PACE PROGRAM

Community Care Program of All-Inclusive Care for the Elderly

Member Handbook & Enrollment Agreement

MILWAUKEE, RACINE, & WAUKESHA COUNTIES

For help or information, please call Customer Service or visit our website at www.communitycareinc.org. Call toll free: 1-866-992-6600. TTY users call the Wisconsin Relay System at 711

COMMUNITY CARE™

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

DHS Approved: 6/29/2017
CMS Approved: 6/29/2017

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

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

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

If you need this handbook in another language, Braille, or large print, please call:

Toll-free: 1-866-992-6600
TTY: Call the Wisconsin Relay System at 711.

Interpreter and translation services are available free of charge. If you have special needs, this document may be available in other formats.

INTERPRETER SERVICES
For help to interpret this, free of charge, please call 866-992-6600 (TTY: Call the Wisconsin Relay System at 711)

Si necesita este documento en otro idioma, Braille o en letra grande, por favor llame al:

Toll-free: 1-866-992-6600
TTY: 711

Los servicios de intérprete y traducción están disponibles de forma gratis. Si tiene necesidades especiales, puede disponer de este documento en otros formatos.

SERVICIOS DE INTÉRPRETE
Si desea ayuda para interpretar esto, de forma gratis, por favor llame al *866-992-6600* (TTY: 711)

Если вам нужен данный документ на другом языке, напечатанным шрифтом Брайля или крупным шрифтом, обращайтесь по телефону:

Toll-free: 1-866-992-6600
TTY: 711

Услуги переводчика предоставляются бесплатно. Если у вас есть особые потребности, данный документ можно получить в другом формате.

Чтобы бесплатно получить помощь в переводе данного документа, обращайтесь по телефонv:*866-992-6600* (TTY: 711)

Yog koj xav tau phau ntawv no ua lwm hom lus, Braille, los yog ib phau uas cov tsiaj ntawv ntaus loj dua, thov hu rau:

Toll-free: 1-866-992-6600
TTY: 711

Cov kev pab txhais lus thiab txhais ntawv yog pab dawb xwb. Yog koj muaj teeb meem nyeem tsis tau phau ntawv no, nws kuj muaj lwm hom kom koj nyeem tau.

KEV PAB TXHAIS LUS
Yog xav kom pab txhais qhov no, uas yog pab dawb xwb, thov hu rau*866-992-6600* (TTY: 711)

Table of Contents

Chapter 1. Important phone numbers and resources

General phone number: 1-866-992-6600

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

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

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

Contacting Customer Service

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

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

Medicaid

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

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

Wisconsin Department of Health Services (DHS)	
CALL	1-800-362-3002
WEBSITE	www.dhs.wisconsin.gov/Medicaid

Ombudsman Programs

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

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

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

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

PACE Interdisciplinary Team (IDT) Contact Information

Community Care has a PACE site in each county within our service area. You may contact your PACE IDT at the numbers below.

County	**Address**	**City State Zip**	**Phone**
Waukesha	1801 Dolphin Dr.	Waukesha, WI 53166	262-953-8550
Milwaukee	3220 West Vliet St.	Milwaukee, WI 53208	414-231-4000
Racine	1801 Dolphin Dr. 3220 West Vliet St.	Waukesha, WI 53166 Milwaukee, WI 53208	262-953-8550 414-231-4000

In addition, Community Care PACE has two Alternative Care Settings (ACS).

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

- Community Care Layton Clinic
  1555 S. Layton Blvd.
  Milwaukee WI 53215
  The services that are provided at the Layton Clinic include physician and nursing services, restorative therapies, nutrition counseling, dental services and behavioral health treatment and counseling.

Your IDT can give you more information about Community Care's ACS.

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

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

You can contact your local ADRC as listed below.

Milwaukee County ARC	414-289-6874 **For individuals age 60 and older**
Milwaukee County DRC	414-289-6660 **For individuals under age 60**
Racine County ADRC	262-833-8777
Waukesha County ADRC	262-548-7848

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

Welcome to Community Care PACE

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

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

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

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

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

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

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

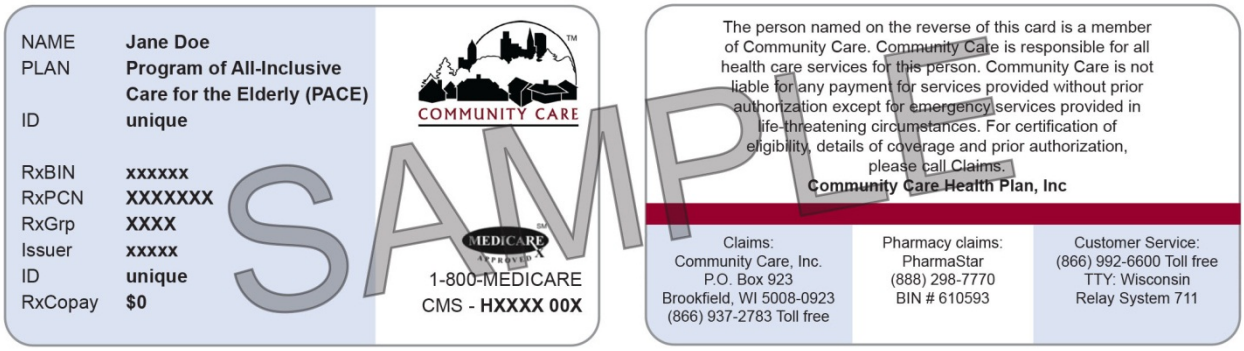
Chapter 10 at the end of this document contains definitions of important words. These definitions can help you understand the words and phrases frequently used in this handbook.

Your Membership Card

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

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

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



Who can be a member of Community Care PACE?

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

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

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

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

- For PACE you may have:
  - Medicaid, or
  - Both Medicaid and Medicare, or
  - Medicare and able to pay the monthly premium for Medicaid and Part D Services, or
  - Neither Medicare or Medicaid and able to pay the monthly premium for Medicare, Medicaid and Part D services.

- If you are eligible for Medicare, you must enroll in Medicare to remain eligible for PACE.

- If you are eligible for Medicare, you must be enrolled in and remain enrolled in all the parts of Medicare for which you are eligible (Part A, Part B, and Part D) and obtain all Medicare services from Community Care PACE.

- If you are eligible for Medicare, but do not enroll, you will be disenrolled from PACE. If you are eligible for Medicare and you do not currently have Medicare because you feel you can't afford it, contact your Income Maintenance Agency. They may help you find a program to help pay for your Medicare premiums.

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

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

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

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

How can the PACE program help me?

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

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

Who will help me?

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

- Anyone you want to be on your IDT, including family members or friends
- Primary Care Physician
- Nurse Practitioner
- Registered Nurse
- Social Worker/Care Manager
- Occupational Therapist
- Physical Therapist
- Recreational therapist or activity coordinator
- Dietician
- PACE Center Manager
- Home Care Coordinator
- Personal Care Attendant or his/her representative
- Driver or his/her representative

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

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

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

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

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

How does PACE work?

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

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

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

What 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**. It is an option you can use if you want to have more responsibility and be more involved in the direction of your own care.

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

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

What are "network providers" and "covered services?"

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

- "**Providers**" are doctors, pharmacists, and other health care professionals licensed by the state to provide medical services. The term "providers" also includes hospitals, health care facilities and long-term care agencies that provide things like home delivered meals or rides.

- "**Network providers**" are the doctors and other health care professionals, medical groups, hospitals, pharmacists, and other health care facilities that have an agreement with us to accept our payment as payment in full. We have arranged for these providers to deliver covered services that have been authorized to members in our plan. The providers in our network generally bill us directly for care they give you. When you see a network provider, you usually pay nothing for covered services. Network pharmacies have agreed to fill covered prescriptions for our plan.

- "**Covered services**" include all the medical care, long-term care services, supplies and equipment our plan covers. Long-term care consists of services to meet your daily needs such as assistance with eating, bathing, supportive home care, residential care and case management. Prescription drugs are also "covered services". See Chapter 4 for a complete list of covered services.

- **"Provider Directory"** is a list of all of Community Care's contracted network providers for PACE.

How are services selected and authorized?

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

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

Your care plan will include:

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

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

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

Important rules for getting your care and services.

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

1.) The services are included in your care plan and are approved by your IDT.

2.) The care you receive is included in the PACE benefit package. (This information is in Chapter 4.)

3.) The care you receive is considered medically necessary. "Medically necessary" means that you need the services, supplies or drugs for the prevention, diagnosis or treatment of your medical condition and the care meets accepted standards of medical practice.

4.) You must receive your care from a network provider. In most cases, we will not cover services you get from an out-of-network provider, except for emergency services or urgently needed care.

How do I use the provider network?

As a Community Care PACE member, all of your medical and long-term care services are provided and arranged by your IDT. Our provider network is intended to give you a choice of providers whenever possible. After your IDT approves your services, you and your IDT will choose from the providers in Community Care's provider network. If you get services from non-contracted providers **without prior authorization** (with the exception of urgent care and emergency services), neither Community Care PACE, Medicaid nor Medicare will pay for those services.

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

The list of the providers we routinely use is on our website at www.communitycareinc.org. We call this the Provider Directory.

What is a Primary Care Provider (PCP)?

Your PCP is the physician who is part of your IDT and who provides your routine or basic medical care. Your PCP collaborates with the rest of your IDT to manage your health care and coordinate the other covered services you get as a PACE member.

How do I choose a PCP?

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

How do I change my PCP?

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

How to get care from specialists and other network providers

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

What if a network provider leaves our plan?

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

The plan's List of Covered Drugs (Formulary)

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

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

Getting care if you have a medical emergency

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

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

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

If you have a medical emergency:

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

What is covered if you have a medical emergency?

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

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

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

What is "urgently needed care?"

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

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

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

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

Chapter 4. PACE benefits and coverage

What services are provided?

This chapter focuses on what services our plan covers. The PACE program provides health care, long-term care and prescription drug services. The list of services we provide is called the "PACE Benefit Package."

You and your IDT will use the Resource Allocation Decision (RAD) process to develop your care plan. 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 PACE member. You will get the services that your IDT has approved in your care plan and which are necessary to assure your health and safety.

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

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

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

PACE benefits and coverage

The services listed below are available if they are:

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

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

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

Outpatient Health Services

- General medical and specialist care including a woman's health specialist as requested.
- Nursing care.
- Social services.
- Prescribed medications and pharmacy services when prescribed by a PACE contracted physician or PACE nurse practitioner and dispensed by a Community Care PACE contracted pharmacy.
- Physical, occupational, speech and respiratory therapies.
- Laboratory tests, X-ray and other diagnostic tests.
- Vision care, including examinations and treatment.
- Hearing services, including evaluation, hearing aids, repairs, and regular care.
- Podiatry services, including routine foot care.

- Psychiatric care including evaluation, consultation, diagnosis, and treatment.
- Artificial limbs, disposable medical supplies, and durable medical equipment (such as hospital beds, wheelchairs, and walkers).
- Nutritional counseling and special diet assistance.
- Alcohol and other drug treatment.
- Chiropractic services.

Inpatient Hospital Care

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

Nursing Home Care

- Semi-private room and meals.
- Doctor and nursing services.
- Custodial care.
- Personal care and assistance.
- Prescribed drugs and medicines.
- Physical, occupational, and speech therapies.
- Social services and planning for discharge.
- Medical supplies and appliances.

Dental Care

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

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

End of Life Care

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

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

Medicaid Benefits

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

- Adaptive aids
- Adult day care services
- Assistive Technology / Communication aids
- Care/case management
- Consultative clinical and therapeutic services for caregivers
- Consumer education and training services
- Counseling and therapeutic services
- Environmental accessibility adaptations / Home modifications
    - ☐ Individual employment support
    - ☐ Small group employment support
- Vocational futures planning and support
- Home delivered meals
- Housing counseling
- Personal Emergency Response Systems
- Relocation services
- Residential Care
    - Adult family homes of 1-2 beds
    - Adult family homes of 3-4 beds
    - Community-based residential facilities (CBRF)
    - Residential care apartment complexes (RCAC)
- Respite care
- Self-directed personal care services
- Self-directed Supports (SDS)
- Skilled Nursing services RN/LPN
- Specialized medical equipment and supplies

- Support broker
- Supportive home care
- Training services for unpaid caregivers
- Transportation (specialized transportation)
  - Community transportation
  - Other transportation

Benefits *not* covered by the plan (exclusions)

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

Neither Community Care, Medicare nor Medicaid will pay for the excluded benefits. In addition to any exclusions described anywhere else in this handbook, the following items and services are not covered:

- Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary, covered under Medicaid and if applicable, Medicare.
- 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).

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 IDT 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

Will I pay for any services?

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

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

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

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

- Cost share
- Room and board
- Premium Payments

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

Cost share

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

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

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

Failure to pay your monthly cost share may result in loss of eligibility for Medicaid, and you might be disenrolled from PACE. If you think your cost share is incorrect, you can file an appeal with the Wisconsin Division of Hearings and Appeals (DHA).

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

Room and board

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

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

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

Monthly Premium Payments

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

If you are eligible for:

- **MEDICARE AND MEDICAID or MEDICAID ONLY**
  If you are eligible for both Medicare and Medicaid, or Medicaid only, you will make no monthly premium payment to Community Care PACE, and you will continue to receive all PACE services, including prescription drugs.

- **MEDICARE ONLY**
  If you have Medicare and are not eligible for Medicaid, then you will pay a monthly premium to Community Care PACE.

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

- **PRIVATE PAY** (Neither eligible for Medicare or Medicaid)
  If you are not eligible for either Medicare or Medicaid, then you will pay a monthly premium to Community Care PACE for both the Medicare and Medicaid services.
  Because this premium does not include the cost of Medicare prescription drug coverage, you will be responsible for an additional monthly premium for Medicare prescription drug coverage.

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

How do I make a payment?

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

Community Care
205 Bishops Way
Brookfield, WI 53005

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

What if I get a bill for services?

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

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

Does PACE pay for residential services or nursing homes?

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

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

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

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

You will be required to pay the "room and board"(rent and food) portion of the facility's cost.

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

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

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

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

Phone:	Toll-free: 1-800-362-3002 TTY: 711 or 1-800-947-3529
Visit:	https://www.dhs.wisconsin.gov/medicaid/erp.htm
Or write to:	DHS - Estate Recovery Program P.O. Box 309 Madison, WI 53701-0309

Chapter 6. Your rights

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 IDT.

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 have reasonable access to a telephone.
- To be encouraged and helped to suggest changes to policies or services
- To be encouraged to exercise your rights as a member of Community Care.
- To be free from discrimination. Community Care must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, mental or physical disability, religion, gender, 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 IDT is available to talk with you about these issues. They can help you with reporting or securing services for safety. You should always call 911 in an emergency.

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

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

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

Milwaukee County ARC (over age 60)
414-289-6874
TTY Call the Wisconsin Relay System at 711
aging_webinfo@milwaukeecounty.com

Racine County ADRC
262-833-8777
TTY Call the Wisconsin Relay System at 711
adrc@racinecounty com

Waukesha County ADRC
262-548-7848
TTY Call the Wisconsin Relay System at 711
adrc@waukeshacounty.gov

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

We must ensure that you get timely access to your covered services. As a member of Community Care, you have a right to receive the services listed in your care plan when you need them. Your IDT will arrange for your covered services. Your IDT will also coordinate with your health care providers. Contact your IDT for assistance in choosing your providers.

As a member of Community Care, you have the right to choose a primary care provider (PCP) from within the PACE network. If you think that you are not getting your medical care or drugs within a reasonable amount of time, talk to your IDT.

3.) **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 IDT. See Chapter 12 for Community Care's Notice of Privacy Practices.

4.) **We must give you access to your medical records.** Ask your IDT if you want a copy of your records. You have the right to ask Community Care to change or correct your records.

5.) **We must give you information about Community Care's network of providers, and available services**. Please contact your IDT if you want this information or go to our website www.communitycareinc.org.

6.) **We must support your right to make decisions about your care**.

- You have a right to know about all of the options that are available, what they cost and whether they are covered by PACE. 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 by developing 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 IDT if you want to know more about advance directives.

7.) **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 IDT. We're here to help.

1.) Become familiar with the services in the PACE benefit package. This includes understanding what you need to do to get your services.

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 IDT 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 IDT agreed to.**

6.) Be responsible for your actions if you refuse treatment or do not follow the instructions from your IDT or providers.

7.) Use the providers that are part of Community Care's network, unless you and your IDT decide otherwise.

8.) Follow Community Care's procedures for getting care after hours.

9.) Notify us if you move to a new address or change your phone number.

10.) Notify us of any planned temporary stay or move out of the service area.

11.) 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.

12.) Treat your IDT, home care staff and providers with dignity and respect.

13.) Accept services without regard to the provider's race, color, religion, age, gender, sexual orientation, health, ethnicity, creed (beliefs), or national origin.

14.) Pay any monthly costs on time, including any cost share or room and board charges you may have. Let your IDT know as soon as possible if you have problems with your payment.

15.) If applicable, 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 coverage.

16.) Take care of any durable medical equipment (DME), such as wheelchairs and hospital beds provided to you by Community Care.

17.) Report fraud or abuse on the part of providers or Community Care employees.

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

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

18.) 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 PACE or possible criminal prosecution.

19.) Help your IDT doctors and other providers help you by giving them information, asking questions, sharing concerns, and following through on your care.

20.) Call your IDTIDT for help if you have questions or concerns.

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

Chapter 8. Grievances and appeals

Introduction

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

You can also call 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 or appeal process to try to find a workable solution.

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

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

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

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

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

Grievances

What is a grievance?

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

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

What is the deadline to file a grievance?
Medicaid grievances can be filed at any time. Medicare grievances must be filed within **60 calendar days of the event.**

What are my options? If you want to file a grievance, you have two options. You can:

1.) Start by filing a grievance with Community Care.
→ See Option 1 below.

2.) Start by asking for a review by the Wisconsin Department of Health Services (DHS).
→ See Option 2 below.

You can use Option 1 and/or Option 2 together or at different times.

GRIEVANCE OPTION 1: File your grievance with Community Care

Many times your concerns can be resolved informally. If we are unable to solve your concerns, you can file a grievance with Community Care by calling or writing to us.

What happens next?

If you file a grievance with Community Care, we will send you a letter within five business days to let you know we received your grievance. Then, Community Care staff who are not on your IDT will try to help informally address your concerns or come up with a solution that satisfies both Community Care and you. If we are 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 with you.
- The Committee will give you a chance to explain your concerns. You may provide information to the Committee.
- Your IDT or other Community Care staff will likely be at the meeting.
- The Committee will make a decision within 20 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?
If you disagree, you can ask for a review by the Department of Health Services, unless you have already done so.

GRIEVANCE OPTION 2: Ask for a DHS review

You can also ask the State of Wisconsin Department of Health Services (DHS) to review your grievance before, after or instead of filing a grievance with Community Care. DHS is the Medicaid agency that is in charge of the PACE program. The purpose of a DHS review is to see if you and Community Care can work out an informal solution.

Using Community Care's grievance process first is not a requirement, but it is encouraged.

To ask for a DHS review, call or e-mail:
DHS PACE Grievances
Toll-free: 1-888-203-8338
E-mail: dhsfamcare@wisconsin.gov

What happens next?
DHS works with an outside organization called "MetaStar" to review grievances. If you ask for a DHS review, MetaStar 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 IDT. 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 and send you a letter with their findings within 20 business days of your request.

Appeals

What is an appeal?
An appeal is a request for a review of a decision made by Community Care. You can file an appeal if your IDT denies, reduces or ends a service or suspends a Medicaid-covered service.

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

Are You Eligible for Medicare or Medicaid?

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

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

For help in filing an appeal talk with your IDT or call the Member Rights Specialist at 1-866-992-6600. TTY call the Wisconsin Relay System at 711. We can help you decide which process to use.

Medicaid Appeal Process

When can I file a Medicaid Appeal?
You have the right to file an appeal in the following types of situations:

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

If we take one of the actions listed above, we must send you a "**Notice of Action."** The Notice of Action includes the date we plan to stop, suspend or reduce your services and explains the appeal process.

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

- Requires you to accept care, treatment or support items you don't want or you believe are unnecessarily restrictive.

- 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 Notice of Action which explains your appeal rights.

3.) You can file an appeal related to decisions about your Medicaid eligibility.

- If the Income Maintenance agency decides you are no longer financially eligible for Medicaid, you will receive a written notice. If your functional eligibility for PACE changes, you will also receive a written notice. These notices have information about your right to request a State Fair Hearing with the Division of Hearings and Appeals.

- **Filing an appeal with the Division of Hearings and Appeals is the only way to challenge decisions related to financial and functional eligibility for Medicaid.** This includes decisions about your cost share.

- **You cannot appeal a loss of financial or functional eligibility with Community Care.**

What is the deadline to file an appeal?

You must file your Medicaid appeal no later than 45 days after you receive the Notice of Action. (For example, if you get a notice in the mail on August 1, you must file your appeal on or before September 15.)

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

What are my options?

If you want to file a Medicaid appeal, you have three options. You can:

1.) Start by filing an appeal with Community Care.
   → See Option 1 if you want to file with Community Care.

2.) Start by asking the Wisconsin Department of Health Services (DHS) to review our decision.
   → See Option 2 if you want to file with DHS.

3.) Start by filing an appeal with the State Division of Hearings and Appeals (DHA).
   → See Option 3 if you want to file with DHA.

E**ach option has 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 file a request for a fair hearing instead of, or after receiving an appeal decision from Community Care.

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 a Medicaid appeal.

Continuing Your Services During Your Appeal

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

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

If you want your services to continue, you must:

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

Medicaid APPEAL OPTION 1: Filing your appeal with Community Care

To file a standard appeal with Community Care you can:

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

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

To file an appeal with Community Care, contact us at:
Community Care
Member Rights Specialist
205 Bishops Way.
Brookfield, WI 53005
1-866-992-6600
TTY: Call the Wisconsin Relay System at 711
Fax: 262-827-4044

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 Appeal Committee will meet to review your appeal.

- We will let you know when the Committee plans to meet to review your appeal.
- The Committee is made up of Community Care representatives and at least one consumer. The consumer is a person who also receives services from us (or represents someone who does). We train this person on how to protect the privacy of others while serving on the Committee. Sometimes other people who specialize in the area of your appeal might be part of the Committee.
- The meeting is confidential. You can ask that the consumer not be on the Committee if you are concerned about privacy or have other concerns.
- You have the right to appear in person. You can bring an advocate, friend, family member, or witnesses with you.
- Your IDT or other Community Care staff will likely be at the meeting.
- The Committee will give you a chance to explain why you disagree with your IDT's decision. You or your representative can present information, bring witnesses, or describe your concerns to help the Committee understand your point of view.
- After the Committee hears your appeal, Community Care will send you a decision letter within 20 business days after we first got your appeal. Community Care may take up to 30 business 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 20 business days to decide your appeal. If you think waiting that long could seriously harm your health or your ability to regain maximum function, you can ask us to speed up your appeal. We call this an "expedited appeal." If you ask for a fast appeal, we will

decide if your health requires a fast appeal. We will let you know as soon as possible if we will expedite your appeal. You can request an expedited appeal in the same ways as described for a standard appeal.

In an expedited appeal, you will get a decision on your appeal within 72 hours of your request. However, Community Care may extend this to a total of 14 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.

What if I disagree with the Grievance and Appeal Committee's decision?
If you disagree and if you haven't already done so, you can request a State Fair Hearing with the Division of Hearings and Appeals (DHA) or ask for a review by the Department of Health Services. You must do so within 45 days from the date of the Grievance and Appeal Committee's decision. You can file an appeal with DHA if Community Care does not issue an appeal decision in a timely manner.

Reviews by the Department of Health Services

MEDICAID APPEAL OPTION 2: Asking the Department of Health Services (DHS) to review Community Care's decision

The Wisconsin Department of Health Services (DHS) is the Medicaid agency that is in charge of the PACE program. DHS works with an outside organization called MetaStar to review decisions made by Community Care. Staff from 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.

A DHS review will not typically result in DHS ordering Community Care to do what you want. Nor will DHS order you to accept what Community Care is planning to do. However, if MetaStar tells DHS that we didn't follow certain requirements; DHS may order Community Care to take steps to correct the problem.

How do I ask for a DHS review?
You may request a DHS review by calling or e-mailing:

DHS PACE Appeals
Toll-free: 1-888-203-8338
E-mail: dhsfamcare@wisconsin.gov

What is the deadline to ask for a DHS review?
You must ask for a DHS review within 45 days after you receive a Notice of Action or decision letter from Community Care. (For example, if you get a notice or decision letter in the mail on

August 1, you must file your appeal on or before September 15.)You can ask DHS to review Community Care's decision before or instead of filing an appeal with Community Care or DHA.

What happens next?

- MetaStar will reply in writing to let you know they received your request.
- They will contact you and ask why you disagree with Community Care's decision. They will also contact your IDT. MetaStar will try to resolve your concerns informally.
- MetaStar will complete the review and send you a letter with their findings within 20 business days of your request.

What if I disagree with the results of the DHS review?
If you are not happy with the result of the DHS review and you have not already done so, you can file an appeal with Community Care or the Division of Hearings and Appeals. After you receive the letter from MetaStar with their findings, you have up to 45 days to appeal with Community Care or DHA.

State Fair Hearings

APPEAL OPTION 3: 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.

An appeal with DHA is the final level of appeal. If you go to DHA first, you cannot file the same appeal with Community Care or ask for a Department of Health Services review.
How do I request a State Fair Hearing?
To ask for a State Fair Hearing, you can either:

- **Send a request form**. You can get a copy from Community Care's Member Rights Specialist. Or, download the form at 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:
PACE Request for Fair Hearing
c/o Wisconsin Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875
(Or fax your request to 608-264-9885)

What is the deadline to file an appeal with DHA?
You must file your appeal within 45 days after you receive a Notice of Action 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 September 15.) 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 45 days from the date you receive that decision to file a request for a State Fair Hearing.

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

What can I do if I disagree with the Judge's decision?
If you disagree with Administrative Law Judge's decision, you have two options.

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

Medicare Appeal Process

If you are eligible for Medicare and Community Care plans to stop or reduce an authorized service you are getting, has denied a service you requested or denies payment for a service you received, you have the right to submit a Medicare appeal to Community Care. Members cannot submit a Medicare appeal outside of Community Care until they have gone through Community Care's appeal process.

Denial of Medicare Services

When you make a request for a service to your IDT, we must give you an answer within 3 days. This time frame can be extended up to a total of 5 days if it is in your best interests to do so.

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

- Standard Appeal Process for Denial of Medicare Services

  If you request a standard appeal, Community Care must notify you in writing of its decision no later than 30 days from the time that you submitted the appeal. If we deny your appeal, you can request a review of our decision by MAXIMUS, the Independent Review Organization hired by Medicare. The letter which explains that we denied your appeal tells you how to submit your appeal to MAXIMUS for review.

  MAXIMUS is not connected to Community Care, and it is not a government agency. Medicare chose MAXIMUS to independently review appeal decisions made by organizations like Community Care.

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

  If Community Care agrees to provide the service you requested, we must authorize or provide the service as quickly as your health requires, but no later than 30 days from the time you submitted your appeal. If we fail to do so, you may submit an appeal to MAXIMUS.

- Expedited Appeal Request for Denial of Medicare Services

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

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

     When we expedite your appeal, we will review your appeal very quickly and give you a decision within 72 hours after receiving your appeal. If we fail to give you an appeal decision in that time frame, you can appeal to MAXIMUS.

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

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

  2. Extending the Expedited Review Timeframe

     If you ask for more time, or if Community Care justifies a need for additional information and how the delay is in your best interest, Community Care may extend the 72-hour timeframe by up to 14 calendar days.

Reduction of Medicare Services

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

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

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

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

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

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

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

Denial of Payment for Medicare Services

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

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

If Community Care does not respond in the required time frame, you may appeal to MAXIMUS.

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

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

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

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

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

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

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

How does Community Care handle your Medicare appeal?

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

- 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 IDT or other Community Care staff will likely be at the meeting.
- The Committee will give you a chance to explain why you disagree with your IDT's decision. You or your representative can present information, bring witnesses, or describe your concerns to help the Committee understand your point of view.
- After the Committee hears your appeal, Community Care will send you a decision letter within 20 business days after we first got your appeal. Community Care may take up to 30 business 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.

If Community Care's Grievance and Appeal Committee's decision is not in your favor, you can request a review of the decision by contacting MAXIMUS. You can contact MAXIMUS at 1-585-348-3300or on the internet at http://www.medicareappeal.com.

How and Where To File A Medicare Appeal

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

Community Care PACE
Member Rights Specialist
205 Bishops way
Brookfield, WI 53005
Toll-Free: 1-866-992-6600
TTY: Call the Wisconsin Relay System at 8711

Your appeal should be submitted in writing.

Who can help me with my Medicare 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. You can ask anyone you want to act as an advocate for you, including family members, friends, an attorney, or any other person willing to help.

Below are some additional places you can contact for assistance.

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

Wisconsin Board on Aging and Long Term Care
Ombudsmen from this agency provide advocacy to PACE members **age 60 and older**.

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

Disability Rights Wisconsin (DRW)
Ombudsmen from this agency provide advocacy to PACE members **under age 60**.

Disability Rights Wisconsin
131 W. Wilson St., Suite 700
Madison, WI 53703
608-267-0214
TTY: 1-888-758-6049
Fax: 608-267-0368

Madison Toll-free: 1-800-928-8778
Milwaukee Toll-free: 1-800-708-3034
Rice Lake Toll-free: 1-877-338-3724
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 PACE due to your health condition. You might leave our plan because you have decided that you *want* to leave. However, there are some situations when your membership will end even if that wasn't your choice.

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

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

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

Voluntary Disenrollment

You may choose to disenroll from PACE for any reason. Your disenrollment date for the Medicare benefits in PACE usually takes place on the last day of the month after your disenrollment request. Your disenrollment date from the Medicaid benefits in PACE may take place on any day of the month after your disenrollment request.. Please discuss the timing of your disenrollment with your IDT.

If you are eligible for Medicare at the time of disenrollment, you may go back to Original Medicare or another Medicare health plan. If you switch to Original Medicare and do not enroll in a Medicare prescription drug plan, you will not have coverage for prescription drugs. If you go without "creditable" prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare prescription drug plan later.

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

Loss of PACE Eligibility

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

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

You can end your membership at any time.

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

- You lose your financial eligibility for Medicaid, are not eligible for Medicare and are unable to pay or make satisfactory arrangements to pay the premium amounts owed to Community Care.

- You lose Medicaid eligibility, are eligible for Medicare but are unable to pay or make satisfactory arrangements to pay the premium amounts owed to Community Care.

- You fail to pay the required monthly premium and are unable to pay or make satisfactory arrangements to pay the premium owed to Community Care.

- You are no longer functionally eligible as determined by the Wisconsin Adult Long-Term Care Functional Screen.

- You do not pay your cost share.

- You permanently move out of Community Care's service area. If your IDT 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 IDT. If you plan to move within Wisconsin but outside of the PACE service area, your IDT may be able to ease the transition and help you find services in your new residence, so it is a good idea to let them know if you plan to move.

- You are in jail or prison.

- You are admitted to an Institute for Mental Disease (IMD) and 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 Wisconsin Department of Health Services (DHS). DHS 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 because you filed a grievance or appeal.

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

Chapter 10. Definitions of important words

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

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

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

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

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

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

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 PACE.

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 PACE 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 IDT and listed in the member's care plan. See Chapter 4 for a complete list of the services in the PACE 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 IDT and member meet regularly to review the member's care plan.

Choice – The PACE program supports a member's choice when receiving services. Choice means members have a say in how and when care is provided. Choice also means members are responsible for helping their IDT identify services that are cost-effective. Members can also choose to direct one or more of their long-term care services by using the 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 PACE. See Chapter 5 for information about cost share and spend down.

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

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

DHS Review – A review of a member's grievance or appeal by the Department of Health Services (DHS). DHS works with MetaStar to review grievances and appeals. MetaStar reviews member concerns and tries to come up with informal solutions. A DHS review will not lead to a decision. See Chapter 8 for information about DHS reviews.

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

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

Enroll/Enrollment – Enrollment in PACE is voluntary. To enroll, individuals should contact their local Aging and Disability Resource Center (ADRC). The ADRC determines whether an individual is functionally eligible for PACE. The Income Maintenance agency determines whether an individual is financially eligible for Medicaid and PACE. If the individual is eligible and wants to enroll in PACE, 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. **Functional Eligibility** – The Wisconsin Long Term Care Functional Screen determines whether a person is functionally eligible for PACE. The Functional Screen collects information on an individual's health condition and need for help in such things as bathing, getting dressed and using the bathroom.

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

Guardian – 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, PACE, and other public benefits.

Interdisciplinary Team (IDT) – Every PACE member is assigned an IDT. The member is a central part of his or her IDT. The IDT includes the member, and at least a care manager and a registered nurse. Members can choose anyone else they want involved on their IDT, 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 IDT works with members to assess needs, identify outcomes and create care plans. The team authorizes, coordinates and monitors services.

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

Long-Term Care Outcome – A situation, condition or circumstance, that a member of the IDT identifies that maximizes a member's highest level or independence. During the assessment, IDTs works with member to assess their physical health needs and ability to perform daily

activities. The IDT uses this information to determine a member's long-term care outcomes. The MCO authorizes services based on long-term care outcomes.

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

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

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

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

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

Notice of Action – 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 Action if the MCO denies a member's request for a new service, refuses to pay for a service, or plans to stop, suspend or reduce a member's service. See Chapter 8 for more information about appeals.

Notification of Appeal Rights – A written notice sent to members explaining their options for filing an appeal. MCOs must send a notification of appeal rights to members if the MCO didn't provide services in a timely way or didn't meet the deadlines for handling an appeal. Other situations when MCOs send this notice include times when members didn't like their care plan because it didn't support their outcomes or requires members to accept care they didn't want. Income Maintenance agencies send members a notification of appeal rights when members

lose financial or functional eligibility for PACE. See Chapter 8 for more information about appeals.

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

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

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.

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

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

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

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

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

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

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

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 PACE.

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

Chapter 11. Home and Community-Based Waiver Service Definitions

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

Chapter 12. Notice of privacy practices

Notice of Privacy Practices

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

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

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

Your Rights

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

Get a copy of health and claims records

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

Ask us to correct health and claims records

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

Request confidential communications

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

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

Ask us to limit what we use or share

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

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

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

Get a copy of this privacy notice

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

Choose someone to act for you

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

File a complaint if you feel your rights are violated

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

Your Choices

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

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

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

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

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation
  If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

Our Uses and Disclosures

How do we typically use or share your health information?

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

To help manage the health care treatment you receive

- We can use your health information and share it with professionals who are treating you. Treatment means providing, coordinating, or managing your health care and related services.
  Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

To run our organization

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

To pay for your health services

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

How else can we use or share your health information?

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

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

Help with public health and safety issues

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

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

Do research

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

Comply with the law

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

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

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

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

We can use or share health information about you:

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

Respond to lawsuits and legal actions

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

Our Responsibilities

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

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our web site. We will provide you with a copy of the revised notice within 60 days of the change.
This notice is effective as of November, 2013.

Please contact us for more information:

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

Chapter 13. Community Care PACE Enrollment Agreement Form

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

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

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

I have received information on grievance and appeal procedures.

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

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

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

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

I understand that I may voluntarily disenroll from the Community care program at any time. I understand that my disenrollment will be effective within two (2) months of signing the Disenrollment Request Form.

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

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

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

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

Signature: _____ Date: _____

Printed Name: _____

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

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

COMMUNITY CARE™

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