Disability Rights California

*California's Protection & Advocacy System*

# Medi-Cal Managed Care: Appeals and Grievances

***Updated July 2018, Pub #5606.01***

**What can I do if I do not like something my Medi-Cal managed care plan did?**

California as of July 1, 2017, is following new federal regulations about how you appeal a decision or dispute about benefits, and about how you bring other matters to the attention of the managed care plan through a grievance. First, it is always best to talk directly with your provider or call your plan's customer service number. If that does not resolve the issue, you can take one of the following actions. For more information about the new federal regulations, you can read the National Health Law Program's (NHeLP) publication on the issue here: click for 'Issue Brief 2: Medicaid Managed Care Final Regulations Grievance & Appeals Systems' page on NHeLP's website. NHeLP also produced a very detailed publication about Medi-Cal managed care appeals and grievances (*Issue 4: Internal Grievances and External Review for Service Denials in Medi-Cal Managed Care Plans*), and it is available for download at click for 'Managed Care in California Series, Issue 4: Internal Grievances and External Review for Service Denials in Medi-Cal Managed Care Plans' page on NHeLP's website.

NOTE: All Plan Letter 17-006 contains more detailed information on what is discussed below, such as the form of notices, and it is available at click here for the PDF of All Plan Letter 17-006 re: "Grievance and Appeal Requirements and Revised Notice Templates and 'Your Rights' Attachments" from DHCS' website.

## I. File an appeal with your managed care plan.

First, it is important to know about Adverse Benefit Determinations (ABD).[1] An ABD is an action taken by your managed care plan that affects your care, such as delay, modification, denial or reduction of services, denial or only partial payment for a service, or the determination that the requested service was not a covered benefit. The term ABD is now used instead of "Notice of Action," or "NOA." For more information on what an ABD includes, see page 2 of the All Plan Letter 17-006 mentioned above.

Each managed care plan must have an appeal system in place for beneficiaries. An appeal is a review by your managed care plan of an ABD.[2] You must file your appeal within 60 days after you receive notice of an ABD. You can file your appeal either orally or in writing, but if you file it orally, you will need to send in a signed, written appeal to your health plan.[3] In addition, make sure you are filing the appeal with your managed care plan, and not your physician's group or other provider group.

Your managed care plan must provide written acknowledgement of your appeal within 5 days of receipt of the appeal.[4] Your plan must generally resolve the issue within 30 days and will send you a Notice of Appeal Resolution (NAR) when they have made a decision about your appeal.[5] A NAR) is a formal letter informing you that an ABD has been overturned or upheld, and should include information on how to request a state fair hearing if you are unhappy with the decision.[6]

You can also file for an expedited appeal if you think you are at risk of imminent and serious threat to your health, such as severe pain or potential loss of life, limb, or major bodily function. In those cases, your health plan must respond to your appeal within 72 hours. Here again, an extension of 14 days to respond may apply.[7] You can get an expedited appeal if there is a serious threat to your health.

If your health plan does not provide a decision within the required timeframes discussed above, it is considered a denial and is therefore an ABD on the date the timeframe expires.[8]

Once you have exhausted your plan's internal appeals procedures, you can request a Medi-Cal fair hearing with the California Department of Social Services ("CDSS").[9] You can also request a Medi-Cal fair hearing if your

managed care plan did not send you a NAR within the required timeframe.[10] You must request a state hearing no later than 120 calendar days from the date of your managed care plan's NAR.[11] You can also ask for an expedited review.

A. Use this two-step process:

It used to be that you could file for fair hearing within 90 days of the date of the NOA. NOW, it is a two-step process: first, appeal to your managed care plan within 60 days of receipt of the ABD, and second, file for a fair hearing within 120 days of the date you received the NAR. You should use this two-step process even if you have not received a written ABD but you are disputing action or inaction that affects your care.

The CDSS hearing website is here: click for 'Medi-Cal Fair Hearing' page on DHCS' website. Information about requesting a fair hearing is here: click for 'Your Hearing Rights' page on DSS' website.

## II. File a Grievance with your managed care plan

Each managed care plan must have a grievance system in place. You can file a grievance, also known as a "complaint", if you are unhappy with something your managed care plan or a health plan provider did, not related to an ABD. A grievance may include the quality of care you received from a doctor, or if a doctor or other staff was rude to you.[12] Sometimes, it may not be obvious if you should file a grievance or an appeal. In those cases, if you file a grievance where you should have filed an appeal, your managed care plan should identify which it should be and proceed accordingly.

Your managed care plan must provide written acknowledgment of your grievance within 5 days of receipt of the grievance.[13] Your managed care plan must generally resolve a grievance within 30 days. You can also file for an expedited grievance if you think you are at risk of imminent and serious threat to your health, such as severe pain or potential loss of life, limb, or major bodily function. In those cases, your health plan must respond to your grievance within 72 hours.

You can file a grievance with your Medi-Cal managed care plan orally or in writing.

### A. Medi-Cal fair hearing

You can also file for a Medi-Cal Fair Hearing if you have a grievance against your health plan, or if you are otherwise dissatisfied with your Medi-Cal services.[14] However, this does not always mean that the Administrative Law Judge (ALJ) who decides your case will have the power to correct the problem. For example, if you file a grievance because a staff member was rude to you, and you do not like how your managed care plan resolved your grievance, the ALJ cannot correct that problem. However, the ALJ might be able to help you if, for instance, your managed care plan never answers the phone because it can involve access to care issues.

You must file your hearing within 90 days from the date of the situation giving rise to the grievance. You do not need to exhaust your plan's internal grievance procedure before going to a hearing for something other than an Adverse Benefit Determination (ABD, explained below), so you might want to file a grievance and a hearing request at the same time. The only time you need to file an appeal before requesting a fair hearing is when it involves an ABD. The CDSS hearing website is here: click for 'Medi-Cal Fair Hearing' page on DHCS' website. Information about requesting a fair hearing is here: click for 'Your Hearing Rights' page on DSS' website.

## III. Ask the Department of Managed Health Care for Help

The Department of Managed Health Care (DMHC) can help you if you have a dispute with your health plan, including requesting an Independent Medical Review, reviewing grievances, and filing complaints. The DMHC regulates health plans under the Knox-Keene Act. The Knox-Keene Act is a set of laws that regulate managed health care plans. For more information on the Knox-Keene Act, you can visit click here for the 'Laws Relating to Health Care Services Plans in California' page on DMHC's website. Knox-Keene does not apply to County Operated Health Systems (COHS) counties, except for the COHS plan - Health Plan of San Mateo. This health plan voluntarily subjected itself to Knox-Keene requirements but not other COHS which are:

- CalOptima – Orange;
- CenCal Health - Santa Barbara and San Luis Obispo;

- Central California Alliance for Health - Santa Cruz, Monterey, Merced;
- Gold Coast Health Plan – Ventura;
- Partnership HealthPlan of California - Solano, Napa, Yolo, Sonoma, Mendocino, Marin, Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, Trinity.

### A. Filing a complaint with DMHC

You can file a complaint with DMHC if you don't like how your managed care plan resolved your grievance or the time for it to respond has passed. You can do this by filing a "complaint" with DMHC within 180 days of the incident giving rise to the grievance.[15] You can contact DMHC at (888) 466-2219 or TDD: (877) 688-989. Also see click here for the 'File a Complaint' page on DMHC's website. You can also call DMHC's Help Center at 1 (888) 466-2219. Information about DMHC can be found here: click this link for the 'About the DMHC' page on their website.

### B. Filing a complaint for non Knox-Keene plans

If you have one of the five non Knox-Keene plans above, then you cannot get help settling your dispute from the DMHC. Although DMHC does not review complaints for members in who are not in Knox Keene Plans, you can contact the Department of Health Care Services (DHCS) Medi-Cal Managed Care Office of the Ombudsman. You can call them at 1-888-452-8609 or by email at MMCDOmbudsmanOffice@dhcs.ca.gov. For more information, visit click here for the 'Medi-Cal Managed Care and Mental Health Office of the Ombudsman' page on DHCS' website.

You can also settle the dispute internally through your health plan.

### C. Request an Independent Medical Review

If your issue is denial, reduction, or delay of a service/device/supply because your managed care plan does not think that it is medically necessary, or they say it is experimental or investigational, and you have exhausted your appeal process, under Knox Keene licensed managed care plans, you can file a request for independent medical review (IMR) with the DMHC. You have 6 months from receiving the NAR to request an IMR.

IMPORTANT: If you choose to ask for an IMR first, the 120 days to request a state fair hearing continues to run. Also, you cannot ask for an IMR if you have already attended a state fair hearing. It is very important that you keep this in mind.

You can also request an IMR at click this link for the 'Submit an Independent Medical Review/Complaint Form' page on DMHC's website.

See our publication on independent medical reviews at click here for the DRC publication titled "Medi-Cal Managed Care: An Independent Medical Review (IMR) Can Change a Plan's No to Yes" PDF.

**NOTE:** You can only ask for an IMR if you are in a health plan that is licensed under the Knox-Keene Act. See above for non-Knox-Keene licensed health plans.

**Will my benefits continue after I file an appeal?**

Yes, but only if you request an appeal and ask for aid-paid-pending the hearing with your managed care plan or a Medi-Cal fair hearing before your services are reduced, suspended or terminated.[16] (Note: you can also get your services reinstated pending the hearing if you were not given proper written notice of the reduction, suspension or termination.)

If you want an IMR and a Medi-Cal fair hearing with aid paid pending the hearing, you must request the fair hearing before your services are reduced, suspended or terminated. To ensure you continue receiving services, you may want to request an IMR and request a fair hearing with aid paid pending at the same time. You can then request a postponement of the fair hearing pending resolution of the IMR. That way, you can get aid paid pending the hearing while you wait for the resolution of the IMR.

*Disability Rights California is funded by a variety of sources, for a complete list of funders, go to* click here for the 'List of Funding Grants and Contracts' page under Documents on Disability Rights California's website.

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[1] All Plan Letter 17-006, at p. 6, available at this link for the PDF - (Return to Main Document)

[2] 42 C.F.R. § 438.400(b) - (Return to Main Document)

[3] 42 C.F.R. §§ 438.402(c)(3)(ii) and 438.406(b)(3) - (Return to Main Document)

[4] All Plan Letter 17-006, at p. 14, available at this link for the PDF - (Return to Main Document)

[5] 42 C.F.R. § 438.408(b)(2)- (Return to Main Document)

[6] All Plan Letter 17-006, at p. 9, available at this link for the PDF - (Return to Main Document)

[7] All Plan Letter 17-006, at p. 15, available at this link for the PDF - (Return to Main Document)

[8] 42 C.F.R. § 438.404(c)(5); All Plan Letter 17-006, at p. 5, available at this link for the PDF - (Return to Main Document)

[9] 42 C.F.R. § 438.404(b)(3) - (Return to Main Document)

[10] 42 C.F.R. § 438.408(c)(3) - (Return to Main Document)

[11] 42 C.F.R. § 438.408(f)(2) - (Return to Main Document)

[12] 42 C.F.R. § 438.400(b) - (Return to Main Document)

[13] All Plan Letter 17-006, at p. 11, available at this link for the PDF - (Return to Main Document)

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[14] Welfare & Institutions Code § 10950 ("If any applicant for or recipient of public social services is dissatisfied with any action of the county department relating to his or her application for or receipt of public social services…he or she…shall be…accorded an opportunity for a state hearing."). See also 22 C.C.R. § 51014.1. - (Return to Main Document)

[15] 28 C.C.R. § 1300.68(b)(9) - (Return to Main Document)

[16] 42 C.F.R. § 438.420 - (Return to Main Document)