4. Member Rights and Responsibilities

KP recognizes that Members have both rights and responsibilities in the management of their health care.

Members have certain rights to which they are entitled when they interact with representatives of KP, including Providers, Provider employees, and KP employees and physicians.

Likewise, Members are expected to be responsible for knowing about their health care needs and coverage. They are also responsible for maintaining appropriate attitudes and behavior when receiving health care as a Member.

All Kaiser Permanente QUEST Integration Members are sent a Member Handbook with information about their rights and responsibilities.

4.1 MEMBER RIGHTS AND RESPONSIBILITIES

KP has developed a statement of Member rights which includes a Member's right to participate in the Member's own medical care decisions. These decisions range from selecting a personal physician to making informed decisions regarding recommended treatment plans.

The Member Rights and Responsibilities Statement also includes a Member's responsibility to understand the extent and limitations of his/her health care benefits, to follow established procedures for accessing care, to recognize the impact lifestyle has on physical condition, to

provide accurate information to caregivers, and to follow agreed upon treatment plans. Providers, Practitioners and their staff need to be aware of these Rights and Responsibilities and shall respect, support and uphold Members' rights and responsibilities. For more information about the Member Rights and Responsibilities Statement, see https://healthy.kaiserpermanente.org/health/poc?uri=center:rights-responsibilities&article=3D232AB6-B7E8-11E0-820B-CFECBC7B2824&kpSearch=rights

4.1.1. Non-Compliance with Member Rights and Responsibilities

Failure to act in a way that is consistent with the Member Rights and Responsibilities Statement can result in action against the Member, the Provider, or KP, as appropriate.

4.1.1.1. Members

In the event a Member has a complaint or grievance, the Member is instructed in the Member Handbook and their EOC, or *Certificate of Insurance*, to discuss the situation with Member Services. Members can file a grievance for any issue, including complaints against the Provider and/or the Provider's staff. Resolution of the problem or concern is processed through the Member Complaint and Grievance procedure that is described later in this section.

Although the Member should contact Member Services about a grievance, you may be approached directly by the Member. If you receive a complaint from or on behalf of a Member that, in your reasonable judgment, is not resolvable within two business days, you must notify Provider Relations as soon as possible.

4.1.1.2. Providers

If a Member fails to meet an obligation as outlined in the Member Rights and Responsibilities Statement and you have attempted to resolve the issue, please contact Member Services.

4.2 HEALTH CARE DECISION-MAKING

KP and contracted hospitals, physicians, and health care professionals make medical decisions based on the appropriateness of care for Members' medical needs. KP does not compensate anyone for denying coverage or services, nor does KP use financial incentives to encourage denials. In order to maintain and improve the health of Members, all Providers should be especially vigilant in identifying any potential underutilization of care or service.

KP encourages open communication between Providers and patients regarding available treatment alternatives. We do not penalize Providers for discussing all available care options with our Members.

Our Members have the right to choose among treatment or service options, regardless of benefit coverage limitations. Providers are expected to inform our Members of appropriate care options,

even when one or more of the options are not covered benefits under the Member's benefit plan. If the Provider and the patient decide upon a course of treatment that is not covered in the Member's EOC, the Member must be advised they are responsible for the cost of that care.

If the Member is dissatisfied with this arrangement, the Member should be advised to contact Member Services for an explanation of the Member's benefit plan. If the Member persists in requesting non-covered services and the Provider is willing to provide such service, the Provider should make payment arrangements with the Member in advance of any non-emergent treatment to be provided.

KP's UM program and procedures are:

- Based on objective guidelines adopted by KP
- Used to determine medical necessity and appropriateness of care
- Designed to establish whether services provided or to be provided are covered under a Member's benefit plan

The ultimate decision on whether to proceed with treatment rests with the Provider and the Member.

4.3 ADVANCE DIRECTIVES

An Advance Directive is a written instruction recognized under Hawaii and/or federal law that allows Members to appoint a representative to make personal health care decisions on their behalf. KP requires that all Providers comply with federal and Hawaii law concerning Advance Health Care Directives. To avoid potential conflicts of interest, KPMCP personnel, volunteers, and physicians may not serve as witnesses for a Member's Advance Directive.

To ensure compliance with governing law, the existence of any Advance Directive must be documented in a prominent place in the medical record. An institutional Provider is required to provide written information regarding Advance Directives to all Members admitted to the facility, and provide staff and patient education regarding Advance Directives. Members should be encouraged to provide copies of their completed Advance Directives to all Providers of their medical care.

An Advance Directive may be revoked by the Member at any time, orally or in writing, as long as the Member is capable of doing so. An Advance Directive is automatically invalidated by divorce if the spouse was designated as the surrogate decision-maker prior to the divorce. In addition, the designation of a Health Care Agent can also be revoked. If a Member has more than one written Advance Directive, then the most recently executed document should be recognized.

Please note: revoked forms should not be discarded, but remain a part of the Member's medical record. Members are provided with information regarding Advance Directives in the *Evidence of Coverage*, Member Handbook, and on kp.org. Members may also contact Member Services regarding Advance Directives for an informational brochure and appropriate forms.

4.4 MEMBER COMPLAINT AND GRIEVANCE PROCESS

Members are assured a fair and equitable process for addressing their complaints and grievances against Providers, their staff, and KP employees. This review process is designed to evaluate all aspects of the situation and arrive at a solution that strives to be mutually satisfactory to the Member and the organization, including you, our Provider. Members are notified of the processes available for resolving complaints and grievances in the *Evidence of Coverage* and Member Handbook.

A Member complaint or grievance may relate to quality of care, access to services, Provider or staff attitude, operational policies and procedures, benefits, eligibility or other related issues. Valid Member complaints and grievances against a Provider are included in the Provider's quality file at KP and reviewed as part of the re-credentialing process. Complaints and grievances are tracked and trended on an ongoing basis to identify potential problems with a Provider or with our own policies and procedures. Members may call Member Services at: **808-432-5955** to report a complaint..

4.4.1 Provider Participation in Member Complaint Resolution

The established procedures for resolving Member complaints may require the Provider's participation under certain circumstances. KP will advise you of any involvement required or information that must be provided.

4.4.2 Member Complaint and Grievance Resolution Procedure

One of the rights that Members are apprised of in the Member Handbook is the right to participate in a candid discussion with the Provider of all available options regardless of cost or benefit coverage.

4.4.3 Medicare Process for Grievances and Complaints

Medicare complaints are categorized into the following case types: Part C and Part D grievances; Part C organization determinations and reconsiderations; and Part D coverage determinations and redeterminations. If the problem is not amenable to immediate resolution at the POS, the Member Handbook instructs Members to call Member Services at **808-432-5955** or **1-800-777-1370** (TTY) to discuss their issue(s). Our representatives will advise the Member about our resolution process and ensure that the appropriate parties review the complaint. For more information about Medicare Process for Grievances and Complaints, call 1+800 432-5955

4.4.3.1 Quality of Care Complaint

A complaint received by the health plan concerning the quality of care a Member received is a grievance. The written response to a quality of care grievance will inform the Member of the right to file the quality of care complaint with the Quality Improvement Organization (QIO). The QIO is an organization comprised of practicing doctors and other health care experts under contract with the federal government to monitor and improve the care given to Medicare members.

Members' complaints, grievances, organization determinations, reconsiderations, coverage determinations, or reconsiderations that contain potential quality of care concerns are forwarded by Member Services to the Member Services Clinical Consultants for case review. Clinical Consultants will forward cases to the responsible quality departments as appropriate.

4.4.3.2 Reconsideration

Reconsideration is a Member's first step in the appeal process after an adverse organization determination. If the organization determination decision is not favorable to the Member, the Member may submit a written request for an appeal to Member Services at:

http://providers.kaiserpermanente.org/html/cpp_hi/appeals.html

The case and summary of the research performed is presented to decision-makers not involved with the organization determination decision. A final decision will be made no later than 30 days pre-service and 60 days post-service from our receipt of the written appeal. If the reconsideration decision affirms, in whole or in part, the adverse organization determination, the issues that remain in dispute must be submitted to MAXIMUS Federal Services for review and resolution. If MAXIMUS upholds the adverse determination, the Member has further appeal rights that include subsequent review by the following agencies, as applicable:

- Hearings before Administrative Law Judges (ALJ)
- Review by the Medicare Appeals Council (MAC)
- Judicial review

4.4.3.3 Coverage Determinations

A coverage determination is defined as any decision made by KP regarding a Part D payment or benefits to which the Member believes he or she is entitled.

Questions about Medicare Part D coverage may be directed to 800 805-2739.

4.4.3.4 Redeterminations

A redetermination is a Member's first step in the appeal process after an adverse coverage determination. If the coverage determination decision is not favorable to the Member, the Member may submit a written request for an appeal to Member Services. Redeterminations are processed through PDU in Member Services. The case and summary of the investigation are presented to decision-makers not involved in the coverage determination decision. The decision will be made no later than seven days from our receipt of the written appeal.

If the redetermination decision is adverse, in whole or part, the Member may submit a written appeal to MAXIMUS Federal Services for reconsideration. If MAXIMUS upholds the adverse determination, the Member has further appeal rights that include subsequent review by the following agencies, as applicable:

- Hearings before Administrative Law Judges (ALJ)
- Review by the Medicare Appeals Council (MAC)
- Judicial review

4.4.3.5 Expedited Review

A Member who believes that his/her health status would be seriously jeopardized by submitting an issue through the standard process may request an expedited review.

Members may request an expedited review by calling Member Services at **808-432-5955**.

4.4.4.1 Instructions for Filing a Grievance

Members may follow the grievance for denied claims or services by calling 1+800 432-5955.

HOW TO FILE A GRIEVANCE

KP is committed to providing you with quality care and with a timely response to your concerns. You can discuss your concerns with our Member Services representatives at **808-432-5955**.

You can file a grievance for any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about services you

received. You must submit your grievance orally or in writing within 60 days (Medicare) or 180 days (non-Medicare) of the date of the incident that caused your dissatisfaction:

- To a Member Services representative by calling Member Services at **808-432-5955.**
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We will acknowledge your grievance within five days of receipt. We will send you our written decision within 30 days of receipt. If we do not approve your request, we will tell you the reason and inform you about additional dispute resolution options.