State of California—Health and Human Services Agency
Department of Health Care Services

JENNIER KENT
DIRECTOR

EDMUND G. BROWN JR.
GOVERNOR

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ALL PLAN LETTER 17-006
SUPERSEDES ALL PLAN LETTERS 04-006 AND 05-005
AND POLICY LETTER 09-006

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: GRIEVANCE AND APPEAL REQUIREMENTS AND REVISED NOTICE TEMPLATES AND "YOUR RIGHTS" ATTACHMENTS

PURPOSE:
The purpose of this All Plan Letter (APL) is to provide Medi-Cal managed care health plans (MCPs) with clarification and guidance regarding the application of new federal and existing state regulations for processing Grievances and Appeals.

BACKGROUND:
On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule[1], which aimed to align Medicaid managed care regulations with requirements of other major sources of coverage. The final rule stipulated new requirements for the handling of Grievances and Appeals that become effective July 1, 2017.[2]

The Department of Health Care Services (DHCS) previously issued APLs 04-006 and 05-005, which provided MCPs with standardized templates for use when notifying beneficiaries of a denial, termination, delay, or modification in benefits. In addition, DHCS issued Policy Letter (PL) 09-006, which clarified federal and state timeframes for filing Grievances and Appeals and for requesting State Hearings and Independent Medical Reviews (IMR).

This APL supersedes APLs 04-006 and 05-005 and PL 09-006 and provides all-encompassing guidance to MCPs regarding Grievance and Appeal requirements. In addition to clarifying the application of new federal regulations and addressing discrepancies with existing state laws[3] and regulations[4], this APL also includes revised notice templates for each type of action that MCPs may decide, including revised "Your

[1] 81 FR 27497
[2] Title 42, Code of Federal Regulations (CFR), Part 438, Subpart F
[3] California Health & Safety Code (HSC) Section 1368
[4] Title 22, California Code of Regulations (CCR), Section 53858 and Title 28, CCR, Section 1300.68

Rights" attachments that must be sent in conjunction with beneficiary notifications. Requirements pertaining to IMRs remain unchanged. Attachment A is included to provide MCPs with a summary table of all changes that become effective July 1, 2017.

REQUIREMENTS:

I. DEFINITIONS

A. Adverse Benefit Determination

The term "Action," which was used in prior APLs and PLs, has been replaced with "Adverse Benefit Determination."[5] The definition of an "Adverse Benefit Determination" encompasses all previously existing elements of "Action" under federal regulations with the addition of language that clarifies the inclusion of determinations involving medical necessity, appropriateness, setting, covered benefits, and financial liability. An "Adverse Benefit Determination" is defined to mean any of the following actions taken by an MCP:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, 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.
5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.
6. For a resident of a rural area with only one MCP, the denial of the beneficiary's request to obtain services outside the network.
7. The denial of a beneficiary's request to dispute financial liability.

B. Notice of Action

Under new federal regulations, the term "Notice of Action" (NOA) has been replaced with "Notice of Adverse Benefit Determination."[6] However, because this new terminology may be confusing for beneficiaries, DHCS will retain use of "NOA" for ease of understanding. Therefore, a NOA shall be redefined as a formal letter informing a beneficiary of an Adverse Benefit Determination.

[5] Title 42, CFR, Section 438.400(b)
[6] Title 42, CFR, Section 438.404

C. Grievance

While the state definition[7] does not specifically distinguish "Grievances" from "Appeals," federal regulations[8] have redefined "Grievance and Appeal System" to mean processes the MCP implements to handle Grievances and Appeals. The terms "Grievance" and "Appeal" are separately defined. Due to distinct processes delineated for the handling of each, MCPs shall adopt the federal definition but also incorporate applicable sections of the existing state definition that do not pose conflicts.

1. A Grievance is an 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 of a provider or employee, and the beneficiary's right to dispute an extension of time proposed by the MCP to make an authorization decision.[9]

2. A complaint is the same as a Grievance. Where the MCP is unable to distinguish between a Grievance and an inquiry, it shall be considered a Grievance.[10]

3. An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include, but are not limited to, questions pertaining to eligibility, benefits, or other MCP processes.

MCPs shall not discourage the filing of Grievances. A beneficiary need not use the term "Grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a Grievance. If a beneficiary expressly declines to file a Grievance, the complaint shall still be categorized as a Grievance and not an inquiry. While the MCP may protect the identity of the beneficiary, the complaint shall still be aggregated for tracking and trending purposes as with other Grievances.

D. Appeal

Under new federal regulations, an "Appeal" is defined as a review by the MCP of an Adverse Benefit Determination.[11] While state regulations[12] do not explicitly

[7] Title 28, CCR, Sections 1300.68(a)(1) and (2)
[8] Title 42, CFR, Section 438.400(b)
[9] Title 42, CFR, Section 438.400(b)
[10] Title 28, CCR, Sections 1300.68(a)(1) and (2)
[11] Title 42, CFR, Section 438.400(b)
[12] Title 28, CCR, Sections 1300.68(d)(4) and (5)

define the term “Appeal”, they do delineate specific requirements for types of Grievances that would fall under the new federal definition of Appeal. These types of Grievances involve the delay, modification, or denial of services based on medical necessity, or a determination that the requested service was not a covered benefit. The MCP shall treat these Grievances as Appeals under federal regulations.

MCPs shall adopt the formal definition of “Appeal” in accordance with new federal regulations, but still comply with all existing state regulations as it pertains to Appeal handling, as applicable. These requirements are further delineated in Section IV of this APL.

II. ADVERSE BENEFIT DETERMINATION

A. Authorization Timeframes

1. Standard Requests

Excluding pharmacy, MCPs must approve, modify, or deny a provider’s prospective or concurrent request for health care services in a timeframe that is appropriate for the nature of the beneficiary’s condition, but no longer than five business days from the MCP’s receipt of information reasonably necessary and requested by the MCP to make a determination.[13] The timeframe to make a decision may not exceed 14 calendar days following receipt of the request. An extension of 14 calendar days may be granted if either the beneficiary or provider requests the extension, or the MCP justifies a need for additional information and how the extension is in the beneficiary’s best interest.[14] If the MCP fails to render a decision within the required timeframe, it shall be considered a denial and therefore constitutes an Adverse Benefit Determination on the date that the timeframe expires.[15] The beneficiary would then have the right to request an Appeal with the MCP.

The MCP’s written response (NOA) to the beneficiary shall be dated and postmarked within two business days of the decision.[16]

[13] HSC Section 1367.01(h)(1)
[14] Title 42, CFR, Section 438.210(d)(1)
[15] Title 42, CFR, Section 438.404(c)(5)
[16] HSC Section 1367.01(h)(3)

2. Retrospective Requests

MCPs must approve, modify, or deny a provider's retrospective request for health care services within 30 calendar days from receipt of information that is reasonably necessary to make a determination.[17]

3. Expedited Requests

In instances where a provider indicates, or the MCP determines, that the standard timeframe may seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the MCP must approve, modify, or deny a provider's prior authorization or concurrent request for health care services, and send the appropriate NOA template, in a timeframe which is appropriate for the nature of the beneficiary's condition, but no longer than 72 hours from the receipt of the request. An extension of 14 calendar days may be granted if the beneficiary requests the extension, or the MCP justifies a need for additional information and how the extension is in the beneficiary's best interest. If the MCP fails to render a decision within the required timeframe, it shall be considered a denial and therefore constitutes an Adverse Benefit Determination on the date that the timeframe expires.[18] The beneficiary would then have the right to request an Appeal with the MCP.

4. Deferrals

In instances where the MCP cannot make a decision to approve, modify, or deny a request for authorization within the required timeframe for standard or expedited requests because it is not in receipt of information reasonably necessary and requested, the MCP shall send out the NOA "delay" template to the provider and beneficiary within the required timeframe or as soon as the MCP becomes aware that it will not meet the timeframe.[19] A deferral notice is warranted if the MCP extends the timeframe an additional 14 calendar days because either the beneficiary or provider requests the extension, or the MCP justifies a need for additional information and how the extension is in the beneficiary's best interest.[20]

The NOA shall specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The MCP shall also include the anticipated date when a decision will be rendered.[21]

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[17] HSC Section 1367.01(h)(1)
[18] Title 42, CFR, Sections 438.210(d)(2) and 438.404(c)(5); HSC Section 1367.01(h)(2)
[19] HSC Section 1367.01(h)(5)
[20] Title 42, CFR, Section 438.210(d)(2)(ii)
[21] HSC Section 1367.01(h)(5)

Upon receipt of all information reasonably necessary and requested by the MCP, the MCP shall approve, modify, or deny the request for authorization within five business days or 72 hours for standard and expedited requests, respectively.

5. Terminations, Suspensions, or Reductions

For terminations, suspensions, or reductions of previously authorized services, MCPs must notify beneficiaries at least ten days before the date of the action with the exception of circumstances permitted under Title 42, CFR, Sections 431.213 and 431.214.[22]

B. Notice of Action

Beneficiaries must receive written notice of an Adverse Benefit Determination. MCPs currently utilize DHCS-developed, standardized NOA templates for common scenarios (denial, delay, modification, termination) as directed by APLs 04-006 and 05-005. DHCS continues to provide standardized templates for use and has revised all existing NOA templates and corresponding "Your Rights" attachments to comply with new federal regulations. The following five distinct NOA templates accommodate actions that MCPs may commonly take:

1. Denial of a treatment or service
2. Delay of a treatment or service
3. Modification of a treatment or service
4. Termination, suspension, or reduction of the level of treatment or service currently underway
5. Carve-out of a treatment or service

Effective July 1, 2017, MCPs shall utilize the revised NOA templates and corresponding "Your Rights" attachments included in this APL. MCPs shall not make any changes to the NOA templates or "Your Rights" attachments without prior review and approval from DHCS, except to insert information specific to beneficiaries as required.

C. Contents of Notice

Content requirements of the NOA are delineated in federal regulations[23], state laws[24], and state regulations.[25] The DHCS standardized templates are comprised of two components: 1) the NOA and 2) "Your Rights" attachments.

[22] Title 42, CFR, Section 438.404(c)(1)
[23] Title 42, CFR, Section 438.404(b)
[24] HSC Section 1367.01
[25] Title 22, CCR, Sections 51014.1, 51014.2, and 53894

These revised documents are viewed as a "packet" and must be sent in conjunction to comply with all requirements of the NOA.

1. NOA

New federal regulations necessitate minimal changes to the existing NOA template. DHCS has added a clarifying statement to indicate that beneficiaries may request, free of charge, copies of all documents and records relevant to the NOA, including criteria or guidelines used.[26]

MCPs shall comply with all other existing state laws and regulations in determining whether to approve, modify, or deny requests by providers prospectively, concurrently, or retrospectively. For decisions based in whole or in part on medical necessity, the written NOA shall contain all of the following:

a. A statement of the action the MCP intends to take.[27]
b. A clear and concise explanation of the reasons for the decision.[28]
c. A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedures that support the decision, as well as an explanation of the criteria or guideline.[29]
d. The clinical reasons for the decision. The MCP shall explicitly state how the beneficiary's condition does not meet the criteria or guidelines.[30]
e. For written notification to the provider, the name and direct telephone number or extension of the decision maker. Decisions shall be communicated to the beneficiary in writing. In addition, decisions shall be communicated to the provider initially by telephone or facsimile, and then in writing. Decisions rendered retrospectively only need to be communicated to providers in writing.[31]

   If the MCP can substantiate through documentation that effective processes are in place to allow the provider to easily contact the decision-maker through means other than a direct phone number (e.g., telephone number to the specific unit of the Utilization Management Department that handles provider Appeals directly), a direct telephone

[26] Title 42, CFR, Section 438.404(b)(2)
[27] Title 22, CCR, Sections 51014.1(c)(1) and 53894(d)(1)
[28] HSC Section 1367.01(h)(4); Title 22, CCR, Sections 51014.1(c)(2) and 53894(d)(2)
[29] HSC Section 1367.01(h)(4); Title 22, CCR, Sections 51014.1(c)(3) and 53894(d)(3)
[30] HSC Section 1367.01(h)(4)
[31] HSC Section 1367.01(h)(4)

number or extension shall not be required. However, the MCP must conduct ongoing oversight to monitor the effectiveness of this process.

The above requirements shall only pertain to decisions based in whole or in part on medical necessity. For all other Adverse Benefit Determinations (e.g., denials based on a lack of information, or benefit denials, etc.) that are not based on medical necessity, MCPs shall ensure that the NOA still provides a clear and concise explanation of the reasons for the decision.

2. "Your Rights" Attachment

New federal regulations warrant substantial revision to the "Your Rights" attachment, which informs beneficiaries of critical Appeal rights. Currently, existing federal and state regulations permit a beneficiary to file an Appeal and request a State Hearing at the same time. New federal regulations require beneficiaries to exhaust the MCP's internal Appeal process and receive notice that the Adverse Benefit Determination has been upheld prior to proceeding to a State Hearing. If the MCP fails to adhere to the required timeframe when resolving the Appeal, the beneficiary is deemed to have exhausted the MCP's internal Appeal process and may request a State Hearing.

In accordance with both new and existing federal regulations, the written NOA shall, at a minimum, meet all language and accessibility standards set forth in Title 42, CFR, Section 438.10, Health & Safety Code (HSC) Section 1367.01, and Title 28, CCR, Section 1300.67.04, and include all of the following requirements:

a. The beneficiary's or provider's right to request an internal Appeal with the MCP within 60 calendar days[32] from the date on the NOA.[33]
b. The beneficiary's right to request a State Hearing only after filing an internal Appeal with the MCP and receiving notice that the Adverse Benefit Determination has been upheld.[34]
c. The beneficiary's right to request a State Hearing if the MCP fails to send a resolution notice in response to the Appeal within the required timeframe.[35]

[32] New federal regulations (Title 42, CFR, Section 438.402(c)(2)(ii)) revise the timeframe that beneficiaries have to request an Appeal from 90 to 60 calendar days.
[33] Title 42, CFR, Section 438.404(b)(3)
[34] Title 42, CFR, Section 438.404(b)(3)
[35] Title 42, CFR, Section 438.408(c)(3)

d. Procedures for exercising the beneficiary's rights to request an Appeal.[36]
e. Circumstances under which an expedited review is available and how to request it.[37]
f. The beneficiary's right to have benefits continue pending resolution of the Appeal and how to request a continuation of benefits in accordance with Title 42, CFR, Section 438.420.[38]

Due to the significant impact that these new changes have on beneficiaries' Appeal rights, DHCS has deemed it necessary to create two distinct "Your Rights" attachments to accommodate the following scenarios: 1) beneficiaries who receive a NOA and 2) beneficiaries who receive a Notice of Appeal Resolution (NAR). A NAR is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld.

While the "Your Rights" attachment sent out to beneficiaries who receive a NOA will contain general information on State Hearing and IMR rights, the notice will primarily inform the beneficiary on how to request an Appeal with the MCP. A State Hearing form will not be attached, as the beneficiary would need to exhaust the MCP's Appeal process first. Similarly, an IMR form will not be attached, as the beneficiary would also need to exhaust the MCP's Appeal process prior to requesting an IMR unless the Department of Managed Health Care (DMHC) determines that an expedited review is warranted due to extraordinary and compelling circumstances.[39] Requirements pertaining to IMRs remain unchanged.

Conversely, the "Your Rights" attachment sent out to beneficiaries who receive a NAR that upholds the original Adverse Benefit Determination will not contain information on how to file a request for an Appeal as the beneficiary will have already exhausted the MCP's Appeal process. The notice will primarily inform the beneficiary on how to request a State Hearing and/or IMR. State Hearing and IMR application forms will be attached as appropriate.

Current versions of State Hearing[40] and IMR[41] forms shall be used when sending the NAR, and MCPs must check the DMHC and Department of

[36] Title 42, CFR, Section 438.404(b)(4)
[37] Title 42, CFR, Section 438.404(b)(5)
[38] Title 42, CFR, Section 438.404(b)(6)
[39] HSC Section 1368.03(a); Title 28, CCR, Section 1300.74.30(b)
[40] The SFH form can be accessed at the following link: www.cdss.ca.gov/cdssweb/entres/forms/English/NABACK9ACAMediCal.pdf
[41] The IMR form can be accessed at the following link: http://www.dmhc.ca.gov/

Social Services (DSS) websites periodically to ensure use of the most updated forms. MCPs may include State Hearing and IMR forms that contain tracking numbers to more easily identify and administer beneficiary rights. Such tracking numbers should contain initials, acronyms, or names that identify the MCP.

MCPs shall use the revised NOA/NAR and "Your Rights" attachments contained in this APL, selecting the appropriate packet for use depending on whether the MCP is issuing a NOA or NAR. Furthermore, all County Organized Health System MCPs, except those that are Knox-Keene licensed, must use the "Your Rights" attachment for non-Knox-Keene licensed MCPs, whereas all Knox-Keene licensed MCPs must use the "Your Rights" attachment for Knox-Keene licensed plans. Knox-Keene licensed MCPs must comply with additional state laws[42] and include verbatim language required in all notices sent to beneficiaries. This required paragraph is already incorporated into the templates and requires no action by the MCP.

D. Translation of Notices

The DHCS Contract[43] additionally requires MCPs to fully translate beneficiary-informing materials into the required threshold languages. DHCS acknowledges the challenges associated with the timely translation of clinical rationale that must be inserted into the NOA. If translating the clinical rationale will jeopardize an MCP's ability to comply with the mailing timeframes, DHCS will accept NOAs where the rationale is written in English. However, the body of the NOA must be translated into required threshold languages and a sentence in the beneficiary's preferred language must be inserted to explain how the beneficiary can obtain a verbal translation of the clinical rationale. The body of the NOA constitutes the entire content of the NOA with the exception of the clinical rationale. MCPs must also provide a written translation of the clinical rationale if specifically requested by the beneficiary.

III. GRIEVANCES

A. Timeframes for Filing

Timeframes for filing Grievances are delineated in both federal[44] and state[45] regulations. While existing state regulations establish a timeframe of at least 180 calendar days from the date of the incident subject to the beneficiary's dissatisfaction, new federal regulations allow Grievances to be filed at any time.

[42] HSC Section 1368.02(b)
[43] Exhibit A, Attachment 13 (Member Services), Written Member Information
[44] Title 42, CFR, Section 438.402(c)(2)(i)
[45] Title 28, CCR, Section 1300.68(b)(9)

MCPs shall adopt the standard which is least restrictive to beneficiaries and allow Grievances to be filed at any time in accordance with new federal regulations.

B. Method of Filing

In accordance with both existing federal[46] and state[47] regulations, a Grievance may be filed by a beneficiary, a provider acting on behalf of the beneficiary, or an authorized representative either orally or in writing.

C. Standard Grievances

1. Acknowledgment

In accordance with existing state laws[48] and regulations[49], MCPs shall provide written acknowledgment to the beneficiary that is dated and postmarked within five calendar days of receipt of the Grievance. The acknowledgment letter shall advise the beneficiary that the Grievance has been received, the date of receipt, and provide the name, telephone number, and address of the representative who may be contacted about the Grievance.

2. Resolution

Timeframes for resolving Grievances and sending written resolution to the beneficiary are delineated in both federal[50] and state[51] regulations. Federal regulations, which remain unchanged, allow the State to establish a timeframe for Grievance resolution that does not exceed 90 calendar days from the date of receipt of the Grievance. The State's established timeframe is 30 calendar days. MCPs shall continue to comply with the State's established timeframe of 30 calendar days for Grievance resolution.

a. "Resolved" means that the Grievance has reached a final conclusion with respect to the beneficiary's submitted Grievance as delineated in existing state regulations.[52]
b. The MCP's written resolution shall contain a clear and concise explanation of the MCP's decision.[53]
c. Federal regulations[54] allow for a 14-calendar day extension for standard and expedited Appeals. This allowance does not apply to Grievances.

[46] Title 42, CFR, Section 438.402(c)(3)(i)
[47] Title 28, CCR, Section 1300.68(a)(1)
[48] HSC Section 1368(a)(4)(A)
[49] Title 28, CCR, Section 1300.68(d)(1)
[50] Title 42, CFR, Section 438.408(b)(1)
[51] HSC Section 1368.01(a); Title 28, CCR, Sections 1300.68(a) and (d)(3)
[52] Title 28, CCR, Section 1300.68(a)(4)
[53] HSC Section 1368(a)(5); Title 28, CCR, Section 1300.68(d)(3)
[54] Title 42, CFR, Sections 438.408(b) and (c)

However, in the event that resolution of a standard Grievance is not reached within 30 calendar days as required, the MCP shall notify the beneficiary in writing of the status of the Grievance and the estimated date of resolution, which shall not exceed 14 calendar days.

D. Exempt Grievances

MCPs shall continue to comply with all state laws[55] and regulations[56] pertaining to exempt Grievance handling as follows:

Grievances received over the telephone that are not coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment and that are resolved by the close of the next business day are exempt from the requirement to send a written acknowledgment and response. MCPs shall maintain a log of all such Grievances containing the date of the call, the name of the complainant, beneficiary identification number, nature of the Grievance, nature of the resolution, and the representative's name who took the call and resolved the Grievance. The information contained in this log shall be periodically reviewed by the MCP.

MCPs shall ensure exempt Grievances are incorporated into the quarterly Grievance and Appeal report that is submitted to DHCS.

Under new federal regulations, coverage disputes, disputed health care services involving medical necessity, or experimental or investigational treatment would qualify as Appeals and not Grievances. Therefore, Appeals are not exempt from written acknowledgment and resolution.

E. Expedited Grievances

State laws[57] and regulations[58] delineate processes for expedited Grievance handling and require resolution within three calendar days. Congruent with state regulations, DHCS acknowledges that there are instances that may involve an imminent and serious threat to the health of a beneficiary, including, but not limited to, severe pain or potential loss of life, limb or major bodily function that do not involve the appeal of an Adverse Benefit Determination, yet are “urgent” or “expedited” in nature. For consistency, MCPs shall apply the revised federal timeframe for resolving expedited Appeals (72 hours) to expedited Grievances. The 72-hour timeframe would require MCPs to additionally record the time of

[55] HSC Section 1368(a)(4)(B)
[56] Title 28, CCR Section 1300.68(d)(8)
[57] HSC Section 1368.01(b)
[58] Title 28, CCR, Section 1300.68.01

Grievance receipt, and not just the date, as the specific time of receipt would drive the timeframe for resolution.

Federal regulations[59] require the MCP to make reasonable efforts to provide oral notice to the beneficiary of the resolution. MCPs shall apply this requirement of oral notice for expedited Appeals to expedited Grievances.

MCPs shall comply with all other existing state regulations pertaining to expedited Grievance handling in accordance with HSC Section 1368.01(b) and Title 28, CCR, Section 1300.68.01.

IV. APPEALS

A. Timeframes for Filing

Timeframes for filing Appeals are delineated in the DHCS Contract[60], as well as in both state[61] and federal[62] regulations.

Existing federal regulations allow beneficiaries 90 days from the date on the NOA to file an Appeal. By contrast, existing state regulations, which do not distinguish Grievances from Appeals, allow at least 180 calendar days to file Grievances, which are inclusive of Appeals. Currently, MCPs comply with the 90-day timeframe in accordance with the DHCS Contract and existing federal regulations.

New federal regulations require beneficiaries to file an Appeal within 60 calendar days from the date of the NOA. MCPs shall adopt the 60-calendar day timeframe in accordance with the new federal regulations. Beneficiaries must also exhaust the MCP's Appeal process prior to requesting a State Hearing.

B. Method of Filing

In accordance with existing federal[63] and state[64] regulations, Appeals may be filed by a beneficiary, a provider acting on behalf of the beneficiary, or an authorized representative either orally or in writing. Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary.[65] MCPs

[59] Title 42, CFR, Section 438.408(d)(2)(ii)
[60] Exhibit A, Attachment 14 (Member Grievance and Appeal System), Member Appeal System
[61] Title 28, CCR, Section 1300.68(b)(9)
[62] Title 42, CFR, Section 438.402(c)(2)(ii)
[63] Title 42, CFR, Section 438.402(c)(3)(ii)
[64] Title 28, CCR, Section 1300.68(a)(1)
[65] Title 42, CFR, Sections 438.402(c)(1)(ii)

shall continue to comply with this existing requirement in accordance with the DHCS Contract[66] and federal regulations.

In addition, an oral Appeal (excluding expedited Appeals) shall be followed by a written, signed Appeal.[67] The date of the oral Appeal establishes the filing date for the Appeal. MCPs shall request that the beneficiary's oral request for a standard Appeal be followed by written confirmation in accordance with federal regulations. MCPs shall assist the beneficiary in preparing a written Appeal, including notifying the beneficiary of the location of the form on the MCP's website or providing the form to the beneficiary upon request. MCPs shall also advise and assist the beneficiary in requesting continuation of benefits during the Appeal of the Adverse Benefit Determination in accordance with federal regulations.[68] In the event that the MCP does not receive a written, signed Appeal from the beneficiary, the MCP shall neither dismiss nor delay resolution of the Appeal.

C. Standard Appeals

1. Acknowledgment

In accordance with existing state laws[69] and regulations[70], MCPs shall provide written acknowledgment to the beneficiary that is dated and postmarked within five calendar days of receipt of the Appeal. The acknowledgment letter shall advise the beneficiary that the Appeal has been received, the date of receipt, and provide the name, telephone number, and address of the representative who may be contacted about the Appeal.

2. Resolution

Federal regulations revise the timeframe for resolving Appeals from 45 to 30 calendar days.[71] MCPs may extend the timeframe for Appeals resolution by 14 calendar days in accordance with federal regulations delineated under Section IV(E) below.

[66] Exhibit A, Attachment 14 (Member Grievance and Appeal System), Member Appeal System
[67] Title 42, CFR, Sections 438.402(c)(3)(ii) and 438.406(b)(3)
[68] Title 42, CFR, Section 438.420
[69] HSC Section 1368(a)(4)(A)
[70] Title 28, CCR, Section 1300.68(d)(1)
[71] Title 42, CFR, Section 438.408(b)(2)

D. Expedited Appeals

State laws[72] and regulations[73], which do not distinguish Grievances from Appeals, require expedited resolution of Grievances within three calendar days, which is inclusive of Appeals. Federal regulations[74] revise the timeframe for resolving Appeals from three working days to 72 hours. MCPs shall comply with the 72-hour timeframe in accordance with new federal regulations. The 72-hour timeframe would require MCPs to additionally record the time of Appeal receipt, and not just the date, as the specific time of receipt would drive the timeframe for resolution. MCPs may extend the timeframe for expedited Appeals resolution by 14 calendar days in accordance with federal regulations delineated under Section IV(E) below.

Additionally, MCPs are required to make reasonable efforts to provide oral notice to the beneficiary of the resolution.[75]

MCPs shall comply with all other existing state regulations pertaining to expedited Appeal handling in accordance with Title 28, CCR, Section 1300.68.01.

E. Extension of Timeframes

1. MCPs may extend the resolution timeframes for either standard or expedited Appeals by up to 14 calendar days if either of the following two conditions apply:

    a. The beneficiary requests the extension.[76]
    b. The MCP demonstrates, to the satisfaction of DHCS upon request, that there is a need for additional information and how the delay is in the beneficiary's best interest.[77]

2. For any extension not requested by the beneficiary, MCPs are required to provide the beneficiary with written notice of the reason for the delay. New federal regulations delineate the following additional requirements that MCPs must comply with:

[72] HSC Section 1368.01(b)
[73] Title 28, CCR, Section 1300.68.01
[74] Title 42, CFR, Section 438.408(b)(3)
[75] Title 42, CFR, Section 438.408(d)(2)(ii)
[76] Title 42, CFR, Section 438.408(c)(1)(i)
[77] Title 42, CFR, Section 438.408(c)(1)(ii)

a. The MCP shall make reasonable efforts to provide the beneficiary with oral notice of the extension.[78]
b. The MCP shall provide written notice of the extension within two calendar days and notify the beneficiary of the right to file a Grievance if the beneficiary disagrees with the extension.[79]
c. The MCP shall resolve the Appeal as expeditiously as the beneficiary's health condition requires and in no event extend resolution beyond the initial 14-calendar day extension.[80]
d. In the event that the MCP fails to adhere to the notice and timing requirements, the beneficiary is deemed to have exhausted the MCP's internal Appeal process and may initiate a State Hearing.[81]

F. Upheld Decisions

Federal definitions separately define Notice of Adverse Benefit Determination (NOA) and NAR, which in turn trigger a separate set of Appeal rights, necessitating the need for unique notices for denials and Appeals. DHCS has therefore created distinct notice templates to inform beneficiaries of their Appeal rights depending on whether a NOA or NAR is issued.

For Appeals not resolved wholly in favor of the beneficiary, MCPs shall utilize the DHCS template packet for upheld decisions, which is comprised of two components: 1) the NAR and 2) "Your Rights" attachments. These revised documents are viewed as a "packet" and must be sent in conjunction to comply with all requirements of the NAR.

1. Notice of Appeal Resolution (NAR)

MCPs shall comply with federal and state regulations in sending written response to Appeals as follows:

a. The results of the resolution and the date it was completed.[82]
b. If the MCP's denial determination is based in whole or in part on medical necessity, the MCP shall include in its written response the reasons for its determination and clearly state the criteria, clinical guidelines, or medical policies used in reaching the determination.[83]
c. If the MCP's determination specifies the requested service is not a covered benefit, the MCP shall include in its written response the provision

[78] Title 42, CFR, Section 438.408(c)(2)(i)
[79] Title 42, CFR, Section 438.408(c)(2)(ii)
[80] Title 42, CFR, Section 438.408(c)(2)(iii)
[81] Title 42, CFR, Section 438.408(c)(3)
[82] Title 42, CFR, Section 438.408(e)(1)
[83] HSC Section 1367.01(b); Title 28, CCR, Sections 1300.68(d)(4)

in the DHCS Contract, Evidence of Coverage, or Member Handbook that excludes the service. The response shall either identify the document and page where the provision is found, direct the beneficiary to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear and concise language how the exclusion applied to the specific health care service or benefit requested.[84]

2. "Your Rights" Attachment

In accordance with federal and state regulations, the written NAR shall, at a minimum, include all of the following required requirements:

a. The beneficiary's right to request a State Hearing no later than 120 calendar days from the date of the MCP's written Appeal resolution and instructions on how to request a State Hearing.[85]
b. The beneficiary's right to request and receive continuation of benefits while the State Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made in accordance with Title 42, CFR, Section 438.420.[86]
c. For Knox-Keene licensed MCPs, the beneficiary's right to request an IMR from the DMHC if the MCP's decision is based in whole or in part on a determination that the service is not medically necessary, is experimental/investigational, or is an emergency service.[87] The MCP shall include the IMR application, instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC.[88]

G. Overturned Decisions

For Appeals resolved in favor of the beneficiary, written notice to the beneficiary shall include the results of the resolution and the date it was completed. MCPs shall also ensure that the written response contains a clear and concise explanation of the reason, including the reason for why the decision was overturned.[89] MCPs shall utilize the DHCS template packet for Appeals, which contains the NAR for overturned decisions.

MCPs must authorize or provide the disputed services promptly and as expeditiously as the beneficiary's condition requires if the MCP reverses the

[84] HSC Section 1367.01(b); Title 28, CCR, Sections 1300.68(d)(5)
[85] Title 42, CFR, Section 438.408(e)(2)(i); Title 22, CCR, Section 53858(e)(5)
[86] Title 42, CFR, Section 438.408(e)(2)(ii)
[87] HSC Sections 1370.4 and 1374.30(d); Title 28, CCR, Section 1300.74.30(a)
[88] Title 28, CCR, Section 1300.68(d)(4)
[89] HSC Section 1368(a)(5); Title 28, CCR, Section 1300.68(d)(3)

decision to deny, limit, or delay services that were not furnished while the Appeal was pending. MCPs shall authorize or provide services no later than 72 hours from the date it reverses the determination.[90]

V. STATE HEARINGS

A beneficiary has the right to request a State Hearing when a claim for medical assistance is denied or is not acted upon with reasonable promptness.[91]

A. Timeframes for Filing

Existing federal regulations[92] and state laws[93] currently require beneficiaries to request a State Hearing within 90 days from the date of the NOA. However, new federal regulations[94] require beneficiaries to request a State Hearing within 120 calendar days from the date of the NAR, which informs the beneficiary that the Adverse Benefit Decision has been upheld. This presents a significant change for beneficiaries who previously did not have to exhaust the MCP's Appeal process prior to requesting a State Hearing. DHCS has updated all "Your Rights" attachment templates so that beneficiaries are informed of the revised 120-calendar day requirement in accordance with new federal regulations.

The parties to State Hearing include the MCP as well as the beneficiary and his or her representation or the representative of a deceased beneficiary's estate.

B. Standard Hearings

The MCP shall notify beneficiaries that the State must reach its decision within 90 calendar days of the date of the request.[95]

C. Expedited Hearings

The MCP shall notify beneficiaries that the State must reach its decision within three working days of the date of the request.[96]

D. Overturned Decisions

The MCP shall authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires, but no later than 72 hours from the date it receives notice reversing the determination.[97]

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[90] Title 42, CFR, Section 438.424(a)
[91] Title 42, United States Code, Section 1396a(a)(3); Welfare & Institutions Code (WIC), Section 10950
[92] Title 42, CFR, Section 438.408(f)
[93] WIC, Section 10951
[94] Title 42, CFR, Sections 438.408(f)(1) and (2)
[95] Title 42, CFR, Section 431.244(f)(1)
[96] Title 42, CFR, Section 431.244(f)(2)
[97] Title 42, CFR, Section 438.424(a)

VI. NONDISCRIMINATION NOTICE AND LANGUAGE ASSISTANCE TAGLINES

Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. On May 18, 2016, the United States Department of Health and Human Services (HHS), Office for Civil Rights (OCR) issued the Nondiscrimination in Health Program and Activities Final Rule[98] to implement Section 1557. Federal regulations[99] require MCPs to post nondiscrimination notice requirements and language assistance taglines in significant communications to beneficiaries. DHCS has thus created a sample "Nondiscrimination Notice" and "Language Assistance" taglines, which are available for MCP use. MCPs may utilize the templates provided by DHCS, make modifications to the templates, or create new templates. If modifications or new templates are created, DHCS review and approval must be obtained prior to use. These templates must be sent in conjunction with each of the following significant notices sent to beneficiaries: NOA, Grievance acknowledgment letter, Appeal acknowledgment letter, Grievance resolution letter, and NAR.

VII. GRIEVANCE AND APPEAL SYSTEM OVERSIGHT

MCPs shall establish, implement, and maintain a Grievance and Appeal System to ensure the receipt, review, and resolution of Grievances and Appeals. The Grievance and Appeal System shall operate in accordance with all applicable federal regulations[100], state laws[101], and state regulations.[102]

A. The MCP shall operate in accordance with its written procedures. These procedures shall be submitted to DHCS prior to use.[103]

B. The MCP shall designate an officer that has primary responsibility for overseeing the Grievance and Appeal System. The officer shall continuously review the operation of the Grievance and Appeal System to identify any emergent patterns of Grievances and Appeals. The Grievance and Appeal System shall include the reporting procedures in order to improve MCP policies and procedures.[104]

C. The MCP shall notify beneficiaries about its Grievance and Appeal System and

[98] 81 FR 31375
[99] Title 45, CFR, Section 92.8
[100] Title 42, CFR, Section 438
[101] HSC Section 1368
[102] Title 22, CCR, Section 53858; Title 28, CCR, Section 1300.68
[103] Title 22, CCR, Section 53858
[104] Title 28, CCR, Section 1300.68(b)(1)

shall include information on the MCP's procedures for filing and resolving Grievances and Appeals, a toll-free telephone number or a local telephone number in each service area, and the address for mailing Grievances and Appeals. The notice shall also include information regarding the DMHC's review process, the IMR system, and DMHC's toll-free telephone number and website address, as appropriate.[105]

D. The MCP shall notify beneficiaries of the process for obtaining Grievance and Appeals forms. A description of the procedure for filing Grievances and Appeals shall be readily available at each facility of the MCP, on the MCP's website, and at each contracting provider's office or facility. The MCP shall ensure that assistance in filing Grievances and Appeals will be provided at each location where Grievances and Appeals are submitted. Grievance and Appeal forms shall be provided promptly upon request.[106]

E. The MCP shall ensure adequate consideration of Grievances and Appeals and rectification when appropriate. If multiple issues are presented by the beneficiary, the MCP shall ensure that each issue is addressed and resolved.[107]

F. The MCP shall maintain a written record for each Grievance and Appeal received by the MCP. The record of each Grievance and Appeal shall be maintained in a log and include the following information:[108]

    1. The date and time of receipt of the Grievance or Appeal
    2. The name of the beneficiary filing the Grievance or Appeal
    3. The representative recording the Grievance or Appeal
    4. A description of the complaint or problem
    5. A description of the action taken by the MCP or provider to investigate and resolve the Grievance or Appeal
    6. The proposed resolution by the MCP or provider
    7. The name of the MCP provider or staff responsible for resolving the Grievance or Appeal
    8. The date of notification to the beneficiary of resolution.

G. The written record of Grievances and Appeals shall be submitted at least quarterly to the MCP's quality assurance committee for systematic aggregation and analysis for quality improvement. Grievances and Appeals reviewed shall

[105] Title 22, CCR, Section 53858(b); Title 28, CCR, Sections 1300.68(b)(2) and (4)
[106] Title 22, CCR, Sections 53858(c), (d), and (f); Title 28, CCR, Sections 1300.68(d)(6) and (7)
[107] HSC Section 1368(a)(1)
[108] Title 22, CCR, Section 53858(e)(1); Title 28, CCR, Section 1300.68(b)(5)

include, but not be limited to, those related to access to care, quality of care, and denial of services. Appropriate action shall be taken to remedy any problems identified.[109]

H. The written record of Grievances and Appeals shall be reviewed periodically by the governing body of the MCP, the public policy body, and by an officer of the MCP or designee. The review shall be thoroughly documented.[110]

I. The MCP shall ensure the participation of individuals with authority to require corrective action. All Grievances and Appeals related to medical quality of care issues shall be immediately submitted to the MCP's medical director for action.[111]

J. The MCP shall address the linguistic and cultural needs of its beneficiary population as well as the needs of beneficiaries with disabilities. The MCP shall ensure all beneficiaries have access to and can fully participate in the Grievance and Appeal System by assisting those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include, but is not limited to, translations of Grievance and Appeal procedures, forms, and MCP responses to Grievances and Appeals, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate.[112]

K. The MCP shall assure that there is no discrimination against a beneficiary on the grounds that the beneficiary filed a Grievance or Appeal.[113]

L. The MCP shall establish and maintain a system of aging of Grievances and Appeals that are pending and unresolved for 30 days or more and shall include a brief explanation of the reasons each Grievance and Appeal is pending and unresolved.[114]

M. The MCP shall ensure that the person making the final decision for the proposed resolution of a Grievance or Appeal has not participated in any prior decisions related to the Grievance or Appeal. Additionally, the decision-maker shall be a health care professional with clinical expertise in treating a beneficiary's condition or disease if any of the following apply[115]:

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[109] Title 22, CCR, Sections 53858(e)(3) and (4)
[110] Title 28, CCR, Section 1300.68(b)(5)
[111] Title 22, CCR, Section 53858(e)(2)
[112] Title 22, CCR, Section 53858(e)(6); Title 28, CCR, Section 1300.68(b)(3)
[113] Title 28, CCR, Section 1300.68(b)(8)
[114] HSC Section 1368(b)(8)
[115] Title 42, CFR, Section 438.406(b)(2)

1. An Appeal of an Adverse Benefit Determination that is based on lack of medical necessity.
2. A Grievance regarding denial of an expedited resolution of an Appeal.
3. Any Grievance or Appeal involving clinical issues.

N. The MCP shall ensure that individuals making decisions on clinical Appeals take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's designated representative, regardless of whether such information was submitted or considered in the initial Adverse Benefit Determination.[116]

O. The MCP shall provide the beneficiary or beneficiary's designated representative the opportunity to review the beneficiary's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCP in connection with any standard or expedited Appeal of an Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe.[117]

P. The MCP shall provide the beneficiary a reasonable opportunity, in person and in writing, to present evidence and testimony. The MCP must inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for Appeals as specified and in the case of expedited resolution.[118]

MCPs are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including APLs and Dual Plan Letters. These requirements must be communicated by each MCP to all delegated entities and subcontractors.

All member notices and attachments referenced in this APL may be viewed in PDF format on the DHCS website. To obtain copies in Word format, please send a request via email to: Jeanette.Fong@dhcs.ca.gov.

[116] Title 42, CFR, Section 438.406(b)(2)(iii)
[117] Title 42, CFR, Section 438.406(b)(5)
[118] Title 42, CFR, Section 438.406(b)(4)

If you have any questions regarding this APL, please contact your Managed Care Operations Division Contract Manager.

Sincerely,

Original signed by Nathan Nau

Nathan Nau, Chief
Managed Care Quality and Monitoring Division
Attachment(s)

Attachment A

The summary table below outlines key Grievance and Appeal requirements, including a comparison of new and existing requirements. Where discrepancies between federal and state requirements exist, an asterisk (*) is indicated to denote the standard MCPs currently comply with.

SUMMARY OF GRIEVANCE & APPEAL REQUIREMENTS

TOPIC	EXISTING REQUIREMENT	NEW REQUIREMENT *(Effective 07/01/17)*
DEFINITIONS		
	"Action"	"Adverse Benefit Determination"
	"Grievance System"	"Grievance and Appeal System"
"Grievance"	• State: Definition is inclusive of Appeals • Federal: An expression of dissatisfaction about any matter other than an Action*	An expression of dissatisfaction about any matter other than an Adverse Benefit Determination
"Appeal"	• State: Not defined • Federal: A request for review of an Action*	A review by an MCP of an Adverse Benefit Determination
GRIEVANCES		
Filing	180 days	Any time
Acknowledgment	5 calendar days	5 calendar days
Standard Resolution	• 30 calendar days (State)* • 90 days but based on State-established standard (Federal)	30 calendar days
Exempt Resolution	24 hours	24 hours
Expedited Resolution	• 3 calendar days (State)* • Expedited Grievances not defined (Federal)	72 hours
APPEALS		
Filing	• 90 days (Federal)* • 180 days (State)	60 calendar days
Filing	Oral appeal followed by signed, written appeal (existing requirement not delineated in the Contract)	Oral appeal followed by signed, written appeal (no change)
Acknowledgment	5 calendar days	5 calendar days
Standard Resolution	• 30 calendar days (State)* • 45 days (Federal)	30 calendar days
Expedited Resolution	• 3 calendar days (State)* • 3 working days (Federal)	72 hours
Extension	14 calendar days	14 calendar days
Notification of Extension	No specified timeframe	• Reasonable efforts to provide prompt oral notice

TOPIC	EXISTING REQUIREMENT	NEW REQUIREMENT *(Effective 07/01/17)*
		• Written notice within 2 calendar days
Effectuation of Overturned Decisions	As expeditiously as the health condition requires	72 hours
STATE HEARINGS		
Filing	90 days from NOA	120 calendar days from NAR
Standard Resolution	90 days	90 calendar days
Expedited Resolution	3 working days	3 working days
Effectuation of Overturned Decisions	As expeditiously as the health condition requires	72 hours
NOTICE OF ACTION (NOA)		
NOA	• Clear & Concise • Criteria/Guideline • Clinical Reason	• Clear & Concise • Criteria/Guideline • Clinical Reason
NOA	Must provide the reason for the decision	Must provide the reason for the decision, including the beneficiary's right to request free of charge copies of all documents and records relevant to the NOA, including criteria or guidelines used
"Your Rights" Attachment	Beneficiary informed of right to request an Appeal, State Hearing, and IMR at the same time	Beneficiary informed of requirement to exhaust the MCP's internal Appeal process prior to proceeding to a State Hearing or IMR
State Hearing & IMR Forms	Attached to NOA	Not attached to NOA
NOTICE OF APPEAL RESOLUTION (NAR)		
NAR (Uphold)	Same NOA template used as with initial denial	Distinct NAR template created for appeal resolution
"Your Rights" Attachment	Same "Your Rights" attachments used as with initial denial	Distinct "Your Rights" attachment created to inform beneficiary of only State Hearing and IMR rights
State Hearing & IMR Forms	Attached to NOA	Attached to NAR
NAR (Overturn)	No standard template required	Standard template created for consistency