***i*Care Family Care Partnership HMO SNP**

Family Care Partnership Member Handbook

for people enrolled in Medicaid only

IMPORTANT:

If you are covered by **Medicare**, you should to refer to the Evidence of Coverage for Partnership members who are enrolled in **Medicare** AND **Medicaid**.

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

For help or information, please call Customer Service
or visit our website at www.icare-wi.org.
Call toll free: 1-800-777-4376.
TTY users call the Wisconsin Relay System at 711.

INDEPENDENT CARE HEALTH PLAN

1555 N. RiverCenter Dr., Suite 206
Milwaukee, WI 53212

Last Updated: 09/04/2015 DHS Approved: 12/01/2015

ATTENTION: If you speak English, language assistance services are available to you free of charge. Call 1-800-777-4376 (TTY: 1-800-947-3529).

ATENCIÓN: Si habla español, los servicios de asistencia de idiomas están disponibles sin cargo, llame al 1-800-777-4376 (TTY: 1-800-947-3529).

CEEB TOOM: Yog koj hais lus Hmoob, kev pab rau lwm yam lus muaj rau koj dawb xwb. Hu 1-800-777-4376 (TTY: 1-800-947-3529).

注意：如果您说中文，您可获得免费的语言协助服务。请致电 1-800-777-4376 (TTY 文字电话: 1-800-947-3529).

DIGTOONI: Haddii aad ku hadasho afka Soomaaliha, adeegyada caawimada luqadda waxaa laguu heli karaa iyagoo bilaash ah. Wac 1-800-777-4376 (TTY: 1-800-947-3529).

ໝາຍເຫດ: ຖ້າທ່ານເວົ້າພາສາລາວ, ທ່ານສາມາດໃຊ້ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ໄດ້ໂດຍບໍ່ເສຍຄ່າ. ໂທ 1-800-777-4376 (TTY: 1-800-947-3529).

ВНИМАНИЕ: Если Вы говорите по-русски, Вам будут бесплатно предоставлены услуги переводчика. Позвоните по номеру: 1-800-777-4376 (TTY: 1-800-947-3529).

ကော်ဇူးပြုပြီ၍ နားဆင်ပါ - သင့်သည့်ပြန်မာစကားပြောသူဖစ်ပါက၊ သင့်အတွက် အခမဲ့ဖြင့် ဘာသာစကားကူညီရေး ဝန်ဆောင်မှုမ်ား ရရှိနိုင်သည်။ 1-800-777-4376 (TTY: 1-800-947-3529) တင်ြ ဖုန်းခေၚဆိုပါ။

Independent Care Health Plan:

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

If you need these services, contact Independent Care Health Plan at 1-800-777-4376. TTY: 1-800-947-3529.

Table of Contents

Chapter 1. Important phone numbers and resources

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

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

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

General phone number 1-800-777-4376
TTY: call the Wisconsin Relay System at 711. You can call these numbers 24 hours a day, 7 days a week.
Corporate Office:
1555 N. RiverCenter Dr., Suite 206
Milwaukee, WI 53212
Office hours: 8:30 a.m. to 5:00 p.m., Monday-Friday. **For assistance after hours, on weekends and holidays, call the number above.**

How to contact Customer Service

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

***i*Care Family Care Partnership Contacts**	
CALL	1-800-777-4376 Calls to this number are free. Office hours: 8:30 a.m. to 5:00 p.m., Monday-Friday. **For assistance after hours, on weekends and holidays, call the number above.** Customer Service also has free language interpreter services available for non-English speakers.
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. Calls to this number are free. Office hours: 8:30 a.m. to 5:00 p.m., Monday-Friday. **For assistance after hours, on weekends and holidays, call the number above.**
FAX	414-231-1092
WRITE	Independent Care Health Plan 1555 N. RiverCenter Dr., Suite 206

	Milwaukee, WI 53212
WEBSITE	www.icare-wi.org

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

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

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

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

Coverage Decisions for Medical Care, Long-Term Care Services, or Prescription drugs	
CALL	1-800-777-4376 Calls to this number are free. You can call from 8:00 a.m. to 8:00 p.m., 7 days a week. Customer Service also has free language interpreter services available for non-English speakers.
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. Calls to this number are free. You can call from 8:00 a.m. to 8:00 p.m., 7 days a week.
FAX	414-231-1092
WRITE	Independent Care Health Plan 1555 N. RiverCenter Dr., Suite 206 Milwaukee, WI 53212
WEBSITE	www.icare-wi.org

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

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. This type of complaint is called a grievance. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, long-term care services, or prescription drugs, see Chapter 8.

Complaints about Medical Care, Long-Term Care Services, or Prescription Drugs	
CALL	1-800-777-4376 Calls to this number are free. You can call from 8:00 a.m. to 8:00 p.m., 7 days a week. Customer Service also has free language interpreter services available for non-English speakers.
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. Calls to this number are free. You can call from 8:00 a.m. to 8:00 p.m., 7 days a week.
FAX	414-231-1092
WRITE	Independent Care Health Plan 1555 N. RiverCenter Dr., Suite 206 Milwaukee, WI 53212
WEBSITE	www.icare-wi.org

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

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

Appeals for Medical Care, Long-Term Care Services, or Prescription drugs	
CALL	1-800-777-4376 Calls to this number are free. You can call from 8:00 a.m. to 8:00 p.m., 7 days a week. Customer Service also has free language interpreter services available for non-English speakers.
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. Calls to this number are free. You can call from 8:00 a.m. to 8:00 p.m., 7 days a week.
FAX	414-231-1092
WRITE	Independent Care Health Plan 1555 N. RiverCenter Dr., Suite 206 Milwaukee, WI 53212

WEBSITE	www.icare-wi.org

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

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

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

Payment Requests	
CALL	1-800-777-4376 Calls to this number are free. You can call from 8:00 a.m. to 8:00 p.m. 24 hours a day, 7 days a week. Customer Service also has free language interpreter services available for non-English speakers.
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. Calls to this number are free. You can call from 8:00 a.m. to 8:00 p.m. 7 days a week.
FAX	414-231-1092
WRITE	Independent Care Health Plan 1555 N. RiverCenter Dr., Suite 206 Milwaukee, WI 53212
WEBSITE	www.icare-wi.org

Social Security

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

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

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

Medicaid

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

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

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

All Medicaid applicants and members can use ACCESS. ACCESS is an online tool at www.access.wi.gov that you can use to:

- Find out if you are eligible for a program
- Apply for benefits
- Check your benefits
- Report changes
- Get a new ForwardHealth Card

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

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

You can contact your Local County or Tribal Agency for:

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

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

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

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

Ombudsman Programs

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

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

How to contact the Railroad Retirement Board

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

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

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

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

You can contact your local ADRC as listed below.

Dane County

2865 N. Sherman Avenue
Northside Town Center
Madison WI 53704

1-608-240-7400, 1-855-417-6892
TTY: 1-608-240-7404
www.daneadrc.org

Kenosha County

Kenosha County Division of Aging & Disability Services
8600 Sheridan Road, Suite 500
Kenosha, WI 53143-6514
1-262-605-6646, 1-800-472-8008
TTY: 262-605-6663
www.co.kenosha.wi.us/dhs/Divisions/Aging

Milwaukee County

- **For people 60 years of age or over call:**

Milwaukee Aging Resource Center
1220 W. Vliet St., Suite 300
Milwaukee, WI 53221
1-414-289-6874
1-866-229-9695
(TTY/TDD: 414-289-8591)
http://www.county.milwaukee.gov/ResourceCenter12673.htm

- **For people under 60 years of age call:**

Milwaukee Disability Resource Center
1220 W Vliet St., Suite 300
Milwaukee, WI 53205
1-414-289-6660
(TTY/TDD: 414-289-8559)

Racine County

ADRC of Racine County
14200 Washington Ave
Sturtevant, WI 53177
1-262-833-8777
1-866-219-1043
TTY: Wisconsin Relay 711
www.adrc.racineco.com

FoodShare Wisconsin

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

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

Chapter 2. Introduction to Family Care Partnership (Partnership)

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

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

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

Welcome to *i*Care Family Care Partnership

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

This handbook will give you the information you need to:

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

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

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

The end of this document (page 72) contains definitions of important words. These definitions can help you understand the words and phrases frequently used in this handbook.

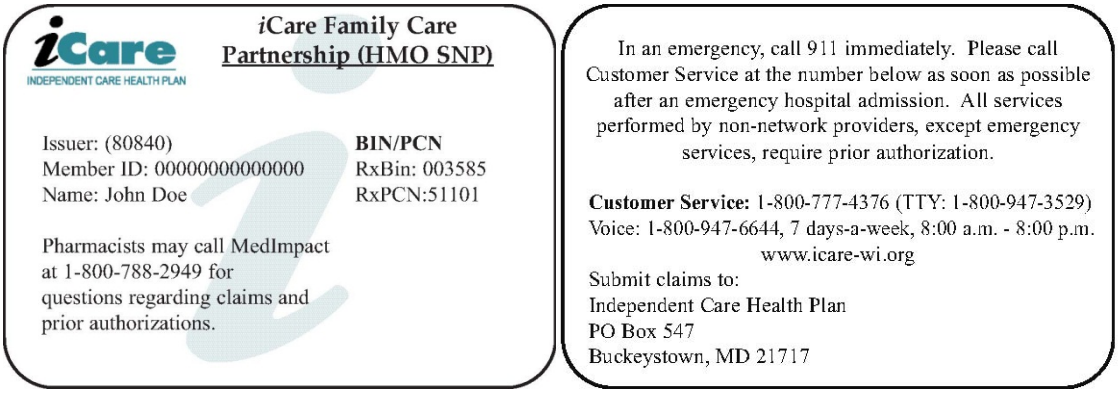
The word "services" in this document generally refers to all the medical care, health care, long-term care, supplies and equipment, and prescription drugs our plan covers. See Chapter 4 for a list of covered services.

Your Membership Card

One of the first things you will get when you join Partnership 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.

Here's why it is so important to use your membership card: If you get covered services using a different insurance card while you are a plan member, **you may have to pay the full cost yourself**.

If your membership card is damaged, lost, or stolen, call Customer Service at 1-800-777-4376 right away and we will send you a new card. Here's a sample membership card to show you what yours will look like:



How can the Partnership program help me?

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

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

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

Partnership gives you services in a personal way. We will work with you and your family to give you the kind of care you need and want. We want you to live as independently as possible for as long as possible in your home or other cost-effective setting. We will encourage you to do as

much for yourself as possible. We will help you make informed health choices. We will make sure you get the care you need to be healthy and safe. We will also help you maintain your ties with your family, friends and community.

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

Who will help me?

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

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

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

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

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

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

*i*Care Family Care Partnership encourages family members, friends and other people that are important to you to be involved in your care. Partnership does not replace the help you get from your family, friends or others in the community. We will work with you to build on these important relationships. We can also help find resources in your community that can assist you, such as libraries, senior centers and churches.

When needed, we can also help find ways to strengthen your support network. For example, if the people who help you need a break, we can provide respite services. Respite provides a temporary break for your caregivers to give them time to relax and maintain their own health.

What does it mean to be a member?

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

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

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

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

Who can be a member of *i*Care Family Care Partnership?

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

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

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

Only individuals that are residents of one of the counties in our service area can enroll in *i*Care Family Care Partnership. To stay a member of our program, you must remain a resident in a county in this service area. Our service area includes these counties in Wisconsin:

- Dane County
- Kenosha County
- Milwaukee County

- Racine County

If you plan to move out of the service area, you must notify your care team. If you move outside of our service area, you can no longer be a member of *i*Care Family Care Partnership's Partnership program. (For more information, see Chapter 3. Your Team will work with you to transition you to a program available in your new service area.)

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

- **Financial eligibility** means eligibility for Medicaid (also known as Medical Assistance, MA, or Title 19). The Income Maintenance agency (formerly known as the Economic Support agency) looks at an individual's income and assets to determine if the person is eligible for Medicaid. Sometimes to be financially eligible members will have to pay a share of the cost of the services they receive. This is called "cost share" and it must be paid to remain eligible for Medicaid. If you will have a cost share, staff from the ADRC will discuss this with you before you make a final decision about enrolling. For more information about cost share, see Chapter 5. The Income Maintenance agency will review your financial eligibility and cost share at least once a year to make sure you are still eligible for Partnership.

- **Functional eligibility** is related to a person's health and need for help with such things as bathing, getting dressed, and using the bathroom. The ADRC can tell you if you are functionally eligible for Partnership. Your care team will review your functional eligibility at least once a year to make sure you are still eligible.

How does Partnership work?

Personnel Experience Outcomes

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

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

- Input on:
    - Where and with whom to live.
    - Needed supports and services.
    - Your daily routines

- Personal Experience – having:
    - Interaction with family and friends.

  - A job or other meaningful activities
  - Community involvement
  - Stability
  - Respect and fairness
  - Privacy

- Health and Safety – being:
  - Healthy
  - Safe
  - Free from abuse and neglect.

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

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

You have a right to expect that your care team will work with you to identify your personal experience outcomes. This does not mean *i*Care Family Care Partnership will always cover services to help you achieve your outcomes. **The things you do for yourself and the help you get from your family, friends, and others will still be a very important part of the plan to support your outcomes**.

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

Long-Term Care Outcomes

During the assessment process, you and your care team will also identify your **long-term care outcomes**. This helps you and your team know which services will meet your long-term care needs. Long-term care outcomes are those things Partnership can help you achieve to have the kind of life you want. For example,

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

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

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

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

What should be covered in your care plan?

Your care plan will be clear about:

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

Your care team will ask you to sign your care plan showing, which shows that you participated in its development. You will get a copy of your signed plan. If you are not happy with your plan, there are grievance and appeal procedures available to you. (See Chapter 8, page 55 for more information.)

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

How does Partnership help you manage your own services?

*i*Care Family Care Partnership strives to respect the choices of our members. For example:

- Living arrangement, daily routine and support services of your choice are examples of the outcome categories Partnership supports. You will say what is important to you in these outcome areas. You will work with your care team to find reasonable ways to support your outcomes. If you do not think your care plan offers reasonable supports for your outcomes, you can file a grievance or appeal. (See page 55 for more information).

- If you ask, we will consider using a provider we do not usually use.

- For providers that come to your home or provide intimate personal care, we will—at your request—purchase services from any qualified provider you choose, including a family member. **The provider must meet our requirements and accept our rates**.

- You have a right to change to a different care team up to two times per calendar year. You do not have to say why you want a different Team. *i*Care Family Care Partnership may not always be able to meet your request or give you the specific team you want.

- You may choose to self-direct.

What are self-directed supports (SDS)?

You can choose the Self-Directed Supports (SDS) option if you want to manage some of your long-term care services. Choosing SDS means you will have more say in how and from whom you receive your long-term care services. It is an option you can use if you want to have more responsibility and be more involved in the direction of your own services.

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

Though frequently used for in-home care, SDS can also be used outside of the home for services such as transportation and personal care at your work place. You are not able to self-direct all of your services. For example, you cannot self-direct residential care services or medical care such as lab tests or x-rays. Your care team can tell you which services can be self-directed in Partnership

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

If you choose SDS, you will work with your care team to determine a budget for services based on your care plan. You will manage the purchase of services within that budget, either directly or with the help of another person you choose.

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

Chapter 3. Things to know about getting your medical care, long-term care services, 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 Partnership:

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

- "**Network providers**" are the doctors and other health care professionals, medical groups, hospitals, 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, health care services, long-term care services, supplies, and equipment our plan covers. Long-term care consists of services to meet your daily needs such as assistance with eating, bathing, using the telephone, supportive home care, home delivered meals, residential care, and case management. See Chapter 4 for a complete list of covered services.

- **"Provider Directory"** is a list of all of the MCOs contracted network providers.

How are services selected and authorized?

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

Note: If you are considering moving to an assisted living facility or nursing home, please see Chapter 5. *i*Care Family Care Partnership will only authorize residential services in certain situations.

*i*Care Family Care Partnership is responsible for supporting your outcomes, but we also have to consider **cost when planning your care and choosing providers to meet your needs.**

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

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

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

During the RAD, you and your care team will talk about the services you need. Together you will explore the options available to meet your outcomes. This includes talking about how friends, family or others can help. Many times you can achieve one or more of your outcomes without a lot of help from *i*Care Family Care Partnership because family, friends or other people are able to help you. *i*Care Family Care Partnership purchases services that your own supports cannot provide.

Our goal is to support the people in your life who are already helping you. These "natural supports" keep people that are important to you in your day-to-day life. Building on, instead of replacing, the assistance you get from your family and friends strengthens these invaluable relationships and helps *i*Care Family Care Partnership pay for services where and when they are needed.

At the end of the RAD, you and your care team will talk about how you can have more control in your life and if you are interested in directing your services. For more information about directing your services, see page 29.

Your care team will find service providers to help you. These providers must have a contract with *i*Care Family Care Partnership. See page 22 for information about using our providers.

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

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

Your care plan will be clear about:

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

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

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

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

Your services may change over time as your health and life situation change. For example, your services may decrease if your physical health improves. If your needs increase, we will make sure you get the assistance you need to remain safe, healthy and as independent as possible. One of our goals is to provide the right service, in the right amount and in the right place.

If your needs change, let your Team know. *i*Care Family Care Partnership can provide more or less services based on your changing needs. Please know we will always be there to support you.

Important rules for getting your care and services.

*i*Care Family Care Partnership will generally cover your care and services as long as:

1.) **The services support your outcomes**.

2.) **The services are the most cost-effective way to support your outcomes.**

3.) **The services are included in your care plan and approved by your Team.**

4.) **The care you receive is included in the Partnership benefit package. (This chart is in Chapter 4.)**

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

6.) **You have a network primary care provider (PCP) (**physician) **who is providing and overseeing your care**. As a member of our plan, you must choose a network PCP (for more information about this, see Chapter 3.

- In most situations, our program must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies.

- Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without getting approval from your team ahead of time.

7.) **You must receive your care from a network provider**. In *most* cases, we will not cover services you get from an out-of network provider.

Two exceptions to this rule:

- The Partnership program covers emergency care or urgently needed care that you get from an out-of-network provider.

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

How do I use the provider network?

You and your care team will select your providers from our "provider network." The list of the providers we routinely use is on our website at www.icare-wi.org. We call this the Provider Network Directory. If you want a paper copy of the Provider Network Directory instead of using the Internet, you can request a copy from your team.

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

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

After your care team approves your services, you and your Team will choose from the providers in *i*Care Family Care Partnership's Provider Directory. You usually have to receive your care from a network provider. However, we might use a provider outside of our network if we don't have one that can meet your needs. At other times we might use an outside provider if our network providers are all located too far from where you live. You must talk with your Team about using a provider outside of our network.

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

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

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

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

What is a Primary Care Provider (PCP)?

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

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

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

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

How do I choose a PCP?

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

How do I change my PCP?

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

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

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

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

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.

- Flu shots **and** pneumonia vaccinations as long as you get them from a network provider.

- **Emergency** services from network providers or from out-of-network providers.

- Urgently needed care from in-network providers or from out-of-network providers when network providers are unavailable or inaccessible, e.g., when you are temporarily outside of the plan's service area.

- Family planning services.

How to get care from specialists and other network providers

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

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

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

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

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

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 Medicaid.

The Drug List also tells you if there are any rules that restrict coverage for your drugs. The Drug List includes information for the covered drugs that our members commonly use. We may cover additional drugs that are not included on the Drug List. If one of your drugs is not on the Drug List, you should visit our website or contact Customer Service or your Team to find out if we cover it. To get the most complete and current information about which drugs are covered, you can go to our website at www.icare-wi.org or call your Team.

Getting care if you have a medical emergency

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

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

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

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.

- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Call the number on the back of your membership card.

What is covered if you have a medical emergency?

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

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

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

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

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all.

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

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

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

What is "urgently needed care?"

"Urgently needed care" is a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care. The unforeseen condition could be an unforeseen flare-up of a known condition that you have (for example, a flare-up of a chronic skin condition).

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

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

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

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

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

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

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

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

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

- If you will **no longer be a resident**, you will lose eligibility for Partnership and be disenrolled (You may have to re-apply for Partnership if you return to the service area.)

- If you will **still be considered a resident**, *i*Care Family Care Partnership will work with you to try to plan a cost-effective way to support your needs and keep you healthy and safe while you are gone.

If *i*Care Family Care Partnership believes it cannot develop a cost-effective plan that meets your needs and assures your health and safety while you are out of our service area, we can ask the State of Wisconsin Department of Health Services (DHS) to disenroll you from the program. If we ask DHS to disenroll you, you will be given the opportunity to challenge our request through the appeal process. (See Chapter 8 for more information.)

*i*Care Family Care Partnership does not pay for care if you permanently move out of the service area. **If you are planning a permanent move, contact your care team as far ahead of time as possible.** Your Team will talk with you about how a permanent move will affect your care. You can work with your Team to coordinate the transition of services to providers in your new location.

Chapter 4. The Partnership benefit package

What services are provided?

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

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

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

Please note that:

- Some members may have to pay a cost share for Medicaid eligibility. See chapter 5 for more information.

- There are rules for authorization of residential services, nursing home stays and other types of services in Partnership. *i*Care Family Care Partnership will only authorize these services in certain situations. See Chapter 3 for more information.

- Only certain services in the benefit package are eligible for self-direction in Partnership. Please ask your care team if you would like more information.

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

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

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

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

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

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

Partnership benefit package chart

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

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

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

Abdominal aortic aneurysm screening Covered when medically necessary for people at risk.	Prior authorization may be required. Contact your care team for more information.
Ambulance services The transportation necessary for emergency situations if you are suffering from an illness or injury which cannot be supplied through transportation of any other means, including your or your family's vehicle, public transportation, or a specialized medical vehicle (SMV). Services are covered: • For emergency care, when immediate medical treatment or examination is needed to deal with or guard against a worsening of the recipient's condition: o From the recipient's residence or the site of an illness or accident to a hospital, physician's office, or emergency care center; o From a nursing home to a hospital; o From a hospital to another hospital; and • For non-emergency transportation and care when authorized by a physician, physician assistant, nurse midwife or nurse practitioner by written documentation which states the specific medical problem requiring the non-emergency ambulance transport: o From a hospital or nursing home to the recipient's residence; o From a hospital to a nursing home; o From a nursing home to another nursing home, a hospital, a hospice care facility, or a dialysis center; or o From a recipient's residence or nursing home to a hospital or a physician's or dentist's office, if the transportation is to obtain a physician's or dentist's services which require special equipment for diagnosis or treatment that cannot be obtained in the nursing home or recipient's residence.	Prior authorization may be required, except in an emergency. Contact your care team for more information.
Bone mass measurement	Prior authorization

For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the services listed below are covered every 24 months or more frequently if medically necessary. These are procedures to: • Identify bone mass, • Detect bone loss, or • Determine bone quality, including a physician's interpretation of the results.	may be required. Contact your care team for more information.
Breast cancer screening (mammograms) Covered services typically include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months or as medically necessary.	Prior authorization may be required. Contact your care team for more information.
Cardiac rehabilitation services Comprehensive programs that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	Prior authorization may be required. Contact your care team for more information.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) are covered when medically necessary.	Prior authorization may be required. Contact your care team for more information.
Cervical and vaginal cancer screening Covered services typically include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age. One Pap test is covered every 12 months	Prior authorization may be required. Contact your care team for more information.
Chiropractic services Covered services typically include: • We cover only manual manipulation of the spine to correct subluxation.	Prior authorization may be required. Contact your care team for more information.
Colorectal cancer screening Screenings are administered when medically necessary. Typically, screenings are covered as follows: For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months	Prior authorization may be required. Contact your care team for more information.

• Fecal occult blood test, every 12 months For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	
Community Support Program (CSP) CSP provides non-institutional medical treatment and related care and rehabilitative services to a person with mental illness. Covered services include assessment, development of a treatment plan, treatment services, rehabilitation services, other support services and on-going monitoring and service coordination. Services must be prescribed by a physician and provided by a Medicaid-certified provider.	Prior authorization may be required. Contact your care team for more information.
Dental services Dental services covered by Wisconsin Medicaid, which includes but are not limited to: • Routine dental care, including exams, cleanings, and x-rays • Fillings • Surgery of the jaw or related structures • Setting fractures of the jaw or facial bones • Extraction of teeth • Services that would be covered when provided by a doctor	Prior authorization may be required. Contact your care team for more information.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months or more often, if medically necessary.	Prior authorization may be required. Contact your care team for more information.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services typically include: • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: Therapeutic custom-molded shoes (including inserts provided with such shoes). Coverage includes fitting.	Prior authorization may be required. Contact your care team for more information.

• Diabetes self-management training is covered under certain conditions.	
Drugs [Prescription and some over the counter (OTC)] All prescription drugs and covered over-the-counter drugs that are listed in the Plan Formulary are covered. The drug formulary contains further information about your coverage.	Prior authorization may be required. Contact your care team for more information.
Durable medical equipment and related supplies Covered items include, but are not limited to: • Wheelchairs • Crutches • Hospital beds • IV infusion pumps • Oxygen equipment • Nebulizers • Walkers	Prior authorization may be required. Contact your care team for more information.
Emergency care Emergency care is care that is needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Coverage is for care provided within the U.S. and its territories.	Prior authorization is **NOT** required in a medical emergency.
End-stage renal disease Renal dialysis and kidney transplantation services are for persons with renal impairment which requires a regular course of dialysis or kidney transplantation. Covered services typically include outpatient, inpatient and home dialysis including self-dialysis training, as well as inpatient kidney transplantation services and outpatient services for evaluation, care and follow-up of kidney transplant patients.	Prior authorization may be required. Contact your care team for more information.
Health and wellness education programs These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness, and stress management.	Prior authorization may be required. Contact your care team for more information.
Hearing services Basic hearing evaluations performed by your PCP or network provider are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. Coverage includes, but is not	Prior authorization may be required. Contact your care team for more

limited to: • Routine hearing exams • Diagnostic hearing exams • Hearing aids and batteries and repair as needed	information.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, coverage includes, but is not limited to: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	Prior authorization may be required. Contact your care team for more information.
Home care Covered services include, but are not limited to: • Personal Care services are covered by Medicaid • Skilled nursing and home health aide services • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies • Private duty nursing	Prior authorization may be required. Contact your care team for more information.
Hospice care You may elect to receive hospice care or other end of life care. You must contact your Care team so they can arrange these services. Our plan also covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	Prior authorization may be required. Contact your care team for more information.
ICF-MR Services Services in a licensed, certified intermediate care facility for persons with a developmental disability if the primary purpose of the facility is to provide health and rehabilitation services for developmentally disabled persons, the person with a developmental disability DHS 107.09(4)(g)2.b.receives active treatment and the facility meets federal and state standards for protecting and promoting the health, safety and well-being of its residents.	Prior authorization may be required. Contact your care team for more information.
IMD Services **Coverage for adults under age 21 or age 65 and above** for services in a nursing facility that has been designated by the state and federal government as an institution for mental disease (IMD) because it is primarily engaged in providing diagnosis, treatment or care of persons with mental illness. IMD services are not covered for persons between the ages of 21 and 64. If you are between the ages of 21 and 64 and are admitted to an IMD, your Medicaid enrollment will end.	Prior authorization may be required. Contact your care team for more information.
Immunizations Immunizations include, but are not limited to: • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of	Prior authorization may be required. Contact your care team for more information.

getting Hepatitis B • Other vaccines if you are at risk and meet Medicaid coverage rules	
Inpatient hospital care You must get prior authorization from your Care team for non-emergency inpatient care. If you get inpatient care at an out-of-network hospital after your emergency condition stabilizes, you are responsible for the cost. Covered services include, but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, we cover certain types of transplants. If you need a transplant, we will decide whether you are a candidate for a transplant. If we provide transplant services at a distant location (farther away than the normal community patterns of care) and we authorize the transplant at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion • Blood - including storage and administration. • Physician services	Prior authorization is required for non-emergency inpatient hospital care.
Inpatient mental health care • Covered services include mental health care services that require a hospital stay.	Prior authorization may be required. Contact your care team for more information.
Long-term care services Coverage is based on your outcomes included in your care plan. Coverage includes but is not limited to: • Adaptive aids • Adult day care services • Assistive technology/communication aids • Care/case management • Consultative clinical and therapeutic services for caregivers	Prior authorization may be required. Contact your care team for more information.

• Consumer education and training services
• Counseling and therapeutic services
• Environmental accessibility adaptations/ home modifications
• Financial management services
• Habilitation:
  o Daily living skills training
  o Day habilitation services
• Home delivered meals
• Housing counseling
• Peer recovery support services
• Personal Emergency Response Systems (PERS)
• Prevocational services
• Relocation services
• Residential Care
  o Adult family homes of 1-2 beds
  o Adult family homes of 3-4 beds
  o Community-based residential facilities (CBRF)
  o Residential care apartment complexes (RCAC)
• Respite care services
• Self-directed personal care services
• Skilled nursing services RN/LPN
• Specialized medical equipment and supplies
• Support broker
• Supported employment - Individual employment support
• Supported employment - Small group employment support services
• Supportive home care (SHC)
• Training services for unpaid caregivers
• Transportation (specialized transportation) community transportation
• Transportation (specialized transportation) – other transportation
• Vocational futures planning and support (VFPS)
An alternative service to support your outcomes may be available. Please talk to your Care team for more information.	

Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when referred by your doctor and in other circumstances when nutritional therapy is medically necessary A physician must prescribe these services.	Prior authorization may be required. Contact your care team for more information.
Nurse practitioner service Services provided by a nurse practitioner, including diagnostic, preventive, therapeutic, rehabilitative or palliative services which are delegated by a licensed physician, as well as general nursing procedures.	Prior authorization may be required. Contact your care team for more information.

Nurse-midwife services Services provided by a certified nurse-midwife which may include the care of mothers and their babies throughout the maternity cycle, including pregnancy, labor, normal childbirth and the immediate postpartum period up to six weeks after giving birth.	Prior authorization may be required. Contact your care team for more information.
Nursing Facility Services Skilled nursing, skilled rehabilitation and long-term care services prescribed by a physician and provided to an individual who lives in a certified nursing home. The costs of all routine, day-to-day health care services and materials provided to recipients by the nursing facility are covered under the daily rate, including nursing and nurse aide services, rehabilitation services, activity therapy, recreation, social services and religious services, dietary, housekeeping and laundry services, personal comfort items, medical supplies and special care supplies.	Prior authorization may be required. Contact your care team for more information.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood, including storage and administration. • Other outpatient diagnostic tests	Prior authorization may be required. Contact your care team for more information.
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, including same-day surgery • Laboratory tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain screenings and preventive services • Certain drugs and biologicals that you can't give yourself	Prior authorization may be required. Contact your care team for more information.
Outpatient mental health care Covered services include, but are not limited to: Mental health services provided by a doctor, clinical psychologist,	Prior authorization may be required. Contact your care

clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicaid certified mental health care professional as allowed under applicable state laws.	team for more information.
Outpatient rehabilitation services Covered services include, but are not limited to: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	Prior authorization may be required. Contact your care team for more information.
Outpatient substance abuse services Services are provided to address the negative symptoms from substance abuse and to restore functioning in people with substance abuse dependency or addiction when they are medically necessary.	Prior authorization may be required. Contact your care team for more information.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	Prior authorization may be required. Contact your care team for more information.
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	Prior authorization may be required. Contact your care team for more information.
Physician services, including doctor's office visits Covered services include, but are not limited to: • Medically-necessary medical or surgical services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or Network Provider if your doctor orders it to see if you need medical treatment • Telehealth office visits including consultation, diagnosis and treatment by a specialist • Second opinion by another network provider prior to surgery	Prior authorization may be required. Contact your care team for more information.
Podiatry services Covered services include, but are not limited to: • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).	Prior authorization may be required. Contact your care team for more

• Routine foot care for members with certain medical conditions affecting the lower limbs	information.
Prenatal care coordination Services are to help a pregnant woman and, when appropriate, her family, gain access to medical, social, educational and other services needed for the birth of a healthy infant to a healthy mother. May include nutrition counseling and health education. Services are available to high risk women from the beginning of the pregnancy up to the sixty-first day after delivery.	Prior authorization may be required. Contact your care team for more information.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months or more frequently if medically necessary: • Digital rectal exam • Prostate Specific Antigen (PSA) test	Prior authorization may be required. Contact your care team for more information.
Prosthetic devices and related supplies Devices (other than dental) that replace a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	Prior authorization may be required. Contact your care team for more information.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.	Prior authorization may be required. Contact your care team for more information.
Rural Health clinic services Services provided by a clinic serving a rural, under-served area. Covered services are professional services furnished by a physician, physician assistant or nurse practitioner and include incidental services and supplies, and other services.	Prior authorization may be required. Contact your care team for more information.
Services to treat kidney disease and conditions Covered services include, but are not limited to: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area). • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)	Prior authorization may be required. Contact your care team for more information.

• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	
Skilled nursing facility (SNF) care Covered services include, but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician services	Prior authorization may be required. Contact your care team for more information.
Smoking and tobacco use cessation (counseling to stop smoking) If you use tobacco, we cover counseling and assistance to quit smoking.	Prior authorization may be required. Contact your care team for more information.
Urgently needed care Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care. Coverage is for care provided within the U.S. and its territories.	Prior authorization may be required. Contact your care team for more information.
Vision care Covered services include, but are not limited to: • Eyeglasses, as needed. • Outpatient physician services for the diagnosis and treatment of diseases and conditions of the eye. • Glaucoma screening and testing as recommended by your eye care provider.	Prior authorization may be required. Contact your care team for more information.

Benefits *not* covered by the plan (exclusions)

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

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

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

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

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

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

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

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

Will I pay for any services?

You are not required to pay for any covered services in the Partnership benefit package that are identified in your care plan as necessary to support your outcomes and as long as you follow the plan's rules for getting your care. See Chapter 3 for the rules you must follow. You are responsible for paying the full cost of services that are not covered by our plan, because they:

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

If you have questions about whether we will pay for any medical care, 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 two other types of expenses you may have to pay for each month in order to remain eligible for Partnership:

- Cost share
- Room and board

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

Cost share

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

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

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

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

Room and board

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

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

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

How do I make a payment?

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

Independent Care Health Plan
Attention: Finance Department
1555 N. RiverCenter Drive, Suite 206
Milwaukee, WI 53212

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

What if I get a bill for services?

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

If we decide that the medical care 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 sending the payment and your rights to appeal that decision.

Does Partnership pay for residential services or nursing homes?

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

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

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

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

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

Even if residential care is the only option, you may not be able to stay at or move to the facility you want. That facility may not have a contract with *i*Care Family Care Partnership or may not be willing to accept the rate we pay. *i*Care Family Care Partnership cannot force providers to accept our rates.

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

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

Your care team must authorize all residential services. It is very important that you do not select a residential provider on your own. You must work with your care team on these decisions to make sure *i*Care Family Care Partnership will pay for these services.

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

How are my other insurance benefits coordinated?

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

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

It is important that you give us information about other insurance you have. **If you choose not to use your other insurance, we may refuse to pay for any services they would have covered**. Before Medicaid, including Partnership, pays for services, other insurance must be billed first. *i*Care Family Care Partnership expects members to:

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

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

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

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

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

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

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

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

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

Chapter 6. Your rights

We must honor your rights as a member of *i*Care Family Care Partnership.

1.) **We must provide information in a way that works for you**. To get information from us in a way that works for you, please contact your care team.

2.) **We must treat you with dignity, respect, and fairness at all times**. You have the right:

- To get compassionate, considerate care from *i*Care Family Care Partnership staff and providers.
- To get your care in a safe, clean environment.
- To not have to do work or perform services for *i*Care Family Care Partnership.
- To be encouraged and helped in talking to *i*Care Family Care Partnership staff about changes in policy that you think should be made or services that you think should be provided.
- To be encouraged to exercise your rights as a member of *i*Care Family Care Partnership.
- To be free from discrimination. *i*Care Family Care Partnership 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 care team is available to talk with you about issues that you feel may be abuse, neglect, or financial exploitation. They can help you with reporting or securing services for safety. You should always call 911 in an emergency.

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

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

Call your Team at 1-800-777-4376 (TTY: 1-800-947-3529) to consult with you regarding issues that you feel may constitute abuse, neglect, or financial exploitation. They will assist you with coordination of reporting or securing services for safety.

- You should always call 911 in an emergency for immediate assistance. The County Health and Human Services Department offers Adult Protective Services which are provided to people with developmental disabilities, degenerative brain disorder, serious and persistent mental illness, or other similar incapacity to keep the individual safe from abuse, neglect, financial exploitation, or misappropriation of property or prevent the individual from experiencing deterioration or from inflicting harm on himself or herself or another person.

Dane County

- ADRC of Dane County
  2865 N. Sherman Avenue
  Northside Town Center
  Madison WI 53704
  1-608-240-7400, 1-855-417-6892
  TTY: 1-608-240-7404
  www.daneadrc.org
- Kenosha County Division of Aging & Disability Services
  1-262-605-6646
  1-800-472-8008 (toll free)
  TTY: 262-605-6663
- Milwaukee County
  For people 60 years of age or over call:

Milwaukee Aging Resource Center
1-414-289-6874
1-866-229-9695 (toll free)
(TTY/TDD: 414-289-8591)

For people under 60 years of age call:
Milwaukee Disability Resource Center
1-414-289-6660
(TTY/TDD: 414-289-8559)

ADRC of Racine County
1-262-833-8777
1-866-219-1043
TTY: Wisconsin Relay 711
You may contact the numbers listed above 24 hours a day, 7 days a week.

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

As a member of *i*Care Family Care Partnership, you have the right to choose a primary care provider (PCP) in the provider network and receive the services listed in your care plan when you need them. Call *i*Care Family Care Partnership to learn which doctors are accepting new patients. If you think that you are not getting your medical care or drugs within a reasonable amount of time, talk to your care team. You may also refer to Chapter 8 which explains what you can do.

4.) **We must protect the privacy of your personal health information**. If you have questions or concerns about the privacy of your personal health information, please call your team. See Appendix 6 for *i*Care Family Care Partnership's Notice of Privacy Practices.

5.) **We must give you access to your medical records.** Ask your care team if you want a copy of your records. You have the right to ask *i*Care Family Care Partnership to change or correct your records.

6.) **We must give you information about *i*Care Family Care Partnership, our network of providers, and available services**. Please contact your Team if you want this information or go to our website (www.icare-wi.org).

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

- You have a right to know about all of your choices. This means you have the right to be told about all of the options that are available, what they cost and whether they are covered by Partnership. You can also suggest other services or supports that you think would meet your needs.

- You have the right to be told about any risks involved in your care.

- You have the right to say "no" to any recommended care or services.

- You have the right to get second medical opinions.

- You have the right to give instructions about what you want done if you are not able to make decisions for yourself. Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means if you want, you can develop an "**advance directive**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives. Contact your care team if you want to know more about advance directives.

8.) **You have the right to file a grievance or appeal if you are dissatisfied with your care or services.** Chapter 8 includes information about what you can do if you want to file a grievance or appeal.

Chapter 7. Your responsibilities

Things you need to do as a member of *i*Care Family Care Partnership are listed below. If you have any questions, please contact your care team. We're here to help.

1.) Become familiar with the services in the Partnership benefit package. This includes understanding what you need to do to get your services. See Chapters 3 and 4 for more information.

2.) Participate in the initial and ongoing development of your care plan.

3.) Participate in the Resource Allocation Decision (RAD) process to find the most cost-effective ways to meet your needs and support your outcomes. Members, families and friends share responsibility for the most cost-effective use of public tax dollars.

4.) Talk with your care team about ways your friends, family or other community and volunteer organizations may help support you or ways in which you can do more for yourself.

5.) Follow the care plan that you and your care team agreed to.-.

6.) Tell your doctors and other providers that you are in Partnership so they can work with you and your care team to be a part of your care plan.

7.) Be responsible for your actions if you refuse treatment or do not follow the instructions from your care team or providers.

8.) Use the providers that are part of *i*Care Family Care Partnership, unless you and your care team decide otherwise.

9.) Show your Partnership membership card whenever you get medical care or prescription drugs. It is important to show your membership card so that providers know to bill Partnership not you.

10.) Follow *i*Care Family Care Partnership's procedures for getting care after hours.

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

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

13.) Provide *i*Care Family Care Partnership with correct information about your health care needs, finances, and preferences and tell us as soon as possible about any changes in your status. This includes signing a "release of information" form when we need other information you do not have easily available.

14.) Treat your Team, home care staff, and providers with dignity and respect.

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

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

17.) Complete an **"Annual Renewal"** for Medicaid eligibility. The Income Maintenance agency uses the annual renewal to determine your financial eligibility. The renewal is to make sure you still meet all of the program requirements. You will be notified by mail the month before your renewal is due. This letter will tell you how to do your renewal.

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

18.) Use your private insurance benefits, when appropriate. If you have any other health insurance coverage, tell *i*Care Family Care Partnership and the Income Maintenance agency. Let your care team know right away if you enroll in **Medicare**, or think you may be eligible for Medicare.

19.) Take care of any durable medical equipment (DME), such as wheelchairs, and hospital beds provided to you by *i*Care Family Care Partnership.

20.) Report fraud or abuse on the part of providers or *i*Care Family Care Partnership employees.

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

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

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

- Misrepresenting your level of disability
- Misrepresenting income and asset level
- Misrepresenting residency
- Selling medical equipment supplied by *i*Care Family Care Partnership

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

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

23.) Call your care team for help if you have questions or concerns.

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

Chapter 8. Grievances and appeals

This Chapter includes information about grievances and appeals for members who are on Medicaid only. If you are enrolled in **Medicare**, you should refer to the Evidence of Coverage (EOC) booklet. The EOC includes information for members who have both **Medicaid** AND **Medicare**.

Introduction

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

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

For assistance with the grievance and appeal process contact iCare Family Care Partnership's Member Rights Specialist, at:

*i*Care Family Care Partnership
Member Rights Specialist
Independent Care Health Plan
1555 N. RiverCenter Dr., Suite 206
Milwaukee, WI 53212
Toll-free: 1-800-777-4376
TTY: 1-800-947-3529

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

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

Each way has different rules, procedures and deadlines.

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

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

Coordination with other insurance
If you have other insurance and want to file a grievance or appeal, you should file your grievance or appeal with the other insurance first.

When you have other insurance (like employer group health coverage), there are rules that decide whether our plan or your other insurance pays first. We are required to follow these rules to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the benefits you get from our plan with any other benefits available to you.

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

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

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

You will not get into trouble if you complain or disagree with your care team.
If you file a grievance or appeal with *i*Care Family Care Partnership, 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 *i*Care Family Care Partnership, one of our providers, or have concerns about the quality of your care or services. For example, you might want to file a grievance if:

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

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

What is the deadline to file a grievance?
You can file a grievance at any time.

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

1.) Start by filing a grievance with *i*Care Family Care Partnership.
→ See Option 1, listed below.

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

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

GRIEVANCE OPTION 1: File your grievance with *i*Care Family Care Partnership

*i*Care Family Care Partnership wants you to be happy with your care and services. Our Member Rights Specialist can work with you and your care team to try to resolve your concerns informally. A lot of the time we can take care of your concerns without going further. However, if we are unable to solve your concerns, you can file a grievance with *i*Care Family Care Partnership by calling or writing to us at:

*i*Care Family Care Partnership
Member Rights Specialist,
Independent Care Health Plan
1555 N. RiverCenter Dr., Suite 206
Milwaukee, WI 53212

Toll-free: 1-800-777-4376
TTY: 1-800-947-3529

What happens next?
If you file a grievance with *i*Care Family Care Partnership, we will send you a letter within five business days to let you know we received your grievance. Then, *i*Care Family Care Partnership staff who are not on your care team will try to help informally address your concerns or come up with a solution that satisfies both *i*Care Family Care Partnership and you. If we are unable to come up with a solution, or if you do not want to work with *i*Care Family Care Partnership 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 *i*Care Family Care Partnership representatives and at least one "consumer". The consumer is a person who also receives services from us or represents someone who does. We train this person on how to protect the privacy of others while serving on the Committee. Sometimes other people who specialize in the area of your grievance might be part of the Committee.
- We will let you know when the Committee plans to meet to review your grievance.
- The meeting is confidential. You can ask that the consumer not be on the Committee if you are concerned about privacy or have other concerns.
- You have the right to appear in person. You can bring an advocate, friend or family member, or witnesses with you.
- The Committee will give you a chance to explain your concerns. You may provide information to the Committee.
- Your care team or other *i*Care Family Care Partnership 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. You could also talk to our Member Rights Specialist or an advocate for advice on other options.

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 *i*Care Family Care Partnership. DHS is the agency that is in charge of the Partnership program. The purpose of a DHS review is to see if you and *i*Care Family Care Partnership can work out an informal solution.

Your concerns can often be resolved directly with *i*Care Family Care Partnership before asking DHS to review the situation. Using *i*Care Family Care Partnership's grievance process first is not a requirement, but it is encouraged.

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

DHS Partnership 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, that external review organization will contact you.

- MetaStar will reply in writing to let you know they received your grievance.
- They will ask you for information about your concerns. They will also contact your care team. MetaStar will try to resolve your concerns informally.
- MetaStar **will not issue a decision**. Instead, they will review your concerns and try to come up with an informal solution that is acceptable to you and iCare Family Care Partnership.
- If MetaStar tells DHS that we failed to comply with certain requirements, DHS may order iCare Family Care Partnership 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.

What if I disagree with the DHS review?
If you are not happy with the result of the DHS review, you can file a grievance with *i*Care Family Care Partnership, if you have not already done so. You could also talk to our Member Rights Specialist or an advocate for advice on other options.

Appeals

What is an appeal?
An appeal is a request for a review of a decision made by *i*Care Family Care Partnership. For example, you can file an appeal if your Team denies a service or support you requested. Other examples are decisions to reduce, suspend or end a service, or to deny payment for a service.

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

What types of issues can I appeal?
You have the right to file an appeal in the following types of situations:

1.) You can file an appeal if *i*Care Family Care Partnership:

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

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

> *Note: Partnership provides the services listed in the benefit package chart in Chapter 4. If you ask for a service that is not listed, *i*Care Family Care Partnership does not have to provide or pay for the service. We will consider your request, but if we deny it, you cannot appeal our decision. We will send you a letter to notify you that the service you requested is not in the benefit package.

2.) You can file an appeal if:

- You do not like your care plan because it:
  - Doesn't support you to live in the place where you want to live.
  - Doesn't provide enough care, treatment, or support to meet your needs and identified outcomes. (Refer to Chapter 3 for information about outcomes.)
  - Requires you to accept care, treatment or support items you don't want or you believe are unnecessarily restrictive.

- *i*Care Family Care Partnership fails to:
  - Arrange or provide services in a timely manner.
  - Meet the required timeframes to resolve your appeal.

In these situations, *i*Care Family Care Partnership will send you a notification of your appeal rights.

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

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

  If the Income Maintenance agency decides you are no longer financially eligible for Partnership, or says your cost share payment will change, the agency will send you a notice with information about your eligibility for Partnership. These notices have the

words "About Your Benefits" on the first page. The last page has information about your right to request a State Fair Hearing with the Division of Hearings and Appeals.

- If your functional eligibility for Partnership changes, you will receive a written notice.

- **Filing an appeal with the Division of Hearings and Appeals is the only way to challenge decisions related to financial and functional eligibility for Partnership**. This includes decisions about your cost share. See Chapter 5 for more information.

- **You cannot appeal a loss of financial or functional eligibility with *i*Care Family Care Partnership.**

What is the deadline to file an appeal?

- You should file your appeal as soon as possible.
- *i*Care Family Care Partnership will send you a **Notice of Action** if we:
  - Plan to stop, suspend or reduce an authorized service you are getting.
  - Deny a new service you asked for and that service is in the Partnership benefit package.
  - Won't pay for a service that is in the Partnership benefit package.

  You must file your appeal no later than 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 this notice carefully. The notice may tell you the deadline for filing your appeal. You can always call our Member Rights Specialist for assistance.

What are my options?
If you want to file an appeal, you have three options. You can:

1.) Start by filing an appeal with *i*Care Family Care Partnership.
   → See Option 1 if you want to file with *i*Care Family Care Partnership.

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 *i*Care Family Care Partnership 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 *i*Care Family Care Partnership.

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

An appeal with DHA is the final level of appeal.

Continuing Your Services During Your Appeal

If *i*Care Family Care Partnership decides to stop, suspend or reduce a service you are currently receiving, you have the right to ask *i*Care Family Care Partnership, DHS, or DHA to continue your services during your appeal.

If you want your services to continue, you must:

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

No matter which appeal option(s) you use, if you want your services to continue, you must make that request at every level of your appeal. For example, if your services were continued during an appeal with *i*Care Family Care Partnership and you lose the appeal, you must once again ask for your services to continue if you file an appeal with DHS and/or DHA.

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

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

APPEAL OPTION 1: Filing your appeal with *i*Care Family Care Partnership

To file an appeal with *i*Care Family Care Partnership you can:

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

To file an appeal with *i*Care Family Care Partnership, call:

iCare Family Care Partnership
Member Rights Specialist
1-800-777-4376
TTY Call the Wisconsin Relay System at 711

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

iCare Family Care Partnership
Member Rights Specialist
1555 N. RiverCenter Dr., Suite 206
Milwaukee, WI 53212

What happens next?
If you file an appeal with *i*Care Family Care Partnership, 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 *i*Care Family Care Partnership and you. If we are not able to come up with a solution or if you do not want to work with *i*Care Family Care Partnership staff to informally address your concerns, our Grievance and Appeals Committee will meet to review your appeal.

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

In an expedited appeal, you will get a decision on your appeal within 72 hours of your request. However, *i*Care Family Care Partnership 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.

To request an expedited appeal, contact:

iCare Family Care Partnership
Member Rights Specialist
Independent Care Health Plan
1555 N. RiverCenter Dr., Suite 206
Milwaukee, WI 53212
Toll-free: 1-800-777-4376
TTY Call the Wisconsin Relay System at 711

What if I disagree with the Grievance and Appeal Committee's decision?
If you disagree, you can request a State Fair Hearing with the Division of Hearings and Appeals (DHA) or, if you have not already done so, 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 *i*Care Family Care Partnership does not issue an appeal decision in a timely manner.

Reviews by the Department of Health Services

APPEAL OPTION 2: Asking the Department of Health Services (DHS) to review *i*Care Family Care Partnership's decision

The Wisconsin Department of Health Services (DHS) is the agency that is in charge of the Partnership program. DHS works with an outside organization called MetaStar to review decisions made by *i*Care Family Care Partnership. 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 *i*Care Family Care Partnership.

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

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

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

What is the deadline to ask for a DHS review?
You can ask DHS to review *i*Care Family Care Partnership's decision before or instead of filing an appeal with iCare Family Care Partnership or DHA.

You should ask DHS to review *i*Care Family Care Partnership's decision as soon as possible. You must ask for a DHS review within 45 days after you receive a Notice of Action or decision letter from *i*Care Family Care Partnership. (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 request to have your services continue during the review if you request the review **on or before** the date *i*Care Family Care Partnership plans to stop, suspend or reduce your services.

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 *i*Care Family Care Partnership's decision. They will also contact your Team. 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, you can file an appeal with *i*Care Family Care Partnership, if you haven't already done so 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 *i*Care Family Care Partnership 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 *i*Care Family Care Partnership. 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 *i*Care Family Care Partnership or ask for a Department of Health Services review. However, if you request a State Fair Hearing, the Department of Health Services will automatically review your appeal.

How do I request a State Fair Hearing?
To ask for a State Fair Hearing, you can either:

- **Send a request form**. A copy of the form you can use is in Appendix 5. You can also get a copy from *i*Care Family Care Partnership's Member Rights Specialist or from one of the advocacy organizations listed in this handbook. Or, go to the Web to download the form at www.dhs.wisconsin.gov/forms/f0/f00236.doc.
- **Mail a letter**. Include your name and contact information and explain what you are appealing. If you received a Notice of Action or other notification of your appeal rights, it's a good idea to include a copy of that notice with your request for a State Fair Hearing. Do not send your original copy.

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

To request a State Fair Hearing

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

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

What is the deadline to file an appeal with DHA?
You should file your appeal as soon as possible. You must file your appeal within 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 *i*Care Family Care Partnership 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.

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

What happens next?

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

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

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

Who can help me with my grievance or appeal?

You can contact *i*Care Family Care Partnership's Member Rights Specialist any time you need help with a grievance or appeal, or have questions about your rights. Advocates are also available to answer questions about the grievance and appeal processes. An advocate can also tell you more about your rights and help make sure *i*Care Family Care Partnership is supporting your needs and outcomes. You can ask anyone you want to act as an advocate for you, including family members, friends, an attorney, or any other person willing to help.

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

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

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

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

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

Disability Rights Wisconsin
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 *i*Care Family Care Partnership

You can choose to end your membership in *i*Care Family Care Partnership at any time. We cannot advise or encourage you to disenroll from Partnership due to your situation or condition. However, there are limited situations when your membership will end even if that wasn't your choice. For example, your membership will end if you lose eligibility for Medicaid.

You must continue to get your care through *i*Care Family Care Partnership until your membership ends. Your membership could end because you are no longer eligible, or because you have decided to get your health care, long-term care and prescription drugs outside of the Partnership program. This would include a decision to enroll in a different program or a different Managed Care Organization, if available.

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

To end your membership, contact the Aging and Disability Resource Center (ADRC) in your area (see Chapter 1 for ADRC contact information). The ADRC can also answer any questions you have about ending your membership. If you decide to disenroll, you should also notify your care team.

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

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

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

- You are admitted to an Institute for Mental Disease (IMD) and lose Medicaid eligibility.

- You stop accepting services for more than 30 days, and we don't know why. *i*Care Family Care Partnership will send a certified letter to your last known address. If you do not respond, we will report this to the Department of Health Services. The Department of Health Services will determine if your membership should end.

- You refuse to participate in care planning and we cannot ensure your health and safety. In this situation, we will work with the Department of Health Services to determine if your membership should end.

- You intentionally give us incorrect information that affects your eligibility for the program.

- You continuously behave in a way that is disruptive or unsafe to staff, providers or other members. This makes it difficult for us to provide care for you and other members. Your membership cannot be ended for this reason unless we first get permission from the Department of Health Services.

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

You have the right to file an appeal if you are disenrolled from Partnership or your membership in *i*Care Family Care Partnership ends. You will get a notice from the Income Maintenance agency that tells you the reason for ending your membership. This notice will have the words "About Your Benefits" on the first page. The notice will explain how you can file an appeal. See Chapter 8 for information.

APPENDICES

1. Definitions of important words

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Division of Hearings and Appeals (DHA) – The State of Wisconsin agency that hears Medicaid appeals for Partnership. 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 Partnership is voluntary. To enroll, individuals should contact their local Aging and Disability Resource Center (ADRC). The ADRC determines whether an individual is functionally eligible for Partnership. The Income Maintenance agency determines whether an individual is financially eligible for Medicaid and Partnership. If the individual is eligible and wants to enroll in Partnership, he or she must complete and sign an enrollment form.

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

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

Family Care Partnership Program – See "Partnership"

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MetaStar – The agency that the Wisconsin Department of Health Services (DHS) works with to review requests of grievances 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 Partnership. See Chapter 8 for more information about appeals.

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

Ombudsman – A person who investigates reported concerns and helps members resolve issues. Disability Rights Wisconsin provides ombudsman services to potential and current Partnership members under age 60. The Board on Aging and Long Term Care provides ombudsman services to potential and current members age 60 and older. Contact information for these agencies is on pages 7-8.

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

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

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

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

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

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

Service Area – The geographic area where a member must reside in order to enroll and remain enrolled in [Insert Plan's Name} Partnership. See Chapter 2 for a list of the iCare Family Care Partnership service area.

State Fair Hearing – A hearing held by an Administrative Law Judge who works for the Wisconsin Division of Hearing and Appeals. Members may file a request for a State Fair Hearing when they want to appeal a decision made by their Team. 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.

2. Home and Community-Based Waiver Service Definitions

Full definitions available upon request

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

Daily Living Skills Training teaches members and their natural supports the skills involved in performing activities of daily living, including skills to increase the member's independence and participation in community life. Examples include teaching money management, home care maintenance, food preparation, mobility training, self-care skills and the skills necessary for accessing and using community resources.
Day Services is the provision of regularly scheduled activities in a non-residential setting (day center) to enhance social development and to develop skills in performing activities of daily living and community living.
Financial Management Services assist members and their families to manage service dollars or manage their personal finances. This service includes a person or agency paying service providers after the member authorizes payment for services included in the member's self-directed support plan. Fiscal Management Services also includes helping members with budgeting personal funds to ensure resources are available for housing and other essential costs.
Home Delivered Meals (sometimes called "meals on wheels") include the costs associated with the purchase and planning of food, supplies, equipment, labor and transportation to deliver one or two meals a day to members who are unable to prepare or obtain nourishing meals without assistance.
Home Modifications are the provision of services and items to assess the need for, arrange for and provide modifications or improvements to a member's living quarters in order to provide accessibility or increase safety. Home modifications may include materials and services such as ramps, stair lifts, wheelchair lifts, kitchen/bathroom modifications, specialized accessibility/safety adaptations and voice-activated, light activated, motion activated and electronic devices that increase the member's self-reliance and capacity to function independently.
Housing Counseling is a service that helps members to obtain housing in the community, where ownership or rental of housing is separate from service provision. Housing counseling includes exploring home ownership and rental options, identifying financial resources, identifying preferences of location and type of housing, identifying accessibility and modification needs and locating available housing.
Personal Emergency Response System is a service that provides a direct communications link (by phone or other electronic system) between someone living in the community and health professionals to obtain immediate assistance in the event of a physical, emotional or environmental emergency.
Prevocational Services involve learning and work experiences where a member can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated, community settings. These services develop and teach general skills which include the ability to communicate effectively with supervisors, co-workers and customers, generally accepted community workplace conduct and dress, ability to follow directions, ability to attend to tasks, workplace problem solving skills, general workplace safety and mobility training. Prevocational services are designed to create a path to integrated community-based employment for which a person is paid at or above the minimum wage, but not less than the usual wage and level of benefits paid for the same or similar work performed by people without disabilities.

Relocation Services are services and items a member would need in order to move from an institution or a family home to an independent living arrangement in the community. Relocation services may include payment for moving the member's personal belongings, payment for general cleaning and household organization services, payment of a security deposit, payment of utility connection costs and telephone installation charges, the purchase of necessary furniture, telephones, cooking/serving utensils, basic cleaning equipment, household supplies, bathroom and bedroom furnishings and kitchen appliances.
Residential Care: 1-2 Bed Adult Family Home is a place in which the operator provides care, treatment, support, or services above the level of room and board for up to two adults. Services typically include supportive home care, personal care and supervision. Services may also include transportation and recreational/social activities, behavior and social support and daily living skills training.
Residential Care: 3-4 Bed Adult Family Home is a place where 3-4 adults who are not related to the licensee reside and receive care, treatment or services above the level of room and board, and may include up to seven hours per week of nursing care per resident. Services typically include supportive home care, personal care and supervision. Services may also include behavior and social support, daily living skills training and transportation.
Residential Care: Community-Based Residential Facility (CBRF) is a homelike setting where five or more adults who are not related to the operator or administrator reside and receive care, treatment, support, supervision, training, transportation, and up to three hours per week of nursing care per resident.
Residential Care: Residential Care Apartment Complex (RCAC) is a homelike, community-based setting where five or more adults reside in their own living units that are separate and distinct from each other. Services include supportive services (laundry, house cleaning), personal care, nursing services (wound care, medication management) and assistance in the event of an emergency.
Respite Care Services are services provided on a short-term basis to relieve the member's family or other primary caregiver(s) from daily stress and care demands. Respite care may be provided in the member's home, a residential facility, a hospital or a nursing home.
Self-Directed Personal Care Services are services to assist members with activities of daily living and housekeeping services members need to live in the community. Activities of daily living include help with bathing, eating, dressing, managing medications, oral, hair and skin care, meal preparation, bill paying, mobility, toileting, transferring and using transportation. The member selects an individual or agency to provide his or her services, pursuant to a physician's order and following his or her member-centered plan.
Skilled Nursing are medically necessary skilled nursing services that may only be provided by an advanced practice nurse, a registered nurse (RN) or a licensed practical nurse (LPN) working under the supervision of a registered nurse. Skilled nursing includes observation and recording of symptoms and reactions, general nursing procedures and techniques, and may include periodic assessment of the member's medical condition and ongoing monitoring of a member's complex or fragile medical condition.

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

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

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

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

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

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

Transportation (specialized transportation) – Community and Other Transportation

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

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

3. *i*Care Family Care Partnership Sample Notice of Action

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Notice of Denial of Medical Coverage
{Replace *Denial of Medical Coverage* with *Denial of Payment*, if applicable**}**

Date: Date Denial Mailed
Service Subject to Notice: Insert Service in Question
Effective Date of Intended Action: Enter Date
Name: Enter Name
Address: Enter Street Address
Enter City, State, and Zip Code

Member MA or MCI number: Enter Number
Date of Service: Enter Date
Provider Name: (optional) Enter Provider Name

Your request was denied
We've Insert appropriate term the medical services/items listed below requested by you, your doctor or provider:

Insert service in question

Why did we deny your request?
We Insert appropriate term the medical services/items listed above because:

Click here to enter text, include rationale and alternatives

This decision is based on the MCO contract with Department of Health Services approved by the Centers for Medicare & Medicaid Services under s.1932(a) of the Social Security Act [42 USC 1396u–2] and under 42 CFR 438.6(a).

You have the right to appeal our decision
You have the right to ask Plan Name to review our decision by asking us for an appeal. For a Medicaid covered service or support *you can request a State Fair Hearing. You can ask for a State Fair Hearing instead of or after asking Plan Name for an appeal.* If you choose a State Fair Hearing first, you cannot go back and take the matter through Plan Name Appeals process. If you are considering an appeal, please contact a Member Rights Specialist for help.

Appeal: Ask Plan Name for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. **IMPORTANT!** If you are appealing a Medicaid covered service, you must appeal within **45 days** of the date of this notice.

State Fair Hearing: *Ask for a State Fair Hearing within 45 days of the date of this notice. You have up to (0) days if you have a good reason for being late.*

If we're stopping or reducing a service, you can keep getting the service while your case is being reviewed. ***If you want the service to continue, you must ask for an appeal or a State Fair Hearing*** on or before *the effective date of this notice or before the service is stopped or reduced, whichever is later. Your provider must agree that you should continue getting the service. If you lose your State Fair Hearing appeal, you may have to pay for these services.*

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: Click here to enter phone number(s) to learn how to name your representative. TTY users call: Click here to enter TTY number. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us.

Important Information About Your Appeal Rights

There are 2 kinds of appeals

Standard Appeal – We'll give you a written decision on a standard appeal within **30 days** after we get your appeal. If you are appealing a Medicaid covered service, we'll give you a written decision within 20 business days after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 days**.

Fast Appeal – We'll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision.

We'll automatically give you a fast appeal if a doctor asks for one for you or supports your request. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 days.

How to ask for an appeal with Plan Name

Step 1: You, your representative, your doctor or provider must ask us for an Choose an item. Your request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

[Insert, if applicable: *You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.*]

Step 2: Mail, fax, or deliver your appeal. Choose an item.

For a Standard Appeal: Address: Click here to enter text.
Phone: Click here to enter phone number Fax: Click here to enter fax.

If you ask for a standard appeal by phone, we will send you a letter confirming what you told us.

For a Fast Appeal: Phone: Click here to enter phone number. Fax: Click here to enter fax number.

What happens next?
If you ask for an appeal and we continue to deny your request for Choose One a service, we'll send you a written decision and automatically send your case to an independent reviewer. **If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.**

If you are appealing a Medicaid covered service or support, we will not automatically send your case to an independent reviewer. However, you can choose to start your appeal with Plan Name or a State Fair Hearing. If you choose to start with a State Fair Hearing, you cannot go back and take the matter through Plan Name's Grievance and Appeals process.

Department of Health Services Review. If you are appealing a Medicaid covered service, you may choose to have this decision reviewed by MetaStar, the Department of Health Services' external quality review organization. MetaStar will try to resolve your concerns informally. You can request to have your services continued during the review, if you request the review ***on or before*** **the effective date of the intended action**. If you request a state fair hearing, MetaStar will automatically review your appeal. *Please note that MetaStar cannot require Plan Name change its decision.*

To request that MetaStar review your case immediately or to learn more about a MetaStar review, call 1-888-203-8338. You may also request a MetaStar review by mail, fax, or email:

By Mail: DHS Partnership Grievances
C/O MetaStar
2909 Landmark Place
Madison, WI 53713
By Fax : (608) 274-8340
By Email: dhsfamcare@wisconsin.gov

Copies of Your Records. You or your legal representative have a right to a free copy of your records that are related to your appeal including but not limited to medical records. To request copies contact the Member Rights Specialist at Specialist Phone Number.

How to ask for a Medicaid State Fair Hearing

You have the right to ask for a State Fair Hearing without asking ***Plan Name*** *to review our decision first.*

Step 1: *You or your representative must ask for a State Fair Hearing (in writing) within 45 days of the date of this notice. You have up to (0) days if you have a good reason for your request being late.*

Your written request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

Step 2: *Send your request to:*
Partnership Request for Fair Hearing,
c/o Wisconsin Division of Hearings and Appeals,
PO Box 7875, Madison, WI 53707-7875,
or fax it to 608-264-9885.

What happens next?
The State will hold a hearing. You may attend the hearing in person or by phone. You'll be asked to tell the State why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You'll get a written decision within 90 days. The written decision will explain if you have additional appeal rights.

[Insert, if applicable: A copy of this notice has been sent to: Click here to enter text.]

Get help & more information
Plan Name Toll Free: Toll Free Number TTY users call: TTY Number
Insert plan hours of operation
1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
Medicare Rights Center: 1-888-HMO-9050
Elder Care Locator: 1-800-677-1116

- The Plan Name **Member Rights Specialist** can inform you of your rights, attempt to informally resolve your concern, and assist you with filing an appeal. He or she ***cannot*** represent you at a meeting with Plan Name Grievance & Appeal Committee or at a State fair hearing. To contact a Plan Name Member Rights Specialist, call Specialist phone number

- The following independent ombudsman agencies advocate for Partnership members. They may be able to provide you with free assistance.
- ***For members age 18 to 59:***

Disability Rights Wisconsin Family Care and IRIS Ombudsman Program
Call the office closest to you:
Toll Free Madison: (800) 928-8778
Milwaukee: (800) 708-3034
Rice Lake: (877) 338-3724
TTY (888) 758-6049

For members age 60 and older:
Wisconsin Board on Aging and Long Term Care
Toll Free (800) 815-0015

Interpreter and Translation Services. Interpreter and translation services are available free of charge. If you need this form in another language, Braille or large print, please call Plan Name toll-free at Toll Free Number. TTY users should call TTY Number.

4. iCare Family Care Partnership appeal request form

DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Long Term Care ss 46.287(2)(c)
F-00237 (04/2014)

APPEAL REQUEST – INDEPENDENT CARE HEALTH PLAN

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

Name – Member	Today's Date

Mailing Address

City	State	Zip Code
	WI	

☐ Check this box if you would like to appeal Independent Care Health Plan's decision by requesting a meeting with the Independent Care Health Plan Grievance and Appeal Committee.

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

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

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

☐ Check this box if you would like to receive records from Independent Care Health Plan that apply to your appeal.

If you need this form in another language, Braille or large print, please call Independent Care Health Plan at 414-231-1076 or toll-free 800-777-4376, Monday thru Friday, 8 a.m. to 4:30 p.m. TTY users should call 800-947-3526. Interpreter and translation services are available free of charge.

SIGNATURE – Member Date Signed

Mail or fax this form to:

Independent Care Health Plan
1555 N River Center Dr, Suite 206
Milwaukee WI 53212-3958
Fax: 414-231-1090

To start your appeal as soon as possible, you can call Independent Care Health Plan at 414-231-1076 before mailing this form.

- If appealing a **Medicaid** covered service, your appeal must be postmarked or faxed within **45 days** of the date of the Notice of Action.
- If appealing a **Medicare** covered service, your appeal must be postmarked or faxed within **60 days** of the date of the Notice of Action.

5. State Fair Hearing request form

DEPARTMENT OF HEALTH SERVICES **STATE OF WISCONSIN**
Division of Long Term Care ss 46.287(2)(c)
F-00236 (03/2012)

REQUEST FOR A STATE FAIR HEARING

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

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

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

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

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

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

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

_____ _____
SIGNATURE – Member Date Signed

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

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

6. Notice of privacy practices

Español - Si necesita ayuda para traducir o entender este texto, por favor llame al 414-223-4847.

Hmoob - Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau 414-223-4847.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND SHARED. IT WILL ALSO TELL YOU HOW YOU CAN GET THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The law says we must keep your health information private. This Notice will tell you what information we collect. It also will tell you how we use it. You can call our **Member Services Department at 414 223-4847** if you have questions about this Notice. If you do not have any questions, you do not have to do anything.

How We May Use or Share Your Health Information
There are instances when the law allows us to use and share your health information without your written consent. The following is a list of those times.

1. **For Treatment**
   We may use your health information to provide you with health care treatment or services. We also use it to arrange social services you may need. For example:
   - Your care coordinator or case manager may share information they got from you or your healthcare providers with others involved in your treatment, including other health care providers. The information they share will be used to help you get the services you may need.
   - Your health information may be shared with social service agencies. This information will be used to help you get the services you may need.
   - We may share your Medicaid ID number with transport companies if we need to get you a ride to your health care appointments.
   - We may have to share your health information with health education programs you need or are participating in.

2. **For Payment Functions**
   We may use your health information to pay for services you had or to manage benefits. For example:
   - Your provider will submit a bill to *i*Care for payment of services you received. This bill shows your name and Medical Assistance number. It may give the services you received and what was wrong with you.
   - Information about you may be shared with the State of Wisconsin. It may be used to see if you can join *i*Care. It may be used to see if you can get Medicaid or other program benefits.

3. For Health Care Operations

Your health information may be used or shared to carry out benefit or service related activities. This means that your health information may be shared with our staff or others to:

- Look at the quality of care you had;
- Learn how to improve our services;
- Provide case management services;
- Provide care coordination services;
- Resolve your complaint or grievance;
- See how our employees are doing in providing you with service.

4. For Appointments and Treatment Choices

Your health information may be used or shared to remind you of appointments. It may also be used to tell you about different ways you can be treated. Or, it can be used to tell you about other health and services that you might like.

5. To Family and Personal Representatives

We may share your health information with a relative, close personal friend or other person who is involved in your care.

6. Business Associates

We work with others outside of *i*Care to provide certain services. These others are called business associates. Your health information may be disclosed to them so they can do the job we ask them to do. They must also protect your health care information. For example, we work with a company to pay your claims.

7. As Required by Law

Your health information may be used or shared as required by any federal, state or local law. This means that we may share information when:

- Requested by a court for legal reasons;
- Needed by public health and Food and Drug Administration authorities;
- Needed for administrative actions, such as Fair Hearings

8. Health Oversight Actions

Your health information may be given to state or federal agencies to do reviews or to check on our licensure. This helps the government to see what we are doing to meet civil rights or other laws.

9. For Law Enforcement

Your health information may be shared if the law says we must. We will also share it if there is a valid court order to help identify or find suspects, persons hiding from the law or missing persons.

10. For Serious Threats to Health or Safety

Your health information may be shared in order to prevent or lessen a serious threat to your health or safety. It may also be shared if there is a threat to the health and safety of the public.

11. For the Country's Safety
Your health information may be shared for the safety of the country. It may also be shared for government benefit reasons.

12. To Jails or Prisons
We may need to share your health information with jail or prison staff if you become an inmate.

13. For Research
Your health information may be used for research needs, but only after steps are taken to protect your privacy. We will ask for your permission if the researcher asks for information that says who you are or if the researcher will be giving you care.

14. For Worker's Compensation or Social Security Reviews
Your health information may be shared as needed to follow the laws related to worker's compensation. It may also be shared to help decide if you can get social security benefits.

15. Coroners, Medical Examiners or Funeral Directors
Health information may be shared to help confirm the identity of a deceased person.

16. Organ Donations
Information may be given to agencies if you need an organ transplant. It may also be shared with agencies if you want to donate an organ.

17. Other Uses
At times we may need to use or share your health information for other reasons. Other uses and disclosures not described in this Notice will be done only with your consent. You may cancel your consent, but it must be done in writing. When you cancel your consent we will no longer be able to use or share your health information as stated in the consent. But, we will not be able to take back any use or sharing that was already made with your consent. You will be told as soon as possible after the information is shared.

18. Uses That Require an Authorization by You
There are certain uses and disclosures that require your written consent. These uses include:

- Use or disclosure of psychotherapy notes: ***unless*** the notes are being used by the person who created the notes to help treat you, being used by the provider of your treatment to help train mental health providers in better treatment, or being used by the provider to defend themselves in a lawsuit brought against them by you.
- Use for Marketing: unless the communication is in the form of either a face to face communication with you, or a promotional gift to you of small value.
- Sale of protected health information: *i*Care does not sell any member's protected health information.

Your Health Information Rights
All questions about your rights must be in writing. You can send your written request to Member Advocate/Member Rights Specialist, Independent Care Health Plan, 1555 N. RiverCenter Drive, Suite 206, Milwaukee, WI. 53212. You can also call our Member Advocate/Member Rights Specialist to help make your request at 414-223-4847.

1. *Request Limits:* You can ask us to limit some uses and sharing of your health information. But the law does not say we must agree to these limits, unless your request is to not disclose protected health information about a health care service you received that was paid for in full by you or by another person (other than an insurance company like *i*Care) on your behalf .

2. *Request That You Be Informed About Your Health in a Way or at a Location That Will Keep Your Information Private:* Your request will be evaluated. We will let you know if it can be done.

3. *Inspect and Copy:* You have the right to view and copy certain health information about you. In some cases you may request a review if you are denied access to these records. You may be charged a reasonable fee if you want extra copies of records.

4. *Request a Change:* You have the right to request us to change your health information that you believe is not correct or complete. You must give a reason for your request. We do not have to make the change. If we say no to your request, we will give you information about why we will not make the change and how you can disagree with it.

5. *Report of When Your Information Was Shared:* You can ask for a list of when and why we shared your health information. This list will only be for reasons ***other than*** treatment, payment or health care operations. Your request should specify a time period of up to six years. It may not include dates before April 14, 2003.

6. *Paper Copy:* You can ask to get a paper copy of this Notice at any time. Send a written request to our Privacy Officer at 1555 N. RiverCenter Dr. Suite 206, Milwaukee, WI 53212. You may also get a copy of this Notice at our website: www.*i*Care-wi.org.

Changes to this Notice of Privacy Practices

We have the right to change the terms of this Notice at any time. The new Notice will be effective for all health information we have. Any changes to the Notice will be mailed to you at the address you gave us. It will also be posted to our website. Until changes are made to the Notice, we will comply with this version.

Complaints

You may complain to us if you believe your privacy rights have been violated. Complaints must be in writing. If you need help filing a complaint, contact our Member Advocate/Member Rights Specialist at 414 223-4847. You will not be treated any differently if you file a complaint.
You may also file a complaint with the Secretary of the Department of Health and Human Services by writing to Office of Civil Rights, Department of Health and Human Services, 200 Independence Ave. SW, Washington, D.C. 20201.

Our Responsibilities

We must:

- Keep your protected health information private.
- Tell you about our legal duties and privacy practices about your health information.
- Stand by the terms of this notice.
- Tell you if we cannot agree to a limit on how you want your information used or disclosed.
- Notify you if there has been a breach of your protected health information.

- Meet reasonable requests you may make to send health information by other means or to other locations

Contact Information

If you have any questions or complaints, please contact us at:

414-223-4847
Toll Free 1-800-777-4376
TTY 1-800-947-3529 or 7-1-1
Voice 1-800-947-6444 or 7-1-1

Effective Date of This Notice

May 22, 2013