Government Business Division
Policies and Procedures

Section (Primary Department) **Quality Management**		**SUBJECT (Document Title)** **Member Rights and Responsibilities - CA**	
Effective Date 09/11/2014	**Date of Last Review** 04/01/2024	**Date of Last Revision** 07/19/2023	**Dept. Approval Date** 04/01/2024
Department Approval/Signature:			

Policy applies to health plans operating in the following State(s). Applicable products noted below.

Products				
☒ **Medicaid/CHIP**	☐ Arkansas	☐ Iowa	☐ Nevada	☐ Tennessee
☐ **Medicare/SNP**	☒ California	☐ Kentucky	☐ New Jersey	☐ Texas
☐ **MMP/Duals**	☐ Colorado	☐ Louisiana	☐ New York	☐ Virginia
	☐ District of Columbia	☐ Maryland	☐ New York (WNY)	☐ Washington
	☐ Florida	☐ Minnesota	☐ North Carolina	☐ West Virginia
	☐ Georgia	☐ Missouri	☐ Ohio	☐ Wisconsin
	☐ Indiana	☐ Nebraska	☐ South Carolina	

POLICY:

Anthem Blue Cross Medicaid (Plan) shall maintain written policies and procedures that set forth the Member's rights and responsibilities and shall communicate its policies to its Members and Providers, and upon request, to potential Members.

The rights and responsibilities of the Medicaid enrollees participating in Anthem Blue Cross are published in the Member Handbook also called the Combined Evidence of Coverage (EOC) and Disclosure Form/Member Handbook. The Member Handbook/EOC is available online at the member and provider websites, respectively. The plan distributes member materials according to contract requirements.

DEFINITIONS:

None

PROCEDURE:

The following information regarding member's rights and responsibilities is included in the Member Handbook also called the Combined Evidence of Coverage (EOC) and Disclosure Form/Member Handbook which is sent to Members as part of the new member Welcome Kit and is also available to Members on the Anthem Blue Cross Medicaid Member website. This information is also available for Providers in the Provider Manual as published on the Anthem Blue Cross Medicaid Provider website.

Anthem Blue Cross Medicaid Members have the right:

- To be treated with respect, and dignity, giving due consideration to your right to privacy and the need to maintain confidentiality of your Protected Health Information (PHI) and Private Information (PI).
- To receive information about the Plan, and all services available, its practitioners and providers and member rights and responsibilities.

- To be able to choose a Primary Care Provider (PCP) within the Plan's network unless the PCP is unavailable or is not accepting new patients.
- To participate in decision making regarding your health care, including the right to refuse treatment.
- To submit Grievances, either verbally or in writing, about the Plan and/or network Providers, care received, and any other expression of dissatisfaction not related to an Adverse Benefit Determination.
- To request an Appeal of an Adverse Benefit Determination within 60 calendar days from the Notice of Adverse Benefit Determination (NABD) and how to continue benefits during the in-plan appeal process through the State Fair Hearing, when applicable.
- To request a State Fair Hearing, including information on circumstances under which an expedited State Fair Hearing is available.
- To receive interpretation services and written translation of critical informing materials in their preferred threshold language, including oral interpretation and American Sign Language.
- To have a valid Advance Directive in place, and to an explanation on what an Advance Directive is.
- To make recommendations regarding the organization's member rights and responsibilities policy.
- To have access to family planning services and sexually transmitted disease services, from a Provider of your choice, without referral or Prior Authorization, either in or outside of the Plan's Network. To have Emergency Services provided in or outside of the Plan's Network, as required pursuant to federal law
- To have access to Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and Indian Health Service (HIS) Programs outside of the Plan's Network, pursuant to federal law.
- To have access to, and receive a copy of your Medical Records, and request that they be amended or corrected, as specified in 45 CFR sections 164.524 and 164.526.
- To change Medi-Cal managed plans upon request, if applicable.
- To access Minor Consent Services
- To receive written Member informing materials in alternative formats, including Braille, large size print no small than 20 point font, accessible electronic format, and audit format, upon request and in accordance with 45 CRF sections 84.52(d), 92.102, and 438.10.
- To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- To receive information on available treatment options and alternatives, presented in a manner appropriate for your condition and ability to understand available treatment options and alternatives.
- To have a candid discussion of appropriate or medically necessary treatment options for their conditions, regardless of cost or benefit coverage.
- To freely exercise these rights without retaliation or any adverse conduct by the Plan, Subcontractors, Downstream Subcontractors, Network Providers, or the State.

Anthem Blue Cross Medicaid Members have the responsibility:

- To contact your PCP right away to schedule an Initial Health Appointment (within 120 days of enrollment) for you or your child.
- To give us, your doctors, and other health care providers the information needed to help you receive the best possible care and all the benefits you are entitled to.
- To understand your health problems as well as you can and work with your doctors or other health care providers to make a treatment plan that you all agree on.
- To follow the care plan that you have agreed on with your doctors and other health care providers.
- To follow your doctor's advice about taking good care of yourself.
- To use the right sources of care.
- To bring your Anthem ID card with you when you visit your doctor.
- To treat your doctors and other caregivers with respect.
- To understand this health plan.
- To know and follow the rules of this health plan.
- To know that laws govern this health plan and the types of service you receive.
- To know that we cannot discriminate against you because of your age, sex, race, national origin, culture, language needs, sexual orientation, or health.

REFERENCES:

- 45 CFR Sections 164.524 and 164.526
- 45 CFR Sections 84.52(d), 92.102, and 438.10
- Anthem Blue Cross Medicaid Member Handbook aka Evidence of Coverage (EOC)
- Anthem Blue Cross Medicaid Provider Manual
- Civil Code Section 1798 *et seq.*
- DHCS Contract Exhibit A, Attachment III, Section 5.1.1.A Member's Rights and Responsibilities
- L.A. Care Health Plan Service Agreement
- NCQA Standards and Guidelines for the Accreditation of Health Plans

RESPONSIBLE DEPARTMENTS:

Primary Department:
Quality Management

Secondary Department(s):
CA Medicaid Quality and Accreditation
Marketing
Medicaid Compliance

EXCEPTIONS:

None

REVISION HISTORY:

Review Date	Changes
06/18/12	• Revised last review/revision date • Changed all references to "Anthem Blue Cross Partnership Plan (Anthem)" to read "Anthem Medicaid (Anthem)" • Added a statement that the Member Rights and Responsibilities appear on the member website
06/05/13	• Revised last review/revision date • Revised content to reflect language appearing in the revised Medi-Cal EOC recently approved by DHCS and DMHC
05/14/14	• Updated NCQA Standards Reference
11/12/15	• Annual review by PPOC and QIC. • Updated Organization's member rights and responsibilities and member responsibilities • No changes to CA Medi-Cal-specific content
10/18/16	• Annual review - Retired combined Member Rights & Responsibilities policy that had included CA, IN, WI & WV and created California plan specific policy • Minor editing changes to CA plans messaging
09/27/17	• Annual review • Revised Anthem Medi-Cal rights and responsibilities sections • Removed MCAP language
09/06/18	• Annual review • Revised/re-organized Procedure section
09/03/19	• Annual Review • Small change to procedure
08/24/20	• Annual Review • Updated the procedure • Update Rights and Responsibilities to align with Member Handbook and Evidence of Coverage
11/17/20	• Off-Cycle Review • Procedure updated • Addition of new language to Member Rights and Responsibilities
06/07/21	• Early Annual Review; no changes
05/09/22	• Annual Review • Changed owner from Clinical Quality Management to Quality

Section (Primary Department)	**SUBJECT (Document Title)**
Clinical Quality Management	**Member Rights and Responsibilities - CA**

Review Date	Changes
	Management • Revised naming in "Policy" section to align with Member Handbook naming referenced • Revised naming in "Procedure" section to align with Member Handbook naming referenced • Members Rights Section: Per Medicaid Compliance "change P&P bullets to exactly match Member Handbook bullets" • Members Responsibility Section: Per Medicaid Compliance "change P&P bullets to exactly match Member Handbook bullets" • Marketing added as Secondary Owner (Marketing owns the Member Handbook that requires DHCS approval and ensures the Members Rights & Responsibilities published in the Handbook are in compliance with DHCS contract. Marketing to verify that Member Rights & Responsibilities in this P&P are aligned with the current, DHCS approved, Member Handbook.)
04/10/23	• Annual Review • Updated GBD Template to match current version • Minor update to Policy section • Updated Procedure section to match the 2023 Anthem Blue Cross Medicaid Member Handbook published on the Member Portal • Updated References section
07/19/23	• Off-Cycle Review • Updated policy content to comply with DHCS 2024 Contract Readiness, Artifact R.0153 • Updated Policy and Procedure sections • Revised entire Member's Rights section to align with DHCS 2024 Contract Requirements (Exhibit A, Attachment III, Section 5.1.1.A – Member Rights and Responsibilities), with the exception of all NCQA required language that must remain. • Updated References section to include correct CFR references, Provider Manual, update DHCS contract information, and Civil Code. • Added CA Medicaid Quality and Accreditation as a secondary department
04/01/24	• Annual Review – no changes