

This Advisory Bulletin is issued by the U.S. Department of Health and Human Services' Office of Inspector General and the Health Care Financing Administration's Office of Managed Care. It addresses issues related to HMO enrollment, the provision of services, and the disenrollment of Medicare program beneficiaries.

The Office of Inspector General was established by Congress to find and eliminate fraud, waste and abuse. It issues Special Fraud Alerts and Advisory Bulletins to show Medicare beneficiaries where and how to look for potential problems. The Health Care Financing Administration's Office of Managed Care works to ensure that Medicare beneficiaries are given quality health care in their HMO plans.

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Know Your Rights

INTRODUCTION

If you are thinking of joining a Medicare contracting health maintenance organization (HMO), or are enrolled in an HMO, this advisory bulletin gives you important information. In addition, this bulletin also tells you how you can get help and where you can make complaints if you believe any of your rights have been violated or the HMO has acted inappropriately.

What Are Medicare Contracting HMOs?

Medicare contracts with HMOs to provide a full range of Medicare benefits to you. **Medicare contracting HMOs must give you all the health care services that are covered under the Medicare program, except hospice services** (See your Medicare Handbook for specific details). In addition, HMOs may offer additional benefits, either at no charge or for an additional charge.

There are two types of Medicare contracting HMOs - **risk HMOs** and **cost HMOs**. Most HMOs are risk HMOs, and **this bulletin deals exclusively with risk HMOs¹**.

¹You should find out whether the HMO you are considering joining is a risk or cost HMO. If it is a cost HMO, be sure to request additional information about the operation and benefits associated with this type of plan. Some of the issues raised in this bulletin may also apply to cost HMOs.

In general, if you enroll in a **risk HMO plan**, sometimes called a health plan or plan:

- You must get all of your medical care through the plan's doctors, hospitals, skilled nursing facilities, home health agencies, and other health care providers. You are "locked-in" to receive care through your HMO plan. You may, however, get emergency care and unforeseen out-of-area urgently needed care, when necessary, from non-plan providers. Some plans may offer a **point-of-service option** which allows members to use non-plan providers in certain cases.
- You must select a primary care doctor participating in the plan. This doctor is responsible for coordinating your care. You must obtain a referral from this doctor in order to see a specialist or obtain other services through the plan.

Part I:

Enrollment and Disenrollment Rights

ENROLLMENT RIGHTS

When you are considering enrolling in an HMO, the HMO:

- Must provide you with complete and accurate information;
- Must enroll you without regard to your health status;
- Must not offer you gifts or other financial inducements to encourage you to enroll.

Complete and Accurate Information

Before you decide to enroll in a plan, HMO sales, marketing or other plan representatives must give you complete and accurate information about the benefits and the services their HMO provides.

Make sure the HMO representative tells you whether the HMO offers any additional benefits besides those benefits covered under the Medicare program. If so, there may be limits on how often you can use the benefits or how much the HMO will pay for them.

For example, if you take prescription drugs, you should ask the plan before you enroll if the drugs you take are

covered. If the drugs are covered, ask about whether there are limits to the coverage and whether you are required to use certain pharmacies. [NOTE: Many plans do not cover all prescription drugs. Plans may set a maximum dollar amount on the drugs they cover each quarter or each year.]

In addition, the HMO representative must tell you if the HMO requires copayments for any services, including drugs, and the amount of such copayments. [NOTE: Additional benefits and copayments may change each year.]

Make sure that sales, marketing or other plan representatives tell you about how their HMO operates and about all HMO providers and facilities that will be available to you in your area. This includes the home health agencies and skilled nursing facilities associated with their HMO. Make sure you understand if there are any limitations on using the HMO-affiliated providers. For example, certain hospitals may only be used for special services such as transplants. Some doctors may only work at certain hospitals or with certain specialists.

Make sure you understand which primary care doctors will accept you as a new patient. Some doctors may not be accepting new patients. Also make sure you understand under what circumstances and how frequently you can change primary care doctors and what happens if any of your doctors leave the plan. In addition, sales, marketing and other plan representatives must tell you that you will be “**locked-in**” to the HMO and its providers once you enroll and what this will mean to you.

Sales, marketing and other plan representatives must tell you that when you enroll in a risk HMO, you cannot continue to use any of your current doctors or hospitals unless they are affiliated directly with the HMO.

If your current doctor is affiliated with the HMO, you still need to be sure that he or she can accept you as an HMO patient.

If you should choose to go to a doctor or hospital not affiliated with your plan, you will have to pay the entire bill yourself.

Sales, marketing and other plan representatives must clearly and accurately describe, and must not misrepresent, HMO benefits and services.

Medicare law prohibits HMO representatives from enrolling you in an HMO without your permission.

- **You are not required to sign any HMO forms unless you are enrolling in an HMO. If a sales representative gives you a form to sign and you are not sure what it is, do not sign it.**
- **Do not give the HMO your Medicare or Social Security number unless you are enrolling.**
- **HMO marketing representatives are not allowed to come to your home unless you have given them permission in advance. This restriction applies to any personal residence, including your room in a nursing home, rest home or assisted living arrangement.**

If you received false, misleading or incomplete information, then you may have been improperly enrolled in an HMO. If so, you have the right to be retroactively disenrolled and to return to traditional Medicare coverage, or to enroll in another HMO. [NOTE: Of course, you can disenroll from an HMO at any time. See Disenrollment Rights section. Also, enrolling in a new Medicare HMO automatically disenrolls you from your current HMO.]

Enrollment Without Health Screenings

An HMO must enroll all eligible Medicare beneficiaries who want to enroll, regardless of their age, health status or the amount or cost of the health services needed.

HMOs are not allowed to make you undergo a health screening before you enroll. **Pre-enrollment health screening or questions about your health or physical status are against the law.** These screenings can be used by the HMO to identify sick beneficiaries and those with chronic conditions, and to discourage them from enrolling. [NOTE: There are two exceptions to the rule about health screening before enrollment. An HMO can ask you whether you are receiving kidney dialysis or have received a kidney transplant, or whether you are receiving hospice services. If you are receiving these services or have these conditions, you can not enroll in an HMO.]

Before you enroll, sales, marketing or other HMO plan representatives should not ask:

- **how often you visit the doctor;**
- **how many doctors you have;**
- **how many times you have been hospitalized in the last year;**
- **whether you have any conditions for which you take medicine on a regular basis, or;**
- **whether you exercise regularly.**

Also be alert for improper screenings when an HMO requires or offers:

- **free physical exams before enrollment;**
- **free screening or diagnostic tests at health fairs or at marketing presentations.**

In addition, watch for sales, marketing or other HMO plan representatives who tell you that the HMO would not be a good choice for you because (1) referrals to specialists would be limited, (2) you might have to wait for services, or (3) services would be more limited in an HMO.

After you enroll, the HMO may ask you questions, give you questionnaires to fill out, or give you a physical exam to assist them in providing your care.

Enrollment Without Being Offered Free Gifts or Other Inducements

It is illegal for an HMO to offer you free gifts or incentives to get you or anyone else to enroll in an HMO.

HMOs are not allowed to offer you free gifts to encourage you to enroll or as a reward for attending marketing presentations. They are not allowed to offer incentives to get you to recommend them to your friends either. These incentives are not allowed because they could affect your decision to enroll or to recommend that a friend enroll. It's okay for the HMO to offer promotional materials worth less than \$10, such as key chains, mugs and calendars, as well as light refreshments at a marketing presentation, as long as these are given to everyone regardless of their decision to enroll.

DISENROLLMENT RIGHTS

Disenrollment Is Your Decision

Once you are enrolled in an HMO, you may wish to disenroll at some point. Whether you stay enrolled in or leave an HMO, it is your decision. Your HMO cannot try to keep you from disenrolling nor can the HMO try to get you to leave.

When You Decide to Leave Your HMO

HMOs must process written requests for disenrollment in a timely manner.

HMOs may not delay, withhold disenrollment information or forms, or otherwise make it hard for you to disenroll from a plan. If you want to disenroll from your HMO because you are unhappy or dissatisfied with services, or for any other reason, your

HMO should help you disenroll. You must submit a written request to disenroll, and the HMO should help you complete any necessary paperwork. [NOTE: Whoever has authority under State law to make health care decisions for you can enroll you in or disenroll you from an HMO.] You may also go to a Social Security office to disenroll from your HMO.

Make sure your HMO tells you the date when your disenrollment is effective. It is usually the first day of the month following receipt of your disenrollment request. If you get services from a non-HMO provider when you are still a member of your HMO, neither your HMO nor Medicare will pay.

[NOTE: If you disenroll from a HMO and have any pre-existing medical conditions, many Medicare supplemental insurance (Medigap) policies will not sell you a policy or will impose a waiting period for those conditions. That means you could be without supplemental insurance coverage for that condition for a period of time unless you enroll in another HMO. Also, some Medigap policies only have open enrollment periods once a year. Remember to look for a policy that will provide coverage for your pre-existing conditions, and will be available when you disenroll.]

If Your HMO Encourages You to Disenroll

The premiums that your HMO gets from the Medicare program are designed to reimburse the plan for all the covered services you need. **The HMO is not allowed to try to get you to leave or to delay or deny you**

services because you need heart surgery, transplants, long term nursing or rehabilitative services or other expensive treatments.

Your HMO must not encourage you to disenroll:

- **Because it will be expensive to treat your condition or meet your medical needs.**
- **By delaying expensive medical care for a long time, or by denying such care.**
- **By telling you that you can re-enroll in the HMO after you have received the necessary high cost services outside the HMO.**

Unless you enroll in another HMO, if you disenroll from the HMO to get a specific service or procedure, you will have to pay any deductibles or coinsurance under the payment rules of the traditional Medicare program.

Part II: Your Rights to Medical Services in an HMO

This part addresses your rights to medical services and benefits in a Medicare contracting HMO once you are enrolled.

Your Rights To Services

When you are enrolled in an HMO, you have a right to:

- **Medically necessary care in a timely manner.**
- **Emergency medical care and unforeseen out-of-area urgent care.**

Your HMO must provide all medically necessary covered services. Covered services include all the benefits provided under the Medicare program and any additional services offered by the HMO.

Your HMO must have enough qualified primary care and specialty care doctors, as well as other health care providers and facilities, to provide you with all medically necessary covered services. If the HMO does not have enough qualified providers, it must arrange for services to be provided to you outside the plan at no extra cost to you.

HMOs must make necessary medical care and services available and accessible to you. The HMO may not:

- **Create or permit delays like repeated busy signals when you call to make appointments;**
- **Make you wait an unreasonably long time for appointments;**
- **Unreasonably restrict the days or hours that you may be seen by the plan's providers;**
- **Create or permit unreasonable delays in arranging for surgery, hospitalization or other services by using review or approval mechanisms;**
- **Inappropriately deny or limit referrals to specialists in or outside the plan;**
- **Unreasonably limit the amount of nursing home, home health or therapy services.**

Getting Emergency and Out-of-Area Care

Your HMO must pay for emergency care and for unforeseen, urgently needed, out-of-area care you get from non-HMO health care providers, including necessary follow-up care.

Emergency Care

Emergencies are situations when you need medical care immediately because of sudden or suddenly worsening illness or injury, and the time needed to reach

your plan doctor or hospital appears to you to risk permanent damage to your health.

Your HMO must not:

- **Tell you that you can only get emergency care through its doctors and at its facilities;**
- **Require you to get prior authorization for emergency services;**
- **Deny your claim for emergency services after you get the services, because what appeared to be an emergency condition turned out not to be an emergency condition.**

If you believe you have an emergency, you may seek emergency care outside the plan and the HMO must cover and pay for those emergency services you got from the outside provider. Your HMO must pay for all procedures performed during the evaluation and treatment of your emergency condition, unless those services were completely unrelated to the emergency condition. If possible, you should call (or have someone call) your HMO as soon as possible when receiving emergency care.

[**NOTE:** You should be aware that hospitals are required by law to provide screening for emergency medical conditions. If necessary, hospitals must provide stabilizing treatment or arrange for an appropriate transfer to another facility, whether or not your HMO authorizes these services. The hospital may not refuse to provide emergency services to you because your HMO will not authorize such services.]

Out-of-Area Urgent Care

Urgent care situations are when you have an unexpected illness or injury while you are temporarily outside the HMO's service area. Your HMO must pay for your urgent care if:

- **Your illness or injury is unexpected; and**
- **You are temporarily away from the HMO service area; and**
- **Your illness or injury requires medical care which cannot be delayed until you return home.**

If possible, you should call (or have someone call) your HMO as soon as possible when receiving out-of-area urgent care.

Transfers From Another Facility

If you have received emergency or urgent care services from a non-HMO facility, your HMO may not attempt to transfer you back to its own facility from another facility outside its plan before the non-HMO facility decides that your condition is stabilized.

Coverage of Follow-Up Care

Your HMO must cover all medically necessary follow-up care related to your emergency condition, or unforeseen out-of-area urgent care, provided outside the plan if that care cannot be delayed without adverse medical effects to you.

Part III:

How to Make a Complaint

You should be aware that you and your HMO may disagree about what care is medically necessary.

You have the right to appeal if you believe that medically necessary care has been denied, reduced or terminated inappropriately.

Here are some examples of situations in which you have the right to appeal:

- **Your doctor does not prescribe covered treatments or tests, refer you to a specialist, or does not admit you for hospital services you believe you need;**
- **Your HMO refuses to authorize or provide tests, treatments or referrals recommended by your primary care doctor;**
- **Your HMO does not authorize a second opinion on the need for surgery. (Second opinions are a Medicare covered benefit.)**
- **Your HMO or your doctor decides to reduce or terminate services you are already receiving, such as home health care or physical therapy, or decides to discharge you from a nursing home;**
- **You encounter an unreasonable delay or difficulty in arranging for surgery, hospitalization, tests, doctor visits or any other needed services, and you believe this is a way of denying you care;**

- **Your HMO will not pay your claims for emergency care or out-of-area urgent care you received from a non-HMO provider;**
- **A decision is made to discharge you from a hospital before you believe you are ready to be discharged.** [NOTE: When you are in the hospital and your HMO decides that you do not need to be there any longer, you can ask for immediate review by a Peer Review Organization (PRO). If you ask for an immediate review, you can stay in the hospital at no charge during the review. The review usually takes at least 24 hours.]

The Appeals Process

Your HMO is required to notify you when it **denies, reduces, or terminates services or payment for services.** (Whether or not you have written notification, you may appeal.) The HMO must also provide you with written information about your appeal rights and the process you must follow, including time frames for each step.

The appeals process begins with your written request to the HMO asking it to review the denial, reduction or termination. If the HMO does not reverse its decision, the appeal automatically goes next to an independent review organization that contracts with Medicare to review HMO denials. If the review organization does not decide fully in your favor, you may request a hearing from Medicare.

If you need help in deciding whether to appeal, or if you have questions regarding what you must do to appeal, you can contact your local or State Insurance Counselling and Assistance (ICA) Program. Call the Medicare Hot Line at 1-800-638-6833 to get the number of the ICA in your area.

Complaints About Quality

If you have complaints about the quality of care you have received by your HMO or any of its providers, including hospitals, skilled nursing facilities and home health agencies, you can complain to your HMO or a Peer Review Organization (PRO). PROs are groups of doctors and health care professionals that monitor the quality of care provided to Medicare beneficiaries. Call the Medicare Hot Line or your ICA to get the number of the PRO serving your area (See *Part IV: Where to Go For Help*). The PRO will investigate your complaint.

Other Complaints

If you have other complaints about the HMO, such as physician demeanor or adequacy of the facilities, contact your HMO directly. Your HMO must have written procedures, including time frames, for investigating these types of complaints (also called grievances). The HMO representatives will review these complaints and notify you in writing of their conclusions.

Part IV:

Where to Go for Help

What you need to do if you believe your HMO is not meeting its obligations or may be violating your rights:

- Complain directly to the HMO. You must write to your HMO asking it to reconsider its decision to deny, reduce or terminate care, coverage or payment. Every HMO is required to have a process to handle complaints, and the HMO must give you detailed information on how to file a complaint.
- Contact your local or State Insurance Counselling and Assistance Program (ICA) which has been set up to assist Medicare beneficiaries in resolving problems with, or answering questions about, their Medicare benefits. To obtain the phone number of your ICA, you can call the Medicare toll-free Hot Line at **1-800-638-6833** or your local area Agency on Aging office. To obtain the number of your local aging office, you can call **1-800-677-1116** (the Eldercare locator number).
- Contact the HHS Office of Inspector General through its toll-free Hot Line at **1-800-HHS-TIPS** (1-800-447-8477), or contact the HCFA Medicare toll-free Hot Line at **1-800-638-6833**. Contacting one of these offices about improper practices will not resolve your individual problem, but may help to stop any improper practices.

QUIZ YOURSELF

There are several important questions you should ask yourself regarding HMO participation.

Do you know:

- What lock-in means?
- The role of your primary care doctor?
- How the HMO's referral process works?
- The HMO's rules and responsibilities about paying for emergency and out-of-area urgent care?
- Whether HMO enrollment is a good choice for you if you travel or are out of the HMO service area for long periods of time?
- How to disenroll from an HMO?
- How to complain if you have a problem?