

**MEMBER ENROLLMENT**

**AGREEMENT**

**TERMS AND CONDITIONS**

Effective 01-01-2022

Gary and Mary West PACE

1706 Descanso Ave.

San Marcos, California 92078

(760) 280-2230

For the Hearing-Impaired

TTY/TDD: (760) 280-2279

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| THIS BOOKLET BELONGS TO: |
| CENTER:      Gary and Mary West PACE |
| TELEPHONE NUMBER (760) 280-2230 |
| ADDRESS   1706 Descanso Ave., San Marcos, CA 92708 |
| CENTER DIRECTOR:      Azaria Taber |
| PROVIDER: |
| SOCIAL WORKER: |

|  |
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| **FOR 24 HOUR EMERGENCY SERVICES** |
| CALL GMWP MAIN NUMBER: (760) 280-2230 |
| EMERGENCY TELEPHONE NUMBER 911 |

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# **Chapter 1 – Welcome to**

# **Gary and Mary West PACE**

Gary and Mary West PACE (GMWP) is a health care services plan designed just for people age 55 and older who have ongoing health care needs. We are very pleased to welcome you as a participant. Since we enroll only individuals, dependents are not covered when you enroll.

Please keep this booklet. Your signed copy of the GMWP Enrollment Agreement form, along with these terms and conditions, will be your enrollment agreement, a legally binding contract between you and GMWP.

This document should be read carefully and completely. Individuals with special health care needs should read carefully those sections that apply to them. You can find a Summary of Benefits and Coverage Table containing the major provisions of the GMWP at the end of this chapter. GMWP has an agreement with the Centers for Medicare and Medicaid Services (CMS) and the Department of Health Care Services that is subject to renewal on a periodic basis, and if the agreements are not renewed the program will be terminated.

If you would like further information about the benefits of the GMWP, please feel free to contact us at (760) 280-2230. In this agreement, GMWP is sometimes called “we” and you are sometimes called the “participant” or “member”. The term “participant” is most often used at GMWP. *Some of the terms used in this document may not be familiar to you. Please refer to the “Definitions” section in the back for explanations of various terms used.*

Our philosophy at GMWP is to help you remain as independent as possible, living in your own community and home. We offer a complete program of health and health-related services and focus on *preventive* measures to maintain your well-being.

One unique feature of GMWP is our personal approach to health care and services. We make sure that you and our health care staff all know each other well, so we can work together effectively on your behalf. We do not replace the care of your family and friends. Rather, we collaborate with you, your family and friends to provide the care you need. Your suggestions and comments are always encouraged and welcomed.

GMWP operates 24 hours a day, seven days a week, 365 days a year. To treat the multiple chronic health care problems of our participants, our health care professionals assess and evaluate changes, provide timely intervention and encourage participants to help themselves. Based on your needs, we provide medical, nursing and nutrition services; rehabilitation therapy; in-home services and training; pharmaceuticals; podiatry; audiology; and vision; dental; mental health; and any other service approved by the interdisciplinary team (IDT). On an inpatient basis, we provide acute and skilled nursing care in contracted facilities. *(See Chapter 4 for a more detailed description of covered benefits.)*

**Please examine this *Member Enrollment Agreement Terms and Conditions* carefully.** Enrollment in the GMWP is voluntary. If you are not interested in enrolling in our program, you may return the Enrollment Agreement to us without signing. If you do sign and enroll with us, your benefits under GMWP continue until you choose to disenroll from the program or you no longer meet the conditions of enrollment. *(See Chapter 10 for information on termination of benefits.)*

Upon signing and enrolling in GMWP, you will receive the following items:

* A copy of the signed *Enrollment Agreement*
* A copy of the GMWP *Member Enrollment Agreement Terms and Conditions* (this document)
* A GMWP Membership card
* A magnet with our emergency telephone numbers to post in your home

**Summary of Benefits and Coverage Table**

The following table is intended to help you compare coverage benefits and is a summary only. There are no co-payments for PACE services.

Please read this entire booklet, which constitutes your Enrollment Agreement with GMWP, for a detailed description of coverage benefits and limitations.

Services must be either pre-approved or obtained from specified doctors, hospitals, pharmacies and other health care providers who contract with GMWP.

Prior authorization is never required for Emergency, Preventive (items or services that have an “A” or “B” rating in the recommendations of the US Preventive Services Task Force) or Sensitive Services (diagnosis and treatment of a sexually transmitted disease episode and testing and counseling for HIV). *Please refer to Chapter 4, Benefits and Coverage.*

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| --- | --- |
| CATEGORY | COPAYMENTS AND LIMITATIONS |
| **Deductibles** | None |
| **Lifetime** | None |
| **Professional Services** | Physician services including primary care providers and medical specialists, routine physicals, preventive health care, sensitive services, outpatient surgical services and outpatient mental health. No copayments.  Basic dental coverage (routine, preventive Services including exam, X-rays and cleanings). Cosmetic dentistry is not included. No copayments.  Vision care. Prescription eyeglasses and corrective lenses after cataract surgery. No Copayments.  Audiology services. Hearing exams and hearing aids. No copayments.  Routine podiatry. No copayments.  Medical social services and case management. No copayments.  Rehabilitation therapy. Includes physical, occupational and speech therapies. No copayments. |
| **Outpatient**  **Service** | Coverage for surgical services, mental health, diagnostic X-ray and laboratory service. No copayments. |
| **Hospitalization**  **Services** | Coverage for semi-private room and board and all medically necessary services including general medical and nursing services, psychiatric services, operating room fees, diagnostic or therapeutic services, laboratory services, X-ray, dressings, casts, anesthesia, blood and blood products, drugs and biologicals. Not covered are private rooms or private duty nursing, unless a medically necessary, and non-medical items. No copayments. |
| **Emergency**  **Health**  **Coverage** | Coverage for emergency services. GMWP does not cover emergency services outside the United States except for emergency services requiring hospitalization in Canada or Mexico. No Copayments |
| **Ambulance**  **Services** | No copayments. |
| **Prescription**  **Drug Coverage** | Coverage for medications from the PACE organization when prescribed by a physician. No copayments. |
| **Durable Medical**  **Equipment** | No copayments. |
| **Mental Health**  **Services** | No copayments. |
| **Chemical**  **Dependency**  **Services** | No copayments. |
| **Home Health**  **Services** | No copayments. |
| **Other** | Medicare covered skilled nursing facility. Coverage provided for semi-private rooms only.  Home care services.  Day center services (including nutrition, hot meals, escort and transportation).  Necessary education, materials, supplies and services for management of diabetes mellitus.  End of Life Care. No copayments. |

**PLEASE NOTE: All services and benefits are determined by the PACE Care Plan at the discretion of the GMWP IDT.**

*Prospective Enrollee Initials: \_\_\_\_\_\_\_\_\_\_*

*PACE Staff Member Initials: \_\_\_\_\_\_\_\_\_\_*

# **Chapter 2 – Special Features of GMWP**

Our health care services plan has several unique features:

**1. Expertise in Caring**

GMWP specializes in caring for older people with health problems. Our successful approach focuses on developing customized care plans addressing specific health and health-related issues for each participant. Our dedicated, highly skilled care team both plan and provide care, so the care you receive is comprehensive and coordinated.

**2. The Interdisciplinary Care Team (IDT)**

Your care is planned and provided by a team of specialists, working together with you. Your team includes a physician, possibly a nurse practitioner, registered nurses, a home care nurse, social worker, physical therapist, occupational therapist, a dietician and others who assist you, such as health workers, home health aides and drivers of our vehicles. Each team member’s special expertise is employed to assess your health care needs. Other staff may be called upon if necessary.

The care team begins by conducting a comprehensive initial assessment during or promptly after your enrollment into the GMWP program. Following the initial assessment, taking into consideration your preferences and goals, a Care Plan is developed just for you. At least every six months—and more frequently if you are having problems or are hospitalized—your care team assesses your needs and adjusts services and your care plan if necessary. If your situation changes, the care team adjusts your services, based on your care plan assessment and other needs. You and/or your family may request an assessment at any time. At least every six months, your care team conducts an assessment and updates the care plan.

**3. Facilities**

You will receive many of your health care services at our center—where your team is. *Our PACE team and center is located at 1706 Descanso Ave., San Marcos, CA 92078.*

We provide transportation for you to come to the center. **How often you come to the center will be based on your care plan.**

The PACE Center is open Monday – Friday, 8am – 4:30pm and closed on Saturday and Sunday. GMWP offers you access to medical care through our GMWP Center and on-call medical staff on a 24-hour basis, 365 days of the year. At any time, you can reach GMWP at our main number (760) 280-2230 (or for the hearing impaired the TTY/TDD number is (760) 280-2279).

We will work with you to ensure that transportation is available to bring you to the GMWP Center at a regular schedule. We will also provide transportation for necessary services when you need it. Please contact the GMWP Center at the main number (760) 280-2230 (or for the hearing impaired the TTY/TDD number is (760) 280-2279) to arrange a trip or to change your regular transportation schedule. Transportation provided by GMWP should not be used in an emergency. If you are experiencing an emergency, please call 911.

**4. Choice of Physicians and Providers**

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOUR HEALTH CARE MAY BE OBTAINED.

Because care is provided at GMWP through an IDT, the PACE Physician you choose is a member of your IDT. You will be assigned other providers for your team. Your Physician is responsible for all your primary health care needs and, with the help of your IDT, arranges for other medical services that you may need. Participants have the option to seek gynecological physician services directly from a participating gynecologist.

You may request to change your Physician. Also, it’s possible that your Physician might leave GMWP or our network. If your Physician leaves the network, we can help you find a new one. Also, if for any reason you want to change your Physician, you may call us to ask for the change at our main number (760) 280-2230 (or for the hearing impaired the TTY/TDD number is (760) 280-2279). We will process your change as soon as possible.

Once enrolled, you receive all your health care services from GMWP participating network of providers including medical specialists, home health care services, dental, podiatry and many more. A complete listing of covered services is described in this handbook. Your care team can choose or assist you in choosing the providers that meet your needs.

When necessary, services are provided in your home, a hospital or nursing home. We have contracts with physician consultants (such as cardiologists, urologists, orthopedists, and others), pharmacies, laboratories and X-ray services, as well as with hospitals and nursing homes. Should you need such care, your team will continue working with you to monitor these services, your health and your ongoing needs.

If you wish to have the names, locations and hours of our contracting hospitals, nursing homes and other providers, you may request this information from your social worker.

**5. Authorization and Management of Care**

You will know each member of the team very well, for they will all work closely with you to help you remain as healthy and independent as possible. Before you can receive any service from GMWP, the IDT must approve the service. However, prior authorization is never required for Emergency, Preventive, or Sensitive Services. If you or your family think you need a service you are not currently receiving, or that you need adjustments made to your plan of care, or if you are hospitalized, your IDT will assemble to reassess your needs and change your plan of care, including authorizing additional services you need.

**6. Medicare/Medi-Cal Relationship**

The benefits under this Enrollment Agreement are made possible through an agreement GMWP has with Medicare (the Centers for Medicare and Medicaid Services of the Department of Health and Human Services) and Medi-Cal (California Department of Health Care Services). When you sign this Enrollment Agreement, you are agreeing to accept benefits from GMWP, in place of the usual Medicare and Medi-Cal benefits. GMWP will provide services based on your needs - the same benefits to which you are entitled under Medicare and Medi-Cal, plus more.

For additional information concerning Medicare-covered benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP). HICAP provides health insurance counseling for California senior citizens. Call the HICAP toll-free telephone number, 1-800-434-0222, for a referral to your local HICAP office. HICAP is a service provided free of charge by the State of California.

**7. No Pre-set Limits to Care**

GMWP has no pre-set limit to services. There are no limits or restriction to the number of hospital or nursing home days that are covered if your GMWP physician and IDT determines that they are necessary services. Home care is authorized and provided to you on a frequency and duration based on the evaluation of your needs by the team’s clinical experts.

**8. “Lock-in” Provision**

When you enroll with GMWP, we will be your sole service provider and you agree to receive medical services ***exclusively*** from our organization, except in the case of an emergency or for urgently needed services. You will have access to all the care you need through our staff or through arrangements that GMWP makes with contract providers, but **you will no longer be able to obtain services from other doctors or medical providers under the traditional fee-for-service Medicare and Medi-Cal system. Enrollment in GMWP requires disenrollment from any other Medicare or Medi-Cal pre-payment plan or optional benefit (IHSS, MSSP, etc.).**

*Prospective Enrollee Initials: \_\_\_\_\_\_\_\_*

*PACE Staff Initials: \_\_\_\_\_\_\_\_\_\_\_\_*

Electing enrollment in any other Medicare or Medi-Cal prepayment plan or optional benefit, including the hospice benefit, after enrolling in GMWP is considered a voluntary disenrollment from GMWP.(Please note that any services you use before your enrollment will not be paid for by GMWP unless these are specifically authorized.)

*Prospective Enrollee Initials: \_\_\_\_\_\_\_\_*

*PACE Staff Initials: \_\_\_\_\_\_\_\_\_\_\_\_*

**9. Estate Recovery**

If you are enrolled in Medi-Cal benefits, the State of California is required to seek repayment of some types of Medi-Cal benefits from your estate after you die. In particular, if you are a GMWP member enrolled in Medi-Cal, and you have estate assets subject to probate at the time of your death, your estate must repay the State of California for nursing facility services, home and community-based services, and related hospital and prescription drug services received when you were an inpatient in a nursing facility or received home and community-based services. California will seek this repayment from GMWP and GMWP will in-turn be required to seek repayment from your estate as applicable. Please note that the State of California Department of Health Care Services (DHCS) may waive its claim if payment of the claim would cause a substantial hardship. Any request for a substantial hardship waiver must be submitted to DHCS within 60 days of the date on the DHCS Estate Recovery claim letter. In addition, certain income and resources of American Indians and Alaska Natives are exempt from Estate Recovery. Please be sure to inform GMWP if the decedent’s property is on or near a federally recognized reservation, Pueblo, or Colony. For specific details on what assets are exempt from Estate Recovery please see the State Medicaid Manual, Section 3810 (7) and (8).

# Chapter 3 – Eligibility

You are eligible to enroll in GMWP if you:

* Reside in the GMWP service area, which includes the following ZIP codes:



* Are 55 years of age or older.
* Require the State’s nursing facility level of care, as assessed by our IDT. A “Skilled Nursing Facility” is a level-of-care designation of the need for continuous 24-hour availability of skilled nursing. An “Intermediate Care Facility,” is a level-of-care designation of the need for 24-hour supervised care during the day on weekdays.
* Are able to live in the community without jeopardizing the health and safety of yourself and others.

You must also be:

* Certified by the California Department of Health Care Services requirements. Because GMWP serves only older individuals who meet the State’s level-of-care requirements for coverage of nursing facility services, an outside review must confirm that your health situation, in fact, qualifies you for our care.
* The California Department of Health Care Services provides this review before you sign the GMWP Enrollment Agreement based on a review of the documents prepared by the members of the IDT who have assessed your health.
* Once determined eligible by the California Department of Health Care Services, GMWP can proceed with your enrollment.

# Chapter 4 – Benefits and Coverage

*Please see Chapter 5 to learn how to receive care if you have a medical emergency or other urgent need for care.*

What Do I Do if I Need Care?

GMWP offers you access to medical care through the GMWP Center and on-call medical staff on a 24-hour basis, 365 days of the year. At any time, you can reach GMWP at our main number (760) 280-2230 (or for the hearing impaired the TTY/TDD number is (760) 280-2279).

Our plan provides ready access to a whole array of professionals and health care services. Upon enrollment, you will be assigned a PACE Physician at the center where you will receive services.

All benefits are covered by GMWP and will be provided according to your needs as assessed and determined by your IDT, in accordance with professionally recognized standards. If you would like more specific information about how we authorize or deny health care services, please request this from the GMWP Social Worker.

**Benefits Include:**

Services in the Center and the Community

Primary care clinic visits (with GMWP physician, nurse practitioner and/or nurse)

Routine physicals and preventive health evaluations and care (including pap smears, mammograms, immunizations, and all generally accepted cancer screening tests). These services do not require prior authorization. Specific preventive services that are covered without prior authorization include: Items or services that have an ‘A’ or ‘B’ rating in the recommendations of the U.S. Preventive Services Task Force (USPSTF).

Sensitive Services, defined as an episode of care for the diagnosis and treatment of a sexually transmitted disease or testing and counseling for HIV do not require prior authorization.

Consultation with medical specialists

Kidney dialysis

Outpatient surgical services

Outpatient mental health

Medical social services/case management

Health education and counseling

Rehabilitation therapy (physical, occupational and speech)

Personal care

Recreational therapy

Social and cultural activities

Nutritional counseling and hot meals

Transportation, including escort

Ambulance service

X-rays

Laboratory procedures

Emergency coverage anywhere in the United States and its territories

Durable medical equipment

Prosthetic and orthotic appliances

Routine podiatry

Prescribed drugs and medicines

Vision care (prescription eyeglasses, corrective lenses after cataract surgery)

Hearing exams and hearing aids

Dental care from the GMWP dentist, with the goal of restoring participant oral function to a condition which will help maintain optimal nutritional and health status. Dental services include *Preventive Care* (initial and yearly examinations, radiographs, prophylaxis and oral hygiene instructions); *Basic Care* (fillings and extractions); and *Major Care* (treatment which is determined by the condition of the mouth, for example, the amount of remaining supporting bone, the participant’s ability to comply with instruction, and the participant’s motivation to pursue oral health care). Major Care includes temporary crowns, full or partial dentures and root canals. Not included under dental care is: cosmetic dentistry.

Diagnosis and treatment of male erectile dysfunction provided that the care is from GMWP staff physician or a physician specialist under contract to GMWP, and that such care is deemed a necessary service. The Plan does not cover treatment, including medication, devices and surgery, which is deemed harmful to the participant or which is deemed to be for cosmetic or recreational purposes and not a necessary service.

Mastectomy, lumpectomy, lymph node dissection, prosthetic devices and reconstructive surgery.

Necessary education, materials, supplies and services for the management of diabetes mellitus.

Home Services

* Home Care
  + Personal care (i.e., grooming, dressing, assistance in using the bathroom)
  + Homemaker and chore services (meal preparation, laundry, light housekeeping, etc.)
  + Rehabilitation maintenance
  + Evaluation of home environnement
* Skilled Home Health
  + Skilled nursing services
  + Physician visits (at discretion of physician)
  + Medical social services
  + Home health aide service

Hospital Inpatient Care

* Semi-private room and board
* General medical and nursing services
* Psychiatric services
* Meals
* Prescribed drugs, medicines and biologicals
* Diagnostic or therapeutic items and services
* Laboratory tests, X-rays and other diagnostic procedures
* Medical/Surgical, Intensive Care, Coronary Care Unit, as necessary
* Kidney dialysis
* Dressings, casts, supplies
* Operating room and recovery room
* Oxygen and anesthesia
* Organ and bone marrow transplants (non-experimental and non-investigative)
* Use of appliances, such as a wheelchair
* Rehabilitation services, such as physical, occupational, speech and respiratory therapy
* Radiation therapy
* Blood, blood plasma, blood factors and blood derivatives
* Medical social services and discharge planning

Skilled Nursing Facility

* Semi-private room and board
* Physician and nursing services
* Custodial care
* All meals
* Personal care and assistance
* Prescribed drugs and biologicals
* Necessary medical supplies and appliances, such as a wheelchair
* Physical, occupational, speech and respiratory therapy
* Medical social services

End of Life Care

GMWP’s comfort care program is available to care for the terminally ill. If needed, your Physician and other clinical experts on your IDT will work with you and your family to provide these services directly by GMWP staff or through GMWP contracts with local Hospice providers. Through this process, GMWP can provide all the palliative and support services traditionally offered through the Medicare Hospice benefit*. If you want to receive the Medicare Hospice benefit, you will need to disenroll from our program and enroll in a Medicare-certified Hospice provider.*

GMWP does not cover private room and private duty nursing unless it is deemed aa necessary service, nor any non-medical items for which there is an additional charge, such as telephone charges or television rental.

# Chapter 5 – Emergency Services and Urgent Care

GMWP provides emergency care 24 hours per day, 7 days per week, and 365 days per year. An **Emergency Medical Condition** means a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

(1) Serious jeopardy to the health of the participant;

(2) Serious impairment to bodily functions;

(3) Serious dysfunction of any bodily organ or part;

A psychiatric emergency medical condition includes psychiatric screening, examination, evaluation and treatment by physician or other personnel to the extent permitted by applicable law and within the scope of their licensure and privileges. Coverage is provided for care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition within the capability of a facility.

**Emergency Services** include inpatient or outpatient services furnished immediately in or outside the service area because of an Emergency Medical Condition.

**Call “911” if you reasonably believe that you have an Emergency Medical Condition which requires an emergency response and/or ambulance transport services.** Shock, unconsciousness, difficulty breathing, symptoms of a heart attack, severe pain or a serious fall are all examples of Emergency Medical Conditions that require an emergency response.

After you have used the “911” emergency response system, you or your family must notify GMWP as soon as reasonably possible in order to maximize the continuity of your medical care. GMWP physicians who are familiar with your medical history will work with the emergency service providers in following up with your care and transferring your care to a GMWP contracted provider when your medical condition is stabilized.

**Preparing to Go Out of the GMWP Service Area**

Before you leave the GMWP service area to go out of town, please notify your IDT through your GMWP Social Worker. Your Social Worker will explain what to do if you become ill while you are away from your GMWP Physician. Make sure that you keep your GMWP membership card with you at all times, especially when traveling out of the service area. Your card identifies you as a GMWP participant and provides information to care providers (emergency rooms and hospitals) about your health care coverage and how to reach us, if necessary.

**Emergencies and Urgent Care When You Are Out of the Service Area**

GMWP covers both Emergency Services and Urgent Care when you are temporarily out of our service area but still in the United States or its territories. Urgent Care includes inpatient or outpatient services that are necessary to prevent serious deterioration of your health resulting from an unforeseen illness or injury for which treatment cannot be delayed until you return to our service area. (GMWP does not cover emergency services outside the United States except for emergency services requiring hospitalization in Canada or Mexico.)

If you use Emergency Services or Urgent Care when out of the service area (for example, ambulance or inpatient services), you must notify GMWP within 48 hours or as soon as reasonably possible. If you are hospitalized, we have the right to arrange a transfer when your medical condition is stabilized, to a GMWP contracted hospital or another hospital designated by us. We may also transfer your care to a GMWP physician.

GMWP will pay for all necessary health care services provided to a participant to maintain the participant’s stabilized condition up to the time that GMWP arranges the participant’s transfer or the participant is discharged.

GMWP must approve any routine medical services (i.e. medical services that do not constitute a medical emergency or other urgent need for care) when you are out of the service area. For authorization of any non-emergency, out-of-the-area services, you must call GMWP at (760) 280-2230 (For the Hearing-Impaired TTY/TDD: (760) 280-2279) and speak with your nurse, social worker or PACE Physician.

**Reimbursement Provisions**

If you have paid for Emergency Services or Urgent Care you received when you were outside our service area but still in the United States, GMWP will reimburse you. Request a receipt from the facility or physician involved at the time you pay. This receipt must show: the physician’s name, your health problem, date of treatment and release, as well as charges. Please send a copy of this receipt to your GMWP social worker within 30 business days.

Please note that if you receive any medical care or covered services as described in this document outside of the United States, GMWP will not be responsible for the charges.

# Chapter 6 – Exclusions and Limitations on Benefits

**Please see Chapter 5 to learn how to receive care if you have a medical emergency or other urgent need for care. Except for Emergency Services and Urgent Care received outside our service area, Preventive, and Sensitive Services, all care requires authorization in advance by the appropriate member of the Interdisciplinary Team.**

The following general and specific exclusions are in addition to any exclusions or limitations described in Chapter 4 for particular benefits.

**Covered Benefits Do Not Include:**

* Any service not authorized by the GMWP physician or other qualified decision maker on the IDT, even if it is listed as a covered benefit, except Emergency, Urgent, Preventive, and Sensitive Services. If a GMWP provider requests prior approval to provide health care services and the IDT decision maker, Director or Medical Director denies, defers or modifies the request, you will be notified in writing of the reason for this denial and information on how to appeal this decision, in accordance with California and federal law.
* Prescription drugs and over-the-counter drugs not prescribed by a GMWP physician except when prescribed as part of Emergency Services or Urgent Care provided to you.
* Cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.
* Experimental or investigational medical, surgical or other health procedures not generally available.
* Gender alteration procedures.
* Family planning, including sterilization operations or procedures.
* Care in a government hospital (VA, federal/state hospitals), except for Emergency Services and Urgent Care.
* Services in any county hospital for the treatment of tuberculosis or chronic medically uncomplicated drug dependency or alcoholism.  
  Short-Doyle/Medi-Cal Services.
* In an inpatient facility, private room and private duty nursing services (unless medically necessary), and non-medical items for personal convenience, such as telephone charges and radio or television rental, unless specifically authorized by the IDT as part of your Care Plan.
* Any services rendered outside the United States, except as follows:
  + (1) In accordance with §424.122 and §424.124 of this chapter.
  + (2) As permitted under the State's approved MediCal plan.
* The cost of labor and materials to modify your home environment, unless authorized by your IDT.
* If you are out of GMWP service area for more than 30 calendar days, GMWP may disenroll you unless other prior arrangements have been approved by the Director or Medical Director, upon recommendation of the IDT.
* GMWP will make every reasonable effort to provide a safe and secure environment at the center. However, we strongly advise participants and their families to leave valuables at home. GMWP is not responsible for safeguarding personal belongings.

# Chapter 7 – Your Rights and Responsibilities

**Participant Bill of Rights and Responsibilities**

**PARTICIPANT RIGHTS**

At GMWP, we are dedicated to providing you with quality health care services so that you may remain as independent as possible. Our staff seeks to affirm the dignity and worth of each Participant by assuring the following rights:

**Respect and Non-Discrimination**

You have the right to be treated with dignity and respect at all times, to have all of your care kept private, and to get compassionate, considerate care.

*You have the right to:*

* Be treated in a respectful manner that honors your dignity and privacy.
* Receive care from professionally trained staff.
* Know the names and responsibilities of the people providing your care.
* Know that decisions regarding your care will be made in an ethical manner.
* Receive comprehensive health care provided in a safe and clean environment and in an accessible manner.
* Be free from harm, including unnecessary physical or chemical restraints or isolation, excessive medication, physical or mental abuse or neglect, and hazardous procedures.
* Be encouraged to use your rights in the PACE program.
* Receive reasonable access to a telephone at the center, both to make and receive confidential calls, or to have such calls made for you if necessary.
* Not have to do work or services for the PACE Program.
* Not be discriminated against in the delivery of PACE services based on race, ethnicity, national origin, religion, sex, age, sexual orientation, mental or physical disability or source of payment.

**Information Disclosure**

You have the right to get accurate, easy-to-understand information and have someone help you make informed health care decisions.

*You have the right to:*

* Be fully informed, in writing, of your rights and responsibilities and all rules and regulations governing participation in GMWP.
* Be fully informed, in writing, of the services offered by GMWP, including services provided by contractors instead of GMWP staff. You must be given this information before enrollment, at enrollment, and at the time your needs necessitate the disclosure and delivery of such information, in order for you to make an informed choice.
* A full explanation of the Enrollment Agreement and an opportunity to discuss it.
* Have an interpreter or a bilingual provider available to you if your primary language is not English.
* Examine the results of the most recent federal or state review of GMWP and how GMWP plans to correct any problems that are found at inspection.

**Confidentiality**

You have the right to talk with health care providers in private and have your personal health care information kept private as protected under state and federal laws.

*You have the right to:*

* Speak with health care providers in private and have all the information, both paper and electronic, related to your care kept confidential within required regulations. Be assured that your written consent will be obtained for the release of medical or personal information or photographs or images to persons not otherwise authorized under law to receive it. You have the right to limit what information is released and to whom it is released to.
* Be assured that your health record will remain confidential.
* Review and copy your medical records and request amendments to those records and have them explained to you.
* Be assured of confidentiality when accessing Sensitive Services such as Sexually Transmitted Disease (STD) and HIV testing.

**If you have any questions, you may call the Office for Civil Rights toll-free at 1-800-368-1019. TTY users should call** **1-800-537-7697.**

**Choosing Your Provider**

*You have the right to:*

* Choose your own primary care provider and specialists from the GMWP provider panel.
* Request a qualified specialist for women’s health services or preventive women’s health services.
* To have reasonable and timely access to specialists as indicated by your health condition and consistent with current clinical practice guidelines.
* To receive necessary care in all settings, up to and including placement in a long-term care facility when the PACE organization can no longer provide the services necessary to maintain you living safely in the community.
* Initiate the disenrollment process at any time.

**Emergency Care**

*You have the right to:*

* Receive health care services in an emergency without prior approval from the GMWP Interdisciplinary Team.

**Treatment Decisions**

*You have the right to:*

* Participate in the development and implementation of your care plan. If you cannot fully participate in your treatment decision you may designate a health spokesperson to act on your behalf.
* Have all treatment options explained to you in a language you understand and acknowledge this explanation in writing.
* Be fully informed of your health status and make your own health care decisions.
* Refuse treatment or medications and be informed how this may affect your health.
* Request and receive complete information about your health and functional status by the GMWP Interdisciplinary Team.
* Request a reassessment by the GMWP Interdisciplinary Team at any time.
* Receive reasonable advance notice if you are to be transferred to another treatment setting for medical reasons or for your welfare or the welfare of other Participants. Any such actions will be documented in your health record.
* Have our staff explain advance directives to you and to establish one on your behalf, if you desire.

**Exercising Your Rights**

*You have the right to:*

* Assistance to exercise civil, legal and participant rights, including GMWP grievance process, the Medi-Cal State hearing process and the Medicare and Medi-Cal appeals processes.
* Voice your complaints and recommend changes in policies and services to our staff and to outside representatives of your choice. There will be no restraint, interference, coercion, discrimination or reprisal by our staff if you do so.
* Appeal any treatment decision made by GMWP or our contractors through our appeals process and request a state hearing.
* Leave the program at any time and have such disenrollment be effective the first day of the month following the date the PACE organization receives the participant's notice of voluntary disenrollment

To contact 1-800-MEDICARE for information and assistance, including to make a complaint related to the quality of care or the delivery of a service.

*If you feel any of your rights have been violated or you are dissatisfied and want to file a grievance or an appeal, please report this immediately to your social worker or call our office during regular business hours at (760) 280-2230 (For the Hearing-Impaired TTY/TDD: (760) 280-2279).*

*If you would like to talk to someone outside of GMWP about your concerns you may contact 1-800-MEDICARE (1-800-633-4227) or 1-888-452-8609 (Department of Health Care Services Office of the Ombudsman).*

Please refer to other sections of your GMWP *Member Enrollment Agreement Terms and Conditions* booklet for details about GMWP as your sole provider; a description of GMWP services and how they are obtained; how you may obtain emergency and urgently needed services outside GMWP’s network; the grievance and appeals procedure; conditions for disenrollment; and a description of premiums, if any, and payment of these.

**Participant Responsibilities**

We believe that you and your caregiver play crucial roles in the delivery of your care. To assure that you remain as healthy and independent as possible, please establish an open line of communication with those participating in your care and be accountable for the following responsibilities:

*You have the responsibility to:*

* Cooperate with the Interdisciplinary Team in implementing your care plan.
* Accept the consequences of refusing treatment recommended by the Interdisciplinary Team.
* Provide the Interdisciplinary Team with a complete and accurate medical history.
* Utilize only those services authorized by GMWP.
* Take all prescribed medications as directed.
* Call the GMWP physician for direction in an urgent situation.
* Notify GMWP within 48 hours or as soon as reasonably possible if you require emergency services out of the service area.
* Notify GMWP in writing when you wish to initiate the disenrollment process.
* Notify GMWP of a move or lengthy stay outside of the service area.
* Pay required monthly fees as appropriate.
* Treat our staff with respect and consideration.
* Not ask staff to perform tasks that they are prohibited from doing by PACE or agency regulations.
* Voice any concerns or dissatisfaction you may have with your care.

# Chapter 8 – Member Grievance and Appeals Process

All of us at GMWP share responsibility for your care and your satisfaction with the services you receive. Our grievance procedures are designed to enable you or your representative to express any concerns or dissatisfaction you have so that we can address them in a timely and efficient manner. You also have the right to appeal any decision about our failure to approve, furnish, arrange for or continue what you believe are covered services or to pay for services that you believe we are required to pay.

The information in this Chapter describes our grievance and appeals processes. You will receive written information of the grievance and appeals processes when you enroll and annually after that. At any time, if you wish to file a grievance or an appeal, we are available to assist you. If you do not speak English, a bilingual staff member or translation services will be available to assist you.

You will not be discriminated against because a grievance or appeal has been filed. GMWP will continue to provide you with all the required services during the grievance or appeals process. The confidentiality of your grievance or appeal will be maintained throughout the grievance or appeal process and information pertaining to your grievance or appeal will only be released to authorized individuals.

**Grievance Procedure**

**Definition:** A grievance is defined as a complaint, either written or oral, expressing dissatisfaction with the services provided or the quality of participant care. A grievance may include, but is not limited to:

* The quality of services a PACE participant receives in the home, at the PACE Center or in an inpatient stay (hospital, rehabilitative facility, skilled nursing facility or intermediate care facility).
* Waiting times on the telephone, in the waiting room or exam room;
* Behavior of any of the care providers or program staff;
* Adequacy of center facilities;
* Quality of the food provided;
* Transportation services; and
* A violation of a participant’s rights.

**Filing of Grievances**

The information below describes the grievance process for you or your representative to follow should you or your representative wish to file a grievance.

1. You or your representative can verbally discuss your grievance either in person or by telephone with GMWP program staff of the center you attend. The staff person will make sure that you are provided with written information on the grievance process and that your grievance is documented on the *Grievance Report* form. You will need to provide complete information of your grievance so the appropriate staff person can help to resolve your grievance in a timely and efficient manner. If you wish to submit your grievance in writing, please send your written grievance to: GMWP Quality Improvement and Compliance Director, Gary and Mary West PACE, 1706 Descanso Ave., San Marcos, California 92078.

You may also contact your assigned Social Worker at (760) 280-2230 to request a *Grievance Report* form and receive assistance in filing a grievance. For the hearing impaired (TTY/TDD), please call (760) 280-2279. Your Social Worker will provide you with written information on the grievance process.

1. The staff member who receives your grievance will help you document your grievance (if your grievance is not already documented) and coordinate investigation and action. All information related to your grievance will be held in strict confidence.
2. You will be sent a written acknowledgement of receipt of your grievance within five (5) calendar days. Investigation of your grievance will begin immediately to find solutions and take appropriate action.
3. The GMWP staff will make every attempt toresolve your grievance within thirty (30) calendar days of receipt of your grievance and you will receive a written letter with the resolution. If you are not satisfied with that resolution, you and/or your representative have the right to pursue further action.
4. In the event resolution is not reached within thirty (30) calendar days, you or your representative will be notified in writing of the status and estimated completion date of the grievance solution.

**Expedited Review of Grievances**

1. If you feel your grievance involves a serious or imminent threat to your health, including, but not limited to potential loss of life, limb or major bodily function, severe pain or violation of your participant rights, we will expedite the review process to a decision within 72 hours of receiving your written grievance and request for expedition. In this case, you will be immediately informed by telephone of: (a) the receipt of your request for expedited review, and (b) your right to notify the Department of Social Services of your grievance through the State hearing process.

**Resolution of Grievances**

1.Upon GMWP completion of the investigation and reaching a final resolution of your grievance, you will receive written notification that will provide you with a written report describing the reason for your grievance, a summary of actions taken to resolve your grievance, and options to pursue if you are not satisfied with the resolution of your grievance.

**Grievance Review Options**

If after completing the grievance process or after participating in the process for at least thirty (30) calendar days, and you or your representative are still dissatisfied, you or representative may pursue the options described below. *Note:* If you feel that waiting thirty (30) calendar days represents a serious health threat, you and/or your representative need not complete the entire grievance process nor wait thirty (30) calendar days to pursue the options described below.

1. ***Medi-Cal Ombudsman:*** If you are covered by Medi-Cal only or by Medi-Cal and Medicare, you are entitled to pursue your grievance with the California Department of Health Care Services, by contacting or writing to:

Ombudsman Unit

Medi-Cal Managed Care Division

Department of Health Care Services

P.O. Box 997413, Mail Station 4412

Sacramento, CA 95899-7413

Telephone: 1-888-452-8609

TTY: 1-800-735-2922

1. ***State Hearing Process:*** At any time during the grievance process, per California State law, you may also request a State hearing from the California Department of Social Services by contacting or writing to:

California Department of Social Services

State Hearing Division

P.O. Box 944243, Mail Station 19-37

Sacramento, CA 94244-2430

Telephone: 1-800-952-5253

Fax: (916) 229-4410

TTY: 1-800-952-8349

If you want a State hearing, you must ask for it within 90 days from the date of receiving the letter for resolved grievance. You or your representative may speak at the State hearing or have someone else speak on your behalf, including a relative, friend or an attorney. You may also be able to get free legal help. You or your representative will be provided a list of Legal Services offices in San Joaquin and Stanislaus Counties the time you file a grievance.

1. ***Home Health Hotline:*** If you have a question or concern regarding GMWP’s home health services, we recommend that you first discuss the matter with your Nurse or Social Worker. However, please be informed that the State of California has established a confidential process for submitting complaints against certified nursing assistants, hemodialysis technicians, and home health aides. You may complete the complaint form or draft your own complaint and submit via email, fax, or mail. You may also file a complaint over the phone.

**San Diego District Office**

7575 Metropolitan Drive, Suite 211

San Diego, CA 92108-4402

Phone: (619) 278-3700

Toll Free: (800) 824-0613

Fax: (619) 278-3725

Monday through Friday, from 9:00 a.m. to 5:00 p.m.

**Appeals Process**

**Definition:** An appeal is a participant’s action taken with respect to GMWP’s decision not to cover, or not to pay for a service, including denials, deferrals, modifications, reductions or termination of services. *For all disputes other than those involving decisions not to cover or not pay for services, including but not limited to those involving allegations of professional negligence, see the “Arbitration” chapter at the end of this Manual.*

When GMWPdecides not to cover or pay for a service you want, you may take action to change our decision. The action you take—whether verbally or in writing— is called an “**appeal**.” You have the right to appeal any decision to deny, defer, or modify your request for us to furnish, arrange for or continue what you believe are covered services or to pay for services that you believe we are required to pay.

You will receive written information on the appeals process when you enroll and annually after that. You will also receive this information and necessary appeals forms whenever GMWP denies, defers or modifies a request for a service or request for payment.

**Standard and Expedited Appeals Processes:** There are two types of appeals processes: standard and expedited. Both of these processes are described below.

If you request a **standard appeal**, your appeal must be filed within sixty calendar days of when your request for service or payment of service was denied, deferred or modified. This is the date which appears on the *Notice of Action for Service* or *Payment Request*. (The 60-day limit may be extended for good cause.) We will respond to your appeal as quickly as your health requires, but no later than thirty (30) calendar days after we receive your appeal.

If you believe that your life, health or ability to get well is in danger without the service you want, you or any treating physician may ask for an **expedited appeal**. If the treating physician asks for an expedited appeal for you, or supports you in asking for one, we will automatically make a decision on your appeal as promptly as your health requires, but no later than seventy-two (72) hours after we receive your request for an appeal. We may extend this time frame up to fourteen (14) calendar days if you ask for the extension or if we justify to the Department of Health Care Services the need for more information and how the delay benefits you.

If you ask for an **expedited appeal** without support from a treatingphysician, we will decide if your health condition requires us to make a decision on an expedited basis. If we decide to deny you an **expedited appeal**, we will let you know within seventy-two (72) hours. If this happens, your appeal will be considered a **standard appeal**.

*Note: For**GMWP participants, the**GMWP**will continue to provide the disputed service(s) if you choose to continue receiving the service(s) until the appeals process is completed. If our initial decision to NOT cover or reduce services is upheld, you may be financially responsible for the payment of disputed service(s) provided during the appeals process.*

**The information below describes the appeals process for you or your representative to follow should you or your representative wish to file an appeal**:

1. If you or your representative has requested a service or payment for a service and GMWP denies, defers or modifies the request, you may appeal the decision. A written “*Notice of Action of Service Determination or Payment Request*” (NOA) will be provided to you and/or your representative which will explain the reason for the denial, deferral or modification of your service determination request or request for payment.
2. You can make your appeal either verbally, in person or by telephone, or in writing with PACE Program staff of the center you attend. The staff person will make sure that you are provided with written information on the appeals process, and that your appeal is documented on the appropriate form. You will need to provide complete information of your appeal so the appropriate staff person can help to resolve your appeal in a timely and efficient manner. You or your representative may present or submit relevant facts and/or evidence for review, either in person or in writing to us at the address listed below. If more information is needed, you will be contacted by the GMWP Quality Improvement Coordinator who will assist you in obtaining the missing information.
3. If you wish to make your appeal by telephone, you may contact our Quality Improvement and Compliance Director at (760) 280-2230 at any time to request an appeal form and/or to receive assistance in filing an appeal. For the hearing impaired (TTY/TDD), please call (760) 280-2279.
4. If you wish to submit your appeal in writing, please ask a staff person for an appeal form. Please send your written appeal to:

Quality Improvement and Compliance Director

Gary and Mary West PACE

1706 Descanso Ave.

San Marcos, California 92078

1. You will be sent a written acknowledgement of receipt of your appeal within five (5) working days for a **standard appeal.** For and **expedited appeal**, we will notify you or your representative within one (1) business day by telephone or in person that the request for an expedited appeal has been received.
2. The reconsideration of GMWP decision will be made by a person(s) not involved in the initial decision-making process in consultation with the Interdisciplinary Team. We will ensure that this person(s) is both impartial and appropriately credentialed to make a decision regarding the necessity of the services you requested.
3. Upon GMWP completion of the review of your appeal, you or your representative will be notified in writing of the decision on your appeal. As necessary and depending on the outcome of the decision, GMWP will inform you and/or your representative of other appeal rights you may have if the decision is not in your favor.  Please refer to the information described below:

**The Decision on Your Appeal:**

***If we decide fully in your favor*** on a **standard appeal** for a request for **service**, we are required to provide or arrange for services as quickly as your health condition requires, but no later than thirty (30) calendar days from when we received your request for an appeal. **If we decide fully in your favor** on a request for **payment**, we are required to make the requested payment within sixty (60) calendar days after receiving your request for an appeal.

***If we do not decide fully in your favor*** on a **standard appeal** or if we fail to provide you with a decision within thirty (30) calendar days, you have the right to pursue an external appeal through either the Medicare or Medi-Cal program **(see Additional Appeal Rights, below).** We also are required to notify you as soon as we make a decision and also to notify the federal Centers for Medicare and Medicaid Services and the Long-Term Care Division, California Department of Health Care Services. We will inform you in writing of your **external** appeal rights under the Medicare or Medi-Cal Program, or both. We will help you choose which to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

***If we decide fully in your favor***on an **expedited appeal**, we are required to obtain the service or provide you the service as quickly as your health condition requires, but no later than seventy-two (72) hours after we received your request for an **appeal**.

***If we do not decide fully in your favor*** onan **expedited appeal** or fail to notify you within seventy-two (72) hours, you have the right to pursue an external appeal process under either Medicare or Medicaid (**see Additional Appeal Rights**). We are required to notify you as soon as we make a decision that is not fully in your favor and also to notify the Centers for Medicare and Medicaid Services and the Integrated Systems of Care Division (ISCD) Department of Health Care Services. We will let you know in writing of your **external appeal** rights through theMedicare or Medi-Cal Program, or both. We will help you choose which to pursue if both are applicable. We also will send your appeal to the appropriate external program for review.

**Additional Appeal Rights under Medi-Cal and Medicare**

If we do not decide in your favor on your appeal or fail to provide you a decision within the required timeframe, you have additional appeal rights. Your request to file an external appeal can be made either verbally or in writing. The next level of appeal involves a new and impartial review of your appeal request through either the Medicare or Medi-Cal program.

The **Medicare program** contracts with an “Independent Review Organization” to provide external review on appeals involving PACE programs. This review organization is completely independent of our PACE organization.

The **Medi-Cal program** conducts their next level of appeal through the State hearing process. If you are enrolled in Medi-Cal, you can appeal if GMWP wants to reduce or stop a service you are receiving. Until you receive a final decision, you may choose to continue to receive the disputed service. However, you may have to pay for the service(s) if the decision is not in your favor.

If you are enrolled in both **Medicare and Medi-Cal**, we will help you choose which appeals process you should follow. We also will send your appeal on to appropriate external program for review.

If you are not sure which program you are enrolled in, ask us. The Medicare and Medi-Cal external appeal processes are described below.

**Medi-Cal External Appeals Process**

If you are enrolled in both **Medicare and Medi-Cal OR Medi-Cal only**, and choose to appeal our decision using Medi-Cal’s external appeals process, we will send your appeal to the California Department of Social Services. At any time during the appeals process, you may request a State hearing through:

California Department of Social Services

State Hearings Division

P.O. Box 944243, Mail Station 19-37

Sacramento, CA 94244-2430

Telephone: 1-800-952-5253

Fax: (916) 229-4410

TTY: 1-800-952-8349

If you choose to request a State hearing, you must ask for it within ninety (90) days from the date of receiving the Notice of Action (NOA) for Service or Payment Request from GMWP.

You may speak at the State hearing or have someone else speak on your behalf such as someone you know, including a relative, friend or attorney. You may also be able to get free legal help. We will provide you with a list of Legal Services offices in San Joaquin and Stanislaus Counties at the time that we deny, modify or defer a service or payment of a service.

If the Administrative Law Judge’s (ALJ) decision is in your favor of your appeal, GMWP will follow the judge’s instruction as to the timeframe for providing you with services you requested or payment for services for a standard or expedited appeal.

If the ALJ’s decision is not in your favor of your appeal, for either a standard or an expedited appeal, there are further levels of appeal, and we will assist you in pursuing your appeal.

**Medicare External Appeals Process**

If you are **enrolled in both Medicare and Medi-Cal OR Medicare only**, and choose to appeal our decision using Medicare’s external appeals process, we will send your appeal to the current contracted Medicare appeals entity to impartially review your appeal. The current contracted Medicare appeals entity will contact us with the results of their review. The current contracted Medicare appeals entity will either maintain our original decision or change our decision and rule in your favor.

Maximus Federal Services

Medicare Part A West

3750 Monroe Avenue, Suite 706

Pittsford, NY 14534-1302

Appeals may be submitted to C2C’s Portal at https://www.c2cinc.com//Appellant-Signup

**Part D Prescription Drug Benefit and DMP At-Risk Appeals:**

C2C Innovative Solutions, Inc.

Part D Drug Reconsiderations

P.O. Box 44166

Jacksonville, FL 32231-4166

**Expedited and Standard Appeals Process**

You can request an **expedited** external appeal if you believe your health would be jeopardized by not receiving a specific service. In an expedited external review, we will send your appeal to the current contracted Medicare appeals entity as quickly as your health requires. The current contracted Medicare appeals entity must give us a decision within 72 hours after they receive the appeal from us. The current contracted Medicare appeals entity may ask for more time to review the appeal, but they must give us their decision within fourteen (14) calendar days.

You can request a **standard** external appeal if we deny your request for non-urgent services or do not pay for a service. For a standard external appeal, you will receive a decision on your appeal no later than thirty (30) calendar days after you request the appeal.

If the current contracted Medicare appeals entity’s decision is in your favor for a standard appeal:

If you have requested a service that you have not received, we will provide you with the service you asked for as quickly as your health condition requires;

**-OR-**

If you have requested payment for a service that you have already received, we will pay for the service within sixty (60) calendar days for either a standard or expedited.

If the current contracted Medicare appeals entity’s decision is **not** in your favor for either a standard or expedited appeal, there are further levels of appeal, and we will assist you in pursuing your appeal.

For more information regarding the appeals process or to request forms, please call us at (760) 280-2230 at any time. For the hearing impaired (TTY/TDD), please call (760) 280-2279 or contact GMWP Quality Improvement and Compliance Director at GMWP, 1706 Descanso Ave., San Marcos, California 92078.

# Chapter 9 – Monthly Fees

GMWP sets its fees on an annual basis and has the right to change its fees with a 30-day written notice.

**Prepayment Fees**

Your payment responsibility will depend upon your eligibility for Medicare, Medi-Cal and Medi-Cal’s Medically Needy Only (MNO) programs:

1. If you are eligible for Medi-Cal or a combination of Medi-Cal and Medicare, you will pay nothing to GMWP for the benefits and services described in CHAPTER 4, including prescription drugs.
2. If you qualify for Medicare and Medi-Cal’s Medically Needy Only (MNO) program, you are not liable for any premiums but will be responsible for paying your MNO share of cost.
3. If you are eligible only for Medicare, you will be charged a monthly premium. Because this premium does not include the cost of Medicare prescription drug coverage, you will be responsible for an additional monthly premium for Medicare prescription drug coverage. This monthly premium may be reduced if you qualify for a low-income subsidy.
4. If you are not eligible for Medi-Cal or Medicare, you will be charged the full monthly premium. This premium will include the cost of prescription drugs.

Please refer to your signed Enrollment Agreement for the amount you will be charged. If you have a monthly responsibility for payment of a premium or prescription drug coverage, the Enrollment Representative will explain this to you. We will also discuss your payment with you at the enrollment conference and write the amount on your Enrollment Agreement before you are asked to sign it. If you are charged both premiums, you may pay them together or you may contact the GMWP finance department for additional payment options. We will notify you in writing of any change in your monthly premium at least 30 calendar days before the change takes effect.

Your usual monthly Medicare Part B premium will continue to be deducted from your Social Security check.

**Prescription Drug Coverage Late Enrollment Penalty**

Please be aware that if you are eligible for Medicare prescription drug coverage and are enrolling in GMWP after going without Medicare prescription coverage or coverage that was as least as good as Medicare drug coverage for 63 or more consecutive days, you may have to pay a higher monthly amount for Medicare prescription drug coverage. You may contact the GMWP finance department for more information about whether this applies to you.

If you are required to pay a monthly premium or a premium for prescription drug coverage, you will receive an invoice. You must pay this amount by the first day of the month after you sign the Enrollment Agreement and on the first day of each subsequent month. Payment may be made by check or money order to:

Gary and Mary West PACE

1706 Descanso Ave.

San Marcos, CA 92078

Attention: Finance Department

**Late Charges**

Monthly payments are due on the first day of each month. If you have not paid this premium by the tenth day of the month, you may be assessed a late fee of $20.00, in accordance with applicable law. Late charges do not apply to participants with Medi-Cal coverage.

**Termination for Non-Payment**

If you pay a monthly premium, your monthly invoice will remind you that you are required to pay your monthly fee by the first day of each month. If you have not paid your monthly premium by the tenth day of the month, GMWP may terminate your coverage. If this occurs, GMWP will mail you a written Cancellation Notice on the tenth day of the month, informing you that your Enrollment Agreement will be terminated if you still have not paid the premium due (the monthly premium and late charge) by the cancellation date given in the Cancellation Notice. The cancellation date will be at least fifteen (15) calendar days after GMWP mails you the Cancellation Notice. The Cancellation Notice will also inform you that, if you pay the required amount within a thirty (30) calendar-day grace period after GMWP gives you the Cancellation Notice you will be reinstated with no break in coverage. You are obligated to pay the premium for any month in which you use GMWP services. If your benefits are terminated and you wish to re-enroll, please refer to CHAPTERS 10 and 11 regarding GMWP termination policy and renewal provisions.

**Other Charges:** None. There are no co-payments or deductibles for authorized services.

# Chapter 10 – Coverage and Termination of Benefits

Your enrollment in GMWP is effective the first day of the calendar month following the date you sign the “Enrollment Agreement.” For example, if you sign the Enrollment Agreement on March 14, your enrollment will be effective on April 1. Please note that you may not enroll in GMWP at a Social Security office.

* The GMWP will complete the initial assessments and Care Plan for you. The California Department of Health Care Services, ISCD will make the final determination of clinical eligibility. If you are determined eligible by California Department of Health Care Services, ISCD, the GMWP will then initiate the enrollment process.
* If you do not meet the financial eligibility requirements for Medi-Cal, you may pay privately for your care (see CHAPTER 9).

After signing the Enrollment Agreement, your benefits under GMWP continue indefinitely unless you choose to disenroll from the program (“voluntary disenrollment”) or you no longer meet the conditions of enrollment (“involuntary disenrollment”). The effective date of termination is midnight of the last day of a month (except termination for failure to pay a required fee, see CHAPTER 9).

GMWP will work to transition you back into traditional Medi-Cal and/or Medicare services as quickly as possible. Medical records will be forwarded as requested and authorized by the participant or designated representative and referrals to other resources in the community will be made to assure continuity of care.

You are required to continue to use GMWP’s services and to pay the monthly fee, if applicable, until termination becomes effective. If you should require care before your reinstatement occurs, GMWP will pay for the service to which you are entitled by Medicare or Medi-Cal.

**Voluntary Disenrollment**

If you wish to cancel your benefits by disenrolling, you should discuss this with your Social Worker. You may disenroll from GMWP without cause at any time. You will need to sign a *Disenrollment Form*. This form will indicate that you will no longer be entitled to services through GMWP after midnight on the last day of the month. Please note that you may not disenroll from GMWP at a Social Security office.

If a Medi-Cal only or private pay participant becomes eligible for Medicare after enrollment in GMWP, the participant will be disenrolled from GMWP if he or she elects to obtain Medicare coverage other than from the GMWP organization.

**Involuntary Disenrollment**

A participant’s involuntary disenrollment occurs after the GMWP organization meets the requirements set forth in this section and is effective on the first day of the next month that begins 30 days after the day GMWP organization sends notice of the disenrollment to the participant. All involuntary disenrollments are reviewed and approved by DHCS.

We may terminate your enrollment with GMWP if:

* You move out of the GMWP service area and no longer live in the service area zip codes or are out of the service area for more than 30 days without prior approval (see CHAPTER 6).



* You (or your caregiver) engages in disruptive or threatening behavior, i.e. your behavior jeopardizes the health or safety of yourself or others or you consistently refuse to comply with the terms of your Plan of Care or Enrollment Agreement, when you have decision-making capacity. Disenrollment under these circumstances is subject to prior approval by the DHCS and will be sought in the event that you display disruptive interference with care planning or threatening behavior which interferes with the quality of PACE services provided to you and other PACE participants.
* You are determined to no longer meet the Medi-Cal nursing home level of care criteria and are not deemed eligible.
* You fail to pay or fail to make satisfactory arrangements to pay any premium due to GMWP within the 30-day period specified in any cancellation notice (see CHAPTER 9).
* The agreement between GMWP, the Centers for Medicare and Medicaid Services and the DHCS is not renewed or is terminated.
* GMWP is unable to offer health care services due to the loss of our state licenses or contracts with outside providers.

All rights to benefits will stop at midnight on the last day of the month following a voluntary or involuntary disenrollment (except in the case of termination due to failure to pay fees owed, see CHAPTER 9). We will coordinate the disenrollment date between Medicare and Medi-Cal, if you are eligible for both programs. You are required to use GMWP services (except for Emergency Services and Urgent Care provided outside our service area) until termination becomes effective.

If you are hospitalized or undergoing a course of treatment at the time your disenrollment becomes effective, GMWP has the responsibility for service provision until you are reinstated with Medicare and Medi-Cal benefits (according to your entitlement and eligibility).

# Chapter 11 – Renewal Provisions

Your coverage by GMWP is continuous indefinitely (with no need for renewal). However, your coverage may be terminated if: (1) you fail to pay or fail to make satisfactory arrangements to pay any amount due GMWP after the 30-day grace period (see CHAPTER 9), (2) you voluntarily disenroll (see CHAPTER 10), or (3) you are involuntarily disenrolled due to one of the other conditions specified in CHAPTER 10.

If you choose to leave GMWP (“disenroll voluntarily”), you may be re-enrolled. To be re-enrolled, you must reapply, meet the eligibility requirements and complete our assessment process.

If you are disenrolled due to failure to pay the monthly fee (see CHAPTER 9), you can re-enroll simply by paying the monthly fee provided you make this payment before the end of the 30-day grace period (see CHAPTER 9). In this case, you will be reinstated with no break in coverage.

# Chapter 12 – General Provisions

**Authorization to Obtain Medical Records**

By accepting coverage under this Enrollment Agreement, you authorize GMWP to obtain and use your medical records and information from any and all health care facilities and providers who have treated you in the past. This will include information and records concerning treatment and care you received before the effective date of this Enrollment Agreement.

Access to your own medical record is permitted in accordance with California law. This information will be stored in a secured manner that will protect your privacy and be kept for the time period required by law.

**Authorization to Take and Use Photographs**

By accepting coverage under this Enrollment Agreement, you authorize GMWP to make and use photographs, video tapes, digital or other images for the purpose of medical care, identification, payment for services or internal operation of GMWP. Images will only be released or used outside GMWP upon your authorization.

**Changes to Enrollment Agreement**

Changes to this Enrollment Agreement may be made if they are approved by the Centers for Medicare and Medicaid Services and the California Department of Health Care Services. We will give you at least a 30-day advance written notice of any such change, and you will be deemed to have contractually agreed to such change.

**Confidentiality of Medical Records Policy**

The personal and medical information collected by GMWP adheres to a confidentiality policy to prevent disclosure of your personal and medical information other than as needed for your care. You may request a copy of our confidentiality policy by calling at (760) 280-2230 at any time. For the hearing impaired (TTY/TDD), please call (760) 280-2279.

**Continuation of Services on Termination**

If this Enrollment Agreement terminates for any reason, you will be reinstated back into the traditional Medicare and Medi-Cal programs, according to your eligibility. GMWP will work to transition you back into the traditional Medicare and/or Medi-Cal programs so your care is not jeopardized. This process takes between 30 to 90 days to complete.

**Cooperation in Assessments**

So we can determine the best services for you, your full cooperation is required in providing medical and financial information to us.

**Non-discrimination**

GMWP shall not unlawfully discriminate against participants in the rendering of service on the basis of race, age, religion, color, national origin, ancestry, sex, marital status, sexual orientation or disability. GMWP shall not discriminate against participants in the provision of service on the basis of having or not having an Advance Health Care Directive.

**Notice**

Any notice which we give you under this Enrollment Agreement will be mailed to you at your address as it appears on our records. It is your responsibility to notify us promptly of any change to your address. When you give us any notice, please mail it to:

Gary and Mary West PACE

1706 Descanso Ave.

San Marcos, CA 92078

**Notice of Certain Events**

If you may be materially and adversely affected, we shall give you reasonable notice of any termination, breach of Enrollment Agreement or inability to perform by hospitals, physicians or any other person with whom we have a contract to provide services. We will give you a 30-day written notice if we plan to terminate a contract with a medical group or individual practice association from whom you are receiving treatment. In addition, we will arrange for the provision of any interrupted service by another provider.

**Organ and Tissue Donation**

Donating organs and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak with your GMWP Physician. Organ donation begins at the hospital when a patient is pronounced brain dead and identified as a potential organ donor. An organ procurement organization helps coordinate the donation.

**Our Relationship to GMWP Providers**

GMWP providers other than GMWP staff are independent organizations and are related to us by contract only. These providers are not our employees or agents. GMWP providers maintain a relationship with you and are solely responsible for any of their acts or omissions, including malpractice or negligence. Nothing in this Enrollment Agreement changes the obligation you have to any provider who renders care to you to abide by the rules, regulations and other policies established by the provider.

**Participation in Public Policy of Plan**

The Board of Directors of GMWP has a standing subcommittee, known as the Participant Advisory Committee (PAC) which provides advice to the governing body on matters of concern to participants. The PAC is intended to help improve service delivery within the PACE program through increased consumer feedback and recommendations within the QI structure. This committee shall meet on a quarterly basis and be facilitated by the Center Manager or designee.

Any material changes in our health care services plan are communicated to participants at least annually.

**Recovery from Third Party Liability**

If you are injured or suffer an ailment or disease due to an act or omission of a third party giving rise to a claim of legal liability against the third party, GMWP must report such instances to the California Department of Health Care Services. If you are a Medi-Cal beneficiary, any proceeds which you collect, pursuant to the injury, ailment or disease, are assigned to the California Department of Health Care Services.

**Reduction of Benefits**

We may not decrease in any manner the benefits stated in this Enrollment Agreement, except after a period of at least a 30-day written notice. The 30-day period will begin on the date postmarked on the envelope.

**Reimbursement from Insurance**

If you are covered by private or other insurance, including but not limited to motor vehicle, liability, health care or long-term care insurance, GMWP is authorized to seek reimbursement from that insurance if it covers your injury, illness or condition. (Instances of tort liability of a third party are excluded.) We will directly bill these insurers for the services and benefits we provide (and upon receipt of reimbursement reduce any payment responsibility you may have to GMWP. You must cooperate and assist us by giving us information about your insurance and completing and signing all claim forms and other documents we need to bill the insurers. If you fail to do so, you, yourself, will have to make your full monthly payment. (See CHAPTER 9 for payment responsibility.)

**Safety**

To provide a safe environment, GMWP’s safety policies includes mandatory use of quick release wheelchair seat belts for all participants while in transit, either in a vehicle or from one program area to another.

**Second Opinion Policy**

You may request a second medical opinion, as may others on your behalf, including your family, your PCP and the IDT. If you desire a second opinion you should notify your PCP or nurse practitioner. GMWP will issue a decision on second opinions within 72 hours. The timeline is available upon request by calling the GMWP Medical Director at at (760) 280-2230 at any time. For the hearing-impaired (TTY/TDD), please call (760) 280-2279.

**Tuberculosis Testing**

A tuberculosis (TB) skin test(s) or chest X-ray is required upon enrollment and annually as appropriate. GMWP will provide treatment if the TB test is positive.

**Payment for Unauthorized Services**

You will be responsible to pay for unauthorized services, except for Emergency Services and Urgent Care (see “Reimbursement Provisions” in CHAPTER 5).

**Payment for Services under this Enrollment Agreement**

Payment for services provided under this Enrollment Agreement will be made by GMWP to the provider. You cannot be required to pay anything that is owed by GMWP to the selected providers.

# Chapter 13 – Arbitration

This chapter governs the resolution of actions taken against GMWP with respect to allegations of professional negligence of a GMWP Health Care Provider, and other disputes not involving the decision not to cover/pay for a service (*see* Chapter 8, “Participant Grievance and Appeals Process,” for resolution of disputes involving GMWP’s decision not to cover/pay for a service).

It is understood that any dispute, whether arising from tort, contract, negligence or otherwise, including but not limited to, any claims for loss of consortium, wrongful death, emotional distress, punitive damages, and/or any actions brought on behalf of the Patient by third parties, shall be submitted to binding arbitration as provided by California law and according to the Arbitration Procedures set forth below, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are agreeing to the use of arbitration to resolve their dispute instead of submitting any such claim to a court of law of competent jurisdiction. Any dispute not involving decisions not to cover or pay for services shall be determined by submission to binding arbitration pursuant to the Arbitration Procedures set forth below. By participating in GMWP, you are waiving the right to a trial for medical malpractice and other disputes relating to the delivery or arrangement of services by GMWP.

Arbitration Procedures

Arbitration as described under this chapter shall be binding. The binding arbitration shall be conducted in accordance with California law, including the provisions set forth at Cal. Code of Civil Procedure, Title 9, and the following provisions, including Cal. Civ. Pro. § 1280 *et seq.* (the “California Arbitration Provisions”). To the extent that California law conflicts with any of the following provisions, the provisions set forth below shall govern except to the extent: (a) otherwise prohibited by California law; or (b) one or more of the provisions below would render this agreement to arbitrate invalid.

(a) **Notice of Arbitration**. If you wish to initiate an arbitration proceeding against GMWP, you must submit a notice (an “Arbitration Notice”) to GMWP indicating your intent to arbitrate a dispute. This Arbitration Notice should describe in detail the circumstances of your complaint and should be submitted to GMWP, 1706 Descanso Ave.

San Marcos, California 92078.

If GMWP wishes to initiate an arbitration proceeding against you, it will submit an Arbitration Notice to you indicating its intent to arbitrate a dispute. The Arbitration Notice will be sent to the residence address (or mailing address, if one was provided) that you provided to GMWP when you enrolled, or, if you have updated your address, the Arbitration Notice will be sent to your updated address. If you need to change this address at any time, please contact GMWP.

(b) **Arbitrator Selection**. The Parties shall appoint a single, mutually agreed upon, neutral Arbitrator (the “Arbitrator”). If the Parties are unable to agree upon an Arbitrator within 30 Days after receipt of the Arbitration Notice, each Party shall serve a written list of three (3) arbitrators on the other Party. Within 7 Days following service, each Party shall strike two (2) names and shall rank the remaining four (4) candidates in order of preference. The remaining arbitrator candidate with the highest composite ranking shall be appointed as the Arbitrator. In his/her conduct of the Arbitration, the Arbitrator shall comply with the ethics standards for arbitrators adopted by the Judicial Council of California in all respects.

(c) **Venue**. The Arbitration shall be conducted in San Marcos, California unless the Arbitrator orders an alternate place for the hearing for good cause. The Arbitrator shall comply with Cal. Civ. Pro. § 1280 *et seq.* in all respects, including the service of notice on the parties to the arbitration.

(d) **Administration of Arbitration**. The provisions of this Agreement shall control any matters addressed by it, unless otherwise prohibited by California law. In all other respects, the construction, validity, and performance of the Arbitration shall be governed by California law, including Cal. Civ. Pro. § 1280 *et seq.*

(e) **Arbitration Participants**. Each Party may choose those Persons it wishes to have participate in the Arbitration on its behalf, including legal counsel, provided that each Party is represented by a Person who shall have final and requisite corporate or other authority on behalf of such Party to settle the dispute at issue, and each such Person shall be clearly identified as such to the other Party and the Arbitrator (each, an “Arbitration Principal”).

(f) **Discovery**. Each Party will, upon the written request of the other Party, promptly provide the other Party with copies of non-privileged documents relevant to the dispute at issue, and any disagreement regarding discovery, or the relevance or scope thereof, shall be determined by the Arbitrator, which determination shall be conclusive. All discovery shall be completed within the 45 Day period following the appointment of the Arbitrator.

(g) **Arbitrator’s Authority**. The Arbitrator shall have the power to grant any remedy or relief (including all remedies available under federal, state, or local laws) that he/she deems just and equitable and that is in accordance with the terms of this Agreement and with applicable law, including specific performance, and including, without limitation, injunctive relief, whether interim or final, and any such relief and any interim, provisional or conservatory measure ordered by the Arbitrator may be specifically enforced by any court of competent jurisdiction. The Arbitrator shall also have the power to order the deposition of a witness to be taken pursuant to Cal. Civil Pro. § 1283 (in the manner set forth in Cal. Civil Pro. § 1283.05) and to issues subpoenas and subpoenas duces tecum pursuant to Cal. Civil Pro. § 1282.6.

(h) **Attorney’s Fees/Costs**. Each Party shall be responsible for its own attorneys’ fees and costs incurred in preparing for and attending the Arbitration. Each Party to the Arbitration shall pay its pro rata share of the expenses and fees of the neutral Arbitrator, together with other expenses of the Arbitration incurred or approved by the neutral Arbitrator, not including counsel fees or witness fees or other expenses incurred by a Party for its own benefit. The allocation of costs and fees shall in all cases be determined in accordance with Cal. Civil Pro. § 1284.2 and 1284.3.

(i) **Joinder of Interested Parties**. The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

(j) **General Provisions.** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrator shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

(k) **Written Decision**. The Arbitrator shall issue a binding written decision setting forth the Parties’ contentions and the Arbitrator’s determination of all the questions submitted to the Arbitrator which are necessary to determine the controversy (the “Decision”). The Decision shall apply California and applicable federal law and shall be signed by the Arbitrator and copies provided to both Parties within the 30-day period immediately following the conclusion of the Arbitration hearing. The Arbitrator’s final Decision shall be conclusive and binding, and it may be confirmed thereafter as a judgment by the California Superior Court, subject only to challenge on the grounds set forth in Cal. Civ. Pro. § 1280 *et seq.*

(l) **Arbitration Confidentiality**. The entire Arbitration process shall be confidential (including that the Parties are participating in Arbitration).

(m) **Waiver of Rights**. By agreeing to Arbitration as set forth in this Chapter 13, each Party acknowledges that it is waiving certain substantial rights and protections which otherwise may be available if a dispute between the Parties were determined by litigation in a court, including the right to a jury trial, attorneys’ fees and certain rights of appeal.

(n) **Judicial Remedy**. Either Party may petition any court having jurisdiction to confirm, enforce, and/or enter judgment on the Arbitrator’s award. In the event that litigation is commenced to confirm, enforce and/or enter an Arbitration award, to the extent permitted by law, the prevailing Party shall be entitled to recover reasonable attorney’s fees and costs whether or not such action proceeds to judgment, and the court shall separately determine the prevailing party.

(o) **Revocation.** If you sign this Enrollment Agreement and then change your mind, the law permits you to revoke Chapter 13 of the Enrollment Agreement, providing you give written notice within thirty (30) days from signing that you want to withdraw from the arbitration provision of the Enrollment Agreement. However, you and GMWP agree that any claim arising from medical services rendered prior to revocation shall be subject to arbitration. If notice of revocation of this Chapter 13 of the Enrollment Agreement is not received within thirty (30) calendar days of its signing, the right to cancel the arbitration provision of the Enrollment Agreement is forever waived.

(p) **Miscellaneous.** The parties agree that provisions of California law applicable to health care providers shall apply to disputes within the arbitration provision of this Enrollment Agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring a motion for summary judgment or summary adjudication in the arbitration.

# Chapter 14 – Definitions

**Benefits and coverage** are the health and health-related services we provide through this Enrollment Agreement. These services take the place of the benefits you would otherwise receive through Medicare and/or Medi-Cal. Their provision is made possible through an agreement between GMWP, Medicare (Centers for Medicare and Medicaid Services of the Department of Health and Human Services) and Medi-Cal (Department of Health Care Services). This Enrollment Agreement gives you the same benefits you would receive under Medicare and Medi-Cal plus many additional benefits. To receive any benefits under this Enrollment Agreement, you must meet the conditions described in this Enrollment Agreement.

**Enrollment Agreement** means the agreement between you and GMWP which establishes the terms and conditions and describes the benefits available to you. This Enrollment Agreement remains in effect until Disenrollment and/or Termination take place.

**Contracted provider** means a health facility, health care professional or agency that has contracted with GMWP to provide health and health-related services to GMWP participant.

**Coverage decision** means the approval or denial of health services by GMWP substantially based on a finding that the provision of a particular service is included or excluded as a covered benefit under the terms and conditions of our Enrollment Agreement with you.

**Credentialed** refers to the requirement that all practitioners (physicians, psychologists, dentists and podiatrists) who serve GMWP participants must undergo a formal process that includes thorough background checks to verify their education, training and experience and confirm competence.

**Department of Health Care Services (California Department of Health Care Services)** means the single State Department responsible for administration of the federal Medicaid Program (referred to as Medi-Cal in California), California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP) and other health-related programs.

**Disputed health care service** means any health care service eligible for payment under your Enrollment Agreement with GMWP that has been denied, modified or delayed by a decision of GMWP in whole or in part due to the finding that a service is not necessary. A decision regarding a “disputed health care service” relates to the practice of medicine and is not a coverage decision.

**Eligible for nursing home care** means that your health status, as evaluated by the GMWP Interdisciplinary Team, meets the State of California’s criteria for placement in either an Intermediate care facility (ICF), or a Skilled Nursing Facility (SNF). GMWP’s goal, however, is to help you to stay in the community as long as possible, even if you are eligible for nursing home care.

**Emergency Medical Condition** and **Emergency Services** are defined in CHAPTER 5.

**Exclusion** means any service or benefit that is not included in this Enrollment Agreement. For example, non-emergency services received without authorization from the GMWP’s Interdisciplinary Team of qualified clinical professionals are excluded from coverage. You would have to pay for any unauthorized services.

**Experimental and Investigational service** means a service that is not seen as safe and effective treatment by generally accepted medical standards (even if it has been authorized by law for use in testing or other studies in humans); or has not been approved by the government to treat a condition.

**Family** means your spouse, “significant other,” children and relatives; the definition of “family” may also be expanded to include close friends or any other person you choose to involve in your care.

**Health services** are services such as medical care, diagnostic tests, medical equipment, appliances, drugs, prosthetic and orthopedic devices, nutritional counseling, nursing, social services, therapies, dentistry, optometry, podiatry and audiology. Health services may be provided in a GMWP center or clinic, in your home, or in professional offices of contracted specialists or other providers, hospitals or nursing homes under contract with GMWP.

**Health-related services** are those services which help GMWP provide health services and enable you to maintain your independence. Such services include personal care, homemaker/chore service, attendant care, recreational therapy, escorts, translation services, transportation, home-delivered meals and assistance with housing problems.

**Home health care** refers to two categories of services—supportive and skilled services. Based on individualized Plans of Care, supportive services are provided to participants in their homes and may include household services and related chores such as laundering, meal assistance, light cleaning and shopping, as well as assistance with bathing and dressing as needed. Skilled services may be provided by the program’s social workers, nurses, occupational therapists and on-call medical staff.

**Hospital services** are those services which are generally and customarily provided by acute general hospitals.

**Interdisciplinary Team (IDT)** means GMWP’s team of service providers, facilitated by a program manager, and consisting of, at minimum, a Primary Care Provider (PCP), registered nurse(s), master’s-level social worker (MSW), personal care attendant, home care coordinator, transportation representative, physical, recreational and occupational therapists and a dietitian. Members of the IDT will assess your medical, functional and psychosocial status and develop a Care Plan which identifies the services needed. Many of the services are provided and monitored by this team. All services you receive must be authorized by your GMWP physician or other qualified clinical professionals on the IDT. Periodic reassessment of your needs will be done by the team and changes in your treatment plan may occur.

**Life threatening** means diseases or conditions where the likelihood of death is high unless the course of the disease or condition is interrupted.

**Medically Necessary** means medical or surgical treatments provided to a participant by a participating provider of the Plan which are: (a) appropriate for the symptoms and diagnosis or treatment of a condition, illness or injury; (b) in accordance with accepted medical and surgical practices and standards prevailing at the time of treatment; and (c) not for the convenience of a participant or a participating provider of the Plan.

**Monthly fee** means the amount you must pay each month in advance to GMWP to receive benefits under this Enrollment Agreement.

**Necessary Service means** appropriate to participant’s current medical, physical, emotional, and social needs; and follow current clinical practice guidelines and professional standards of care applicable to the particular service

**Nursing home** means a health facility licensed as either an Intermediate Care Facility or a Skilled Nursing Facility by the Department of Health Care Services.

**Out-of-area** is any area beyond GMWP’s service area. (See below for definition of service area).

**PACE** is the acronym for the **P**rogram of **A**ll-Inclusive **C**are for the **E**lderly. PACE is the comprehensive service plan which integrates acute and long-term care for older people with serious health problems. Payments for services are on a monthly capitation basis, combining both state and federal dollars through Medicare and Medi-Cal. Individuals not eligible for these programs pay privately. PACE arranges for participants to come to the GMWP Center to receive individualized care from doctors, nurses and other health and social service providers. The goal is to help participants stay independent in the community for as long as safely possible.

**GMWP Health Care Provider** includes (a) GMWP; (b) any clinic, health dispensary, or health facility, licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code, that is owned, operated by, or contracted with, GMWP; and (c) any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act, or licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code, who is lawfully employed by, or

contracted with, GMWP to provide services to PACE participants.

**GMWP Physician** is a doctor who is either employed by GMWP or has a contract with GMWP to provide primary care medical services to participants.

**Representative** means a person who is acting on behalf of or assisting a PACE participant, and may include, but is not limited to, a family member, a friend, a PACE employee, or a person legally identified as Power of Attorney for Health Care/Advanced Directive, Conservator, Guardian, etc.

**Sensitive Services** means those services related to an episode of diagnosis and treatment of a sexually transmitted disease and testing and counseling for HIV.

**Service area** means the geographical location that GMWP serves. 

**Urgent care** means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (for example, sore throats, fever, minor lacerations and some broken bones). Urgent care includes inpatient or outpatient services from an unforeseen illness or injury for which treatment cannot be delayed until you return to our service area.

# Appendix I

*This Appendix explains your rights to make health care decisions and how you can plan what should be done in the event that you cannot speak for yourself. A federal law requires us to give you this information. We hope this information will help increase your control over the medical treatment you receive.*

**Who Decides About My Treatment?**

Your doctors will give you information and advice about treatment. You have the right to choose. You may say “Yes” to treatments you want. You may say “No” to treatments you don’t want. You are entitled to say “No” to a treatment you don’t want even if that treatment might keep you alive longer. If you have a conservator, you still may make your own health care decisions. This only changes if and when a judge decides that your conservator will also make your health care decisions on your behalf.

**How Do I Know What I Want?**

Your doctor must tell you about your medical condition and about what different treatments can do for you. Many treatments have “side effects.” Your doctor must offer you information about serious problems that medical treatment may cause.

Often, more than one treatment might help you—and people have different ideas about which is best. Your doctor can tell you which treatments are available to you and which treatments may be most effective for you. Your doctor can also discuss whether the benefits of treatment are likely to outweigh potential drawbacks. However, your doctor can’t choose for you. That choice depends on what is important to you.

**What If I Am Too Sick to Decide?**

If you are unable to make treatment decisions, your doctor will ask your closest available relative, friend or the person you have personally identified to the doctor as the one you want to speak for you to help decide what is best for you. That works most of the time. But sometimes everyone doesn’t agree about what you want to happen if you cannot speak for yourself. There are several ways you can prepare in advance for someone you choose to speak for you. Under California Law, these are called Advance Health Care Directives.

An Advance Health Care Directive lets you write down the name of the person you want to make health care decisions for you when you are unable to do so. This part of an Advance Health Care Directive is called a Durable Power of Attorney for Health Care. The person you choose is called the “agent.” There are Advance Health Care Directive forms you can use, or you can write down your own version as long as you follow a few basic guidelines.

**Who Can Write an Advance Health Care Directive?**

You can if you are 18 or older and of sound mind. You do not need a lawyer to make or fill out an Advance Health Care Directive.

**Who Can I Name to Make Medical Treatment Decisions When I’m Unable to Do So?**

When you make your Advance Health Care Directive, you can choose an adult relative or friend whom you trust. That person will then be able to speak for you in the event that you’re too sick to make your own decisions.

**How Does This Person Know What I Would Want?**

Talk to the family member or friend whom you are considering to be your agent about what you would want. Make sure they feel comfortable with your wishes and able to carry them out on your behalf. You may write down your treatment wishes in the Advance Health Care Directive. You may include when you would or wouldn’t want medical treatment. Talk to your doctor about what you want and give your doctor a copy of the form. Give another copy to the person named as your agent. Take a copy with you when you go into a hospital or other treatment facility.

Sometimes treatment decisions are hard to make and it truly helps your family and doctors if they know what you want. The Advance Health Care Directive also gives your health care team legal protection when they follow your decisions.

**What If I Do Not Have Anybody to Make Decisions For Me?**

If you do not want to choose someone, or do not have anybody to name as your agent, you may just write down your wishes about treatment. This is still an Advance Health Care Directive. There is a place on the standard form to write your wishes or you may write them on your own piece of paper. If you use the form, simply leave the Power of Attorney for Health Care section blank.

Writing down your wishes this way tells your doctor what to do in the event that you can no longer speak for yourself. You may write that you do not want any treatment that would only prolong your dying or you may write that you *do* want life-prolonging care. You may provide more detail about the type and timing of the treatment you would want. (Whatever you write, you would still receive care to keep you comfortable.)

The doctor must follow your wishes about your treatment unless you have requested something illegal or against accepted medical standards. If your doctor does not want to follow your wishes for another reason, your doctor must turn your care over to another doctor who will follow your wishes. Your doctors are also legally protected when they follow your wishes.

**May I Just Tell My Doctor Who I Want Making Decisions for Me?**

Yes, as long as you personally tell your doctor the name of the person you want making these health care decisions. Your doctor will write what you said in your medical chart. The person you named will be called your “surrogate.” Your surrogate will be able to make decisions based on your treatment wishes, but only for 60 days or until your specific treatment is done.

**What If I Change My Mind?**

You may change your mind or revoke your Advance Health Care Directive at any time as long as you communicate your wishes.

**Do I Have To Fill Out One Of These Forms?**

No, you do not have to fill out any of these forms if you do not want to. You may just talk to your doctors and ask them to write down in your medical chart what you have said; and you may talk with your family. But people will be clearer about your treatment wishes if you write them down. And your wishes are more likely to be followed if you write them down.

**Will I Still Be Treated if I Do Not Fill Out These Forms or Do Not Talk to My Doctor About What I Want?**

Absolutely. You will still get medical treatment. We just want you to know that if you become too sick to make medical decisions, someone else will have to make them for you. Remember that:

* A Durable Power of Attorney for Health Care lets you name someone to make treatment decisions for you. That person can make most medical decisions—not just those about life-sustaining treatment—when you can’t speak for yourself.
* If you do not have someone you want to name to make decisions when you cannot, you may also use an Advance Health Care Directive to just say when you would and would not want particular types of treatment.
* If you already have a “Living Will” or Durable Power of Attorney for Health Care, it is still legal and you do not need to make a new Advance Health Care Directive unless you wish to do so.