

H6517- 0004

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY



Family HealthCare Network PACE

**PARTICIPANT ENROLLMENT
AGREEMENT**

TERMS AND CONDITIONS

July 1, 2024

Family HealthCare Network

PACE Health Plan

Administration

500 E School Ave

Visalia, CA 93292

877-960-3426

For Hearing-Impaired

TTY/VCO/HCO to VOICE:

(1-800-735-2929)

VOICE to TTY/VCO/HCO:

(1-800-735-2922)

H6517- 0004

THIS BOOKLET BELONGS TO

CENTER – FHCN PACE

TELEPHONE NUMBER

ADDRESS – 500 E. School Ave Visalia, CA 93292

CENTER MANAGER:

PHYSICIAN

SOCIAL WORKER

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CHAPTER 1

WELCOME TO FHCN PACE

FHCN PACE is a healthcare services plan for people aged 55 and older with ongoing healthcare needs. We are happy to welcome you as a participant. Since we enroll only individuals, dependents are not covered when you register.

Please keep this booklet. Your signed copy of the FHCN PACE Enrollment Agreement form is a legally binding contract between you and FHCN PACE.

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

If you would like further information about the benefits of the FHCN PACE, please get in touch with us at 877-960-3426. In this agreement, FHCN PACE is sometimes called “we,” and you are sometimes called the “participant” or “member.” The term “participant” is most often used at FHCN PACE. *Some of the terms in this document may not be familiar to you. Please refer to the “Definitions” section in the back (Chapter 13) to explain various terms used.*

Our philosophy at FHCN PACE is to help you remain independent, living in your community and home. We offer a complete health and health-related services program focusing on *preventive* measures to maintain your well-being.

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

FHCN PACE operates 24 hours a day, seven days a week, 365 days a year. To treat our participants' chronic healthcare problems, our healthcare 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 scrutinize this Enrollment Agreement. Enrollment in the FHCN PACE 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 FHCN PACE 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 FHCN PACE, you will receive the following items:

- A copy of the signed FHCN PACE Participant Enrollment Agreement, which includes Terms and Conditions (this document)
- A FHCN PACE Membership card
- A sticker 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 FHCN PACE, 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 contracting with FHCN PACE.

Prior authorization is never required for Emergency Services. *Please refer to Chapter 4, Benefits and Coverage.*

CATEGORY	SERVICES AND LIMITATIONS
Deductibles	None
Lifetime Maximums	None
Professional Services	<ul style="list-style-type: none"> • Physician services, including primary care providers and medical specialists, routine physicals, preventive health care, sensitive services, outpatient surgical services, and outpatient mental health. <ul style="list-style-type: none"> • Basic dental coverage (routine Preventive Services including exams, X-rays, and cleanings). • Vision care. Prescription eyeglasses and corrective lenses after cataract surgery. • Audiology services. Hearing exams and hearing aids. <ul style="list-style-type: none"> • Routine podiatry. • Medical social services/case management. <ul style="list-style-type: none"> • Rehabilitation therapy. Includes physical, occupational, and speech therapies.

CATEGORY	SERVICES AND LIMITATIONS
Outpatient Service	Coverage for surgical services, mental health, diagnostic X-ray, and laboratory services.
Hospitalization Services	Coverage for semi-private room and board and all necessary services, including general medical and nursing services, psychiatric services, operating room fees, diagnostic or therapeutic services, laboratory services, X-rays, dressings, casts, anesthesia, blood and blood products, drugs, and biologicals. Not covered are private rooms or private duty nursing, and non-medical items unless authorized by the IDT.
Emergency Health Coverage	Coverage for emergency services. FHCN PACE does not cover emergency services outside the United States except for emergency services requiring hospitalization in Canada or Mexico.
Ambulance Services	
Prescription Drug Coverage	Coverage for medications from the PACE organization formulary when prescribed by a provider.
Durable Medical Equipment	
Mental Health Services	
Chemical Dependency Services	

CATEGORY	SERVICES AND LIMITATIONS
Home Health Services	

Other	<ul style="list-style-type: none">• Medicare-covered skilled nursing facility. Coverage is provided for semi-private rooms only unless authorized by the IDT.
	<ul style="list-style-type: none">• Home care services. Day center services (including nutrition, hot meals, escort, and transportation). Necessary materials, supplies, and services for managing diabetes mellitus. <ul style="list-style-type: none">• End of Life Care.

Please note: All services and benefits are determined through the plan of care (or treatment plan) at the discretion of the IDT.

CHAPTER 2

SPECIAL FEATURES OF FHCN PACE

Our healthcare services plan has several unique features:

1. Expertise in Caring

Our successful approach focuses on developing customized care plans addressing each participant's health and health-related issues. Our dedicated, highly skilled providers both plan and provide care so the care you receive is comprehensive and coordinated.

2. The Interdisciplinary Team (IDT)

A team of specialists working with you plans and provides your care. Your team includes a primary care provider (physician or nurse practitioner), registered nurse, home care coordinator, social worker, physical therapist, occupational therapist, recreational therapist, dietician, the PACE center manager, and others who assist you, such as personal care attendants and drivers of our vans. Each team member's particular expertise is employed to assess your healthcare needs. Other staff may be called upon if necessary. Together, a plan of care is developed just for you.

3. Facilities

You will receive many healthcare services at our center— where your team is. *Our teams and center are located at the following address in Visalia:*

500 E School Ave

Visalia, CA 93292

Several factors, including your preference, home location, and unique needs, will determine which center you attend. We provide transportation for you to come to the center. How often you come to the center will depend upon your care plan.

FHCN PACE offers you access to medical care through our physicians and center on a 24-hour basis, 365 days a year.

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

FHCN PACE through an IDT, the Primary Care Provider (PCP) you choose is a member of your IDT. You will be assigned other providers for your team. Your PCP is responsible for all of your primary health care needs and, with the help of your IDT, arranges for other medical services you may need. Participants have the option to seek gynecological services directly from a participating gynecologist.

Services are provided in your home, a hospital, or a nursing home when necessary. We have contracts with specialists (such as cardiologists, urologists, and orthopedists), 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 Grady Dodson, Program Director, at 877-960-3426 or 1-800-735-2929.

5. Authorization and Management of Care

You will know each team member well; they will all work closely with you to help you remain as healthy and independent as possible. The IDT must approve the service before receiving any service from FHCN PACE. However, prior authorization is never required for Emergency Services.

At least every six months—more frequently if you have problems—your team assesses your needs and adjusts services if necessary. You and your family may request an assessment. If your situation changes, the IDT adjusts your services based on your care plan assessment and other needs.

6. Medicare/Medi-Cal Relationship

The benefits under this Enrollment Agreement are made possible through an agreement FHCN PACE has with Medicare (the Centers for Medicare and Medicaid Services of the Department of Health and Human Services) and Medi-Cal (DHCS). When you sign this Enrollment Agreement, you agree to accept FHCN PACE benefits instead of the usual Medicare and Medi-Cal benefits. FHCN PACE will provide services based on your needs - the same benefits you are entitled to under Medicare and Medi-Cal, plus more.

Contact the Health Insurance Counseling and Advocacy Program (HICAP) for additional information concerning Medicare-covered benefits. 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

FHCN PACE has no pre-set limit to services. There are no limits or restrictions to the number of hospital or nursing home days covered if your FHCN PACE provider determines they are necessary. Home care is authorized and provided to you on a frequency and duration based on the team's clinical experts' evaluation of your needs.

8. “Lock-in” Provision

When you enroll with FHCN PACE, 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 the arrangements FHCN PACE makes with contract providers. However, you **can no longer obtain services from other doctors or medical providers under the traditional fee-for-service Medicare and Medi-Cal system.** Enrollment in FHCN PACE results in disenrollment from any other Medicare or Medi-Cal prepayment plan or optional benefit.

Electing enrollment in any other Medicare or Medi-Cal prepayment plan or optional benefit, including the hospice benefit, after enrolling in FHCN PACE is considered a voluntary disenrollment from FHCN PACE. If you are not eligible for Medicare when you enroll in FHCN PACE and become eligible after enrollment, you will be disenrolled if you elect to obtain Medicare coverage other than from FHCN PACE. (Please note that FHCN PACE will only pay for services you have used before your enrollment if these are specifically authorized by the IDT.)

CHAPTER 3 ELIGIBILITY AND ENROLLMENT

You are eligible to enroll in FHCN PACE if you:

- Reside in FHCN PACE's service area, that includes:

Kings County

93202, 93212, 93230, 93245, and 93266;

Tulare County

93201, 93212, 93215, 93218, 93219, 93221, 93223, 93235, 93244, 93247, 93256, 93257, 93267, 93270, 93271, 93272, 93274, 93277, 93286, 93291, 93292, 93615, 93618, 93631, 93646, and 93647.

- 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 requiring continuous 24-hour availability of skilled nursing. An "Intermediate Care Facility" is a level-of-care designation that identifies the need for 24-hour supervised care during the day on weekdays.
- You can live in the community without jeopardizing your health and safety and that of others at the time of enrollment.

You must also be:

- Certified by the DHCS' Long-Term Care Division (LTCD) as having met these level-of-care requirements. Because FHCN PACE 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 qualifies you for our care.
- The DHCS' LTCD provides this review before you sign the FHCN PACE Enrollment Agreement based on a review of the documents prepared by the members of the IDT who have assessed your health.

Your enrollment in FHCN PACE 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 April 1. You may not enroll or disenroll from FHCN PACE at a Social Security office.

- The FHCN PACE will complete the initial assessments and plan of care for you. The DHCS' LTCD will make the final determination of clinical eligibility. If you are determined eligible by DHCS' LTCD, the FHCN PACE 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).
- If you are denied enrollment because your health or safety would be jeopardized by living in a community setting, FHCN PACE will do the following:
 - (1) Notify you in writing of the reason for the denial and your right to appeal the denial through the State Fair Hearing process.
 - (2) Refer you to alternative services, as appropriate.
 - (3) Maintain supporting documentation of the reason for the denial.
 - (4) Notify CMS and the State administering agency in the form and manner specified by CMS and make the documentation available for review.

After signing the Enrollment Agreement, your benefits under FHCN PACE continue indefinitely unless you choose to disenroll from the program (voluntary disenrollment) or no longer meet enrollment conditions (involuntary disenrollment).

CHAPTER 4

BENEFITS AND COVERAGE

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

What Do I Do if I Need Care?

All you need to do is call your center, as listed on the inside cover of this booklet, at any time.

Our plan provides ready access to various professionals and healthcare services. Upon enrollment, you will be assigned a PCP at the center where you will receive services.

FHCN PACE covers all benefits and will be provided according to your needs as assessed by your IDT and professionally recognized standards. If you would like more specific information about how we authorize or deny health care services, please request this from the Social Worker.

Benefits include:

- Services in the PACE center, your home, the community, hospitals, and nursing facilities
- Primary care clinic visits (with FHCN PACE physician, nurse practitioner, and nurse)
- Routine physicals and preventive health evaluations and care (including pap smears, mammograms, immunizations, and all generally accepted cancer screening tests).
- Sensitive Services, which are services related to sexually transmitted diseases and HIV testing.
- 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 FHCN PACE dentist to restore the participant's oral function to a condition that 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 that 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). Primary Care includes temporary crowns, full or partial dentures, and root canals.
- Diagnosis and treatment of male erectile dysfunction provided that the care is from an FHCN PACE staff physician or a physician specialist under contract to FHCN PACE and that the IDT authorizes such care.
- Mastectomy, lumpectomy, lymph node dissection, prosthetic devices, and reconstructive surgery.
- Necessary materials, supplies, and services for managing diabetes mellitus.

Home Services

- Home Care
 - Personal care (i.e., grooming, dressing, assistance in using the bathroom)
 - Homemaker/chore services
 - Rehabilitation maintenance
 - Evaluation of home environment
- Home Health
 - Skilled nursing services
 - Physician visits (at the discretion of the 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

FHCN PACE will only cover private rooms and private duty nursing, or any non-medical items with an additional charge, such as telephone or television rental, when authorized by the IDT.

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

FHCN PACE comfort care program is available to care for the terminally ill. If needed, your PCP and other clinical experts on your IDT will work with you and your family to provide these services directly or through contracts with local hospice providers. To receive the Medicare hospice benefit, you must disenroll from our program and enroll in a Medicare-certified hospice provider program.

CHAPTER 5 EMERGENCY SERVICES AND URGENT CARE

FHCN PACE provides emergency care 24 hours per day, seven days per week, and 365 days per year.

An emergency is a life-threatening medical condition. If not diagnosed and treated immediately, emergent medical conditions could result in severe and permanent damage to your health.

Examples of an emergency can include:

- Chest pain/symptoms of a heart attack
- Unexpected or sudden loss of consciousness
- Choking
- Severe difficulty breathing
- Symptoms of a stroke
- Severe bleeding
- Sudden, unexpected onset of a serious illness
- Serious injury from a fall

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 you have an Emergency Medical Condition requiring 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 using the “911” emergency response system, you or your family must notify FHCN PACE as soon as reasonably possible to maximize the

continuity of your medical care. FHCN PACE physicians who are familiar with your medical history will work with the emergency service providers to follow up with your care and to transfer your care to an FHCN PACE contracted provider when your medical condition is stabilized.

Preparing To Go Out of the FHCN PACE Service Area

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

If you are out of the FHCN PACE service area for more than 30 days, FHCN PACE may disenroll you unless FHCN PACE agrees to a more prolonged absence due to extenuating circumstances, such as when a participant is hospitalized or out of the service area during the initial 30 days of enrollment, or services are disrupted due to catastrophic weather-related events.

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

FHCN PACE 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.

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

Urgent Care includes inpatient or outpatient services necessary to prevent severe deterioration of your health resulting from an unforeseen illness or injury where treatment cannot be delayed until you return to our service area.

Post-stabilization care means services provided after an emergency that a treating physician views as medically necessary after an emergency medical condition has been stabilized. FHCN PACE will pay for all medically necessary health care services provided to a participant to maintain the participant's stabilized condition until the time that FHCN PACE arranges the participant's transfer, or the participant is discharged.

FHCN PACE must approve any urgent care services or post-stabilization care services when you are out of the service area. For non-emergency, out-of-the-area services authorization, call FHCN PACE at 877-960-3426 and speak with your nurse, social worker, or PCP. If we do not respond to your request for approval within one (1) hour of being contacted, or we cannot be contacted for approval, these services will be covered.

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, FHCN PACE will reimburse you. Request a receipt from the facility or physician involved when you pay. This receipt must show the physician's name, your health problem, date of treatment and release, and charges. Please send a copy of this receipt to your FHCN PACE 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 (other than as described above), FHCN PACE 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 care needs. Except for Emergency 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:

- Cosmetic surgery, unless it is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.
- Experimental medical, surgical, or other health procedures.
- Any services rendered outside the United States, except emergency services requiring hospitalization in Canada or Mexico.

CHAPTER 7 YOUR RIGHTS AND RESPONSIBILITIES

FHCN PACE Participant Bill of Rights

When you join a PACE program, you have certain rights and protections. FHCN PACE, as your PACE program, must fully explain and provide your rights to you or someone acting on your behalf in a way you can understand when you join.

At FHCN PACE, we are dedicated to providing you with quality healthcare services so that you may remain as independent as possible. This includes providing all Medicare-covered items and services, Medicaid services, and other services determined to be necessary by the interdisciplinary team across all care settings, 24 hours a day, seven days a week. Our staff and contractors seek to affirm the dignity and worth of each participant by assuring the following rights:

You have the right to be treated with respect.

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

- To get all of your health care in a safe, clean environment and an accessible manner.
- To be free from harm. This includes excessive medication, physical or mental abuse, neglect, physical punishment, being placed by yourself against your will, and any material or chemical restraint that is used on you for discipline or the convenience of staff and that you do not need to treat your medical symptoms.
- To be encouraged and helped to use your rights in the PACE program.
 - To get help, if needed, to use the Medicare and Medicaid complaint and appeal processes, and your civil and other legal rights.

- To be encouraged and helped in talking to PACE staff about changes in policy and services you think should be made.
- To use a telephone while at the PACE Center.
- To not have to do work or services for the PACE program.

You have a right to protection against discrimination.

Discrimination is against the law. Every company or agency that works with Medicare and Medicaid must obey the law. They cannot discriminate against you because of your:

- Race
- Ethnicity
- National Origin
- Religion
- Age
- Sex
- Mental or physical disability
- Sexual Orientation
- Source of payment for your health care (For example, Medicare or Medicaid)

If you think you have been discriminated against for any of these reasons, contact a staff member at the PACE program to help you resolve your problem.

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

You have a right to information and assistance.

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

- To have someone help you if you have a language or communication barrier so you can understand all the information given to you.
- To have the PACE program interpret the information into your preferred language in a culturally competent manner if your first language is not English, and you can't speak English well enough to understand the information being given to you.
- To get marketing materials and PACE participant rights in English and any other frequently used language in your community. You can also get these materials in Braille, if necessary.
- To have the enrollment agreement fully explained to you in a manner you understand.
- To get a written copy of your rights from the PACE program. The PACE program must also post these rights in a public place in the PACE center where it is easy to see them.
- To be fully informed, in writing, of the services offered by the PACE program. This includes telling you which services contractors provide instead of the PACE staff. You must be given this information before you join, at the time you join, and when you need to choose what services to receive.
- To be provided with a copy of individuals who provide care-related services not provided directly by FHCN PACE upon request.
- To look at, or get help to look at, the results of the most recent review of your PACE program. Federal and State agencies review all PACE programs. You also have the right to review how the PACE program plans to correct any problems found at inspection.

You have a right to choose providers.

You have the right to choose a health care provider, including your primary care provider and specialists, from within the PACE program's network and to get quality health care. Women have the right to get services from a qualified women's health care specialist for routine or preventive women's health care services.

You have the right to have reasonable and timely access to specialists as indicated by your health condition.

You also have the right to receive care across all care settings, up to and including placement in a long-term care facility when FHCN PACE can no longer maintain you safely in the community.

You have a right to access emergency services.

You have the right to get emergency services when and where you need them without the PACE program's approval. A medical emergency is when you think your health is in serious danger— when every second counts. You may have a bad injury, sudden illness, or illness that is quickly getting much worse. You can get emergency care anywhere in the United States and you do not need to get permission from FHCN PACE before seeking emergency services.

You have a right to participate in treatment decisions.

You have the right to participate in all decisions related to your health care entirely. If you cannot fully participate in your treatment decisions or you want to have someone you trust help you, you have the right to choose that person to act on your behalf. You have the right:

- To have all treatment options explained to you in a language you understand, to be fully informed of your health status and how well you are doing, and to make health care decisions. This includes the right not to get treatment or take medications. If you choose not to get treatment, you must be told how this will affect your health.
- To have the PACE program help you create an advance directive. An advance directive is a written document that says how you want medical decisions to be made in case you cannot speak for yourself. You should give it to the person who will carry out your instructions and make health care decisions for you.
- To participate in making and carrying out your plan of care. You can ask for your care plan to be reviewed at any time.
- To be given advance notice, in writing, of any plan to move you to another treatment setting and the reason you are being moved.

You have a right to keep your health information private.

- You have the right to talk with health care providers in private and to keep your personal health care information confidential, including health data collected and kept electronically, as protected under State and Federal laws.
- You have the right to look at and receive copies of your medical records and request amendments.
- You have the right to be assured that your written consent will be obtained for the release of information to persons not otherwise authorized under law to receive it.
- You have the right to provide written consent that limits the degree of information and the persons to whom information may be given.

There is a patient privacy rule that gives you more access to your medical records and more control over how your personal health information is

used. If you have questions about this privacy rule, call the Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800- 537- 7697.

You have a right to file a complaint, request additional services, or make an appeal.

You have a right to complain about the services you receive or that you need and don't receive, the quality of your care, or any other concerns or problems you have with your PACE program. You have the right to a fair and timely process for resolving concerns with your PACE program. You have the right:

- To a full explanation of the complaint process.
- To be encouraged and helped to freely explain your complaints to PACE staff and outside representatives of your choice. You must not be harmed in any way for telling someone your concerns. This includes being punished, threatened, or discriminated against.
- **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.**

You have the right to request services from FHCN PACE that you believe are necessary. You have the right to a comprehensive and timely process for determining whether those services should be provided.

You also have the right to appeal any denial of a service or treatment decision by the PACE program, staff, or contractors.

You have a right to leave the program.

If, for any reason, you do not feel that the PACE program is what you want, you have the right to leave the program at any time and have such

disenrollment effective the first day of the month following the date FHCN PACE receives your notice of voluntary disenrollment.

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

877-960-3426.

If you would like to talk to someone outside of FHCN PACE about your concerns, you may contact 1-800-MEDICARE (1-800-633- 4227) or 1-888-804-3536 (Health Consumer Alliance – Medi-Cal Ombudsman Program)

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 FHCN PACE.
- Take all prescribed medications as directed.
- Call the FHCN PACE physician for direction in an urgent situation.

- Notify FHCN PACE within 48 hours or as soon as reasonably possible if you require emergency services out of the service area.
- Notify FHCN PACE when you wish to initiate the disenrollment process.
- Notify FHCN PACE of a move or lengthy stay outside 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.
- FHCN PACE 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. FHCN PACE is not responsible for safeguarding personal belongings.

CHAPTER 8

PARTICIPANT GRIEVANCE AND APPEALS PROCESS

All of us at FHCN PACE 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 promptly and efficiently. You also have the right to appeal any decision to deny, reduce, or stop what you believe are covered services or to pay for services you believe we are required to pay.

The information in this Chapter describes our grievance and appeals processes. We are available to assist you whenever you wish to file a grievance or an appeal. If you do not speak English, a bilingual staff member or translation services will be available to help you.

You will not be discriminated against because a grievance or appeal has been filed. FHCN PACE will continue to provide you with all your 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 about your grievance or appeal will only be released to authorized individuals.

Grievance Procedure

Definition: A grievance is a written or oral complaint expressing dissatisfaction with the services provided or the quality of participant care. You will receive written information on the grievance process when you enroll and at least annually after that. A grievance may include, but is not limited to:

- The quality of services you receive in your home, at the PACE Center, or in an inpatient stay (hospital, rehabilitative facility, skilled nursing facility, intermediate care facility, or residential 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 your 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 can verbally discuss your grievance in person or by telephone with the PACE program staff of the center you attend. The staff person will ensure 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 details of your grievance so the appropriate staff person can respond and help resolve your grievance promptly and efficiently. If you wish to submit your grievance in writing, please send your written grievance to:
PACE Program Administration 500 E. School Ave Visalia, CA 93292

You may also contact the Program Director at (559) 741-4346 to request a Grievance Report form and receive assistance filing a grievance. For people who are deaf or hard of hearing (TTY/TDD), please call 877-960-3426. Our Program Director will provide you with written information on the grievance process. You may also access our website at www.fhcn.org/pace to receive information about the grievance process.

2. 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.
3. You will be sent a written acknowledgment of receipt of your grievance within five (5) calendar days, which will provide the specific steps, including timeframes for a response, that will be taken to resolve your grievance. We will also discuss this information with you. Investigation of your grievance will begin immediately to find solutions and take appropriate action.
4. The FHCN PACE staff will make every attempt to resolve 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.
5. If the 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.

Resolution of Grievances

1. Upon FHCN PACE's completion of the investigation and reaching a final resolution of your grievance, you will receive a written notification that will provide you with a written report describing the reason for your grievance and a summary of actions taken to resolve your grievance.
2. FHCN PACE will continue to furnish you with all the services you require during the grievance process.

Grievance Review Options

1. If FHCN PACE is unable to provide a satisfactory resolution, you are entitled to pursue your grievance with the DHCS by contacting:

Health Consumer Alliance
Medicare Medi-Cal Ombudsman Program
www.healthconsumer.org
Telephone: 1-888-804-3536
TTY: 1-877-735-2929

Home Health Hotline: If you have a question or concern regarding FHCN PACE's home health services, we recommend that you first discuss the matter with your quality insurance team, home health nurse, social worker, or center manager. However, please be informed that California has established a confidential toll-free telephone number to receive questions or complaints about home health services. The telephone number is:

L&C Office PACE Unit, Mail Station 4502
PO Box 997413
Sacramento, CA 95899-7413
(916) 713- 8444, Monday through Friday,
from 9:00 a.m. to 5:00 p.m.

Appeals Process

Definition: An appeal is an action taken by you concerning the PACE organization's decision not to cover or not to pay for a service, including denials, reductions, or termination of services. You will receive written information on the appeals process when you enroll and at least annually after that or whenever the interdisciplinary team denies a service determination request or request for payment.

When FHCN PACE decides not to cover or pay for a service you want, you may take action to change your decision. The action you take—whether verbally or in writing— is called an “**appeal.**” You have the right to appeal against any decision we have made to deny, reduce, or stop what you believe are covered services or to pay for services that you think we are required to pay.

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

If you request a **standard appeal**, your appeal must be filed within one hundred and eighty (180) calendar days of when your request for service or payment of service was denied, reduced, or stopped. This date appears on the Notice of Action for Service or Payment Request. (The 180-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 or stay well is in danger without the service you want, you or any treating physician may ask for an **expedited appeal**. We will automatically decide on your appeal as promptly as your health requires, but no later than seventy-two (72) hours after receiving your appeal request. 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.

*Note: If the reason for your appeal is that **FHCN PACE** decided to reduce or stop the service(s) you were receiving, you may request to continue receiving the disputed service(s) until the appeals process is completed. If our initial decision to reduce or stop 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 FHCN PACE denies a service or payment for a service that you or your representative has requested or reduces or stops a service you were already receiving, you may appeal the decision. A written notification will be provided to you and your representative explaining the reason for the denial of your service request or payment request, and you will also receive verbal notification.
2. You can make your appeal either verbally, in person by telephone, or in writing with the PACE Program staff of the center

you attend. The staff person will ensure 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 on 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, in person as well as in writing, at the address listed below. If more information is needed, you will be contacted by the Program Director who will assist you in obtaining the missing information.

3. If you wish to make your appeal by telephone, you may contact our Program Director at (559) 741-4346 Monday to Friday 8:00 am to 5:00 pm to request an appeal form and/or to receive assistance in filing an appeal. For the hearing impaired (TTY/TDD), please call 1-800-735-2929.
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:

FHCN PACE Organization Administrative Office
ATTN: Program Director
500 E. School Ave
Visalia, CA 93292

5. You will be sent a written acknowledgment of receipt of your appeal within five (5) business days for a standard appeal. For an 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.
6. The FHCN PACE decision will be reconsidered by a person(s) not involved in the initial decision-making process in consultation with the Interdisciplinary Team and who does not have a stake in the outcome of your appeal. We will ensure that this person(s) is both impartial and appropriately credentialed in the field(s) or discipline(s) related to your requested services.

7. Upon FHCN PACE's completion of the review of your appeal, you and your representative will be notified in writing of the decision on your appeal. As necessary and depending on the outcome of the decision, FHCN PACE will inform you and 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, we are required to provide or arrange for services as quickly as your health condition requires. **If we decide fully in your favor** on a payment request, 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, we will provide you with written notification that will include the specific reason(s) for the denial, why the service would not improve or maintain your overall health, your right to appeal the decision, and a description of your external appeal rights through either the Medicare or Medi-Cal program (**see Additional Appeal Rights, below**). We must also notify the federal Centers for Medicare and Medicaid Services and the Long-Term Care Division, DHCS.

Additional Appeal Rights under Medi-Cal and Medicare

If we do not decide in your favor on your appeal or fail to provide you with a decision within the required timeframe, you have additional appeal rights. Your request to file an external appeal can be made 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 entirely independent of our PACE organization.

The **Medi-Cal program** conducts its next level of appeal through the State hearing process.

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) calendar days from the date of the decision by the third-party reviewer.

If the decision is not in your favor of your 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. A written request for reconsideration must be filed with the current contracted Medicare appeals entity within sixty (60) calendar days from the decision by the impartial reviewer of the internal appeal. The current acquired 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.

For more information regarding the appeals process or to request forms, please call (877) 960-3426 or TTY/TDD 1-800-735-2929, Monday to Friday, 8:00 am to 5:00 pm, or contact FHCN PACE Quality Assurance Team at 500 E. School Ave Visalia, CA 93292.

CHAPTER 9 MONTHLY FEES

Your monthly premium, if any, will depend upon your eligibility for Medicare and Medi-Cal and your personal income and assets. Your premium is determined by the State of California and payable to FHCN PACE, and FHCN PACE will make the premium payment to the State of California on your behalf. FHCN PACE can automatically withdraw the premium from your bank account if you choose.

The information below can help you understand your premium based on your payer source.

A. Dually Eligible (Medi-Cal and Medicare) or Medi-Cal Only

You may not be required to make a monthly premium payment to FHCN PACE.

Your IDT will help determine if you will have a monthly premium payment or a share of the cost.

If you have to pay for a share of the cost, your approximate monthly payment of \$_____ starts on _____ (date).

B. Medicare only

If you have Medicare and are not eligible for Medi-Cal, you will pay a monthly premium to FHCN PACE. Your IDT will help determine the monthly premium.

Your monthly premium of \$_____ starts on _____(date). Because this fee does not include the cost of Medicare prescription drug coverage, you will be responsible for an additional monthly premium for Medicare prescription drug coverage in the amount of \$_____. * You may pay both fees together, or you may contact your social worker for additional payment options.

C. Private pay (Neither Medicare nor Medi-Cal eligible)

If you do not qualify for Medicare or Medi-Cal, you will pay a monthly premium to FHCN PACE. Your monthly premium of \$_____ starts on _____(date). Because this fee does not include the cost of Medicare prescription drug coverage, you will be responsible for an additional monthly premium for Medicare prescription drug coverage in the amount of \$_____.*

*The monthly Medicare Prescription drug coverage fee will be the rate that is approved by the Centers for Medicare and Medicaid Services (CMS). This rate is calculated on an annual basis. You will be notified of the current approved prescription drug rate at enrollment and annually after that.

D. Paying my fees

If you are required to pay a monthly premium to FHCN PACE, you must pay this amount by the first day of the month after you sign the Enrollment Agreement. After that, payments will be due on the first of each month. Payment can be made by check, money order, cash, or automatic withdrawal. We can help you set up automatic withdrawal for your premium.

Send your check or money order to:

FHCN PACE
500 E School Ave
Visalia, CA 93291

E. I Received a Bill or Claim

If you receive a bill or claim from a provider, please contact a member of your IDT for payment consideration.

You are not liable for approved, in-network services, and the bill or claim was likely sent to you in error. It may not be covered if it is an unapproved or out-of-network service, and you will be liable for payment.

FHCN PACE will provide you with a letter explaining why it is not covered and your appeal rights.

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 your Social Worker for additional payment options. We will notify you in writing of any change in your monthly premium at least 30 days before the change takes effect.

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

F. Prescription Drug Coverage Late Enrollment Penalty

Please be aware that if you are eligible for Medicare prescription drug coverage and are enrolling in FHCN PACE after going without Medicare prescription coverage or coverage that was at 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 your FHCN PACE social worker for more information about whether this applies to you.

You will receive an invoice if you are required to pay a monthly premium or a premium for prescription drug coverage. 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:

500 E School Ave
Visalia, CA 93291
Attention: Accounting Department

G. 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 after a thirty (30) day grace period, FHCN PACE may send you a notification that you will be involuntarily disenrolled. If this occurs, FHCN PACE will mail you a written Disenrollment Notice thirty (30) calendar days in advance, informing you that your Enrollment Agreement will be terminated if you still have not paid the premium due by the disenrollment date given in the Disenrollment Notice. The disenrollment date will be the first day of the next month that begins thirty (30) days after the date that FHCN PACE mails you the Disenrollment Notice. The Disenrollment Notice will also inform you that, if you pay the required amount before the effective date of your disenrollment, you will remain enrolled with no break in coverage. You must pay the premium for any month you use FHCN PACE services. If your benefits are terminated and you wish to re-enroll, please refer to CHAPTERS 10 and 11 regarding FHCN PACE termination policy and renewal provisions.

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

CHAPTER 10

TERMINATION OF BENEFITS

FHCN PACE 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 ensure continuity of care.

You must continue to use FHCN PACE's services and pay the monthly fee, if applicable, until termination becomes effective. FHCN PACE will continue to provide all necessary services until disenrollment is effective. If you should require care before your reinstatement occurs, FHCN PACE will pay for the service that you are entitled by Medicare or Medi-Cal.

FHCN PACE will provide information on the consequences of subsequent enrollment in other optional Medicare or Medicaid programs following disenrollment from PACE.

Voluntary Disenrollment

If you wish to cancel your benefits by disenrolling, you should discuss this with your social worker. You may disenroll from FHCN PACE without cause at any time. You will be asked to sign a "Disenrollment Form." This form will indicate that you will no longer be entitled to services through FHCN PACE after midnight on the last day of the month. The effective date of your disenrollment will be the first day of the month following the date we receive your disenrollment notification. Please note that you may not enroll or disenroll from FHCN PACE at a Social Security office.

Involuntary Disenrollment

We may terminate your enrollment with FHCN PACE if:

- You move out of the FHCN PACE service area or are out of the service area for more than 30 days without prior approval (see CHAPTER 6).

- You or your caregiver engage 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 if you or your caregiver display disruptive interference with care planning or threatening behavior that interferes with the quality of PACE services provided to you and other PACE Participants.
- It is determined that you 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 FHCN PACE, any applicable Medicaid spend down liability, or any amount due under the post-eligibility treatment of income process after a 30-day grace period (see CHAPTER 9).
- The agreement between FHCN PACE, the Centers for Medicare and Medicaid Services, and the DHCS is not renewed or terminated.
- FHCN PACE cannot offer healthcare services due to losing our state licenses or contracts with outside providers.

Involuntary disenrollments are effective on the first day of the next month that begins 30 days after the day we send you notice of your disenrollment.

All rights to benefits will stop at midnight on the last day of the month following a voluntary or involuntary disenrollment. We will coordinate the disenrollment date between Medicare and Medi-Cal if you are eligible for both programs. You are required to use FHCN PACE services (except for Emergency Services and Urgent Care provided outside our service area) and to pay the monthly fee, if applicable, until the disenrollment becomes effective. FHCN PACE will continue to provide all necessary services until the disenrollment is effective.

If you are hospitalized or undergoing a course of treatment at the time your disenrollment becomes effective, FHCN PACE 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 FHCN PACE is continuous and indefinite (with no need for renewal). However, your coverage will be terminated if:

(1) you voluntarily disenroll (see CHAPTER 10), or (2) you are involuntarily disenrolled due to one of the other conditions specified in CHAPTER 10.

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

CHAPTER 12

GENERAL PROVISIONS

Authorization to Obtain Medical Records

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

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

Authorization to Take and Use Photographs

By accepting coverage under this Enrollment Agreement, you authorize FHCN PACE will make and use photographs, videotapes, and digital or other images for medical care, identification, payment for services, or internal operation of FHCN PACE. Images will only be released or used outside FHCN PACE 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 DHCS. We will give you at least a 30-day advance written notice of any such change, and we will provide you with an updated copy and explain the changes to you and your caregiver.

Confidentiality of Medical Records Policy

The personal and medical information collected by FHCN PACE 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 a FHCN PACE Registered Nurse at (559) 741-2691.

Continuation of Services on Termination

If this Enrollment Agreement terminates for any reason, you will be reinstated into the traditional Medicare and Medi-Cal programs, according to your eligibility. FHCN PACE will work to transition you back into the traditional Medicare and Medi-Cal programs so your care is not jeopardized.

Cooperation in Assessments

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

Non-discrimination

FHCN PACE shall not unlawfully discriminate against participants in the rendering of service based on race, ethnicity, age, religion, color, national origin, ancestry, sex, marital status, sexual orientation, mental or physical disability, or source of payment. FHCN PACE shall not discriminate against participants in the provision of service based on whether or not they have an Advance Health Care Directive.

Notice

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

500 E School Ave
Visalia, CA 93291
Attention: Intake Coordinator

Notice of Certain Events

If you may be materially and adversely affected, we shall give you reasonable notice of any termination, breach of contract, 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 FHCN PACE PCP. 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 with FHCN PACE Providers

FHCN PACE providers other than FHCN PACE staff are independent organizations and are only related to us by contract. These providers are not our employees or agents. FHCN PACE 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 FHCN PACE has a standing committee, known as the Participant Advisory Committee, that reports to the board every quarter and advises the board on issues related to the actions of FHCN PACE and our staff to assure participants comfort, dignity, and convenience. The committee has nine members, at least five of whom are participants enrolled in FHCN PACE. In addition, at least one committee member is a FHCN PACE board member, and at least one is a provider. All committee members are appointed by the board but are nominated by the committee itself. The committee elects its co-chairs, at least one of whom must be a participant. 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, FHCN PACE must report such instances to the DHCS. If you are a Medi-Cal beneficiary, any proceeds you collect under the injury, ailment, or disease are assigned to the DHCS.

Reduction of Benefits

We may not decrease in any manner the benefits stated in this Enrollment Agreement, except after 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, FHCN PACE 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 FHCN PACE. 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 total monthly payment. (See CHAPTER 9 for payment responsibility.)

Safety

To provide a safe environment, FHCN PACE's Safety Policy includes mandatory use of quick-release wheelchair seat belts for all participants 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 want a second opinion, notify your PCP or nurse practitioner.

Tuberculosis Testing

Upon enrollment, a tuberculosis (TB) skin test(s), IGRA blood test, or chest X-ray is required. FHCN PACE will provide treatment if the TB test is positive.

Payment for Unauthorized Services

You may be fully and personally responsible for paying for unauthorized or out-of-PACE-network services, except for Emergency Services (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 FHCN PACE to the provider. You cannot be required to pay anything that FHCN PACE owes to the selected providers.

CHAPTER 13 DEFINITIONS

Benefits and coverage are the health and health-related services we provide through this Enrollment Agreement. These services replace the benefits you would otherwise receive through Medicare and Medi-Cal. Their provision is made possible through an agreement between FHCN PACE, 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 FHCN PACE that 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 FHCN PACE to provide health and health-related services to FHCN PACE participants.

Coverage decision means the approval or denial of health services by FHCN PACE 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 FHCN PACE 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 (DHCS) is the single State Department responsible for administering the federal Medicaid Program (referred to as Medi-Cal in California).

Disputed health care service means any health care service eligible for payment under your Enrollment Agreement with FHCN PACE that has been denied, reduced, or stopped by a decision of FHCN PACE in whole or in part due to the finding that a service is not medically 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 FHCN PACE Interdisciplinary Team, meets the State of California’s criteria for placement in either an Intermediate care facility (ICF) or a Skilled Nursing Facility (SNF). However, FHCN PACE’s goal is to help you stay in the community as long as possible, even if you are eligible for nursing home care.

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

Exclusion means any service or benefit that FHCN PACE cannot provide according to Federal regulation.

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; “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 an FHCN PACE center or clinic, in your home, or in professional offices of

contracted specialists or other providers, hospitals, or nursing homes under contract with FHCN PACE.

Health-related services are those services that help FHCN PACE 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. They may include household services and related chores such as laundering, meal assistance, 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 that acute general hospitals generally and customarily provide.

Interdisciplinary Team (IDT) means FHCN PACE’s team of service providers, facilitated by a program manager and consisting of a Primary Care Provider (PCP), registered nurse(s), master’s-level social worker (MSW), personal care attendant, home care coordinator, physical, recreational, and occupational therapists, PACE center manager, transportation coordinator/driver, and a dietitian. Members of the IDT will assess your medical, functional, and psychosocial status and develop a Plan of Care that identifies the services needed. This team provides and monitors many of the services. All services you receive must be authorized by your physician or other qualified clinical professionals on the IDT. The team will do periodic reassessments of your needs 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.

The monthly fee means the amount you must pay each month in advance to FHCN PACE to receive benefits under this Enrollment Agreement.

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 FHCN PACE's service area. (See below for a definition of service area).

PACE is the acronym for the **Program of All-Inclusive Care for the Elderly**. PACE is a comprehensive service plan integrating acute and long-term care for older people with serious health problems. Payments for services are made on a monthly capitation basis, combining 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 FHCN PACE 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.

FHCN PACE Physician is a doctor who is either employed by FHCN PACE or has a contract with FHCN PACE to provide medical services to participants.

Primary Care Provider (PCP) is a doctor, nurse practitioner, or physician assistant who is either employed by FHCN PACE or has a contract with FHCN PACE to provide 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 sexually transmitted diseases (STDs) and HIV testing.

Service area means the geographical location that FHCN PACE serves. This area includes:

Kings County

93202, 93212, 93230, 93245, and 93266;

Tulare County

93201, 93212, 93215, 93218, 93219, 93221, 93223, 93235, 93244,
93247, 93256, 93257, 93267, 93270, 93271, 93272, 93274, 93277,
93286, 93291, 93292, 93615, 93618, 93631, 93646, and 93647.

Urgent care means services provided to you when you are out of the PACE service area, and you believe your illness or injury is too severe to postpone treatment until you return to the service area, but your life or function is not in extreme jeopardy.

APPENDIX I

This Appendix explains your rights to make health care decisions and how you can plan what should be done if you cannot speak for yourself. A federal law requires us to give you this information. 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 may still make health care decisions. These only changes 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 what different treatments can do for you. Many treatments have “side effects.” Your doctor must inform you about serious problems that medical treatment may cause.

Often, more than one treatment might help you—and people have different ideas about the best. Your doctor can tell you which treatments are available, and which are 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?

Suppose you are unable to make treatment decisions. In that case, 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. You can prepare in advance for someone you choose to convey for you in several ways. 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 cannot 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.” Advance Health Care Directive forms can be used, 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 you trust. That person will then be able to speak for you if 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 are 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 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 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 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 if 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 note that you *do* want life-prolonging care. You may provide more detail about the treatment type and timing you want. (Whatever you write, you will 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, you 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 Tell My Doctor Who I Want to Making Decisions for Me?

Yes, as long as you personally tell your doctor the name of the person you want to make 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 these forms if you do not want to. You may just talk to your doctors and ask them to write down what you have said in your medical chart, and you may talk with your family. But if you write them down, people will be clearer about your treatment wishes. 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 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.

SIGNATURE PAGE

A. Effective Dates of Enrollment

Your enrollment is effective:	
Your FHCN PACE Center is located.	
The telephone number is	
You will attend the FHCN PACE Center on	

Your driver will pick you up at approximately:

(While we plan to be on time, we will do our best to let you know if we will be later than expected.)

Your driver will take you home at approximately:

**B. Enrollment Agreement Signature Sheet/Family
Conference Packet**

Name of Applicant:

Date of Birth: _____ **Sex:** _____

Permanent Address:

Mailing Address (if different from Permanent Address):

Medicare Beneficiary Status:

Part A Part B Part D ALL NONE

Medicare Number:

Medi-Cal Recipient Status:

Medi-Cal Number:

Other Health Insurance Information (other insurance coverage, current Prescription Drug Plan, etc.):

Primary Language:

Secondary Language:

IN WITNESS of which, I _____ agree to enroll in the services of FHCN PACE. I have received a copy of the participant enrollment agreement and talked with a FHCN PACE staff member about my enrollment benefits. I understand that once I enroll in FHCN PACE, I am to receive all my health care benefits from FHCN PACE.

The FHCN PACE staff member has reviewed the following information with me and my caregiver:

- Introduction and Program Description
- The Mission Statement of FHCN PACE
- Eligibility requirements for participation in FHCN PACE
- The process of enrolling in FHCN PACE
- Health Care Power of Attorney and Advanced Directives

Benefits and Coverage information that include:

- Effective Dates of Enrollment and a sample of the Enrollment Conference Checklist (that is located in the Enrollment agreement)
- A description of the benefits and coverage I receive with FHCN PACE.
- Information about the FHCN PACE Center I will attend, including location, hours, and what to do when the weather is bad.
- Information about the PACE Interdisciplinary Team that will care for me.
- FHCN PACE Employees
- FHCN PACE Contract Providers.
- Financing - Monthly Payment Information, including what I may have to pay, if anything. Also, I understand what FHCN PACE will not pay for.
- Notification that a participant with Medi-Cal may be liable for any applicable spend-down liability and any amounts due under the post-eligibility treatment of income process
- Information about long-term care facilities and how they may be used for my care.
- Emergency and Urgent Care coverage.
- Information about what should be done if I am hurt in an accident.
- A copy of the Participant Bill of Rights.
- My responsibilities as a Participant of FHCN PACE.
- Information about the FHCN PACE Participant Advisory Committee.

- Information about the FHCN PACE Grievance process.
- Information about the FHCN PACE Appeal process.
- Information about the Medi-Cal and Medicare appeals processes.
- Information about stopping my FHCN PACE benefits.
- Information about re-applying to FHCN PACE.
- A Confidentiality Statement.
- Definitions of terms in the agreement booklet.
- Notice that I may not enroll or disenroll from FHCN PACE at a Social Security office.

I have received copies of the above information and have been allowed to ask questions, and my questions have been answered. I understand the FHCN PACE program and wish to become a Participant.

I understand that enrollment in FHCN PACE will result in automatic disenrollment from any other Medicare or Medi-Cal prepayment plan. I also understand that enrollment in any other Medicare or Medi-Cal prepayment plan or optional benefit, including the hospice benefit, after enrolling in FHCN PACE will subject me to voluntary disenrollment from FHCN PACE. Additionally, I understand that if I am not eligible for Medicare when I enroll in FHCN PACE and become eligible after enrollment, I will be disenrolled if I elect to obtain Medicare coverage other than from FHCN PACE.

I understand that if I move out of the service area or am absent from the service area for a period of time longer than thirty (30) days, I must notify FHCN PACE.

I agree to accept my health services from FHCN PACE instead of other programs sponsored by Medicare and Medi-Cal and understand that they will be my sole service provider, and that my effective date of enrollment is:
_____ (Date)

I understand that I am authorizing the disclosure and exchange of my personal information between the Centers for Medicare and Medicaid Services (CMS) and its agents, the DHCS and FHCN PACE.

_____	_____	_____
Name of Participant	Signature of Participant	Date

_____	_____	_____
Name of Witness	Signature of Witness	Date

_____	_____	_____
Name of Designated Representative*	Signature of Designated Representative*	Date

Signature of Authorized FHCN PACE Representative	Date
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* Signature other than that of the participant or immediate family member will be accompanied by the appropriate documentation in accordance with State law and FHCN PACE policies & procedures.

Your Enrollment/Family Conference Packet

Checklist

This packet includes important items you will receive as a FHCN PACE Participant. Please read and follow these directions carefully so that if an emergency happens, you, your family, and any healthcare facility will know precisely what to do.

- Your FHCN PACE CARD is a small white card. It identifies you as a Participant of FHCN PACE and must be shown when you need to use the hospital. Keep this card with your Medi-Cal and Medicare cards.

- The YELLOW EMERGENCY STICKER is the long, bright yellow sticker. The sticker shows the numbers to dial in case of an emergency. This sticker must be placed on or near your telephone, so it will be handy when needed.

- The EMERGENCY PLAN is the detailed sheet you will sign that has instructions on “what to do” in case of an emergency. This also outlines the health care wishes you have chosen (Basic Life Support, or Do Not Resuscitate (DNR), or Full Code). You may also have the option of using a Physician Orders for Life Sustaining Treatment (POLST) medical order. You will receive an original or copy of the pink DNR or POLST form to post in your home if you have chosen that course for your care.

In addition, this packet contains:

- Your copy of the signed **Enrollment Agreement**. This must be signed before you can receive FHCN PACE services.
- Your signed **Acknowledgement of the Care Plan** that your Interdisciplinary Team designed for you.
- **Your FHCN PACE Center** information that includes your scheduled days of attendance and pick-up and return times
- **Your Interdisciplinary Team** information including the names of team members. Any future changes in your Interdisciplinary Team will be communicated to you.
- **FHCN PACE Contract Providers** list. Any future changes in FHCN PACE contract providers will be communicated to you.
- Information about the **FHCN PACE Participant Advisory Committee**.
- A **Confidentiality Statement**.
- **Consent** forms for **immunizations** and **marketing**
- Information about what you must bring to the FHCN PACE Center on your attendance days and a sample calendar of activities.