

**ALABAMA MEDICAID AGENCY**

**NOTICE OF INTENDED ACTION**

**RULE NO. & TITLE:** 560-X-62-.23 Grievances and Appeals of Medicaid Enrollees in Regional Care Organizations and Alternate Care Providers

**INTENDED ACTION:** Add New Rule 560-X-62-.23

**SUBSTANCE OF PROPOSED ACTION:** The above referenced rule is being created to establish a grievance process, appeal process, and access to the Medicaid Agency's fair hearing system for enrollees in a regional care organization or an alternate care organization.

**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 April 3, 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.



---

Stephanie McGee Azar  
Acting Commissioner

**Rule No. 560-X-62-.23 Grievances and Appeals of Medicaid Enrollees in Regional Care Organizations and Alternate Care Providers – NEW RULE**

(1) This rule is promulgated pursuant to Section 22-6-153 (d) of the Alabama Code to establish a grievance and appeal system consisting of a grievance process, appeal process, and access to the Medicaid Agency's fair hearing system (the "grievance system") for enrollees in a regional care organization or an alternate care organization (hereafter collectively referred to in this rule as "organization").

(2) For the purposes of this rule an "enrollee" in an organization shall be construed to mean a Medicaid beneficiary currently enrolled in an organization, or a provider authorized in writing on a Medicaid Agency approved form to act on behalf of an enrollee, and any other person authorized in writing on a Medicaid Agency approved form or by court order to act as a representative on behalf of an enrollee who has filed a grievance or appeal pursuant to this rule (all of whom shall be collectively referred to in this rule as "enrollee").

(3) For the purposes of this rule a "grievance" means an expression of dissatisfaction by an enrollee about any matter related to the enrollee's care and treatment by the organization in accordance with 42 CFR 438.400. A grievance does not include matters that constitute an "action" under the following subsection 5 or any matter that may be in litigation.

(4) An enrollee may submit a grievance orally or in writing to the organization within 5 business days of learning of the basis of the grievance. A grievance may only be filed with the organization. The organization must acknowledge receipt of the grievance within 5 business days, consider each enrollee grievance and, provide notice of the resolution of the grievance as expeditiously as the enrollee's health condition requires and in any event no more than 30 calendar days from receipt of the grievance. The organization must assign a person(s) not directly involved in the matter that is the subject of the grievance to conduct a reasonable review of the circumstances surrounding the grievance. The reviewer shall review any relevant parts of the enrollee's case file and medical records as well as all documents submitted on behalf of the enrollee and may, as it deems necessary, conduct additional investigation into the grievance and/or consult with medical or behavioral professionals. The response to the grievance by the organization shall be in writing and fully explain the decision reached as to each part of the grievance presented and the reasons for the decision. Enrollees have no right to appeal an adverse determination of a grievance. The failure on the part of an organization to act on a grievance as required by this section shall constitute an action under subsection 5.

(5) For the purposes of this rule an "action" means action the organization has taken or plans to take that could result in a material change or limitation to enrollee's care and treatment including but not limited to the approval or denial of care, adverse decisions related to billing and payment or bundling matters, and other decisions related to the provision of health care services offered, made available or denied to the enrollee by the organization that constitutes an action under 42 CFR 438.400. For the purposes of this rule "the provision of health care services" shall include, but not be limited to, the denial or limited authorization of a claim or requested service, including the type or level of service; the reduction, suspension, or termination of an authorized service; the total or partial denial of payment for a service; the failure to provide services in a timely manner as required by state or federal law or rules of the Medicaid Agency; the failure of an organization to act within timeframes established by the

Medicaid Agency or within the timeframes provided in 42 CFR 438.408(b); or in applicable cases, the denial of an enrollee's request to exercise his or her right to obtain services outside of the delivery network of the organization. For the purposes of this rule, an appeal shall be construed to mean the request for review of an "action."

(6) (a) In the event the organization takes or decides to take an action (as defined herein) regarding an enrollee, a written "notice of action" shall be provided to the enrollee as expeditiously as possible but whenever possible not less than 10 calendar days before the date of any proposed action that would involve termination, suspension or reduction of a previously authorized covered service, unless the delay resulting from such a notice is reasonably believed to be injurious to enrollee's health and welfare by enrollee's treating physicians or except as otherwise required by § 438.404(c). The notice shall be sent by mail to enrollee's last known address and may also be communicated to enrollee by email or facsimile transmission. All such notices of action must at a minimum, clearly and thoroughly explain, on forms approved by the Medicaid Agency:

- (1) The action the organization has taken or proposes to take and when;
- (2) The reasons for the action taken or proposed;
- (3) The full rights of appeal the enrollee has to challenge the action under the provisions of this rule and Section 22-6-153 (d), including but not limited to the right to seek an expedited appeal in certain cases;
- (4) The procedures an enrollee must follow to exercise his/her rights to appeal;
- (5) The enrollee's right to request and receive a continuation of benefits pending resolution of the appeal, the process to request continuation of benefits and the circumstance under which the enrollee may later be required to pay for the services continued during appeal; and
- (6) The time by which all appeals must be filed by the enrollee.

(b) The period of advanced notice is shortened to five (5) calendar days if probable enrollee fraud has been verified.

- (c) The period of notice shall be the date of the action for the following:
- i. In case of the death of an enrollee;
  - ii. A signed written enrollee statement requesting service termination or giving information requiring termination or reduction of services (where he or she understands that this must be the result of supplying that information);
  - iii. The enrollee's admission to an institution where he or she is ineligible for further services;
  - iv. The enrollee's address is unknown and mail directed to him or her has no forwarding address;

- v. The enrollee has been accepted for Medicaid services by another local jurisdiction; and
- vi. The enrollee's physician prescribes the change in the level of medical care.

(d) Pursuant to 42 CFR 438.404(c)(2), when the notice of action is a denial of payment, the organization shall provide enrollee written notice on the date of the action.

(e) Pursuant to 42 CFR 438.210(c), the organization must notify the requesting provider of any decision to deny a service authorization request or of any decision to authorize a service in amount, scope or duration that is less than requested. The notice need not be in writing but must meet the requirements of 42 CFR 438.404.

(7) The enrollee may within 20 calendar days of receipt of notice of an action file an appeal orally or in writing of the action before the medical director of the organization, who shall be a primary care physician. The enrollee shall state in the notice of appeal whether oral hearing is requested. An oral notice of appeal must be confirmed in writing within 3 calendar days.

(a) The medical director must send the enrollee notice of receipt of the appeal within 3 calendar days. The acknowledgment shall state when the enrollee's appeal will be decided, which, except as otherwise provided herein, shall be no later than 10 calendar days from the date of filing of the notice of appeal. In the event enrollee requests an oral hearing, that hearing shall be no later than 20 calendar days of filing the notice of appeal.

(b) The organization shall immediately provide the medical director all relevant parts of enrollee's case file and medical records and any information submitted by enrollee.

(c) Within 5 calendar days of filing the notice of appeal, enrollee shall submit to the medical director all written materials the enrollee would like to be considered. The medical director shall consider all relevant parts of the enrollee's case file and medical records as well as any additional material submitted on behalf of the enrollee. If oral hearing has been requested in the notice of appeal, the enrollee shall have an opportunity to present evidence, allegations of fact and law, as well as arguments, in person, writing or by telephone, at the election of enrollee.

(d) The rules of evidence shall not apply.

(e) The medical director's decision shall be binding on the organization and must be provided to enrollee orally or in writing within 1 calendar day of resolution of enrollee's appeal. Oral notices of the resolution must be confirmed in writing within 2 additional calendar days on a form approved by the Medicaid Agency. The written notice of the decision shall state in reasonable detail the basis for the decision.

(8) If the enrollee is dissatisfied with the decision of the medical director, the enrollee may within 10 calendar days of notification of the decision file a written or oral notice of appeal with the organization to be heard by a peer review committee of the organization. An oral appeal must be confirmed in writing within 5 calendar days.

(a) The peer review committee shall be composed of at least three physicians who have the same specialty as the ordering or prescribing physician and who work within the region in which the services or matter is at issue. If three physicians cannot be found to serve who work within the region served by the organization, then the positions may be filled by physicians of the same specialty who work outside of the region.

(b) The organization shall send enrollee acknowledgment of receipt of the appeal within 3 calendar days of receipt of the notice. The acknowledgment shall state when the enrollee's appeal will be heard, which shall be no less than 7 and no more than 21 calendar days of the filing of the notice of appeal.

(c) The organization shall provide the peer review committee all relevant parts of enrollee's case file and medical records and all other information submitted by enrollee.

(d) The peer review committee shall consider all relevant parts of the enrollee's case file and medical records along with any additional material submitted on behalf of the enrollee.

(e) The enrollee shall have the right to present arguments, evidence, and allegations of fact or law in person, writing or by telephone.

(f) The rules of evidence shall not apply.

(g) The peer review committee's decision shall be sent to enrollee within 14 calendar days of the hearing on appeal on a form approved by the Medicaid Agency and be binding on the organization.

(h) A peer review committee formed pursuant to Section 22-6-153 (d) and this rule shall be separate and distinct from a peer review committee created pursuant to Administrative Rule 560-X-2-.01 et seq. and not subject to the provisions of that rule.

(9) If the enrollee is dissatisfied with the decision of the peer review committee, the enrollee may within 20 calendar days of notice of the decision submit a notice of appeal to the Medicaid Agency on a form approved by the Medicaid Agency. The enrollee shall also submit a copy of the notice of appeal to the organization on the same date. Timely oral requests shall be permitted so long as the oral request is reduced to writing within 48 hours. In the event an enrollee files a notice of appeal with the organization instead of the Medicaid Agency, the organization shall forward such request to the Medicaid Agency within two business days of receipt.

(a) The Medicaid Agency shall within 10 calendar days of receipt of the notice of the appeal provide the enrollee written notice of such receipt and of the date and time the appeal will be heard by the Medicaid Agency. The appeal shall be heard no sooner 10 calendar days or any longer than 30 calendar days from the date of the notice setting the date and time of appeal. Hearings may be continued for up to 14 calendar days at the request of the enrollee, or for good cause shown, at the request of the regional care organization. For extensions not requested by the enrollee, the organization must provide the enrollee prompt written notice of the reason for the delay.

(b) The Medicaid Agency shall request the following information from the organization which must be provided within 14 calendar days from the filing of the notice of appeal:

- i. A copy of the relevant parts of enrollee's case file and medical records; and
- ii. All documents considered by or presented to the medical director and the peer review committee and the decisions rendered by each.

(c) The enrollee shall be entitled to review all such information before and during the hearing on enrollee's appeal.

(d) The enrollee shall be afforded a full evidentiary hearing in the region in which the enrollee resides.

(e) The parties to the appeal shall be the regional care organization and the enrollee. The enrollee may represent himself/herself before the Medicaid Agency or have someone else appear on enrollee's behalf in person, by telephone or in writing at the election of the enrollee and be provided a reasonable opportunity to present arguments, evidence and allegations of fact or law.

(f) A record must be made of the hearing and the organization shall be responsible for the cost.

(g) The Medicaid Agency will send to the enrollee and the provider a written finding within 90 calendar days of the notice of the decision of the Medicaid Agency stating with specificity the basis for the decision as well as all matters considered in reaching the decision which shall be binding upon the regional care organization.

(10) If the enrollee is dissatisfied with the decision rendered by the Medicaid Agency, enrollee may file an appeal to the circuit court in the county in which the enrollee resides, or the county in which the provider provides the services at issue to the enrollee. The enrollee must file the appeal in circuit court by no later than 30 calendar days after receipt of the decision rendered in connection with the appeal to the Medicaid Agency.

(11) Each organization must have written policies and procedures approved by the Medicaid Agency that clearly and fully explain an enrollee's right to file grievances and appeals of actions, as well as forms approved by the Medicaid Agency for filing grievances and appeals pursuant to sections (7) and (8) of this rule. Any material changes to such policies and procedures must be approved by the Medicaid Agency and copies provided to enrollees and providers in writing at least 30 calendar days prior to implementation.

(a) All policies, procedures and forms required herein shall meet the requirements of 42 CFR §438.10 and Medicaid Agency Administrative Rule No. 560-X-62-.21. The rights of enrollees to file grievances and appeals, the process to do so, and the required forms shall be posted on the website of the organization and provided to the enrollee within 60 days of enrollment. Such documents shall also be provided to providers when contracts are entered into.

(b) Each organization must maintain a toll free number for enrollees to use to orally submit a grievance or notice of appeal.

(c) The organization must cooperate with the enrollee and provide reasonable assistance as needed to explain and complete forms and take other procedural steps related to the filing of grievances and appeals, including but not limited to providing free interpreter services.

(d) At each stage of the appeals process the organization, or the Medicaid Agency in the event of an appeal pursuant to Section 9 hereof, shall:

- i. Timely acknowledge in writing receipt of the notice of appeal and state the date, time and process by which the appeal is to be heard and decided;
- ii. Advise enrollee or his/her provider or duly appointed representative of the enrollee's rights on appeals including the right to examine the enrollee's file, medical records and all other information considered or submitted by the organization; and
- iii. Advise enrollee of the right to request benefits while the appeal is pending and that the enrollee may in such case be held liable for the cost of those benefits if the appeal is not decided in favor of enrollee.

(e) The organization may not discourage any enrollee from using any aspect of the grievance system set forth in this rule nor encourage the withdrawal of a grievance, appeal or hearing request filed pursuant to this rule. The organization may not use the filing or resolution of a grievance, appeal of an action or hearing request as a reason to retaliate against the enrollee or provider or as a basis to seek disenrollment of the enrollee. The right of an enrollee to file a grievance or appeal and the rights of an enrollee during the grievance and appeal process shall be fully set forth in the Provider Manual and Enrollee Handbook supplied to all providers and enrollees by the organization.

(12) Each grievance and appeal submitted pursuant to this rule must be appropriately considered and timely resolved in accordance with the following:

(a) The organization shall ensure that persons making decisions in connection with any grievance or appeal were not involved in any previous level of review or decision-making regarding the matters at issue. The organization shall ensure that appropriate healthcare professionals participate in all decisions in which (i) the grievance or appeal involves clinical issues; (ii) the appeal is of a denial of a request based on lack of medical necessity, or (iii) a grievance is received regarding denial of a request for an expedited appeal.

(b) All decisions rendered as part of any grievance or appeal filed on behalf of an enrollee shall be in writing, clearly state the decision reached and fully explain the reasons for the decision and documents and criteria considered in rendering the decision.

(c) The organization shall, if requested by the enrollee, provide reasonable assistance to help the enrollee understand the decision rendered and if necessary provide an interpreter to assist the enrollee.

(d) At each level of the grievance and appeal process set forth herein in which a decision is rendered that is adverse to enrollee, the enrollee shall be advised in writing by the organization (or by the Alabama Medicaid Agency in the event of an appeal pursuant to section 9 of this rule) of any rights of appeal provided the enrollee pursuant to Section 22-6-153(d) and under this rule. All such notices shall comply with the requirements of 42 CFR § 438.10(c) and (d) and Rule No. 560-X-62-.21.

(e) The organization must provide written notice of disposition of the appeal, which notice must include:

1. The results of and date of the resolution of the appeal.
2. For decisions not wholly in the enrollee's favor:
  - i. The right to request further appeal;
  - ii. How to request further appeal;
  - iii. The right to continue to receive benefits pending an appeal;
  - iv. How to request the continuation of benefits; and
  - v. If the action taken by the organization is upheld on appeal, the enrollee may be liable for the cost of any continued benefits.

(13) Consistent with rules promulgated by the Medicaid Agency and otherwise required by law, the enrollee's right to confidentiality shall be maintained as much as practical through each step of the grievance and appeal system taking into consideration the need for disclosure of medical and other information necessary to resolve enrollee's grievance or appeal, to determine payments or benefits that may be due and/or to evaluate quality of care by the organization or the effectiveness of the grievance system established by the organization. By participating in the grievance system provided for in this rule the enrollee will be deemed to have consented to the release of his/her medical records to the extent necessary in order to act upon enrollee's grievance or appeal and shall execute any necessary releases for such disclosure.

(14) Notwithstanding anything herein to the contrary, an enrollee shall have the right to request an expedited appeal to the organization that would not follow the standard time for appeals otherwise set forth in this rule, if following the standard time for appeal could reasonably be expected to seriously jeopardize the enrollee's life or health or the ability to attain, maintain or regain maximum function. The request may be filed orally or in writing after which no additional enrollee follow-up is required.

(a) When a request for expedited appeal is received the enrollee must be advised within 2 business days of receipt of the request whether such request is accepted or denied.

(b) If the expedited appeal is accepted, the enrollee must be advised within 2 business days of receipt of the request of the limited time available in such case for the enrollee to present evidence, present or question witnesses, present allegations of fact or law and to appear in person, writing or by telephone.

(c) In the case of an expedited appeal pursuant to this section an enrollee shall be advised of the decision on enrollee's appeal orally or in writing within 3 business days of receipt of the request for expedited appeal. Regardless of any written notice, reasonable efforts must be made to provide oral notice within 3 business days. Written confirmation of any oral notice shall be sent within an additional 2 business days.

(d) If the decision is made to deny an expedited appeal the enrollee shall be advised orally within twenty-four hours and also in writing within 2 business days of the request after which the standard review and appeals process outlined in this rule shall apply.

(e) The expedited appeal process may be extended by up to 14 calendar days if requested by the enrollee or if the organization shows to the satisfaction of the Medicaid Agency that there is need for additional information and how the delay is in the interest of the enrollee.

(f) If the extension requested by the organization is granted, the enrollee must be promptly notified in writing of the extension and the reason for the extension.

(g) The organization must ensure that punitive action by the organization is not taken against an enrollee or provider who requests an expedited resolution.

(15) (a) During each appeal provided for herein, the organization must continue the enrollee's covered benefits if:

- i. the enrollee files the notice of appeal timely;
- ii. the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
- iii. the services were ordered by an authorized provider;
- iv. the original period covered by the original authorization has not expired; and
- v. the enrollee requests extension of benefits.

(b) If, at the enrollee's request, the organization continues or reinstates the enrollee's benefits while the appeal is pending, the benefits must be continued until one of following occurs:

- i. the enrollee withdraws the appeal;
- ii. 10 calendar days pass after the organization mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10 calendar day timeframe, has requested an appeal and has requested a continuation of benefits until that decision is reached;
- iii. a State fair hearing Officer issues a hearing decision adverse to the enrollee; and
- iv. the time period or service limits of a previously authorized service has been met.

(c) If the final resolution of the appeal is adverse to the enrollee, that is, upholds the organization's action, the organization may recover from the enrollee the cost of the services furnished to the enrollee while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section, and in accordance with the policy set forth in 42 CFR § 431.230(b).

(d) Pursuant to 42 CFR 438.424(a), if services were not furnished to the enrollee while the appeal was pending and the decision to deny, limit or delay services is reversed, the organization must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.

(e) Pursuant to 42 CFR 438.424(b), the organization must pay for disputed services in accordance with State policy and regulations if the decision of the organization to deny authorization of services is reversed and the enrollee received the disputed services while the appeal was pending.

(16) The regional care organization shall maintain a grievance log and copies of all grievances and appeals filed by an enrollee pursuant to this rule, as well as all decisions rendered in response, for at least 7 years.

(a) The organization shall review the grievance log for completeness and accuracy regularly, but at least quarterly, and monitor the outcomes of such grievances and appeals as part of its quality assurance responsibility. The organization's grievance log shall set forth at a minimum the enrollee's name, the date and a description of each grievance and matter appealed; the basis for each grievance and appeal; the enrollee's provider for the service at issue, if any; whether continuation of benefits were requested and provided in each instance; the total number of grievances and appeals; the dates responses to the grievance or appeal were provided to the enrollee; the date of decision by the organization; and the outcomes of the grievance and appeals.

(b) The organization shall file a report at least annually with the Medicaid Agency that fairly and accurately summarizes the information required to be set forth on the grievance log.

(c) The Medicaid Agency shall be entitled to review all documents in the possession of the organization related to such grievances and appeals as a means of monitoring quality of care and the effectiveness of the policies and procedures of the organization in responding to enrollee grievances and appeals.

(17) Notwithstanding any provisions of this rule to the contrary, an organization shall be governed by grievance system regulations which may be found in their entirety in 42 CFR Section 438 Subpart F which are hereby incorporated by reference and made a part of this rule as if set out in full and all provisions thereof are adopted as rules of the Medicaid Agency. In addition, the Medicaid Agency may impose additional requirements for the grievance and appeal system in the risk contract executed with any organization.

(18) Should the Medicaid Agency reasonably conclude from the information provided that an organization has not established, maintained and enforced a grievance system that satisfies the provisions of this rule and Section 22-6-153(d), the Medicaid Agency shall require the organization to immediately take appropriate corrective action. Failure to take appropriate corrective action after a reasonable opportunity to cure can lead to action brought by the Medicaid Agency against the organization, including but not limited to suspension or termination of its certificate as a regional care organization.

(19) In the event of any conflict or discrepancy between the provisions of this rule and the hearing rules set forth in Medicaid Administrative Rules 560-X-3-.01 through 560-X-3-.07, this rule shall control and the conflicting provisions of the other stated rules shall not apply.

**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 431.

**History:** New Rule: Filed February 19, 2015.