Family Care Partnership Member Handbook

IMPORTANT: If you are covered by **Medicare**, you should refer to the Evidence of Coverage for information about your benefits.

Please ask your Care Team for a copy of the Evidence of Coverage or view on our website www.iCareHealthPlan.org/memdocs

iCare
INDEPENDENT CARE HEALTH PLAN
*i*Care is a wholly-owned subsidiary of Humana

For help or information, please call Customer Service or visit our web site at www.iCareHealthPlan.org.

Call toll-free at 1-800-777-4376, 24 hours a day, 7 days a week.
TTY users call the Wisconsin Relay System at 711.

Independent Care Health Plan
1555 N. RiverCenter Dr., Ste. 206
Milwaukee, WI 53212

Our office hours are Monday through Friday, 8:30 a.m. to 5:00 p.m.

Template provided by the Wisconsin Department of Health Services. (01/2023)

IC458 - DHS approved: 10/14/2024

Last updated 08/22/2024

Notice of Non-Discrimination

Independent Care Health Plan complies with applicable Federal civil rights laws and does not discriminate or exclude people because of their race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services. Independent Care Health Plan:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services 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 assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids, or language assistance services contact **1-800-777-4376 (TTY: 1-800-947-3529)**, 24 hours a day, 7 days a week (Office hours: Monday – Friday, 8:30 a.m. – 5:00 p.m.). If you believe that Independent Care Health Plan has not provided these services or discriminated on the basis of race, color, religion, gender, gender identity, sex, sexual orientation, age, disability, national origin, military status, veteran status, genetic information, ancestry, ethnicity, marital status, language, health status, or need for health services, you can file a grievance in person or by mail, fax, or email with Independent Care Health Plan's Grievance and Appeal Coordinator at 1555 North RiverCenter Drive, Suite 206, Milwaukee, WI 53212, **1-800-777-4376 x1076 (TTY: 1-800-947-3529)**, fax: 414-918-7598, or advocate@icarehealthplan.org. If you need help filing a grievance, Independent Care Health Plan's Grievance and Appeal Coordinator can help you.

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

- U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building Washington, D.C. 20201. **800-368-1019**, **800-537-7697 (TDD)**.

If you need any documents or communications translated, please call Customer Service at 1-800-777-4376 (TTY: 711).

Fulfillment materials and time frames:

- Large Print: Two (2) weeks
- Braille and Foreign Language: Varies by request

Auxiliary aids and services, free of charge, are available to you.
1-800-777-4376 (TTY: 1-800-947-3529), available 24 hours a day, 7 days a week (Standard office hours: Monday – Friday, 8:30 a.m. – 5:00 p.m. Central time).

Independent Care Health Plan (*i*Care), a wholly-owned subsidiary of Humana, complies with Section 1557 by providing free auxiliary aids and services to people with disabilities when auxiliary aids and services are necessary to ensure an equal opportunity to participate. Services include qualified sign language interpreters, video remote interpretation, and written information in other formats.

English: Call the number above to receive free language assistance services.

Español (Spanish): Llame al número que se indica arriba para recibir servicios gratuitos de asistencia lingüística.

Hmoob (Hmong) Hu rau tus xov tooj saum toj sauv kom tau txais kev pab txhais lus dawb.

မြန်မာနိုင်ငံ (Burmese) အခမဲ့ ဘာသာစကား အကူအညီ ဝန်ဆောင်မှုများ ရယူရန် အထက်ပါ ဖုန်းနံပါတ်ကို ခေါ်ဆိုပါ။

簡體中文 (Simplified): 您可以拨打上面的电话号码以获得免费的语言协助服务。

Soomaali (Somali): Wac lambarka kore si aad u hesho adeegyada caawimaada luuqada oo bilaash ah.

ພາສາລາວ (Lao): ໂທຫາເບີໂທລະສັບຂ້າງເທິງ ເພື່ອຮັບບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາຟຣີ.

العربية (Arabic): اتصل برقم الهاتف أعلاه للحصول على خدمات المساعدة اللغوية المجانية.

Tiếng Việt (Vietnamese) Gọi số điện thoại ở trên để nhận các dịch vụ hỗ trợ ngôn ngữ miễn phí.

Русский (Russian): Позвоните по вышеуказанному номеру, чтобы получить бесплатную языковую поддержку.

Srpsko-hrvatski (Serbo-Croatian) Nazovite gore navedeni broj ako želite besplatne usluge jezične pomoći.

This notice is available at **icarehealthplan.org**

WIHMEKWEN

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-777-4376. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-777-4376. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Hmong: Peb muaj kev pab txhais lus dawb los teb cov lus nug uas koj muaj txog peb txoj kev npaj khomob lossis tshuaj. Yog xav tau ib tug neeg txhais lus, hu rau peb ntawm 1-800-777-4376. Ib tug neeg uas hais lus Hmong lwm yam lus tuaj yeem pab koj. Qhov no yog ib qho kev pab dawb.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-777-4376。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-777-4376。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-777-4376. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-777-4376. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-777-4376 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-777-4376. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Chapter 1. Important Phone Numbers and Resources

Corporate Office

Independent Care Health Plan (*i*Care)
1555 North RiverCenter Drive
Suite 206
Milwaukee, Wisconsin 53212

How to Contact *i*Care Customer Service

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

METHOD	CUSTOMER SERVICE
CALL	1-800-777-4376 Calls to this number are free. Our office hours are Monday through Friday, 8:30 a.m. to 5:00 p.m. For help after hours, on weekends, and holidays, call 1-800-777-4376. Calls to this number are free. Customer Service also has free language interpreter services available for non-English speakers.
TTY	Call the Wisconsin Relay System at 711. Calls to this number are free.
FAX	414-231-1092
WRITE	Independent Care Health Plan 1555 North RiverCenter Drive Suite 206 Milwaukee, Wisconsin 53212
EMAIL	Info@iCareHealthPlan.org
WEBSITE	www.iCareHealthPlan.org

If you are experiencing an 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.

METHOD	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 8:30 a.m. to 5:00 p.m., Monday through Friday. For help after hours, on weekends, and holidays, call 1-800-777-4376. Calls to this number are free. Customer Service also has free language interpreter services available for non-English speakers.
TTY	Call the Wisconsin Relay System at 711. Calls to this number are free.
FAX	414-231-1092
WRITE	Independent Care Health Plan 1555 North RiverCenter Drive, Suite 206 Milwaukee, Wisconsin 53212
EMAIL	Info@iCareHealthPlan.org
WEBSITE	www.iCareHealthPlan.org

How to contact ForwardHealth when you are asking for a coverage decision for prescription drugs if you do not have Medicare.

If you do not have Medicare, you will get your prescription drugs from Wisconsin Medicaid with your ForwardHealth card.

METHOD	FORWARDHEALTH MEMBER SERVICES
CALL	1-800-362-3002 Free language interpreter services are available for non-English speakers.
WEBSITE	www.dhs.wisconsin.gov/forwardhealth/resources.htm

How to contact us 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. For more information on making a complaint about your medical care or long-term care services, see Chapter 8.

METHOD	COMPLAINTS ABOUT MEDICAL CARE OR LONG-TERM CARE SERVICES
CALL	1-800-777-4376 Calls to this number are free. You can call 8:30 a.m. to 5:00 p.m., Monday through Friday. For help after hours, on weekends, and holidays, call 1-800-777-4376. Calls to this number are free. Customer Service also has free language interpreter services available for non-English speakers.
TTY	Call the Wisconsin Relay System at 711. Calls to this number are free.
FAX	414-231-1092
WRITE	Independent Care Health Plan 1555 North RiverCenter Drive, Suite 206 Milwaukee, Wisconsin 53212
EMAIL	Info@iCareHealthPlan.org
WEBSITE	www.iCareHealthPlan.org

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

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

METHOD	APPEALS FOR MEDICAL CARE OR LONG-TERM CARE SERVICES
CALL	1-800-777-4376 Calls to this number are free. You can call 8:30 a.m. to 5:00 p.m., Monday through Friday. For help after hours, on weekends, and holidays call 1-800-777-4376. Calls to this number are free. Customer Service also has free language interpreter services available for non-English speakers.
TTY	Call the Wisconsin Relay System at 711. Calls to this number are free.
FAX	414-231-1092
WRITE	Independent Care Health Plan 1555 North RiverCenter Drive, Suite 206 Milwaukee, Wisconsin 53212
EMAIL	Info@iCareHealthPlan.org
WEBSITE	www.iCareHealthPlan.org

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

METHOD	PAYMENT REQUESTS
CALL	1-800-777-4376 Calls to this number are free. You can call from 8:30 a.m. to 5:00 p.m., Monday through Friday. For help after hours, on weekends, and holidays, call 1-800-777-4376. Calls to this number are free. Customer Service also has free language interpreter services available for non-English speakers.
TTY	Call the Wisconsin Relay System at 711. Calls to this number are free.
FAX	414-231-1092
WRITE	Independent Care Health Plan 1555 North RiverCenter Drive, Suite 206 Milwaukee, Wisconsin 53212
EMAIL	Info@iCareHealthPlan.org
WEBSITE	www.iCareHealthPlan.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.

METHOD	SOCIAL SECURITY ADMINISTRATION
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 a.m. to 7:00 p.m., CST, 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 Calls to this number are free.
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 help you get from Medicaid, contact ForwardHealth Member Services.

METHOD	FORWARDHEALTH MEMBER SERVICES
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 Member Services at 1-800-362-3002 to:

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

You can contact your Local County or Tribal Agency to:

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

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

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

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

To report fraud at the federal level, call 800-424-9121 or visit https://hotline.oig.usda.gov/eCasePortal/InvestigationsCaptcha.aspx.

Ombudsman Programs

An Ombudsman investigates reported concerns and helps members solve issues. They can also help you file a grievance or appeal with our plan. The organization to contact depends on your age.

METHOD	DISABILITY RIGHTS WISCONSIN Ombudsmen from this agency help people **under age 60.**
CALL	General: 800-928-8778 Fax: 833-635-1968
TTY	1-888-758-6049
WRITE	1502 West Broadway, Suite 201 Madison, WI 53713
EMAIL	info@drwi.org
WEBSITE	https://disabilityrightswi.org/ (See website for contact information for other locations.)

METHOD	WISCONSIN BOARD ON AGING AND LONG-TERM CARE Ombudsmen from this agency help people **age 60 and older.**
CALL	1-800-815-0015
WRITE	1402 Pankratz Street, Suite 111 Madison WI 53704-4001
EMAIL	BOALTC@wisconsin.gov
WEBSITE	https://longtermcare.wi.gov

How to contact the Railroad Retirement Board

The Railroad Retirement Board is a federal agency that administers benefit programs for railroad workers and their families. If you have questions about your benefits from the Railroad Retirement Board, contact the agency.

METHOD	RAILROAD RETIREMENT BOARD
CALL	1-877-772-5772
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	https://rrb.gov/

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

If you have questions about aging or living with a disability, your local ADRC can help. ADRCs provide information on a variety of programs and services. This includes long-term care options. You can get services by calling your local ADRC on the phone, scheduling a home visit, or by visiting their office in person. The ADRC handles enrollment and disenrollment for the Partnership Program. Visit www.dhs.wisconsin.gov/adrc for more information about ADRCs.

You can contact your local ADRC as listed below.

Adams County
ADRC of Adams, Green Lake, and Waushara Counties
569 N. Cedar Street
Adams, WI 53910
Toll-free: 1-877-883-5378
TTY: 711
www.adrcinformation.org

Columbia County
ADRC of Columbia County
111 E. Mullett Street
Portage, WI 53901
Local: 608-742-9233
Toll-free: 1-888-742-9233
TTY: 711
www.co.columbia.wi.us/columbiacounty/adrc/

Dane County
ADRC of Dane County
2865 N. Sherman Avenue
Madison WI 53704
Local: 608-240-7400
Toll-free: 1-855-417-6892
TTY: 711
www.daneadrc.org

Dodge County
ADRC of Dodge County 1
99 County Road DF, 3rd Floor
Juneau, WI 53039
Local: 920-386-3580
Toll-free: 1-800-924-6407
TTY: 920-386-3883
https://www.co.dodge.wi.gov/departments/departments-a-d/aging-and-disability-resource-center

Green Lake County
ADRC of Adams, Green Lake, and Waushara Counties
571 County Road A
Green Lake, WI 54941
Local: 608-328-9499
Toll-free: 1-877-883-5378
TTY: 711
www.adrcinformation.org

Jefferson County
ADRC of Jefferson County
1541 Annex Road
Jefferson, WI 53549
Local: 920-674-8734
Toll-free: 866-740-2372
TTY: 800-947-3529
www.jeffersoncountywi.gov/departments/human_services/aging_and_disability_resource_center/

Kenosha County
ADRC of Kenosha County 8600
Sheridan Road, Suite 500
Kenosha, WI 53143
Local: 262-605-6646
Toll-free: 1-800-472-8008
TTY: 711
https://www.kenoshacounty.org/155/Aging-Disability-Resource-Center

Marquette County
ADRC of Marquette County
428 Underwood Ave
P.O. Box 405
Montello, WI 53949
Toll-free: 1-855-440-2372
TTY: 711
www.adrcmarquette.org

Milwaukee County
ADRC of Milwaukee County
1220 W. Vliet Street, Suite 300
Milwaukee, WI 53205
Local: 414-289-6874
Toll-free: 1-866-229-9695
TTY: 711
https://county.milwaukee.gov/EN/DHHS/Disabilities-Services/Disability-Resource-Center

Racine County
ADRC of Racine County
14200 Washington Ave
Sturtevant, WI 53177
Local: 262-833-8777
Toll-free: 1-866-219-1043
TTY: 711
www.adrc.racinecounty.com/

Sauk County
ADRC of Sauk County
West Square Building
Room #102
505 Broadway
Baraboo, WI 53913
Local: 608-355-3289
Toll-free: 1-800-482-3710
TTY: 711
www.co.sauk.wi.us/adrc

Waushara County
ADRC of Adams, Green Lake, and Waushara Counties
209 S. Saint Marie Street
P.O. Box 621
Wautoma, WI 54982
Local: 920-787-0403
Toll-free: 1-877-883-5378
TTY: 711
https://www.adrcinformation.org

FoodShare Wisconsin

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

METHOD	FOODSHARE WISCONSIN
CALL	QUEST Card Service at 877-415-5164 » Get general information about your QUEST card. » Report that you did not get a QUEST card. » Report a lost, stolen, or damaged QUEST card. » Get your current account balance.
TTY	711 Wisconsin Relay Calls to this number are free.
WEBSITE	www.dhs.wisconsin.gov/foodshare/eligibility.htm

Chapter 2. Introduction to Family Care Partnership

Welcome to *i*Care Family Care Partnership

Welcome to *i*Care Family Care Partnership, a managed care organization (MCO) that runs the Family Care Partnership program (also known as Partnership). Partnership is a Medicaid program that helps elders and adults with physical, developmental, or intellectual disabilities. People in the program receive services to help them live in their own home whenever possible. Partnership is funded by state and federal tax dollars.

This handbook will give you the information you need to:

» Learn the basics of Partnership.

» Become familiar with the medical care and long-term care services in the benefit package.

» Discover which services Partnership covers.

» Know 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 Care Team's contact information is in Chapter 1.

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

The end of this document has definitions of important words. These definitions can help you understand the words and phrases used in this handbook.

Your Membership Card

You will get a ForwardHealth card from Wisconsin Medicaid. You will need your ForwardHealth card to get your prescription drugs. If your ForwardHealth card is damaged, lost, or stolen, call ForwardHealth Member Services at 1-800-362-3002 right away to ask for a new card.

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

If your card is damaged, lost, or stolen, call ForwardHealth Member Services right away at 1-800-362-3002.

How can the Partnership program help me?

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

When you join Partnership, we will talk with you about what services will help you live as independently as possible. Help with bathing, transportation, housekeeping, and home delivered meals are some of the services we offer. This might include building a wheelchair ramp or using a medical alert system.

We also cover medical care, including laboratory tests and dental care. (See Chapter 4 for a list of covered services.)

Partnership provides care management and a range of services designed to meet your needs. We will make sure you get the care you need to be healthy and safe. We will also help you maintain ties with your family, friends, and community.

If you are a young adult preparing to move out on your own, *i*Care Family Care Partnership can help you become more independent. For example, we can help you develop the skills you need to find a job or learn how to prepare your own meals.

Partnership:

» Can improve or maintain your quality of life.

» Helps you live in your own home or apartment, among family and friends.

» Involves you in decisions about your care and services.

» Maximizes your independence.

Who will help me?

When you become a Partnership member, you will work with a Team of professionals from *i*Care Family Care Partnership. You are a central part of your Care Team and you should be involved in every part of planning your care.

Your Care Team will include you and:

» A nurse practitioner

» Registered nurse

» A care manager or social services coordinator

» Other professionals, depending on your needs, such as your doctor, an occupational or physical therapist, or a mental health specialist.

» Anyone you want to be involved, including family members or friends.

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

» Make sure the services Partnership provides meet your needs and are cost-effective.

» Ensure the services in your plan are provided to you.

» Make sure your care plan continues to work for you.

Let your Care Team know if you need any help taking part in the process.

*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 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 and long-term care services from *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 our members. We can only do that if all our members help us develop care plans that not only 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 meet all the following requirements:

» 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

» Be functionally eligible with a nursing home level of care, as determined by the Wisconsin Adult Long-Term Care Functional Screen

» Sign an enrollment form

Our service area includes these counties in Wisconsin: Adams, Columbia, Dodge, Dane, Green Lake, Jefferson, Kenosha, Marquette, Milwaukee, Racine, Sauk and Waushara.

If you plan to move out of the service area, you must notify your Care Team. If you move outside of our service area, you may not be able to stay enrolled with the *i*Care Family Care Partnership program.

Requirements to Stay Enrolled

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 looks at an individual's income and assets to determine if the person is eligible for Medicaid. If you are not financially eligible for Medicaid, you may have to pay a monthly cost share to remain eligible for the Partnership program. Your county income maintenance agency determines your cost share amount. The income maintenance agency will review your financial eligibility and cost share at least once a year to make sure you are still financially 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 will 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 do I become a member?

If you are not already a member but are interested in becoming a member of *i*Care Family Care Partnership, please call or visit the ADRC in your area. The address and phone number of your local ADRC can be found in Chapter 1.

The ADRC will help assess your level of need for services and make sure you are functionally eligible for Partnership. They will give you information about other available programs and help you choose the most appropriate resource or program for you.

During the enrollment process, the ADRC will ask you to:

» Provide information about your health and needs

» Provide information about your income and assets

» Sign a "Release of Information" form for your medical records

» Complete and sign an enrollment form

You will also speak with an income maintenance worker. This person will determine if you meet financial eligibility for the Partnership program.

How does Partnership work?

Personal Experience Outcomes

When you enroll in Partnership, you and your Care Team will assess your needs, strengths, and preferences. Part of this process is for you to tell your Care 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 Care Team a clear understanding of what is important to you.

Identify Your Personal Experience Outcomes

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/friends
» Community involvement
» Respect and fairness
» A job or other meaningful activities
» Stability
» 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 grandchildren.

» Have a paid job.

» Be independent enough to live in their own apartment.

You have a right to expect that your Care Team will work with you to identify your personal experience outcomes. Before *i*CareFamily Care Partnership buys services for you, your Care Team has to consider which services support your needs best and are the most cost-effective. 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 an important part of the plan to support your outcomes.

Identify Your 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 Care 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 Care Team identify during the assessment process.

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

Your Care Team will be in contact with you on a regular basis to talk about how you are doing and check if your services are helping you. Your Care Team is required to meet with you in person regularly. Your Care 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.

» 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, accept our rates and enter into a contract with *i*Care Family Care Partnership.**

» 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 Care Team. *i*Care Family Care Partnership may not always be able to meet your request or give you the specific Care Team you want.

» You may choose to self-direct some of your services.

What are self-directed supports (SDS)?

You can choose the self-directed supports (SDS) option if you want to manage some of your long-term care services. Choosing SDS means you will have more say in how 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 often used for in-home care, SDS can also be used outside of the home for services such as transportation and personal care at your workplace. 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 Services

How are services selected and authorized?

In most cases, your Care Team must approve services **BEFORE** you receive them. ***i*Care Family Care Partnership is generally 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 Care 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 **must 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 or RAD** process as a guide in making decisions about services.

About the Resource Allocation Decision process

The RAD is a step-by-step tool you and your Care 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 process. 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 your outcomes and needs and explore the options available to meet them. 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 process, 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 self-directing your services, see page 37.

Your Care Team will find service providers to help you. These providers must have a contract with *i*Care Family Care Partnership. This chapter has more information about using our providers.

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

What if my needs change?

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 Care Team know. *i*Care Family Care Partnership can provide 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 cover your care and services as long as:

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

There are some 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 our plan covers and the providers in our network cannot provide this care, or are located too far from where you live, you can get this care from an out-of-network provider. You must get authorization from your Care Team prior to seeking care.

» If you are an American Indian or Alaska Native, you can get covered services from an Indian health care provider outside of our network.

How does *i*Care Family Care Partnership evaluate new technology to include as a covered benefit?

Sometimes your provider may ask *i*Care to pay for a new medical technology. Technology means using scientific knowledge and applying it to human life. One example of a new medical technology is a telehealth visit. Another example is using a robotic arm or a new machine used during an operation.

Sometimes the new technology is not a covered by your health insurance. When this happens, your provider will need to ask *i*Care to cover the procedure or service. Sometimes we cover it once. Other times we decide to always cover the new technology (like a telehealth visit). Our medical team of nurses and doctors look at all the facts to decide if we will cover it. They ask questions like:

» Will it improve the member's health?

» Will it be harmful to the member?

» Is this new treatment necessary?

» Is it safe?

» Are other doctors using the technology?

» Is it approved by the government or state agency?

If your doctor asks us to cover a treatment or service that requires new technology, we will make a coverage decision after receiving the information we need.

If we decide not to cover the new technology, we will tell you the reason for the denial. We will also tell your provider. We will then explain how you can appeal the decision.

Your provider can submit a request for review of a new technology to us in writing. Our mailing address is: Independent Care Health Plan, Attention: *i*Care Family Care Partnership, 1555 North RiverCenter Drive, Suite 206, Milwaukee, Wisconsin 53212 or call 1-800-777-4376.

How do I use the provider network?

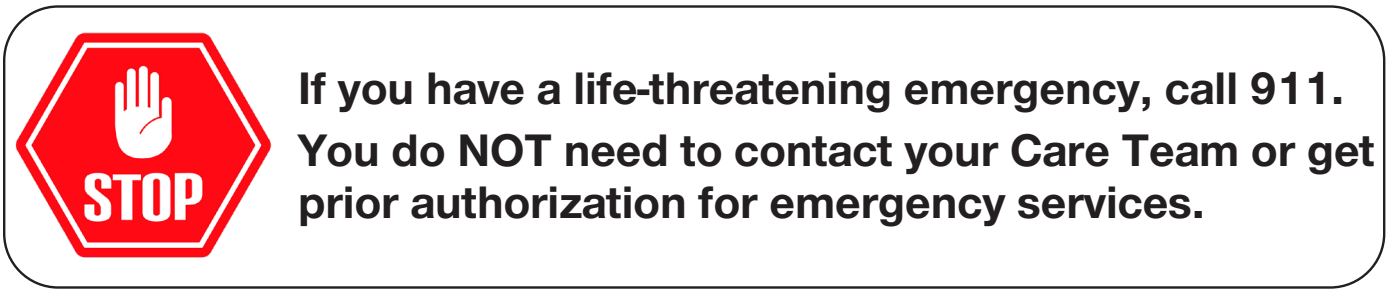
You and your Care Team will select your providers from our "provider network." The list of the providers we have contracts with is on our web site at www.icarehealthplan.org/Find-a-Provider.htm. We call this the Provider Network Directory. The Provider Network Directory on our web site is updated at least every 30 days and is available in alternate formats and languages. If you want a paper copy of the Provider Network Directory, you can request a copy from your Care Team.

The provider directory lets you know 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. Your Care Team can also tell you if the provider's office is accessible.

There might be times when you want to switch providers. Contact your Care Team if you want to change from one provider to another in the network. **If you change providers without talking to your Care 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, while you are a member of our plan, you must use network providers to get your medical care and long-term care services.



What is a Primary Care Provider (PCP)?

Your PCP is the physician who collaborates with your Care Team and our plan to oversee your health care. It is important to have a primary care provider (PCP) to manage all your health care. However, *i*Care does not require you to select a PCP. If you are an American Indian or Alaska Native, you can choose to see an Indian health care provider outside of our network.

Your PCP and other providers and specialists in the *i*Care Provider Network practice culturally sensitive or culturally competent care. This means your provider can provide care to patients with their individual backgrounds in mind, such as ethnic background and cultural beliefs. This can also include speaking the same language, having the same religious beliefs, and more.

The physicians, specialists, and other providers in the *i*Care Provider Network meet state licensing requirements and receive education and training to provide you medical care. If you would like more information about the people providing your health care, such as residency of the provider or the medical school they attended, please call *i*Care Customer Care at 1-800-777-4376 or contact the provider office directly.

Talk with your Care Team about getting care from your PCP. You will usually see your PCP for most of your routine health care needs. Your Care 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 Care or your Care Team. PCPs do not automatically accept new patients. You may keep your current PCP if they are part of our network. If you are an American Indian or Alaska Native, you can choose to see an Indian health care provider outside of our network. You can tell us your choice of PCP by calling your Care Team. If there is a particular specialist or hospital that you want to use, be sure to ask if your PCP makes referrals to that specialist or uses that hospital.

How do I change my PCP?

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

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

Your provider handles most referrals. To obtain an referral to an in-network provider, please contact your provider.

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

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

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

» Flu shots **and** pneumonia vaccinations if 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

What kinds of medical care or services require prior approval from my Care Team?

Emergency services DO NOT require prior authorization.

*i*Care must authorize certain visits and procedures. For example, if you receive a referral for an out-of-network provider, you will need to obtain a Prior Authorization. Your provider should contact *i*Care for Prior Authorizations.

The following types of services require Prior Authorization review:

» Admission to an inpatient hospital for medical or behavioral/mental health care

» Admission to a subacute facility (Skilled Nursing Facility, Long-Term Acute Care Hospital, Inpatient Rehabilitation Hospital)
» Nursing care or therapy delivered in your home (home health care)
» Hospice services
» Some durable medical equipment (DME) and supplies (DMS)
» Some medical procedures and laboratory testing
» Outpatient physical, occupational, and speech therapy
» Cardiac and pulmonary rehabilitation
» Transplants
» Referrals for second (additional) opinions
» Referrals to non-participating providers (out-of-state or out-of-network) for all non-emergency services (emergency services do not require Prior Authorization)
» Long-term care services under *i*Care's Family Care Partnership (FCP)
» Some dental procedures*
» Some vision procedures*

* These requests are reviewed by delegated partners, DentaQuest or National Vision Administrators (NVA).

The *i*Care web site has a listing of procedures that require Prior Authorization.

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 Care Team if you need health care from a specialist. You may need to get prior authorization from your Care Team.

How to obtain behavioral health care services

A behavioral health care professional is someone who can help people get relief from mental health conditions and help you find ways to improve mental wellness and resiliency. They may be a psychiatrist, psychologist, social worker, marriage and family therapist, psychiatric nurse, or counselor with mental health training. You do not need to get prior authorization from your Care Team for behavioral health services, however, you must use a provider in the Provider Network Directory. Contact your Care Team if you have questions about these services and for help coordinating care.

If you are in imminent danger or experiencing a medical emergency, call 911. If you are having thoughts of suicide or hurting yourself, call your county's crisis line (https://www.preventsuicidewi.org/county-crisis-lines) or the National Suicide Prevention Lifeline at 1-800-273-TALK (8255).

How to obtain hospital services

Hospital Services mean those medically necessary services for inpatients and outpatients, which are generally and customarily provided by acute care general hospitals, and are prescribed, directed, or authorized by a physician.

Hospital services include anything and everything that hospitals offer to their recipients. Most hospitals provide some core and mandatory services, like emergency care (see "Getting care if you have a medical emergency" for more information on emergency care), nursing services, intensive care unit, outpatient services and a pharmacy.

*i*Care Family Care Partnership covers the cost of medically necessary hospital services, provided at a hospital, on an inpatient or outpatient basis within the United States and provided at a hospital in our provider network. Your PCP will arrange for your care at a hospital unless it is an emergency. Contact your Care Team if you need hospital services. For most services, you need to get prior authorization from your Care 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.

How do you get your prescription drugs?

If you have Medicare, *i*Care Family Care Partnership (HMO D-SNP) will cover your prescription drugs. The pharmacies in our network are listed in the Medicare Provider/Pharmacy Directory.

If you do not have Medicare, Wisconsin Medicaid covers your prescription drugs. You must go to a Medicaid certified pharmacy. You can ask the pharmacy if they accept Medicaid. You can also search for pharmacies on the interactive Medicaid provider search https://www.forwardhealth.wi.gov/WIPortal/Subsystem/Public/DirectorySearch.aspx

If you are not sure if you have Medicare please ask your Care Team for help.

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

You do NOT need to contact your Care Team or get prior authorization for emergency services.

Getting care if you have a medical emergency

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

If you have a medical emergency:

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

» **Please make sure 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 your Partnership Care Team at 1-800-777-4376.

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 was not 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 danger — and the doctor may say that it was not a medical emergency after all. If it turns out that it was not an emergency, if you thought your health was in 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 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

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).

How do you receive help after normal business hours?

If you have an urgent need or questions about urgently needed care that cannot wait until the next business day, call 1-800-777-4376 (TTY: 711). On-call staff are available 24 hours a day, seven days a week. The on-call staff can temporarily authorize needed services to continue until the next business day. Your Care Team will follow up with you to determine whether the services should continue.

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 network providers are 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.

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**. (For more information about the plan's service area, see Chapter 2.)

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

» If the income maintenance agency informs you that you will **not be considered a resident** of a county served by *i*Care Family Care Partnership, contact the ADRC in the county you are moving to. The ADRC can tell you about the programs available in that county.

» If you **will still be considered a resident**, *i*Care Family Care Partnership will work with you 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 while you are out of our service area, we can ask the state to disenroll you from the program. If the state disenrolls you, you will be able to challenge this decision with the appeal process. (See Chapter 8 for more information.)

*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 soon as possible. Your team can help you plan for medical care in your new area.

What is Utilization Management in health care and how does it affect me?

*i*Care's Utilization Management (UM) is a process done by the *i*Care UM Team to make sure the care you get is necessary and follows medical and behavioral health standards. Doctors and nurses are on the UM Team. There are three times we review and monitor your care:

1. Before you receive health care or a service.
2. During your health care or service.
3. After you received health care or a service.

The decisions made during any of the reviews explained below may result in a denial. This denial could be on the health care or service. We could also make the decision not to pay for the health care or service. If you or your provider disagree with the UM decision, you have the right to file an appeal. Appeals are processed according to *i*Care's policies and procedures. For more information on how to file an appeal, see Filing a Grievance or Appeal.

*i*Care does not reward providers or our own staff for denying coverage or services. We do not offer financial rewards to our staff that affects their decisions. We do not deny or limit the amount, length of time or scope of the service only because of the diagnosis or type of illness or condition. Any financial incentives for decision makers do not encourage decisions that result in under use of services.

How do we review *before* you get health care?

*i*Care reviews and monitors your care through Prior Authorization. Prior Authorization (PA) means that our doctors and nurses review medical and behavioral services before you get care. They look at the type of care or service to see how complex it is. They also look to see if there could be any risks to your health. Services that require PA are listed on the Prior Authorization List on *i*Care's web site. Some are also listed in the Medical Care or Services that Require Prior Approval (Authorization) section.

Your provider will work with *i*Care's Prior Authorization department to request the review and get approvals, if needed.

How do we review *during* your health care?

*i*Care's doctors and nurses may monitor certain types of care you get and where you get that care. They work with your providers to make sure where and how you are getting health care and services is appropriate for your individual needs and situation. For example, *i*Care doctors and nurses may monitor care you get during an inpatient hospital stay.

*i*Care's doctors and nurses also make sure you have access to the resources and services you need after you are discharged. They also work with your providers to make sure you continue to get care at a place that is best for your needs. This could be at a skilled nursing facility, at a long-term care facility, or at your home or community-based care.

How do we review after your health care?

This happens before or after *i*Care pays the claim. We look at the care you received and then look at the claim. We look for things like making sure the care or service was necessary and appropriate. We also look at the claim to make sure you received the services *i*Care was billed for and the cost is correct.

*i*Care provides free aids and services to people with disabilities to communicate effectively with us. We also provide free language services to people whose primary language is not English. If you need these services to communicate with us on your Utilization Management needs, contact Customer Care at 1-800-777-4376 (TY: 711)24 hours a day, 7 days a week. Our office hours are Monday – Friday, 8:30 a.m. – 5:00 p.m.

Chapter 4. The Partnership Benefit Package

What Medicaid services are provided?

Partnership provides health care and long-term services. The list of services we provide is called the "Partnership Benefit Package."

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

If you have both Medicare and Medicaid, 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 to remain eligible for Partnership. See Chapter 5 for more information.

» *i*Care Family Care Partnership will only cover residential services and nursing homes stays in certain situations. See Chapter 3 for more information.

» Only certain services in the benefit package are eligible for self-direction. Ask your Care Team if you would like more information.

Your Care Team must approve all services before you start receiving them.

The services listed in the table are available if:

» They are required to support your outcomes

» Pre-approved by your Care Team

» Stated in your care plan

Your services may be in person or through telehealth

*i*Care Family Care Partnership covers live two-way telehealth over video or telephone (audio) for services that your provider can deliver at the same quality as in-person services. Some services that are covered through telehealth are doctor office visits, mental health/substance abuse services, dental consultations, and more. Your provider cannot provide some services over telehealth, like services where the provider needs to touch or physically examine you.

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

*i*Care Family Care Partnership and Wisconsin Medicaid providers are required to follow privacy and security laws when providing services over telehealth.

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 Medicaid Benefit Package

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.

Partnership covers the following services:

» Alcohol and other drug abuse (AODA) services
» Audiology
» Adaptive aids
» Adult day care services
» Assistive technology/communication aids
» Care management – Individualized assessment and care planning, authorizing, arranging and coordinating services in the member's care plan. Care management also includes assistance in filing grievances and appeals, maintaining eligibility, accessing community resources and obtaining advocacy services.
» Case management - Provided by a Care Team. The member is the center of the Care Team. The Care 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.
» Chiropractic
» Consultative clinical and therapeutic services for caregivers
» Consumer education and training services
» Counseling and therapeutic services
» Dental services
» Diagnostic testing services
» Dialysis services
» Drugs
» Durable medical equipment and medical supplies
» Environmental accessibility adaptations / Home modifications
» Financial management services
» Habilitation Services:
  • Daily living skills training
  • Day habilitation services
  • Prevocational services
» Home care services (Home health, nursing, and personal care)
» Home delivered meals
» Hospice care services
» Hospital services
» Housing counseling
» Medicare deductible and coinsurance

» Mental health services
» Nursing home services.
» Personal Emergency Response Systems
» Physician services
» Podiatry services
» Respiratory care for ventilator-assisted recipients
» Supported employment
  • Individual employment support
  • Small group employment support
» Relocation services
» Residential services
» Residential Care
  • Adult family homes of 1-2 beds
  • Adult family homes of 3-4 beds
  • Community-based residential facilities (CBRF)
  • Residential care apartment complexes (RCAC)
» Respite care
» Self-directed personal care services
» Self-directed Supports (SDS)
» Skilled Nursing services RN/LPN
» Specialized medical equipment and supplies
» Support broker
» Supportive home care
» Therapy – physical therapy, occupational therapy and speech and language pathology services
» Training services for unpaid caregivers
» Transportation, emergency services
» Transportation, non-emergency specialized transportation
  • Community transportation
  • Other transportation
» Vision care services
» Vocational futures planning and support

Prescription Drugs

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

Available through ForwardHealth

The following services are not in the Partnership benefit package, but are available to you through your ForwardHealth card:

- Behavioral treatment services
- Comprehensive community services
- Community recovery services
- Prenatal care coordination
- School-based services
- Medication therapy management
- Tuberculosis-related services

Services not covered

Partnership does not cover the following items and services:

- Services that your Care Team hasn't 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 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 and 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, if they:

» Are not covered services in the benefit package, or

» Were obtained without prior approval.

If you have questions about whether we will pay for any service, you have the right to ask us about coverage before you receive the service. If we say we will not cover the service, you have the right to appeal our decision.

You may have to pay the following each month:

» Cost share

» Room and board

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

Cost Share

Some members have to make a monthly payment to remain eligible for Partnership. This monthly payment is known as a **cost share.** Cost share is based on a member's income and certain expenses. Certain expenses may lower a cost share. Your Care Team can explain the types of expenses that may reduce a cost share and receipts that should be kept.

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 cost share will be looked at once a year, or anytime income changes. **You are required to report all income and asset changes to your Care Team and the income maintenance agency within 10 days of the change.** Assets include things like cars, checking and savings accounts, and cash value of life insurance.

Failure to pay your monthly cost share may result in the loss of eligibility for Partnership. If you think your cost share is incorrect, you can file an appeal with the Wisconsin Division of Hearings and Appeals. (See Chapter 8. Grievances and appeals for more information.)

If you have questions about your cost share, contact your Care Team.

Cost Share Reduction

If you are unable to pay your monthly cost share because of your necessary living expenses, you may qualify for a reduction of your cost share amount. Necessary living expenses include mortgage payments, rent, home or renter's insurance, property taxes, utilities, food, clothing, hygiene items, and the cost of operating and maintaining a vehicle.

To request a reduction of your cost share, you must complete an "Application for Reduction of Cost Share." Your Care Team can give you an application or you can get it online at www.dhs.wisconsin.gov/library/f-01827.htm

Along with the application, you will need to submit proof of your monthly income, your monthly expenses, and the cost share amount you pay to *i*Care Family Care Partnership each month. The application tells you what kind of proof is needed and gives examples of the types of documents you will need to provide.

If you need help completing the application, you can get help, free of charge, from an Ombudsman. Contact information for the Partnership Ombudsman program is listed in Chapter 1. Important phone numbers and resources.

Room and Board

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

*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
P.O.Box 778845
Chicago, IL 60677-8845

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

What if I get a bill for services?

Providers may not bill you for covered benefits that were authorized by *i*Care Family Care Partnership and received while you were enrolled in our plan. 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, do not pay it. Instead, contact your Care Team so they can help. After you contact your Care Team, mail a copy of the bill to:

Independent Care Health Plan
1555 North RiverCenter Drive, Suite 206
Milwaukee, Wisconsin 53212

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

How do I submit a claim for covered services?

A health insurance claim is what a doctor, provider or supplier submits to *i*Care so they can get paid. It shows the medical services that were provided to you.

Because you are enrolled in *i*Care Family Care Partnership, the program rules require doctors, providers, and suppliers to submit the claim for you. You should not have to submit a claim. Contact your Care Team with questions or if a provider asks you to submit a claim.

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 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 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 could include Veterans benefits (VA), pension plan health coverage, and private health insurance.

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.

Medicare

If you are enrolled in Medicare, you must enroll in the Partnership Medicare plan.

If you are eligible for Medicare and you do not currently have Medicare because you feel you cannot afford it, talk to your care team. Your care team may be able to find a program that will help you pay for Medicare premiums.

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

Medicaid estate recovery applies to all Medicaid services you receive from *i*Care Family Care Partnership.

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

Recovery is made by filing claims on estates. The state 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:

Toll-free: 1-800-362-3002

TTY: 711 or 800-947-3529

Web site: www.dhs.wisconsin.gov/medicaid/erp.htm

Chapter 6. Your Rights

As an *i*Care member, you have the right to make recommendations regarding the member rights and responsibilities policy. You, your provider or your designated representative also have the right to receive a copy of *i*Care's Member Rights and Responsibilities statement.

If you would like to make recommendations or receive a copy of this statement separate from this handbook, please visit the *i*Care web site at www.iCareHealthPlan.org. You may also contact *i*Care Customer Care at 1-800-777-4376 (TTY: 711).

*i*Care provides free aids and services to people with disabilities to communicate effectively with us. We also provide free language services to people whose primary language is not English. If you need these services to communicate with us, contact Customer Service at 1-800-777-4376 (TY: 711) 24 hours a day, 7 days a week. Our office hours are Monday – Friday, 8:30 a.m. – 5:00 p.m.

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

1. **You have the right to be included in the care management process of an assessment of your understanding of your rights**, such as control of money, freedom of speech, freedom of religion, right to vote, right to privacy, freedom of association, right to possessions, right to employment, right to education, access to healthcare, and right to choose leisure and rest. You also have the right to an assessment on your understanding of executing advance directives and whether you are aware and understand you can choose a guardian, durable power of attorney or activated power of attorney for health care.

2. **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.

3. **We must treat you with dignity, respect, and fairness always. 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, gender identity, sexual orientation, health, ethnicity, creed (beliefs), age, national origin, or source of payment.
   - » To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. This means you have the right to be free from being restrained or forced to be alone 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 i**s 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 Care Team at 1-800-777-4376 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. Below are the ADRC's in your area. See Chapter 1 for complete contact information:

ADRC of Adams County
1-877-883-5378

ADRC of Dane County
1-855-417-6892

ADRC of Dodge County
1-800-924-6407

ADRC of Columbia County
1-888-742-9233

ADRC of Jefferson County
1-866-740-2372

ADRC of Kenosha County
1-800-472-8008

ADRC of Green Lake County
1-877-883-5378

ADRC of Marquette County
1-855-440-2372

ADRC of Milwaukee County
1-866-229-9695

ADRC of Racine County
1-866-219-1043

ADRC of Sauk County
1-877-794-2372

ADRC of Waushara County
1-877-883-5378

4. **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 Care Team will also coordinate with your health care providers. Examples of these are doctors, dentists, and podiatrists. Contact your Care 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.

5. **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 Care Team. See Appendix 7 for *i*Care Family Care Partnership's Notice of Privacy.

6. **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.

7. **We must give you information about *i*Care Family Care Partnership, our network of providers, and available services.** Please contact your Care Team if you want this information or go to our web site (www.iCareHealthPlan.org).

8. **We must support your right to make decisions about your care.**
   - » You have a right to know about all your choices. This means you have the right to a discussion about all 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 request a primary care provider (PCP) who shares the same race or ethnicity as you.

     You have the right to say what you want to happen if you are in this situation. You can appoint a guardian, durable power of attorney or activated power of attorney for health care.

     You can develop an **"advance directive."** There are several types of advance directives and different names for them. Documents called **"living will" a**nd **"power of attorney for health care"** are examples of advance directives. Contact your Care Team if you want to know more about advance directives.

9. **You have the right to receive your Partnership services in places that let you be a true part of the community in which you live.** This is your right under the federal home and community-based services settings rule. The rule applies to the setting where you live and the settings outside of your home where you receive services during the day. *i*Care must make sure you receive your Partnership services in places that connect you to your community and support your independence. This means places that support your ability to:
   - » Live where you want to live.
   - » Participate in community life.
   - » Find and participate in work in the same way as other people in your community.
   - » Control your schedule.
   - » Access and control your money.
   - » Decide who to see and when to see them.
   - » Maintain your privacy.

10. **You have a right to voice or 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 are 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 agree 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. Show your ForwardHealth card whenever you get prescriptions drugs. It is important to show your ForwardHealth card so that providers know who to bill.
11. Follow *i*Care Family Care Partnership's procedures for getting care after hours.
12. Tell us if you move to a new address or change your phone number.
13. Let us know of any planned temporary stay or move out of the service area.
14. 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.
15. Treat your Team, home care staff, and providers with dignity and respect.
16. Accept services without regard to the provider's race, color, national origin, disability, language, religion, age, gender, gender identity, sex, sexual orientation, health, ancestry, marital status, ethnicity, creed (beliefs), or national origin.
17. 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.

18. 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 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. Contact your Care Team if you need assistance or have questions about the annual renewal.

19. 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 Medicare or think you may be eligible for Medicare.

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

21. 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

22. Do not engage in any fraudulent activity or abuse benefits. This may include:
    - » Misrepresenting your level of disability
    - » Misrepresenting income and asset level
    - » Misrepresenting residency
    - » Selling medical equipment supplied by *i*Care Family Care Partnership

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

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

24. Call your Care Team for help if you have questions or concerns.

25. Tell us how we are doing. From time to time, we may ask if you want to take part in member interviews, satisfactions surveys, or other quality review activities. Your responses and comments will help us identify our strengths as well as find 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 Care Team is usually the easiest and fastest way to address your concerns. If you do not want to talk with your Care Team, you can call our Member Rights Specialist. The Member Rights Specialist can tell you about your rights, try to informally 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 *i*Care Family Care Partnership's Member Rights Specialist at:

Independent Care Health Plan
Attention: *i*Care Family Care Partnership Member Rights Specialist
1555 North RiverCenter Drive, Suite 206
Milwaukee, Wisconsin 53212

Toll-free: 1-800-777-4376 • TTY: 711 • www.iCareHealthPlan.org

If you are unable to resolve your concerns by working directly with your Care Team or our Member Rights Specialist, *i*Care Family Care Partnership gives you several ways to address your concerns.

Each way has different rules, procedures, and deadlines.

This handbook tells you how to file a grievance or appeal, which can seem confusing because each option has different deadlines.

NOTE: When this handbook refers to "days," it means any day of the year, including holidays. When this handbook refers to "business days," it means Monday through Friday, excluding holidays.

You do not have to know or understand all the information in this chapter because people are available to help you.

If you have a particular type of concern that you do not know how to resolve, you can ask your Care 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 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 may consider filing your grievance or appeal with the other insurance first.

When you have other insurance (like employer group health coverage), there are rules that decide whether our plan or your other insurance pays first. This is called "coordination of benefits" 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 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 case file

You have a right to a free copy of the information in your case file related to your grievance or appeal. Information means all documents, medical records, and other materials related to your grievance or appeal. This includes any new or additional information that *i*Care Family Care Partnership gathers during your grievance or appeal. To request a copy of your case file, contact *i*Care Family Care Partnership, Member Rights Specialist.

You will not get into trouble if you complain or disagree with your Care Team or your providers. 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 does not listen to you.

» You have trouble getting appointments with a provider.

» You are not satisfied with your provider's incontinence products.

Who can file a grievance?

A grievance may be filed by any of the following:

» You

» Your legal decision maker. For example, a legal guardian or activated power of attorney for health care.

» A person or organization you have designated as your authorized representative for Medicaid purposes.

» Any person with your written permission. For example, a family member, friend, or provider.

What is the deadline to file a grievance?

You can file a grievance at any time.

1. Start by filing a grievance with *i*Care Family Care Partnership. See GRIEVANCE OPTION 1, listed below.
2. If you don't agree with *i*Care Family Care Partnership's decision regarding your grievance, you can ask for a review by the Wisconsin Department of Health Services (DHS). See GRIEVANCE OPTION 2, page 42.

GRIEVANCE OPTION 1: File your grievance with iCare 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:

Independent Care Health Plan
Attention: *i*Care Family Care Partnership, Member Rights Specialist
1555 North RiverCenter Drive, Suite 206
Milwaukee, Wisconsin 53212

Toll-free: 1-800-777-4376, ext. 1076 • TTY: 711

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, a health care professional who possesses the appropriate clinical expertise, 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 topic of your grievance 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.

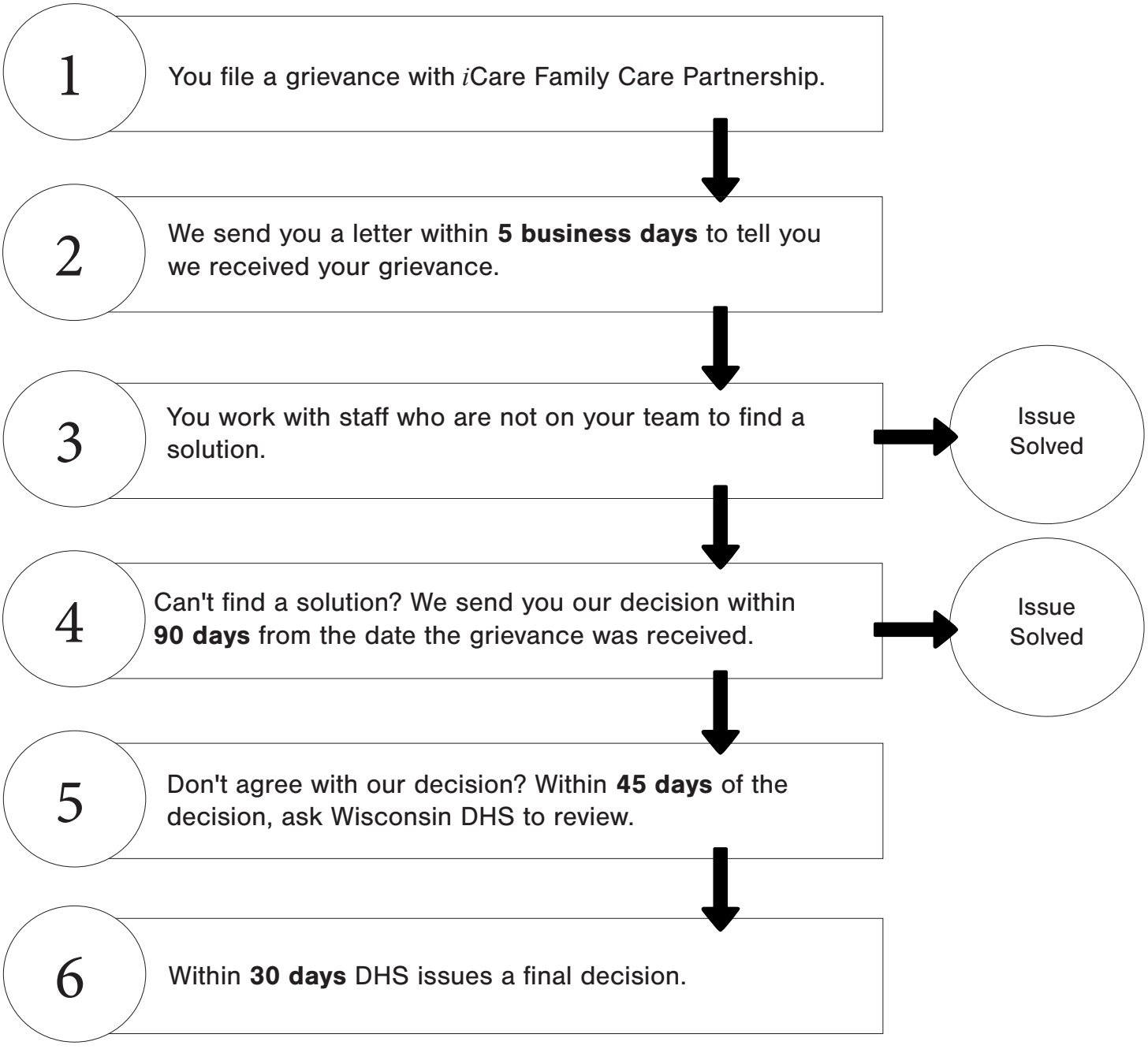
» We will let you know when the committee plans to meet to review your grievance.

» You have the right to appear in person before the Committee. You can bring an advocate, friend or family member, or witnesses with you. The Committee will give you a chance to explain your concerns. You may provide information, evidence, and testimony to the Committee.

» Your Care Team or other *i*Care Family Care Partnership staff will be at the meeting.

» The Committee will decide within 90 calendar days from the date we first got your grievance. You will get a written notice of the decision.

Grievances: What are my options?



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

GRIEVANCE OPTION 2: Ask for a DHS review

NOTE: You must first go through iCare Family Care Partnership's grievance process before you can ask for a DHS review.

You can ask DHS to review the Grievance and Appeal Committee's decision about your grievance. DHS is the state agency in charge of the Family Care program. DHS works with an outside organization called MetaStar to review grievances. If you ask for a DHS review, MetaStar will contact you. MetaStar will review the facts of your grievance and the Grievance and Appeal Committee's decision.

To ask for a DHS review, call or email:

DHS Partnership Grievances

Toll-free: 1-888-203-8338

E-mail: dhsfamcare@wisconsin.gov

What is the deadline to ask for a DHS review?

*i*Care Family Care Partnership's Grievance and Appeal Committee is required to send you a decision on your grievance within 90 days from the date we receive your grievance. For example, if *i*Care Family Care Partnership receives your grievance on May 1, we must send you our decision by July 30.

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

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

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

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

What happens next?

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

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

» If MetaStar tells DHS that *i*Care Family Care Partnership didn't follow certain requirements, DHS may order us to take steps to fix the problem.

» MetaStar will complete its review of your grievance within 30 days of the date it receives your request.

» MetaStar will send you and *i*Care Family Care Partnership a final decision on your grievance within seven days of completing its review.

What if I disagree with the DHS review?

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

Appeals

What is an appeal?

An appeal is a request for a review of a decision made by *i*Care Family Care Partnership. For example, you can file an appeal if your Care 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:

» 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 Adverse Benefit Determination."** The Notice of Adverse Benefit Determination includes the date we plan to stop, suspend, or reduce your services.

***i*Care Family Care 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.**

» You can file an appeal if:

- You do not like your care plan because it:
  - ◊ Does not support you to live in the place where you want to live.
  - ◊ Does not 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 do not 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.

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

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

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

eligibility for Partnership. These notices say "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 eligibility for Partnership.** This includes decisions about your cost share. See Chapter 5 for more information.

» **You cannot appeal a loss of financial 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 Adverse Benefit Determination** if we:

- Plan to stop, suspend or reduce an authorized service you are getting.
- Deny a new service you asked for and that service is in the Partnership benefit package.
- Will not pay for a service that is in the Partnership benefit package.

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

If you receive a notification of your appeal rights, you should read this notice carefully. The notice may tell you the deadline for filing your appeal. You can always call our Member Rights Specialist for assistance. You can contact our Member Righst Specialist at 1-800-777-4376.

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

If you want to file an appeal, you have two options. You can:

1. Start by filing an appeal with *i*Care Family Care Partnership. See Option 1 to file with *i*Care Family Care Partnership.
2. File a State Fair Hearing with the State's Division of Hearings and Appeals (DHA) if you disagree with the Grievance and Appeal Committee's appeal decision. See Option 2 if you want to file with DHA.

Each option has different rules, procedures, and deadlines.

You cannot file an appeal with *i*Care Family Care Partnership 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 after receiving an appeal decision from *i*Care Family Care Partnership.

If you want **both** *i*Care Family Care Partnership and DHA to review your issue, then you will have your appeal with *i*Care Family Care Partnership before you file the appeal with DHA.

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 for your services to continue during your appeal. If you want your services to continue, you must make that request at every level of your appeal. For example, if your services were continued during an appeal with *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 DHA.

If you want your services to continue, you must:

» Ask that your services continue throughout the course of your appeal; AND

» Postmark (mail), fax or email your request to continue services **on or before the date *i*Care Family Care Partnership plans to stop or reduce your services.**

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 Ombudsman.

MEDICAID 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. You can request your appeal verbally. Our Member Rights Specialist will assist you with understanding your appeal options and can be contacted at 1-800-777-4376, ext. 1076 or TTY users call 711.

» **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:

*i*Care 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:
*i*Care Family Care Partnership
Member Rights Specialist
1555 North RiverCenter Drive, Suite 206
Milwaukee, Wisconsin 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, a health care professional possessing the appropriate clinical expertise, 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 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 Care Team or other *i*Care Family Care Partnership staff will be at the meeting.

» The Committee will give you a chance to explain why you disagree with your Care Team's decision. You or your representative can present information, bring witnesses, or describe your concerns 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 30 calendar days after we first got your appeal. *i*Care Family Care Partnership may take up to 44 calendar 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 30 calendar 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 17 calendar 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:

*i*Care Family Care Partnership
Member Rights Specialist
Independent Care Health Plan
1555 North RiverCenter Drive, Suite 206
Milwaukee, Wisconsin 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). You must do so within 90 calendar days from the date of the Grievance and Appeal Committee's decision. You can also file an appeal with DHA if *i*Care Family Care Partnership does not issue an appeal decision in a timely manner. Please see the previous section to determine if *i*Care Family Care Partnership has issued its appeal decision in a timely manner.

State Fair Hearing

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

MEDICAID APPEAL OPTION 2: Filing Your Request for a State Fair Hearing

How do I request a State Fair Hearing?

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

» **Send a request form**. A copy of the form you can use is in Appendix 4. 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/f00236.doc

» **Mail a letter.** Include your name and contact information and explain what you are appealing. If you received a Notice of Adverse Benefit Determination or other notification of your appeal rights, it is recommended 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 Ombudsman can help you put your appeal in writing. To contact an Ombudsman, see the end of this chapter.

To request a State Fair Hearing

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

Partnership Request for Fair Hearing
c/o Wisconsin Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

(Or fax your request to 608-264-9885)

What is the deadline to file an appeal with DHA?

You should file your appeal as soon as possible. You must file your appeal within 90 calendar days after you receive a Notice of Adverse Benefit Determination or other notification of your appeal rights. (For example, if you get a notice in the mail on August 1, you must file your appeal on or before October 30). If *i*Care Family Care Partnership fails to send you a written decision within 30 calendar days of receiving your appeal, the 90 days starts the day after the 30-day calendar period ends.

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, like a friend, family member, attorney or Ombudsman with you.

» Your Care 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 Care 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. Ombudsman are also available to answer questions about the grievance and appeal processes. An Ombudsman 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*Carevv 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 Ombudsman programs are available to help all Partnership members with grievances and appeals. They can respond to your concerns in a timely fashion. Both Ombudsman programs will typically use informal negotiations to resolve your issues without a hearing.

Wisconsin Board on Aging and Long-Term Care

Ombudsman from this agency provide advocacy to Partnership members aged **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 • BOALTC@wisconsin.gov • https://longtermcare.wi.gov

Disability Rights Wisconsin (DRW)

Ombudsman from this agency provide advocacy to Partnership members **under age 60.**

Disability Rights Wisconsin
1502 W. Broadway, Suite 201
Madison, WI 53713

1-800-928-8778 • TTY: 1-888-758-6049 • Fax: 1-833-635-1968 • Email: info@drwi.org

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 was not 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.

You can end your membership at any time. You can choose the effective date when you want your membership to end for your Medicaid covered services. If you have Medicare, *i*Care Family Care Partnership will continue to cover your Medicare services until the last day of the month in which you requested disenrollment from our plan if you qualify for a Special Election Period or (SEP). Please contact your Care Team, refer to Chapter 9, Section 2 of your Evidence of Coverage (EOC), or your Summary of Benefits for more information about Special Election Periods.

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

   To end your membership, contact the Aging and Disability Resource Center (ADRC) in your area (see Chapter 1 for ADRC contact information). The ADRC will process your disenrollment and ask if you want to enroll in a different managed care organization or Medicaid program, such as the IRIS program. The ADRC will help you make the switch and transition your services to providers in your new program or organization. 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.

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

   » *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.

   Reasons you may lose eligibility include:

   - 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 you move or take a long trip, you need to contact your Care Team.
   - You are in jail or prison.
   - You are admitted to an Institute for Mental Disease (IMD) and lose Medicaid eligibility.

3. ***i*Care Family Care Partnership may end your enrollment with approval from DHS**

   » You stop accepting services for more than 30-days, and we do not know why.

   » You refuse to participate in care planning, and we cannot ensure your health and safety.

   » You continuously behave in a way that is disruptive or unsafe to staff, providers, or other members. DHS will review our request to disenroll you and they will decide if your membership should end.

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

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

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

Appendix 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 several 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.

Appeal: A request for your managed care organization to review a decision that denied, reduced, or suspended a service. The 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 for Medicaid: A person or organization you appoint to help you get and keep Medicaid using form F-10126A (www.dhs.wisconsin.gov/library/F-10126.htm) or F-10126B (www.dhs.wisconsin.gov/library/F-10126.htm).

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 Care Team and member meet regularly to review the member's care plan.

Care Team: Every Partnership member is assigned a Care Team, which includes the member, and at least a social worker (or care manager or social services coordinator) and a registered nurse. You and your Care Team assess your needs, identify your outcomes, and create your care plan. Your social worker (or care manager or social services coordinator) and nurse authorize, coordinate, and monitor your 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.

Co-payment: A fixed amount ($5, for example) you may be required to pay for a covered health care service.

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 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 Care 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. 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 must 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.

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

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

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

Enroll/Enrollment: Enrollment in Partnership is voluntary. To enroll, 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 5 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: Staff from the Income Maintenance agency determine an individual's financial eligibility for Medicaid, Partnership, and other public benefits.

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

Level of Care: Refers to the amount of help you need to perform your daily activities. You must be a "nursing home" level of care to be eligible for Partnership.

Long-Term Care (LTC): A variety of services that people may need because 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 a facility like a nursing home or and assisted living.

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.

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 downstairs.

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 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 aged 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.

Natural Supports: The people in your life who already choose to help you.

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

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

Notice of Adverse Benefit Determination: A written notice from the MCO explaining a specific change in service and the reason(s) for the change. The MCO must send the member a Notice of Adverse Benefit Determination if the MCO denies or limits a member's request for a service in the benefit package, 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 did not provide services in a timely way or did not meet the deadlines for handling an appeal. Other situations when MCOs send this notice include times when members did not like their care plan because it did not support their outcomes or requires members to accept care they did not 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 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 aged 60 and older. Contact information for these agencies is in Chapter 1.

Out-of-Network Provider: A person or group who doesn't have a contract with your MCO to give you services. To use a non-network provider, members first must contact their MCO.

Partnership Program: An integrated program providing medical and long-term care services and Medicare Part D covered drugs to frail elderly and adults with physical and developmental disabilities. All Partnership members must have a nursing home level of care as determined by the Wisconsin Long-term Care Functional Screen and must be enrolled in Wisconsin Medicaid. They may also be enrolled in Medicare. Partnership members must reside in a county in which Partnership is available.

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

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

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

Prior Authorization (Prior Approval or Pre-Authorization): 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.

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

Residential Services: 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 Care 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 to enroll and remain enrolled in *i*Care Family Care Partnership. See Chapter 2 for a list of the *i*Care Family Care Partnership service area.

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

State Fair Hearing: A hearing held by an Administrative Law Judge who works for the Wisconsin Division of Hearing and Appeals. See Chapter 8 for information about State Fair Hearings.

Home and Community-Based Waiver Service Definitions

Full-service 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 Care 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-decision makers. 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 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, 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 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 helps 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.

Appendix 2: Sample Notice of Adverse Benefit Determination

FAMILY CARE
NOTICE OF ADVERSE BENEFIT DETERMINATION

Mailing Date: Insert Date Notice Mailed

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

Member ID: Member's ID or MCI Number

Dear Member Name,

This notice confirms our discussion on insert date.

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

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

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

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

The details about this denial are as follows:

☐ **Terminate current service.**
Effective date of intended action:

☐ **Reduce current service.**
Effective date of intended action:
Description of current level:
New level after reduction:

☐ **Suspend current service.**
Effective date of intended action:
Expected date service will resume:

☐ **Deny request for service or support.**
Date of request:

☐ **Limit request for service or support.**

Date of request:
Description of requested level:
Authorized level of service or support:

☐ **Deny payment for service or support (member request).**
Date of request:
Date(s) service provided:
Provider or supplier:
Payment amount being denied: $

☐ **Deny payment for service or support (provider claim).**
Service or support:
Date(s) of denial(s):
Date(s) of claims(s):
Provider/Supplier:

The reason for our decision is that:

☐ The service or support is not an effective way to support your outcome(s).
☐ You do not need this service or level of service or support to support your outcome.
☐ We are already supporting your outcome in another way.
☐ The service or support you received was not authorized.
☐ An informal support has been identified and has agreed to provide this service or support for you.
☐ The service or support is being performed by a member of your household and the service or support benefits the other individuals residing in the household with you.
☐ Other:

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

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

Sincerely,

care manager name
care manager title
phone number

RN care manager name
RN Care Manager title
phone number

Appeal Rights

1. How to appeal this decision

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

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

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

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

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

2. Grievance and Appeal Committee

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

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

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

3. Continuation of services

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

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

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

4. Deadline to file your appeal with MCO name

You should file your appeal as soon as possible.

Your appeal to MCO name must be postmarked, faxed, or emailed no later than 60 calendar days from the mailing date on page one of this notice. **Important**: If you would like your benefits to continue during your appeal, your appeal must be postmarked, faxed, or emailed **insert effective date of intended action.**

5. Speeding up your appeal with MCO name

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

6. State fair hearing

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

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

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

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

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

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

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

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

a. MCO name's member rights specialist can inform you of your rights, try to informally resolve your concerns, and assist you with filing an appeal. The member rights specialist **cannot** represent you at a meeting with our Grievance and Appeal Committee or at a state fair hearing. To contact a member rights specialist, call Member Rights Specialist phone number.

b. Anyone receiving Family Care services can get free help from an **independent ombudsman**. The following agencies advocate for Family Care members:

For members age 18 to 59:
Disability Rights Wisconsin
Toll Free: 800-928-8778
TTY: 711

For members age 60 and older:
Wisconsin Board on Aging and Long Term Care
Toll Free: 800-815-0015
TTY: 711

Copy of your case file

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

Appendix 3: Sample Appeal Request Form

DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00237 (01/2019)

STATE OF WISCONSIN
Wis. Stats. § 46.287(2)(c)

APPEAL REQUEST – INDEPENDENT CARE HEALTH PLAN

Completing this form is voluntary. Personally identifiable information collected on this form is used to identify your case and process your request only.

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, suspension, or termination of a service
If you are getting benefits and you ask for an appeal before your benefits change, you can keep getting the same benefits until a decision on your appeal has been made. If you want to keep your benefits during your appeal, your request must be postmarked or faxed ***on or before*** **the effective date of the intended action**. If the Grievance and Appeal Committee decides that Independent Care Health Plan's decision was correct, you may need to repay the extra benefits that you got between the time you asked for your appeal and the time that the Grievance and Appeal Committee makes a decision. However, if it would cause you a large financial burden, you might not be required to repay this cost.

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

Copy of your case file
You have a right to a free copy of the information in your case file related to your appeal. Information means documents, records and other related material including any new or additional information Independent Care Health Plan gathers during your appeal.

☐ **Check this box if you would like to receive the information in your case file from Independent Care Health Plan related to your appeal.**

_____ _____
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.

Your appeal must be postmarked or faxed no later than **60 calendar days** from the date on the Notice of Adverse Benefit Determination.

Appendix 4: Sample State Fair Hearing Request Form

DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00236 (02/2020)

STATE OF WISCONSIN
Wis. Stats. § 46.287(2)(c)

REQUEST FOR A STATE FAIR HEARING

SECTION A – REQUIRED

Completing this form is voluntary. Personally identifiable information collected on this form is used to identify the case and process your request only.

Name – Member		Phone	Medicaid ID #
Mailing Address		Program ☐ Family Care ☐ Partnership ☐ PACE	
City	Zip Code	Managed Care Organization (MCO)	
Today's Date		Effective Date of Adverse Benefit Determination	

Continuing your services: If the adverse benefit determination affects your services and your request is received before the effective date, your services in most cases will not stop or be reduced. (If the judge decides that the MCO's decision was right, you may need to repay the extra services that you got between the time you asked for a fair hearing and the time that the judge makes a decision. However, if it would cause you a large financial burden, you might not be required to repay this cost.)

Do you wish your services to be continued? ☐ Yes ☐ No

SECTION B

Complete only if fair hearing request is related to: ☐ Eligibility ☐ Cost Share	Why are you asking for a hearing? (Attach additional sheet if needed.)

SECTION C

Complete only if fair hearing request is related to one of the below. To request a fair hearing related to one of the below, you must first go through your MCO's appeals process.

- ☐ Functional eligibility screen conducted by MCO
- ☐ Reduction, suspension or termination of service/support
- ☐ Denial or limited authorization of a requested service
- ☐ Denial of payment for a service
- ☐ Care plan
- ☐ Failure to provide services/supports in a timely manner
- ☐ Involuntary disenrollment from the MCO
- ☐ Denial of request to dispute a financial liability
- ☐ Denial of request to obtain services outside the MCO's network
- ☐ Failure of the MCO to make an appeal decision within the required timeframe

Why are you asking for a hearing? (Attach additional sheet if needed.)

☐ Yes	☐ No	1. Did you file an appeal with your MCO's Grievance and Appeal Committee? Date you filed the appeal:
☐ Yes	☐ No	2. Did you request the same services to continue during your appeal with the MCO?
☐ Yes	☐ No	3. Have you received a written decision from the MCO's Grievance and Appeal Committee? Attach a copy of the decision to this form **or** briefly describe the decision below: Summary of decision:
☐ Yes	☐ No	4. If you answered "No" to question 3, when was the MCO's Appeal and Grievance Committee decision due: . (If possible, attach a copy of the MCO's letter that told you when you would receive a decision.) Note: The MCO Appeal and Grievance Committee has up to 30 days to make a decision on your appeal. You must wait to see if the MCO sends you a decision on your appeal by the date in the letter before you can request a fair hearing.

SECTION D - REQUIRED

_____ _____

SIGNATURE – Member Date Signed

Mail or fax this form **AND** a copy of the MCO's appeal decision letter (or, if the MCO did not provide you with an appeal decision letter, the MCO's letter informing you of the date by which it would provide you with its decision) 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

Appendix 5: Sample Application for Reduction of Cost Share

DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-01827 (09/2020)

STATE OF WISCONSIN
Administrative Rule
DHS 10.34

APPLICATION FOR REDUCTION OF COST SHARE

Although completion of this form is voluntary, all the information requested on this form needs to be submitted as part of the approval process. Personally identifiable information is collected on this form for the sole purpose of identifying the program participant and processing the request, and will not be used for any other purpose.

Request for Reduction of Cost Share

- Are you a Family Care, Partnership, or PACE member?
- Do you have to pay a monthly cost share?
- Are you unable to pay your monthly cost share due to your necessary monthly living expenses?

If yes, you may qualify for a reduction of your cost share.

A cost share reduction may make your monthly living expenses more affordable, and allow you to stay enrolled in Family Care, Partnership, or PACE. Necessary monthly living expenses include costs such as mortgage payments, rent, home/renter's insurance, property taxes, utilities, food, clothing, hygiene items, and the cost of operating and maintaining a vehicle.

To request a reduction of your cost share, please complete the attached form, "Application for Reduction of Cost Share," and mail or fax it to the Bureau of Managed Care at:

Member Rights Specialist
Department of Health Services
Bureau of Managed Care
1 West Wilson Street, Room 518
P.O. Box 7851
Madison, WI 53707-7851
Phone: 1-855-885-0287
TTY: 711
Fax: 608-266-5629

Along with the application, you will need to submit proof of your monthly income, your monthly expenses, and the cost share you owe to your MCO each month. The application will tell you what kind of proof is needed and gives examples of the types of documents that provide that proof. The Wisconsin Department of Health Services will review your application to decide if the amount of cost share you pay each month can be reduced. The Department of Health Services will send you a letter approving or disapproving your request. If you have questions, please call 1-855-885-0287.

Who Can Help Me Complete This Form?

If you need help completing this form, you can obtain assistance, free of charge, from the following resource:

Benefit Specialists

A benefit specialist can help answer your questions. Services are free and confidential. To find a benefit specialist in your county of residence, contact your local Aging and Disability Resource Center or county aging office: https://www.dhs.wisconsin.gov/benefit-specialists/counties.htm.

APPLICATION FOR REDUCTION OF COST SHARE

Answer the questions on this form as completely as you can. If you are filling out this form for someone else, answer the questions as they apply to that person. If more space is needed, attach a separate sheet(s) of paper and indicate the number and letter (if any) of the question you are answering.

Section 1—Applicant Information

Last Name	First Name		Middle Initial
Mailing Address—Street	City	State	Zip Code
Telephone Number	Email Address		

Name of Managed Care Organization (MCO) Member is Enrolled in

Date of Birth (mm/dd/yyyy)	Medicaid ID Number or CARES ID

Section 2—Authorized Representative (complete this section if applicable)

Last Name—Representative	First Name—Representative		Middle Initial
Mailing Address—Street	City	State	Zip Code
Telephone Number	Email Address		

A. Source of Authority to Act as Member's Representative:

Check the boxes that apply. *Proof Required:* For any box you have checked, attach a copy of the document that grants you the authority to act as the member's representative. For example, a signed guardianship order or activated power of attorney document.

☐ Guardian of Estate ☐ Guardian of the Person ☐ Power of Attorney for Finances ☐ Attorney

☐ Power of Attorney for Health Care ☐ Other—Specify:

Section 3—Current Cost Share and Amount of Cost Share Reduction Requested

Answer the questions below. *Proof Required:* Attach a copy of your monthly cost share bill from the MCO or the State of Wisconsin.

A. What is your current monthly cost share amount? *(This is the amount of cost share you must pay to the MCO now.)*	$	per month
B. What is the amount of monthly cost share you can afford to pay? (*This is the amount of cost share you would pay the MCO if your request is fully granted.)*	$	per month

Section 4—Why Cost Share Reduction is Necessary

Please explain why you need a reduction in cost share (attach additional pages, if needed):

Section 5—Past Cost Share Amount	
A. Do you owe the MCO cost share for past months?	☐ Yes ☐ No
B. If yes, how much do you owe?	$

Section 6—Current Income Amount

List all types of income you receive below. *Proof required:* Attach documentation such as copy of social security statement, annual tax return, statement from a pension or annuity company, paystubs, bank records of deposits into your checking or savings account from social security, pension, or annuity.

A. Total monthly *gross* income (This is income before taxes, Medicare Part B and D premiums, and other deductions are taken out).	$ per month
B. Total monthly *net* income (This is the actual income you receive after taxes, Medicare Part B and D premiums, and other deductions are taken out). Also known as "take-home" pay.	$ per month

C. Source of income

TYPE	AMOUNT
☐ Social Security	$
☐ Pension	$
☐ Annuity	$
☐ Other Specify:	$
☐ Other Specify:	$
☐ Other Specify:	$
☐ Other Specify:	$

Section 7—Current Monthly Living Expenses

A. List your total monthly necessary living expenses below. *Proof required*: Attach documentation such as a copy of a mortgage statement, rental agreement or lease, condo fee invoice, property tax bill, insurance bill, utility bill.

TYPE	AMOUNT
☐ Mortgage	$
☐ Rent	$

☐ Home owner's insurance	$
☐ Renter's insurance	$
☐ Property taxes	$
☐ Condo fees	$
☐ Phone	$
☐ Gas	$
☐ Electric	$
☐ Sewer/septic	$
☐ Water	$
☐ Food	$
☐ Clothing	$
☐ Hygiene	$
☐ Maintenance and operation of vehicle	$
☐ Other Specify:	$
☐ Other Specify:	$
☐ Other Specify:	$
☐ Other Specify:	$

Section 8—Fair Hearing Request

Have you requested a fair hearing with the Wisconsin Department of Administration, Division of Hearings and Appeals regarding your cost share amount? ☐ Yes ☐ No

If yes, what is the date the hearing occurred or is set to occur?
Date (mm/dd/yyyy)

SIGNATURE – Member or Authorized Representative	Date Signed

Appendix 6: *i*Care Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The privacy of your personal and health information is important. You do not need to do anything unless you have a request or complaint.

This Notice of Privacy Practices applies to all entities that are part of the Insurance ACE, an Affiliated Covered Entity under HIPAA. The ACE is a group of legally separate covered entities that are affiliated and have designated themselves as a single covered entity for purposes of HIPAA. A complete list of the members of the ACE is available at https://huma.na/insuranceace

We may change our privacy practices and the terms of this notice at any time, as allowed by law, including information we created or received before we made the changes. When we make a significant change in our privacy practices, we will change this notice and send the notice to our health plan subscribers.

What is nonpublic personal or health information?

Nonpublic personal or health information includes both medical information and personal information, like your name, address, telephone number, Social Security number, account numbers, payment information, or demographic information. The term "information" in this notice includes any nonpublic personal and health information. This includes information created or received by a healthcare provider or health plan. The information relates to your physical or mental health or condition, providing healthcare to you, or the payment for such healthcare.

How do we collect information about you?

We collect information about you and your family when you complete applications and forms. We also collect information from your dealings with us, our affiliates, or others. For example, we may receive information about you from participants in the healthcare system, such as your doctor or hospital, as well as from employers or plan administrators, credit bureaus, and the Medical Information Bureau.

What information do we receive about you?

The information we receive may include such items as your name, address, telephone number, date of birth, Social Security number, premium payment history, and your activity on our website. This also includes information regarding your medical benefit plan, your health benefits, and health risk assessments.

How do we protect your information?

We have a responsibility to protect the privacy of your information in all formats including electronic and oral information. We have administrative, technical, and physical safeguards in place to protect your information in various ways including:

- Limiting who may see your information
- Limiting how we use or disclose your information
- Informing you of our legal duties about your information
- Training our employees about our privacy program and procedures

How do we use and disclose your information?

We use and disclose your information:

- To you or someone who has the legal right to act on your behalf
- To the Secretary of the Department of Health and Human Services

We have the right to use and disclose your information:

- To a doctor, a hospital, or other healthcare provider so you can receive medical care.
- For payment activities, including claims payment for covered services provided to you by healthcare providers and for health plan premium payments.
- For healthcare operation activities, including processing your enrollment, responding to your inquiries, coordinating your care, improving quality, and determining premiums.
- For performing underwriting activities. However, we will not use any results of genetic testing or ask questions regarding family history.
- To your plan sponsor to permit them to perform, plan administration functions such as eligibility, enrollment, and disenrollment activities. We may share summary level health information about you with your plan sponsor in certain situations. For example, to allow your plan sponsor to obtain bids from other health plans.

- Your detailed health information will not be shared with your plan sponsor. We will ask your permission, or your plan sponsor must certify they agree to maintain the privacy of your information.
- To contact you with information about health-related benefits and services, appointment reminders, or treatment alternatives that may be of interest to you. If you have opted out, we will not contact you.
- To your family and friends if you are unavailable to communicate, such as in an emergency.
- To your family and friends, or any other person you identify. This applies if the information is directly relevant to their involvement with your health care or payment for that care. For example, if a family member or a caregiver calls us with prior knowledge of a claim, we may confirm if the claim has been received and paid.
- To provide payment information to the subscriber for Internal Revenue Service substantiation.
- To public health agencies, if we believe that there is a serious health or safety threat.
- To appropriate authorities when there are issues about abuse, neglect, or domestic violence.
- In response to a court or administrative order, subpoena, discovery request, or other lawful process.
- For law enforcement purposes, to military authorities and as otherwise required by law.
- To help with disaster relief efforts.
- For compliance programs and health oversight activities.
- To fulfill our obligations under any workers' compensation law or contract.
- To avert a serious and imminent threat to your health or safety or the health or safety of others.
- For research purposes in limited circumstances and provided that they have taken appropriate measures to protect your privacy.
- For procurement, banking, or transplantation of organs, eyes, or tissue.
- To a coroner, medical examiner, or funeral director.

Will we use your information for purposes not described in this notice?

We will not use or disclose your information for any reason that is not described in this notice, without your written permission. You may cancel your permission at any time by notifying us in writing.

The following uses and disclosures will require your written permission:

- Most uses and disclosures of psychotherapy notes
- Marketing purposes
- Sale of personal and health information

What do we do with your information when you are no longer a member?

Your information may continue to be used for purposes described in this notice. This includes when you do not obtain coverage through us. After the required legal retention period, we destroy the information following strict procedures to maintain the confidentiality.

What are my rights concerning my information?

We are committed to responding to your rights request in a timely manner

- Access – You have the right to review and obtain a copy of your information that may be used to make decisions about you. You also may receive a summary of this health information. As required under applicable law,we will make this personal information available to you or to your designated representative.
- Adverse Underwriting Decision – If we decline your application for insurance, you have the right to be provided a reason for the denial.
- Alternate Communications – To avoid a life-threatening situation, you have the right to receive your information in a different manner or at a different place. We will accommodate your request if it is reasonable.
- Amendment – You have the right to request correction of any of this personal information through amendment or deletion. Within 60 business days of receipt of your written request, we will notify you of our amendment or deletion

of the information in dispute, or of our refusal to make such correction after further investigation. If we refuse to amend or delete the information in dispute, you have the right to submit to us a written statement of the reasons for your disagreement with our assessment of the information in dispute and what you consider to be the correct information. We shall make such a statement accessible to any and all parties reviewing the information in dispute.*

- Disclosure – You have the right to receive a listing of instances in which we or our business associateshave disclosed your information. This does not apply to treatment, payment, health plan operations, and certain other activities. We maintain this informationand make it available to you for six years. If you request this list more than once in a 12-month period, we may charge you a reasonable, cost-based fee.
- Notice – You have the right to request and receive a written copy of this notice any time.
- Restriction – You have the right to ask to limit how your information is used or disclosed. We are not required to agree to the limit, but if we do, we will abide byour agreement. You also have the right to agree to or terminate a previously submitted limitation.

If I believe that my privacy has been violated, what should I do?

If you believe that your privacy has been violated, you may file a complaint with us by calling us at 1-866-861-2762 any time.

You may also submit a written complaint to the U.S. Department of Health and Human Services, Office for Civil Rights (OCR). We will give you the appropriate OCR regional address on request. You can also email your complaint to OCRComplaint@hhs.gov. If you elect to file a complaint, your benefits will not be affected, and we will not punish or retaliate against you in any way.

We support your right to protect the privacy of your personal and health information.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

We can change the terms of this notice, and the changes will apply to all information we have about you.

The new notice will be available upon request, in our office, and on our web site.

How do I exercise my rights or obtain a copy of this notice?

All of your privacy rights can be exercised by obtaining the applicable forms. You may obtain any of the forms by:

- Contacting us at 1-866-861-2762
- Accessing our website at Humana.com and going to the Privacy Practices link
- Send completed request form to:
  Humana Inc. Privacy Office 003/10911
  101 E. Main Street
  Louisville, KY 40202

*This right applies only to our Massachusetts residents in accordance with state regulations.

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Use this page to write any notes or details of your *i*Care Partnership Program you would like to remember.

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Not a member yet?

For more information about the *i*Care Family Care Partnership Program, please contact your local Resource Center. A few are listed below.

More ADRC sites can be found on www.dhs.wisconsin.gov/adrc

- Adams County: 1-877-883-5378
- Columbia County: 1-888-742-9233
- Dane County: 1-855-417-6892
- Dodge County: 1-800-924-6407
- Green Lake County: 1-877-883-5378
- Jefferson County: 1-866-740-2372
- Kenosha County: 1-800-472-8008
- Marquette County: 1-855-440-2372
- Milwaukee County: 1-414-289-6874
- Racine County: 1-866-219-1043
- Sauk County: 1-877-794-2372
- Waushara County: 1-877-883-5378
- TTY for all sites: 711

Existing Members call Customer Service

1-800-777-4376, TTY: 711, 24 hours a day, 7 days a week.

Our office hours are Monday – Friday, 8:30 a.m. – 5:00 p.m.

For more information, please call us at the phone number above or visit us on the web.

You can see our plan's Provider/Pharmacy Directory at our web site at www.iCareHealthPlan.org

You can see the complete plan Formulary (list of Part D prescription drugs) and any restrictions on our web site at www.iCareHealthPlan.org

iCare
INDEPENDENT CARE HEALTH PLAN
*i*Care is a wholly-owned subsidiary of Humana

Corporate Office
1555 North RiverCenter Drive, Suite 206
Milwaukee, Wisconsin 53212

www.iCareHealthPlan.org