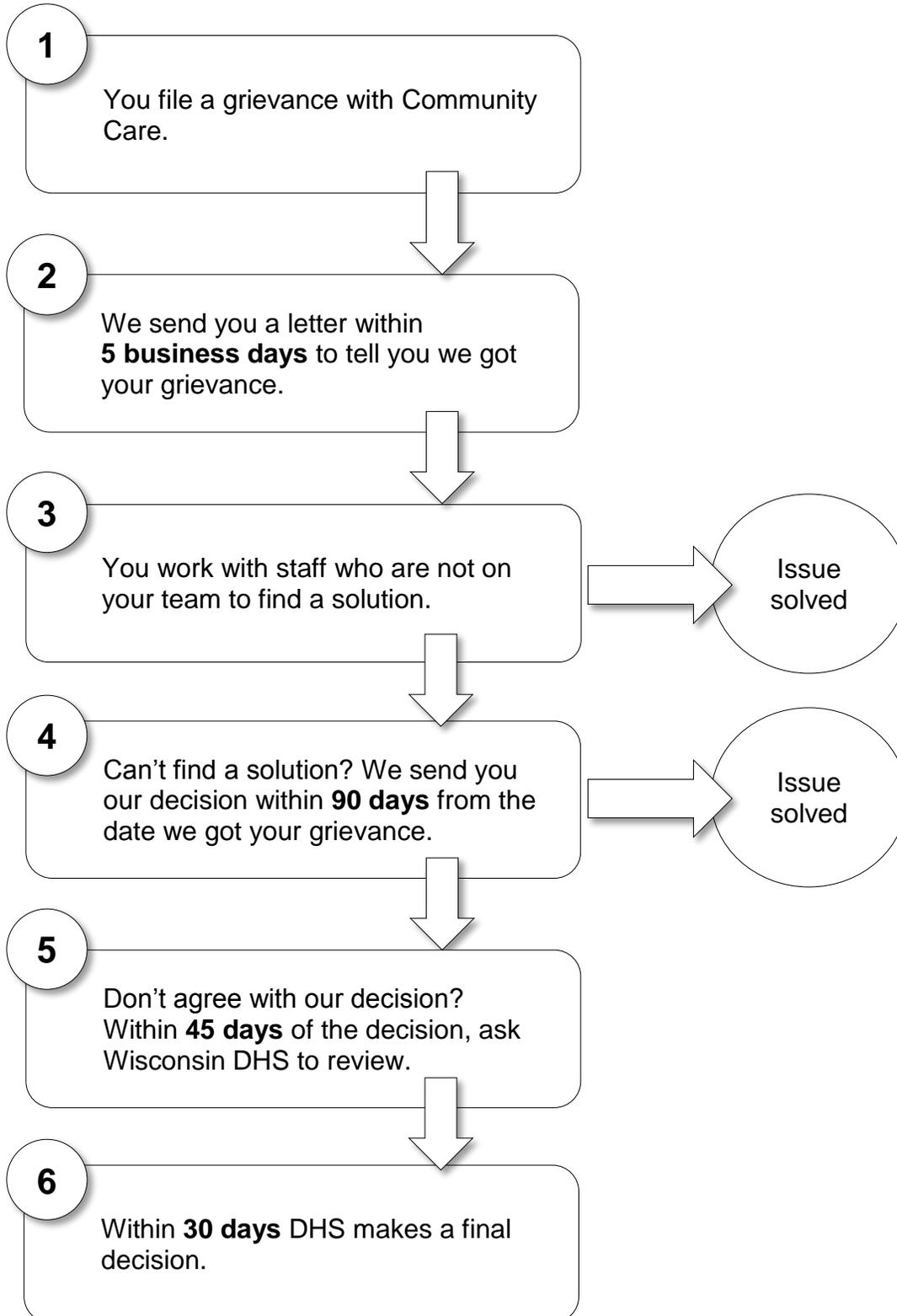
Community Care
Member Rights Specialist
205 Bishops Way
Brookfield, WI 53005
Toll free: 866-992-6600
TTY: 711
Member Rights Specialist Phone: 262-207-9325.
Email: MemberRights@communitycareinc.org

What happens next?

We will send you a letter within five business days to let you know we got your grievance. Then, Community Care staff who are not on your care team will try to help resolve your concerns or come up with a solution that works for both Community Care and you. Sometimes, we are not able to come up with a solution or you may not want to work with Community Care staff to informally address your concerns. In that case, our Grievance and Appeal Committee will review your grievance and make a decision.

- The Committee is made up of:
 - Community Care staff
 - A health care professional with the right clinical experience
 - At least one “consumer.” The consumer is a person who also gets 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 topic of your grievance. The meeting is confidential. You can ask that the consumer not be on the Committee if you are worried about privacy or have other concerns.
- We will let you know when the committee plans to meet to review your grievance.
- You have the right to appear in person before the Committee. You can bring an advocate, such as a family member, friend, attorney, or Ombudsman with you.
- You will have the chance to explain your concerns. You can also give information, evidence, and testimony to the Committee.
- Your care team or other Community Care staff will be at the meeting.
- The Committee will decide within 90 days from the date we first got your grievance. You will get a letter with the decision.

Grievances: What are my options?



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

2: Ask for a DHS review

Note: You must first go through Community Care's grievance process before you can ask for a DHS review.

You can ask DHS to review the Grievance and Appeal Committee's decision about your grievance. DHS is the state agency in charge of the Partnership program. DHS works with an organization called MetaStar to review grievances. MetaStar will review the facts of your grievance. They'll also review the Grievance and Appeal Committee's decision. MetaStar will send you the final decision on your grievance.

To ask for a DHS review, call or email:

DHS Partnership Grievances
Toll-free: 888-203-8338
E-mail: dhsfamcare@wisconsin.gov

What is the deadline to ask for a DHS review?

Community Care's Grievance and Appeal Committee must send you a decision on your grievance within 90 days from the date we get your grievance. For example, if Community Care gets your grievance on May 1, we must send you our decision by July 30.

- If the Grievance and Appeal Committee sends you a decision within 90 days, you have 45 days from the date you get the decision to ask for a DHS review.

For example, Community Care has until July 30 to send you a decision. You get the decision on June 1. You disagree with the decision. You have until July 16 to request a DHS review of Community Care's decision.

- If the Grievance and Appeal Committee does **not** send you a decision within 90 days, you have 45 days from the date the timeframe expires to ask for a DHS review.

For example, Community Care has until July 30 to send you a decision. When July 30 arrives, Community Care has not sent you a decision. Starting on July 31, you have until September 14 to request a DHS review of your grievance.

What happens next?

If you ask for a DHS review, MetaStar will contact you. MetaStar is the agency DHS works with to review grievances.

- MetaStar will reply in writing to let you know they got your request for DHS review of your grievance.
- If MetaStar tells DHS that Community Care didn't follow certain requirements, DHS may order us to take steps to fix the problem.
- MetaStar will complete its review of your grievance within 30 days of the date it gets your request.
- MetaStar will send you and Community Care a final decision on your grievance within seven days of completing its review.

What if I disagree with the DHS review?

MetaStar's decision is final. You cannot request a state fair hearing for a grievance.

Appeals

What is an appeal?

An appeal is a request for a review of a decision made by Community Care. For example, you can file an appeal if your care team:

- Denies a service or support you asked for
- Reduces, suspends, or ends a service
- Denies payment for a service

Who can file an appeal for me?

Others can file an appeal for you if needed. Your authorized representative, such as a legal guardian or activated power of attorney for health care, can file an appeal for you. Your family, a friend, or a provider can file an appeal for you if they have your written permission.

What types of issues can I appeal?

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

1.) You can file an appeal about **services** if Community Care:

- Plans to stop, suspend, or reduce an authorized service you are currently getting.
- Denies a service you asked for and that service is in the benefit package.*
- Decides not to pay for a service that is in the benefit package.*

If we take one of the actions listed above, we must send you a "**Notice of Adverse Benefit Determination.**" This is a letter that has the date we plan to stop, suspend, or reduce your services.

*Note: Community Care provides the services listed in the benefit package. Find it in Chapter 4. If you ask for a service that is not listed, Community Care does not have to provide or pay for the service. We will consider your request. But if we deny it, you cannot appeal our decision. We will send you a letter to let you know that the service you asked for is not in the benefit package.

2.) You can file an appeal about **your care plan** if:

- You do not like your care plan because it:
 - Does not help you live in the place you want to live.
 - Does not provide enough care, treatment, or support to meet your needs and outcomes. (See Chapter 2 for information about outcomes.)
 - Requires you to accept care, treatment, or support items you do not want. This includes care you believe is needlessly restrictive.
- Community Care doesn't:
 - Arrange or provide services in on time.
 - Meet the deadline to resolve your appeal.

In these situations, Community Care will send you a letter about your appeal rights.

3.) You can file an appeal about **eligibility decisions** for Partnership.

- At least once a year, a worker from the county or tribal agency will make sure you are still financially eligible for Partnership. If you have a cost share, the county or tribal agency will also make sure you are paying the right amount.

The county or tribal agency may decide you are not financially eligible for Partnership. Or, they may say your cost share payment will change. If so, they will send you a letter with information about your eligibility for Partnership. These letters have the words “About Your Benefits” on the first page. The last page has information about your right to request a state fair hearing. You can do this with the Division of Hearings and Appeals.

- If your functional eligibility for Partnership changes, you will get a letter.
- **Filing an appeal with the Division of Hearings and Appeals is the only way to challenge decisions about financial and functional eligibility for Partnership.** This includes decisions about your cost share. See Chapter 5 for more information.
- **You cannot appeal a loss of financial or functional eligibility with Community Care.**

What is the deadline to file an appeal?

- You should file your appeal as soon as possible.
- Community Care will send you a letter. It's called a **Notice of Adverse Benefit Determination**. We will send you one if we:
 - Plan to stop, suspend, or reduce an approved service you are getting.
 - Deny a new service you asked for and that service is in the Partnership benefit package.
 - Will not pay for a service that is in the Partnership benefit package.

You must file your appeal no later than 60 days from the date on the Notice of Adverse Benefit Determination. (For example, if the notice is dated August 1, you must file your appeal on or before September 30.)

If you get a letter about your appeal rights, you should read it carefully. The letter may tell you the deadline for filing your appeal. You can always call our member rights specialist for help. You can contact our member rights specialist at 262-207-9325.

What steps do I need to take to file an appeal?

1. Start by filing an appeal with Community Care. See option 1 below to file with Community Care.
2. You may disagree with Community Care's decision about your appeal. Next, you can ask for a state fair hearing. This is with the State's Division of Hearings and Appeals (DHA). See option 2 below if you want to file with DHA.

Appeal options 1 and 2 have different rules, procedures, and deadlines.

You cannot file an appeal with Community Care and with the Division of Hearings and Appeals (DHA) at the **same** time.

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

You may want **both** Community Care and DHA to review your issue. If so, you'll have to file your appeal with Community Care **before** you file the appeal with DHA.

Continue Service During Your Appeal

If Community Care decides to stop, suspend, or reduce a service you are currently getting, you can ask to keep getting your services while you appeal. If you want to keep getting your services, you must ask at every level of your appeal. For example, if you keep getting services during an appeal with Community Care and you lose the appeal, you must ask again for your services to continue.

If you want your services to continue, you must **both**:

- Ask that your services continue throughout the course of your appeal
- Postmark (mail), fax, or email your request to continue services **on or before the date Community Care plans to stop or reduce your services**

You may not agree with the final decision of the appeal. If that happens, **you might have to pay Community Care for the service you got during the appeal process.** If you can show that this would be a hard financially, you may not have to pay us back.

If you want someone to help you file an appeal, you can talk with Community Care's member rights specialist. An advocate may also be able to help you. An advocate might be a family member, friend, attorney, Ombudsman, or any other person willing to help. Ombudsman programs are available to help all Partnership members with appeals. See the end of this chapter for information on how to contact an Ombudsman.

APPEAL OPTION 1: Filing your appeal with Community Care

To file an appeal with Community Care you can:

- **Call** Community Care. You can ask for an appeal over the phone. Our member rights specialist will help you understand your appeal options. To talk with a member rights specialist, call 262-207-9325 or TTY users call 711.
- **Mail or fax a request form.** Your care team can give you a copy of the form. You can also get it online at www.dhs.wisconsin.gov/familycare/mcoappeal.htm.
- **Write your request in a letter or on a piece of paper.** Then you can mail, fax, or email it to the address below.

To file an appeal with Community Care, call:

Community Care

Member Rights Specialist

Toll free: 866-992-6600

Member Rights Specialist Phone: 262-207-9325.

TTY Call the Wisconsin Relay System at 711

Or mail a completed request form, letter, or written note to:

Community Care

Member Rights Specialist

205 Bishops Way

Brookfield, WI 53005

What happens next?

We will send you a letter within five business days to let you know we got your appeal. Then, we will try to help resolve your concerns or come up with a solution that satisfies both Community Care and you. Sometimes, we are not able to come up with a solution. Or, you may not want to work with Community Care staff to informally address your concerns. In that case, our Grievance and Appeals Committee will review your appeal.

- We will let you know when the Committee plans to review your appeal.
- The Committee is made up of:
 - Community Care staff
 - A health care professional with the right clinical experience
 - At least one “consumer.” The consumer is a person who also gets 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 meeting is confidential. You can ask that the consumer not be on the Committee if you are worried about privacy or have other concerns.
 - Sometimes, other people who specialize in your appeal.
- You have the right to go to the meeting in person. You can bring an advocate, such as a friend, family member, or Ombudsman.
- Your care team or other Community Care staff will be at the meeting.
- The Committee will have you explain why you disagree with your care team’s decision. You or your representative can present information, bring witnesses, or describe your concerns. This helps the Committee understand your point of view.
- After the Committee hears your appeal, Community Care will send you a decision letter. We will send it within 30 days after we first got your appeal. Community Care may take up to 44 days to issue a decision if:
 - You ask for more time to give the Committee information

- We need more time to gather information. If we need more time, we will send you a letter telling you about the reason for delay.

Speeding up your appeal

Community Care has 30 days to decide on your appeal. If you think waiting that long could seriously harm your health or your ability to do daily activities, you can ask us to speed up your appeal. We call this an “expedited appeal.” You may ask for an expedited appeal only if you believe that waiting for a decision could seriously harm your health or your ability to function. If you ask for an expedited appeal, we will decide if your health requires an expedited appeal. We will let you know as soon as possible if we will expedite your appeal.

In an expedited appeal, you will get a decision on your appeal within 72 hours of your request. However, it may take up to 17 days if we need more information and if the delay is in your best interest. If you have extra evidence you want us to see, you will need to send it quickly.

To request an expedited appeal, contact:

Community Care
Member Rights Specialist
20.5 Bishops Way
Brookfield, Wi 53005
Toll free: 866-992-6600
Member Rights Specialist Phone: 262-207-9325
TTY: 711

What if I disagree with the Grievance and Appeal Committee’s decision?

If you disagree, you can request a state fair hearing with the Division of Hearings and Appeals (DHA). You must do so within 90 days of the date you get a letter with the Grievance and Appeal Committee’s decision. You can also file an appeal with DHA if Community Care does not issue an appeal decision on time. Please see the earlier section to figure out if Community Care issued its appeal decision on time.

State fair hearing

You can ask for a state fair hearing after you get a letter from the Community Care Grievance and Appeal Committee’s with their decision on your appeal. You can also ask for a state fair hearing if Community Care did not make a decision by the due date.

APPEAL OPTION 2: Filing your request for a state fair hearing

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 the request form from Community Care’s member rights specialist or from one of the advocacy organizations listed in this handbook. You can also get the form online at www.dhs.wisconsin.gov/library/collection/f-00236.
- **Mail a letter.** Explain what you are appealing. Make sure to include your name and contact information. If you got a Notice of Adverse Benefit Determination or other letter about your appeal rights, include a copy of that letter with your request for a state fair hearing. Do not send your original copy.

The member rights specialist or an Ombudsman can help you put your appeal in writing. To contact an Ombudsman, 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:

Partnership 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 should file your appeal as soon as possible. **You must file your appeal within 90 days after you receive a Notice of Adverse Benefit Determination or other letter about your appeal rights.** (For example, if you get a letter in the mail on August 1, you must file your appeal on or before October 30.)

If Community Care doesn’t send you a letter with a decision within 30 days of getting your appeal, the 90 days starts the day after those 30 days are up. For example, Community Care receives your appeal on August 1. Community Care does not send you a letter with a decision by August 30. The 90-day period starts on August 31; you must file your appeal on or before November 29.

You can ask to keep getting your services during the state fair hearing process. You can ask for this if you file your appeal **on or before** the date Community Care plans to stop or reduce your services. You can find more information about continuing services earlier in this chapter.

What happens next?

- After you send your request for a state fair hearing, DHA will mail you a letter with the date, time, and location of your hearing.
- An administrative law judge will run the hearing by phone, or it may be at an office in your county.
- You have the right to take part in the hearing. You can bring an advocate, such as a family member, friend, attorney, or Ombudsman.
- Your care team or other Community Care staff will be at the hearing to explain their decision.
- You will have a chance to explain why you disagree with your care team's decision. You or your representative can present information, bring witnesses, or describe your concerns. This helps the judge understand your point of view.
- The administrative law judge must make a decision within 90 days of the date you filed a request for the hearing.

What can I do if I disagree with the judge's decision?

If you disagree with the 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
 - You have new evidence that you were not able to get 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 administrative law judge's decision.

Who can help me with my grievance or appeal?

You can contact Community Care's member rights specialist any time you need help with a grievance or appeal. You can also contact them with questions about your rights. Ombudsman are also available to answer questions about grievances and appeals. They can tell you more about your rights and help make sure Community Care is supporting your needs and outcomes. You can ask anyone you want to act as an advocate for you. Advocates can be family members, friends, an attorney, or any other person willing to help.

Below are some places you can contact for help. Community Care's member rights specialist can help you find other places that can help you too.

Ombudsman Programs

Regional Ombudsman programs are available to help all Partnership members with grievances and appeals. They can respond to your concerns quickly. Both Ombudsman programs usually try to resolve your issues without a hearing.

Wisconsin Board on Aging and Long Term Care

Ombudsman from this agency work with Partnership members **age 60 and older**.

Board on Aging and Long Term Care
1402 Pankratz Street, Suite 111
Madison, WI 53704-4001
Toll-free: 800-815-0015
Fax: 608-246-7001
Email: BOALTC@wisconsin.gov
<https://longtermcare.wi.gov>

Disability Rights Wisconsin (DRW)

Ombudsmen from this agency work with Partnership members **under age 60**.

Disability Rights Wisconsin
1502 W Broadway, Suite 201
Madison, WI 53713
Toll-free: 800-928-8778
TTY: 888-758-6049
Fax: 833-635-1968
Email: info@drwi.org
<https://disabilityrightswi.org>

Chapter 9. Ending your membership in Community Care

You can choose to end your membership in Community Care at any time. We cannot tell or encourage you to disenroll from Partnership due to your situation or condition. There are some situations when your membership will end even if that wasn't your choice. For example, your membership will end if you lose eligibility for Medicaid.

You must continue to get your care through Community Care until your membership ends. Your membership could end because you are no longer eligible, or you may decide to enroll in a different program or a different managed care organization.

You can end your membership at any time. You can choose the date when you want your membership to end for your Medicaid covered services. If you have Medicare, Community Care will keep covering your Medicare services until the last day of the month in which you requested disenrollment if you qualify for a Special Election Period (SEP). Contact your care team for more information. See Chapter 9, Section 2 of your Summary of Benefits and Evidence of Coverage for more information about SEP.

1.) If you want to end your membership in Partnership.

To end your membership, contact the Aging and Disability Resource Center (ADRC) in your area. (See Chapter 1 for ADRC contact information). The ADRC will process your disenrollment. They will ask if you want to enroll in a different managed care organization or Medicaid program. The ADRC can also answer questions about ending your membership. If you decide to disenroll, you should also tell your care team.

2.) You will be disenrolled from Partnership if your eligibility ends.

Community Care must report the information listed below to the county or tribal agency. An agency worker will see if you are still eligible for Partnership. If they decide you are no longer eligible, they will end your membership in Partnership.

Reasons you may lose eligibility:

- You lose your financial eligibility for Medicaid.
- You are no longer functionally eligible. The Wisconsin Adult Long Term Care Functional Screen determines this.
- You do not pay your cost share. See Chapter 5 for more information about cost share.
- You permanently move out of Community Care's service area. If you move or take a long trip, you need to tell your care team.
- You are in jail or prison.

- You are admitted to an Institute for Mental Disease (IMD) and lose Medicaid eligibility.
- You choose a primary care provider who is not in Community Care's network

3.) Community Care may end your Partnership enrollment with approval from DHS.

Community Care may ask DHS to disenroll you because:

- You stop accepting services and we don't know why.
- You refuse to participate in care planning and we cannot ensure your health and safety.
- You keep behaving in a way that is disruptive or unsafe to staff, providers, or other members.

DHS will review our request to disenroll you. They will decide if your membership should end.

Your membership CANNOT be ended for any reason related to your health or if your use of services changes. Exception: If you stop accepting services and we don't know why.

You have the right to file an appeal if you are disenrolled from Partnership or your membership in Community Care ends. You will get a letter from the county or tribal agency that tells you why your membership is ending. This letter will have the words "About Your Benefits" on the first page. The letter will explain how you can file an appeal. See Chapter 8 for information.

APPENDICES

1. Definitions of important words

Abuse – The physical, mental, or sexual abuse of a person. This includes treatment you didn't agree to. It also includes confinement or restraint that is not reasonable. See Chapter 6 for full descriptions of the types of abuse.

Administrative law judge – An official who holds a state fair hearing. They help solve a dispute between you and your managed care organization (MCO). See Chapter 8 for information about state fair hearings.

Advance directive – A written statement of your wishes about medical treatment. It makes sure medical staff carry out your wishes if you are not able to communicate your 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. See Chapter 6 for more information on advance directives.

Advocate – Someone who can help you make sure your MCO is addressing your needs and outcomes. An advocate can help you work with your MCO to informally resolve disputes. They can also represent you if you decide to file an appeal or grievance.

Aging and Disability Resource Center (ADRC) – Service centers that give you information. They help with all parts of life related to aging or living with a disability. The ADRC handles enrollment and disenrollment in the Partnership program.

Appeal – A request for your MCO to look at a decision that affects your services. You have the right to file an appeal if your care team stops, denies, or reduces a service. Other types of appeals and the process for filing one are in Chapter 8.

Assets – Assets include cars, cash, bank accounts, investments, cash value of life insurance, and other things. Medicaid eligibility depends on the amount of assets you have. You must be eligible for Medicaid to be in Partnership.

Authorized representative for Medicaid – A person or organization you choose to help you get and keep Medicaid. Use form F-10126A (www.dhs.wisconsin.gov/library/collection/f-10126a) or F-10126B (www.dhs.wisconsin.gov/library/collection/f-10126b).

Benefit package – Services you can get when enrolled in Partnership. These include medical care, hospital care, personal care, home health, transportation, medical supplies, nursing care, and other services. Your care team must approve services. They must also list them in your care plan. See Chapter 4 for a complete list of the services.

Care plan – A plan that documents your personal experience and long-term care outcomes, needs, preferences, and strengths. The plan lists the services you get from family or friends. It also lists the services the MCO will provide. You are central to the care plan process. You and your team meet regularly to review your care plan.

Care team – You will have a care team when enrolled in Partnership. It includes you, a care manager, registered nurse, and a nurse practitioner. You and your care team look at your needs, identify your outcomes, and create your care plan. Your social worker and nurse approve, coordinate, and track your services.

Choice – The Partnership program supports your choice when getting services. Choice means having a say in how and when you get care. It also means you are responsible for helping your care team find the most cost-effective ways to support you. You can also choose to direct one or more of their long-term care services. You can do this using the self-directed supports (SDS) option.

Copayment – A fixed amount of money you pay for a covered health care service. For example, you may have a \$5 copay for a visit to the doctor.

Cost share – A monthly amount you may have to pay to stay eligible for Partnership.

Cost-effective – The option that best supports your long-term care outcome at a reasonable cost and effort. You and your care team use the Resource Allocation Decision (RAD) method. It helps you find ways to support your long-term care outcomes. Then, you and your team look at the options. You'll choose the most cost-effective way to support your outcomes. It isn't always the cheapest option.

County or tribal agency – Local agencies that determine your financial eligibility for Medicaid. This includes partnership and other public benefits.

Department of Health Services (DHS) – A State of Wisconsin agency. DHS runs Wisconsin's Medicaid programs, including Partnership.

DHS review – A decision about your grievance by the Department of Health Services (DHS). DHS works with MetaStar to review and make final decisions on grievances. See Chapter 8 for information about DHS reviews.

Disenroll/disenrollment – The process of ending your membership in Partnership.

Division of Hearings and Appeals (DHA) – A State of Wisconsin agency. It holds state fair hearings.

Durable medical equipment (DME) – An item or device meant for you to use each day. You may need it to help with a health issue or disability. Examples include oxygen equipment, wheelchairs, and walkers.

Emergency medical condition – An illness, injury, symptom, or condition that is very serious. Most people would seek care right away to avoid harm.

Emergency room care – Health care services you get in the emergency department of a hospital.

Enroll/enrollment – Enrollment in Partnership is voluntary. To enroll, you should contact your local Aging and Disability Resource Center (ADRC).

Estate recovery – The process where the State of Wisconsin seeks repayment for costs of Medicaid services you received from Medicaid-funded long-term care. The State recovers money from your estate after your spouse dies.

Expedited appeal – A process to speed up appeals. You can ask your MCO to speed up your appeal if you think waiting the normal amount of time could seriously harm your health or ability to function. See Chapter 8 for information about expedited appeals.

Family Care Partnership Program – See “Partnership”

Financial eligibility – Eligibility for Medicaid. The county or tribal agency looks at your income and assets to find out if you are eligible for Medicaid. You must be eligible for Medicaid to be in Partnership.

Functional eligibility – Your need for help with things like bathing, getting dressed, and using the bathroom. We use the Wisconsin Long Term Care Functional Screen for this. It determines whether a person is functionally eligible for Partnership.

Grievance – A statement that you are unhappy about care or services or other general matters. Grievances can be about quality of care. They can also be about how you and your care team interact about your rights. Chapter 8 explains grievances and how to file one.

Guardian – A person who makes decisions about your life. The court may appoint a guardian if you can’t make your own decisions.

Legal decision maker – A person who has legal authority to make decisions for you. A legal decision maker may be a guardian of the person or estate (or both), conservator, a person appointed as an agent under a power of attorney for health care or finances document.

Level of care – The amount of help you need to do daily activities. You must be a “nursing home” level of care to be eligible for Partnership.

Long-term care (LTC) – Services you may need because of a disability, getting older, or having a chronic illness. Long-term care helps you do the things you need to do every day. This includes bathing, getting dressed, making meals, and going to work. Long-term care can be provided at home, in the community, or in a facility. This could be a nursing home or assisted living facility.

Long-term care outcome – A situation, condition, or circumstance you or your care team identify that helps you be as independent as possible.

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

Managed care organization (MCO) – The agency that runs the Partnership program.

Medicaid – A medical and long-term care program run by the Wisconsin Department of Health Services (DHS). Medicaid is also known as “Medical Assistance,” “MA,” and “Title 19.” You must meet Medicaid eligibility requirements to be a member.

Medical care (acute and primary) – Diagnosing, treating, and preventing chronic disease, illness, injury, and other physical and mental illness. It includes short-term care in a hospital or emergency room (acute care). It also includes care from a physician (primary care). There are other levels of care as well.

Medicare – A federal health insurance program. It is for people age 65 or older and some people under age 65 with certain disabilities. It is also for people with end-stage renal disease (permanent kidney failure that needs dialysis or kidney transplant). Medicare covers hospitalizations, health care, and prescription drugs.

Member – A person in Partnership. You must meet functional and financial eligibility criteria.

Member rights specialist – An MCO staff member who can help you understand your rights and responsibilities. The member rights specialist also helps with concerns about care and services. They can help you file a grievance or appeal. See Chapter 8 for information about grievance and appeals.

MetaStar – The agency that the Wisconsin Department of Health Services (DHS) works with to review requests of grievances and appeals. They also review the quality of MCOs. See Chapter 8 for information about DHS reviews.

Natural supports – The people in your life who already choose to help you.

Network – Who your MCO contracts with to provide health and long-term care services. Includes physicians, hospitals, facilities, and suppliers.

Network provider (or participating provider or provider) – A person or group who has a contract with your MCO. They can give you services.

Non-network provider (or non-participating provider)—A person or group who doesn't have a contract with your MCO to give you services. To use a non-network provider, members first must contact their MCO.

Notice of adverse benefit determination – A decision from your MCO. Common types include an MCO stopping or reducing your services. An MCO may also deny a request for a new service.

Notification of appeal rights – A letter that explains your options for filing an appeal. See Chapter 8 for more information about appeals.

Nursing home level of care – Members who are at this level of care have needs that make them eligible to get 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 Partnership.

Ombudsman – A person who looks at reported concerns and helps you solve issues with your care and services.

Partnership program – A program providing medical and long-term care services to older adults and adults with physical and developmental disabilities. All Partnership members must:

- Have a nursing home level of care as determined by the Wisconsin Long Term Care Functional Screen
- Be enrolled in Wisconsin Medicaid. They may also be enrolled in Medicare.
- Live in a county where Partnership is available.

Personal outcomes – The goals you have for your life.

Power of attorney for health care – A legal document you can use to allow someone to make health care decisions for you. This is used if you are ever unable to make those decisions on your own.

Primary care provider – The person who gives, directs, or helps you get health care services. Includes doctors and nurse practitioners, physician assistants, and other licensed providers.

Prior authorization (or **pre-authorization**)—Written approval for a service or prescription. You may need this from your MCO or DHS before you get a service or fill a prescription.

Provider network – A list of agencies and people the MCO contracts with to provide services. Your care team must approve your services before you can choose a provider from the directory. See Chapter 3 for information about the MCO’s provider network.

Prescription drugs – Drugs and medicines that, by law, you must have a prescription to get. This means a medical provider says you need the drugs or medicine.

Residential services – Services you get in residential care settings. This includes adult family homes (AFHs), community based residential facility facilities (CBRFs), residential care apartment complexes (RCACs), and nursing homes. The member’s care team must approve all residential services.

Resource Allocation Decision (RAD) Method – A tool you and your care team use to help find the best ways to meet your needs and support your outcomes.

Room and board – The part of the cost of living in a residential care setting related to rent and food costs. You are responsible for paying your room and board expenses. See Chapter 5 for information about room and board.

Self-directed supports (SDS) – SDS is a way for you to arrange, purchase, and direct some of your long-term care services. You have more responsibility, flexibility, and control over how you get services. With SDS, you can choose to control your own budget for long-term care services. You may also have control over your providers. This includes hiring, training, supervising, and firing your own direct care workers.

Service area – The area where you must live to enroll and stay in Community Care Partnership. See Chapter 2 for a list of the Community Care service area.

Specialist – A doctor who is an expert in an area of medicine.

State fair hearing – A hearing held by an administrative law judge who works for the State of Wisconsin Division of Hearing and Appeals. See Chapter 8 for information about state fair hearings.

2. Home and Community-Based Waiver Services

You can ask your Care Team for more information about services.

Adaptive Aids are items that help people 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, take part in, and function in their community. This includes vehicle modifications (such as van lifts, hand controls), and may include getting a fully trained service dog from a reputable provider, any post-purchase training with a reputable provider needed for the member and the fully trained service dog to work together and ongoing maintenance costs for a fully trained service dog obtained from a reputable provider. (When a member obtains a service dog as a covered benefit, the member recognizes he or she owns the service dog and agrees to be responsible for and liable for the actions of the service dog).

Adult Day Care Services are services for part of a day in a non-residential group setting. It's for adults who need social interaction. It's also for those who need help with daily activities, supervision, or protection. Services may include personal care and supervision, light meals, medical care, and rides to and from the day care site.

Assistive Technology/Communication Aids are items that help members at home, work, and in the community. They could be devices or services that help members hear, speak, or see. This includes communication systems, hearing aids, speech aids, interpreters, and technology (tablets, mobile devices, software).

Care Management Services (also known as case management or service coordination) are provided by a care team. The member is the center of the care team. The team includes a registered nurse, nurse practitioner, and a care manager [or social worker or social services coordinator]. It may also include other professionals based on 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.

Consultative Clinical and Therapeutic Services help unpaid caregivers and paid support staff carry 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 who serve members with complex needs (beyond routine care).

Consumer Education and Training helps people with disabilities develop self-advocacy skills, support self-determination, exercise civil rights, and build skills needed to exercise control and responsibility over other support services. These services include education and training for members, their caregivers, and legal decision makers. It may pay for enrollment fees, books and other educational materials, and rides to training courses, conferences, and other similar events.

Counseling and Therapeutic Services treat personal, social, physical, medical, behavioral, emotional, cognitive, mental health, or alcohol or other drug abuse disorders. It may include help adjusting to aging and disability, help with relationships, recreational therapies, art therapy, nutritional counseling, medical counseling, weight counseling, and grief counseling.

Daily Living Skills Training teaches members and their natural supports how to do everyday tasks. This includes skills to increase the member's independence and take part in community life. Examples include teaching money management, home care maintenance, food preparation, mobility training, self-care skills, and how to access and use community resources.

Day Services are routine activities in a non-residential setting (day center). They enhance social development and develop skills to do daily living and community living activities.

Financial Management Services help members and their families manage service dollars or manage their personal finances. After the member authorizes payment for a service included in the member's self-directed support plan, the person or agency pays the bill. These services also help members budget for housing and other essential costs.

Home Delivered Meals (sometimes called "meals on wheels") include the costs associated to get and plan food, supplies, equipment, labor, and transportation to deliver one or two meals a day. This is for members who are not able to make or get healthy meals without help.

Home Modifications are services and items that make a member's home easier and safer to get around in. This may include ramps, stair lifts, wheelchair lifts, kitchen or 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 helps members find housing in the community. This service does not pay for housing. Housing counseling helps members explore ownership and rental options and find available housing. It also helps find funding, decide on location and type of housing, and identifying accessibility needs.

Personal Emergency Response System directly connects a member with health professionals in case of emergency. It is a phone or other electronic system.

Prevocational Services are learning and work experiences that help members develop strengths and skills for jobs. Members can learn general skills to work with supervisors, co-workers, and customers. They can also learn about how to dress, follow directions, do tasks, solve problems, stay safe, and get around. These services help members get a job in the community.

Relocation Services help members move from an institution or family home to their own home within the community. They can pay for moving expenses, cleaning and organization, a security deposit, utility connection costs, phones and their installation, furniture, cooking utensils, cleaning and household supplies, and basic furnishings and appliances.

Residential Care: 1-2 Bed Adult Family Home is a place that provides care, treatment, support, or services for up to two adults. Services usually include supportive home care, personal care, and supervision. It 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 that provides care, treatment, or services for 3-4 adults. The person who runs the home is not related to the members. Services may include up to seven hours of nursing care per resident each week. Services usually 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 live. The person who runs the home is not related to the members. Services include care, treatment, support, supervision, training, transportation, and up to three hours of nursing care per resident each week.

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 help during an emergency.

Respite Care Services are short-term breaks for family members or other primary caregivers. This helps relieve daily stress and care demands. Respite care may be provided in the member's home, a residential facility, a hospital, or a nursing home.

Self-Directed Personal Care Services help members with daily activities and housekeeping. This includes help with bathing, eating, dressing, managing medications, oral, hair, and skin care, meal preparation, bill paying, mobility, toileting, and transferring and using transportation. The member has a physician prescription for the service and chooses the person or agency that provides their services. Members choose providers based on their care plan.

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 items that maintain the member's health, manage a medical or physical condition, improve functioning, or enhance independence. This 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 who helps members plan, get, and direct self-directed support (SDS). The member chooses their support broker.

Supported Employment Services (individual and small group employment support services) help members who need help getting or keeping a job in their community because of a disability. The goal is to keep a job at or above minimum wage. The job should also meet their personal and career goals.

- *Individual* employment services are made to match the member's needs. They can help explore job options, plan for employment, get a job, grow skills for that job, and get interviews. It could also include coaching and training, rides to work, career advancement, and self-employment support.
- *Small group* employment services are the same as above, but for a group of two to eight workers with disabilities. They are provided in a business, industry, or community setting. Examples of groups include mobile crews and other business-based workgroups employing small groups of workers with disabilities.

Supportive Home Care (SHC) directly helps members with daily living activities and personal needs. This helps them function 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 help the people who provide unpaid care, training, companionship, supervision, or other support to a member. It trains unpaid caregivers in treatments and other services included in the member's care plan, use of equipment specified in the service plan, and guidance to keep the member safe in the community.

Transportation (specialized transportation) – Community and Other Transportation

- Community transportation services help members access community services, activities, and resources. This 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 get 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.

3. Notice of Privacy Practices

Community Care, Inc. / Community Care Health Plan, Inc.
205 Bishops Way
Brookfield, WI 53005 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. Recent changes to HIPAA give you significant new 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 will 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.

Partnership Member Handbook (Medicaid Only) Notice of privacy

- 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 have shared information

- You can ask for a list (accounting) of the times we have 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 will 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/**.
- 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.

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: 262-207-9440

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, Inc. | 205 Bishops Way | Brookfield, WI 53005
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