



**Internal and External Review:
Medi-Cal Managed Care Plans
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Introduction

Federal and state law and the state and federal Constitutions require that enrollees in Medi-Cal managed care plans receive notice, and grievance and appeal rights when they are denied access to medically necessary services.¹ Frequently, however, enrollees fail to receive the required notice, get an inadequate notice, or do not understand their right to appeal the plan's decision.

Medi-Cal Managed Care is a provider payment and delivery system through which the California Department of Health Care Services (DHCS) contracts with independent managed care plans to provide health care services to Medi-Cal beneficiaries.² A large majority of Medi-Cal beneficiaries receive their health care services through these Medi-Cal managed care health plans (MCPs).³ MCPs are subject to federal and state laws enforced by various state and federal regulators.

DHCS "carves out" Specialty Mental Health Services (SMHS) from responsibility of MCPs. Instead, County Mental Health Plans (MHPs) are charged with providing SMHS to enrollees.⁴ MHPs are specialized plans operated by counties and implemented through a contract with DHCS; the MHPs are responsible for providing or arranging for the provision of SMHS to enrollees who meet specific SMHS criteria.⁵

DHCS also administers the Drug Medi-Cal program, which funds the treatment of Medi-Cal enrollees who receive substance use disorder services through a Drug Medi-Cal-certified program.⁶ The Drug Medi-Cal Organization Delivery System (DMC-ODS) is a voluntary pilot program established through a Medicaid waiver, approved by CMS in 2015 under § 1115 of the Social Security Act, that requires participating counties to provide expanded access to a "full continuum" of substance use disorder benefits for Drug Medi-Cal enrollees.⁷

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Most—but not all—MCPs are also licensed by the California Department of Managed Health Care (DMHC) and are subject to a set of consumer protection laws called the “California Knox-Keene Act” (KKA).⁸ Certain other MCPs – called County Organized Health System (COHS) plans –are exempt from DMHC licensure.⁹ Likewise, MHPs and DMC-ODS are not licensed by DMHC.¹⁰ However, MHPs and DMC-ODS must generally comply with the same standards as Medi-Cal health plans pursuant to Behavioral Health Parity laws.¹¹

This issue brief will provide an overview of the rules and processes that apply to all Medi-Cal plans, as well as the additional protections that apply to DMHC-licensed plans.

I. Medi-Cal Managed Care Rules

All Medi-Cal managed care plans are subject to federal and state Medicaid laws regarding notice and appeal rights. These federal rules and some additional state regulations govern MHPs and DMC-ODS.¹² The federal Medicaid managed care rules were updated in 2016 and went into effect July 1, 2017.¹³ In addition, certain provisions of the state KKA apply to all Medi-Cal managed care plans, regardless of whether they are DMHC-licensed. This section provides an overview of the requirements that apply to all Medi-Cal plans.

a. Notice

Medi-Cal managed care plans must provide written notice before making an “adverse benefit determination” to deny, delay, or modify of all or part of a requested service, or reduce, suspend, or terminate an existing service.¹⁴ A Medi-Cal plan must provide notice concerning an adverse benefit determination to reduce, suspend, or terminate an existing service at least 10 days in advance.¹⁵ The written notice to enrollees provided by Medi-Cal plans must explain what adverse benefit determination the plan is taking and why, and must also inform the enrollee about his or her rights including: the right to a grievance or appeal and how to file one, the right to a fair hearing and how to request one, the right to continue benefits pending the appeal and how to exercise that right, and the circumstances in which the enrollee has a right to expedited review and how to request it.¹⁶ Notices must be translated in prevalent non-English languages, and oral interpretation must be available in all languages upon request.¹⁷ The notices must also be available in alternative formats, such as large print or Braille.¹⁸

MCPs must provide notice according to particular timeframes: within 72 hours of a decision to approve, deny, or modify requested care for cases involving an imminent threat to health (or shorter if required by the insured’s health); two business days for a decision to deny, delay, or modify a request for prior or concurrent authorization of a service; five business days for any other decision regarding prior authorization and concurrent claims (claims involving services the enrollee is currently receiving); and 30 days for post-service (reimbursement) claims.¹⁹

b. Continuing benefits

In cases where a Medi-Cal plan proposes to reduce, suspend, or terminate an enrollee's current services ordered by an authorized provider, the enrollee is entitled to continue receiving those services while they appeal the decision.²⁰ If an enrollee or their representative requests continued benefits when filing an internal grievance or appeal within 10 days from the date of the notice or before the date of the proposed adverse benefit determination, the plan must continue benefits until the internal appeal is resolved.²¹ Similarly, if the enrollee requests continued benefits when requesting a Medi-Cal state fair hearing within 10 days from the date of the notice or before the date of the proposed adverse benefit determination, the plan must continue benefits until the authorization period expires or the fair hearing is resolved, whichever is first.²² If an enrollee requests continuing benefits pending an internal grievance/appeal (but does not request a fair hearing), and the internal appeal is not resolved in their favor, they must request a fair hearing (with continuing benefits) within 10 days of notice of the internal appeal decision or before the effective date of the proposed adverse benefit determination, in order to continue those benefits pending the fair hearing resolution.²³

In certain instances where an MCP enrollee has previously received a service, and the treating provider requests reauthorization of the service but the plan denies the request, the enrollee has the right to continue benefits pending appeal. If the enrollee requests to continue benefits within 10 days of the date of the notice or before the effective date of the proposed adverse benefit determination, the plan must continue benefits until the enrollee withdraws the appeal or fair hearing request, the enrollee does not request a state fair hearing within 10 calendar days after the health plan sends notification of its adverse resolution of the appeal, or the state fair hearing decision is issued and is unfavorable to the enrollee.²⁴ MCP enrollees may also request to continue benefits for any other previously authorized service as long as the treating doctor substantiates that services should continue because the treatment goal of the original authorization request has not been met, even if the original authorization period has expired.²⁵

c. Internal Review

In Medi-Cal, plans are required to offer two separate tracks for internal plan grievances or appeals: one to resolve issues related to "adverse benefit determinations" (i.e. to deny, delay, or modify of all or part of a requested service, or reduce or terminate an existing service), which are formally known as appeals, and one to resolve any other enrollee complaints that do not qualify as an adverse benefit determination, which are known as grievances.²⁶ Medi-Cal plan enrollees must file any plan appeal related to an adverse benefit determination within 60 days; however, Medi-Cal plan enrollees may file a plan grievance on any other complaints (i.e. non-adverse benefit determinations) at any time after the incident.²⁷ In most cases, enrollees must exhaust the plan's internal grievance/appeal process before they may request a fair hearing or other types of external review (see below).²⁸ By contract, Medi-Cal plans' internal

grievance/appeal processes must meet the KKA requirements to which DMHC-licensed plans are held, as well as additional requirements imposed by federal and state Medicaid rules.²⁹

When a plan delays, denies, reduces, modifies, suspends, or terminates a service, it must inform the enrollee about the right to file an internal appeal on the written notice of the adverse benefit determination.³⁰ Plans must provide forms and a toll-free number through which enrollees can file a grievance/appeal.³¹ Plans must help enrollees to file a grievance/appeal when necessary, including by providing language assistance and reasonable accommodations for enrollees with disabilities.³² When an enrollee files a grievance/appeal, the plan must acknowledge the receipt of most internal grievance/appeal within five days.³³ The acknowledgement must include the date the plan received the grievance/appeal and provide the name, telephone number, and address of the plan representative handling the grievance.³⁴ Enrollees may file a grievance/appeal orally or in writing for any reason, and they may authorize an advocate or provider to assist them in the process.³⁵

MCPs must ordinarily resolve all internal grievances/appeals via written response within 30 days.³⁶ MHPs and DMC-ODS have 90 days to resolve internal non-adverse benefit determination grievances via written response unless the grievance concerns a plan's decision to extend the timeframe for making an authorization decision, in which case the plans must resolve the grievance within 30 days.³⁷ Plans must, however, resolve an internal grievance/appeal within 72 hours when it involves an "imminent and serious threat" to the enrollee's health.³⁸ For all internal grievances/appeals, a Medi-Cal plan must ensure that the person who makes the decision resolving the internal grievance/appeal: (1) has the ability to require corrective action, (2) was not involved in any prior decisions on the case, (3) has appropriate clinical expertise, and (4) will take into account all information submitted by the enrollee whether or not it was previously submitted or considered.³⁹ In cases involving an adverse benefit determination, the Medi-Cal plan must allow the enrollee to present evidence and allegations in person and in writing, and allow the enrollee or her representative to examine any case records.⁴⁰

Medi-Cal plans may extend the 30-day grievance/appeal resolution timeframe by 14 days if the enrollee requests an extension or the plan proves to DHCS that it requires additional information and that the delay is in the enrollee's interest.⁴¹ If a plan extends the grievance/appeal response timeframe, and the enrollee did not request the extension, the plan must: (1) give the enrollee "prompt" oral notice of the delay, (2) give the enrollee written notice within two days providing the plan's reasons for the extension and informing the enrollee of their right to file a grievance/appeal about the extension, and (3) resolve the grievance/appeal as quickly as the enrollee's health requires and before the extended timeframe expires.⁴²

For Medi-Cal plans, when an internal appeal involving an adverse benefit determination is resolved, the plan must provide written notice that explains the resolution, the reason for the

resolution and the notice date.⁴³ If an internal appeal involves medical necessity or coverage of a service, an MCP must explain the criteria used to reach its decision, including any clinical criteria, if applicable.⁴⁴ When adverse benefit determinations involve medical necessity determinations for MHPs and DMC-ODS, the plan must explicitly state why the enrollee's condition does not meet specialty mental health services criteria, including DMC-ODS medical necessity criteria, and describe the criteria used and the clinical reasons for the determination.⁴⁵ If the internal grievance/appeal is not completely resolved in an enrollee's favor, the notice must explain that the enrollee has the right to appeal to a state fair hearing, and must explain how to exercise that right.⁴⁶ In situations where an MHP denies mental health services to an enrollee because those services are the responsibility of a different plan, the MHP must send a Delivery System Notice explaining such to the enrollee.⁴⁷ However, this requirement does not extend to other Medi-Cal managed care plans; current DHCS guidance does not obligate a MCP or DMC-ODS plan to provide an enrollee with a Delivery System Notice if it denies the enrollee mental health services because it determined that the enrollee's condition qualifies instead for SMHS under an MHP or SUDS under DMC-ODS.⁴⁸ In addition, the MCP must explain that the enrollee has the right to continue benefits pending a fair hearing, and how to request continued benefits.⁴⁹ The Medi-Cal plan must also explain that if the enrollee continues benefits pending a hearing, they may be liable for cost of benefits if they do not ultimately succeed in the hearing.⁵⁰

All Medi-Cal plans must establish a process to monitor and track all internal grievances/appeals.⁵¹ Plans must keep records of all internal grievances/appeals for five years, and make them available to DHCS for review.⁵² Plans must designate an officer to oversee the internal grievance & appeal process.⁵³ MCPs must report on internal grievances/appeals not resolved within 30 days on a quarterly basis.⁵⁴ In their reports, Medi-Cal plans must report the total number of internal grievances/appeals received; the average time taken to resolve internal grievances/appeals; a listing of the zip codes, ethnicity, gender, and primary language of enrollees who filed internal grievances/appeals; and the final outcome of all grievances/appeals received.⁵⁵ Medi-Cal plans must also identify the number of internal grievances/appeals filed in each of the following categories: untimely assignments to a provider, issues related to cultural and linguistic sensitivity, difficulty with accessing specialists, and grievances related to out-of-network request.⁵⁶ DHCS performs periodic review of Medi-Cal plans' internal grievance & appeal systems for compliance, and may assess penalties for plans' failure to comply.⁵⁷

d. Fair Hearing

Medi-Cal beneficiaries always have the right to request a state fair hearing any time they are dissatisfied with their receipt of Medi-Cal.⁵⁸ When a Medi-Cal plan takes an "adverse benefit determination," enrollees usually must request a hearing within 120 days of the plan's notice upholding the adverse benefit determination in its internal grievance/appeal process.⁵⁹ That is,

an enrollee must exhaust the plan-level appeal and can request a state fair hearing only after receiving notice that the adverse benefit determination has been upheld. There is a notable exception to the exhaustion requirement: If the Medi-Cal plan fails to adhere to the notice and timing requirements for adverse benefit determinations, the enrollee is deemed to have exhausted the in-plan appeal process and can immediately request an impartial state fair hearing.⁶⁰ The request can be made by an authorized representative.⁶¹

The Department must set the hearing within thirty working days of the enrollee's request for a state fair hearing and must, at least ten days before the hearing, provide written notice of the time and place of the hearing to all interested parties.⁶²

After receiving notice that an enrollee has requested a state fair hearing, the Medi-Cal plan has three business days to submit the enrollee's case file and any appeal information to the Department.⁶³ The Department has seventy-two hours to take final administrative action on a state fair hearing request unless the enrollee requests a delay, fails to take required action, or some emergency prevents the Department from taking timely action. The Department must document the reasons for any delays in the enrollee's file.⁶⁴

Fair hearings are heard by Administrative Law Judges (ALJs) employed by the state, who must be impartial.⁶⁵ The hearing must afford enrollees and their representatives the chance to present evidence and witnesses, cross-examine adverse witnesses, and examine their case files.⁶⁶ The adverse party (the state, the plan, or both) must provide a written statement of position, if any, at least two days in advance of the hearing.⁶⁷ The ALJ may request an independent medical evaluation if needed to make a decision on the case.⁶⁸ Hearings must ordinarily be resolved within 90 days.⁶⁹ Enrollees may request an expedited hearing if waiting 90 days would put the enrollee's health at risk; expedited hearings must be resolved within three business days, or sooner if required by the enrollee's health condition.⁷⁰ The final decision must summarize the facts, identify the regulations supporting the decision, inform the enrollee of the reason for the decision, and inform the enrollee of the right to request a rehearing or judicial review; it can only be based on evidence and law presented in the hearing.⁷¹ The plan must implement any decisions favorable to the enrollee within 72 hours, or more quickly if required by the enrollee's health.⁷² If the decision is not favorable, the enrollee has 30 days to request a rehearing, which may be offered at the state's discretion.⁷³

e. Medi-Cal Managed Care Ombudsman

MCP enrollees may also seek external review of any dispute with the Medi-Cal plan by complaining to the Medi-Cal Managed Care Ombudsman. The Ombudsman's responsibility is to "investigate[] and resolve[] complaints about managed care plans."⁷⁴ Existing law or regulation does not define the precise scope of the Ombudsman's jurisdiction, nor any timelines by which enrollees must avail themselves of the Ombudsman's assistance.

II. Additional Protections for Knox-Keene Licensed Plans

The KKA places additional requirements on MCPs licensed by DMHC.⁷⁵ DMHC- licensed MCPs must comply with any requirements of the KKA that go beyond Medi-Cal requirements.

a. Notice

In addition to providing written notice to enrollees when a DMHC-licensed MCP denies, delays, or modifies all or part of a requested service, or reduces, suspends, or terminates an existing service, it must give the requesting provider an explanation of the reasons for the decision (including clinical reasons for cases concerning medical necessity) and the criteria used to reach the decision.⁷⁶ For DMHC-licensed MCPs, notices are considered “vital documents” for the purposed of California’s Language Access law, and must be translated into certain non-English languages for enrollees who have indicated that they prefer to receive information in those languages rather than English.⁷⁷

b. Internal Review

When a DMHC-licensed MCP does not resolve an internal grievance involving a determination that a service is not medically necessary in the enrollees’ favor, the plan must explain that the enrollee has the right to seek independent medical review (IMR).⁷⁸ Like DHCS, DMHC performs periodic review of their plans’ internal grievance systems for compliance, and may assess penalties for plans’ failure to comply.⁷⁹ For plans that are jointly regulated by DHCS and DMHC, the departments’ practice is to coordinate this periodic review to the greatest extent possible.

c. External Review

In addition to requesting a Medi-Cal state fair hearing or complaining to the Medi-Cal Ombudsman, enrollees in DMHC-licensed MCPs may either request IMR or file a DMHC Complaint. Note that MCP enrollees may request a state fair hearing without using the other external review processes available, such as the IMR or DMHC Complaint process. Once MCP enrollees have gone through the fair hearing process, however, they may no longer request IMR.⁸⁰

IMR is available for enrollees in DMHC-licensed MCPs in three situations: (1) when the plan denies, terminates, reduces, modifies or delays health care services based on medical necessity, (2) when the plan denies reimbursement for emergency or urgent care claiming that no emergency or urgency existed, and (3) when an enrollee seeks treatment for a life-threatening or debilitating condition, and the plan denies the treatment sought as “experimental or investigational.”⁸¹ Enrollees must generally pursue an internal plan grievance first, and may then request an IMR within six months of an unfavorable grievance decision.⁸² When a

grievance is not resolved within 30 days, the enrollee may also proceed to IMR. In expedited cases—those involving an “imminent and serious threat” to the enrollee’s health—enrollees need only participate in the grievance process for three days before proceeding to IMR, and at DMHC’s discretion, may forgo the grievance process all together.⁸³ In cases involving experimental or investigational treatment, enrollees need not file a grievance before seeking IMR.⁸⁴ Note that enrollees in DMHC-licensed MCPs may not request IMR if they have already gone to a Medi-Cal fair hearing on the denial, modification or delay at issue.⁸⁵

IMR is performed by independent medical professionals who are not connected to the plan.⁸⁶ MCPs contract with outside organizations to perform the review, so enrollees must consent to participating in the process and sharing their medical records with the outside review entity.⁸⁷ The MCP bears the cost of the IMR, and may not charge the enrollee any fee for participating in the process.⁸⁸ The reviewers must be knowledgeable with respect to the treatment or proposed treatment at issue.⁸⁹ They are charged with reviewing all documents related to the denial, along with the enrollee’s medical records, relevant peer-reviewed scientific and medical evidence, national professional standards, expert opinion, and accepted standards of medical practice.⁹⁰ Enrollees may provide any information they deem relevant along with their request for IMR.⁹¹ Enrollees may use an authorized representative to make the request.⁹²

A standard IMR must be completed within 30 days of the review organization receiving all of the documents for review, and expedited review must be completed within three days.⁹³ The review organization must make a written decision, including an explanation of its decision in layperson’s terms, and provide it to Department, enrollee, and plan.⁹⁴ If the review organization finds in favor of the enrollee, the Department must adopt its decision immediately and the plan must implement it within five days.⁹⁵ The odds of success favor enrollees: in 2018, 62% of IMRs filed with DMHC-licensed plans resulted in a favorable decision for the enrollee.⁹⁶

DMHC’s Consumer Complaints process provides external review of matters that are not eligible for IMR.⁹⁷ While there is nothing in the law that prohibits someone from seeking both IMR and a Consumer Complaint, in practice, these two options are usually offered as alternatives to each other. Similar to the process for an IMR, DMHC-licensed MCPs enrollees must generally pursue an internal grievance first, and may then file a Consumer Complaint after an unfavorable grievance decision, or after waiting 30 days for the plan to resolve an internal grievance.⁹⁸ In expedited cases—those involving an “imminent and serious threat” to the enrollee’s health—enrollees need only participate in the internal grievance process for three days before filing a Consumer Complaint, and, at DMHC’s discretion may forgo the grievance process all together.⁹⁹

When it receives a Consumer Complaint, DMHC must analyze all documents from the enrollee and the MCP and determine appropriate resolution, communicated to the enrollee in writing.¹⁰⁰

DMHC is charged with resolving Consumer Complaints within 30 days, and its written resolution must include an explanation of the Department’s findings and reasons for the decision, a summary of any discussion the Department undertook with any medical provider or independent expert (and that expert’s qualifications), and information about any corrective action taken.¹⁰¹ For any Consumer Complaint that involves delayed, denied, terminated, reduced or modified medically necessary health care services that should have been covered, the MCP must promptly provide or reimburse for the service.¹⁰²

III. Pursuing other legal remedies

Enrollees in Medi-Cal plans may also seek to enforce their rights in state or federal court. The Welfare and Institutions Code affirmatively grants enrollees the right to seek a writ of mandate under California Code of Civil Procedure § 1094.5 within one year of receiving an adverse fair hearing decision.¹⁰³ In some cases, enrollees may also be able to enforce violations of federal Medicaid law in federal court.¹⁰⁴ The Health and Safety Code provides that “the grievance or resolution procedures authorized by [DMHC] shall be in addition to any other procedures that may be available to any person, and failure to pursue, exhaust, or engage in the[se] procedures . . . shall not preclude the use of any other remedy provided by law.”¹⁰⁵ Thus, to the extent that an enrollee has a potential legal claim against the state or a plan, the enrollee is not required to exhaust the internal grievance or external appeals processes before going to court, but may be required to complete a fair hearing in order to comply with exhaustion requirements.

Conclusion

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

ENDNOTES

¹ This paper uses the terms “Medi-Cal managed care plan[s],” “Medi-Cal plan[s],” and “plan[s]” interchangeably. When the paper uses any of these terms, assume that the paper is referring not only to Medi-Cal Managed Health Care Plans (in which the State, through Medi-Cal Managed Care, contracts with health maintenance organizations’ plans to provide Medi-Cal enrollees with health care services and benefits) but also to Medi-Cal County Mental Health Plans and Drug Medi-Cal Organized Delivery Systems, unless stated otherwise.

² See CAL. WELF. & INST. CODE § 14093.05; *id.* §§ 14200-14499.77; Cal. Office of the Patient Advocate, *Medi-Cal Managed Care Health Plans*, <http://reportcard.opa.ca.gov/rc2013/medi-calrating.aspx> (last visited June 24, 2019); Cal. Dep’t of Health Care Servs., *Medi-Cal Managed Care*, <https://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx> (last visited June 26, 2019).

³ See Cal. Dep’t of Health Care Servs., *Medi-Cal at a Glance 1* (2018), https://www.dhcs.ca.gov/dataandstats/statistics/Documents/Medi-Cal_at_a_Glance_Nov2018.pdf; see also Cal. Health Care Found., *2019 Edition – Medi-Cal Facts and Figures 31* (2019), <https://www.chcf.org/publication/2019-medi-cal-facts-figures-crucial-coverage>.

⁴ Cal. Dep’t of Health Care Servs., *Medi-Cal Specialty Mental Health Services* [hereinafter *Medi-Cal SMHS Page*], https://www.dhcs.ca.gov/services/Pages/Medi-cal_SMHS.aspx (last visited July 11, 2019). See generally Cal. Health Care Found., *Behavioral Health Integration in Medi-Cal: A Blueprint for California 24* (2019) (defining “carve out” as “excluding a set of behavioral health benefits from managed care contracts and instead managing the services through either a separate managed behavioral health entity or fee-for-service”), <https://www.chcf.org/wp-content/uploads/2019/02/BehavioralHealthIntegrationBlueprint.pdf>; Cal. Dep’t of Health Care Servs., *Section 1915(b) Waiver Proposal for MCO, PIHP, PAHP, PCCM Programs And FFS Selective Contracting Programs* (2015) (describing the proposed parameters of the “Medi-Cal Specialty Mental Health Services (SMHS) Consolidation” waiver program later renewed by CMS in 2015 under § 1915(b) of the Social Security Act), [https://www.dhcs.ca.gov/services/MH/Documents/1915\(%20b\)_SMHS_Waiver.pdf](https://www.dhcs.ca.gov/services/MH/Documents/1915(%20b)_SMHS_Waiver.pdf).

⁵ Cal. Dep’t of Health Care Servs., *Sample Medi-Cal Mental Health Plan Contract for MHPs*, Ex. A (2017) (contract for 2017 to 2022) [hereinafter *MHP Boilerplate Contract*], https://www.dhcs.ca.gov/services/MH/Documents/PPQA%20Pages/Boilerplate_2017-2022_MHP_Contract-Exhibits_A_B_and_E.pdf; *id.* at Ex. A, Att. 2 (listing the services that qualify as medically necessary SMHS that MHPs must provide to enrollees); see also *Medi-Cal SMHS Page*, *supra* note 4. The medical necessity criteria for determining enrollee qualification for SMHS are set out in CAL. CODE REGS. tit. 9, §§ 1820.205, 1830.205, 1830.210. A recent law, however, clarified that the EPSDT standard applies to all Medi-Cal services for children under age 21, including children seeking SMHS, such that those services must be provided when necessary to correct or ameliorate an illness or condition. See CAL. WELF. & INST. CODE § 14059.5.

⁶ See CAL. WELF. & INST. CODE §§ 14021, 14021.30, 14021.31, 14021.35, 14021.6, 14021.9, 14124.20-14124.29; CAL. CODE REGS. tit. 9, § 9533; Cal. Dep’t of Health Care Servs., *Drug Medi-Cal Overview*, <https://www.dhcs.ca.gov/services/adp/Pages/default.aspx> (last visited July 12, 2019). Substance use disorder services that qualify for funding through Drug Medi-Cal are listed in CAL. CODE REGS. tit. 22, § 51341.1(d).

⁷ Cal. Dep’t of Health Care Servs., *Drug Medi-Cal Overview*, <https://www.dhcs.ca.gov/services/adp/Pages/default.aspx> (last visited Aug. 14, 2019); CMS, *California Medi-Cal 2020 Demonstration: Special Terms and Conditions* (2018) (describing the terms and conditions the California Health and Human Services Agency has agreed to be bound by as a precondition of the waiver’s renewal by CMS), <https://www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal2020STCsAmended060718.pdf>. See generally Héctor Hernández-Delgado, Nat’l Health Law Prog.,

Substance Use Disorders in Medi-Cal: An Overview (2019), <https://healthlaw.org/resource/substance-use-disorders-in-medi-cal-an-overview>; see also Cal. Health Care Found., *The Drug Medi-Cal Organized Delivery System 1-2* (2018) (providing a general overview of DMC-ODS), <https://www.chcf.org/wp-content/uploads/2018/11/DrugMediCalOrganizedDeliverySystem.pdf>.

⁸ See generally CAL. HEALTH & SAFETY CODE §§ 1340-1399.818.

⁹ CAL. WELF. & INST. CODE § 14087.95. Currently, only Health Plan of San Mateo, a COHS, is KKA licensed. See Cal. Health Benefits Rev. Prog., *The California Cost and Coverage Model*, App'x 13 at 7 (2013), http://www.chbrp.org/other_publications/docs/ap_13.pdf.

¹⁰ See generally CAL. HEALTH & SAFETY CODE §§ 1340-1399.864; see also *id.* § 1343(b)-(d) (explaining that the DHCS Director has the discretion to exempt MHPs and DMC-ODS from certain Knox-Keene Act requirements); *id.* § 1374.72(g)(1) (exempting some separate specialized health care services plans, including MHPs, from DMHC licensure); Cal. Dep't of Health Care Servs., *Medicaid Managed Care Final Rule: Network Adequacy Standards 12* (2018) ("KKA licensing requirements do not apply to MHPs or DMC-ODS Waiver Plans"), <https://www.dhcs.ca.gov/formsandpubs/Documents/FinalRuleNAStandards3-26-18.pdf>.

¹¹ See Cal. Dep't of Health Care Servs., *Medicaid Managed Care Final Rule Information* (2019) (the Medicaid Managed Care Final Rule and Mental Health Parity and Addiction Equity Act apply "to Medi-Cal Managed Care Plans, County Mental Health Plans (MHPs), Drug Medi-Cal Organized Delivery System (DMC-ODS) Pilot Counties, and Dental Managed Care Plans"), <https://www.dhcs.ca.gov/services/Pages/Mental-Health-Plan-Final-Rule-and-Parity-Information.aspx>; Cal. Dep't of Health Care Servs., *Medicaid Managed Care Final Rule: Network Adequacy Standards 12-14, 20-21* (2018) (explaining that mental health parity rules have generally aligned the network adequacy standards and requirements for DMHC-licensed MCPs, non-DMHC MCPs, MHPs, and DMC-ODS), <https://www.dhcs.ca.gov/formsandpubs/Documents/FinalRuleNAStandards3-26-18.pdf>; Cal. Dep't of Health Care Services, *MHSUDS Information Notice 18-011* at 2-5 (2018) (explaining that MHPs and DMC-ODS must comply with the standards set out in the Parity in Mental Health and Substance Use Disorder Services Final Rule and CAL. CODE REGS. tit. 28, § 1300.67.2.2), https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/IN%2018-%20Network%20Adequacy/MHSUDS_IN_18-011_Network_Adequacy.pdf.

¹² See Cal. Dep't of Health Care Services, *MHSUDS Information Notice 18-010E* (2018) [*hereinafter* MHSUDS 18-010E], https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/NOABD%20IN/MHSUDS_IN_18-010_Federal_Grievance_Appeal_System_Requirements.pdf. MHPs and DMC-ODS plans are classified as "Prepaid Inpatient Health Plans" and must comply with federal managed care rules. *Id.* at 2.

¹³ See 42 C.F.R. § 438.400; see also Cal. Dep't of Health Care Services, *APL 17-006* (2017) [*hereinafter* APL 17-006], <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf>. While there have been subsequent updates to the federal rules, those updates do not change these provisions.

¹⁴ 42 C.F.R. § 438.404; CAL. WELF. & INST. CODE § 14197.3(a); APL 17-006, *supra* note 13, at 2. Previously, the rule used the term "action" to describe the event that triggered notice and appeal rights, but that term has been replaced with the phrase "adverse benefit determination," which is intended to align with terminology used in private insurance, and to capture a slightly broader array of circumstances. See Jane Perkins, Nat'l Health Law Prog., *Medicaid Managed Care Final Regulations Grievance & Appeals Systems 1-2* (2016), <http://www.healthlaw.org/publications/browse-all-publications/Brief-2-MMC-Final-Reg>. Thus, adverse benefit determination is a term of art in the federal Medicaid rules, defined in 42 C.F.R. § 438.400(b). An adverse benefit determination under the federal rules is: "(1) The denial or limited authorization of a requested service, including determinations based

on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service; (4) The failure to provide services in a timely manner, as defined by the State; (5) The failure of [a plan] to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals; (6) For a resident of a rural area with only one [plan], the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network; or (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities." *Id.*; see also MHSUDS 18-010E, *supra* note 12, at 5 (MHPs and DMC-ODS). In other words, the rules go beyond instances where a service is delayed, reduced, modified, delayed, suspended, or terminated, though this paper focuses on those instances. . All plans must use DHCS-specified forms and templates when sending notice of an adverse benefit determination. APL 17-006, *supra* note 13, at 1-2 (MCPs); MHSUDS 18-010E, *supra* note 12, at 7-9 (MHPs and DMC-ODS). Note that the guidance and template notices for MHPs and DMC-ODS make clear that a plan's declining to provide a service because they do not cover it and referring a beneficiary to another plan to obtain the requested service constitutes a denial of the service, for which the beneficiary is entitled to notice. See MHSUDS 18-010E, *supra* note 12, at 7.

¹⁵ 42 C.F.R. § 438.404(c)(1) (referencing *id.* § 431.211); APL 17-006, *supra* note 13, at 6 (MCPs); MHSUDS 18-010E, *supra* note 12, at 6 (MHPs and DMC-ODS) (referencing 42 C.F.R. §§ 431.211, 438.404(c)).

¹⁶ 42 C.F.R. § 438.404(b); APL 17-006, *supra* note 13, at 5-8 (MCPs); MHSUDS 18-010E, *supra* note 12, at 8, 9 (MHPs and DMC-ODS); CAL. CODE REGS. tit. 22, § 51014.1; *id.* § 53894(a) (Two-plan county plans); *id.* § 53261(a) (all other MCPs); CAL. CODE REGS. tit. 9, § 1850.212(b) (MHPs); see also, e.g., *MHP Boilerplate Contract* *supra* note 5, at Ex. A, Attach. 12 (MHPs); Cal. Dep't of Health Care Servs., *Sample DMC-ODS Boilerplate Contract*, Ex. A, Att. I, at § E.4.v.e (2018) [hereinafter *DMC-ODS Boilerplate Contract*], [https://www.dhcs.ca.gov/provgovpart/Documents/DMC-ODS Waiver/Exhibit A Attachment I ODS final 11 13 18.pdf](https://www.dhcs.ca.gov/provgovpart/Documents/DMC-ODS%20Waiver/Exhibit%20A%20Attachment%20I%20ODS%20final%2011%2013%2018.pdf); Cal. Dep't of Health Care Servs., *Sample Contract Boilerplate for COHS Counties*, Ex. A, Att. 14 (2014) [hereafter *COHS Boilerplate Contract*], <http://www.dhcs.ca.gov/provgovpart/Documents/COHSBoilerplate032014.pdf>; Cal. Dep't of Health Care Servs., *Sample Contract Boilerplate for GMC Counties*, Ex. A, Att. 14 (2014), <http://www.dhcs.ca.gov/provgovpart/Documents/GMCBoilerplate032014.pdf>; Cal. Dep't of Health Care Servs., *Sample Contract Boilerplate for Imperial / Regional / San Benito / Two-Plan Counties*, Ex. A, Att. 14 (2014), <http://www.dhcs.ca.gov/provgovpart/Documents/ImpReqSB2PlanBp32014.pdf>.

Hereafter, I will hereafter cite to the COHS contract, but provisions can generally be found in the same section of the other MCP contracts.

¹⁷ 42 C.F.R. § 438.10(d); APL 17-006, *supra* note 13, at 10, 19 (MCPs); MHSUDS 18-010E, *supra* note 12, at 15 (MHPs and DMC-ODS); see also CAL. CODE REGS. tit. 22, § 53876(a)(3) (Two-plan county plans); *COHS Boilerplate Contract*, *supra* note 16, at Ex. A, Att. 9.

¹⁸ 42 C.F.R. § 438.10(d); MHSUDS 18-010E, *supra* note 12, at 15 (MHPs and DMC-ODS); see also *COHS Boilerplate Contract*, *supra* note 16, at Ex. A, Att. 13.

¹⁹ See APL 17-006, *supra* note 13, at 4-6; see also Cal. Health & Safety Code § 1367.01(h) (Knox Keene rule).

²⁰ 42 C.F.R. §§ 431.230, 438.420(b); CAL. CODE REGS. tit. 22, § 51014.2 (MCPs); APL 17-006, *supra* note 13, at 9 (MCPs); MHSUDS 18-010E, *supra* note 12, at 10 (MHPs and DMC-ODS).

²¹ 42 C.F.R. § 438.420(b); APL 17-006, *supra* note 13, at 9 (MCPs); MHSUDS 18-010E, *supra* note 12, Enclosure 9 (MHPs and DMC-ODS).

²² 42 C.F.R. § 438.420; see CAL. CODE REGS. tit. 22, § 51014.2 (MCPs); CAL. CODE REGS. tit. 9, § 1850.215 (MHPs); APL 17-006, *supra* note 13, at 5-8 (MCPs); MHSUDS 18-010E, *supra* note 12, Enclosure 11 (MHPs and DMC-ODS).

²³ 42 C.F.R. § 438.420(c); APL 17-006, *supra* note 13, at 9 (MCPs); MHSUDS 18-010E, *supra* note 12, Enclosures 9 and 11 (MHPs and DMC-ODS). Note that the California regulations only speak to continued benefits pending a fair hearing, not continued benefits pending a grievance; the California regulations do not reflect some changes to the rules around continued benefits made in the new federal rules, but the federal rules control. See CAL. CODE REGS. tit. 22, § 51014.2. Also note that enrollees are not entitled to continue benefits pending IMR or a DMHC Consumer Complaint; thus enrollees may wish to request a fair hearing to ensure that benefits continue, even if they pursue another form of review.

²⁴ 42 C.F.R. § 438.420(c); CAL. CODE REGS. tit. 22, § 51014.2(d); MHSUDS 18-010E, *supra* note 12, Enclosures 9 and 11 (MHPs and DMC-ODS).

²⁵ CAL. CODE REGS. tit. 22, § 51003(c)(1)(E).

²⁶ In the federal rules, a grievance related to an adverse benefit determination is called an “appeal,” and all other complaints are called “grievances.” See 42 C.F.R. § 438.400; APL 17-006, *supra* note 13, at 3-4.

²⁷ Compare APL 17-006, *supra* note 13, at 10-11 with 42 C.F.R. § 438.402(c)(2)(i)-(ii); *COHS Boilerplate Contract*, *supra* note 16, at Ex. A, Att. 14. See also MHSUDS 18-010E, *supra* note 12, at 3, 9 (MHPs and DMC-ODS) (referencing 42 C.F.R. § 438.402(c)(3)(ii)).

²⁸ 42 C.F.R. §§ 438.402(c)(1), 438.408(f)(1); MHSUDS 18-010E, *supra* note 12, at 9 (MHPs and DMC-ODS). Previously, California did not require enrollees to exhaust the plan’s internal process before requesting a fair hearing.

²⁹ See *COHS Boilerplate Contract*, *supra* note 16, at Ex. A, Att. 14 (incorporating KKA requirements against COHS plans); MHSUDS 18-101E, *supra* note 12, at 3, 9, 10, 13, 16-18 (incorporating KKA requirements against MHPs and DMC-ODS).

³⁰ 42 C.F.R. § 438.404; CAL. CODE REGS. tit. 22, § 51014.1; *id.* § 53894(a) (Two-plan county plans); *id.* § 53261(a) (all other plans); *COHS Boilerplate Contract*, *supra* note 16, at Ex. A, Att. 14.

³¹ *COHS Boilerplate Contract*, *supra* note 16, at Ex. A, Att. 14 (incorporating CAL. CODE REGS. tit. 28, §§ 1300.68(b)(4), (7)); MHSUDS 18-010E, *supra* note 12, at 6 (MHPs and DMC-ODS).

³² *COHS Boilerplate Contract*, *supra* note 16, at Ex. A, Att. 14 (incorporating CAL. CODE REGS. tit. 28, § 1300.68(b)(3)); MHSUDS 18-010E, *supra* note 12, at 9, 15, 17 (MHPs and DMC-ODS). Note that, for non-expedited MHP and DMC-ODS cases, enrollees must sign and submit a written grievance after submitting an oral grievance. However, an enrollee’s failure to submit a subsequent written grievance does not authorize a plan to dismiss a grievance or delay its resolution. The date of the oral grievance establishes the filing date. *Id.* at 9-10 (referencing 42 C.F.R. §§ 438.402(c)(3)(ii), 438.406(b)(3)).

³³ *COHS Boilerplate Contract*, *supra* note 16, at Ex. A, Att. 14 (incorporating CAL. CODE REGS. tit. 28, §§ 1300.68(d)(1), (8)); MHSUDS 18-010E, *supra* note 12, at 10 (MHPs and DMC-ODS).

³⁴ CAL. CODE REGS. tit. 28, § 1300.68(d)(1); MHSUDS 18-010E, *supra* note 12, at 3, 10 (MHPs and DMC-ODS).

³⁵ *COHS Boilerplate Contract*, *supra* note 16, at Ex. A, Att. 14 (incorporating CAL. CODE REGS. tit. 28, §§ 1300.68(a)(1), (b)(6)); MHSUDS 18-010E, *supra* note 12, at 3, 9, 10 (MHPs and DMC-ODS) (referencing 42 C.F.R. § 438.402(c)(3)(ii)).

³⁶ CAL. WELF. & INST. CODE § 14197.3(b); *COHS Boilerplate Contract*, *supra* note 16, at Ex. A, Att. 14 (incorporating CAL. CODE REGS. tit. 28, § 1300.68(a), (d)(3)); MHSUDS 18-010E, *supra* note 12, at 10.

³⁷ MHSUDS 18-010E, *supra* note 12, at 3.

³⁸ See *COHS Boilerplate Contract*, *supra* note 16, at Ex. A, Att. 14 (incorporating CAL. HEALTH & SAFETY CODE § 1368.01(b), CAL. WELF. & INST. CODE § 10951.5(a), and CAL. CODE REGS. tit. 28, § 1300.68.01(a)); see also 42 C.F.R. § 438.410 (federal rule requiring Medicaid plans to “maintain an expedited review process . . . [for cases where] taking the time for a standard resolution could seriously jeopardize the enrollee’s life, physical or mental health, or ability to attain, maintain, or regain maximum function”); APL 17-006, *supra* note 13, at 12, 15; MHSUDS 18-010E, *supra* note 12, at 11, 12 (MHPs

and DMC-ODS). Note that if a plan denies a request for expedited case resolution, it must resolve the grievance within the standard 30-day timeframe. See generally 42 C.F.R. § 438.410(c).

³⁹ 42 C.F.R. § 438.406(b)(2); see also *COHS Boilerplate Contract*, supra note 16, at Ex. A, Att. 14 (requiring plans to abide by CAL. CODE REGS. tit. 28, § 1300.68(d)(2), which mandates that grievances be decided by management level staff responsible for the operations or services at issue); CAL. CODE REGS. tit. 22, § 53858(e)(2); MHSUDS 18-010E, supra note 12, at 17 (MHPs and DMC-ODS).

⁴⁰ 42 C.F.R. § 438.406(b)(4)-(5); see also MHSUDS 18-010E, supra note 12, at 6, 18 (MHPs and DMC-ODS).

⁴¹ 42 C.F.R. § 438.408(c); see also MHSUDS 18-010E, supra note 12, at 4, 10, 12 (MHPs and DMC-ODS).

⁴² 42 C.F.R. § 438.408(c)(2); see also MHSUDS 18-010E, supra note 12, at 4, 10 (MHPs and DMC-ODS).

⁴³ 42 C.F.R. § 438.408(e)(1); see also CAL. CODE REGS. tit. 22, § 53858(e)(5) (Two-plan county plans); *COHS Boilerplate Contract*, supra note 16, at Ex. A, Att. 14 (incorporating CAL. HEALTH & SAFETY CODE § 1368(a)(5) & CAL. CODE REGS. tit. 28, § 1300.68(d)(3)); MHSUDS 18-010E, supra note 12, at 5, 6, 12-14 (MHPs and DMC-ODS). Note that MHPs and DMC-ODS must send enrollees certain DHCS- and federally-specified forms and templates depending on whether the plan upholds or overturns the adverse benefit determination. *Id.* at 7-9, 12-14. MCPs must also send DHCS- and federally-specified forms and templates depending on whether the plan upholds or overturns the adverse benefit determination. APL 17-006, supra note 13, at 6-10, 16, 17, 25.

⁴⁴ *COHS Boilerplate Contract*, supra note 16, at Ex. A, Att. 14 (incorporating CAL. HEALTH & SAFETY CODE § 1368(a)(5) and CAL. CODE REGS. tit. 28, § 1300.68(d)(4)).

⁴⁵ MHSUDS 18-010E, supra note 12, at 5-6.

⁴⁶ 42 C.F.R. § 438.408(e)(2)(i); see also CAL. CODE REGS. tit. 22, § 53858(e)(5) (Two-plan county plans); MHSUDS 18-010E, supra note 12, at 13 (MHPs and DMC-ODS).

⁴⁷ Kimberly Lewis et al., Nat'l Health Law Prog., *Navigating the Challenges of Medi-Cal's Mental Health Services in California: An Examination of Care Coordination, Referrals and Dispute Resolution* 40 (2018), <https://healthlaw.org/resource/navigating-the-challenges-of-medi-cals-mental-health-services-in-california-an-examination-of-care-coordination-referrals-and-dispute-resolution>.

⁴⁸ *Id.*

⁴⁹ 42 C.F.R. § 438.408(e)(2)(ii); see also CAL. CODE REGS. tit. 22, § 53858(e)(5) (Two-plan county plans); MHSUDS 18-010E, supra note 12, at 13 (MHPs and DMC-ODS).

⁵⁰ 42 C.F.R. § 438.408(e)(2)(iii); MHSUDS 18-010E, supra note 12, at 13 (MHPs and DMC-ODS).

⁵¹ See CAL. CODE REGS. tit. 22, § 53858(e) (Two-plan county plans); *id.* § 53260 (all other plans); *COHS Boilerplate Contract*, supra note 16, at Ex. A, Att. 14 (incorporating CAL. HEALTH & SAFETY CODE § 1368(a)(4)(B) and CAL. CODE REGS. tit. 28, § 1300.68(e); MHSUDS 18-010E, supra note 12, at 4, 12, 16-18 (MHPs and DMC-ODS)). See generally 42 C.F.R. § 438.406(b); CAL. CODE REGS. tit. 22, § 53858(e).

⁵² See CAL. CODE REGS. tit. 28, § 1300.68(d)(6) (MCPs) (incorporating CAL. HEALTH & SAFETY CODE § 1368(a)(7)); CAL. CODE REGS. tit. 22, § 53858(h) (Two-plan county plans); *COHS Boilerplate Contract*, supra note 16, at Ex. A, Att. 14; MHP Boilerplate Contract, supra note 5, at Ex. E, at 6 (2017) (mandating MHP contractors and subcontractors retain beneficiary grievance and appeal records for at least 10 years); Cal. Dep't of Health Care Servs., *Sample DMC-ODS Boilerplate Contract*, Ex. A, Att. I, at 6 (2018) (same), [https://www.dhcs.ca.gov/provgovpart/Documents/DMC-ODS Waiver/Exhibit A Attachment I ODS final 11 13 18.pdf](https://www.dhcs.ca.gov/provgovpart/Documents/DMC-ODS%20Waiver/Exhibit%20A%20Attachment%20I%20ODS%20final%2011%2013%2018.pdf).

⁵³ *COHS Boilerplate Contract*, supra note 16, at Ex. A, Att. 14 (incorporating CAL. CODE REGS. tit. 28, § 1300.68(b)(1)).

⁵⁴ *Id.* (incorporating CAL. CODE REGS. tit. 28, § 1300.68(f) and CAL. HEALTH & SAFETY CODE § 1368(c)). Note that state regulations do not explicitly mandate MHPs to report quarterly on internal grievances

not resolved within 30 days. See CAL. CODE REGS. tit. 9, § 1810.375 (explaining that MHPs must report to DHCS on “the total number of grievances, appeals and expediated appeals by type, by subject areas established by the Department, and by disposition” and any other “reports required in the contracts between the Department and the MHP”).

⁵⁵ *COHS Boilerplate Contract*, *supra* note 16, at Ex. A, Att. 14; see also MHSUDS 18-010E, *supra* note 12, at 4. For each internal grievance, MHPs and DMC-ODS must report the receipt date of the internal grievance; the name of the enrollee involved; the nature of the internal grievance; the end result of the internal grievance; and the name of the plan representative who received and resolved the grievance. *Id.*

⁵⁶ *COHS Boilerplate Contract*, *supra* note 16, at Ex. A, Att. 14; see also CAL. CODE REGS. tit. 22, § 53858(e)(3).

⁵⁷ See CAL. WELF. & INST. CODE § 14304 (Medi-Cal plans); CAL. CODE REGS. tit. 22, § 53872 (Two-plan county plans); *COHS Boilerplate Contract*, *supra* note 16, at Ex. E, Att. 2; MHSUDS 18-010E, *supra* note 12, at 4, 17 (MHPs and DMC-ODS).

⁵⁸ CAL. WELF. & INST. CODE § 10950; see also CAL. CODE REGS. tit. 22, § 51014.1. Note that under federal Medicaid rules, fair hearings are limited to adverse “adverse benefit determinations,” which include a denial, delay, or modification of all or part of a requested service, or reduction or termination an existing service. 42 C.F.R. §§ 438.408(f), 431.201, 431.220. California law permits enrollees to request hearings for a wider scope of service problems, which could potentially involve problems like a plan’s not offering a provider of a needed service within the enrollee’s geographic area.

⁵⁹ 42 C.F.R. § 438.408(f)(2); APL 17-006, *supra* note 13, at 17; MHSUDS 18-010E, *supra* note 12, at 14 (MHPs and DMC-ODS). Note that an enrollee may file a request for a state fair hearing after an adverse benefit determination after the 120-day deadline if good cause exists. The Department’s Director determines if good cause exists but may not grant a request for a state fair hearing if the request is filed more than 180 days after the plan gave notice that it upheld an adverse benefit determination. CAL. WELF. & INST. CODE § 10951(b)(2).

⁶⁰ 42 C.F.R. §§ 438.402(c)(1)(i)(A), 438.408(f)(1)(i) (called deemed exhaustion in the final rule and this issue brief); MHSUDS 18-010E, *supra* note 12, at 11, 14 (MHPs and DMC-ODS).

⁶¹ 42 C.F.R. §§ 431.201, 438.402(c)(3)(ii); CAL. WELF. & INST. CODE §§ 10950(a), 10951(a); Letter from Cal. Dep’t of Health Care Services to All Medi-Cal Managed Care Health Plans 2 (Apr. 17, 2009), <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/PL2009/PL09-006.PDF>; MHSUDS 18-010E, *supra* note 12, at 9, 10 (MHPs and DMC-ODS). Note that despite the change to “adverse benefit determination” as described above, some of the sources cited herein maintain the use of the word “action,” which is also used elsewhere in the federal Medicaid regulations. We use the phrase “adverse benefit determination” throughout for consistency.

⁶² *Id.* § 10952(a). Note that the 30- and 10-day requirements do not apply in expedited cases. CAL. WELF. & INST. CODE § 10952(b).

⁶³ CAL. WELF. & INST. CODE § 10951.5(b).

⁶⁴ *Id.* § 10951.5(c).

⁶⁵ *Id.* §§ 10953, 10955; see also 42 C.F.R. § 431.240(a)(3); MHSUDS 18-101E, *supra* note 12, at 17, 18 (MHPs and DMC-ODS).

⁶⁶ 42 C.F.R. § 431.242; CAL. WELF. & INST. CODE §§ 10955, 10952.5.

⁶⁷ CAL. WELF. & INST. CODE § 10952.5(a).

⁶⁸ 42 C.F.R. § 431.240(b).

⁶⁹ *Id.* § 431.244(f)(1); MHSUDS 18-010E, *supra* note 12, at 14 (MHPs and DMC-ODS). The ALJ must submit a proposed decision to the Director of DHCS within 75 days, and the Director then has 30 days (or three days, in expedited cases) to adopt or alternate it. CAL. WELF. & INST. CODE §§ 10958, 10959. Failure of the Director to adopt the proposed ALJ decision, personally decide the matter on the record, or order another hearing within 30 days (or three days, in expedited cases) is deemed affirmation of the

ALJ's proposed decision. If the Director personally decides the matter, a copy of their decision must be served to the relevant parties along with the proposed ALJ decision, should the latter differ "materially" from the Director's decision. Re-hearings must be held in the same manner and are subject to the same rules as the original hearing. CAL. WELF. & INST. CODE § 10959.

⁷⁰ 42 C.F.R. § 431.244(f)(2); Cal. Dep't of Health Care Services, *APL 03-009* (Aug. 27, 2003), <http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2003/MMCDAPLO3009.pdf>; MHSUDS 18-101E, *supra* note 12, at 15 (MHPs and DMC-ODS).

⁷¹ 42 C.F.R. §§ 431.244, 431.245; CAL. WELF. & INST. CODE §§ 10958, 10958.1.

⁷² 42 C.F.R. § 438.424; APL 17-006, *supra* note 13, at 17-18; MHSUDS 18-010E, *supra* note 12, at 14, 15 (MHPs and DMC-ODS). Note that CAL. WELF. & INST. CODE § 10961 provides 30 days for compliance, but is superseded by the federal regulation, APL, and MHSUDS notice.

⁷³ CAL. WELF. & INST. CODE § 10960. The Director must grant or deny an enrollee's request for rehearing within between five and 15 days of receiving the request. CAL. CODE REGS. tit. 22, § 50953(c)(2).

⁷⁴ CAL. CODE REGS. tit. 22, § 53893(a).

⁷⁵ See generally CAL. HEALTH & SAFETY CODE §§ 1340-1399.818.

⁷⁶ See *id.* § 1367.01(h)(4).

⁷⁷ See *id.* § 1367.04; CAL. CODE REGS. tit. 28, § 1300.67.04.

⁷⁸ CAL. CODE REGS. tit. 28, § 1300.68(d)(4).

⁷⁹ See CAL. HEALTH & SAFETY CODE § 1368(b)(4).

⁸⁰ See CAL. CODE REGS. tit. 28, § 1300.74.30(f)(3).

⁸¹ CAL. HEALTH & SAFETY CODE §§ 1370.4, 1374.30(j)(1).

⁸² *Id.* §§ 1374.30(j)(3), (k). Note that, for ordinary grievances, plans may require enrollees to exhaust multiple levels of review in their grievance processes before proceeding to IMR, as long as all internal review is completed within 30 days. See CAL. CODE REGS. tit. 28, § 1300.68(a)(4)(A).

⁸³ CAL. HEALTH & SAFETY CODE §§ 1374.30(j)(3), 1374.31(a); CAL. CODE REGS. tit. 28, § 1300.74.30(b).

⁸⁴ CAL. HEALTH & SAFETY CODE § 1370.4.

⁸⁵ See CAL. CODE REGS. tit. 28, § 1300.74.30(f)(3).

⁸⁶ CAL. HEALTH & SAFETY CODE § 1374.32.

⁸⁷ *Id.* § 1374.30(m)(2).

⁸⁸ *Id.* § 1374.30(l).

⁸⁹ *Id.* § 1374.32(d)(4).

⁹⁰ *Id.* § 1374.33.

⁹¹ CAL. HEALTH & SAFETY CODE § 1374.30(m)(3).

⁹² See CAL. CODE REGS. tit. 28, § 1300.74.30(e).

⁹³ CAL. HEALTH & SAFETY CODE § 1374.33(c).

⁹⁴ *Id.*

⁹⁵ *Id.* § 1374.34(a).

⁹⁶ Cal. Dep't of Managed Health Care, *2018 Annual Report 7* (2018), https://www.dmhca.gov/Portals/0/Docs/DO/2018AR_FINAL_DRAFT.pdf.

⁹⁷ See CAL. HEALTH & SAFETY CODE § 1368.02.

⁹⁸ See *id.* § 1368.03.

⁹⁹ *Id.* § 1368(b)(1)(A).

¹⁰⁰ See *id.* § 1368.02.

¹⁰¹ *Id.* § 1368(b)(5).

¹⁰² *Id.* § 1368(b)(6).

¹⁰³ CAL. WELF. & INST. CODE § 10962.

¹⁰⁴ Note, however, that enforceability of many provisions has been greatly curtailed by the federal courts. See Jane Perkins, *Armstrong v. Exceptional Child—The Supreme Court's "Fairest Reading"*

Really Isn't Fair, GEORGETOWN CHILDREN'S HEALTH POLICY BLOG (Apr. 17, 2015), <http://ccf.georgetown.edu/all/armstrong-v-exceptional-child-supreme-courts-fairest-reading-really-isnt-fair>.

¹⁰⁵ CAL. HEALTH & SAFETY CODE § 1368(d).