Excerpt from HAP Empowered MI Health Link Medicare-Medicaid Plan

2021 Member Handbook

Effective January 1, 2021

Rights and Responsibilities

Chapter 8: Your rights and responsibilities

Introduction

In this chapter, you will find your rights and responsibilities as a member of the plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of the *Member Handbook*.

A. Your right to get information in a way that meets your needs

We must tell you about the plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call Customer Service or your Care Coordinator at (888) 654-0706 (TTY: 711), seven days a week, 8 a.m. to 8 p.m. Our plan has people who can answer questions in any language.
- Our plan can also give you materials in languages other than English and in formats such as large print or audio. Contact the HAP Empowered MI Health Link Customer Service department to request documents in different languages, for example Arabic or Spanish.
- You may also request your materials be sent to you in your preferred language other than English and/or alternate format for future mailings.
- We will keep your preference for mailings and communications on file, so you do not need to make a separate request each time. If you ever change your mind, you can always contact Customer Service.
- A right to make recommendations regarding the organization's member rights and responsibilities policy.
- A right to receive information about the organization, its services, its practitioners, and provider and member rights and responsibilities.
- If you are having trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call Medicare at 1-800-MEDICARE (800) 633-4227. You can call 24 hours a day, 7 days a week. TTY users should call (877) 486-2048. You may also file a complaint with Michigan Medicaid. Please see Chapter 9 for more information.

B. Our responsibility to treat you with respect, fairness, and dignity at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** against members because of any of the following:

- Age
- Appeals
- Behavior
- Claims experience
- Ethnicity
- Evidence of insurability
- Gender identity
- Genetic information
- Geographic location within the service area
- Health status
- Medical history
- Mental ability
- Mental or physical disability
- National origin
- Race
- Receipt of health care
- Religion
- Sex
- Sexual orientation
- Use of services

Under the rules of the plan, you have the right to be free of any form of physical restraint or seclusion that would be used as a means of coercion, force, discipline, convenience, or retaliation.

We cannot deny services to you or punish you for exercising your rights.

- For more information, or if you have concerns about discrimination or unfair treatment, call the Department of Health and Human Services' **Office for Civil Rights** at (800) 368-1019 (TTY (800) 537-7697). You can also visit https://www.hhs.gov/ocr for more information.
- You can also call the Michigan Department of Civil Rights at (800) 482-3604. The office nearest to our service area is located in Detroit. They can be

reached at (313) 456-3700 or toll free at (800) 482-3604. TTY users dial (877) 878-8464.

- If you have a disability and need help accessing care or a provider, call Customer Service. If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

C. Our responsibility to ensure that you get timely access to covered services and drugs

As a member of our plan:

- You have the right to choose a primary care provider (PCP) in the plan's network. A network provider is a provider who works with the health plan. You also have the right to change the PCP within your health plan. You can find more information about choosing a PCP in Chapter 3.
    - Call Customer Service or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You have the right to go to a women's health specialist without getting a referral. A referral is approval from your PCP to see someone that is not your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
    - This includes the right to get timely services from specialists.
- You have the right to get emergency services or care that is urgently needed without prior approval.
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can see an out-of-network provider. To learn about out-of-network providers, see Chapter 3.

Chapter 9 tells what you can do if you think you are not getting your services or drugs within a reasonable amount of time. Chapter 9 also tells what you can do if we have denied coverage for your services or drugs and you do not agree with our decision.

D. Our responsibility to protect your personal health information (PHI)

We protect your personal health information (PHI) as required by federal and state laws.

- Your PHI includes the information you gave us when you enrolled in this plan. It also includes your medical records and other medical and health information.

- You have rights to get information and to control how your PHI is used. We give you a written notice that tells about these rights. The notice is called the "Notice of Privacy Practice." The notice also explains how we protect the privacy of your PHI.

D1. How we protect your PHI

- We make sure that unauthorized people do not see or change your records.
- In most situations, we do not give your PHI to anyone who is not providing your care or paying for your care. If we do, we are required to get written permission from you first. Written permission can be given by you or by someone who has the legal power to make decisions for you.
- There are certain cases when we do not have to get your written permission first. These exceptions are allowed or required by law.
    - We are required to release PHI to government agencies that are checking on our quality of care.
    - We are required to give Medicare and Michigan Medicaid your PHI. If Medicare or Michigan Medicaid releases your information for research or other uses, it will be done according to Federal and State laws.

D2. You have a right to see your medical records

- You have the right to look at your medical records and to get a copy of your records. We are allowed to charge you a reasonable fee for making a copy of your medical records.
- You have the right to amend or correct information in your medical records. The correction will become part of your record.
- You have the right to know if and how your PHI has been shared with others.

If you have questions or concerns about the privacy of your PHI, call Customer Service at (888) 654-0706 or HAP's Compliance Hotline at (877) 746-2501 (TTY: 711). You can remain anonymous.

E. Our responsibility to give you information about the plan, its network providers, and your covered services

As a member of HAP Empowered MI Health Link, you have the right to get information from us. If you do not speak English, we have free interpreter services to answer any questions you may have about our health plan. To get an interpreter, just call us at (888) 654-0706 (TTY: 711), seven days a week, 8 a.m. to 8 p.m. This is a free service. We can also give you information in large print, audio, or different languages, for example Arabic or Spanish.

If you want information about any of the following, call Customer Service:

- How to choose or change plans

- Our plan, including:
  - Financial information
  - How the plan has been rated by plan members
  - The number of appeals made by members
  - How to leave the plan
- Our network providers and our network pharmacies, including:
  - How to choose or change primary care providers
  - Qualifications of our network providers and pharmacies
  - How we pay providers in our network
  - For a list of providers and pharmacies in the plan's network, see the *Provider and Pharmacy Directory*. For more detailed information about our providers or pharmacies, call Customer Service, or visit our website at www.hap.org/mihealthlink.
- Covered services and drugs and about rules you must follow, including:
  - Services and drugs covered by the plan
  - Limits to your coverage and drugs
  - Rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it, including asking us to:
  - Put in writing why something is not covered
  - Change a decision we made
  - Pay for a bill you got

F. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot charge you if we pay for less than the provider charged us. To learn what to do if a network provider tries to charge you for covered services, see Chapter 7.

G. Your right to leave the plan

No one can make you stay in our plan if you do not want to.

- You have the right to get most of your health care services through Original Medicare or a Medicare Advantage plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from a Medicare Advantage plan.
- See Chapter 10 for more information about when you can join a new Medicare Advantage or prescription drug benefit plan.
- If there is another MI Health Link plan in your service area, you may also change to a different MI Health Link plan and continue to get coordinated Medicare and Michigan Medicaid benefits.
- You can get your Michigan Medicaid benefits through Michigan's original (fee-for-service) Medicaid.

H. Your right to make decisions about your health care

H1. Your right to know your treatment options and make decisions about your health care

You have the right to get full information from your doctors and other health care providers when you get services. Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- A candid discussion of appropriate or medically necessary treatment options for your health conditions, regardless of cost or benefit coverage.
- Participate with practitioners in making decisions about your health care.
- **Know your choices.** You have the right to be told about all the kinds of treatment.
- **Know the risks.** You have the right to be told about any risks involved. You must be told in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to see another doctor before deciding on treatment.
- **Say "no."** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You also have the right to stop taking a drug. If you refuse treatment or stop taking a drug, you will not be dropped from the plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.

- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider has denied care that you believe you should get.
- **Ask us to cover a service or drug that was denied or is usually not covered.** This is called a coverage decision. Chapter 9 tells how to ask the plan for a coverage decision.

H2. Your right to say what you want to happen if you are unable to make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form to **give someone the right to make health care decisions for you.**
- **Give your doctors written instructions** about how you want them to handle your health care if you become unable to make decisions for yourself.

The legal document that you can use to give your directions is called an advance directive. There are different types of advance directives and different names for them. Examples are a psychiatric advance directive and a durable power of attorney for health care.

Now is a good time to write down your advance directives because you can make your wishes known while you are healthy. Your doctor's office has an advance directive you fill out to tell your doctor what you want done. Your advance directive often includes a do-not-resuscitate order. Some people do this after talking to their doctor about their health status. It gives written notice to health care workers who may be treating you should you stop breathing or your heart stops. Your doctor can help you with this if you are interested.

You do not have to use an advance directive, but you can if you want to. Here is what to do:

- **Get the form.** You can get a form from your doctor, a lawyer, a legal services agency, or a social worker. Organizations that give people information about Medicare or Michigan Medicaid, such as the Medicare/Medicaid Assistance Program (MMAP) may also have advance directive forms. You can also contact Customer Service to ask for the forms.
- **Fill it out and sign the form.** The form is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to people who need to know about it.** You should give a copy of the form to your doctor. You should also give a copy to the person you name as the one to make decisions for you. You may also want to give copies to close friends or family members. Be sure to keep a copy at home.
- If you are going to be hospitalized and you have signed an advance directive, **take a copy of it to the hospital**.

The hospital will ask you whether you have signed an advance directive form and whether you have it with you.

If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice to fill out an advance directive or not.

H3. What to do if your instructions are not followed

In Michigan, your advance directive has binding effect on doctors and hospitals. However, if you believe that a doctor or a hospital did not follow the instructions in your advance directive, you may file a complaint with the Michigan Department of Licensing and Regulatory Affairs, Bureau of Health Care Services at (**800) 882-6006.**

I. Your right to make complaints and to ask us to reconsider decisions we have made

Chapter 9 tells what you can do if you have any problems or concerns about your covered services or care. For example, you could ask us to make a coverage decision, make an appeal to us to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other members have filed against our plan. To get this information, call Customer Service.

I1. What to do if you believe you are being treated unfairly or you would like more information about your rights

If you believe you have been treated unfairly—and it is **not** about discrimination for the reasons listed in Chapter 11, or you would like more information about your rights, you can get help by calling:

- Customer Service.
- The State Health Insurance Assistance Program (SHIP). In Michigan, the SHIP is called the Medicare/Medicaid Assistance Program (MMAP). For details about this organization and how to contact it, see Chapter 2.
- Medicare at 1-800-MEDICARE (800) 633-4227, 24 hours a day, 7 days a week. TTY users should call (877) 486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
- The MI Health Link Ombudsman program. For details about this organization and how to contact it. Call toll-free (888) 746-6456 or email help@MHLO.org.

J. Your responsibilities as a member of the plan

As a member of the plan, you have a responsibility to do the things that are listed below. If you have any questions, call Customer Service.

- **Read the *Member Handbook*** to learn what is covered and what rules you need to follow to get covered services and drugs. For details about your:
  - Covered services, see Chapters 3 and 4. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
  - Covered drugs, see Chapters 5 and 6.
- **Tell us about any other health or prescription drug coverage** you have. We are required to make sure you are using all of your coverage options when you get health care. Please call Customer Service if you have other coverage.
- **Tell your doctor and other health care providers** that you are enrolled in our plan. Show your Member ID Card whenever you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
  - Give them the information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
  - A responsibility to understand their health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
  - Make sure your doctors and other providers know about all of the drugs you are taking. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you do not understand the answer, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act with respect in your doctor's office, hospitals, and other providers' offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - Medicare Part A and Medicare Part B premiums. For almost all HAP Empowered MI Health Link members, Michigan Medicaid pays for your Part A premium and for your Part B premium.

  - The amount of money you may be asked to pay for the time you stay in a nursing home is based on your income and determined by the State of Michigan. Chapter 4 provides additional information about the Patient Pay Amount (PPA) for nursing facility services.
  - Any Freedom to Work program premium you have. If you have questions about the Freedom to Work program, contact your local Michigan Department of Health & Human Services (MDHHS) office. You can find contact information for your local MDHHS office by visiting https://www.michigan.gov/mdhhs/0,5885,7-339-73970_5461---,00.html.
  - **If you get any services or drugs that are not covered by our plan, you must pay the full cost.**
  - If you disagree with our decision to not cover a service or drug, you can make an appeal. Please see Chapter 9 to learn how to make an appeal.
- **Tell us if you move.** If you are going to move, it is important to tell us right away. Call Customer Service.
  - **If you move outside of our service area, you cannot stay in this plan.** Only people who live in our service area can get HAP Empowered MI Health Link. Chapter 1 tells about our service area.
  - We can help you figure out whether you are moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can let you know if we have a plan in your new area.
  - Also, be sure to let Medicare and Michigan Medicaid know your new address when you move. See Chapter 2 for phone numbers for Medicare and Michigan Medicaid.
  - **If you move within our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- Call Customer Service for help if you have questions or concerns.
- Enrollees age 55 and older who are getting long-term care services may be subject to estate recovery upon their death. For more information, you may:
  - Contact your Care Coordinator, **or**
  - Call the Beneficiary Helpline at (800) 642-3195, **or**
  - Visit the website at www.michigan.gov/estaterecovery, **or**
  - Email questions to MDHHS-EstateRecovery@michigan.gov

K. Information about our quality program

How HAP ensures quality service and care

HAP's quality program ensures all our members get the highest quality health care. This means that medical and behavioral health services are safe and effective, based on patients' needs and delivered efficiently, fairly, and when they're needed. We constantly assess the program to find out what's working well and where we need to improve. Here are some of the questions we study:

- Are our members getting the right kind of care, in the right place and at the right time?
- Are they satisfied with their care?
- Are our members up-to-date on screenings, vaccinations, and other services needed to keep them healthy?
- How well are our members managing chronic diseases like diabetes and heart failure?
- Do our members and providers understand important guidelines that are based on medical research and evidence?
- How well do our hospitals perform on certain quality and safety measures?
- What else can we do to make sure that our members have access to the highest quality health care, programs, and services to keep them healthy and safe?

Our Quality Plan includes goals such as:

1. Improving clinical data and processes. Evaluation to ensure that data collection is timely, accurate, and relevant to our members, and that processes are in place to meet National Committee for Quality Assurance (NCQA), State of Michigan, and Federal regulatory compliance standards.
2. Improving quality and safety of services and health outcomes for members. Evaluation of members' health care against national or evidence-based standards. This allows us to identify gaps in care and services that directly affect safety and health outcomes. Examples of services that are evaluation are flu shots, medication adherence, screening tests, and preventive care visits.
3. Assuring appropriate utilization of health care services. Evaluation of medical necessity and cost effectiveness of health care services delivered to members, using accepted and standardized utilization criteria to screen for benefit coverage medical necessity.

4. Improving member and provider satisfaction. Evaluation of members' and providers' satisfaction with care through surveys and by tracking complaints and grievances. One type of survey is called CAHPS (Consumer Assessment of Healthcare Providers and Systems). This tells HAP if you are happy with your care and your provider. It also tells us what we can make better for you.

Read the annual Quality Program report

Each year, we show HAP's ongoing commitment to improved performance by conducting an extensive analysis that you can use to identify trends and make informed choices about health care. We summarize our objectives and progress in our quality program report, go to www.hap.org/mihealthlink and then click on *Member Resources* and select Rights and Responsibilities/Safe and Quality Care. Members can also contact the Customer Service department at (888) 654-0706 and request to speak with the Quality Management department for copies of the materials.