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

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ALL PLAN LETTER 21-011 *(REVISED)*
ALL PLAN LETTER 17-006

TO: ALL MEDI-CAL MANAGED CARE HEALTH PLANS

SUBJECT: GRIEVANCE AND APPEAL REQUIREMENTS, NOTICE AND "YOUR RIGHTS" TEMPLATES

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 federal and state legal requirements for processing grievances and appeals. This APL supersedes APL 17-006 and includes member notification templates developed by the Department of Health Care Services (DHCS), as well as updated DHCS templates for the attachments that must accompany member notifications. Revised text is found in *italics*.

BACKGROUND:

Grievance and Appeal Process
On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Final Rule (Final Rule),[1] which aligned 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 became effective July 1, 2017.[2] In May 2017, DHCS issued APL 17-006 to provide MCPs with guidance regarding federal and state grievance and appeal requirements, including the Final Rule requirements. As part of APL 17-006, DHCS provided revised notice templates for use when notifying members of a denial, limitation, termination, delay, or modification of benefits and for the "Your Rights" attachments that are sent in conjunction with member notifications.

[1] See Federal Register Volume 81, Issue 88 (May 6, 2016), available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf
[2] See Title 42 of the Code of Federal Regulations (CFR), Part 438, Subpart F. The CFR is searchable at: https://www.ecfr.gov/cgi-bin/ECFR?page=browse.

POLICY:

I. DEFINITIONS

A. Grievance

While state regulations do not specifically distinguish "grievances" from "appeals," federal regulations define "grievance and appeal system" to mean the processes the MCP implements to handle grievances and appeals, with the terms "grievance" and "appeal" each separately defined.[3] Due to distinct processes delineated for the handling of each, MCPs must adopt the federal definition but also incorporate applicable sections of the existing state definition that do not pose conflicts.

1. A grievance is any expression of dissatisfaction about any matter other than an adverse benefit determination (defined below). 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 member's right to dispute an extension of time proposed by the MCP to make an authorization decision.[4]
2. A complaint is the same as a grievance. If the MCP is unable to distinguish between a grievance and an inquiry, it must be considered a grievance.[5]
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 must not discourage the filing of grievances. A member need not use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and processed as a grievance by the MCP. If a member expressly declines to file a grievance, the complaint must still be categorized as a grievance and not an inquiry.

B. Adverse Benefit Determination

An "adverse benefit determination" is defined to mean any of the following actions taken by an MCP:[6]

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[3] Title 28 of the California Code of Regulations (CCR) 1300.68(a)(1) and (2); and 42 CFR 438.400(b). The CCR is searchable at: https://govt.westlaw.com/calregs/Search/Index
[4] 42 CFR 438.400(b)
[5] 28 CCR 1300.68(a)(1)-(2)
[6] 42 CFR 438.400(b)

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. A denial, in whole or in part, of a payment for a service solely because the claim does not meet the definition of a ‘‘clean claim’’ at 42 CFR section 447.45(b) is not an adverse benefit determination.
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 member's request to obtain services outside the network.
7. The denial of a member's request to dispute financial liability.

C. Notice of Action

A "notice of action" (NOA) is defined as a formal letter from a MCP informing a member of an "adverse benefit determination."

D. Appeal

An "appeal" is federally defined as a review by the MCP of an adverse benefit determination.[7] While state regulations do not explicitly define the term "appeal," they do delineate specific requirements for certain types of grievances that would fall under the federal definition of appeal because they involve the delay, modification, or denial of services based on medical necessity or a determination that the requested service is not a covered benefit.[8] The MCP must treat these grievances as appeals under federal regulations.

MCPs must use the federal definition of "appeal" and comply with all existing state regulations as they pertain to the handling of appeals. These requirements are delineated in section IV of this APL.

E. Notice of Appeal Resolution

A "notice of appeal resolution" (NAR) is a formal letter from a MCP informing a member of the outcome of the appeal of an adverse benefit determination.[9] The NAR informs the member whether the MCP has overturned or upheld its decision on the adverse benefit determination.

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[7] 42 CFR 438.400(b)
[8] 28 CCR 1300.68(d)(4)-(5)
[9] 42 CFR 438.408(d)(2)

II. AUTHORIZATION TIMEFRAMES AND ADVERSE BENEFIT DETERMINATIONS

A. Authorization Timeframes

MCPs must render a decision on a provider's request for authorization of health care services for a member, and notify the provider and the member using the appropriate NOA template within the timeframes outlined below and in accordance with notification requirements in federal and state law. For purposes of auditing, the postmark on the MCP's notice to the member will be used to confirm compliance with all prior authorization request timeframes and notice requirements set forth below.

1. Standard Requests

Excluding pharmacy services, MCPs must approve, modify or deny a provider's prospective or concurrent request for health care services for a member within the shortest applicable timeframe that is appropriate for the member'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, not to exceed 14 calendar days following the MCP's receipt of the request for service.[10] Decisions to approve, modify, or deny requests, must be communicated by the MCP to the provider within 24 hours of the decision and to the member within two business days using the appropriate NOA template.[11] The MCP's written notice to the member must also be sent with sufficient time to allow the member to request Aid Paid Pending (i.e., continuation of benefits), if applicable.

Federal law permits an extension of the initial 14 calendar day authorization timeframe by up to 14 days if the member or the provider requests an extension, or if the MCP can justify its need for additional information and demonstrate how the extension is in the member's interest.

If the MCP requires an extension of the initial 14 calendar day authorization timeframe, the MCP must either deny the authorization request or immediately notify the requesting provider to request all specific information the MCP still needs to make its authorization decision. The MCP must also document its justification in the member's medical record of the need for the extension to obtain additional information and demonstrate how the extension

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[10] Health and Safety Code (HSC) 1367.01(h)(1); 42 CFR 438.210(d)(1); and 42 CFR 438.404(c)(3). State law is searchable at: https://leginfo.legislature.ca.gov/faces/codes.xhtml.
[11] HSC 1367.01(c)(3)

is in the member's interest.[12] MCPs must provide this documentation to DHCS upon request.

The MCP's written notice requesting additional medical information must specify the information the MCP requested but did not receive, the expert reviewer to be consulted, or the additional examinations or tests required before the service can be approved or denied. The MCP must also include the anticipated date when its decision will be made, make a decision on the request as expeditiously as the member's health condition requires, and advise the member that they have a right to file a grievance to dispute the delay.[13] The MCP must send this written notice within the required timeframe, or as soon as the MCP becomes aware that it will not meet the initial authorization timeframe, whichever is earlier.[14]

Following the MCP's notification and request for additional and specific information, the MCP must approve, modify, or deny the request within the shortest applicable timeframe that is appropriate for the nature of the member'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, not to exceed the additional 14 calendar days.[15]

Decisions to approve, modify, or deny requests, must be communicated by the MCP to the provider within 24 hours of the decision and to the member within two business days using the appropriate NOA template.[16]

An MCP's failure to render a decision for standard authorization requests within the required timeframes above is considered a denial and therefore constitutes an adverse benefit determination on the date that the timeframe expires.[17] In this situation, the member has the right to request an appeal with the MCP and the MCP must send the member written notice of all appeal rights.[18]

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[12] 42 CFR 438.210(d)(1)
[13] HSC 1367.01(h)(5)
[14] HSC 1367.01(h)(5)
[15] 42 CFR 438.210(d)(1); 42 CFR 438.404(c)(5)
[16] HSC 1367.01(c)(3)
[17] 42 CFR 438.404(c)(5)
[18] 42 CFR 438.404(c)(5)

2. Expedited Requests

In instances where a provider indicates, or the MCP determines, that the standard request timeframe may seriously jeopardize the member'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 for a member, and notify the provider and the member, using the appropriate NOA template, in a timeframe that is appropriate for the nature of the member's condition, but is no longer than 72 hours after the MCP's receipt of all information needed to make an authorization decision for the request for service.[19]

Federal law permits an extension of the initial 72-hour authorization timeframe by up to 14 calendar days if the member requests the extension, or if the MCP can justify its need for additional information and demonstrates how the extension is in the member's interest.[20]

If the MCP requires an extension of the initial 72-hour authorization timeframe, the MCP must either deny the authorization request or document its justification in the member's medical record of the need for the extension to obtain additional information and demonstrate how the extension is in the member's interest.[21] If the MCP requires the extension, it must send written notice to the member and the provider, using the appropriate NOA template, to request the specific information it needs to determine if the service is medically necessary. This notice must be sent within the required timeframe, or as soon as the MCP becomes aware that it will not be able to meet the initial timeframe, whichever is earlier.[22]

The written notice must specify the information the MCP needs but did not receive, the expert reviewer to be consulted, or the additional examinations or tests required before the service can be approved or denied. The MCP must also include the anticipated date when its decision will be made, make a decision on the request as expeditiously as the member's health condition requires, and advise the member that they have a right to file a grievance to dispute the delay.[23]

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[19] HSC 1367.01(h)(2); 42 CFR 438.210(d)(2)(i)
[20] 42 CFR 438.210(d)(ii)
[21] 42 CFR 438.210(d)(2)(ii)
[22] HSC 1367.01(h)(5)
[23] HSC 1367.01(h)(5)

Following this notification and request for specific information, the MCP must approve, modify, or deny the request within the shortest applicable timeframe that is appropriate for the nature of the member's condition, but is no longer than 72 hours from the MCP's receipt of the additional information reasonably necessary and requested by the MCP to make a determination, not to exceed the additional 14 calendar days.[24] The MCP's written response to the member must be sent with sufficient time to allow the member to request Aid Paid Pending, if applicable.

An MCP's failure to render a decision for standard authorization requests within the required timeframes above is considered a denial and therefore constitutes an adverse benefit determination on the date that the timeframe expires.[25] In this situation, the member has the right to request an appeal with the MCP and the MCP must send the member written notice of all appeal rights.[26]

3. **Retrospective Requests**
   In cases where the review is retrospective, the MCP must communicate its decision to the member who received services, or to the member's designee, within 30 days of the receipt of information that is reasonably necessary to make the retro-authorization determination. The MCP is also required to communicate the decision to the provider in a manner that is consistent with current law.[27]

4. **Termination, Suspensions, or Reductions**[28]
   For terminations, suspensions, or reductions of previously authorized services, MCPs must notify members at least ten days prior to the date of the action pursuant to Title 42 CFR section 431.211 to ensure there is adequate time for members to timely file for Aid Paid Pending, with the exception of circumstances permitted under Title 42 CFR sections 431.213 and 431.214.[29]

B. Notice of Action
MCPs must provide members with written notice of an adverse benefit determination using the appropriate DHCS-developed, standardized NOA

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[24] 42 CFR 438.210(d)(2)
[25] 42 CFR 438.404(c)(5)
[26] 438.404(c)(5)
[27] HSC 1367.01(h)(1)
[28] 42 CFR 438.404(c)(1)
[29] 42 CFR Part 431 is available at: https://www.ecfr.gov/cgi-bin/text-idx?SID=a6efa0db86d63173832cb5b584eb1fbe&mc=true&node=pt42.4.431&rgn=div5#_top

template and the NOA "Your Rights" template. 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; and
5. Carve-out of a treatment or service.

MCPs may replace the medical director's name with the medical director's initials or "Office of the Medical Director". MCPs are not permitted to make any other changes to the NOA templates or NOA "Your Rights" templates without prior review and approval from DHCS, except to insert information specific to the member as required.

C. Contents of Notice

Content requirements of the NOA are delineated in federal and state law.[30] The written NOA must meet all language and accessibility standards, including translation, font, and format requirements, as set forth in APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services, federal and state law, and all requirements in the DHCS contract.[31]

The NOA is comprised of two components: 1) the appropriate DHCS standardized NOA template and 2) the DHCS standardized NOA "Your Rights" template. MCPs are required to send these documents together any time a NOA is issued.

1. Written Notice of an Adverse Benefit Determination (NOA Template)

MCPs must comply with all federal and state law in determining whether to approve, modify, or deny requests by providers prospectively, concurrently, or retrospectively. Members may request, free of charge, copies of all documents and records the MCP relied on to make its decision, including any clinical criteria or guidelines used.[32]

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[30] 42 CFR 438.404(b); HSC 1367.01; 22 CCR 51014.1, 51014.2, and 53894

[31] Title 42 CFR sections 438.10, 438.402, 438.404, and 438.408; Title 45 CFR, Part 92; WIC 14029.91 and 10951(b)(1)(A); and Exhibit A, Attachment 9, Linguistic Services. *APLs are available at: https://www.dhcs.ca.gov/formsandpubs/Pages/AllPlanLetters.aspx*

[32] 42 CFR 438.404(b)(2)

For decisions based in whole or in part on medical necessity, the written NOA must contain all of the following:

a. A statement of the action the MCP intends to take.[33]
b. A clear and concise explanation of the reasons for the decision.[34]
c. A description of the criteria or guidelines used. This includes a reference to the specific regulation or authorization procedure(s) that supports the decision, as well as an explanation of the criteria or guideline.[35]
d. The clinical reasons for the decision. The MCP must explicitly state how the member's condition does not meet the criteria or guidelines.[36]
e. For written notification to the provider, the name and direct telephone number or extension of the decision maker. Decisions must be communicated to the member in writing. In addition, with the exception of decisions rendered retrospectively, decisions must be communicated to the provider initially by telephone or facsimile and also in writing.[37]

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

Requirements 'a' through 'e' above only pertain to decisions based in whole or in part on medical necessity. For all other adverse benefit determinations that are not based on medical necessity (e.g., denials based on a lack of information, or benefit denials, etc.), MCPs must still ensure that the NOA provides a clear and concise explanation of the reasons for the decision.

2. NOA "Your Rights" Attachment Template(s)

The NOA "Your Rights" attachment informs members of critical appeal and hearing rights.

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[33] 22 CCR 51014.1(c)(1) and 53894(d)(1)
[34] HSC 1367.01(h)(4); 22 CCR 51014.1(c)(2) and 53894(d)(2)
[35] HSC 1367.01(h)(4); 22 CCR 51014.1(c)(3) and 53894(d)(3)
[36] HSC 1367.01(h)(4)
[37] HSC 1367.01(h)(4)

Federal and state law require that members 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. However, if the MCP fails to adhere to federal and state notice and timeframe requirements, the member is deemed to have exhausted the MCP's internal appeal process and may request a state hearing.[38]

The DHCS-developed NOA "Your Rights" attachment templates include all of the following required elements:

a. The member's or provider's right to request an internal appeal with the MCP within 60 calendar days from the date on the NOA.[39]
b. The member's right to request a state hearing after first filing an internal appeal with the MCP and receiving notice that the adverse benefit determination has been upheld.[40]
c. The member's right to request a state hearing without having to exhaust the MCP's internal appeal process, in instances of deemed exhaustion.[41]
d. Procedures for exercising the member's rights to request an appeal.[42]
e. Circumstances under which an expedited review is available and how to request one.[43]
f. The member's right to Aid Paid Pending and instructions on how to timely file for an appeal (i.e., within 10 days of the NOA or before the effective date of the intended action) of a decision to terminate, suspend, or reduce services. MCPs must provide Aid Paid Pending regardless of whether the member makes a separate request to the MCP when the member timely files an appeal of a decision to terminate, suspend or reduce services.[44]

MCPs must use the NOA "Your Rights" templates attached to this APL. All County Organized Health System (COHS) MCPs, except those that are Knox-Keene licensed, must use the "Your Rights" template for non-Knox-Keene licensed MCPs, whereas all Knox-Keene licensed MCPs must use the "Your Rights" template for Knox-Keene licensed plans.

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[38] 42 CFR 438.402, 438.404, 438.408, and 438.10; WIC 14197.3 and 10951.
[39] 42 CFR 438.402(c)(2)(ii) and 438.404(b)(3)
[40] 42 CFR 438.402(c)(1)
[41] 42 CFR 438.402(c)(1)(a) and 438.408(c)(3); WIC 10951(b)(1)(B)
[42] 42 CFR 438.404(b)(4)
[43] 42 CFR 438.404(b)(5)
[44] 42 CFR 438.404(b)(6) and 438.420, 22 CCR 51014.1 and 51014.2

The NOA "Your Rights" template for Knox-Keene licensed MCPs provides information for members about how to request an Independent Medical Review (IMR). Knox-Keene licensed MCPs are subject to additional state laws, including the requirement that certain written notices to members contain prescribed language advising members of additional rights and directing them to contact the Department of Managed Health Care (DMHC) to request an IMR.[45] This mandatory paragraph is already incorporated into the template and requires no action by MCPs.

When sending the "Your Rights" attachment to members as part of the NOA, MCPs must include the most current version of the state hearing form attached to this APL. Knox-Keene licensed MCPs must also include the IMR form, application instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC.[46] Knox-Keene licensed MCPs are required to check the DMHC website periodically to ensure use of the most current IMR form.[47] MCPs may include state hearing and IMR forms that contain tracking numbers to more easily identify and administer member rights. Such tracking numbers should contain initials, acronyms, or names that identify the MCP.

III. GRIEVANCES

A. Timeframes for Filing

Timeframes for filing grievances are delineated in both federal and state law.[48] While state regulations establish a timeframe of at least 180 calendar days from the date of the incident subject to the member's dissatisfaction, federal regulations allow grievances to be filed at any time. MCPs must adopt the standard that is least restrictive to members and allow grievances to be filed at any time in accordance with federal regulations.

B. Method of Filing

In accordance with both federal and state law, a grievance may be filed either orally or in writing by a member, a provider acting on behalf of the member, or an authorized representative.[49]

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[45] HSC 1368.02(b)
[46] 28 CCR 1300.68(d)(4)
[47] The IMR form can be accessed at the following link: http://www.hmohelp.ca.gov/
[48] 42 CFR 438.402(c)(2)(i); 28 CCR 1300.68(b)(9)
[49] 42 CFR 438.402(c)(3)(i); 28 CCR 1300.68(a)(1)

C. Standard Grievances

1. Acknowledgment

In accordance with state law, MCPs must provide written acknowledgment to the member that is dated and postmarked within five calendar days of receipt of the grievance.[50] The acknowledgment letter must advise the member that the grievance has been received and the date of receipt, and it must 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 member are delineated in both federal and state law.[51] Federal regulations 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 must 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 member's submitted grievance as delineated in state regulations.[52]
b. The MCP's written resolution must contain a clear and concise explanation of the MCP's decision.[53]
c. Even though federal regulations allow for a 14-calendar day extension for standard and expedited appeals, this allowance does not apply to grievances. [54] In the event that resolution of a standard grievance is not reached within 30 calendar days as required, the MCP must notify the member in writing of the status of the grievance and the estimated date of resolution.

D. Exempt Grievances

MCPs must comply with all state laws pertaining to exempt grievance handling.[55] Grievances received over the telephone that are not coverage disputes or disputed health care services involving medical necessity or experimental or

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[50] HSC 1368(a)(4)(A); 28 CCR 1300.68(d)(1)
[51] 42 CFR 438.408(b)(1); HSC 1368.01(a); 28 CCR 1300.68(a) and (d)(3)
[52] 28 CCR 1300.68(a)(4)
[53] HSC 1368(a)(5); 28 CCR 1300.68(d)(3)
[54] 42 CFR 438.408(c)
[55] HSC 1368(a)(4)(B); 28 CCR 1300.68(d)(8)

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 must maintain a log of all such grievances containing the date of the call, the name of the complainant, member identification number, nature of the grievance, nature of the resolution, and the name of the representative who took the call and resolved the grievance. The information contained in the log must be reviewed by the MCP.

MCPs must ensure exempt grievances are incorporated into the quarterly grievance and appeal report that is submitted to DHCS.

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

E. Expedited Grievances

State law delineates processes for expedited grievance handling and requires resolution within three calendar days.[56] DHCS acknowledges that there are instances that may involve an imminent and serious threat to the health of a member – 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 must apply the federal timeframe for resolving expedited appeals (72 hours) to expedited grievances. The 72-hour timeframe requires MCPs to record not just the date of the grievance receipt, but also the time, as the specific time of receipt dictates the timeframe for resolution.

Federal regulations require the MCP to make reasonable efforts to provide the member with oral notice of the expedited resolution.[57] MCPs must apply this requirement of oral notice for expedited appeals to expedited grievances.

MCPs must comply with all other state requirements pertaining to expedited grievance handling in accordance with state law.[58]

[56] HSC 1368.01(b); 28 CCR 1300.68.01(a)(2)
[57] 42 CFR 438.408(d)(2)(ii)
[58] HSC section 1368.01(b); 28 CCR section 1300.68.01

IV. APPEALS

A. Timeframes for Requesting an Appeal

Timeframes for filing appeals are delineated in the DHCS contract, as well as in federal law.[59] Members must file an appeal within 60 calendar days from the date of the NOA. Members must exhaust the MCP's appeal process prior to requesting a state hearing, except in instances of deemed exhaustion.[60]

B. Method of Requesting an Appeal

In accordance with federal and state law, appeals may be filed either orally or in writing by a member, a provider acting on behalf of the member, or an authorized representative.[61] Appeals filed by the provider on behalf of the member require written consent from the member.[62] MCPs must comply with this requirement in accordance with the DHCS contract and federal regulations.[63]

The date of the oral appeal establishes the filing date for the appeal.[64] MCPs must accept a written appeal following the member's oral request for a standard appeal. However, MCPs only have 30 calendar days to resolve the appeal regardless of whether the oral appeal is followed by a written appeal. If the MCP fails to respond within 30 calendar days of receipt of an oral request for an appeal, the member is deemed to have exhausted the MCP's internal appeal requirement and can request a state hearing.

Failure to submit a written appeal is not a basis for the MCP to disregard the oral appeal. MCPs are required to assist any member wishing to file an appeal. This includes assisting the member with navigating the MCP's website or providing the appeal form to the member upon request. MCPs must also advise and assist the member to ensure the provision of Aid Paid Pending during the appeal of the adverse benefit determination, in accordance with federal and state law.[65] MCPs must provide Aid Paid Pending regardless of whether the member makes a separate request to the MCP when the member timely files an appeal (i.e., within 10 days of the NOA, or before the effective date of the intended action) of a decision to terminate, suspend or reduce services. In the event the MCP does

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[59] Exhibit A, Attachment 14; 42 CFR 438.402(c)(2)(ii)
[60] 42 CFR 438.402, 438.404, 438.408, and 438.10; WIC 14197.3 and 10951.
[61] 42 CFR 438.402(c)(3)(ii); 28 CCR 1300.68(a)(1)
[62] 42 CFR 438.402(c)(1)(ii)
[63] Exhibit A, Attachment 14
[64] 42 CFR 438.406(b)(3)
[65] 42 CFR 438.420; 22 CCR 51014.1 and 51014.2.

not receive a written, signed appeal from the member, the MCP is prohibited from dismissing or delaying the resolution of the appeal.

C. Standard Appeals

1. Acknowledgment

In accordance with state law, MCPs must provide the member with written acknowledgment within five calendar days of receipt of the appeal. The acknowledgment letter must advise the member that the appeal has been received and the date of receipt, and it must provide the name, telephone number, and address of the representative who may be contacted about the appeal.[66]

2. Resolution

The timeframe for resolving appeals is within 30 calendar days.[67]

3. Deemed Exhaustion

In the event that the MCP fails to adhere to the state and federal notice and timeframe requirements for either a NOA or a NAR, including the MCP's failure to provide a fully translated notice, the member is deemed to have exhausted the MCP's internal appeal process and may initiate a state hearing.[68]

D. Expedited Appeals

In accordance with federal law, the timeframe for resolving expedited appeals must be no longer than 72 hours.[69] MCPs must comply with the 72-hour timeframe. The 72-hour timeframe requires MCPs to record the time of appeal receipt, and not just the date*,* as the specific time of receipt dictates the timeframe for resolution.

Additionally, MCPs are required to make reasonable efforts to provide the member with oral notice of the expedited appeal resolution.[70] MCPs must comply with all other existing state regulations pertaining to expedited appeal handling.[71]

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[66] HSC 1368(a)(4)(A); 28 CCR 1300.68(d)(1)
[67] 42 CFR 438.408(b)(2); 28 1300.68; HSC 1368.01
[68] Title 42 CFR section 438.10, 42 CFR 438.402(c)(1)(i)(A), and 438.404; and 438.408(c)(3) and (i), WIC 14029.91 and WIC 10951(b)(1)(A); Title 45 CFR, Part 92
[69] 42 CFR 438.408(b)(3)
[70] 42 CFR 438.408(d)(2)(ii)
[71] 28 CCR 1300.68.01

E. Notice of Appeal Resolution

MCPs must provide members with a written NAR using the appropriate DHCS-developed, standardized NAR template. There are two NAR template options:

- Uphold: for appeals not resolved wholly in favor of the member; or
- Overturned: for appeals resolved in favor of the member.

For appeals upholding the original adverse benefit determination, the NAR must also include the NAR "Your Rights" attachment.

MCPs may replace the medical director's name with the medical director's initials or "Office of the Medical Director". MCPs are not permitted to make any other changes to the NAR templates or "Your Rights" templates without prior review and approval from DHCS, except to insert information specific to the member as required.

F. Content of Notice

Content requirements for the NAR are delineated in federal and state law. The written NAR must meet all language and accessibility standards, including translation, font, and format requirements, as set forth in APL 21-004, Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services, federal and state law, and all requirements in the DHCS contract.[72]

For appeals not resolved wholly in favor of the member, the NAR is comprised of two components: 1) the NAR "Uphold" template and 2) the NAR "Your Rights" template. MCPs must send the member both of these documents to comply with all requirements of the NAR.

For appeals resolved in favor of the member, the NAR only consists of the NAR "Overturned" template; the "Your Rights" attachment is not included with the NAR when the appeal overturns the original adverse benefit determination.

1. Notice of Appeal Resolution (NAR Template)

MCPs must comply with federal and state law in determining whether to uphold or overturn an adverse benefit determination in response to member appeals. The written NAR must contain the following:

[72] Title 42 CFR section 438.10, 438.402(c)(1)(i)(A), 438.404, and 438.408(c)(3) and (i); WIC 14029.91 and 10951(b)(1)(A); and Title 45 CFR, Part 92

a. The results of the resolution process and the date it was completed.[73]
b. For decisions to uphold a denial determination that is based in whole or in part on medical necessity: the reasons for its determination and clearly stated criteria, clinical guidelines, or medical policies used in reaching the determination.[74]
c. For decisions to uphold a denial based on a determination that the requested service is not a covered benefit: the provision in the DHCS contract, or in the evidence of coverage/member handbook, that excludes the service. The response must either identify the document and page where the provision can be found, direct the member 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.[75]
d. For appeals resolved in favor of the member: a clear and concise explanation of why the decision was overturned.[76]

2. NAR "Your Rights" Attachment Template(s)

The NAR "Your Rights" template informs members of their rights following an adverse benefit determination that has been upheld on appeal. It does not contain information on how to file a request for an appeal, as the member will have already exhausted the MCP's appeal process.

The DHCS-developed NAR "Your Rights" templates include all of the following required elements:

a. The member's right to request a state hearing no later than 120 calendar days from the date of the MCP's written NAR and instructions on how to request a state hearing.[77]
b. The member's right to Aid Paid Pending and instructions on how to timely file for a state hearing (i.e., within 10 days of the NAR) regarding a decision to terminate, suspend, or reduce services. MCPs must provide Aid Paid Pending regardless of whether the member makes a separate request to the MCP when the member timely files for a state hearing regarding a decision to terminate, suspend or reduce services.[78]

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[73] 42 CFR 438.408(e)(1)
[74] HSC 1367.01(b); 28 CCR 1300.68(d)(4)
[75] HSC 1363.5 and 1367.01; 28 CCR 1300.68(d)(5)
[76] HSC 1368(a)(5); 28 CCR 1300.68(d)(3)
[77] 42 CFR 438.408(e)(2)(i); 22 CCR 53858(e)(5)
[78] 42 CFR 438.408(e)(2)(ii) and 42 CFR 438.420; 22 CCR 51014.1 and 22 CCR 51014.2

c. For Knox-Keene licensed MCPs, the member's right to request an IMR from 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 a disputed emergency service.[79]

MCPs must use the NAR "Your Rights" templates attached to this APL. All COHS MCPs, except those that are Knox-Keene licensed, must use the "Your Rights" template for non-Knox-Keene licensed MCPs, whereas all Knox-Keene licensed MCPs must use the "Your Rights" template for Knox-Keene licensed plans.

The NAR "Your Rights" template for Knox-Keene licensed MCPs provides information for members on how to request an IMR. Knox-Keene licensed MCPs are subject to additional state laws, including the requirement that certain written notices to members contain prescribed language advising members of additional rights and directing them to contact DMHC to request an IMR.[80] This mandatory paragraph is already incorporated into the template and requires no action by MCPs.

When sending the "Your Rights" attachment to members as part of the NAR, MCPs must include the most current version of the state hearing form, which is provided as an attachment to this APL. Knox-Keene licensed MCPs must also include the IMR form, application instructions, DMHC's toll-free telephone number, and an envelope addressed to DMHC.[81] Knox-Keene licensed MCPs are required to check the DMHC website periodically to ensure use of the most current form.[82] MCPs may include state hearing and IMR forms that contain tracking numbers to more easily identify and administer member rights. Such tracking numbers should contain initials, acronyms, or names that identify the MCP.

G. Overturned Decisions

MCPs must authorize or provide the disputed services promptly and as expeditiously as the member's condition requires if the MCP reverses its decision to deny, limit, or delay services that were not furnished while the appeal was pending. MCPs must authorize or provide services no later than 72 hours from the date the determination is reversed.[83]

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[79] HSC 1370.4 and 1374.30(d); 28 CCR 1300.74.30(a)
[80] HSC 1368.02(b)
[81] 28 CCR 1300.68(d)(4)
[82] The IMR form can be accessed at the following link: http://www.hmohelp.ca.gov/
[83] 42 CFR 438.408

V. TRANSLATION OF GRIEVANCE AND APPEALS NOTICES

Federal and state law, the DHCS contract, and APL 21-004 require MCPs to fully translate and provide written member information in a member's required language, as specified, including all grievance and appeals notices referenced in this APL.[84]

Specifically, MCPs must fully translate NOAs/NARs, including the clinical rationale for the MCP's decision that must be included in the NOA/NAR. While DHCS has made it clear that immediate translation of the entire NOA/NAR is required by federal and state law, DHCS acknowledges that MCP Trade Associations have advised that some MCPs do not currently have sufficient technological or contractual processes in place to ensure immediate translation of the clinical rationale.

MCPs that are not currently in compliance with immediate, full translation of the entire NOA/NAR are expected to come into compliance with full translation within six months of the issuance date of this APL. Failure to come into compliance will subject non-compliant MCPs to corrective action and imposition of monetary sanctions.

MCPs that mail a partially translated NOA/NAR with the clinical rationale written in English must ensure all of the following requirements are met during the six month compliance period: 1) the body of the NOA/NAR (i.e., non-clinical NOA/NAR template language) must be translated into the member's required language; 2) a sentence must be inserted in the NOA/NAR in the member's required language explaining how the member can obtain oral interpretation of the clinical rationale on an expedited basis; 3) the MCP must make every effort to provide the member with an explanation of the clinical rationale regarding the requested service, which includes assisting the member in exercising all grievance rights pursuant to federal and state law; 4) provide a fully translated written notice, including a fully translated clinical rationale, as soon as possible but not later than 30 calendar days from the date the partially translated notice was sent; and, 5) the MCP is prohibited from requesting dismissal of a state hearing in all cases where it failed to provide a fully translated notice because this qualifies as deemed exhaustion of the MCP's internal appeal and the member can immediately request a state hearing.[85]

VI. STATE HEARINGS

A member has a due process right to request a state hearing when a claim for medical assistance is denied or is not acted upon with reasonable promptness. [86] A member may also initiate a state hearing if the member is deemed to have

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[84] 42 CFR 438.10(d)(3), 438.404(a), and 438.408(d)(2)(i); 22 CCR 53876; WIC 14029.91(e); Exhibit A, Attachment 9, Linguistic Services
[85] 42 CFR 438.68, 438.402, 438.408
[86] 42 CFR 431.205, 42 C.F.R. § 431.242 and *Goldberg v. Kelly*, 397 US 254 (1970);

exhausted the MCP's appeal process because the MCP failed to comply with notice and timing requirements.[87] The parties to a state hearing include the MCP as well as the member and, if applicable, the member's representative or the representative of a deceased member's estate.[88] To ensure a member's right to due process during the state hearing process, the MCP must ensure that a statement of position is timely filed with the California Department of Social Services (DSS) State Hearings Division and that a witness is available and prepared to present the MCP's position and to be cross-examined at the state hearing.[89]

A. Timeframes for Filing

Federal regulations require members to request a state hearing within 120 calendar days from the date of a NAR informing the member that an adverse benefit decision has been upheld.[90] The DHCS templates for the "Your Rights" attachments inform members of this requirement.

In cases of deemed exhaustion, the member has 120 days from: 1) the expiration date of the timeframe in which the MCP should have sent a NAR to the member; 2) the expiration date of the timeframe in which the MCP should have sent a NOA to the member; or 3) the date of the member's receipt of the MCP's deficient written NAR/NOA (e.g., in cases where the MCP failed to provide a fully translated NOA).[91]

B. Standard Hearings

The MCP must notify members that the state must issue a final decision within 90 calendar days of the date of the request.[92]

C. Expedited Hearings

The MCP must notify members that the state must issue a final decision within three working days of the date of the request.[93]

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[87] 42 CFR 438.10, 438.402, 438.404 and 438.408
[88] 42 CFR 438.408(f)(3)
[89] 42 CFR 431.205, 42 C.F.R. § 431.242; Goldberg v. Kelly, 397 US 254, *supra;* DSS Manual of Policies and Procedures (MPP), MANUAL LETTER NO. CFC-16-01, section 22-049.
[90] 42 CFR 438.408(f)(2)
[91] 42 CFR 438.408
[92] 42 CFR 431.244(f)(1)
[93] 42 CFR 431.244(f)(2)

D. Overturned Decisions

The MCP must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from the date the MCP receives notice of the hearing decision reversing the MCP's adverse benefit determination.[94]

VI. NONDISCRIMINATION NOTICE AND LANGUAGE ASSISTANCE TAGLINES[95]

When sending the required grievance and appeals notifications to members, MCPs must comply with the nondiscrimination and language assistance requirements as outlined in APL 21-004, including any subsequent updates or revisions to this APL.

VII. GRIEVANCE AND APPEAL SYSTEM OVERSIGHT

MCPs must establish, implement, maintain, and oversee a grievance and appeal system to ensure the receipt, review, and resolution of grievances and appeals. The grievance and appeal system must operate in accordance with all applicable federal and state laws.[96]

A. The MCP must operate in accordance with its written procedures for grievance and appeals. These procedures must be submitted to DHCS prior to use.[97]

B. The MCP must designate an officer that has primary responsibility for overseeing the grievance and appeal system. The officer must continuously review the operation of the grievance and appeal system to identify any emergent or systemic issues with grievances and appeals and/or patterns of improper service denials. The grievance and appeal system must include reporting procedures in order to improve MCP policies and procedures (P&P).[98]

C. The MCP must notify members about its grievance and appeal system and include information for members on how the MCP's procedures for filing and resolving grievances and appeals work, a toll-free telephone number or a local telephone number in each service area, and the address for mailing grievances and appeals. The notice must also include information regarding DMHC's review process, the IMR system, and DMHC's toll-free telephone number and website address, as appropriate.[99]

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[94] 42 CFR 438.424(a)
[95] For detailed information, see APL 21-004.
[96] 42 CFR Part 438, Subpart F; HSC 1368; 22 CCR 53858; 28 CCR 1300.68
[97] 22 CCR 53858(a)(1)
[98] 28 CCR 1300.68(b)(1)
[99] 22 CCR 53858(b); 28 CCR 1300.68(b)(2) and (4)

D. The MCP must notify members of the process for obtaining grievance and appeals forms. A description of the procedure for filing grievances and appeals must 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 must ensure that assistance in filing grievances and appeals will be provided at each location where grievances and appeals are submitted. Grievance and appeal forms must be provided promptly upon request.[100]

E. The MCP must ensure adequate consideration of grievances and appeals and rectification when appropriate. If multiple issues are presented by the member, the MCP must ensure that each issue is addressed and resolved.[101]

F. The MCP must maintain a written record for each grievance and appeal received by the MCP. The record of each grievance and appeal must be maintained in a log and include the following information:[102]

    1. The date and time of receipt of the grievance or appeal.
    2. The name of the member 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 its medical professional responsible for making utilization management decisions.
    7. The name of the MCP provider or staff responsible for resolving the grievance or appeal.
    8. The date of notification to the member of resolution.

G. The written record of grievances and appeals must be submitted at least quarterly to the MCP's quality assurance committee for systematic aggregation and analysis for quality improvement. Grievances and appeals reviewed must include, but not be limited to, those related to access to care, quality of care, and denial of services. MCPs must take appropriate action to remedy any problems identified.[103]

H. The written record of grievances and appeals must be reviewed periodically by the governing body of the MCP, the public policy body, and by an officer of the

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[100] 22 CCR 53858(c), (d), and (f); 28 CCR 1300.68(b)(6) and (7)
[101] HSC 1368(a)(1)
[102] 22 CCR 53858(e)(1); 28 CCR 1300.68(b)(5)
[103] 22 CCR 53858(e)(3) and (4)

MCP or designee. The review must be thoroughly documented.[104]

I. The MCP must ensure the participation of individuals with authority to require corrective action. All grievances and appeals related to medical quality of care issues must be immediately submitted to the MCP's medical director for action.[105]

J. The MCP must address the linguistic and cultural needs of its member population as well as the needs of members with disabilities. The MCP must ensure all members have access to and can fully participate in the grievance and appeal system by assisting limited English proficient members or those with a visual or other communicative impairment. Such assistance includes, 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.[106]

K. The MCP must assure that there is no discrimination against a member on the grounds that the member filed a grievance or appeal.[107]

L. The MCP must establish and maintain a system of aging of grievances and appeals that are pending and unresolved for 30 calendar days or more and include a brief explanation of the reasons for each pending and unresolved grievance and each appeal.[108]

M. The MCP must 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 must be a health care professional with clinical expertise in treating a member's condition or disease if any of the following apply:[109]

    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.

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[104] 28 CCR 1300.68(b)(5)
[105] 22 CCR 53858(e)(2)
[106] 22 CCR 53858(e)(6); 28 CCR 1300.68(b)(3)
[107] 28 CCR 1300.68(b)(8)
[108] HSC 1368(b)(8)
[109] 42 CFR 438.406(b)(2)

N. The MCP must ensure that individuals making decisions on appeals take into account all comments, documents, records, and other information submitted by the member or member's designated representative, regardless of whether such information was submitted or considered in the initial adverse benefit determination.[110]

O. The MCP must provide the member or the member's designated representative the opportunity to review the member'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.[111]

P. The MCP must provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony. The MCP must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe.[112]

All templates referenced in this APL may be viewed in PDF format on the DHCS website as attachments to this APL. To obtain copies of any template referenced in this APL in Word format, or to obtain translated state hearing forms, please send a request via email to: *MCQMD@dhcs.ca.gov.*

If the requirements contained in this APL, including any updates or revisions to this APL, necessitate a change in an MCP's *contractually required* P&Ps, the MCP must submit its updated P&Ps to its Managed Care Operations Division (MCOD) contract manager within 90 days of the release of this APL. If an MCP determines that no changes to its P&Ps are necessary, the MCP must submit an email confirmation to its MCOD contract manager within 90 days of the release of this APL, stating that the MCP's P&Ps have been reviewed and no changes are necessary. The email confirmation must include the title of this APL as well as the applicable APL release date in the subject line.

MCPs are responsible for ensuring that their Subcontractors and Network Providers comply with all applicable state and federal laws and regulations, contract requirements,

[110] 42 CFR 438.406(b)(2)(iii)
[111] 42 CFR 438.406(b)(5)
[112] 42 CFR 438.406(b)(4)

and other DHCS guidance, including APLs and Policy Letters.[113] These requirements must be communicated by each MCP to all Subcontractors and Network Providers. If you have any questions regarding this APL, please contact your MCOD Contract Manager.

Sincerely,

Original Signed by Bambi Cisneros

Bambi Cisneros
Acting Chief, Managed Care Quality and Monitoring Division
Assistant Deputy Director, Health Care Delivery Systems
Attachment(s)

[113] For more information on subcontractors and network providers, including the definition and applicable requirements, see APL 19-001, and any subsequent APLs on this topic.

SUMMARY OF GRIEVANCE & APPEAL REQUIREMENTS

TOPIC	REQUIREMENT
GRIEVANCES	
Filing	Any time
Acknowledgment	5 calendar days
Standard Resolution	30 calendar days
Exempt Resolution	Close of next business day
Expedited Resolution	72 hours
APPEALS	
Filing	60 calendar days
Filing	Oral appeal, which may be followed by a signed, written appeal[114]
Acknowledgment	5 calendar days
Standard Resolution	30 calendar days
Expedited Resolution	72 hours
Effectuation of Overturned Decisions	72 hours

[114] MCPs must still adjudicate a verbal appeal, regardless of whether the member submitted a written appeal or not. The thirty-day resolution period begins on the date the MCP receives an oral request for an appeal.

STATE HEARINGS	
Filing	120 calendar days from NAR, or in instances of deemed exhaustion
Standard Resolution	90 calendar days
Expedited Resolution	3 working days
Effectuation of Overturned Decisions	72 hours
NOTICE OF ACTION (NOA)	
NOA	• Clear & Concise • Criteria/Guideline • Clinical Reason
NOA	Must provide the reason for the decision, including the member's right to request free of charge copies of all documents and records relevant to the NOA, including criteria or guidelines used
NOA "Your Rights" Templates	• Member informed of requirement to exhaust the MCP's internal Appeal process prior to proceeding to a State Hearing or IMR • Must include the member's right to request a state hearing without having to complete the MCP's first level appeal process in instances of deemed exhaustion.
State Hearing & IMR Forms	Attached to NOA

NOTICE OF APPEAL RESOLUTION (NAR)	
NAR (Uphold)	Distinct NAR template created for appeal resolution
NAR “Your Rights” Templates	Distinct “Your Rights” template created to inform member of only State Hearing and IMR rights
State Hearing & IMR Forms	Attached to NAR
NAR (Overturn)	Standard template created for consistency