

## FAMILY CARE PARTNERSHIP

Community Care Family Care Partnership Program

# *Family Care Partnership Member Handbook*

FOR PEOPLE ENROLLED IN MEDICAID ONLY

CALUMET, KENOSHA, MILWAUKEE, OUTAGAMIE,  
OZAUKEE, RACINE, WASHINGTON, WAUKESHA  
AND WAUPACA COUNTIES

### IMPORTANT:

If you are covered by **MEDICARE**, you should refer to the Evidence of Coverage for Partnership members who are enrolled in **MEDICARE** and **MEDICAID**.

Please ask your Team for a copy of the Evidence of Coverage.

For help or information, please call Customer Service or visit our website at [www.communitycareinc.org](http://www.communitycareinc.org). Call toll free: 866-992-6600. TTY users call the Wisconsin Relay System at 711.



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

## **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**

مقر لاد اولصنا. تينا جم تيوغا د عاسم مكل رفوتت، تيبير علا نوئدحتت متتك اذا: هيبنت  
711. (هاتف نصي: 1-866-992-6600)

## Community Care:

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

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

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## Chapter 1. Important phone numbers and resources



This handbook is for Partnership members who are enrolled in Medicaid only.

If you are enrolled in **Medicare AND Medicaid**, refer to the Evidence of Coverage booklet.

The handbook you are reading right now does not include all the information you need to know if you are enrolled in Medicare. Ask your Team if you don't know if you are enrolled in Medicare.

General phone number 866-992-6600

TTY: call the Wisconsin Relay System at 711.

You can call these numbers 24 hours a day, 7 days a week.

### Corporate Office:

205 Bishops way

Brookfield, WI 53005

Office hours: 8:00 a.m. to 4:30 p.m. Monday – Friday

### Partnership Care Team Contact Information

Calumet County 4435 W. Lawrence Ave. Appleton, WI 54914 920-750-5575	Outagamie County 4435 West Lawrence Ave. Appleton, WI 54914 920-750-5575	Washington County 910 E. Paradise Drive West Bend, WI 53095 262- 338-5933
Kenosha County 5614 52 <sup>nd</sup> Street Kenosha, WI 53144 262-484-5050	Ozaukee County 910 E. Paradise Dr. West Bend, WI 53095 262-338-5933	Waukesha County 1801 Dolphin Drive Waukesha, WI 53186 262-953-8500
Milwaukee County 3220 W. Vliet St. Milwaukee, WI 53208 414-231- 4000	Racine County 6216 Washington Avenue Suite 200 Racine, WI 53406 262-633-4800	Waupaca County 102 Grand Seasons Drive Waupaca, WI 54981 715-256-3435

### How to contact Customer Service

For assistance with claims, billing or member ID card questions, please call or write to your Team or Community Care Customer Service. We will be happy to help you.

**Note: If you are experiencing a life-threatening emergency call 911**

<b>Community Care Contacts</b>	
<b>CALL</b>	866-992-6600 Calls to this number are free. You can call 24 hours a day, 7 days a week. Customer Service also has free language interpreter services available for non-English speakers.
<b>TTY</b>	Call the Wisconsin Relay System at 711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. You can call 24 hours a day, 7 days a week.
<b>WRITE</b>	205 Bishops Way Brookfield, WI 53005
<b>WEBSITE</b>	<a href="http://www.communitycareinc.org">www.communitycareinc.org</a>

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

**How to contact us when you are asking for a coverage decision about your medical care, long-term care services, or prescription drugs.**

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

You may call us if you have questions about our coverage decision process.

<b>Coverage Decisions for Medical Care or Long-Term Care Services</b>	
<b>CALL</b>	866-992-6600 Calls to this number are free. You can call 24 hours a day, 7 days a week. Customer Service also has free language interpreter services available for non-English speakers.
<b>TTY</b>	Call the Wisconsin Relay System at 711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. You can call 24 hours a day, 7 days a week.
<b>WRITE</b>	205 Bishops Way Brookfield, WI 53005
<b>WEBSITE</b>	<a href="http://www.communitycareinc.org">www.communitycareinc.org</a>

## How to contact ForwardHealth when you are asking for 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 with your ForwardHealth card.

Method	ForwardHealth Member Services
<b>CALL</b>	800-362-3002 Free language interpreter services are available for non-English speakers.
<b>WEBSITE</b>	<a href="http://www.dhs.wisconsin.gov/forwardhealth/resources.htm">www.dhs.wisconsin.gov/forwardhealth/resources.htm</a>

## How to contact us when you are making a *complaint* about your medical care or long-term care services

You can make a complaint about us or one of our network 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. (If your problem is about the plan's coverage or payment, you should look at the section below about making an appeal.) For more information on making a complaint about your medical care, long-term care services, or prescription drugs, see Chapter 8.

Complaints about Medical Care or Long-Term Care Services	
<b>CALL</b>	866-992-6600 Calls to this number are free. You can call 24 hours a day, 7 days a week. Customer Service also has free language interpreter services available for non-English speakers.
<b>TTY</b>	Call the Wisconsin Relay System at 711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. You can call 24 hours a day, 7 days a week.
<b>WRITE</b>	205 Bishops Way Brookfield, WI 53005
<b>WEBSITE</b>	<a href="http://www.communitycareinc.org">www.communitycareinc.org</a>

## How to contact us when you are making an *appeal* about your medical care or long-term care services

<b>Appeals for Medical Care or Long-Term Care Services</b>	
<b>CALL</b>	866-992-6600 Calls to this number are free. You can call 24 hours a day, 7 days a week. Customer Service also has free language interpreter services available for non-English speakers.
<b>TTY</b>	Call the Wisconsin Relay System at 711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. You can call 24 hours a day, 7 days a week.
<b>WRITE</b>	205 Bishops Way Brookfield, WI 53005
<b>WEBSITE</b>	<a href="http://www.communitycareinc.org">www.communitycareinc.org</a>

## Where to send a request asking us to pay for the cost for medical care or long-term care services you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 5.

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

<b>Payment Requests</b>	
<b>CALL</b>	866-992-6600 Calls to this number are free. You can call 24 hours a day, 7 days a week. Customer Service also has free language interpreter services available for non-English speakers.
<b>TTY</b>	Call the Wisconsin Relay System at 711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. You can call 24 hours a day, 7 days a week.
<b>WRITE</b>	205 Bishops Way Brookfield, WI 53005
<b>WEBSITE</b>	<a href="http://www.communitycareinc.org">www.communitycareinc.org</a>

## Social Security

The United States Social Security Administration (SSA) determines eligibility for Social Security benefits. To apply for Social Security, you can call SSA or visit your local Social Security Office. SSA also oversees Medicare. If you receive Medicare benefits, or think you might be eligible for Medicare, contact Social Security. If you are eligible for Medicare, **you must enroll in all of the parts of Medicare you are eligible for** (Part A, B, and D).

This handbook is for members who are enrolled in Medicaid only. If you are enrolled in **Medicaid AND Medicare**, talk with your Team right away.

<b>Social Security Administration</b>	
<b>CALL</b>	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
<b>TTY</b>	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
<b>WEBSITE</b>	<a href="http://www.ssa.gov">www.ssa.gov</a>

## Medicaid

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

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

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

**All Medicaid applicants and members can use ACCESS.** ACCESS is an online tool at [www.access.wi.gov](http://www.access.wi.gov) that you can use to:

- Find out if you are eligible for a program
- Apply for benefits

- Check your benefits
- Report changes
- Get a new ForwardHealth Card

**You can call the ForwardHealth Customer Service at 1-800-362-3002** to get general information about Medicaid.

- To get general information about Medicaid
- To get a new ForwardHealth Card

**You can contact your Local County or Tribal Agency for:**

- Answers about enrollment rules
- Reporting changes by phone, fax or email
- Sending proof/verification of eligibility

To get the address or phone number of your local agency, see your latest Notice of Decision, go to: [www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm](http://www.dhs.wisconsin.gov/forwardhealth/imagency/index.htm) or call ForwardHealth Customer Service at: 1-800-362-3002.

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

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

### **Ombudsman Programs**

Ombudsmen investigate reported concerns and help members resolve issues. The Board on Aging and Long Term Care provides Ombudsman services to potential and current members age 60 and older. Disability Rights Wisconsin provides Ombudsman services to potential and current Partnership members under age 60. Both Ombudsmen programs can help you file a grievance or appeal with our plan.

<b>Disability Rights Wisconsin</b> - Ombudsmen from this agency provide assistance to individuals <b>under age 60</b> .	
<b>CALL</b>	Toll-free: 800-928-8778 TTY: 888-758-6049 Fax: 833-635-1968
<b>TTY</b>	TTY: 1-888-758-6049
<b>WRITE</b>	1502 W Broadway, Suite 201Madison, WI 53713 If desired, email address is: <a href="mailto:infor@drwi.org">infor@drwi.org</a>
<b>WEBSITE</b>	<a href="https://disabilityrightswi.org/program/family-care-and-iris-Ombudsman-program">https://disabilityrightswi.org/program/family-care-and-iris-Ombudsman-program</a>

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

## How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

<b>Railroad Retirement Board</b>	
<b>CALL</b>	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
<b>TTY</b>	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are <i>not</i> free.
<b>WEBSITE</b>	<a href="http://www.rrb.gov">www.rrb.gov</a>

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

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

**You can contact your local ADRC as listed below.**

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

## FoodShare Wisconsin

FoodShare helps people with limited money buy the food they need for good health. Every month, people across Wisconsin get help from FoodShare. They are people of all ages who have a job but have low incomes, are living on small or fixed income, have lost their job, retired or have a disability and not able to work.

<b>FoodShare Wisconsin</b>	
<b>CALL</b>	1-800-362-3002 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
<b>TTY</b>	7-1-1 Wisconsin Relay Calls to this number are free.
<b>WEBSITE</b>	<a href="http://www.dhs.wisconsin.gov/foodshare/eligibility.htm">www.dhs.wisconsin.gov/foodshare/eligibility.htm</a>

## Chapter 2. Introduction to Family Care Partnership (Partnership)



This handbook is for Partnership members who are enrolled in Medicaid only.

If you are enrolled in **Medicare AND Medicaid**, refer to the Evidence of Coverage booklet.

The handbook you are reading right now does not include all the information you need to know if you are enrolled in Medicare. Ask your Team if you don't know if you are enrolled in Medicare.

### Welcome to Community Care

Welcome to Community Care, a Managed Care Organization (MCO) that operates the Family Care Partnership program (also known as Partnership). Partnership is a Medicaid program for eligible adults with physical, developmental or intellectual disabilities and frail elders. Partnership is funded by state and federal tax dollars.

This handbook will give you the information you need to:

- Understand the basics of Partnership.
- Become familiar with the medical care, long-term care and prescription drug services in the benefit package.
- Understand your rights and responsibilities.
- File a grievance or appeal if you have a problem or concern.

If you would like help in reviewing this handbook, please contact your care team. Your team's contact information is on page 1.

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

The end of this document (Appendix 1) contains definitions of important words. These definitions can help you understand the words and phrases frequently used in this handbook.

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

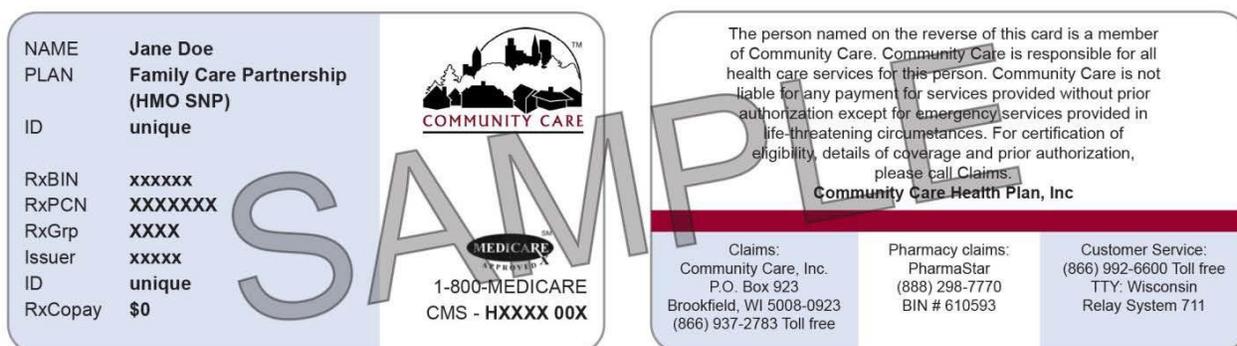
If your Partnership membership card is damaged, lost, or stolen, call Customer Service at 866-992-6600 right away and we will send you a new card. Here's a sample Partnership membership card to show you what yours will look like:

## 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 and show it every time you get care. You may have problems getting health care or long-term care services if you do not have your card with you. If you get services using a different insurance card while you are a Partnership member, **you may have to pay the full cost yourself.**



## How can the Partnership program help me?

Partnership is a program that covers a full range of health and long-term care services. Services are individually tailored to meet your needs. Help with bathing, transportation, housekeeping or medical equipment are just some of the services we offer. We also cover medical care, including laboratory tests, prescription drugs, and dental care. (See Chapter 4. for a list of covered services.)

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

When you join Partnership, we will talk with you about services that can help you live at home. This **might** include building a wheelchair ramp or using a medical alert system.

Partnership gives you services in a personal way. We will work with you and your family to give you the kind of care you need and want. We want you to live as independently as possible for as long as possible in your home or other cost-effective setting. We will encourage you to do as much for yourself as possible. We will help you make informed health choices. We will make sure you get the care you need to be healthy and safe. We will also help you maintain your ties with your family, friends and community.

Partnership is a convenient and efficient program that combines your health care and long-term care services.

## **Who will help me?**

When you become a Partnership member, you will work with a team of professionals from Community Care. This is your care Team. It includes YOU and:

- Anyone you want to be involved, including family members or friends
- A Nurse Practitioner
- A Registered Nurse
- A Care Manager
- Other professionals may be involved depending on your needs. For example, this could be your physician, an occupational or physical therapist, or a mental health specialist.

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

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

The job of your care team is to work with you to:

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

Community Care encourages family members, friends and other people that 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 help find resources in your community that can assist you, such as libraries, senior centers and churches.

When needed, 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 provides a temporary break for your caregivers to give them time to relax and maintain their own health.

## What does it mean to be a member?

As a member of Community Care's Partnership program, you and your care team will work together to make decisions about your health and lifestyle. Together you will make the best possible choices to support you.

You will receive your health care, long-term care services, and prescription drugs through Community Care providers. When you join Partnership, we will give you a list of providers who have agreed to work with us. You and your care team will work together to choose providers that best support your needs.

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

Community Care is responsible for meeting the health and long-term care needs of ALL of our members. We can only do that if all of our members help us develop care plans that work but are also reasonable and cost-effective. By working together, we can make sure Partnership remains available to other people who need our services.

## Who can be a member of Community Care?

It is your choice whether to enroll in Community Care. Membership is voluntary. To be eligible for Partnership you must:

- Be an adult with a physical, intellectual or developmental disability or be age 65 or older;
- Be a resident of our service area (see below for the list of counties in our service area);
- Be financially eligible for Medicaid;
- Be functionally eligible with a nursing home level of care, as determined by the Wisconsin Adult Long-Term Care Functional Screen; and
- Sign an enrollment form.

If you are enrolled in **Medicare**, talk with your Team right away. This handbook does not include all of the information you need to know if you are enrolled in Medicare. You should also talk with your Team if you think you might be eligible for Medicare.

Only individuals that are residents of one of the counties in our service area can enroll in Community Care. To stay a member of our program, you must remain a resident of a county in this service area. 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 can no longer be a member of Community Care’s Partnership program. (For more information, see Chapter 3. Your Team will work with you to transition you to a program available in your new service area.)

Once you become 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 Income Maintenance agency (formerly known as the Economic Support agency) looks at an individual’s income and assets to determine if the person is eligible for Medicaid. Sometimes to be financially eligible members will have to pay a share of the cost of the services they receive. This is called “cost share” and it must be paid to remain eligible for Medicaid. If you will have a cost share, staff from the ADRC will discuss this with you before you make a final decision about enrolling. For more information about cost share, see Chapter 5. The Income Maintenance agency will review your financial eligibility and cost share at least once a year to make sure you are still eligible for Partnership.
- **Functional eligibility** is related to a person’s health and need for help with such things as bathing, getting dressed, and using the bathroom. The ADRC can tell you if you are functionally eligible for Partnership. Your care team will review your functional eligibility at least once a year to make sure you are still eligible.

## How does Partnership work?

### Personnel Experience Outcomes

When you enroll in Partnership, you and your care team will do is to an **assessment** of your needs, strengths and preferences. Part of this process is for you to tell your team about the kind of life you want to live and the supports you need to live the kind of life you want. This gives your team a clear understanding of what is important to you.

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

- Input on:
  - Where and with whom to live.
  - 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, a person might want to:

- Be healthy enough to enjoy visits with his or her grandchildren;
- Have a paid job; or
- Be independent enough to live in his or her own apartment.

You have a right to expect that your care team will work with you to identify your personal experience outcomes. This does not mean Community Care will always cover 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 a very important part of the plan to support your outcomes.**

Before Community Care covers services for you, your care team has to consider which ones support your outcomes best and which are most cost-effective.

### **Long-Term Care Outcomes**

During the assessment process, you and your care team will also identify your **long-term care outcomes**. This helps you and your team know which services will meet your long-term care needs. Long-term care outcomes are those 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 in place will let you focus on the people and activities that are most important to you. For example, getting help to dress or take a bath may also help a person feel well enough to go to work or visit family and friends.

Your care team will develop a care plan that will help you move toward the outcomes that you and your team identify during the assessment process.

Your Team will also find providers to help you. These “formal supports” must have a contract with Community Care. If you are unhappy with any provider, you have the right to request a new

provider, but you must talk with your Team first. Your Team needs to authorize all services you receive.

## What should be covered in your care plan?

Your care plan will be clear about:

- Your physical health needs and your ability to perform 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 showing, which shows that you participated in its development. You will get a copy of your signed plan. If you are not happy with your plan, there are grievance and appeal procedures available to you. (See Chapter 8 for more information.)

Your care team will be in contact with you on a regular basis to talk about how you are doing and check if your services are helping you. Your team is required to meet with you in person at least every three months. Your team may meet with you more often if there is a need for more frequent visits.

## How does Partnership help you manage your own services?

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

- Living arrangement, daily routine and support services of your choice are examples of the outcome categories 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 reasonable supports for your outcomes, you can file a grievance or appeal. (See Chapter 8 for more information).
- 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, including a family member. **The provider must meet our requirements and accept our rates.**
- You have a right to change to a different care team up to two times per calendar year. You do not have to say why you want a different Team. Community Care may not always be able to meet your request or give you the specific team you want.

- You may choose to self-direct.

## **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 and from whom you receive your long-term care services. It is an option you can use if you want to have more responsibility and be more involved in the direction of your own services.

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

Though frequently used for in-home care, SDS can also be used outside of the home for services such as transportation and personal care at your work place. 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 can be self-directed in Partnership

You can choose how much you want to participate in SDS. It is not an “all or none” approach. 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 based on your care plan. You will manage the purchase of services within that budget, either directly or with the help of another person you choose.

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

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

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

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

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

### How are services selected and authorized?

Your Team must approve all services **BEFORE** you receive them. Community Care **is not required to pay for services you receive without our prior approval. If you arrange for services yourself without your care team’s approval, you may have to pay for them.** Please talk with your team if you need a service that is not already approved and in your care plan.

Note: If you are considering 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 is responsible for supporting 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 Decision (RAD)** process as a guide in making decisions about services. The RAD is a step-by-step tool you and your team will use to find the most effective and efficient ways to meet your needs and support your outcomes.

Cost-effectiveness is an important part of the RAD. Cost-effectiveness means effectively supporting an identified outcome at a reasonable cost and effort. For example, if two different providers offer the services you need, Community Care will purchase the more economical service.

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

During the RAD, you and your care team will talk about the services you need. Together you will explore the options available to meet your outcomes. This includes talking about how friends, family or others can help. Many times you can achieve one or more of your outcomes without a lot of help from Community Care because family, friends or other people are able to help you. Community Care purchases services that your own supports cannot 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 assistance you get from your family and friends strengthens these invaluable relationships and helps Community Care pay for services where and when they are needed.

At the end of the RAD, you and your care team will talk about how you can have more control in your life and if you are interested in directing your services. For more information about directing your services, see Chapter 2.

Your care team will find service providers to help you. These providers must have a contract with Community Care. See Chapter 3 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 team must authorize all services you receive.

You don't have to accept a care plan that does not support your outcomes. We will work with you to find the most cost-effective way to support your outcomes. You may have to compromise on some of your outcomes if reaching them fully or right away is very difficult or expensive. You might not get everything you want or ask for, but we will work with you to provide the support you need to find safe and healthy ways to help you reach your outcomes.

**Your care plan will be clear about:**

- Your strengths and preferences.
- Your personal outcomes.

- Your needs.
- The medical care, long-term care services, and supports you will receive.
- Who will provide you with each service or support?
- The things you are going to do yourself or with help from family, friends, or other resources in your community.

Your Team will ask you to sign your care plan showing that you agree and are satisfied with the plan. You will get a copy of your signed plan. If you are not happy with your plan, there are grievance and appeal procedures available to you. (See Chapter 8 for more information.)

Your Team will also find providers to help you. These “formal supports” must have a contract with Community Care. If you are unhappy with any provider, you have the right to request a new provider, but you must talk with your team first. Your team needs to authorize all services you receive.

Your Team will be in contact with you on a regular basis to make sure we are supporting your outcomes and that you are healthy and safe. Your Team is required to meet with you in person at least every three months. Your Team may meet with you more often if there is a need for more frequent visits.

Your services may change over time as your health and life situation change. For example, your services may decrease if your physical health improves. If your needs increase, we will make sure you get the assistance you need to remain 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 Team know. Community Care can provide more or less services based on your changing needs. Please know we will always be there 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 Team.**
- 4.) **The care you receive is included in the Partnership benefit package. (This chart is in Chapter 4.)**
- 5.) **The care you receive is considered medically necessary.** “Medically necessary” means that you need the services, supplies, or drugs for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- 6.) **You have a network primary care provider (PCP) (physician) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Chapter 3).
- In most situations, our program must give you approval in advance before you can use other providers in the plan’s network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies.
  - Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without getting approval from your team ahead of time.
- 7.) **You must receive your care from a network provider.** In *most* cases, we will not cover services you get from an out-of-network provider.

***Two exceptions to this rule:***

- The Partnership program covers emergency care or urgently needed care that you get from an out-of-network provider.
- If you need medical care that Medicaid requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. You must get authorization from your Team prior to seeking care. In this situation, we will cover these services at no cost to you.

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

You and your care team will select your providers from our “provider network.” The list of the providers we routinely use is on our website at [www.communitycareinc.org](http://www.communitycareinc.org). We call this the Provider Network Directory. If you want a paper copy of the Provider Network Directory instead of using the Internet, you can request a copy from your team.

Let your Team know if you want information about the abilities of our providers. For example, providers who have staff that speak a certain language or understand a particular ethnic culture or religious belief.

We contract with providers that help support our members’ outcomes. Our providers work with us in a cost-effective way and must meet our quality standards. Our provider network is intended to give you a choice of providers whenever possible. However, Community Care also has to make sure the provider is a cost-effective choice.

After your care team approves your services, you and your Team will choose from the providers in Community Care’s Provider Directory. You usually have to receive your care from a network provider. However, we might use a provider outside of our network if we don’t have one that can

meet your needs. At other times we might use an outside provider if our network providers are all located too far from where you live. You must talk with your Team about using a provider outside of our network.

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. **If you change providers without talking to your Team and getting approval first, you may be responsible for the cost of the service.**

### **Why do you need to know which providers are part of our network?**

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

The only exceptions are emergencies, urgently needed care when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers. With few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to help you pay for them.

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

Your PCP is the physician who collaborates with your Team and our plan to oversee your health care. When you become a member of Partnership, you must choose a network physician to be your PCP. Your PCP is a physician who meets state licensing requirements and receives training to give you basic medical care.

As we explain below, you will get your routine or basic medical care from your PCP. Your PCP, in collaboration with the rest of your Team, will also coordinate the rest of the covered services you get as a plan member. Please provide your PCP with your past medical records.

Talk with your Team about getting care from your PCP. You will usually see your PCP for most of your routine health care needs. You can get only a few types of covered services without first contacting your Team such as emergency or urgently needed care.

Your Team will arrange or coordinate the covered health care services you get as a plan member. This includes such things as x-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions, and follow-up care. “Coordinating” your services includes checking or consulting with other network providers about your care and making certain the services are approved.

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

You may choose a PCP by using the Provider Network Directory or by getting help from Customer Service or your Team. PCPs do not automatically accept new patients. You may keep your current PCP if he/she is part of our network. You can tell us your choice of PCP by calling your Team. You can change PCPs (as explained later in this section). If there is a particular specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital.

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

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP.

To change your PCP, call your Team. When you call, be sure to tell your Team if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Your Team will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will check to be sure that the PCP you want to switch to is accepting new patients. Your 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 Team?**

You can get the services listed below without getting approval in advance from your Team.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed care from in-network providers or from out-of-network providers when network providers are unavailable or inaccessible, e.g., when you are temporarily outside of the plan's service area.
- Family planning services.

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

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

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

Contact your Team if you need health care from a specialist. For most services, you need to get prior authorization from your Team.

## What if a specialist or another network provider leaves our plan?

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

## Getting care if you have a medical emergency

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

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

A “**life-threatening emergency**” is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb.

The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

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

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

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where 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 to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. If you get your emergency care from an out-of-network provider, we will try to arrange for network providers to take over your care as soon as your medical condition and circumstances allow.

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

### **What if it wasn't a medical emergency?**

Sometimes 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 – and the doctor may say that it wasn't a medical emergency after all.

If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- or -
- The additional 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 a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care. The unforeseen condition could be an unforeseen flare-up of a known condition that you have (for example, a flare-up of a chronic skin condition).

### **What if you are *in* the plan’s service area when you have an urgent need for care?**

In most situations, if you are in the plan’s service area, we will cover urgently needed care *only* if you get this care from a network provider and follow the other rules described earlier in this chapter. However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, we will cover urgently needed care that you get from an out-of-network provider.

### **What if you are *outside* the plan’s service area when you have an urgent need for care?**

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed care that you get from any provider.

Suppose that you are temporarily outside our plan’s service area, but still in the United States. If you have an urgent need for care, you probably will not be able to find or get to one of the providers in our plan’s network. In this situation (when you are outside the service area and cannot get care from a network provider), contact your Team. Our plan often covers urgently needed care that you get from any provider in this situation.

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

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

If you are going to be out of Community Care’s service area and you want to keep getting services while you are gone, you must notify your care team as soon as possible.

Community Care will consult with the Income Maintenance agency to find out if your absence will affect your status as a county resident.

- If you will **no longer be a resident**, you will lose eligibility for Partnership and be disenrolled (You may have to re-apply for Partnership if you return to the service area.)
- If you will **still be considered a resident**, Community Care will work with you to try to plan a cost-effective way to support your needs and keep you healthy and safe while you are gone.

If Community Care believes it cannot develop a cost-effective plan that meets your needs and assures your health and safety while you are out of our service area, we can ask the State of Wisconsin Department of Health Services (DHS) to disenroll you from the program. If we ask DHS to disenroll you, you will be given the opportunity to challenge our request through 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 far ahead of time as possible.** Your Team will talk with you about how a permanent move will affect your care. You can work with your Team to coordinate the transition of services to providers in your new location.

## 4. The Partnership benefit package

### What services are provided?

This chapter focuses on what services our plan covers. The Partnership program provides health care and long-term care. The list of services we provide is called the “Partnership Benefit Package.”

You pay nothing for your covered services **as long as you follow the plans’ rules for getting your care.** (See Chapter 3, for more information about the plans’ rules for getting your care.)

You and your care team will use the Resource Allocation Decision (RAD) process to find the most cost-effective care plan for you. Although the services in the benefit package are available to all members, it does not mean that you can get a service that is listed just because you are a Partnership member. You will only get services that are necessary to support your outcomes and assure your health and safety.

Please note:

- Some members may have to pay a cost share for Medicaid eligibility. See chapter 5 for more information.
- There are rules for authorization of residential services, nursing home stays and other types of services in Partnership. Community Care will only authorize these services in certain situations. See Chapter 3 for more information.
- Only certain services in the benefit package are eligible for self-direction in Partnership. Please ask your care team if you would like more information.
- Because you do not have Medicare and are only covered by Medicaid, **Wisconsin Medicaid covers your prescription drugs, not Community Care Partnership.** You must go to a Medicaid certified pharmacy. You can ask the pharmacy if they accept Medicaid. You can also search for pharmacies on the interactive Medicaid provider search <https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Public/DirectorySearch.aspx>.

Please contact your care team if you need help understanding how to get your prescription drugs through Wisconsin Medicaid.

**Your care team must approve all services before you start receiving them.**

Community Care might provide a service that is not listed. Alternative support or services must meet certain conditions. You and your care team will decide when you need alternative services to meet your outcomes.

The services listed in the table below are available if they are:

- Required to support your outcomes
- Pre-approved by your Team
- Stated in your care plan

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

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

## **Partnership benefit package chart**

You pay nothing when you receive these covered services from network providers. The care team must authorize most non-emergent care.

**Your care team must authorize most of the services listed in the benefit package chart. If you get services that are not authorized, you may have to pay for them yourself.**

The benefit package chart below contains some services that have coverage guidelines. These guidelines are used in the traditional Partnership program (for people with Medicare and Medicaid) and will also be used for Partnership members with Medicaid only.

<p><b>Abdominal aortic aneurysm screening</b>          Covered when medically necessary for people at risk.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Ambulance services</b>          The transportation necessary for emergency situations if you are suffering from an illness or injury which cannot be supplied through transportation of any other means, including your or your family’s vehicle, public transportation, or a specialized medical vehicle (SMV). Services are covered:</p> <ul style="list-style-type: none"> <li>• For emergency care, when immediate medical treatment or examination is needed to deal with or guard against a worsening of the recipient’s condition:           <ul style="list-style-type: none"> <li>○ From the recipient’s residence or the site of an illness or accident to a hospital, physician’s office, or emergency care center;</li> <li>○ From a nursing home to a hospital;</li> <li>○ From a hospital to another hospital; and</li> </ul> </li> <li>• For non-emergency transportation and care when authorized by a physician, physician assistant, nurse midwife or nurse practitioner by written documentation which states the specific medical problem requiring the non-emergency ambulance transport:           <ul style="list-style-type: none"> <li>○ From a hospital or nursing home to the recipient’s residence;</li> <li>○ From a hospital to a nursing home;</li> <li>○ From a nursing home to another nursing home, a hospital, a hospice care facility, or a dialysis center; or</li> <li>○ From a recipient’s residence or nursing home to a hospital or a physician’s or dentist’s office, if the transportation is to obtain a physician’s or dentist’s services which require special equipment for diagnosis or treatment that cannot be obtained in the nursing home or recipient’s residence.</li> </ul> </li> </ul>	<p>Prior authorization may be required, except in an emergency. Contact your care team for more information.</p>

<p><b>Bone mass measurement</b></p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the services listed below are covered every 24 months or more frequently if medically necessary.</p> <p>These are procedures to:</p> <ul style="list-style-type: none"> <li>• Identify bone mass,</li> <li>• Detect bone loss, or</li> <li>• Determine bone quality, including a physician’s interpretation of the results.</li> </ul>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Breast cancer screening (mammograms)</b></p> <p>Covered services typically include:</p> <ul style="list-style-type: none"> <li>• One baseline mammogram between the ages of 35 and 39</li> <li>• One screening mammogram every 12 months for women age 40 and older</li> <li>• Clinical breast exams once every 24 months or as medically necessary.</li> </ul>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Cardiac rehabilitation services</b></p> <p>Comprehensive programs that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor’s referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Cardiovascular disease testing</b></p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) are covered when medically necessary.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Cervical and vaginal cancer screening</b></p> <p>Covered services typically include:</p> <ul style="list-style-type: none"> <li>• For all women: Pap tests and pelvic exams are covered once every 24 months</li> <li>• If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age. One Pap test is covered every 12 months</li> </ul>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Chiropractic services</b></p> <p>Covered services typically include:</p> <ul style="list-style-type: none"> <li>• We cover only manual manipulation of the spine to correct subluxation.</li> </ul>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Colorectal cancer screening</b></p> <p>Screenings are administered when medically necessary. Typically, screenings are covered as follows:</p> <p>For people 50 and older, the following are covered:</p>	<p>Prior authorization may be required. Contact your care team for more</p>

<ul style="list-style-type: none"> <li>• Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months</li> <li>• Fecal occult blood test, every 12 months</li> </ul> <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> <li>• Screening colonoscopy (or screening barium enema as an alternative) every 24 months</li> </ul> <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> <li>• Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy</li> </ul>	<p>information.</p>
<p><b>Community Support Program (CSP)</b></p> <p>CSP provides non-institutional medical treatment and related care and rehabilitative services to a person with mental illness. Covered services include assessment, development of a treatment plan, treatment services, rehabilitation services, other support services and on-going monitoring and service coordination. Services must be prescribed by a physician and provided by a Medicaid-certified provider.</p>	<p>Prior authorization may be required.</p> <p>Contact your care team for more information.</p>
<p><b>Dental services</b></p> <p>Dental services covered by Wisconsin Medicaid, which includes but are not limited to:</p> <ul style="list-style-type: none"> <li>• Routine dental care, including exams, cleanings, and x-rays</li> <li>• Fillings</li> <li>• Surgery of the jaw or related structures</li> <li>• Setting fractures of the jaw or facial bones</li> <li>• Extraction of teeth</li> <li>• Services that would be covered when provided by a doctor</li> </ul>	<p>Prior authorization may be required.</p> <p>Contact your care team for more information.</p>
<p><b>Diabetes screening</b></p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months or more often, if medically necessary.</p>	<p>Prior authorization may be required.</p> <p>Contact your care team for more information.</p>

<p><b>Diabetes self-management training, diabetic services and supplies</b>                  For all people who have diabetes (insulin and non-insulin users).                  Covered services typically include:</p> <ul style="list-style-type: none"> <li>• Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.</li> <li>• For people with diabetes who have severe diabetic foot disease:</li> </ul>	<p>Prior authorization may be required.</p> <p>Contact your care team for more information.</p>
<p>Therapeutic custom-molded shoes (including inserts provided with such shoes). Coverage includes fitting.</p> <ul style="list-style-type: none"> <li>• Diabetes self-management training is covered under certain conditions.</li> </ul>	
<p><b>Drugs Prescription and some over the counter (OTC)</b>  <b>Because you do not have Medicare,</b> Wisconsin Medicaid covers your prescription drugs, not Community Care Partnership. You must go to a Medicaid certified pharmacy. You can ask the pharmacy if they accept Medicaid. You can also search for pharmacies on the interactive Medicaid provider search <a href="https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Public/DirectorySearch.aspx">https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Public/DirectorySearch.aspx</a>.</p> <p>If you are not sure if you have Medicare and/or Medicaid, please ask your care team for help.</p>	
<p><b>Durable medical equipment and related supplies</b>                  Covered items include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Wheelchairs</li> <li>• Crutches</li> <li>• Hospital beds</li> <li>• IV infusion pumps</li> <li>• Oxygen equipment</li> <li>• Nebulizers</li> <li>• Walkers</li> </ul>	<p>Prior authorization may be required.                  Contact your care team for more information.</p>
<p><b>Emergency care</b>                  Emergency care is care that is needed to evaluate or stabilize an emergency medical condition.</p> <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>Coverage is for care provided within the U.S. and its territories.</p>	<p>Prior authorization is <b>NOT</b> required in a medical emergency.</p>

<p><b>End-stage renal disease</b> Renal dialysis and kidney transplantation services are for persons with renal impairment which requires a regular course of dialysis or kidney transplantation. Covered services typically include outpatient, inpatient and home dialysis including self-dialysis training, as well as inpatient kidney transplantation services and outpatient services for evaluation, care and follow-up of kidney transplant patients.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Health and wellness education programs</b> These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness, and stress management.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Hearing services</b> Basic hearing evaluations performed by your PCP or network provider are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. Coverage includes, but is not limited to:</p> <ul style="list-style-type: none"> <li>• Routine hearing exams</li> <li>• Diagnostic hearing exams</li> <li>• Hearing aids and batteries and repair as needed</li> </ul>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>HIV screening</b> For people who ask for an HIV screening test or who are at increased risk for HIV infection, coverage includes, but is not limited to:</p> <ul style="list-style-type: none"> <li>• One screening exam every 12 months</li> </ul> <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> <li>• Up to three screening exams during a pregnancy</li> </ul>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Home care</b> Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Personal Care services are covered by Medicaid</li> <li>• Skilled nursing and home health aide services</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Medical and social services</li> <li>• Medical equipment and supplies</li> <li>• Private duty nursing</li> </ul>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Hospice care</b> You may elect to receive hospice care or other end of life care. You must contact your Care team so they can arrange these services. Our plan also covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>ICF-MR Services</b> Services in a licensed, certified intermediate care facility for persons with a developmental disability if the primary purpose of the facility is to provide health and rehabilitation services for developmentally disabled persons, the person with a developmental disability DHS 107.09(4)(g)2.b. receives active treatment and the facility meets federal and state standards for protecting and promoting the health, safety and well-being of its residents.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>IMD Services</b></p> <ul style="list-style-type: none"> <li>• Coverage for adults under age 21 or age 65 and above for</li> </ul>	<p>Prior authorization may be required.</p>

<p>services in a nursing facility that has been designated by the state and federal government as an institution for mental disease (IMD) because it is primarily engaged in providing diagnosis, treatment or care of persons with mental illness.</p> <ul style="list-style-type: none"> <li>• Coverage for persons between the ages of 21 and 64 when admitted to an IMD for Residential Use Disorder (RSUD) treatment.</li> <li>• Coverage for members admitted to an IMD as an in lieu of service or as an alternate service.</li> </ul>	<p>Contact your care team for more information.</p>
<p><b>Immunizations</b> Immunizations include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Pneumonia vaccine</li> <li>• Flu shots, once a year in the fall or winter</li> <li>• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B</li> <li>• COVID 19 vaccinations and boosters</li> <li>• Other vaccines if you are at risk and meet Medicaid coverage rules</li> </ul>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Inpatient hospital care</b> You must get prior authorization from your Care team for non-emergency inpatient care. If you get inpatient care at an out-of-network hospital after your emergency condition stabilizes, you are responsible for the cost. Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Semi-private room (or a private room if medically necessary)</li> <li>• Meals including special diets</li> <li>• Regular nursing services</li> <li>• Costs of special care units (such as intensive care or coronary care units)</li> <li>• Drugs and medications</li> <li>• Lab tests</li> <li>• X-rays and other radiology services</li> <li>• Necessary surgical and medical supplies</li> <li>• Use of appliances, such as wheelchairs</li> <li>• Operating and recovery room costs</li> <li>• Physical, occupational, and speech language therapy</li> <li>• Inpatient substance abuse services</li> <li>• Under certain conditions, we cover certain types of transplants. If you need a transplant, we will decide whether you are a candidate for a transplant. If we provide transplant services at a distant location (farther away than the normal community patterns of care) and we authorize the transplant at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion</li> <li>• Blood - including storage and administration.</li> <li>• Physician services</li> </ul>	<p>Prior authorization is required for non-emergency inpatient hospital care.</p>

<p><b>Inpatient mental health care</b></p> <ul style="list-style-type: none"> <li>• Covered services include mental health care services that require a hospital stay.</li> </ul>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Long-term care services</b>                  Coverage is based on your outcomes included in your care plan.                  Coverage includes but is not limited to:</p> <ul style="list-style-type: none"> <li>• Adaptive aids</li> <li>• Adult day care services</li> <li>• Assistive technology/communication aids</li> <li>• Care/case management</li> <li>• Consultative clinical and therapeutic services for caregivers</li> <li>• Consumer education and training services</li> <li>• Counseling and therapeutic services</li> <li>• Environmental accessibility adaptations/ home modifications</li> <li>• Financial management services</li> <li>• Habilitation:</li> <li>• Daily living skills training</li> <li>• Day habilitation services</li> <li>• Home delivered meals</li> <li>• Housing counseling</li> <li>• Peer recovery support services</li> <li>• Personal Emergency Response Systems (PERS)</li> <li>• Prevocational services</li> <li>• Relocation services</li> <li>• Residential Care</li> <li>• Adult family homes of 1-2 beds</li> <li>• Adult family homes of 3-4 beds</li> <li>• Community-based residential facilities (CBRF)</li> <li>• Residential care apartment complexes (RCAC)</li> <li>• Respite care services</li> <li>• Self-directed personal care services</li> <li>• Skilled nursing services RN/LPN</li> <li>• Specialized medical equipment and supplies</li> <li>• Support broker</li> <li>• Supported employment - Individual employment support</li> <li>• Supported employment - Small group employment support services</li> <li>• Supportive home care (SHC)</li> <li>• Training services for unpaid caregivers</li> <li>• Transportation (specialized transportation) community transportation</li> <li>• Transportation (specialized transportation) – other transportation</li> <li>• Vocational futures planning and support (VFPS)</li> </ul> <p>An alternative service to support your outcomes may be available. Please talk to your Care team for more information.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>

<p><b>Medical nutrition therapy</b> This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when referred by your doctor and in other circumstances when nutritional therapy is medically necessary. A physician must prescribe these services.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Nurse practitioner service</b> Services provided by a nurse practitioner, including diagnostic, preventive, therapeutic, rehabilitative or palliative services which are delegated by a licensed physician, as well as general nursing procedures.</p>	<p>Contact your care team for more information.</p>
<p><b>Nurse-midwife services</b> Services provided by a certified nurse-midwife which may include the care of mothers and their babies throughout the maternity cycle, including pregnancy, labor, normal childbirth and the immediate postpartum period up to six weeks after giving birth.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Nursing Facility Services</b> Skilled nursing, skilled rehabilitation and long-term care services prescribed by a physician and provided to an individual who lives in a certified nursing home. The costs of all routine, day-to-day health care services and materials provided to recipients by the nursing facility are covered under the daily rate, including nursing and nurse aide services, rehabilitation services, activity therapy, recreation, social services and religious services, dietary, housekeeping and laundry services, personal comfort items, medical supplies and special care supplies.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Outpatient diagnostic tests and therapeutic services and supplies</b> Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• X-rays</li> <li>• Radiation (radium and isotope) therapy including technician materials and supplies</li> <li>• Surgical supplies, such as dressings</li> <li>• Splints, casts and other devices used to reduce fractures and dislocations</li> <li>• Laboratory tests</li> <li>• Blood, including storage and administration.</li> <li>• Other outpatient diagnostic tests</li> </ul>	<p>Prior authorization may be required. Contact your care team for more information.</p>

<p><b>Outpatient hospital services</b></p> <p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Services in an emergency department or outpatient clinic, including same-day surgery</li> <li>• Laboratory tests billed by the hospital</li> <li>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it</li> <li>• X-rays and other radiology services billed by the hospital</li> <li>• Medical supplies such as splints and casts</li> <li>• Certain screenings and preventive services</li> <li>• Certain drugs and biologicals that you can't give yourself</li> </ul>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Outpatient mental health care</b></p> <p>Covered services include, but are not limited to:</p> <p>Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicaid certified mental health care professional as allowed under applicable state laws.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Outpatient rehabilitation services</b></p> <p>Covered services include, but are not limited to: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Outpatient substance abuse services</b></p> <p>Services are provided to address the negative symptoms from substance abuse and to restore functioning in people with substance abuse dependency or addiction when they are medically necessary.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</b></p> <p><b>Note:</b> If you are having surgery in a hospital, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Partial hospitalization services</b></p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>

<p><b>Physician services, including doctor’s office visits</b></p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Medically-necessary medical or surgical services furnished in a physician’s office, certified ambulatory surgical center, hospital outpatient department, or any other location</li> <li>• Consultation, diagnosis, and treatment by a specialist</li> <li>• Basic hearing and balance exams performed by your PCP or Network Provider if your doctor orders it to see if you need medical treatment</li> <li>• Telehealth office visits including consultation, diagnosis and treatment by a specialist</li> <li>• Second opinion by another network provider prior to surgery</li> </ul>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Podiatry services</b></p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).</li> <li>• Routine foot care for members with certain medical conditions affecting the lower limbs</li> </ul>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Prenatal care coordination</b></p> <p>Services are to help a pregnant woman and, when appropriate, her family, gain access to medical, social, educational and other services needed for the birth of a healthy infant to a healthy mother. May include nutrition counseling and health education. Services are available to high risk women from the beginning of the pregnancy up to the sixty-first day after delivery.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Prostate cancer screening exams</b></p> <p>For men age 50 and older, covered services include the following - once every 12 months or more frequently if medically necessary:</p> <ul style="list-style-type: none"> <li>• Digital rectal exam</li> <li>• Prostate Specific Antigen (PSA) test</li> </ul>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Prosthetic devices and related supplies</b></p> <p>Devices (other than dental) that replace a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Pulmonary rehabilitation services</b></p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>

<p><b>Rural Health clinic services</b>                  Services provided by a clinic serving a rural, under-served area. Covered services are professional services furnished by a physician, physician assistant or nurse practitioner and include incidental services and supplies, and other services.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Services to treat kidney disease and conditions</b>                  Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.</li> <li>• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area).</li> <li>• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)</li> <li>• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)</li> <li>• Home dialysis equipment and supplies</li> <li>• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)</li> </ul>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Skilled nursing facility (SNF) care</b>                  Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Semiprivate room (or a private room if medically necessary)</li> <li>• Meals, including special diets</li> <li>• Regular nursing services</li> <li>• Physical therapy, occupational therapy, and speech therapy</li> <li>• Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.)</li> <li>• Blood - including storage and administration. Medical and surgical supplies ordinarily provided by SNFs</li> <li>• Laboratory tests ordinarily provided by SNFs</li> <li>• X-rays and other radiology services ordinarily provided by SNFs</li> <li>• Use of appliances such as wheelchairs ordinarily provided by SNFs</li> <li>• Physician services</li> </ul>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Smoking and tobacco use cessation (counseling to stop smoking)</b>                  If you use tobacco, we cover counseling and assistance to quit smoking.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>

<p><b>Urgently needed care</b> Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care.</p> <p>Coverage is for care provided within the U.S. and its territories.</p>	<p>Prior authorization may be required. Contact your care team for more information.</p>
<p><b>Vision care</b> Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> <li>• Eyeglasses, as needed.</li> <li>• Outpatient physician services for the diagnosis and treatment of diseases and conditions of the eye.</li> <li>• Glaucoma screening and testing as recommended by your eye care provider.</li> </ul>	<p>Prior authorization may be required. Contact your care team for more information.</p>

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

This section tells you what kinds of benefits are “excluded.” Excluded means that our plan doesn’t cover these benefits. For more information about Medicaid benefits, call your care team. (Refer to Chapter 1 for the phone number.)

Neither Community Care nor Medicaid will pay for the excluded benefits listed in this section (or elsewhere in this booklet). The only exception: If a benefit on the exclusion list is found upon appeal to be a benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a service, go to Chapter 8.

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this handbook, the following items and services are not covered:

- Services considered not reasonable and necessary, unless your care plan lists these services as covered services.
- Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Medicaid.
- Private room in a hospital, except when it is considered medically necessary.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body.
- Reversal of sterilization procedures, sex change operations

- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when you get emergency services at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference.

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

**In addition to the above list, the following items and services are not covered:**

- Services that your care team hasn't authorized or are not included in your care plan.
- Services or supports that are not necessary to support your outcomes.
- Normal living expenses like rent or mortgage payments, food, utilities, entertainment, clothing, furniture, household supplies and insurance.
- 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

### 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 as necessary to support your outcomes and as long as you follow the plan's rules for getting your care. 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, because they:

- Are not covered services in the benefit package, or
- Were obtained without authorization.

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

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

- Cost share
- Room and board

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

### Cost share

Some members may have to pay a monthly amount to remain eligible for Medicaid and Partnership. This monthly payment is known as a **cost share**. Your cost share is based on your income and must be paid to maintain eligibility for Medicaid and Partnership.

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

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

Failure to pay your monthly cost share may result in loss of eligibility, and you might be disenrolled from Partnership. If you think your cost share is incorrect, you can file an appeal with the Wisconsin Division of Hearings and Appeals (DHA). See Chapter 8 for more information. If you have questions about cost share, contact your care team.

## **Room and board**

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

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

If you have questions about room and board, or cannot make a payment, contact your 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 authorizes as part of your care plan. If you receive a bill from a provider by mistake, do not pay it. Instead, contact your care team so they can resolve the issue.

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

## **Does Partnership pay for residential services or nursing homes?**

An important goal of Community Care Partnership is to help members live as independently as possible. All people – including people with disabilities and seniors – should be able to live at home with the support they need, participating in communities that value their contributions.

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 and 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 authorize residential care or nursing home stays only when:

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

Even if residential care is the only option, 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 are living in your own home and you and your care team agree that you should no longer live there, you will decide about residential services together.

You and your care team are responsible for finding the most cost-effective residential options within 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 authorize all residential services.** It is very important that you do not select a residential provider on your own. You must work with your care team on these decisions to make sure Community Care will pay for these services.

**You will be required to pay the rent and food portion of the facility’s cost. These costs are also called “room and board” expenses.**

## How are my other insurance benefits coordinated?

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



If you are enrolled in **Medicare AND Medicaid**, let your Team know right away. If you qualify for Medicare, you must enroll in all parts that you are eligible for (Parts A, B and, D).

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

Before Medicaid, including Partnership, pays for services, other insurance must be billed first. Community Care expects members to:

- Let us know if you have other insurance.
- Update us if there are changes to your other insurance.
- Let us know if you receive a payment from an insurance company, since you may have to reimburse Community Care. How you handle these payments may affect your eligibility for Partnership.

If you are eligible for Medicare and you do not currently have Medicare because you feel you can't afford it, your Team may be able to find a program that will help you pay for Medicare premiums.

- **If you are eligible for Medicare, you must enroll in Medicare to remain eligible for Partnership.**
- **If you are eligible for Medicare but do not enroll in Medicare, you will be disenrolled from Partnership.**

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

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

Through estate recovery, the State of Wisconsin seeks to be paid back for the cost of all Medicaid long-term care services. Recovery is made from your estate, or your spouse's estate after both of you have died. The State of Wisconsin uses the recovered money to care for others in need.

Recovery is made by filing claims on estates. The State of Wisconsin will not try to be paid back from your estate when your spouse or child with a disability is still alive. Recovery will happen after their death.

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

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

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

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

## Chapter 6. Your rights

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

- 1.) **We must provide information in a way that works for you.** To get information from us in a way that works for you, please contact your care team.
- 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 environment.
  - 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 in policy that you think should be made or services that you think should be provided.
  - 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 as a means of coercion, discipline, convenience or retaliation. This means you have the right to be free from being restrained or forced to be alone in order to make you behave in a certain way or 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 a treatment such as medication, or experimental research without your informed consent.
    - **Neglect** is when a caregiver fails to provide care, services, or supervision which creates significant risk of danger to the **individual**. Self-neglect is when an individual who is responsible for his or her own care fails to obtain adequate care, including food, shelter, clothing, or medical or dental care.
    - **Financial exploitation** can be fraud, enticement or coercion, theft, misconduct by a fiscal agent, identity theft, forgery, or unauthorized **use** of financial transaction cards including credit, debit, ATM and similar cards.

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

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

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

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

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

- 3.) **We must ensure that you get timely access to your covered services.** As a member of Community Care, you have a right to receive services listed in your care plan when you need them. Your care team will arrange for your covered services. Your team will also coordinate with your health care providers. Examples of these are doctors, dentists, and podiatrists. Contact your team for assistance in choosing your providers.

As a member of Community Care, you have the right to choose a primary care provider (PCP) in the provider network and receive the services listed in your care plan when you need them. Call Community Care to learn which doctors are accepting new patients. If you think that you are not getting your medical care 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.** If you have questions or concerns about the privacy of your personal health information, please call your team. See Appendix 4 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 available services.** Please contact your Team if you want this information or go to our website [www.communitycareinc.org](http://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 of the options that are available, what they cost and whether 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 if you are in this situation. This means 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 of advance directives. Contact your care team if you want to know more about advance directives.
- 8.) **You have the right to file a grievance or appeal if you are dissatisfied with your care or services.** Chapter 8 includes 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. If you have any questions, please contact your care team. We're here to help.

- 1.) Become familiar with 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.) Participate in the initial and ongoing development of your care plan.
- 3.) Participate in the Resource Allocation Decision (RAD) process to find the most cost-effective ways to meet your needs and support your outcomes. Members, families and friends share responsibility for the most cost-effective use of public tax dollars.
- 4.) Talk with your care team about ways your friends, family or other community and volunteer organizations may help support you or ways in which 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 so they can 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 that providers know to bill Partnership not you.
- 10.) Follow Community Care's procedures for getting care after hours.
- 11.) Notify us if you move to a new address or change your phone number.
- 12.) Notify us of any planned temporary stay or move out of the service area.
- 13.) Provide Community Care with correct information about your health care needs, finances, and preferences and tell us as soon as possible about any changes in your status. This includes signing a "release of information" form when we need other information you do not have easily available.

- 14.) Treat your care team, home care staff, and providers with dignity and respect.
- 15.) Accept services without regard to the provider's race, color, religion, age, gender, gender identity, sexual orientation, health, ethnicity, creed (beliefs), or national origin.
- 16.) Pay any monthly costs on time, including any cost share or room and board charges you may have. Let your care team know as soon as possible if you have problems with your payment.
- 17.) Complete an “**Annual Renewal**” for Medicaid eligibility. The Income Maintenance agency uses the annual renewal to determine your financial eligibility. The renewal is to make sure you still meet all of the program requirements. You will be notified by mail the month before your renewal is due. This letter will tell you how to do your renewal.

If you do not complete your renewal timely, you will lose your Medicaid and Partnership coverage and there will be a gap or delay in your benefits.

- 18.) Use your private insurance benefits, when appropriate. If you have any other health insurance coverage, tell Community Care and the Income Maintenance agency. Let your care team know right away if you enroll in **Medicare**, or think you may be eligible for Medicare.
- 19.) Take care of any durable medical equipment (DME), such as wheelchairs, and hospital beds provided to you by Community Care.
- 20.) Report fraud or abuse on the part of providers or Community Care employees.

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

**Report Public Assistance Fraud**

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

- 21.) 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.

- 22.) Help your care team, doctors and other providers help you by giving them information, asking questions, sharing concerns, and following through on your care.
- 23.) Call your care team for help if you have questions or concerns.
- 24.) Tell us how we are doing. From time to time, we may ask if you are willing to participate in member interviews, satisfactions surveys, or other quality review activities. Your responses and comments will help us identify our strengths as well as the areas we need to improve. Please let us know if you would like to know the results of any surveys. We would be happy to share that information with you.

## Chapter 8. Grievances and appeals



This Chapter includes information about grievances and appeals for members who are on Medicaid only. If you are enrolled in **Medicare**, you should refer to 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 about a decision made by Community Care and to receive 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 Team, you can call our Member Rights Specialist. The Member Rights Specialist can tell you about your rights, try to informally resolve your concerns, and help you file a grievance or appeal. The Member Rights Specialist can work with you throughout the entire grievance and appeal process to try to find a workable solution.

**For assistance with the grievance and appeal process contact  
Community Care's Member Rights Specialist, at:**

Community Care  
Member Rights Specialist  
205 Bishops Way  
Brookfield, WI 53005  
Toll-free: 866-992-6600  
Member Rights: (262) 207-9325  
TTY: 711

If you are unable to resolve your concerns by working directly with your care team or our Member Rights Specialist, Partnership gives you several ways to address your concerns. You can:

- File a grievance or appeal with Community Care.
- Ask for a review by the Wisconsin Department of Health Services (DHS).
- Ask for a State Fair Hearing with the Wisconsin Division of Hearings and Appeals (DHA).

**Each way has different rules, procedures and deadlines.**

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

If you have a particular type of concern that you do not know how to resolve, you can ask your Team or Community Care's Member Rights Specialist. There are Ombudsman programs available to help all Partnership members with grievances and appeals. See the end of this chapter 8 for contact information. You can also have a family member, friend, attorney or advocate help you. Our Member Rights Specialist may be able to give you information about other places that can help you too.

**Coordination with other insurance**

If you have other insurance and want to file a grievance or appeal, you should file 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. We are required to follow these rules to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the benefits you get from our plan with any other benefits available to you.

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

If you have other insurance, Medicaid never pays first for services covered by the other insurance. Medicaid always pays last.

**Copies of your records**

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

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

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## Grievances

### What is a grievance?

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

- Your personal care worker often arrives late.
- You feel your care team doesn't listen to you.
- You have trouble getting appointments with a provider.
- You aren't satisfied with your provider's incontinence products.

### Who can file a grievance on my behalf?

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

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

You can file a grievance at any time.

### What are my options?

1. Start by filing a grievance with Community Care. See Grievance option 1, listed 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, listed below.

## GRIEVANCE OPTION 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 unable to solve your concerns, you can file a grievance with Community Care by calling or writing to us at:

Community Care  
Member Rights Specialist,  
205 Bishops Way  
Brookfield, WI 53005  
Member Rights Phone number: (262) 207-9325  
Toll-free: 866-992-6600  
TTY: 711

### **What happens next?**

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

- The Committee is made up of Community Care representatives and at least one “consumer”. The consumer is a person who also receives services from us or represents someone who does. We train this person on how to protect the privacy of others while serving on the Committee. Sometimes other people who specialize in the area of your grievance might be part of the Committee.
- We will let you know when the Committee plans to meet to review your grievance.
- The meeting is confidential. You can ask that the consumer not be on the Committee if you are concerned about privacy or have other concerns.
- You have the right to appear in person. You can bring an advocate, friend or family member, or witnesses with you.
- The Committee will give you a chance to explain your concerns. You may provide information to the Committee.
- Your care team or other Community Care staff will likely be at the meeting.
- The Committee will make a decision within 90 business days from the date we first got your grievance. You will get a written notice of the decision.

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

#### **GRIEVANCE OPTION 2: Ask for a DHS review**

**Note: You must first go through [Insert Plan Name]’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 and 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 e-mail:**

DHS Partnership Grievances  
Toll-free: 1-888-203-8338  
E-mail: [dhsfamcare@wisconsin.gov](mailto: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 receive your grievance. For example, if Community Care receives 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 receive the decision to ask for a DHS review.

For example, Community Care has until July 30 to send you a decision. You receive 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?**

DHS works with an outside organization called “MetaStar” to review grievances. If you ask for a DHS review, that external review organization will contact you.

- MetaStar will reply in writing to let you know they received your grievance.
- They will ask you for information about your concerns. They will also contact your care team. MetaStar will try to resolve your concerns informally.
- MetaStar **will not issue a decision**. Instead, they will review your concerns and try to come up with an informal solution that is acceptable to you and Community Care.
- If MetaStar tells DHS that we failed to comply with certain requirements, DHS may order Community Care to take steps to fix the problem.
- MetaStar will complete the review of your grievance within 30 days of the date it receives 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 Team denies a service or support you requested. Other examples are decisions to reduce, suspend or end a service, or to deny payment for a service.

### Who can file an appeal on my behalf?

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 types of situations:

- 1.) You can file an appeal if Community Care:
  - Plans to stop, suspend or reduce an authorized service you are currently getting.
  - Decides to deny a service you asked for and that service is in the Partnership 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.**” The Notice of Adverse Benefit Determination includes the date we plan to stop, suspend or reduce your services.

\*Note: Partnership provides the services listed in the benefit package chart 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 notify you that the service you requested is not in the benefit package.

2.) You can file an appeal if:

- You do not like your care plan because it:
  - Doesn't support you to live in the place where you want to live.
  - Doesn't provide enough care, treatment, or support to meet your needs and identified outcomes. (Refer to Chapter 3 for information about outcomes.)
  - Requires you to accept care, treatment or support items you don't want or you believe are unnecessarily restrictive.
- Community Care fails to:
  - Arrange or provide services in a timely manner.
  - Meet the required timeframes to resolve your appeal.

In these situations, Community Care will send you a notification of your appeal rights.

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

- At least once a year, a worker from the Income Maintenance agency will review your information to make sure you are still financially eligible for Partnership. If you have a cost share, the Income Maintenance agency will also make sure you are paying the right amount.

If the Income Maintenance agency decides you are no longer financially eligible for Partnership, or says your cost share payment will change, the agency will send you a notice with information about your eligibility for Partnership. These notices have the words "About Your Benefits" on the first page. The last page has information about your right to request a State Fair Hearing with the Division of Hearings and Appeals.

- If your functional eligibility for Partnership changes, you will receive a written notice.
- **Filing an appeal with the Division of Hearings and Appeals is the only way to challenge decisions related to 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 **Notice of Adverse Benefit Determination** if we:
  - Plan to stop, suspend or reduce an authorized service you are getting.
  - Deny a new service you asked for and that service is in the Partnership benefit package.
  - Won't pay for a service that is in the Partnership benefit package.

**You must file your appeal no later than 60 days after you receive the Notice of Adverse Benefit Determination.** (For example, if you get a notice in the mail on August 1, you must file your appeal on or before September 30.)

If you receive a notification of your appeal rights, you should read this notice carefully. The notice may tell you the deadline for filing your appeal. You can always call our Member Rights Specialist for assistance.

**What are my options?**

If you want to file an appeal 1.) Start by filing an appeal with Community Care.

→ See Option 1 if you want to file with Community Care.

**If you disagree with [Insert Plan Name]'s decision about your appeal:**

You can ask for a state fair hearing with the State's Division of Hearings and Appeals (DHA).

See option 2 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 or the Wisconsin Department of Health Services (DHS) **and** file an appeal with the Division of Hearings and Appeals (DHA) at the **same** time.

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

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

If you want **both** Community Care and DHA to review your issue, then you have to file your appeal with Community Care **before** you file the appeal with DHA. Once you file an appeal with DHA, you cannot file the same appeal with Community Care.

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

### Continuing Your Services During Your Appeal

If Community Care decides to stop, suspend or reduce a service you are currently receiving, you have the right to ask for your services to continue your services during your appeal

If you want your services to continue, you must:

- Postmark or fax your appeal **on or before** the date Community Care plans to stop or reduce your services; **AND**
- Ask that your services continue throughout the course of your appeal.

If you want your services to continue, you must make that request at every level of your appeal. For example, if your services were continued during an appeal with Community Care and you lose the appeal, you must once again ask for your services to continue if you file an appeal with DHA.

The final decision of the appeal may not be in your favor. If that happens, **you might have to pay Community Care back for the service you got during the appeal process.** If you can show that this would be a substantial financial burden, you may not have to pay us back.

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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 advocate.

### APPEAL OPTION 1: Filing your appeal with Community Care

To file an appeal with Community Care you can:

- **Call** Community Care. If you file your appeal by calling us, we will ask you to send in a written request. If you want, our Member Rights Specialist can help you put your appeal in writing.
- **Mail or fax a request form.** See Appendix 2 for a copy of the request form. Or you can go online and get the form at: [www.dhs.wisconsin.gov/familycare/mcoappeal.htm](http://www.dhs.wisconsin.gov/familycare/mcoappeal.htm).
- **Write your request in a letter or on a piece of paper** and mail or fax it to the address below.

**To file an appeal with Community Care, call:**

**Community Care**

Member Rights Specialist

866-992-6600

TTY Call the Wisconsin Relay System at 711

Fax: 262-827-4044

**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?**

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

- We will let you know when the Committee plans to meet to review your appeal.
- The Committee is made up of Community Care representatives and at least one consumer. The consumer is a person who also receives services from us (or represents someone who does). We train this person on how to protect the privacy of others while serving on the Committee. Sometimes other people who specialize in the area of your appeal might be part of the Committee.
- The meeting is confidential. You can ask that the consumer not be on the Committee if you are concerned about privacy or have other concerns.
- You have the right to appear in person. You can bring an advocate, friend, family member, or witnesses with you.
- Your Team or other Community Care staff will likely be at the meeting.
- The Committee will give you a chance to explain why you disagree with your Team's decision. You or your representative can present information, bring witnesses, or describe your concerns to help the Committee understand your point of view.
- After the Committee hears your appeal, Community Care will send you a decision letter within 30 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, or
  - We need more time to gather information. If we need additional time, we will send you a written notice informing you of the reason for delay.

**Speeding up your appeal**

Community Care has 30 days to decide your appeal. If you think waiting that long could

seriously harm your health or your ability to perform your daily activities, you can ask us to speed up your appeal. We call this an “expedited appeal.” You may ask for a fast appeal only if you believe that waiting for a decision could seriously harm your health or your ability to function. If you ask for a fast appeal, we will decide if your health requires a fast 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, Community Care may extend this to a total of 17 days if additional information is necessary and if the delay is in your best interest. If you have additional evidence you want us to consider, you will need to submit it quickly.

**To request an expedited appeal, contact:**

Community Care  
Member Rights Specialist  
205 Bishops Way  
Brookfield, WI 53005  
866-992-6600  
TTY Call the Wisconsin Relay System at 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 from the date of the Grievance and Appeal Committee’s decision. You can also file an appeal with DHA if Community Care does not issue an appeal decision in a timely manner.

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## State Fair Hearings

### APPEAL OPTION 2: Filing your appeal with the Wisconsin Division of Hearings and Appeals (DHA)

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

You can't ask for a state fair hearing until you have received the Community Care Grievance and Appeal Committee's written decision on your appeal or if Community Care did not issue a decision by the due date.

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

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

- **Send a request form.** A copy of the form you can use is in Appendix 4. You can also get a copy from Community Care's Member Rights Specialist or from one of the advocacy organizations listed in this handbook. Or, go to the Web to download the form at <https://www.dhs.wisconsin.gov/forms/f0/f00236.doc>
- **Mail a letter.** Include your name and contact information and explain what you are appealing. If you received a Notice of Action or other notification of your appeal rights, it's a good idea to include a copy of that notice with your request for a State Fair Hearing. Do not send your original copy.

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

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

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

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 notification of your appeal rights. (For example, if you get a notice in the mail on August 1, you must file your appeal on or before October 30.) If you began the appeal process by filing an appeal with Community Care and you received a decision you didn't agree with, you have 90 days from the date you receive that decision to file a request for a State Fair Hearing.

You can request to have your services continue during the State Fair Hearing process if you file your appeal **on or before** the date Community Care plans to stop or reduce your services. More information about continuing your services can be found earlier in this chapter.

### **What happens next?**

- After you send in your request for a State Fair Hearing, DHA will mail you a notice with the date, time and location of your hearing.
- The hearing will be at an office in your county or may be done by telephone.
- An Administrative Law Judge will run the hearing.
- You have the right to participate in the hearing. You can bring an advocate, friend or family member, or witnesses with you.
- Your Team or other Community Care staff will be present at the hearing to explain their decision.
- You will have a chance to explain why you disagree with your Team's decision. You or your representative can present information, bring witnesses, or describe your concerns to help the Judge understand your point of view.
- The Administrative Law Judge must issue a decision within 90 days of the date you filed a request for the hearing.

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

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

- 1.) Ask for a re-hearing. If you want DHA to reconsider its decision, you must ask within 20 days from the date of the Judge's decision. The Administrative Law Judge will only grant a re-hearing if:
    - You can show that a serious mistake in the facts or the law happened, or
    - You have new evidence that you were unable to obtain and present at the first hearing.
  - 2.) Take your case to circuit court. If you want to take your case to court, you must file your petition within 30 days from the date of the Judge's decision.
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## 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, or have questions about your rights. Advocates are also available to answer questions about the grievance and appeal processes. An advocate can also 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, including family members, friends, an attorney, or any other person willing to help.

Below are some places you can contact for assistance. Community Care's Member Rights Specialist may be able to give you information about other places that can help you too.

### Ombudsman Programs

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

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

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

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

#### **Disability Rights Wisconsin (DRW)**

Ombudsmen from this agency provide advocacy to 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](mailto:info@drwi.org)  
[www.disabilityrightswi.org](http://www.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 advise or encourage you to disenroll from Partnership due to your situation or condition. However, there are limited 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 because you have decided to get your health care and long-term care. This would include a decision to enroll in a different program or a different Managed Care Organization, if available.

### 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 can also answer any questions you have about ending your membership. If you decide to disenroll, you should also notify your care team.

You can end your membership at any time. You can choose the effective date when you want your membership to end.

### 2.) Community Care must report the information listed below to the Income Maintenance agency. An Income Maintenance worker will see if you are still eligible for Partnership. If they determine you are no longer eligible, they will end your membership in Partnership.

- You lose your financial eligibility for Medicaid.
- You are no longer functionally eligible as determined by the Wisconsin Adult Long-Term Care Functional Screen.
- You do not pay your cost share. For more information about cost share, see Chapter 5.
- You permanently move out of Community Care's service area. If your care team cannot contact you for more than 30 days, we will send a certified letter to your last known address. If you do not respond, we will report this to the Income Maintenance agency, who will assume you have moved. If you move or take a long trip, you need to contact your care team. If you plan to move within Wisconsin, your team may be able to help you with continued services in your new residence, so it is a good idea to let them know if you plan to move.
- You are in jail or prison.

- You are admitted to an Institute for Mental Disease (IMD) and lose Medicaid eligibility.
- You stop accepting services for more than 30 days, and we don't know why. Community Care will send a certified letter to your last known address. If you do not respond, we will report this to the Department of Health Services. The Department of Health Services will determine if your membership should end.
- You refuse to participate in care planning and we cannot ensure your health and safety. In this situation, we will work with the Department of Health Services to determine if your membership should end.
- You intentionally give us incorrect information that affects your eligibility for the program.
- You continuously behave in a way that is disruptive or unsafe to staff, providers or other members. This makes it difficult for us to provide care for you and other members. Your membership cannot be ended for this reason unless we first get permission from the Department of Health Services.

**Your membership CANNOT be ended for any reason related to your health or if your use of services changes.**

**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 notice from the Income Maintenance agency that tells you the reason for ending your membership. This notice will have the words "About Your Benefits" on the first page. The notice will explain how you can file an appeal. See Chapter 8 for information.

## APPENDICES

### 1. Definitions of important words

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

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

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

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

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

**Appeal** – A request for review of a decision. Members can file an appeal when they want the MCO to change a decision their Team made. Examples of this would be when the Team decides to: stop, suspend or reduce a service the member is currently receiving, deny a service the member requests, or not pay for a covered service. Other types of appeals and the process for filing an appeal are in Chapter 8.

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

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

**Benefit Package** – Services that are available to Partnership members. These include, but are not limited to, medical care, prescription drugs, hospital care, personal care, home health, transportation, medical supplies, and nursing care. The services a member receives must be pre-

authorized by the member's care team and listed in the member's care plan. See Chapter 4 for a complete list of the services in the Partnership benefit package.

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

**Care Team** – Every Partnership member is assigned a care team. The member is a central part of his or her team. The team includes the member, and at least a care manager and a registered nurse. Members can choose anyone else they want involved on their care team, such as a family member or friend. Other professionals such as an occupational or physical therapist, or mental health specialist, may be involved, depending on the member's needs. The care team works with members to assess needs, identify outcomes and create care plans. The team authorizes, coordinates and monitors services.

**Choice** – The Partnership program supports a member's choice when receiving services. Choice means members have a say in how and when care is provided. Choice also means members are responsible for helping their care team identify services that are cost-effective. Members can also choose to direct one or more of their long-term care services by using the self-directed supports (SDS) option.

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

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

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

**DHS Review** – A review of a member's grievance by the Department of Health Services (DHS). DHS works with MetaStar to review and make final decisions on grievances. –

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

**Division of Hearings and Appeals (DHA)** – The State of Wisconsin agency responsible for state fair hearings.

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

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

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

**Family Care Partnership Program** – See “Partnership”

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

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

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

**Guardian** – The court may appoint a guardian for an individual if the person is unable to make decisions about his or her own life.

**Income Maintenance Agency** (*formerly known as Economic Support Agency*) – Staff from the Income Maintenance agency determine an individual’s financial eligibility for Medicaid, Partnership, and other public benefits.

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

**Long-Term Care (LTC)** – A variety of services that people may need as a result of a disability, getting older, or having a chronic illness that limits their ability to do the things they need to do throughout their day. This includes such things as bathing, getting dressed, making meals, and

going to work. Long-term care can be provided at home, in the community or in various types of facilities, including nursing homes and assisted living facilities.

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

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

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

**Medicaid** – A medical and long-term care program operated by the Wisconsin Department of Health Services. Medicaid is also known as “Medical Assistance,” “MA,” and “Title 19.” Partnership members must meet Medicaid eligibility requirements in order to be a member.

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

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

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

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

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

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

**Notification of Appeal Rights** – A written notice sent to members explaining their options for filing an appeal. MCOs must send a notification of appeal rights to members if the MCO didn’t provide services in a timely way or didn’t meet the deadlines for handling an appeal.

## Partnership Member Handbook (Medicaid Only)

### Definitions of important words

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

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

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

**Partnership Program** – An integrated program providing medical and long-term care services and drugs to frail elderly 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 and must be enrolled in Wisconsin Medicaid. They may also be enrolled in Medicare. Partnership members must reside in a county in which Partnership is available.

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

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

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

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

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

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

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

5 for information about room and board.

**Self-Directed Supports (SDS)** – SDS is a way for members to arrange, purchase and direct their long-term care services. Members have greater responsibility, flexibility and control over service delivery. With SDS, members can choose to control their own budget for long-term care services, and may have control over their providers including hiring, training, supervising, and firing their own direct care workers. Members can choose to self-direct all or some of their long-term care services.

**Service Area** – The geographic area where a member must reside in order to enroll and remain enrolled in Community Care Partnership. See Chapter 2 for a list of the Community Care service area.

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

## 2. Home and Community-Based Waiver Service Definitions

Full definitions available upon request

**Adaptive Aids** are controls or appliances that enable people to increase their abilities to perform activities of daily living or control the environment in which they live (including patient lifts, control switches, etc.). Adaptive aids are also services that help people to access, participate and function in their community. This includes vehicle modifications (such as van lifts, hand controls), and may include the initial purchase of a service dog and routine veterinary costs for a service dog. (Excludes food and non-routine veterinary care for service dogs.)

**Adult Day Care Services** are the provision of services for part of a day in a non-residential group setting to adults who need an enriched social or health-supportive experience or who need assistance with activities of daily living, supervision and/or protection. Services may include personal care and supervision, light meals, medical care, and transportation to and from the day care site.

**Assistive Technology/Communication Aids** means an item, piece of equipment or product system that increases, maintains or improves the functional ability of members at home, work and in the community. Services include devices or services that assist members to hear, speak or see, such as communication systems, hearing aids, speech aids, interpreters and electronic technology (tablets, mobile devices, software).

**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 consists of, at minimum, a registered nurse and a care manager, and may also include other professionals as appropriate to the needs of the member and family or other natural supports requested by the member. Services include assessment, care planning, service authorization and monitoring the member's health and well-being.

**Consultative Clinical and Therapeutic Services** assist unpaid caregivers and paid support staff in carrying out the member's treatment or support plan. Services include assessments, development of home treatment plans, support plans, intervention plans, training and technical assistance to carry out the plans. Services also include training for caregivers and staff that serve members with complex needs (beyond routine care).

**Consumer Education and Training** are services designed to help a person with a disability develop self-advocacy skills, support self-determination, exercise civil rights, and acquire skills needed to exercise control and responsibility over other support services. These services include education and training for members, their caregivers and legal representatives. Covered expenses may include enrollment fees, books and other educational materials, and transportation to training courses, conferences and other similar events.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Self-Directed Personal Care Services** are services to assist members with activities of daily living and housekeeping services members need to live in the community. Activities of daily living include help with bathing, eating, dressing, managing medications, oral, hair and skin care, meal preparation, bill paying, mobility, toileting, transferring and using transportation. The member selects an individual or agency to provide his or her services, pursuant to a physician's order and following his or her member-centered 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 those items necessary to maintain the member's health, manage a medical or physical condition, improve functioning or enhance independence. Allowable items may include incontinence supplies, wound dressing, orthotics, enteral nutrition (tube feeding) products, certain over the counter medications, medically necessary prescribed skin conditioning lotions/lubricants, prescribed Vitamin D, multi-vitamin or calcium supplements, and IV supplies.

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

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

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

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

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

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

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

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

### 3. Family Care Partnership Notice of Adverse Benefit Determination

Mailing Date:

Member Name

Member ID: Member's ID or MCI Number

Member/Legal Decision Maker's Street Address  
City, State Zip Code

Dear Member Name,

This notice confirms our discussion on insert date.

The service or support in question is: insert service in question

After reviewing the options with you using the Resource Allocation Decision (RAD) process, we have decided to:

Insert provider name asked us to pay for a service or support that you received from them. This is called a "claim." The Wisconsin Department of Health Services decided that Insert provider name cannot be paid for its claim.

It is not your fault the claim was denied. You are **not** responsible for paying any amount to us, <<insert provider name>>, or anyone else.

The details about this denial are as follows:

**Terminate current service.**

Effective date of intended action:

**Reduce current service.**

Effective date of intended action:

Description of current level:

New level after reduction:

**Suspend current service.**

Effective date of intended action:

Expected date service will resume:

**Deny request for service or support.**

Date of request:

**Limit request for service or support.**

Date of request:

Description of requested level:

Authorized level of service or support:

**Deny payment for service or support (member request).**

Date of request:

Date(s) service provided:

Provider or supplier:

Payment amount being denied: \$

**Deny payment for service or support (provider claim).**

Service or support:

Date(s) of denial(s):

Date(s) of claims(s):

Provider/Supplier:

**The reason for our decision is that:**

The service or support is not an effective way to support your outcome(s).

You do not need this service or level of service or support to support your outcome.

We are already supporting your outcome in another way.

The service or support you received was not authorized.

An informal support has been identified and has agreed to provide this service or support for you.

The service or support is being performed by a member of your household and the service or support benefits the other individuals residing in the household with you.

Other:

Explanation of the decision: This detailed explanation is for the member. The rationale used to make the decision should always be included along with any recommended alternative(s).

If you disagree with this decision, the following pages describe your options.

Sincerely,

Care manager name  
Care manager title  
phone number

RN care manager name  
RN Care Manager title  
phone number

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## Appeal Rights

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### 1. How to appeal this decision

You have the right to appeal the denial of Provider name's claim, but you are **not** required to do so. Whether you appeal or not, you are not responsible for paying any amount for this claim to us, Provider name, or anyone else.

If you disagree with this decision, write, call, fax, or email:

MCO name  
MCO address  
appropriate contact phone number  
appropriate fax number  
appropriate email address

You can get the Appeal Request form online at [www.dhs.wisconsin.gov/familycare/mcoappeal.htm](http://www.dhs.wisconsin.gov/familycare/mcoappeal.htm), or by calling one of the independent ombudsman agencies listed at the end of this notice.

**Include a copy of this notice with the completed request form or letter.**

### 2. Grievance and Appeal Committee

After MCO name receives your request, we will set up a meeting with our Grievance and Appeal Committee. The committee is made up of MCO name representatives and at least one person who is also receiving services from us (or represents someone who does).

You have the right to appear in person if you choose. You may bring an advocate, friend, family member, or witnesses. You may also present evidence and testimony to this committee.

You will receive a written decision on your appeal. If you do not agree with the Grievance and Appeal Committee's decision, you can request a state fair hearing. See the "state fair hearing" section below for more information.

### 3. Continuation of services

If you are getting benefits and you ask for an appeal before your benefits change, you can keep getting the same benefits until the Grievance and Appeal Committee makes a decision on your appeal.

If you want to keep your benefits during your appeal, **your request must be postmarked, faxed, or emailed on or before insert effective date of intended action.**

If the Grievance and Appeal Committee decides that MCO name, decision was right, you may need to repay the extra benefits that you received between the time you asked for your appeal and the time that the Grievance and Appeal Committee makes a decision. However, if it would cause you a large financial burden, you might not be required to repay this cost.

### 4. Deadline to file your appeal with MCO name

You should file your appeal as soon as possible.

Your appeal to MCO name must be postmarked, faxed, or emailed no later than 60 calendar days from the

mailing date on page one of this notice. **Important:** If you would like your benefits to continue during your appeal, your appeal must be postmarked, faxed, or emailed **insert effective date of intended action**.

## 5. Speeding up your appeal with MCO name

You may ask MCO name to speed up your appeal. If MCO name decides that taking the standard amount of time could seriously harm your health or ability to perform your daily activities, we will grant you a faster appeal called an “expedited appeal.” This means you will receive a decision on your case within 72 hours of your request. If you want to learn more about an expedited appeal, contact MCO name at MCO phone number.

## 6. State fair hearing

You have the right to ask for a state fair hearing if you do not agree with the Grievance and Appeal Committee’s decision on your appeal.

If you ask for a state fair hearing, you will have a hearing with an independent Administrative Law Judge (ALJ). You may bring an advocate, friend, family member, or witnesses. You may also present evidence and testimony at the hearing.

MCO name’s member rights specialist can assist you with filing a fair hearing request. To contact a member rights specialist, call Member Rights Specialist phone number. You can also get the hearing form from one of the independent ombudsman agencies listed at the end of this notice or online at [www.dhs.wisconsin.gov/library/f-00236.htm](http://www.dhs.wisconsin.gov/library/f-00236.htm).

Send the completed request form or a letter asking for a hearing and a copy of this notice to:

Family Care Request for Fair Hearing  
Wisconsin Division of Hearings and Appeals  
PO Box 7875  
Madison, WI 53707-7875  
Fax: 608-264-9885

**Important Note:** You cannot request a state fair hearing until you have received the Grievance and Appeal Committee’s decision on your appeal or MCO name fails to send you a written decision within 30 calendar days of receiving your appeal.

You have 90 calendar days from the date you receive the Grievance and Appeal Committee’s written decision on your appeal to request a state fair hearing. If MCO name fails to send you a written decision within 30 calendar days of receiving your appeal, the 90 days starts the day after the 30 calendar day period ends.

## 7. Who can help you understand this notice and your rights?

- a. MCO name's member rights specialist can inform you of your rights, try to informally resolve your concerns, and assist you with filing an appeal. The member rights specialist **cannot** represent you at a meeting with our Grievance and Appeal Committee or at a state fair hearing. To contact a member rights specialist, call Member Rights Specialist phone number.
- b. Anyone receiving Family Care services can get free help from an **independent ombudsman**. The following agencies advocate for Family Care members:

### **For members age 18 to 59:**

Disability Rights Wisconsin  
Toll Free: 800-928-8778  
TTY: 711

### **For members age 60 and older:**

Wisconsin Board on Aging and Long Term Care  
Toll Free: 800-815-0015  
TTY: 711

## **Copy of your case file**

You have the right to a free copy of the information in your case file related to this decision. Information means all documents, medical records, and other materials related to this decision. If you decide to appeal this decision, you have the right to any new or additional information MCO name gathered during your appeal. To request a copy of your case file, contact appropriate contact at phone number.

## 4. Community Care Appeal Request Form

DEPARTMENT OF HEALTH SERVICES  
Division of Long Term Care  
F-00237 (05/2013)

STATE OF WISCONSIN  
ss 46.287(2)(c)

**APPEAL REQUEST FORM**  
**COMMUNITY CARE, INC. / Community Care Health Plan, Inc.**  
**(Community Care)**

Completion of this form is voluntary. The personally identifiable information collected on this form is used to identify your case and process your request. It will only be used for that purpose.

Name – Member		Today's Date
Mailing Address		
City	State WI	Zip Code

- Check this box if you would like to appeal Community Care, Inc.'s/ Community Care Health Plan, Inc.'s (HMO SNP) decision by requesting a meeting with the Grievance and Appeal Committee.

**Continuing Medicaid Services During an Appeal of a Reduction or Termination of a Current Service**

**For Family Care and Partnership members:**

If you request to have your benefits continued, we will continue providing your same service during your appeal if you postmark or fax your appeal **on or before the effective date of the intended action**. You might be responsible for repaying us for the cost of this service if you lose your appeal; however, you may not be required to repay this cost if it would be a significant and substantial financial burden on you.

- Check this box if you are a Family Care or Partnership member and would like to request the same services to continue during your appeal.

**For Program of All-Inclusive Care for the Elderly (PACE) members:**

For a PACE member Community Care will continue the current level of a **Medicaid** service during an appeal until the final decision is made **if** the following conditions are met:

- Community Care is planning to terminate or reduce services you are currently receiving;
- You request continuation and understand you may be liable for the costs of the services being appealed if the decision is not in your favor.

You may not be required to repay this cost if it would be a significant and substantial financial burden on you.

**For All Programs**

You have a right to free copies of your records including but not limited to medical records relevant to your appeal.

- Check this box if you would like to receive records from Community Care that apply to your appeal.

If you need this form in another language, Braille or large print, please call Community Care toll-free at 866-992-6600, Monday thru Friday, 8 a.m. to 4:30 p.m. TTY users should call the Wisconsin Relay System at 711. Interpreter and translation services are available free of charge.

\_\_\_\_\_  
**SIGNATURE – Member**

\_\_\_\_\_  
**Date Signed**

Mail or fax this form to:

Community Care  
205 Bishops Way  
Brookfield WI 53005  
Fax: 262-827-4044

To start your appeal as soon as possible, call Community Care at 866-992-6600 before mailing this form.

- If appealing a **Medicaid** covered service, you must appeal within **45 days** of the date of the Notice of Action.
- If appealing a **Medicare** covered service, you must appeal within **60 days** of the date of the Notice of Action.

## 5. State Fair Hearing Request Form

DEPARTMENT OF HEALTH SERVICES  
 Division of Long Term Care  
 F-00236 (03/2012)

STATE OF WISCONSIN  
 ss 46.287(2)(c)

### REQUEST FOR A STATE FAIR HEARING

Completion of this form is voluntary. The personally identifiable information collected on this form is used to identify case and process your request. It will only be used for that purpose.

Name – Member		Telephone Number	Medicaid ID Number
Mailing Address		Program <input type="checkbox"/> Family Care <input type="checkbox"/> Partnership <input type="checkbox"/> PACE	
City	Zip Code	Managed Care Organization	
Today's Date		Effective Date of Action	
Appeal related to: <input type="checkbox"/> eligibility <input type="checkbox"/> cost share <input type="checkbox"/> change to service/support		Briefly describe change to service / support:	

- Yes     No    1. Did you file an appeal with your MCO's Local Grievance and Appeal Committee?
- Yes     No    2. If you answered 'yes' to question one (1), did you request the same services to continue during your appeal with the MCO?
- Yes     No    3. If you answered 'yes' to question one (1), have you appeared before the MCO's Local Grievance and Appeal Committee?
- Yes     No    4. If you answered 'yes' to question three (3), have you received a decision from the MCO's Local Grievance and Appeal Committee? (Please attach a copy of the decision, if available.)

**Continuing Your Services During an Appeal of a Reduction or Termination of a Current Service**

If you request to have your benefits continued, we will continue providing your same service during your appeal if you postmark or fax your appeal **on or before the effective date of the intended action**. You might be responsible for repaying us for the cost of this service if you lose your appeal; however, you may not be required to repay this cost if it would be a significant and substantial financial burden on you.

Check this box if you would like to request the same services to continue during your appeal.

You have a right to free copies of your records including but not limited to medical records relevant to your grievance or appeal. To request copies contact your Care Manager or the Member Rights Specialist.

If you need this form in another language, Braille or large print, please call your Care Manager or the Member Rights Specialist. Interpreter and translation services are available free of charge.

\_\_\_\_\_  
**SIGNATURE** – Member

\_\_\_\_\_  
 Date Signed

Mail or fax this form **AND** a copy of the Notice of Action or decision letter to:

Family Care Request for Fair Hearing  
 c/o Division of Hearings and Appeals  
 PO Box 7875  
 Madison WI 53707-7875  
 Fax: (608) 264-9885

## 6. Notice of Privacy Practices

### Community Care's Notice of Privacy Practices

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

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal law that requires that all medical records and other individually identifiable health information used or disclosed by Community Care in any form, are kept properly confidential. 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.

- 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/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)**.
- We will not retaliate against you for filing a complaint.

## Your Choices

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

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

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

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

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

## Our Uses and Disclosures

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

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

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

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

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

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

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

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

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

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

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

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. We may also create and distribute de-identified health information by removing all references to individually identifiable information.

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

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

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

### **Do research**

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

### **Comply with the law**

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

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

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

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

We can use or share health information about you:

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

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

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

### **Our Responsibilities**

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

For more information see:

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

**Changes to the Terms of this Notice**

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

This notice is effective as of November 2013.

Please contact us for more information:

Compliance Officer  
Community Care, Inc. / Community Care Health Plan, Inc.  
205 Bishops Way  
Brookfield, WI 53005  
414-231-4000  
compliancehotline@communitycareinc.org  
Compliance Hotline: 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  
Telephone: 414-231-4000 • Toll-free: 866-992-6600 • [www.communitycareinc.org](http://www.communitycareinc.org)