BENEFICIARY RIGHTS AND RESPONSIBILITIES

Beneficiaries have specific rights and responsibilities that accompany eligibility and participation in the Medicaid programs. The Office of Aging and Adult Services (OAAS), or its designee, and the Program of All-Inclusive Care for the Elderly (PACE) providers must assist beneficiaries in exercising their rights and responsibilities.

PACE providers:

1. Must assure that applicants and beneficiaries understand their available choices and the consequences of those choices; and

2. Are bound by their provider agreement with Medicaid to adhere to the following policies on beneficiary rights.

Each applicant who requests PACE has the option to designate a responsible representative to assist or act on their behalf in the process of accessing and/or maintaining PACE services. The beneficiary has the right to change their responsible representative at any time. The responsible representative may not concurrently serve as a responsible representative for more than 2 beneficiaries in a Medicaid Home and Community-Based Services (HCBS) program that is operated by the OAAS (unless an exception is granted by OAAS), which programs include, but are not limited to:

1. PACE;

2. Long Term-Personal Care Services (LT-PCS);

3. Community Choices Waiver (CCW); and

4. Adult Day Health Care (ADHC) Waiver.

Rights and Responsibilities Form

During enrollment, the PACE provider is responsible for reviewing the beneficiary's rights and responsibilities with the beneficiary and/or their personal representative as part of the initial intake process and at least annually thereafter. (The PACE providers' Rights and Responsibilities document must adhere to 42 CFR §460.110-114.)

Freedom of Choice of Providers

Beneficiaries have the freedom of choice (FOC) to select their health care providers from within the PACE network. When the beneficiary chooses a primary care provider (PCP), or chooses to change PCP, the beneficiary must contact the PACE provider.

Changing Providers

By choosing PACE as their provider, the beneficiary has exercised their FOC. Beneficiaries will receive all services through the PACE program. PACE providers may allow for a beneficiary to have a PCP or other specialist outside of their network, if the interdisciplinary team (IDT) believes this is what is best for the beneficiary's health.

Participation in Care

Each beneficiary must participate in the assessment and person-centered planning meetings with the appropriate PACE staff and in any other meeting involving decisions about services and supports to be provided. 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 their 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 are delivered according to the approved person-centered plan of care (POC).

Voluntary Participation

Beneficiaries have the right to end their PACE services. If a beneficiary decides to no longer participate in the PACE program, the beneficiary shall notify the PACE provider as soon as possible. If the PACE provider is notified after the 25th day of the month, Medicaid disenrollment will not occur until the last day of the following month that the notice was given.

Quality of Care

Each PACE beneficiary has the right to be treated with dignity and respect and receive humane care and services from PACE providers and their contractors who have been trained and are qualified to provide care and services. In addition, PACE providers and their contractors are required to maintain privacy and confidentiality in all interactions related to the beneficiary's services.

Beneficiaries have the right to be free from harm and abuse (mental, physical, or emotional abuse, neglect, excessive medication, involuntary seclusion, coercion, and any physical or chemical

restraint imposed for discipline purposes or convenience and not required to treat the beneficiary's medical symptoms).

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

Beneficiaries, providers, and contractors must cooperate in the investigation and resolution of reported incidents/complaints.

Civil Rights

PACE providers must operate in accordance with Title VI and VII of the Civil Rights Act of 1964, as amended, with the Vietnam Veterans Readjustment Act of 1974, and with 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, ethnicity, color, religion, age, sex, national origin, sexual orientation, mental or physical disability, and/or source of payment. Beneficiaries have the responsibility to cooperate with their PACE provider and PACE contractors by not requesting services that in any way violate these laws.

Notification of Changes

The Bureau of Health Services Financing (BHSF) is responsible for determining Medicaid financial eligibility for PACE 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 nursing facility level of care (NFLOC). The PACE provider has the responsibility to inform OAAS, or its designee, if the beneficiary no longer meets NFLOC according to criteria established by the Louisiana Department of Health (LDH).

Grievances/Complaints

The beneficiary has a responsibility to bring problems to the attention of PACE staff of contractors or to OAAS, or its designee, and to file a grievance/complaint without fear of restraint, retribution, retaliation, interference, coercion, discrimination, or discharge.

PACE providers must have grievance procedures through which beneficiaries may voice complaints regarding the supports or services that they receive and the quality of the care provided.

Beneficiaries must be provided a copy of the grievance procedures, upon admission into the PACE program and annually thereafter.

Fair Hearings

Beneficiaries must be advised of their rights to appeal any action or decision resulting in non-coverage of services, non-payment of services, and denials, reductions, or termination of services in accordance with 42 CFR 460.122. A PACE provider must inform the beneficiary in writing of additional appeal rights available under Medicare or Medicaid. Medicaid-eligible beneficiaries who appeal through Medicaid shall have the appeal heard by the Division of Administrative Law (DAL) within the timeframes applicable to processing Medicaid appeals except in cases where federal PACE requirements require a more expeditious decision.

Beneficiaries must be provided a copy of the fair hearing procedures upon admission into the PACE program, at least annually, and whenever the interdisciplinary team (IDT) denies a request for services or payment. A PACE provider must also inform a participant, in writing, of additional appeal rights available under Medicare and/or Medicaid if an appeal/fair hearing is not resolved through the PACE hearing process.