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# Internal and External Review in Medi-Cal Managed Care Plans

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## Introduction

Federal and state law and the state and federal Constitutions require that enrollees in Medi-Cal managed care plans receive notice, and grievance and appeal rights when they are denied access to medically necessary services. Frequently, however, enrollees fail to receive the required notice, get an inadequate notice, or do not understand their right to appeal the plan's decision.

Medi-Cal managed care plans are subject to federal and state laws enforced by several state and federal regulators.<sup>1</sup> Medi-Cal plans are regulated by the federal Centers for Medicare and Medicaid Services (CMS) and the California Department of Health Care Services (DHCS). Most—but not all—Medi-Cal managed care plans are also licensed by the California Department of Managed Health Care (DMHC) and are subject to a set of consumer protection laws called the "California Knox-Keene Act" (KKA).<sup>2</sup> Certain other Medi-Cal plans – called County Organized Health System (COHS) plans –are exempt from DMHC licensure.<sup>3</sup> This issue brief will provide an overview of the rules and processes that apply to all Medi-Cal plans, as well as the additional protections that apply to DMHC-licensed plans.

## I. Medi-Cal Managed Care Rules

All Medi-Cal managed care plans are subject to federal and state Medicaid laws regarding notice and appeal rights. These federal rules were updated effective July 1, 2017.<sup>4</sup> In addition, certain provisions of the KKA apply to all Medi-Cal managed care plans, regardless of whether they are DMHC-licensed. This section provides an overview of the requirements that apply to all Medi-Cal plans.

### **a. Notice**

Medi-Cal managed care plans must provide written notice before taking an “adverse benefit determination” to deny, delay, or modify of all or part of a requested service, or reduce, suspend, or terminate an existing service.<sup>5</sup> A Medi-Cal plan must provide notice concerning an adverse benefit determination to reduce, suspend, or terminate an existing service at least 10 days in advance.<sup>6</sup> The written notice to enrollees provided by Medi-Cal plans must explain what adverse benefit determination the plan is taking and why, and must also inform the enrollee about his or her rights including: the right to a grievance and how to file one, the right to a fair hearing and how to request one, the right to continue benefits pending the appeal and how to exercise that right, and the circumstances in which the enrollee has a right to expedited review and how to request it.<sup>7</sup> Notices must be translated in prevalent non-English languages, and oral interpretation must be available in all languages upon request.<sup>8</sup>

### **b. Continuing benefits**

In cases where a Medi-Cal plan proposes to reduce, suspend, or terminate an enrollee’s current services, the enrollee is entitled to continue receiving those services while she appeals the decision.<sup>9</sup> If an enrollee or her representative requests continued benefits when filing an internal grievance within 10 days from the date of the notice or before the date of the proposed adverse benefit determination, the plan must continue benefits until the authorization period expires or the internal grievance is resolved, whichever is first.<sup>10</sup> Similarly, if the enrollee requests continued benefits when requesting a fair hearing within 10 days from the date of the notice or before the date of the proposed adverse benefit determination, the plan must continue benefits until the authorization period expires or the fair hearing is resolved, whichever is first.<sup>11</sup> If an enrollee requests continuing benefits pending an internal grievance (but does not request a fair hearing), and the internal grievance is not resolved in her favor, she must request a fair hearing with continuing benefits within 10 days of notice of the internal grievance decision or before the effective date of the proposed adverse benefit determination, in order to continue those benefits pending the fair hearing resolution.<sup>12</sup>

In certain instances where an enrollee has previously received a service, and the treating provider requests reauthorization of the service but the plan denies the request, the enrollee has the right to continue benefits pending appeal. If the enrollee requests to continue benefits within 10 days of the date of the notice or before the effective date of the proposed adverse benefit determination, the plan must continue benefits until the enrollee withdraws the appeal or fair hearing request, the enrollee does not request a state fair hearing within 10 calendar days after the health plan sends notification of its adverse resolution of the appeal, or the state fair hearing is decided against the enrollee.<sup>13</sup> Enrollees have the right to continue benefits when a plan denies or modifies a reauthorization request for hospitalizations, long-term care, hospice care, community based waiver services, and supplemental nursing services for children.<sup>14</sup> Enrollees may also request to continue benefits for any other previously

authorized service as long as the treating doctor substantiates that services should continue because the treatment goal of the original authorization request has not been met.<sup>15</sup>

### ***c. Internal Review***

In Medi-Cal, plans are required to offer two separate tracks for internal plan grievances: one to resolve grievances related to “adverse benefit determinations” (i.e. to deny, delay, or modify of all or part of a requested service, or reduce or terminate an existing service), and one to resolve any other enrollee complaints that do not qualify as an adverse benefit determination.<sup>16</sup> Medi-Cal plan enrollees must file any plan grievances related to an adverse benefit determination within 60 days in accordance with federal Medicaid law; however, Medi-Cal plan enrollees may file a plan grievance on any other complaints (i.e. non-adverse benefit determinations) at any time after the incident.<sup>17</sup> In most cases, enrollees must exhaust the plan’s internal grievance process before they may request a fair hearing or other types of external review (see below).<sup>18</sup> By contract, Medi-Cal plans’ internal grievance processes must meet the KKA requirements to which DMHC-licensed plans are held, as well as additional requirements imposed by federal and state Medicaid rules.<sup>19</sup>

When a plan delays, denies, reduces, modifies, suspends, or terminates a service, it must inform the enrollee about the right to file an internal grievance on the written notice of the adverse benefit determination.<sup>20</sup> Plans must provide forms and a toll-free number through which enrollees can file a grievance.<sup>21</sup> Plans must help enrollees to file a grievance when necessary, including by providing language assistance and reasonable accommodations for enrollees with disabilities.<sup>22</sup> When an enrollee files a grievance, the plan must acknowledge the receipt of most internal grievances within five days.<sup>23</sup> Enrollees may file a grievance for any reason, and they may authorize an advocate or provider to assist them in the process.<sup>24</sup>

Medi-Cal plans must ordinarily resolve all internal grievances within 30 days.<sup>25</sup> Plans must, however, resolve an internal grievance within three days when it involves an “imminent and serious threat” to the enrollee’s health.<sup>26</sup> For all internal grievances, a Medi-Cal plan must ensure that the person who makes the decision resolving the internal grievance: (1) has the ability to require corrective action, (2) was not involved in any prior decisions on the case, (3) has appropriate clinical expertise, and (4) will take into account all information submitted by the enrollee whether or not it was previously submitted or considered.<sup>27</sup> In cases involving an adverse benefit determination, the Medi-Cal plan must allow the enrollee to present evidence and allegations in person and in writing, and allow the enrollee or her representative to examine any case records.<sup>28</sup>

For Medi-Cal plans, when an internal grievance involving an adverse benefit determination is resolved, the plan must provide written notice that explains the resolution, the reason for the resolution and the notice date.<sup>29</sup> If an internal grievance involves medical necessity or coverage of a service, the plan must explain the criteria used to reach its decision, including any clinical criteria, if applicable.<sup>30</sup> If the internal grievance is not completely resolved in an enrollee’s favor, the notice must explain that the enrollee has the right to appeal to a state fair hearing, and must explain how to exercise that right.<sup>31</sup> In addition, the

Medi-Cal plan must explain that the enrollee has the right to continue benefits pending a fair hearing, and how to request continued benefits.<sup>32</sup> The Medi-Cal plan must also explain that if the enrollee continues benefits pending a hearing, she or he may be liable for cost of benefits if she or he does not ultimately succeed in the hearing.<sup>33</sup>

Medi-Cal plans must establish a process to monitor and track all internal grievances.<sup>34</sup> Plans must keep records of all internal grievances for five years, and make them available to DHCS for review.<sup>35</sup> Plans must designate an officer to oversee the internal grievance process.<sup>36</sup> Plans must report on internal grievances not resolved within 30 days on a quarterly basis.<sup>37</sup> In their reports, Medi-Cal plans must report the total number of internal grievances received; the average time taken to resolve internal grievances; a listing of the zip codes, ethnicity, gender, and primary language of enrollees who filed internal grievances; and the final outcome of all grievances received.<sup>38</sup> Medi-Cal plans must also identify the number of internal grievances filed in each of the following categories: untimely assignments to a provider, issues related to cultural and linguistic sensitivity, difficulty with accessing specialists, and grievances related to out-of-network request.<sup>39</sup> DHCS performs periodic review of Medi-Cal plans' internal grievance systems for compliance, and may assess penalties for plans' failure to comply.<sup>40</sup>

#### **d. Fair Hearing**

Medi-Cal enrollees always have the right to request a state fair hearing any time they are dissatisfied with their receipt of Medi-Cal.<sup>41</sup> When a Medi-Cal plan takes an "adverse benefit determination," enrollees must request a hearing within 120 days of the plan's notice upholding the adverse benefit determination in its internal grievance process.<sup>42</sup> That is, an enrollee must exhaust the plan-level appeal and can request a state fair hearing only after receiving notice that the adverse benefit determination has been upheld. There is a notable exception to the exhaustion requirement: If the Medi-Cal plan fails to adhere to the notice and timing requirements for adverse benefit determinations, the enrollee is deemed to have exhausted the in-plan appeal process and can immediately request an impartial state fair hearing.<sup>43</sup> The request can be made by an authorized representative.<sup>44</sup>

Fair hearings are heard by Administrative Law Judges (ALJs) employed by the state, who must be impartial.<sup>45</sup> The hearing must afford enrollees and their representatives the chance to present evidence and witnesses, cross-examine adverse witnesses, and examine their case files.<sup>46</sup> The adverse party (the state, the plan, or both) must provide a written statement of position, if any, at least two days in advance of the hearing.<sup>47</sup> The ALJ may request an independent medical evaluation if needed to make a decision on the case.<sup>48</sup> Hearings must ordinarily be resolved within 90 days.<sup>49</sup> Enrollees may request an expedited hearing if waiting 90 days would put the enrollee's health at risk; expedited hearings must be resolved within 3 business days, or sooner if required by the enrollee's health condition.<sup>50</sup> The final decision must summarize the facts, identify the regulations supporting the decision, inform the enrollee of the reason for the decision, and inform the enrollee of the right to request a rehearing or judicial review; it can only be based on evidence and law presented in the hearing.<sup>51</sup> The plan must implement any decisions favorable to the enrollee within 72 hours, or more quickly if required by the enrollee's

health.<sup>52</sup> If the decision is not favorable, the enrollee has 30 days to request a rehearing, which may be offered at the state's discretion.<sup>53</sup>

### **e. Medi-Cal Managed Care Ombudsman**

Medi-Cal managed care enrollees may also seek external review of any dispute with the Medi-Cal plan by complaining to the Medi-Cal Managed Care Ombudsman. The Ombudsman's responsibility is to "investigate[] and resolve[] complaints about managed care plans."<sup>54</sup> Existing law or regulation does not define the precise scope of the Ombudsman's jurisdiction, nor any timelines by which enrollees must avail themselves of the Ombudsman's assistance.

## **II. Additional Protections for Knox-Keene Licensed Plans**

The KKA places additional requirements on Medi-Cal plans licensed by DMHC.<sup>55</sup> DMHC-licensed Medi-Cal plans must comply with any requirements of the KKA that go beyond Medi-Cal requirements.

### **a. Notice**

In addition to providing written notice to enrollees when a DMHC-licensed plan denies, delays, or modifies all or part of a requested service, or reduces, suspends, or terminates an existing service, it must give the requesting provider an explanation of the reasons for the decision (including clinical reasons for cases concerning medical necessity) and the criteria used to reach the decision.<sup>56</sup> In addition, DMHC-licensed plans must provide notice more quickly in many instances: within 72 hours of a decision to approve, deny, or modify requested care for cases involving an imminent threat to health (or shorter if required by the insured's health); two business days for a decision to deny, delay, or modify a request for prior or concurrent authorization of a service; five business days for any other decision regarding prior authorization and concurrent claims (claims involving services the enrollee is currently receiving); and 30 days for post-service (reimbursement) claims.<sup>57</sup> For DMHC-licensed plans, notices are considered "vital documents" for the purposes of California's Language Access law, and must be translated into certain non-English languages for enrollees who have indicated that they prefer to receive information in those languages rather than English.<sup>58</sup>

### **b. Internal Review**

When a DMHC-licensed plan does not resolve an internal grievance involving a determination that a service is not medically necessary in the enrollees' favor, the plan must explain that the enrollee has the right to seek independent medical review.<sup>59</sup> Like DHCS, DMHC performs periodic review of their plans' internal grievance systems for compliance, and may assess penalties for plans' failure to comply.<sup>60</sup> For plans that are jointly regulated by DHCS and DMHC, the departments' practice is to coordinate this periodic review to the greatest extent possible.

### **c. External Review**

In addition to requesting a fair hearing or complaining to the Medi-Cal Ombudsman, enrollees in DMHC-licensed Medi-Cal plans may either request IMR or file a DMHC Complaint. Note that Medi-Cal plan enrollees may request a state fair hearing without using the other external review processes available, such as the IMR or DMHC Complaint process. Once a Medi-Cal plan enrollee has gone through the fair hearing process, however, she may no longer request IMR.<sup>61</sup>

IMR is available for enrollees in DMHC-licensed plans in three situations: (1) when the plan denies, terminates, reduces, modifies or delays health care services based on medical necessity, (2) when the plan denies reimbursement for emergency or urgent care claiming that no emergency or urgency existed, and (3) when an enrollee seeks treatment for a life-threatening or debilitating condition, and the plan denies the treatment sought as “experimental or investigational.”<sup>62</sup> Enrollees must generally pursue an internal plan grievance first, and may then request an IMR within six months of an unfavorable grievance decision.<sup>63</sup> When a grievance is not resolved within 30 days, the enrollee may also proceed to IMR. In expedited cases—those involving an “imminent and serious threat” to the enrollee’s health—enrollees need only participate in the grievance process for three days before proceeding to IMR, and at DMHC’s discretion, may forgo the grievance process all together.<sup>64</sup> In cases involving experimental or investigational treatment, enrollees need not file a grievance before seeking IMR.<sup>65</sup> Note that enrollees in DMHC-licensed Medi-Cal plans may not request IMR if they have already gone to a Medi-Cal fair hearing on the denial, modification or delay at issue.<sup>66</sup>

IMR is performed by independent medical professionals who are not connected to the plan.<sup>67</sup> Plans contract with an outside organization to perform the review, so the enrollee must consent to participating in the process and sharing his or her medical records with the outside review entity.<sup>68</sup> Plans bear the cost of the IMR, and may not charge the enrollee any fee for participating in the process.<sup>69</sup> The reviewers must be knowledgeable with respect to the treatment or proposed treatment at issue.<sup>70</sup> They are charged with reviewing all documents related to the denial, along with the enrollee’s medical records, relevant peer-reviewed scientific and medical evidence, national professional standards, expert opinion, and accepted standards of medical practice.<sup>71</sup> Enrollees may provide any information they deem relevant along with their request for IMR.<sup>72</sup> Enrollees may use an authorized representative to make the request.<sup>73</sup>

A standard IMR must be completed within 30 days of the review organization receiving all of the documents for review, and expedited review must be completed within three days.<sup>74</sup> The review organization must make a written decision, including an explanation of its decision in layperson’s terms, and provide it to Department, enrollee, and plan.<sup>75</sup> If the review organization finds favor of the enrollee, the Department must adopt its decision immediately and the plan must implement it within five days.<sup>76</sup> The odds of success favor enrollees: in 2016, 69% of IMRs filed with DMHC-licensed plans resulted in a favorable decision for the enrollee.<sup>77</sup>

DMHC's Consumer Complaints process provides external review of matters that are not eligible for IMR.<sup>78</sup> While there is nothing in the law that prohibits someone from seeking both IMR and a Consumer Complaint, in practice, these two options are usually offered as alternatives to each other. Similar to the process for an IMR, DMHC-licensed plan enrollees must generally pursue an internal grievance first, and may then file a Consumer Complaint after an unfavorable grievance decision, or after waiting 30 days for the plan to resolve an internal grievance.<sup>79</sup> In expedited cases—those involving an “imminent and serious threat” to the enrollee’s health—enrollees need only participate in the internal grievance process for three days before filing a Consumer Complaint, and, at DMHC’s discretion may forgo the grievance process all together.<sup>80</sup>

When it receives a Consumer Complaint, DMHC must analyze all documents from the enrollee and the plan and determine appropriate resolution, communicated to the enrollee in writing.<sup>81</sup> DMHC is charged with resolving Consumer Complaints within 30 days, and its written resolution must include an explanation of the Department’s findings and reasons for the decision, a summary of any discussion the Department undertook with any medical provider or independent expert (and that expert’s qualifications), and information about any corrective action taken.<sup>82</sup> For any Consumer Complaint that involves delayed, denied, terminated, reduced or modified medically necessary health care services that should have been covered, the plan must promptly provide or reimburse for the service.<sup>83</sup>

### III. Pursuing other legal remedies

Enrollees in Medi-Cal plans may also seek to enforce their rights in state or federal court. The Welfare and Institutions Code affirmatively grants enrollees the right to seek a writ of mandate under California Code of Civil Procedure § 1094.5 within one year of receiving an adverse fair hearing decision.<sup>84</sup> In some cases, enrollees may also be able to enforce violations of federal Medicaid law in federal court.<sup>85</sup> The Health and Safety Code provides that “the grievance or resolution procedures authorized by [DMHC] shall be in addition to any other procedures that may be available to any person, and failure to pursue, exhaust, or engage in the[se] procedures . . . shall not preclude the use of any other remedy provided by law.”<sup>86</sup> Thus, to the extent that an enrollee has a potential legal claim against the state or a plan, the enrollee is not required to exhaust the internal grievance or external appeals processes before going to court, but may have to complete a fair hearing.

## Conclusion

As more low-income Californians enroll in private managed care plans for the first time through Medi-Cal, consumer advocates must ensure that enrollees receive notice when services are denied, and that enrollees can exercise their right to contest adverse decisions by their health plans. Consumer advocates should work with DHCS, DMHC, and policymakers to monitor and enforce California’s strong consumer protections that aim to ensure access to services for managed care plan enrollees.



## ENDNOTES

<sup>1</sup> This paper will focus on the rules that apply to Medi-Cal managed care health plans. The same federal rules apply to County Mental Health Plans that provide specialty mental health services to Medi-Cal enrollees, but the KKA does not apply to Mental Health Plans. See 42 C.F.R. § 438.400; CAL. CODE REGS. tit. 9, §§ 1850.205-15.

<sup>2</sup> See generally CAL. HEALTH & SAFETY CODE §§ 1340-1399.818.

<sup>3</sup> CAL. WELF. & INST. CODE § 14087.95. Only Health Plan of San Mateo, a COHS, is KKA licensed. See CAL. HEALTH BENEFITS REV. PROG., THE CALIFORNIA COST AND COVERAGE MODEL, App'x 13 at 7 (2013), [http://www.chbrp.org/other\\_publications/docs/ap\\_13.pdf](http://www.chbrp.org/other_publications/docs/ap_13.pdf).

<sup>4</sup> See 42 C.F.R. § 438.400; see also Letter from Nathan Nau, Cal. Dep't of Health Care Services to All Medi-Cal Managed Care Health Plans (May 9, 2017) [hereinafter APL 17-006], <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf>.

<sup>5</sup> 42 C.F.R. § 438.404; APL 17-006, *supra* note 4, at 2. Previously, the rule used the term "action" to describe the event that triggered notice and appeal rights, but that term has been replaced with the phrase "adverse benefit determination," which is intended to align with terminology used in private insurance, and to capture a slightly broader array of circumstances. See JANE PERKINS, NAT'L HEALTH LAW PROG., MEDICAID MANAGED CARE FINAL REGULATIONS GRIEVANCE & APPEALS SYSTEMS 1-2 (2016), <http://www.healthlaw.org/publications/browse-all-publications/Brief-2-MMC-Final-Reg>. Thus, adverse benefit determination is a term of art in the federal Medicaid rules, defined in 42 C.F.R. § 438.400(b). An adverse benefit determination under the federal rules is: "(1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure of [a plan] to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; (6) For a resident of a rural area with only one [plan], the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network; or (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities." *Id.* Thus the rules go beyond instances where a service is delayed, reduced, modified, delayed, suspended, or terminated, though this paper focuses on those instances.

<sup>6</sup> 42 C.F.R. § 438.404(c)(1) (referencing *id.* § 431.211).

<sup>7</sup> *Id.*; APL 17-006, *supra* note 4, at 6-8; CAL. CODE REGS. tit. 22, § 51014.1; *id.* § 53894(a) (Two-plan county plans); *id.* § 53261(a) (all other plans); see also, e.g., CAL. DEP'T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR COHS COUNTIES, Ex. A, Att. 14 (2014) [hereafter COHS BOILERPLATE CONTRACT], <http://www.dhcs.ca.gov/provgovpart/Documents/COHSBoilerplate032014.pdf>; CAL. DEP'T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR GMC COUNTIES, Ex. A, Att. 14 (2014), <http://www.dhcs.ca.gov/provgovpart/Documents/GMCBoilerplate032014.pdf>; CAL. DEP'T OF HEALTH CARE SERVS., SAMPLE CONTRACT BOILERPLATE FOR IMPERIAL / REGIONAL / SAN BENITO / TWO-PLAN COUNTIES, Ex. A, Att. 14 (2014), <http://www.dhcs.ca.gov/provgovpart/Documents/ImpRegSB2PlanBp32014.pdf>. I will hereafter cite to the COHS contract, but provisions can generally be found in the same section of the other contracts.

<sup>8</sup> 42 C.F.R. § 438.10(d); APL 17-006, *supra* note 4, at 10, 19; see also CAL. CODE REGS. tit. 22, § 53876(a)(3) (Two-plan county plans); COHS BOILERPLATE CONTRACT at Ex. A, Att. 9.

<sup>9</sup> 42 C.F.R. §§ 431.230, 438.420(b); CAL. CODE REGS. tit. 22, § 51014.2; APL 17-006, *supra* note 4, at 9, 17.

<sup>10</sup> 42 C.F.R. § 438.420(b). These provisions are consistent with federal rules that only permit enrollees to continue benefits until the existing authorization period expires. See *id.* §§ 438.420(b)(4), (c)(4). The Health and Human Services Agency recently proposed to eliminate this limit. See 80 Fed. Reg. 31137-39. As described later in this section, California rules provide broader protections when the provider has requested reauthorization of a service. We are concerned, however, that plans are not appropriately applying those protections.

<sup>11</sup> *Id.*; see CAL. CODE REGS. tit. 22, § 51014.2.

<sup>12</sup> 42 C.F.R. § 438.420(c). Note that the California regulations only speak to continued benefits pending a fair hearing, not continued benefits pending a grievance; the California regulations do not reflect some changes to the



rules around continued benefits made in the new federal rules, but the federal rules control. *See* CAL. CODE REGS. tit. 22, § 51014.2. Also note that enrollees are not entitled to continue benefits pending IMR or a DMHC Consumer Complaint; thus enrollees may wish to request a fair hearing to ensure that benefits continue, even if they pursue another form of review.

<sup>13</sup> 42 C.F.R. § 438.420(b); CAL. CODE REGS. tit. 22, § 51014.2(d).

<sup>14</sup> CAL. CODE REGS. tit. 22, § 51014.2(d)...; *see also id.* § 51003(c)(1).

<sup>15</sup> *Id.* § 51003(c)(1)(E).

<sup>16</sup> In the federal rules, a grievance related to an adverse benefit determination is called an “appeal,” and all other complaints are called “grievances.” *See* 42 C.F.R. § 438.400; APL 17-006, *supra* note 4, at 3-4. This paper will follow the California convention of referring to both as grievances, but will note where different rules apply to grievances related to an adverse benefit determination versus a non-adverse benefit determination.

<sup>17</sup> *Compare id.* with 42 C.F.R. § 438.402(c)(2)(i)-(ii); COHS BOILERPLATE CONTRACT at Att. A, Ex. 14.

<sup>18</sup> 42 C.F.R. §§ 438.402(c)(1), 438.408(f)(d). Previously, California did not require enrollees to exhaust the plan’s internal process before requesting a fair hearing.

<sup>19</sup> *See* COHS BOILERPLATE CONTRACT at Att. A, Ex. 14 (incorporating KKA requirements against COHS plans).

<sup>20</sup> 42 C.F.R. § 438.404; CAL. CODE REGS. tit. 22, § 51014.1; *id.* § 53894(a) (Two-plan county plans); *id.* § 53261(a) (all other plans); COHS BOILERPLATE CONTRACT at Ex. A, Att. 14.

<sup>21</sup> COHS BOILERPLATE CONTRACT at Att. A, Ex. 14 (incorporating CAL. CODE REGS. tit. 28, §§ 1300.68(b)(4), (7)).

<sup>22</sup> *Id.* (incorporating CAL. CODE REGS. tit. 28, § 1300.68(b)(3)).

<sup>23</sup> *Id.* (incorporating CAL. CODE REGS. tit. 28, §§ 1300.68(d)(1), (8)).

<sup>24</sup> *Id.* (incorporating CAL. CODE REGS. tit. 28, §§ 1300.68(a)(1), (b)(6)).

<sup>25</sup> *Id.* (incorporating CAL. CODE REGS. tit. 28, § 1300.68(a)).

<sup>26</sup> *See id.* (incorporating CAL. HEALTH & SAFETY CODE § 1368.01(b) and CAL. CODE REGS. tit. 28, § 1300.68.01(a)); *see also* 42 C.F.R. § 438.410 (federal rule requiring Medicaid plans to “maintain an expedited review process . . . [for cases where] taking the time for a standard resolution could seriously jeopardize the enrollee’s life, physical or mental health, or ability to attain, maintain, or regain maximum function”).

<sup>27</sup> 42 C.F.R. § 438.406(b)(2); *see also* COHS BOILERPLATE CONTRACT at Att. A, Ex. 14 (requiring plans to abide by CAL. CODE REGS. tit. 28, § 1300.68(d)(2), which mandates that grievances be decided by management level staff responsible for the operations or services at issue).

<sup>28</sup> *Id.* § 438.406(b)(4)-(5).

<sup>29</sup> *Id.* § 438.408(e)(1); *see also* CAL. CODE REGS. tit. 22, § 53858(e)(5) (Two-plan county plans); COHS BOILERPLATE CONTRACT at Att. A, Ex. 14 (incorporating CAL. HEALTH & SAFETY CODE § 1368(a)(5) & CAL. CODE REGS. tit. 28, § 1300.68(d)(3)).

<sup>30</sup> COHS BOILERPLATE CONTRACT at Att. A, Ex. 14 (incorporating CAL. HEALTH & SAFETY CODE § 1368(a)(5) and CAL. CODE REGS. tit. 28, § 1300.68(d)(4)).

<sup>31</sup> 42 C.F.R. § 438.408(e)(2)(i); *see also* CAL. CODE REGS. tit. 22, § 53858(e)(5) (Two-plan county plans).

<sup>32</sup> 42 C.F.R. § 438.408(e)(2)(ii); *see also* CAL. CODE REGS. tit. 22, § 53858(e)(5) (Two-plan county plans).

<sup>33</sup> 42 C.F.R. § 438.408(e)(2)(iii).

<sup>34</sup> *See* CAL. CODE REGS. tit. 22, § 53858(e) (Two-plan county plans); *id.* § 53260 (all other plans); COHS BOILERPLATE CONTRACT at Ex. A, Att. 14 (incorporating CAL. HEALTH & SAFETY CODE § 1368(a)(4)(B) and CAL. CODE REGS. tit. 28, § 1300.68(e)).

<sup>35</sup> *See* CAL. CODE REGS. tit. 22, § 53858(h) (Two-plan county plans); COHS BOILERPLATE CONTRACT at Ex. A, Att. 14.

<sup>36</sup> COHS BOILERPLATE CONTRACT at Ex. A, Att. 14 (incorporating CAL. CODE REGS. tit. 28, § 1300.68(b)(1)).

<sup>37</sup> *Id.* (incorporating CAL. CODE REGS. tit. 28, § 1300.68(f) and CAL. HEALTH & SAFETY CODE § 1368(c)).

<sup>38</sup> *Id.*

<sup>39</sup> *Id.*; *see also* CAL. CODE REGS. tit. 22, § 53858(e)(3).

<sup>40</sup> *See* CAL. WELF. & INST. CODE § 14304 (Medi-Cal plans); CAL. CODE REGS. tit. 22, § 53872 (Two-plan county plans); COHS BOILERPLATE CONTRACT at Ex. E, Att. 2.

<sup>41</sup> CAL. WELF. & INST. CODE § 10950; *see also* CAL. CODE REGS. tit. 22, § 51014.1. Note that under federal Medicaid rules, fair hearings are limited to adverse “adverse benefit determinations,” which include a denial, delay, or

modification of all or part of a requested service, or reduction or termination an existing service. 42 C.F.R. §§ 438.408(f), 431.201, 431.220. California law permits enrollees to request hearings for a wider scope of service problems, which could potentially involve problems like a plan's not offering a provider of a needed service within the enrollee's geographic area.

<sup>42</sup> 42 C.F.R. § 438.408(f)(2); APL 17-006, *supra* note 4, at 17.

<sup>43</sup> 42 C.F.R. §§ 438.402(c)(1)(i)(A), 438.408(f)(1)(i) (called deemed exhaustion in the final rule and this issue brief).

<sup>44</sup> *Id.* § 431.201; CAL. WELF. & INST. CODE §§ 10950(a), 10951(a); Letter from Cal. Dep't of Health Care Services to All Medi-Cal Managed Care Health Plans 2 (Apr. 17, 2009),

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2009/PL09-006.PDF>. Note that despite the change to "adverse benefit determination" for most situations involving appeals as described above, some of the sources cited herein maintain the use of the word "action," which is also used elsewhere in the federal Medicaid regulations. We use the phrase "adverse benefit determination" throughout for the sake of consistency.

<sup>45</sup> CAL. WELF. & INST. CODE §§ 10953, 10955; *see also* 42 C.F.R. § 431.240(a)(3).

<sup>46</sup> 42 C.F.R. § 431.242; CAL. WELF. & INST. CODE §§ 10955, 10952.5.

<sup>47</sup> CAL. WELF. & INST. CODE § 10952.5.

<sup>48</sup> 42 C.F.R. § 431.240(b).

<sup>49</sup> 42 C.F.R. § 431.244(f)(1). The ALJ must submit a proposed decision to the Director of DHCS within 75 days, and the Director then has 30 days to adopt or alternate it. CAL. WELF. & INST. CODE §§ 10958, 10959.

<sup>50</sup> 42 C.F.R. § 431.244(f)(2); Letter from Cal. Dep't of Health Care Services to All Medi-Cal Managed Care Health Plans (Aug. 27, 2003),

<http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2003/MMCDAPLo3009.pdf>.

<sup>51</sup> 42 C.F.R. §§ 431.244, 431.245; CAL. WELF. & INST. CODE §§ 10958, 10958.1.

<sup>52</sup> 42 C.F.R. § 438.424; APL 17-006, *supra* note 4, at 17-18. Note that CAL. WELF. & INST. CODE § 10961 provides 30 days for compliance, but is superseded by the federal regulation and APL.

<sup>53</sup> CAL. WELF. & INST. CODE § 10960; *see also* CAL. CODE REGS. tit. 22, § 50953(c)(2).

<sup>54</sup> CAL. CODE REGS. tit. 22, § 53893(a).

<sup>55</sup> *See generally* CAL. HEALTH & SAFETY CODE §§ 1340-1399.818.

<sup>56</sup> *See id.* § 1367.01(h)(4).

<sup>57</sup> *See id.* § 1367.01(h).

<sup>58</sup> *See id.* § 1367.04; CAL. CODE REGS. tit. 28, § 1300.67.04.

<sup>59</sup> CAL. CODE REGS. tit. 28, § 1300.68(d)(4).

<sup>60</sup> *See* CAL. HEALTH & SAFETY CODE § 1368(b)(4).

<sup>61</sup> *See id.* § 1300.74.30(f)(3).

<sup>62</sup> *Id.* §§ 1370.4, 1374.30(j)(1).

<sup>63</sup> *Id.* §§ 1374.30(j)(3), (k). Note that, for ordinary grievances, plans may require enrollees to exhaust multiple levels of review in their grievance processes before proceeding to IMR, as long as all internal review is completed within 30 days. *See* CAL. CODE REGS. tit. 28, § 1300.68(a)(4)(A).

<sup>64</sup> CAL. HEALTH & SAFETY CODE §§ 1374.30(j)(3), 1374.31(a); CAL. CODE REGS. tit. 28, § 1300.74.30(b).

<sup>65</sup> CAL. HEALTH & SAFETY CODE § 1370.4.

<sup>66</sup> *See* CAL. CODE REGS. tit. 28, § 1300.74.30(f)(3).

<sup>67</sup> CAL. HEALTH & SAFETY CODE § 1374.32.

<sup>68</sup> *Id.* § 1374.30(m)(2).

<sup>69</sup> *Id.* § 1374.30(l).

<sup>70</sup> *Id.* § 1374.32(d)(4).

<sup>71</sup> *Id.* § 1374.33.

<sup>72</sup> *Id.* § 1374.30(m)(3).

<sup>73</sup> *See* CAL. CODE REGS. tit. 28, § 1300.74.30(e).

<sup>74</sup> CAL. HEALTH & SAFETY CODE § 1374.33(c).

<sup>75</sup> *Id.*

<sup>76</sup> *Id.* § 1374.34(a).

<sup>77</sup> CAL. DEP'T OF MANAGED HEALTH CARE, 2016 INDEPENDENT MEDICAL REVIEW SUMMARY REPORT OVERVIEW 7 (2017), <http://www.dmhca.ca.gov/Portals/0/FileAComplaint/DMHCDecisionsAndReports/AnnualComplaintAndIMRDecisions/2016.pdf>.

<sup>78</sup> *See* CAL. HEALTH & SAFETY CODE § 1368.02.

<sup>79</sup> *See id.* § 1368.03.

<sup>80</sup> *Id.* § 1368(b)(1)(A).

<sup>81</sup> *See id.* § 1368.02.

<sup>82</sup> *Id.* § 1368(b)(5).

<sup>83</sup> *Id.* § 1368(b)(6).

<sup>84</sup> CAL. WELF. & INST. CODE § 10962.

<sup>85</sup> Note, however, that enforceability of many provisions has been greatly curtailed by the federal courts. *See* JANE PERKINS, ISSUE BRIEF: UPDATE ON PRIVATE ENFORCEMENT OF THE MEDICAID ACT: THE SUPREMACY CLAUSE AND 42 U.S.C. § 1983 (2016), <http://www.healthlaw.org/issues/medicaid/private-enforcement>; *see also* Jane Perkins, *Armstrong v. Exceptional Child—The Supreme Court's "Fairest Reading" Really Isn't Fair*, GEORGETOWN CHILDREN'S HEALTH POLICY BLOG (Apr. 17, 2015), <http://ccf.georgetown.edu/all/armstrong-v-exceptional-child-supreme-courts-fairest-reading-really-isnt-fair>.

<sup>86</sup> CAL. HEALTH & SAFETY CODE § 1368(d).