Member Rights and Responsibilities

Eligibility and Enrollment

CMS determines individual eligibility and an individual is not considered enrolled into our plan until we receive the required notification from CMS. Once approval is received, a member Identification card will be issued with the member's effective date and an enrollment packet will be distributed to the member within the CMS specified timeframe. The enrollment packages will include but are not limited to:

Summary of Benefits — A benefit document, which provides a comparison of the health plan's Medicare benefit information against Original Medicare.

Evidence of Coverage — The Evidence of Coverage is part of our contract with the member and CMS and is considered one of the most important documents the member will receive. The Evidence of Coverage booklet will tell our members how to get their Medicare medical care and prescription drugs covered through our plan. It also explains their rights and responsibilities, what is covered, and what they will pay as a member of Harvard Pilgrim's Medicare plan.

Provider Directory — A document that provides a list of providers contracted with a health plan to provide health care services.

Pharmacy Directory — A complete list of our network pharmacies that have agreed to fill covered prescriptions for our plan members.

Plan Formulary — List of Covered Drugs that tells which Part D prescription drugs are covered by Harvard Pilgrim's Medicare plan.

All documents listed above will be distributed to plan members.

Enrollment and Disenrollment Actions

While Medicare beneficiaries choose to enroll in or disenroll from a Harvard Pilgrim Medicare Advantage plan, federal government regulations limit when and how beneficiaries can make plan elections. Requirements specify when beneficiaries may make plan elections and the limits on the number of elections they may make each year.

Medicare beneficiaries may enroll in a Harvard Pilgrim Medicare Advantage plan when: (a) they are covered by both Medicare Parts A and B, (b) they continue to pay the Part B premium, and (c) they meet other eligibility requirements. Federal regulations permit Medicare Advantage members to disenroll from Medicare Advantage plans by:

- Submitting a completed disenrollment form to the Harvard Pilgrim Medicare Advantage Operations department during a valid election period
- Submitting a signed letter requesting disenrollment to the Harvard Pilgrim Medicare Advantage Operations department during a valid election period
- Contacting any Social Security or Railroad Retirement Board office

Harvard Pilgrim must disenroll members if they:

- Lose Part B of their Medicare benefits
- Move outside the service area permanently
- Reside outside the Harvard Pilgrim Medicare Advantage service area for six consecutive months or more
- Fail to pay monthly premiums

In most cases, the disenrollment requests Harvard Pilgrim receives on or before the last business day of the month will be effective on the first day of the following month. Election period rules and limits apply.

Harvard Pilgrim may also disenroll members for failure to fulfill member responsibilities, including the responsibility to be courteous and respectful to providers, staff and fellow patients.

Provider's Advice & Advocacy

Harvard Pilgrim may not prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising or advocating on behalf of an individual who is a Medicare Advantage patient. Such advice may pertain to:

- The patient's health status, medical care or treatment options (including any alternative treatments that may be self-administered) and the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options
- The risks, benefits and consequences of treatment or non-treatment options
- The opportunity for an individual to refuse treatment and to express preferences about future treatment decisions

Providers must provide information about treatment options in a culturally competent manner, including the option of no treatment. Health care professionals must ensure that disabled Medicare Advantage members have access to effective communications throughout the health system in making decisions about treatment options.

HIPAA Privacy Information

Pursuant to regulations under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Harvard Pilgrim discloses only the minimum necessary Protected Health Information (PHI) related to a member's treatment, for payment determination of claims and for the plan's health care operations. Likewise, providers submitting information to Harvard Pilgrim should send only minimum necessary information to complete the task. For example, a provider should remove or cover other patient information on a payment register that contains information not related to the inquiry.

Harvard Pilgrim must verify the identity of all who request information concerning a member's PHI. Information used to verify identity for provider inquiries includes the provider's identification number, tax identification number and first name. The caller's department or position title assists Harvard Pilgrim in accurately documenting each inquiry.

For additional information about Harvard Pilgrim's privacy practices, please review our Notice of Privacy Practices on our website.

Discrimination Prohibited

Discrimination against Harvard Pilgrim Medicare Advantage members based on health status is prohibited [42 CFR 422.110(a)]. Harvard Pilgrim may not deny, limit or condition coverage of benefits to individuals eligible to enroll in a Harvard Pilgrim Medicare Advantage plan based on any factor related to the member's health status including, but not limited to:

- Medical condition, including mental as well as physical illness (except for ESRD status)
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability

Harvard Pilgrim may not enroll any individual in a Harvard Pilgrim Medicare Advantage plan who has been diagnosed with End Stage Renal Disease (ESRD). Members who develop ESRD after enrolling may remain members.

Harvard Pilgrim and its contracted providers must comply with the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act of 1973, the Americans with Disabilities Act and applicable federal funds laws 42 CFR [422.504(h) (l)]. Harvard Pilgrim and Medicare Advantage network providers may not discriminate against a member with respect to the delivery of health care services consistent with the benefits covered in the member's policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment.

Mental Health Parity

Federal and state laws require that we provide behavioral health (mental health and/or substance abuse) services to our members in the same way we provide physical health services. We refer to these laws as "parity." It means that:

- We will give members the same level of benefits and charge the same co-payments, co-insurance and deductibles for mental health and substance abuse needs as for physical needs.
- We have similar prior authorization (permission) requirements and treatment limitations for mental health and substance abuse services and physical health services.
- We will provide you or your member with the medical necessity criteria that we use for prior authorization upon you or your member's request.
- We will give the member the reason for any denial of authorization for mental health or substance abuse services within a reasonable time frame.

Member Protections

Federal regulations establish protections for Medicare Advantage members.

Providers may not distribute marketing or other member materials describing Harvard Pilgrim Medicare Advantage plans unless CMS and Harvard Pilgrim approve the materials in advance (if CMS requires approval for the specific type of material). Harvard Pilgrim employees or representatives and network providers must follow all CMS Medicare Advantage marketing guidelines, including those applicable to health fairs. Providers who want to display or distribute any information about Harvard Pilgrim Medicare Advantage plans or benefits must first contact Provider Services to request approval.

If needed, providers shall cooperate with Harvard Pilgrim to ensure that each member completes the required initial assessment of his or her health care needs within 90 days after the effective date of initial enrollment. Generally, members are able to complete the Health Risk Assessment required by CMS without the assistance of a provider.

Providers shall provide covered services to members in a manner consistent with professionally recognized standards of health care.

Providers may not bill or accept payment from members for any services Harvard Pilgrim determines are not medical necessity according to Harvard Pilgrim Medicare Advantage medical necessity guidelines unless: (a) the provider specified prior to the service being rendered that the service was not medically necessary, and (b) the member agreed, in writing, to pay for the service.

Providers cannot hold any member liable for payment of any fee that is the legal obligation of a Harvard Pilgrim Medicare Advantage plan or an amount that exceeds the contractually allowed amount.

Providers must continue to provide covered services to members for the duration of the contract period for which CMS has made payments to Harvard Pilgrim Medicare Advantage plans. In the event that (a) Harvard Pilgrim's contract with CMS terminates, or (b) Harvard Pilgrim Medicare Advantage plans become insolvent, participating providers must continue to provide covered services to all hospitalized members through the date of discharge.

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their discharge appeal rights by complying with the requirements for providing the Important Message from Medicare, including the time frames for delivery. For copies of the notice and additional information regarding this requirement, go to www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

Hospitals must issue the Medicare Outpatient Observation Notice (MOON) to Medicare beneficiaries who receive observation services as outpatients for more than 24 hours. The hospital or Critical Access Hospital (CAH) must provide the MOON no later than 36 hours after observation services as an outpatient begin. For copies of the notice and the notice instructions go to www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html.

Skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities must notify Medicare beneficiaries about their right to appeal a termination of benefits decision by complying with the requirements for providing Notice of Medicare Non-Coverage (NOMNC), including the time frames for delivery. Providers may be required to furnish a copy of any NOMNC to Harvard Pilgrim upon request. For copies of the notice and the notice instructions, go to www.cms.gov/MMCAG/Downloads/NOMNCInstructions.pdf.

Harvard Pilgrim Medicare Advantage members may appeal a decision regarding a hospital discharge or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility benefits within the time frames specified by law.

PUBLICATION HISTORY

10/15/13	original documentation
12/15/14	reviewed; no changes
01/01/22	updated document format
01/01/23	reviewed; administrative edits
10/01/23	updated with mental health parity information