

SECTION 3 MEMBERS

3-1 Member Rights Statement

Commonwealth Care Alliance is committed to providing easily accessible, high quality services to our members. This objective is best met by establishing a mutually respectful relationship that promotes privacy, effective treatment, and member satisfaction.

3-2 Contacting Commonwealth Care Alliance's Member Services Department

Members, potential members, and/or providers can reach Commonwealth Care Alliance's Member Services Department by calling:

Toll Free 1-866-610-2273

TTY 1-866-322-7357

The Member Services Department is available Monday–Friday, 8 a.m. –6 p.m. Our staff members speak many of the same languages that our members speak, such as Spanish, Russian, Armenian, and Portuguese. In order to meet additional member language needs, Commonwealth Care Alliance utilizes a translation service.

Commonwealth Care Alliance also provides after hours coverage and weekend contact, accessible by dialing the phone numbers listed above. The clinician on-call will answer and assist with any problems. Commonwealth Care Alliance is available 24 hours a day, 7 days a week.

Commonwealth Care Alliance cares about the privacy of our members protected health information (PHI). Commonwealth Care Alliance will ask to verify a provider's identity prior to the release of any member information. Commonwealth Care Alliance asks that providers have their Commonwealth Care Alliance provider ID number or NPI number available each time they contact Commonwealth Care Alliance.

3-3 Member Identification Card

Each member receives a Commonwealth Care Alliance identification card to be used for services covered by this plan and prescription drug coverage at network pharmacies. Commonwealth Care Alliance's Senior Care Options (SCO) program covers the dual population as well as the MassHealth only population. In both scenarios, prescription drugs are a covered benefit. We must display the Medicare Rx symbol on the member card for dually eligible members, thus please be aware that we have two distinct member cards. Please see examples on the following page.

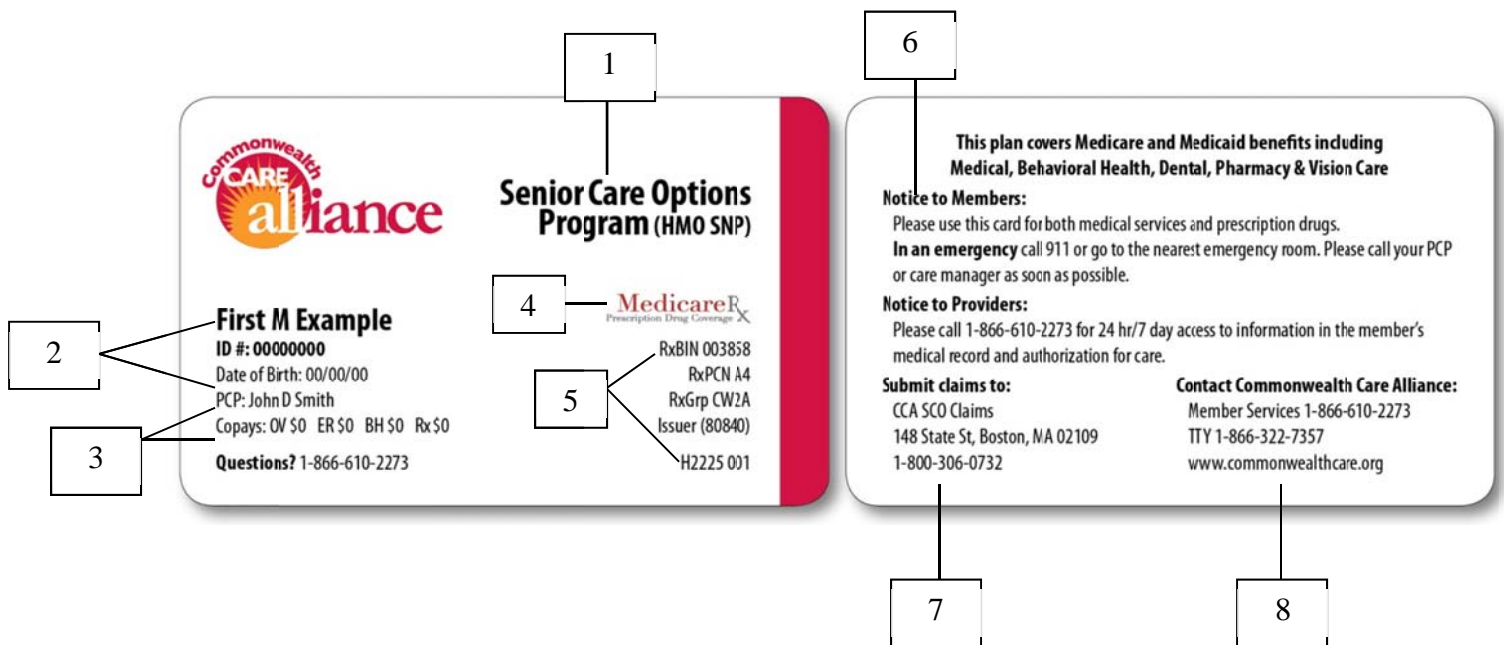
Dually Eligible Member Identification Card

Front of Membership Card

1. Plan Name
2. Member Name, Date of Birth, Member ID number
3. Primary Care Physician (PCP) and Copays
4. Medicare Symbol (required by Medicare)
5. CMS Contract Number, Plan Benefit Package Number, Electronic Routing Information (for use by pharmacies)

Back of Membership Card

6. Member Emergency Contact Info
7. Claim Submission Contact
8. Important Numbers, 24 hr/7 days access



Please call Member Services at Commonwealth Care Alliance to verify eligibility and confirm that the membership is still active.

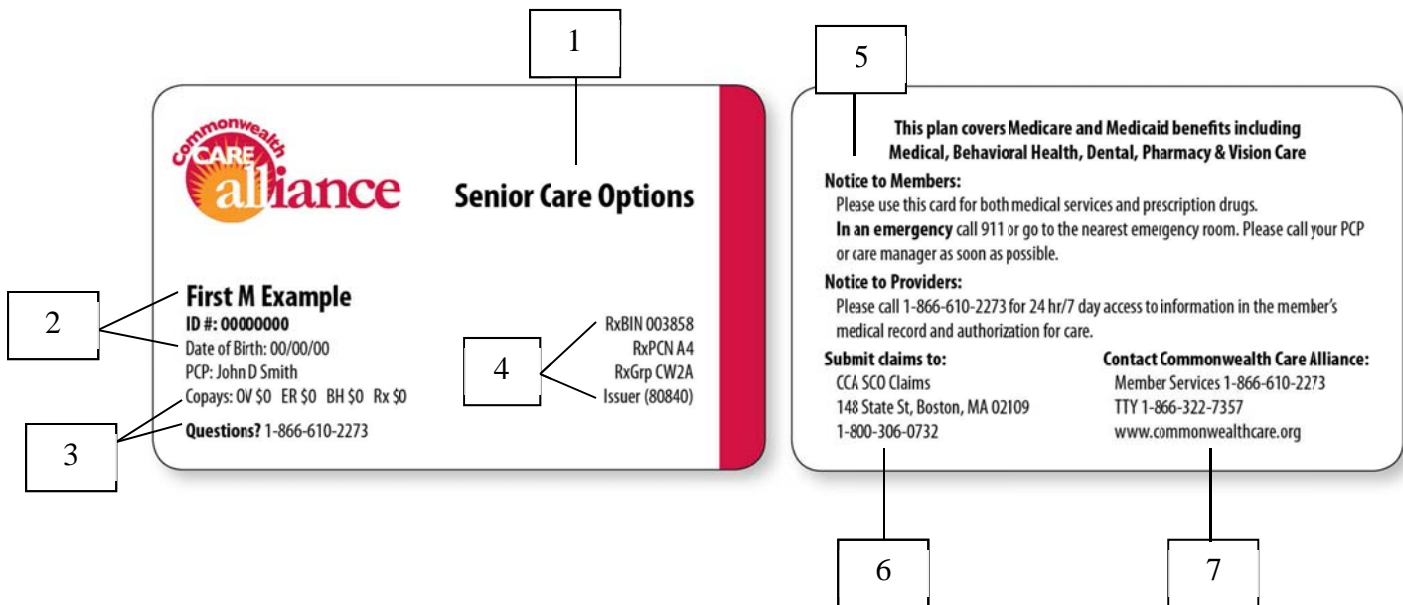
Medicaid Only Member Identification ID

Front of Membership Card

1. Plan Name
2. Member Name, Date of Birth, Member ID Number
3. Primary Care Physician (PCP) and Copays
4. Electronic Routing Information (for use by pharmacies)

Back of Membership Card

5. Member Emergency Contact Info
6. Claim Submission Contact
7. Important Numbers, 24 hr/7 days access



Please call Member Services at Commonwealth Care Alliance to verify eligibility and confirm that the membership is still active.

3-4 Commonwealth Care Alliance Membership Verification Process

Commonwealth Care Alliance strongly advises its contracted providers to verify Commonwealth Care Alliance membership whenever services are rendered.

Eligibility information can be accessed in the following ways:

- [Virtual Gateway](#)
- Automated voice response (AVR) 1-800-554-0042
- Point-of-service (POS) device
- Commonwealth Care Alliance Member Services 1-866-610-2273

Virtual Gateway EVS System

The [Virtual Gateway](#) is an internet portal designed by the Executive Office of Health and Human Services to provide the general public, medical providers, community-based organizations, and EOHHS staff with online access to health and human services. For more information about access methods, call the Virtual Gateway Customer Service at 1-800-421-0938.

3-5 Primary Care Site and Primary Care Physician

All Commonwealth Care Alliance members must select a primary care site (PCS) and a primary care physician (PCP) at the time of enrollment. An Outreach & Marketing Representative will work with the member to ensure the selection of a PCS and PCP within Commonwealth Care Alliance's provider network.

Primary Care Physician

Commonwealth Care Alliance will contract with only licensed physicians who are willing and able to meet all of the following PCP requirements. The PCP must:

- Be licensed by the Massachusetts Board of Registration in Medicine
- Have at least 2 years experience in the care of persons over the age of 65
- Be a provider in good standing with the

- Federal Medicare program
- Abide by Commonwealth Care Alliance's standard credentialing and recredentialing process.

Request to Change Primary Care Physician

A member may request a change in their PCP at any time by calling the Member Services Department. PCP changes within a PCS take place immediately. However, if the member requests to change the PCP to another location, the change will become effective the first day of the following month.

Providers with general concerns or questions about PCP assignments may call Member Services.

3-6 Health Care Proxies and Guardianships

Health Care Proxy

Commonwealth Care Alliance strongly encourages its members to sign a Health Care Proxy (HCP) at the time of enrollment if the member does not have one prior to enrollment. [Click here](#) to download the HCP form.

- The HCP is a written document by which a competent adult (the "principal"), aged 18 years or over, designates another adult as the member's health care agent. The health care agent is authorized to make health care decisions on behalf of the principal, to the extent set forth in the proxy document, in the event the principal becomes unable to make a decision for him or herself
- An alternate agent can also be listed, should the primary health care agent not be available
- An individual under full medical guardianship/guardianship of the person does NOT have the authority to appoint a HCP
- The proxy goes into effect only if/when the principal's attending physician

determines in writing that the principal lacks the capacity to make or to communicate health care decisions for him or herself. If the principle regains capacity, the principal resumes making health care decisions for him or herself

- The HCP is revoked when any of the following four things happens
 - The principal signs a subsequent HCP
 - The principal legally separates from or divorces the spouse who is named in the proxy as the agent
 - The principal notifies the agent, doctor, or other health care provider, orally or in writing that the principal wants to revoke the HCP
 - The principal does anything else that clearly shows he or she wants to revoke the proxy, for example, tearing up or destroying the proxy, crossing it out, telling other people, etc.
- Who can/should not be a health care agent
 - An employee of a facility caring for an individual cannot be a health care agent unless that employee is related to the person by blood, marriage, or adoption
 - A staff person who gives the individual daily care/an administrator of the individual's care may be seen as having a conflict of interest as an agent
 - A person who is not comfortable speaking with doctors of health care staff is not an ideal choice as an agent
 - A person who does not listen to the individual or a person who has demonstrated not listening to the individual would not be a good choice as the agent
- The HCP name and address should be added to the assessment form and the emergency contact sheet

Guardianship

A guardian is appointed when an individual is unable to make decisions for him or

herself due to mental illness, mental retardation, or physical incapacity or illness.

- Scope of authority within the guardianship can vary
- All decisions and determinations are to be communicated to the guardian based on the guardian's level of guardianship.
- Guardianship must be verified
- Commonwealth Care Alliance must be provided with a copy of the person's guardianship decree
- Enrollment process can not be completed without verification/documentation
- Once guardianship is on record for the member, the guardian has the authority to speak on behalf of the member/discuss member's benefits

[Click here](#) to download the guardianship decree.

3-7 Commonwealth Care Alliance's Commitment to its Members

Individualized Plan of Care

The primary care team (PCT) develops an individualized plan of care (IPC) for each enrollee. The IPC describes the areas to be addressed and managed by the PCT in collaboration with the member and/or caregiver. The member or caregiver signs the IPC to indicate their participation in care planning activities. [Click here](#) to view a sample IPC.

Welcome Calls

Commonwealth Care Alliance members receive a welcome call from a Member Services Representative within 30 days of enrollment. Calls are conducted in the primary language of the member. Member Services Representatives reach out to members via telephone and through written communication to introduce Commonwealth Care Alliance and to explain how to access services.

Some of the topics covered by the welcome call include:

- Verification of address and language preference
- Explanation of PCS and PCP
- Description of the PCT
- Overview of hours of operation and important phone numbers
- Accessing care after hours
- Description of Commonwealth Care Alliance benefits (medical, pharmacy, behavioral health, etc.)

Local Consumer Meetings

Consumer participation and involvement are critical to Commonwealth Care Alliance's model of care and organizational identity. Since 2005, Commonwealth Care Alliance has held local consumer forums for its members, their families, and caretakers to come together to share their thoughts and experiences of the program.

The forums give Commonwealth Care Alliance the opportunity to listen to members and ask for ideas on how to improve. Members are informed on issues including flu shots, rights to file complaints or grievances, and opportunities to participate in the Chronic Disease Self-Management program. Commonwealth Care Alliance also uses the meetings to answer questions members have about their coordination of health care needs. Local consumer meetings are a great place for members to meet one another and share experiences. It can be very comforting for members to learn there are others out there with similar challenges and concerns.

Local consumer meetings are held in the communities where our Commonwealth Care Alliance members live, and are conducted in languages that those members speak.

For more information, contact Commonwealth Care Alliance's Department

of Health Education & Caregiver Training at (617) 426-0600.

Complaints and Grievances

Commonwealth Care Alliance is committed to ensuring member satisfaction. Upon the receipt of a member complaint, Member Services staff record the information in the member complaint database.

Commonwealth Care Alliance works to ensure timely resolution for all complaints. Members should hear from Commonwealth Care Alliance with a resolution no longer than 30 days from the date the complaint was filed. Once a member or member's representative has filed a complaint, Commonwealth Care Alliance will discuss it with the member or member's representative and explain the specific steps Commonwealth Care Alliance takes to resolve a complaint. This includes how long Commonwealth Care Alliance expects the process to take. During the complaint process, Commonwealth Care Alliance will continue to furnish the member with all services at the frequency provided in the current IPC. Providers are encouraged to help members file a complaint if asked.

- Commonwealth Care Alliance submits a monthly report to MassHealth of all its complaints for the previous month regardless of disposition or resolution
- Commonwealth Care Alliance submits quarterly Part C and Part D grievance reports to CMS
- Commonwealth Care Alliance performs training for PCPs and other members of the PCT about the Commonwealth Care Alliance complaint and appeals policy and procedure process.

Examples of complaints:

- Waiting times on the phone or in the waiting or exam room or getting a return phone call
- Transportation services (e.g. waiting times for the van, driver is rude, etc.)

- Cleanliness of provider's office
- Behavior of any care providers
- Problems with how long a member spends in the pharmacy
- Disrespectful or rude behavior by providers, pharmacists, home health workers or other any other staff
- If there is a disagreement on a decision not to expedite their request for an expedited service decision (coverage determination) or redetermination
- Complaints about notices and other written materials (difficult to understand)
- The quality of services received at home, during an inpatient stay (hospital, skilled nursing facility, nursing home, etc) or at an Adult Day Health Center
- Medication related concerns — not able to fill, co-pay is too high, etc.

For more information regarding Complaints and Grievances, please go to [Section 9: Clinical Management](#).

3-8 Member Responsibilities and Rights

Member Responsibilities

Members are informed of their responsibilities on joining Commonwealth Care Alliance by receiving an Evidence of Coverage (EOC) handbook. Member responsibilities include, but are not limited to, the following

- Select a PCT from our list of participating doctors
- Agree to receive services within the Commonwealth Care Alliance contracted provider network (except for emergency and out of area urgent care)
- Know coverage details and the rules a member must follow in order to receive care
- Getting familiar with coverage and the rules necessary to follow in order to get care as a member
- Inform Commonwealth Care Alliance if the member has additional health insurance coverage

- Giving the doctor and other providers the information they need in order to give good care, and following the treatment plans and instructions that the member and the members' doctors agree upon. Be sure to ask doctors and other providers if the member has any questions and have the provider explain the treatment in a way the member can understand
- Acting in a way that supports the care given to other patients and helps the smooth running of the doctor's office, hospitals, and other offices
- Paying for services that aren't covered
- Letting Commonwealth Care Alliance know if there are any questions, concerns, problems, or suggestions

Member Rights

- To be treated with dignity, respect and fairness
- Privacy of medical records and personal health information
- To receive information on our plan, plan providers, drugs, health care coverage, and costs
- To see plan providers, get covered services, and get prescriptions filled within a reasonable period of time
- To know treatment options and participate in decisions about health care
- To refuse treatment
- To receive a detailed explanation from Commonwealth Care Alliance if the member believes that a provider has denied care that the member is entitled to receive
- To use advance directives (such as a living will or a power of attorney)
- To make complaints and follow Commonwealth Care Alliance's protocols regarding if and when a member thinks he/she has been treated unfairly or that the member's rights aren't being respected

For additional information about member rights and responsibilities, please call our

Member Services Department. Please also call Member Services if there is reason to believe that a member has been treated unfairly or that the member's rights have not been respected.

Additional Member Resources

- If there is reason to believe that a member has been treated unfairly due to race, color, national origin, disability, age, or religion, please refer the member to the Office for Civil Rights at 1-800-368-1019. TTY/TTD users should call 1-800-537-7697.
- If there are other kinds of concerns or problems related to Medicare rights and protections, members can also get help from the SHINE program, at 1-800-244-3032