BENEFICIARY RIGHTS AND RESPONSIBILITIES

Beneficiaries have specific rights and responsibilities that accompany eligibility and participation in the Medicaid and Medicaid waiver programs. Support coordinators and service providers must assist beneficiaries to exercise their rights and responsibilities. Every effort must be made to assure that applicants or beneficiaries understand their available choices and the consequences of those choices. Support coordinators and service providers are bound by their provider agreement with Medicaid to adhere to the following policies on beneficiary rights.

Each individual who requests Community Choices Waiver (CCW) services has the option to designate a responsible representative to assist or act on his/her behalf in the process of accessing and/or maintaining CCW services. The beneficiary has the right to change his/her responsible representative at any time. The responsible representative may not concurrently serve as a responsible representative for more than two beneficiaries in a Medicaid home and community-based service program that is operated by the Office of Aging and Adult Services (unless an exception is granted by OAAS) which includes, but is not limited to:

1. Program of All-Inclusive Care for the Elderly (PACE);
2. Long-Term Personal Care Services (LT-PCS);
3. Community Choices Waiver (CCW); and
4. Adult Day Health Care (ADHC) Waiver.

Freedom of Choice of Program

Individuals who have been offered waiver services have the freedom to choose between institutional care services and community-based services. They are informed of their alternatives under the waiver at the time they are going through the Medicaid application and determination process. These individuals have the responsibility to participate in this process which includes providing medical and other pertinent information or assisting in obtaining this information to be used in the person-centered planning and service approval process. When applicants are admitted to the waiver, they have access to an array of Medicaid services.

Freedom of Choice of Agencies/Providers

Beneficiaries have the freedom of choice to select their support coordination agency/providers. Beneficiaries may make agency/provider changes based on the following schedule:

Type of Service	Without Good Cause	With Good Cause
Transition Service	Not applicable	Not applicable
Personal Assistance Service	Every three months based on a calendar quarter	Any time
Transition Intensive Support Coordination Support Coordination	Beneficiaries must have been with the agency at least six months	Any time
Adult Day Health Care	Once every six months with the change effective beginning the 1st day of the following calendar quarter	Any time
Environmental Accessibility Adaptation Skilled Maintenance Therapy Nursing Assistive Devices and Medical Supplies Caregiver Temporary Support Service Home Delivered Meals Monitored In-Home Caregiving Services	Every six months	Any time

Good cause is defined as:

1. A beneficiary moving to another region in the state where the current provider/agency does not provide services;

2. The beneficiary and the provider/agency have unresolved difficulties and mutually agree to a transfer;

3. The beneficiary's health or welfare has been compromised; or

4. The provider/agency has not rendered services in a manner satisfactory to the beneficiary.

Support coordinators will provide beneficiaries with their choice of providers and help arrange and coordinate all the services on the Plan of Care (POC).

The Office of Aging and Adult Services (OAAS), or its designee will provide beneficiaries with their choice of support coordination agencies.

Adequacy of Care

All beneficiaries in home and community-based services waiver programs have the right to choose and receive the services necessary to support them to live in a community setting. Beneficiaries have the right to choose how, where, and with whom they live. Services are arranged and coordinated through support coordination and approved by the OAAS regional office or its designee. Administrative limits are placed on some services according to the waiver that is authorized by the Center for Medicare and Medicaid Services (CMS).

Beneficiaries have the responsibility to request only those services they need and not request excess services, or services for the convenience of employees, providers or support coordinators. Units of service are not "saved up". The services are certified as medically necessary for the beneficiary to be able to stay in the community and are revised on the POC as each beneficiary's needs change. The support coordinator must be informed any time there is a change in the beneficiary's health, medication, physical conditions, and/or living situation.

Participation in Care

Each beneficiary shall participate in the assessment and person-centered planning meetings and any other meeting involving decisions about services and supports to be provided as part of the waiver process. Each beneficiary may choose whether or not providers attend assessment and planning meetings. Person-centered planning will be utilized in developing all services and

supports to meet the beneficiary's needs. By taking an active part in planning his/her services, the beneficiary is better able to utilize the available supports and services. The beneficiary is expected to participate in the planning process to the best of the beneficiary's ability so that services can be delivered according to the approved person-centered POC. The beneficiary shall report any service need change to his/her support coordinator and service provider(s).

Changes in the amount of services must be requested by the beneficiary and submitted to the support coordinator as soon as the need is identified. The support coordinator will prepare and submit the POC revision in accordance with the required timelines. Providers may not initiate a request for change/adjustment of service(s), or modifications to the POC, without the participation and consent of the beneficiary. These changes must be approved by the OAAS regional office or its designee.

Voluntary Participation

Beneficiaries have the right to refuse services, to be informed of the alternative services available to them, and to know the consequences of their decisions. Therefore, a beneficiary will not be required to receive services or participate in activities that they do not want, even if they are eligible for these services. The intent of CCW is to provide community-based services to individuals who would otherwise require care in a nursing facility. Providers must reasonably assure that the beneficiary's health and welfare needs are met. As part of the planning process, methods to comply with these assurances may be negotiated to suit the beneficiary's needs.

Quality of Care

Each home and community-based services waiver beneficiary has the right to be treated with dignity and respect and receive services from provider employees who have been trained and are qualified to provide them. In addition, providers are required to maintain privacy and confidentiality in all interactions related to the beneficiary's services.

Beneficiaries have the right to be free from abuse (mental, physical, emotional, coercion, restraints, seclusion, and any other forms of restrictive interventions).

In cases where services are not delivered according to the approved POC, or there are allegations of abuse, neglect, exploitation, or extortion, the beneficiary shall follow the reporting procedures and inform the support coordinator, provider, and appropriate authorities.

Beneficiaries and providers shall cooperate in the investigation and resolution of reported incidents/complaints.

Beneficiaries must maintain a safe and lawful home environment and may not request providers

to perform tasks that are illegal or inappropriate, and they may not violate the rights of other beneficiaries.

Civil Rights

Providers shall operate in accordance with Title VI and VII of the Civil Rights Act of 1964, as amended and the Vietnam Veterans Readjustment Act of 1974 and all requirements imposed by or pursuant to the regulations of the U.S. Department of Health and Human Services. This means that individuals are accepted and that all services and facilities are available to persons without regard to race, color, religion, age, sex, or national origin. Beneficiaries have the responsibility to cooperate with their providers by not requesting services which in any way violate these laws.

Notification of Changes

The Bureau of Health Services Financing (BHSF) is responsible for determining financial eligibility for CCW beneficiaries. In order to maintain eligibility, beneficiaries and providers have the responsibility to inform BHSF of changes in the beneficiary's income, resources, address, and living situation.

OAAS or its designee is responsible for approving level of care and medical certification. Beneficiaries and their providers have the responsibility to inform the OAAS of any changes which affect programmatic waiver eligibility requirements, including changes in level of care.

Grievances/Complaints

The beneficiary has a responsibility to bring problems to the attention of providers or the Medicaid program and to file a grievance/complaint without fear of retribution, retaliation, or discharge.

All support coordination and direct service providers must have grievance procedures through which beneficiaries may voice complaints regarding the supports or services they receive. Beneficiaries must be provided a copy of the grievance procedures upon admission to a direct service provider and complaint/grievance forms shall be given to beneficiaries thereafter upon request. It is the beneficiary's right to contact any advocacy resource as needed, especially during grievance procedures.

If beneficiaries need assistance, clarification, or to report a complaint, toll-free numbers are available (See Appendix A for contact information).

Fair Hearings

Beneficiaries must be advised of their rights to appeal any agency action or decision resulting in suspension, reduction, discontinuance, or termination of services. Beneficiaries have the right to a fair hearing through the Division of Administrative Law (DAL). In the event of a fair hearing, a representative of the DSP and support coordination agency must participate by telephone, or in person, if requested.

An appeal by the beneficiary may be filed with DAL via fax, mail, online request, or by telephone. (See Appendix A for contact information.) Instructions for submitting appeal requests are also included in all adverse action notices.

Rights and Responsibilities Form

The support coordinator is responsible for reviewing the beneficiary's rights and responsibilities with the beneficiary and/or his/her personal representative as part of the initial intake process and at least annually thereafter. (See Appendix B for information on accessing the *Office of Aging and Adult Services (OAAS) Rights and Responsibilities for Applicants/Participants of Home and Community-Based Services (HCBS) Waiver* form).