COMMUNITY HEALTH CHOICE

MEMBER RIGHTS & RESPONSIBILITIES – MEDICARE (HMO D-SNP)

MEMBER RIGHTS

- A Member has the right to respect, dignity, privacy, confidentiality, and nondiscrimination. That includes the right to:
    - Be treated fairly and with respect.
    - Know that their medical records and discussions with their Providers will be kept private and confidential.
- A Member has the right to see the information in their medical records and know how it has been shared with others.
- If a Member feels they have been treated unfairly or their rights are not being respected, they have the right to call the Office for Civil Rights, Community Health Choice Member Services, the State Health Insurance Assistance Program or Medicare.
- A Member has the right to a reasonable opportunity to choose a healthcare plan and PCP. The PCP is the doctor or healthcare Provider they will see most of the time and who will coordinate their care. A Member has the right to change to another plan or Provider in a reasonably easy manner. That includes the right to:
- Be told how to choose and change their health plan and PCP.
- Choose any health plan they want that is available in their area and choose their PCP from that plan.
- Change their PCP.
- Change their health plan during open enrollment or special election period without penalty.
- A Member has the right to ask questions and get answers about anything they do not understand. That includes the right to:
    - Have their Provider explain their healthcare needs to them and talk to them about the different ways their healthcare problems can be treated.
    - Be told why care or services were denied and not given and receive written explanation of why services were denied.
- A Member has the right to agree to or refuse treatment and actively participate in treatment decisions. That includes the right to:
    - Work as part of a team with their Provider in deciding what health care is best for them.
    - Say yes or no to the care recommended by their Provider.
    - Know the risks.
    - A Member has the right to receive instructions about what is to be done if they are not able to make medical decisions for themselves.
- A Member has the right to use each available complaint and appeal process through the managed care organization, through Medicare, and through Medicaid, and get a timely response to complaints, appeals, and fair hearings. That includes the right to:
    - Make a complaint to Community Health Choice, to Medicare or to the state Medicaid program about their health care, their Provider, or Community Health Choice.
    - Use the plan's appeal process and be told how to use it.
    - Ask for a fair hearing from the state Medicaid program or the appeals process allowed under the D-SNP program, and get information about how that process works.
- A Member has the right to timely access to care that does not have any communication or physical access barriers. That includes the right to:
    - Have telephone access to a medical professional 24 hours a day, 7 days a week to get any emergency or urgent care they need.

    - Get medical care in a timely manner. Community Health Choice, and its contracted Providers, are responsible for ensuring that a Member has timely access to covered services and drugs.
    - Be able to get in and out of a healthcare Provider's office. This includes barrier-free access for people with disabilities or other conditions that limit mobility, in accordance with the Americans with Disabilities Act.
    - Have interpreters, if needed, during appointments with their Providers and when talking to Community Health Choice. Interpreters include people who can speak in their native language, help someone with a disability, or help them understand the information.
- Have plan information provided in a way that works for them, including Braille, large print, or other alternative formats.
- Be given information they can understand about Community Health Choice rules, including the healthcare services they can get and how to get them, networks Providers and network pharmacies, and about why something is not covered and what they can do about it.
- A Member has the right to not be restrained or secluded when it is for someone else's convenience, to force them to do something they do not want to do or punish them.
- A Member has a right to know that doctors, hospitals, and others who care for them can advise them about their health status, medical care, and treatment. Community Health Choice cannot prevent them from giving them this information, even if the care or treatment is not a covered service.
- A Member has a right to know that they are not responsible for paying for covered services. Doctors, hospitals, and others cannot require them to pay copayments or any other amounts for covered services when there is no Member liability. Providers cannot balance bill a Member.

MEMBER RESPONSIBILITIES

- A Member must learn and understand each right they have under the Medicare program. That includes the responsibility to:
    - Ask questions if they do not understand their rights.
    - Learn what choices of health plans are available in their area.
- A Member must abide by Community Health Choice, Medicare, and Medicaid policies and procedures. That includes the responsibility to:
    - Learn and follow their health plan, Medicare, and Medicaid rules.
    - Choose their health plan and a PCP quickly.
    - Make any changes in their health plan and PCP in the ways established by Medicaid and by Community Health Choice.
    - Keep their scheduled appointments.
    - Cancel appointments in advance when they cannot keep them.
    - Always contact their PCP first for their non-emergency medical needs.
    - Be sure they have approval from their PCP before going to a specialist.
    - Understand when they should and should not go to the emergency room.
- A Member must share information about their health with their PCP and learn about service and treatment options. That includes the responsibility to:
    - Tell their PCP about their health.
    - Talk to their Providers about their healthcare needs and ask questions about the different ways their healthcare problems can be treated.
    - Help their Providers get their medical records.
- A Member must be involved in decisions relating to service and treatment options, make personal choices, and take action to maintain their health. That includes the responsibility to:
    - Work as a team with their Provider in deciding what health care is best for them.
    - Understand how the things they do can affect their health.
    - Do the best they can to stay healthy.
    - Treat Providers and staff with respect.

- Talk to Providers about all medications, both prescription and non-prescription.

MEMBER INFORMATION ABOUT ADVANCE DIRECTIVES

With advances in medical technology, physicians and the healthcare team have the ability to save the life of a person who would not otherwise have the chance to live. While this is a benefit to many people, it has also caused problems for the patients and/or families of those who are terminally ill or have irreversible injuries. By prolonging their life, it can also prolong the process of dying.

A Member has the right to make advance decisions about their treatment in the event that the Member is not able to make those decisions at the time they are needed. The Member's wishes can be recorded on a document called a "Directive to Physician" or indicated by providing a "Medical Power of Attorney."

A Member has the right to declare preferences or provide directions for behavioral health treatment, including electroconvulsive or other convulsive treatment and treatment of mental illness with psycho-active medication, as defined by the Health and Safety Code, as well as emergency behavioral health treatment. The Member can create a document called a "Declaration for Mental Health Treatment." All Community Health Choice Members have the right to informed choices and to refuse treatment or therapy.

Community Health Choice Members have the right to be informed of their health condition, consent diagnosis, prognosis, and the expected results and associated risks of certain diagnostic, treatment, and therapeutic choices. Community Health Choice recognizes the right of every individual to self-determination concerning his/her own body. This right may prevail even when the decision of the individual is considered to be unwise or contrary to the individual's best medical interest. Community Health Choice physicians have a duty to respect this right and must work within the scope of authorized patient consent. Any time there are risks involved, participating physicians should obtain the informed consent of the Member, in addition to the required permissive consent.

Members may be terminated from Community Health Choice if there are repeated incidents of unreasonable refusal of a Member to follow a prescribed course of medical treatment. In such instances, the physician should contact the Community Health Choice Medical Director to discuss the course of action. Community Health Choice strongly recommends that Providers encourage Members to complete an advanced directive.

How Members Can Designate an Authorized Representative
Individuals who represent Community Health Choice (HMO D-SNP) Members may either be appointed or authorized to act on behalf of the Member in filing a grievance, requesting an initial determination or in dealing with any of the levels of the appeals process. The chart below outlines who can appoint a representative, who can serve as a representative, and the documentation required by Community Health Choice before the appointment of representative is considered valid.

Who can Appoint a Representative	Who can Act or be Appointed as a Representative	Requirement for Representation
Member	Any individual (e.g., relative, friend, advocate, attorney)	The Member must submit Form CMS-1696, Appointment of Representative (AOR), or an equivalent written notice (hereinafter, collectively referred to as a representative form).
A court acting in accordance with state or other applicable law	An individual authorized by the court. Could include, but is not limited to: • Court-appointed guardian • Individual with durable power of attorney • A healthcare proxy • A person designated under a healthcare consent statute	A representative form is not required. • Authorized individual must produce appropriate legal papers supporting his or her status under state law.

All AORs are valid for one year from the date the AOR or equivalent written notice is signed by both the Member and the appointed authorized representative, unless revoked before the one-year expiration date.

Appointment of Representative – Written Request Equivalent to CMS Form 1696
Community Health Choice accepts Appointment of Representative (AOR) requests from its Members that are either on the CMS Form 1696 or an equivalent written notice. The AOR form can be located at this link https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or via the Provider Portal at www.CommunityHealthChoice.org/Medicare. The form is also available in Spanish. If a Member elects not to use the AOR form, s/he can submit an equivalent written notice. The equivalent written notice must include the following elements:

- Name, address, and telephone numbers of the Member and the individual being appointed;
- Member's Medicare Beneficiary Identifier, or plan ID number;
- The appointed representative's professional status or relationship to the party;
- A written explanation of the purpose and scope of the representation;
- A statement that the Member is authorizing the representative to act on his or her behalf for the claim(s) at issue, and a statement authorizing disclosure of individually identifying information to the representative;
- A statement by the individual being appointed that he or she accepts the appointment; and
- Is signed and dated by the Member and the individual being appointed.

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