Beneficiary Protections in the DMC-ODS Pilot
Frequently Asked Questions
April 2016

The following answers to frequently asked questions intend to provide clarification regarding Beneficiary Protections in the Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot Program.

This document will be updated as necessary.

For additional information regarding the DMC-ODS Pilot Program:

- Visit http://www.dhcs.ca.gov/provgovpart/Pages/Drug-Medi-Cal-Organized-Delivery-System.aspx
- Contact us at DMCODSWAIVER@dhcs.ca.gov

1. Are counties participating in the DMC-ODS Pilot considered to be managed care plans?

Counties participating in the DMC-ODS Pilot Program are considered to be managed care plans. Upon approval of the County's implementation plan, the State shall enter into an intergovernmental agreement with the Pilot County to provide or arrange for the provision of DMC-ODS Pilot services through a "Prepaid Inpatient Health Plan" (PIHP) as defined in federal law. Accordingly, DMC-ODS Pilot PIHPs (Counties) must comply with federal managed care requirements (with some exceptions). Participating Pilot Counties will be held to federal managed care requirements as outlined in 42 CFR Part 438, with some exceptions "waived" by the Centers for Medicare and Medicaid Services (CMS).

2. What are the responsibilities of the Pilot County and the State in regards to ensuring enrollee rights under the DMC-ODS Pilot?

Each Pilot County must have written policies regarding enrollee rights. Each Pilot County must comply with any state or federal laws that pertain the enrollee rights and ensure that its staff and affiliated providers take those rights into account when furnishing services. The State must ensure that each enrollee is free to exercise his or her rights. The State must also ensure that the County complies with any other applicable federal and state laws related to patient rights (i.e. ADA, confidentiality).

3. **What rights do enrollees have under the DMC-ODS Pilot Program?**

   Enrollee rights include the right to:
   - Receive information in accordance with federal requirements (easily understood, available in prevalent non-English languages, etc.)
   - Be treated with respect and due consideration for his / her dignity and privacy
   - Receive information on available treatment options and alternatives
   - Participate in decisions regarding his / her health care, including right to refuse treatment
   - Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
   - Request and receive copy of medical records, and request that they be amended or corrected (if privacy rule applies)

4. **What rights does the provider as a patient advisor / advocate have under the DMC-ODS Pilot Program?**

   A Pilot County may not prohibit or otherwise restrict a health care professional acting within the lawful scope of practice from advising or advocating on behalf of an enrollee who is his / her patient, from any of the following information (with some exceptions):
   - The enrollee's health status, medical care, or treatment options, including any alternative treatment that may be self-administered
   - Any information the enrollee needs in order to decide among all relevant treatment options
   - The risks, benefits, and consequences of treatment and non-treatment
   - The enrollee's right to participate in decisions regarding his / her health care, including the right to refuse treatment and to express preferences about future treatment decisions

5. **What are the County responsibilities for ensuring access under the DMC-ODS Pilot Program?**

   Each Pilot County must ensure that all required services covered under the pilot are available and accessible to enrollees. If the Pilot County is unable to provide services, the Pilot County must adequately cover these services out-of-network for as long as the County is unable to provide them in a timely manner. The County shall maintain and monitor a network of appropriate providers that is supported by contracts with subcontractors and sufficient to provide adequate access.

   Access cannot be limited in any way when counties select providers. Hours of operation must be no less than those offered to commercial enrollees or through Medi-Cal Fee-For-Service (FFS). Access must be available 24 hours a day, 7 days a week, when medically necessary. In addition, all Pilot Counties must have a 24/7 toll free number for prospective beneficiaries to call to access DMC-ODS services. Oral interpretation services must be made available for beneficiaries, as needed.

Pilot Counties must participate in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency (LEP) and diverse cultural / ethnic backgrounds.

Pilot Counties must monitor providers regularly to determine compliance and take corrective action if there is a failure to comply.

6. **What are the County responsibilities for informing beneficiaries under the DMC-ODS Pilot Program?**

   Pilot Counties must inform beneficiaries about the amount, duration, and scope of services available under this waiver. Information must be provided upon first contact with a beneficiary or referral, and must be in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled. The Pilot County must make written information available in each prevalent non-English language, with oral interpretation services available free of charge (including in all non-English languages). Informational materials must be provided in a manner and format that may be easily understood

   Pilot Counties must, at minimum, provide the following information to enrollees:
   - Names, locations, telephone numbers, and non-English languages spoken by current contracted providers
   - Any restrictions of the enrollee's freedom of choice among network providers
   - Enrollee rights and protections
   - Information on grievance and fair hearing procedures
   - The amount, duration, and scope of benefits available
   - Procedures for obtaining benefits, including authorization requirements
   - The extent to which, and how, enrollees may obtain benefits from out-of-network providers
   - The extent to which, and how, after-hours and emergency coverage are provided
   - Post-stabilization care rules
   - Policies on referrals for specialty care and other benefits
   - Cost sharing, if any
   - How and where to access any benefits that are covered under the state Medicaid plan, but not under the Pilot contract.

7. **What are the requirements for establishing a local grievance system under the DMC-ODS Pilot Program?**

   Each Pilot County must establish internal grievance procedures under which Medi-Cal enrollees, or providers on their behalf, may challenge the denial of coverage of, or payment for, medical assistance. The Pilot County's grievance system must include a grievance process, appeal process, and access to the State's fair hearing process. Possible subjects for grievances include, but are not limited to, the quality

of care of services provided, aspects of the interpersonal relationships (such as rudeness of a provider or employee), and failure to respect the enrollee's rights.

A reasonable timeframe may be no less than 20 days and may not exceed 90 days from the date on the Pilot County's notice of action. Within that timeframe, the enrollee or provider may file an appeal or request a State fair hearing. Enrollees may file a grievance either orally or in writing and, as determined by the State, either with the State or with the Pilot County. The enrollee or provider may file an appeal either orally or in writing, and unless he or she request expedited resolution, must follow an oral filing with a written, signed appeal.

8. What are the requirements and timing for issuing a County Notice of Action under the DMC-ODS Pilot Program?

The County Notice of Action must be in writing and must meet the language and format requirements specified in federal law to ensure ease of understanding. The notice must explain the following:

- The action the County or its contractor has taken or intends to take
- The reasons for the action
- The enrollee's or the provider's right to file an appeal
- The enrollee's right to a fair hearing
- The procedures for exercising these rights
- The circumstances under which expedited resolution is available and how to request it
- The enrollee's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of the services

Counties must mail the Notice of Action within the following timeframes:

- For terminations, suspension, or reduction of previously authorized Medicaid-covered services: within the specified timeframes.
- For denial of payment: at the time of any action affecting the claim.
- For standard service authorization decisions that deny or limit services: within the specified timeframe.
- For service authorization decisions not reached within the timeframes specified (which constitutes a denial and is thus an adverse action): on the date that the timeframe expires.
- For expedited service authorization decisions: within the specified timeframes.

If the County extends the timeframe, it must give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he / she disagrees with that decision, and issue and carry out its determination as expeditiously as the enrollee's health condition requires, no later than the date the extension expires.

9. What are the County requirements for handling grievances and appeals under

the DMC-ODS Pilot Program?

In handling grievances and appeals, each Pilot County must give enrollees reasonable assistance in completing forms and taking other procedural steps (interpreter services, toll-free numbers, TTY/TTD, etc), acknowledge receipt of each grievance and appeal, and ensure that the individuals who make decisions on grievances / appeals were not involved in any previous level of review or decision-making. If deciding on a denial that is based on lack of medical necessity, a denial of expedited resolution of an appeal, or a denial involving clinical issues, the individual making the decision must be a health care professional with appropriate clinical expertise in treating the condition.

The process for appeals must:

- **Confirm Oral Appeals in Writing.** Oral inquiries seeking to appeal an action must be treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution.
- **Provide the enrollee a reasonable opportunity to present evidence**, and allegations of fact or law, in person as well as in writing.
- **Provide the enrollee and his / her representative opportunity to examine the enrollee's case file**, before and during the appeals process, including medical records, and any other documents and records considered during the appeals process
- **Include the enrollee and his / her legal representation and/or the legal representative of a deceased enrollee's estate** as parties to the appeal.

The timeframe established by the state for the standard disposition of grievances may not exceed 90 days from the day the County receives the grievance. The State must establish a timeframe that is no longer than 45 days from the day the County receives the appeal (this timeframe may be extended up to 14 days in specified circumstances). For expedited resolution of appeals, the state must establish a timeframe that is no longer than 3 working days after the County receives the appeal (this timeframe may be extended up to 14 days in specified circumstances).

10. What is the time period for an enrollee to request a State fair hearing?

The State must permit the enrollee to request a State fair hearing within a reasonable time period specified by the State. This time period must not be less than 20 or in excess of 90 days from the date of the County's notice of resolution. The parties to the State fair hearing include both the County and the enrollee and his / her representative (or the representative of a deceased enrollee's estate).

11. Are Pilot Counties required to continue an enrollee's benefits during the grievance process?

The Pilot County must continue the enrollee's benefits if the enrollee or the provider

files the appeal in a timely fashion; the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired; and/or the enrollee requests an extension of benefits.

"Timely filing" means filing on or before the later of the following:

- Within ten days of the County mailing the Notice of Action
- The intended effective date of the County's proposed action

If, at the enrollee's request, the County continues / reinstates benefits while the appeal is pending, the benefits must be continued until one of the following occurs:

- The enrollee withdraws the appeal
- Ten days pass after the County mails the notice, providing the resolution of the appeal "against" the enrollee (unless the enrollee, within 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached)
- A State fair hearing office issues a hearing decision adverse to the enrollee
- The time period or service limits of a previously authorized service has been met

If the final resolution of the appeal is adverse, the County may recover 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 appeal. If the County or State fair hearing reverses a decision to deny, limit, or delay services that <u>were not</u> furnished while the appeal was pending, the County must authorize and provide the disputed services promptly. If the County or State fair hearing office reverses a decision to deny authorization of services, <u>and the enrollee received the disputed services while the appeal was pending</u>, the County must pay for those services.