Issue Date: 02/14

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SUBJECT	CHAPTER	SECTION	SUBJECT
Enrollee Rights and Information Requirements	07	01	02

CHAPTER	SECTION
Rights of Persons Served	Individual Rights

WRITTEN BY	REVIEWED BY	AUTHORIZED BY
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I. APPLICATION:

☐ PIHP Board ☒ CMH Providers ☒ SUD Providers
☒ PIHP Staff ☒ CMH Subcontractors

II. POLICY STATEMENT:

It shall be the policy of Region 10 that its provider network complies with all applicable Federal and State laws pertaining to enrollee information rights; and to develop policies and mechanisms that ensure its staff, and affiliated providers take those rights into account when furnishing services to all Medicaid beneficiaries.

III. DEFINITIONS:

Appeal: A review of an adverse benefit determination.

Beneficiary: An individual who is eligible for and enrolled in the Medicaid program in Michigan.

Enrollee: A Medicaid beneficiary who is currently enrolled in a Prepaid Inpatient Health Plan (PIHP).

Grievance: Expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships, such as rudeness, a provider, an employee, or failure to respects beneficiary's rights regardless of whether remedial actions are requested. Grievance includes a beneficiary's right to dispute an extension of time proposed by the PIHP or provider to make an authorized decision.

State Fair Hearing: A State level review of beneficiaries' disagreements with a PIHP or Network Provider denial, reduction, suspension, or termination of Medicaid services. State administrative law judges, who are independent of the MDHHS, perform the reviews.

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IV. **STANDARDS:**

A. The PIHP and all Network Providers shall ensure each enrollee is entitled to and receives the informational requirements guaranteed by 42 CFR 438.10 and enrollee rights guaranteed by 42 CFR 438.100.
B. The PIHP and its Network Providers, utilizing existing policy development and review protocols, will develop new and revise existing policies related to enrollee rights and information rights as called for by federal and state law and regulation.
C. The PIHP and its Network Providers have responsibilities for the informational requirements guaranteed by 42 CFR 438.10 and enrollee rights guaranteed by 42 CFR 438.100.

V. **PROCEDURES:** N/A

VI. **EXHIBITS**:

A. Information Requirements from Code of Federal Regulations (42 CFR 438.10)
B. Enrollee Rights from Code of Federal Regulations (42 CFR 438.100)

VII. **REFERENCES**:

(42 CFR 438.10) Information Requirements
(42 CFR 438.100) Enrollee Rights
MDHHS/PIHP Contract
MDHHS Customer Service Standards Policy

MEDICAID INFORMATON REQUIREMENTS
FROM CODE OF FEDERAL REGULATIONS (42 CFR 438.10)

The PIHP, or as delegated to any subcontract affiliate provider, shall:

1. For consistency in the information provided to enrollees, the State must develop and require each PIHP and its Provider Network to use:
   a) Definitions for managed care terminology, including Adverse Benefit Determination (ABD), amount, duration, scope and frequency, appeal, behavioral health, co-payment excluded services, durable medical equipment, emergency medical condition, emergency medical transportation, emergency room care, emergency services, excluded services, Flint 1115 Demonstration Waiver, grievance, grievance and appeal system, habilitation services and devices, health insurance, Healthy Michigan, home health care, hospice services, hospitalization, hospital outpatient care, Intellectual Development Disability, Limited English Proficiency (LEP),Michigan Department of Health and Human Services (MDHHS), medically necessary, network, non-participating provider, participating provider, physician services, plan, Prepaid Inpatient Health Plan (PIHP), preauthorization, participating provider, premium, prescription drug coverage, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services and devices, skilled nursing care, specialist, State Fair Hearing, and urgent care; and
   b) Model enrollee handbooks and enrollee notices.

2. The PIHP and its Provider Network shall ensure the required information in 42 CFR 438.10 is provided to each enrollee.

3. The PIHP and its Provider Network shall ensure Enrollee information required may not be provided electronically unless all the following are met:
   a) The format is readily accessible;
   b) The information is placed in a location on the PIHP's website that is prominent and readily accessible;
   c) The information is provided in an electronic form which can be electronically retained and printed;
   d) The information is consistent with the content and language requirements42 CFR 438.10; and
   e) The enrollee is informed that the information is available in paper form without charge upon request and provides it upon request within 5 business days.

4. The PIHP and its Provider Network shall have in place mechanisms to help Enrollees and potential Enrollees understand the requirements and benefits of the plan.
   a) Establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the PIHP service area;
   b) Make oral interpretation available in all languages and written translation in each prevalent non-English language. Written materials that are critical to obtaining services for potential enrollees must include taglines in the prevalent non-English languages in the State, explaining the availability of written translations or oral interpretation to understand the information provided, information on how to

request auxiliary aids and services, and the toll-free number of the entity providing choice counseling services as required by 438.71(a). Taglines for written materials critical to obtaining services must be printed in a conspicuously visible font size.

c) Make its written materials that are critical to obtaining services, including, at a minimum, provider directories, enrollee handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non-English languages in its particular service area. Written materials that are critical to obtaining services must also be made available in alternative formats upon request of the potential enrollee or enrollee at no cost, include taglines in the prevalent non-English languages as well as large print in the State and in a conspicuously visible font size explaining availability of written translation or oral interpretation to understand the information provided, information on how to request auxiliary aids and services and include the toll-free and TTY/TDY telephone number of the PIHP Provider Network entity's member/customer service unit. Auxiliary aids and services must also be made available upon request of the potential enrollee or enrollee at no cost.

d) Make interpretation services available to each potential Enrollee and require the PIHP and Provider Network to make those services available free of charge to each enrollee. This includes oral interpretation and the use of auxiliary aids such as TTY/TDY and American Sign Language. Oral interpretation requirements apply to all non-English languages, not just those that the State identifies as prevalent. This includes interpretation services for deaf, hard of hearing and deaf/blind populations in accordance with the Michigan Department of Civil Rights Division on Deaf, Deaf Blind and Hard of Hearing Qualified Interpreter-General Rules.

e) Notify potential enrollees, and require the PIHP Provider Network to notify its enrollees:

    i. That oral interpretation is available for any language and written translation is available prevalent languages;

    ii. That auxiliary aids and services are available upon request and at no cost for enrollees with disabilities; and

    iii. How to access these services.

f) The PIHP and its Provider Network provides all written materials for potential enrollees and Enrollees consistent with the following;

    i. All materials must be in an easily understood language and format and use a font size no smaller than 12 point.

    ii. All such materials must be written at or below the 6.9 grade reading level when possible (i.e., in some situations it is necessary to include medications, diagnosis and conditions that do not meet the 6.9 grade level criteria).

    iii. All materials shall be available in the languages appropriate to the people served within the PIHP's area for specific Non-English Language

that is spoken as the primary language by more than 5% of the population in the PIHP Region. Such materials must be available in any language alternative to English as required by the Limited English Proficiency Policy Guidance (Executive Order 13166 of August 11, 2000, Federal Register Vol. 65, August 16, 2000). All such materials must be available in alternative formats in accordance with the Americans with Disabilities Act (ADA), at no cost to the beneficiary. Beneficiaries must be informed of how to access the alternative formats.

iv. Material must not contain false, confusing, and/or misleading information.

v. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of enrollees or potential enrollees with disabilities or limited English proficiency.

5. The PIHP must provide the information specified in this section to each potential enrollee, either in paper or electronic form as follows:
   a) At the time the potential enrollee first becomes eligible to enroll in a voluntary managed care program, or is first required to enroll in a mandatory managed care program; and
   b) Within a timeframe that enables the potential enrollee to use the information in choosing among available MCOs, PIHPs, PAHPs, PCCMs, or PCCM entities.
   c) The information for potential enrollees must include, at a minimum, all of the following:
      i. Information about the potential enrollee's right to disenroll consistent with the requirements of § 438.56 and which explains clearly the process for exercising this disenrollment right, as well as the alternatives available to the potential enrollee based on their specific circumstance;
      ii. The basic features of managed care;
      iii. Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program. For mandatory and voluntary populations, the length of the enrollment period and all disenrollment opportunities available to the enrollee must also be specified;
      iv. The service area covered by the PIHP
      v. Covered benefits including all requirements of 42 CFR 438.10(e)(2)(v).
      vi. The provider directory and formulary information required in 42 CFR 438.10(h) and 42 CFR 438.10(i).
      vii. Any cost-sharing that will be imposed by the PIHP consistent with those set forth in the State plan;

viii. The requirements for each the PIHP to provide adequate access to covered services, including the network adequacy standards established in § 438.68;

ix. The PIHP's responsibilities for coordination of enrollee care; and to the extent available, quality and performance indicators for each the PIHP, including enrollee satisfaction.

6. The PIHP and its Provider Network must make a good faith effort to give written notice of termination of a contracted provider to each enrollee who received his or her primary care from, or was on a regular basis by, the terminated provider. Notice to the enrollee must be provided by the later of 30 calendar days prior to the effective date of the termination, or 15 calendar days after receipt or issuance of the termination notice.

7. The PIHP and its Provider Network provide each enrollee and enrollee handbook, five (5) business days after receiving notice of the beneficiary's enrollment or after receiving a request for an enrollee handbook (Note: see PIHP Customer Service policy for all handbook distribution requirements).

8. The content of the enrollee handbook must include information that enables the enrollee to understand how to effectively use the managed care program. This information must include at a minimum:
   a) Benefits provided by the PIHP and its Provider Network;
   b) How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided;
   c) The amount, duration, and scope of benefits available under the contract in sufficient detail to ensure that enrollees understand the benefits to which they are entitled.
   d) Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.
   e) The extent to which, and how, after-hours and emergency coverage are provided including:
      i. What constitutes an emergency medical condition and emergency services.
      ii. The fact that prior authorization is not required for emergency services.
      iii. The fact that the enrollee has a right to use any hospital or other setting for emergency care.
   f) Any restrictions on the enrollee's freedom of choice among network providers.
   g) The extent to which, and how, enrollees may obtain benefits, including family

planning services and supplies form out-of-network providers.

h) Cost sharing, if any is imposed under the State plan.

i) Enrollee rights and responsibilities, including the elements specified in 438.100.

j) The process of selecting and changing the enrollee's primary care provider.

k) Grievance, appeal, and fair hearing procedures and timeframes, consistent with subpart F of this part, in a State-developed or State-approved description. Such information must include:

   i. The right to file grievances and appeals;

   ii. The requirements and timeframes for filing a grievance or appeal;

   iii. The availability of assistance in the filing process;

   iv. The right to request a State fair hearing after the PIHP has made a determination on an enrollee's appeal which is adverse to the enrollee; and

   v. The fact that, when requested by the enrollee, benefits that the PIHP seeks to reduce or terminate will continue if the enrollee files an appeal or a request for State fair hearing within the timeframes specified for filing, and that the enrollee may, consistent with MDHHS policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the enrollee.

l) How to exercise an advance directive; and as set forth in § 438.3(j),including written information on advance directives policies, and a description of applicable State law

m) How to access auxiliary aids and services, including additional information in alternative formats or languages.

n) The toll-free telephone number for member services, medical management, and any other unit providing services directly to enrollees, including what are customer services and what it can do for the individual; hours of operation; and process for obtaining customer assistance after hours

o) Information on how to report suspected fraud or abuse;

p) Any other content required by the MDHHS.

q) Information required by 42 CFR 438.10 (g)(member handbook) is considered to be provided by the PIHP if the PIHP:

   i. Mails a printed copy of the information to the enrollee's mailing address;

   ii. Provides the information by email after obtaining the enrollee's agreement to receive the information by email;

   iii. Posts the information on the Web site of the PIHP, and advises the enrollee in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that enrollees with disabilities who cannot access this information online are

provided auxiliary aids and services upon request at no cost; or
Provides the information by any other method that can reasonably be expected to result in the enrollee receiving that information.

9. The PIHP and its Provider Network must give each enrollee notice of any change that MDHHS defines as significant at least 30 days before the intended effective date of the change.

10. The PIHP and its CMH Provider Network must make available in paper form upon request and electronic form, the following information about its network providers:
    a) The provider's name as well as any group affiliation.
    b) Street address(es).
    c) Telephone number(s).
    d) Web site URL, as appropriate.
    e) Specialty, as appropriate.
    f) Whether the provider will accept new enrollees.
    g) The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office.
    h) Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

11. The provider directory must include the information in 42 CFR 438.10 (h)(1) for each of the following provider types covered under the contract:
    a) Physicians, including specialists;
    b) Hospitals;
    c) Pharmacies;
    d) Behavioral health providers;
    e) LTSS providers, as appropriate;
    f) Independent facilitators and fiscal intermediary's;
    g) Medical suppliers; and
    h) Ancillary health providers.

12. Information included in a paper provider directory must be updated at least –
    a) Monthly, if the PIHP or its CMH Provider Network does not have a mobile-enabled, electronic directory; or
    b) Quarterly, if the PIHP or its CMH Provider Network has a mobile-enabled, electronic provider directory.

i. An electronic provider directory must be updated no later than 30 calendar days after the PIHP or its CMH Provider Network receives updated provider information.

13. Provider directories must be made available on the PIHP and its CMH Provider Network's Web site in a machine-readable file and format as specified by the Secretary.

14. The PIHP must make available, upon request any physician incentive plans in place as set forth in 42 CFR 438.3(i).

ENROLLEE RIGHTS
FROM CODE OF FEDERAL REGULATIONS (42 CFR 438.100)

1. The PIHP and its Provider Network must ensure that:
   a) Has written policies regarding the enrollee rights; and
   b) Complies with any applicable Federal and State laws that pertain to enrollee rights and ensures that its employees and contracted providers observe and protect those rights.

2. The PIHP and its Provider Network shall ensure that each Enrollee has the right to the following;
   a) Receive information in accordance with 438.10;
   b) Be treated with respect and with due consideration for his or her dignity and privacy;
   c) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in §438.10(g)(2)(ii)(A) and (B).);
   d) Participate in decisions regarding his or health care, including the right to refuse treatment;
   e) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other Federal regulations on the use of restraints and seclusion;
   f) If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526;
   g) The right to be furnished health care services in accordance with 438.206 through 438.210; and
   h) Free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the PIHP, and its Provider Network treat the Enrollee.

3. The PIHP and its Provider Network shall ensure compliance with any other applicable Federal and State laws (including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91; the Rehabilitation Act of 1973; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.

4. The PIHP and its affiliated providers, utilizing existing policy development and review protocols, will develop new and revise existing policies related to enrollee information rights as called for by Federal and State law and regulation.