

**ALABAMA MEDICAID AGENCY**

**NOTICE OF INTENDED ACTION**

**RULE NO. & TITLE:** 560-X-62-.21 Information Requirements for Enrollees and Potential Enrollees

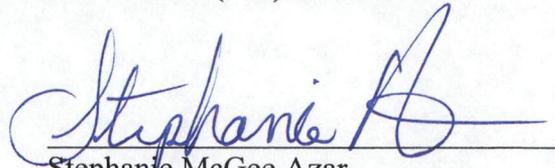
**INTENDED ACTION:** Add New Rule 560-X-62-.21

**SUBSTANCE OF PROPOSED ACTION:** The above referenced rule is being created to set forth the requirements of regional care organizations and alternate care providers to provide information to enrollees and potential enrollees.

**TIME, PLACE, MANNER OF PRESENTING VIEWS:** Written or oral comments may be submitted to the Alabama Medicaid Agency, 501 Dexter Avenue, Post Office Box 5624, Montgomery, Alabama 36103-5624. Agency business hours are 8:00 a.m. to 5:00 p.m. Monday through Friday.

**FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:** Written/Oral comments concerning this change must be received by the Alabama Medicaid Agency no later than March 9, 2015.

**CONTACT PERSON AT AGENCY:** Stephanie Lindsay, Administrative Secretary, Alabama Medicaid Agency, 501 Dexter Avenue, Post Office Box 5624, Montgomery, Alabama 36103-5624. Phone: (334) 242-5833.

A handwritten signature in blue ink, appearing to read "Stephanie A.", written over a horizontal line.

Stephanie McGee Azar  
Acting Commissioner

**Rule No. 560-X-62-.21 Information Requirements for Enrollees and Potential Enrollees –  
NEW RULE**

(1) Duty to Provide Information to Enrollees and Potential Enrollees

(a) Regional Care Organizations and alternate care providers (hereinafter collectively referred to as “organizations”) shall adopt policies and procedures designed to clearly and thoroughly explain the process to enroll in an organization, the rights and responsibilities of enrollees, the grievance and appeals process and the requirements and benefits of the integrated and coordinated health care delivery system implemented pursuant to Section 22-6-150, et seq. of the Alabama Code.

(b) As used in this section, “enrollee” means a Medicaid beneficiary enrolled as a member of an organization. As used herein “potential enrollee” means a Medicaid beneficiary subject to mandatory enrollment in an organization or who may voluntarily or be required to enroll as a member of an organization, but is not yet enrolled in an organization.

(c) The organization shall have written policies, procedures and forms approved by the Medicaid Agency that provide the type of information required herein and that satisfy applicable state and federal law, including but not limited to, 42 CFR 438.10. The organization shall have an ongoing process of participating provider and enrollee education and information sharing designed to effectuate the provisions of this rule. Information for potential enrollees must comply with the marketing prohibitions in 42 CFR 438.104.

(d) Organizations shall ensure that all organization representatives who have contact with enrollees and potential enrollees are properly trained and fully informed of the policies, procedures, and forms of the organization applicable to enrollment, disenrollment and the grievance system set forth under the RCO laws and regulations.

(e) The organization must provide all forms, enrollment notices, informational materials and instructional materials in a manner and format that may be easily understood. The organization must have policies and procedures in place designed to assist enrollees and potential enrollees in making informed decisions and in understanding the organization’s forms, policies and procedures, as well as the benefits and services provided by the organization.

(f) Within 15 calendar days of an organization receiving notice of an enrollee’s enrollment in the organization, the organization shall mail an information packet to new enrollees setting forth the information required herein. The packet shall include, at a minimum, confirmation of enrollment in the organization, an enrollee handbook and a participating provider directory. Alternatively, enrollees may elect but are not required to receive the organization’s materials electronically via e-mail, an on-line enrollee portal, or similar means. An organization wishing to make this option available must contact the enrollee within 5 business days of enrollment to determine if the enrollee prefers to receive information electronically. For enrollees who make this election, the organization must mail written confirmation within 15 calendar days of an organization receiving notice of an enrollee’s enrollment in the organization confirming the enrollee’s decision to receive information

electronically and explaining the method(s) for doing so and how to opt-out and return to paper communications.

(i) The directory shall list by specialty the names, addresses and telephone numbers of all participating providers for the provider types required by the Medicaid Agency.

(ii) The handbook, participating provider directory, as well as forms, policies and procedures provided by the organization pursuant to this rule, shall also be maintained on the organization's website.

(iii) After enrollment, the organization shall upon request provide enrollees the enrollee handbook and a current participating provider directory, in print or online, depending on the request.

(iv) At least once a year the organization shall provide notice to enrollees that the handbook and directory are available upon request.

(v) The handbook shall list the organization's location, mailing address, web address, telephone number and office hours.

(vi) The participating provider directory must be updated at least quarterly.

(vii) The organization shall also provide to enrollees within 15 calendar days an identification card which contains easily understood information on how to access care in an urgent or emergency situation. The enrollee identification card shall also contain the enrollee name, contractor identification number, if applicable, the name and contact information of enrollee's primary care physician and the organization's toll free number.

(2) Language. The organization must at a minimum:

(a) Establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the region served by the organization. "Prevalent" means a non-English language spoken by five (5) percent or more of potential enrollees and enrollees in the region.

(b) Make available written information in each Prevalent non-English language.

(c) Make oral interpretation services available free of charge to each potential enrollee and enrollee in all applicable non-English languages.

(d) Notify enrollees and potential enrollees that oral interpretative services are available for any language and that written information is available in Prevalent languages and how to access those services.

(3) Format. Written material required to be provided to enrollees and potential enrollees must use easily understood language, not to exceed a fifth (5<sup>th</sup>) grade reading level, and format.

The material must be available in alternative formats and in an appropriate manner that takes into consideration special needs of those with visual impairments and/or with limited reading proficiency. Enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats.

(4) Information for Potential Enrollees. In addition to any requirements on the part of the State or its participating provider, upon ten business days of a request, the organization must provide potential enrollees documents approved by the Medicaid Agency that adequately describes:

- (a) The basic features of the RCO program;
- (b) Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program;
- (c) The responsibilities of the organization for coordination of care; and
- (d) Information specific to the organization operating in the potential enrollee's service area, including:
  - (i) Benefits covered;
  - (ii) Cost sharing, if any;
  - (iii) Service area; and
  - (iv) Names, locations and telephone numbers of Non-English language spoken by current participating providers, including identification of those not accepting new patients, including at minimum information on contracted primary care physicians, specialists and hospitals.
- (e) Benefits available under the State Plan that are not covered services in the organization's network, including how and where the enrollee may obtain those benefits, any cost sharing and how transportation may be provided. For counseling or referral services the organization or its participating providers do not cover because of moral or religious objections, information must be provided for how and where to obtain the service.

(5) Information for Enrollees. The organization must provide information required by 42 CFR 438.10(f) and hereunder to all enrollees including:

- (a) Within ten calendar days of request, the organization must notify enrollees of their disenrollment rights.
- (b) The right of enrollees to request and obtain the information listed herein at least once a year.

(c) The right of enrollees to request the information listed herein within a reasonable time after the organization receives notice of the enrollee's enrollment in the RCO program.

(d) Written notice of any significant changes in the information required under this rule provided at least 30 days before the intended effective date of the change.

(e) The organization must make a good faith effort to provide written notice of termination of a participating provider, within 15 days after receipt or issuance of the termination notice to the participating provider, to each enrollee who received his or her care from, or was seen on a regular basis by, the terminated provider.

(f) Names, locations, telephone numbers of non-English languages spoken by current participating providers in the enrollee's service area, including identification of participating providers that are not accepting new patients. At a minimum, this must include information on participating primary care physicians, specialists and hospitals.

(g) Any restrictions on the enrollee's freedom of choice among network providers.

(h) Enrollee rights and protections set forth in 42 CFR § 438.100.

(i) Information on grievances and appeals required by rule(s) promulgated by the Medicaid Agency.

(j) The amount, duration and scope of benefits available under the contract between the organization and the Medicaid Agency in sufficient detail to ensure that enrollees understand the covered services to which they are entitled.

(k) Procedures for obtaining benefits, including authorization requirements.

(l) The extent to which, and how, enrollees may obtain covered services, including family planning services, from out of network providers.

(m) How, when and where after hours coverage, urgent care services and emergency coverage are to be provided as required by 42 CFR 438.10(f)(6)(viii).

(n) Information on available post-stabilization care as required by 42 CFR 422.113(c).

(o) Information on cost sharing, co-payments, charges for non-covered services, and the enrollee's possible responsibility for payments for services if he/she goes outside of the region for non-emergent care.

(p) Information on contracted hospitals in the enrollee's service area and, unless otherwise provided, the enrollee has a right to use any hospital or other setting for emergency care.

- (q) Information on advance directive policies.
  - (r) How to access information on participating providers accepting new enrollees in an organization.
  - (s) How to access and understand forms provided by the organization and how to obtain assistance in completing and submitting forms.
  - (t) The enrollee's right to request and obtain copies of their clinical records and whether they may be charged a reasonable copying fee.
- (6) Grievances and appeals. The organization must provide information to enrollees advising of their rights to file grievances and appeals and of their rights to a hearing pursuant to Section 22-6-153 of the Alabama Code and Rule No. 560-X-62-.19. The organization must provide information which at a minimum advises enrollees:
- (a) The right to file a grievance and the time frame and process for which to do so.
  - (b) The process and time frame for which notices of action are to be provided.
  - (c) The rights to file an appeal of an action and the process and time frame for which to do so.
  - (d) The availability of assistance in the filing process and the type of assistance available.
  - (e) An enrollee's right to hearings and timeframes, rules and procedure related thereto.
  - (f) The toll free numbers that the enrollee can use to file a grievance or an appeal by phone or seek interpretive assistance by phone.
  - (g) That when requested by the enrollee, covered services may continue if the enrollee files a timely appeal and that the enrollee may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the enrollee.
  - (h) The other rights and obligations of the enrollee set forth in Rule No. 560-X-62.-19.
- (7) Compliance with state and federal law. In addition to the information required by this rule, the organization must provide an enrollee and potential enrollee any additional information required by applicable state and federal law and that may be required in a risk contract between the organization and the Medicaid Agency. All such information must be provided in a format required by applicable law or in the risk contract.

**Author:** Sharon Weaver, Administrator, Administrative Procedures Office.

**Statutory Authority:** Code of Alabama, 1975 Section 22-6-150 *et seq.* 42 C.F.R. Part 438, 42 C.F.R Part 422.

**History:** New Rule: Filed January 22, 2015.