CHAPTER 5 - OUTLINE

CHAPTER 5: FILE A GRIEVANCE OR APPEAL

In Chapter 4, we reviewed specific barriers that Medi-Cal managed care plan beneficiaries may face when accessing gender-affirming care and we identified specific rules Medi-Cal plans must follow. In this Chapter, we will explain the protections you have as a Medi-Cal beneficiary and the procedural steps you can take to address any barriers you face when accessing gender-affirming care.

Although there are strong laws in place to ensure you have access to medically necessary services, too often, the laws and protections in place are only as strong as your willingness to learn and fight to enforce your rights. Critical protections for Medi-Cal beneficiaries includes your rights to receive a notice and request a hearing when your gender-affirming care is denied, terminated, or reduced. These rights are generally known as due process rights.

This Chapter will explain the due process rights you have as a beneficiary enrolled in Medi-Cal or a Medicare-Medicaid Plan (Medi-Medi Plan). This Chapter will also serve as a reference guide as you exercise your rights and navigate through various grievance, appeal, and complaint options and processes.

ADVOCACY TIP # 5.1: There are two common misconceptions we hear from clients about the grievance and appeal process. First, some people feel that filing a grievance or appeal with their health plan is similar to asking for a manager at a restaurant to complain about the quality of food or service. However, this comparison is not accurate. Rather, the grievance and appeal process is a formal process to address issues with the plan; any other efforts to address these issues can be considered an informal attempt to resolve. The second misconception is that the grievance and appeal process is a waste of time because the plan already decided to deny coverage for gender-affirming care and will not change its mind. In practice, plans do often overturn denials or address other issues in the grievance and appeal process.

A. MEDI-CAL MANAGED CARE PLANS

Individuals who are enrolled in a Medi-Cal Managed Care Plan (MCP) must receive notice, grievance and appeal rights when a service is denied, delayed, terminated, reduced, suspended, or modified. To determine whether you are enrolled in Medi-Cal MCP and the type of plan you are enrolled in, please refer to Chapter 3: Types of Coverage of this Guide. This section will explain how you can exercise your rights if your gender-affirming services are denied, delayed, terminated, reduced, suspended, or modified by your Medi-Cal managed care plan.

a. Notice

Your Medi-Cal managed care plan's decision to deny, delay, reduce, modify, suspend, or terminate an existing service is known as an **adverse benefit determination**.[1] Your Medi-Cal managed care plan must provide you with a written **notice of adverse benefit determination (NOABD)** that is clear and concise before making an adverse benefit determination.[2] Your plan must provide the NOABD concerning the adverse benefit determination at least 10 days in advance.[3] MCPs must explain in the written notice to you what adverse benefit determination the plan is making and why, and inform you about your 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 you have a right to expedited review and how to request it.[4] The NOABD must be translated in prevalent non-English languages, and oral interpretation must be available in all languages upon request.[5] The NOABD must also be available in alternative formats.[6]

The NOABD must also be timely. MCPs must provide the NOABD according to particular timeframes:[7]

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[1] 42 C.F.R. § 438.404; Cal. Welf. & Inst. Code § 14197.3(a); Cal. Dep't of Health Care Servs., All Plan Letter No. 21-011 (Aug. 31, 2022), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-011.pdf [hereinafter DHCS APL 21-011].

[2] 42 C.F.R. § 438.404; Cal. Welf. & Inst. Code § 14197.3(a); Cal. Dep't of Health Care Servs., All Plan Letter No. 21-011 (Aug. 31, 2022), https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-011.pdf [hereinafter DHCS APL 21-011].

[3] 42 C.F.R. § 438.404(c)(1) (referencing 42 C.F.R. § 431.211); DHCS APL 21-011[MCPs]; Cal. Dep't of Health Care Servs., Mental Health & Substance Use Disorder Services Information Notice 18-010E at 6 (March 27, 2018), https://www.dhcs.ca.gov/services/MH/Documents/Information%20Notices/NOABD%20IN/MHSUDS_IN_18-010_Federal_Grievance_Appeal_System_Requirements.pdf [hereinafter DHCS MHSUDS No. 18-010E] [MHPs and DMC-ODS] (referencing 42 C.F.R. §§ 431.211, 438.404(c)).

[4] 42 C.F.R. § 438.404(b); DHCS APL 21-011 (MCPs); DHCS MHSUDS 18-010E [MHPs and DMC-ODS]; 22 C.C.R. § 51014.1; 22 C.C.R. § 53894(a) [Two-plan county plans]; 22 C.C.R. § 53261(a) [all other MCPs]; 9 C.C.R. § 1850.212(b) (MHPs).

[5] 42 C.F.R. § 438.10(d); DHCS APL 21-011 (MCPs); DHCS MHSUDS 18-010E at 15 [MHPs and DMC-ODS]; *see also* 22 C.C.R. § 53876(a)(3) [Two-plan county plans].

[6] 42 C.F.R. § 438.10(d); DHCS MHSUDS 18-010E at 15 [MHPs and DMC-ODS].

[7] Cal. Health & Safety Code § 1367.01(h).

Type of Decision	Timeframe
Approve, deny, or modify requested care for cases involving an imminent & serious threat to health.	**72 Hours** (or shorter if required by your health)
Deny, delay, or modify a request for prior or concurrent authorization of a service.	**2 Business Days**
Regarding prior authorization & concurrent claims (claims involving services you are currently receiving).	**5 Business Days**
Post-service (reimbursement claims).	**30 Days**

If your MCP makes an adverse benefit determination, you have the right to file an internal grievance or appeal with your MCP. You have the right to file an internal grievance or appeal even if you do not receive a NOABD. If you are not satisfied with the outcome of the internal grievance or appeal, you may proceed with requesting an external review.

b. Continuing Benefits: Aid Paid Pending

If your MCP is reducing, suspending, or terminating your current gender-affirming services ordered by an authorized provider, you are entitled to continue receiving those gender-affirming services while you appeal the decision. This is known as **Aid Paid Pending**. If you want to receive Aid Paid Pending when filing an internal grievance or appeal, you must file a request for Aid Paid Pending within 10 days from the date of the NOABD or before the date of the proposed adverse benefit determination.[8] When this request for Aid Paid Pending is timely filed, the managed care plan must continue the gender-affirming service until the internal grievance or appeal is resolved.

If you request continuing benefits pending an internal review (but do not request a fair hearing), and the internal review is not resolved in your favor, you must request a fair hearing (with Aid Paid Pending) within 10 days of the notice of grievance/appeal resolution or before the effective date of the proposed adverse benefit determination, in order to continue those benefits pending the fair hearing resolution.[9] The next subsections will explain the internal review process (also known as a grievance or appeal) and your options for external review if you are not satisfied with the outcome of the internal review.

[8] 42 C.F.R. § 438.420(b); DHCS APL 21-011 [MCPs].

[9] 42 C.F.R. § 438.420(c); DHCS APL 21-011 [MCPs].

c. Internal Review: Grievance or Appeal

In most cases, you must file a grievance or an appeal about a specific issue before you may proceed to external review regarding that issue – this is known as **internal review**. Once your plan has an official opportunity to resolve the issue through the internal grievance or appeal process, you may seek intervention from the government through either a DMHC Complaint, Independent Medical Review (IMR), or state fair hearing—this is known as **external review**.[10] Only in expedited cases—those involving an "imminent and serious threat" to your health—may you proceed directly to external review without waiting for your plan's internal grievance/appeal process.[11]

ADVOCACY TIP # 5.2: We recommend you file a grievance or appeal in writing via mail, fax, or email. We recommend you keep a copy of the grievance or appeal for your records. If you file it orally over the phone, we recommend asking the health plan representative for a tracking number and/or confirmation number.

MCPs are required to offer two separate tracks for the internal review process: grievances or appeals. An **appeal** is the process to challenge an adverse benefit determination and have it reconsidered. An adverse benefit determination by a health plan may be a denial, delay, reduction, modification, suspension, or termination of services or payment. An appeal must be requested within 60 days of the notice of adverse benefit determination.[12]

EXAMPLE # 5.1: Example of an appeal.

Ash (they/he) is enrolled in a Medi-Cal managed care plan. Ash is seeking top surgery (bilateral mastectomy). Ash's PCP sent the MCP a prior authorization request for a consultation with Dr. A, a surgeon who is in-network with Ash's plan. The MCP denied the request for a consultation with Dr. A. Ash should file an appeal with their MCP to challenge the denial.

A **grievance** is any complaint with the plan that does not involve a notice of adverse benefit determination. A grievance may include a complaint of the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, and your right to dispute an extension of time by the MCP to make an authorization decision.[13] A grievance

[10] 42 C.F.R. § 431.220; 22 C.C.R. § 50951; Cal. Health & Safety Code §§ 1368(b)(1)(A), 1374.30 (only if the MCP is a Knox-Keene licensed plan).

[11] Cal. Health & Safety Code § 1368(b)(1)(A).

[12] 42 C.F.R. § 438.402(c)(2)(ii).

[13] 42 C.F.R. § 438.400(b); DHCS APL 21-011 [MCPs].

may be filed at any time.[14] Health plans commonly treat appeals and grievances as one and are responsible for correctly categorizing these types of complaints when received.[15]

EXAMPLE # 5.2: Example of a grievance.

Prianka (she/her) just moved to San Diego. Prianka was approved for Medi-Cal and enrolled in a Medi-Cal managed care plan. Prianka has not been able to find a new Primary Care Provider (PCP) that is experienced with serving the TGI community and gender-affirming care. Prianka called her managed care plan a few times for help with finding a new PCP, but the plan has not been helpful and instructed Prianka to find a PCP on her own. Prianka should file a grievance with her Medi-Cal managed care plan to address her inability to find an appropriate PCP, and the plan's failure to provide adequate assistance.

The plan has 30 days to provide a written decision to the grievance or appeal, unless the grievance or appeal is urgent.[16] A grievance or appeal is deemed urgent if the case involves an imminent and serious threat to your health, which includes, but is not limited to, severe pain, potential loss of life, limb, or major bodily function.[17] If the grievance or appeal is urgent, the health plan has 72 hours to provide a written decision.[18] For non-expedited cases, the time you may seek a state fair hearing starts from either the time of resolution of the appeal, or if the appeal was not resolved, after 30 days has expired.[19]

d. External Review: DMHC Complaint or IMR (KKA-Licensed Plans Only)

If you are not satisfied with your Medi-Cal managed care plan's resolution of the internal review and your plan is Knox-Keene licensed, then you may proceed to file a DMHC Complaint or IMR. You may also proceed to a DMHC Complaint or IMR if you have not received a decision

[14] DHCS APL 21-011.

[15] 42 C.F.R. § 438.400-424; Cal. Health & Safety Code § 1368.03(a); 22 C.C.R. § 1300.68(a)(1).

[16] 42 C.F.R. § 438.408(b)(2); 28 C.C.R. § 1300.68(a), 22 C.C.R. § 53858(g)(1)[2-Plan], § 53914(g)(1)[Geographic Managed Care]; Cal. Welf. & Inst. Code § 14197.3(b); DHCS APL 21-011 (MCPs); Cal. Health & Safety Code § 1368.01(a)-(b). This written decision is sometimes referred to as a "notice of grievance resolution" or "notice of appeal resolution."

[17] Cal. Health & Safety Code § 1368.01(b); DHCS APL 21-011.

[18] 42 C.F.R. §§ 438.408(b)(3), 438.410(a); Cal. Health & Safety Code §§ 1368.01(b), 1368.03(a), 1374.30(j)(3); 22 C.C.R. § 53858(e)(7)[2-Plan; no Geographic Managed Care equivalent]; DHCS APL 21-011 [MCPs].

[19] Cal. Health & Safety Code § 1368(b)(1)(A).

on your internal review within 30 days of filing it.[20] In certain urgent cases, you may proceed to a DMHC Complaint or IMR without filing an internal grievance or appeal at all.[21] The law does not prohibit you from seeking both a DMHC Complaint and an IMR, and sometimes DMHC processes your submission as a hybrid Complaint/IMR.[22] However, in practice, a Complaint and an IMR are offered as alternatives to each other.[23] DMHC uses a single form for both the IMR and Complaint processes and DMHC will determine whether it should be processed as an IMR or Complaint.

1. Independent Medical Review (IMR)

An IMR is a clinical review process used for cases involving disputes over medical necessity of a service or treatment, payment for an emergency or urgent care service provided out-of-network, or whether a particular service or treatment is experimental or investigational. For example, a health plan's denial of facial feminization surgery as "cosmetic" would proceed through the IMR process. All other cases, such as complaints about network adequacy or timely access to care, are resolved through DMHC's Complaint process.

You can request an IMR within 6 months after an unfavorable grievance or appeal resolution letter, or if your grievance or appeal has been pending for 30 days without a resolution.[24] You may use an authorized representative to make the request.[25] An urgent IMR or complaint should be resolved within 3 days.[26] A case is deemed urgent and will be expedited if it involves an "imminent and serious threat" to your health, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration

ADVOCACY TIP # 5.3: In practice, timeframes typically start once DMHC determines that it has received all the necessary information from the plan. As a result, it is becoming more common that the standard IMR/Complaint processing timeframes may go beyond the 30-day period. There are few remedies when DMHC goes beyond this timeframe.

[20] 42 C.F.R. § 438.408(b)(2); 28 C.C.R. § 1300.68(a), 22 C.C.R. § 53858(g)(1)[2-Plan], § 53914(g)(1)[Geographic Managed Care]; Cal. Welf. & Inst. Code § 14197.3(b); DHCS APL 21-011.

[21] 28 C.C.R. § 1300.74.30(b).

[22] Abbi Coursolle, Nat'l Health Law Prog., *Internal and External Review: Medi-Cal Managed Care Plans* at 8 (2d ed. 2019), https://healthlaw.org/resource/internal-and-external-review-medi-cal-managed-care-plans-managed-care-in-california-series-issue-no-4-revised-october-2019/ [hereinafter NHeLP *Internal and External Review: Medi-Cal Managed Care Plans*].

[23] NHeLP *Internal and External Review: Medi-Cal Managed Care Plans* at 8.

[24] Cal. Health & Safety Code §§ 1370.4, 1374.30(j)(1).

[25] Cal. Health & Safety Code § 1368(b).

[26] Cal. Health & Safety Code § 1374.33(c).

of your health.[27] You should have your provider put in writing that you will face serious harm if you do not receive the service requested.[28] Otherwise, if not deemed urgent, DMHC must resolve the IMR/Complaint within 30 days.[29]

An IMR is performed by independent medical professionals who are not connected to your health plan.[30] DMHC must contract with outside organizations to perform the review, so you must consent to participating in the process and sharing their medical records with the outside review entity.[31] The MCP bears the cost of the IMR, and cannot charge you any fee for participating in the process.[32] The IMR reviewers must review all documents related to the denial, your medical records, relevant peer-reviewed scientific and medical evidence, national professional standards, expert opinions, and accepted standards for medical practice.[33] You may provide any information you deem relevant along with your request for IMR.[34] IMR reviewers do not have access to your out-of-network records, so you must provide any out-of-network records you want considered in the IMR process. Once a decision is rendered, it must be provided to you, the DMHC, and your plan.[35] If the decision is in your favor, the plan must implement the decision within 5 days.[36]

2. DMHC Complaint

DMHC's Complaint process provides external review of matters that are not eligible for IMR, such as network adequacy and timely access to care complaints.[37] Similar to the process for an IMR, you must generally pursue an internal grievance first, and may then file a DMHC Complaint after an unfavorable grievance decision, or after waiting 30 days for the plan to resolve an internal grievance.[38] In expedited cases, you only need to participate in the internal grievance process for 3 days before filing a DMHC Complaint, and, at DMHC's discretion, may

[27] Cal. Health & Safety Code § 1374.33(c).

[28] Cal. Health & Safety Code § 1374.33(c).

[29] Cal. Health & Safety Code § 1374.33(c).

[30] Cal. Health & Safety Code § 1374.32.

[31] Cal. Health & Safety Code § 1374.30(m)(2).

[32] Cal. Health & Safety Code § 1374.30(l).

[33] Cal. Health & Safety Code § 1374.33.

[34] Cal. Health & Safety Code § 1374.30(m)(3).

[35] Cal. Health & Safety Code § 1374.33(c).

[36] Cal. Health & Safety Code § 1374.34(a).

[37] *See* Cal. Health & Safety Code § 1368.02.

[38] *See* Cal. Health & Safety Code § 1368.03.

forgo the grievance process altogether.[39] You may use an authorized representative to file the Complaint.

DMHC must analyze all documents received from you and your plan and determine the appropriate resolution.[40] Once DMHC makes a determination, it must be sent to you in writing.[41] DMHC must resolve a DMHC Complaint within 30 days (although in practice, DMHC tends to resolve complaints beyond 30 days), and the written resolution must include an explanation of its findings and reasons for its decision.[42] For any Complaint that involves delayed, denied, terminated, reduced or modified medically necessary health care services that should have initially been covered, your plan must promptly provide or reimburse you for the service(s).[43]

ADVOCACY TIP # 5.4: Although it is required that your MCP send DMHC all of your relevant medical documents and information so that DMHC can make a fully-informed decision. In practice, this is not always a reality; MCPs may fail to supply all of the relevant documentation that DMHC needs. To ensure DMHC considers all of the relevant documents and information, we recommend including medical documents and information you want DMHC to review when you file a DMHC Complaint or IMR.

e. External Review: State Fair Hearing

You have the right to request a state fair hearing when you are dissatisfied with your Medi-Cal benefits.[44] You may request a hearing for a broad scope of service problems, including denials or delays in receiving a service or your plan not offering a provider of a needed service within your geographic area, which can frequently occur when you are seeking a specific GAC provider.[45] Partaking in the health plan's internal grievance or appeal process, or in the DMHC Complaint or IMR process, does not waive your right to request a state fair hearing when the result of those processes were unfavorable to you.

[39] Cal. Health & Safety Code § 1368(b)(1)(A).

[40] *See* Cal. Health & Safety Code § 1368.02.

[41] *See* Cal. Health & Safety Code § 1368.02.

[42] Cal. Health & Safety Code § 1368(b)(5).

[43] Cal. Health & Safety Code § 1368(b)(6).

[44] Cal. Welf. & Inst. Code § 10950; *see also* 22 C.C.R. § 51014.1; NHeLP *Internal and External Review: Medi-Cal Managed Care Plans* at 5.

[45] *See* Cal. Welf. & Inst. Code § 10950; *see also* NHeLP *Internal and External Review: Medi-Cal Managed Care Plans* at 5.

You may request a state fair hearing within 120 days after completion of the health plan's internal grievance or appeal process, or after the DMHC Complaint or IMR process.[46] You must exhaust the plan's internal review process before proceeding with a state fair hearing.[47] However, if your plan fails to adhere to the notice and timing requirements for adverse benefit determinations (*e.g.*, failing to provide notice of a benefit modification, or providing a late denial notice), you can immediately request a state fair hearing and you will be deemed to have exhausted the internal appeal and grievance processes.[48] Your request for a state fair hearing can be made by an authorized representative.[49]

ADVOCACY TIP # 5.5: Once you proceed to a state fair hearing, you cannot file a DMHC Complaint or IMR after. Make sure to time your Complaint or IMR with the state fair hearing deadline to ensure you have both opportunities to dispute a denial of care. (28 C.C.R. § 1300.74.30(f)(3))

If you file a state fair hearing request more than 120 days after receiving the notice of grievance/appeal resolution, the state fair hearing request may be accepted only if there is good cause.[50] **Good cause** in this context means a "substantial and a compelling reason beyond the party's control," like being hospitalized or seriously ill.[51] However, a request for a hearing for good cause will not be granted if the request is filed more than 180 days after receiving the notice of grievance or appeal resolution from your Medi-Cal managed care plan.[52]

[46] Cal. Welf. & Inst. Code § 10951(b)(1)(A)-(B).

[47] Cal. Welf. & Inst. Code § 10951(b)(1)(A)-(B).

[48] 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); DHCS MHSUDS 18-010E, at 11, 14; *see also* NHeLP *Internal and External Review: Medi-Cal Managed Care Plans* at 6.

[49] 42 C.F.R. §§ 431.201, 438.402(c)(3)(ii); Cal. Welf. & Inst. Code §§ 10950(a), 10951(a); DHCS APL 21-011 at 14; DHCS MHSUDS 18-010E at 9, 10.

[50] Cal. Welf. & Inst. Code § 10951(b)(2).

[51] Cal. Welf. & Inst. Code § 10951(c). Other factors considered when determining whether there is "good cause" include the length of the delay, the diligence of the party making the request, and the potential prejudice to the other party. An instance that would not be considered "good cause" is a person's inability to understand an adequate and language-compliant notice.

[52] Cal. Welf. & Inst. Code § 10951(b)(2).

Hearings must ordinarily be resolved within 90 days.[53] You can request **an expedited hearing** if the 90-day timeframe for a standard hearing would "seriously jeopardize your life, health, or ability to attain, maintain, or regain maximum function."[54] If the request for an expedited hearing is granted, the case must be calendared on an expedited basis and you must be given at least 10 days advance notice detailing the time, date, and type of hearing to be conducted.[55] The Administrative Law Judge's decision must be issued as expeditiously as possible, but no more than 5 days after the hearing, unless you agree to a delay to submit additional documents for the appeals record.[56] If the request is denied, you must be notified of the denial and the case must be set for a regular state hearing.[57]

There are various ways to request a state fair hearing. You may request a state fair hearing with California's Department of Social Services:

- By calling (800) 743-8525
- Online at https://acms.dss.ca.gov/acms/login.request.do
- By faxing your completed form on the NOABD back to (916) 229-4110.
- By mailing your completed form on the NOABD back to:

  California Department of Social Services
  State Hearings Division
  P.O. Box 944243
  Mail Station 9-17-442
  Sacramento, California 94244-2430

1. Informal Resolutions: Conditional & Unconditional Withdrawals

After a hearing request is filed, your Medi-Cal MCP may offer to resolve the matter informally, without need for the hearing. In that case, the appeal is withdrawn in writing, either

[53] 42 C.F.R. § 431.244(f); Cal. Dep't of Social Servs., Manual of Policies & Procedures § 22-060, https://www.cdss.ca.gov/Portals/9/Regs/4CFCMAN.pdf [hereinafter CDSS MPP § 22-060].

[54] 42 C.F.R. § 431.224; 9 C.C.R. § 1810.216.4; Cal. Dep't of Social Servs., All County Letter No. 13-40 at 1-3 (May 20, 2013), https://www.cdss.ca.gov/lettersnotices/EntRes/getinfo/acl/2013/13-40.pdf [hereinafter CDSS ACL 13-40].

[55] 42 C.F.R. § 431.224; 9 C.C.R. § 1810.216.4; CDSS ACL 13-40 at 2.

[56] Cal. Gov. Code § 100506.4(a)(2).

[57] 42 C.F.R. § 431.224; 9 C.C.R. § 1810.216.4; CDSS ACL 13-40 at 2.

conditionally or unconditionally.[58] A **conditional withdrawal** is a retraction of your hearing request based on the agency's agreement to take further actions to resolve the issue.[59] Conditional withdrawals are documented with a written agreement between you and the county, requiring that a party (or both parties) complete the actions agreed upon during the informal resolution process within 30 days.[60] If the conditions are met, the appeal is dismissed.[61] **Unconditional withdrawals** immediately dismiss the appeal without prejudice, meaning you may file a new hearing request on that same issue as long as it is timely.[62]

2. Formal Resolution: Administrative Law Judge's Decision

If your case proceeds to a formal hearing, the State Hearings Division must set the hearing within 30 working days after the request is filed.[63] The date of the hearing request is the date the CDSS receives the request. CDSS must send you a written notice of the date, time, and location of the hearing at least 10 days before the hearing.[64] The notice must explain how the hearing will take place, either by telephone, video conference, or in person.

The MCP's hearing representative must send you a copy of their position statement, at least 2 working days before the hearing, setting forth the issues in question at the Fair Hearing.[65] You may receive the position statement by mail or upon request by electronic communications.[66] If the MCP's hearing representative does not make the position statement available in the required time period or if the MCP's hearing representative modifies it within the 2 days before the hearing, you have the right to ask for postponement, or to move forward with the hearing anyway.[67]

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[58] Cal. Dep't of Social Servs., All County Letter No. 23-82 at 2 (Sept. 19, 2023), https://www.cdss.ca.gov/Portals/9/Additional-Resources/Letters-and-Notices/ACLs/2023/23-82.pdf?ver=2023-10-06-083956-020 [hereinafter CDSS ACL 23-82].

[59] CDSS ACL 23-82 at 4.

[60] CDSS ACL 23-82 at 7.

[61] CDSS ACL 23-82 at 4.

[62] CDSS ACL 23-82 at 3.

[63] Cal. Welf. & Inst. Code § 10952(a).

[64] Cal. Welf. & Inst. Code § 10952(a).

[65] Cal. Welf. & Inst. Code § 10952.5 (This applies to State Fair Hearings for both Medi-Cal eligibility and Medi-Cal scope of benefits).

[66] Cal. Welf. & Inst. Code § 10952.5(a).

[67] Cal. Welf. & Inst. Code § 10952.5(c).

As mentioned earlier, all state fair hearings must be decided or dismissed within 90 days from when the hearing was requested.[68] Once the Administrative Law Judge has issued a proposed decision, it must be sent to you (or your authorized representative) and the Director of DHCS.[69] The Director of DHCS has 30 days from receipt of the Judge's proposed decision, or within 3 business days for an expedited resolution, to accept or change the decision, or to set another hearing date.[70] If the Director does not do anything with the proposed decision, then the proposal is accepted.[71] If the decision is in your favor, then your MCP must implement the Judge's orders within 30 days from when the hearing decision is received by your MCP.[72]

If the decision is not in your favor, or if you are otherwise dissatisfied with the decision, you have a right to seek a rehearing.[73] You can request a rehearing by sending a written request to the State Hearings Division Rehearing unit within 30 days after receiving the decision.[74] The rehearing request must be in writing and state the date of the adverse decision. It must also list any reasons for why a rehearing should be granted, e.g. the adopted decision not being supported by the parties. The Director of DHCS must take action to grant or deny the request for rehearing within 15 days of receiving it; otherwise, the request will be deemed denied.[75] The hearing decision remains final until a rehearing is granted.[76]

[68] 42 C.F.R. § 431.244(f); CDSS MPP § 22-060.

[69] Cal. Welf. & Inst. Code § 10959(a).

[70] Cal. Welf. & Inst. Code § 10959(a).

[71] Cal. Welf. & Inst. Code § 10959(b).

[72] Cal. Welf. & Inst. Code § 10961.

[73] Cal. Welf. & Inst. Code § 10960.

[74] Cal. Welf. & Inst. Code § 10960.

[75] 42 C.F.R. § 431.232(b); Cal. Welf. & Inst. Code § 10960.

[76] Cal. Welf. & Inst. Code § 10960(d).

You may also, with or without requesting a rehearing, file a writ of mandamus in state court.[77] The deadline to file a petition for writ of mandamus is one year from receiving notice of the Director's final decision.[78] There is no filing fee and, if you prevail, you are entitled to attorney fees and costs.[79]

ADVOCACY TIP # 5.6: The criteria to get an approved rehearing request are narrow rather than broad. The grounds to approve a rehearing request includes the adopted decision is inconsistent with the law, is not supported by the evidence in the record, is not supported by the findings, does not address all of the claims or issues raised by the parties, supported by the record or evidence, or lacks sufficient information to determine the basis for its legal conclusion. Additional reasons include: newly discovered evidence, that was not in custody or available to the party requesting rehearing at the time of the hearing, is now available and the new evidence, had it been introduced, could have changed the hearing decision; or for any other reason necessary to prevent the abuse of discretion or an error of law, or for any other reason consistent with Section 1094.5 of the Code of Civil Procedure. Based on these grounds, it is important that evidence provided to receive an approval of your rehearing request is concrete enough to satisfy one or more of the grounds outlined in the law.

B. MEDI-CAL FEE-FOR-SERVICE

Individuals who are enrolled in Medi-Cal Fee-For-Service (FFS) have the constitutional protections to receive an adequate notice from DHCS and an opportunity to seek a state fair hearing to appeal DHCS' actions or decisions.[80] To determine whether you are enrolled in Medi-Cal FFS, please refer to Chapter 3: Types of Coverage of this Guide. If you receive services through Medi-Cal FFS, you do not need to go through an internal review and you can proceed directly to request a state fair hearing after receiving an adverse benefit determination. This section will explain how you can exercise these rights.

a. Notice

DHCS must provide you with an adequate and timely written notice of adverse benefit determination (NOABD) when DHCS decides to deny, terminate, or reduce your gender-affirming services.[81] The NOABD must inform you of the action being taken by DHCS, the reasons for the action, the specific legal support for the action, your right to a hearing, your right to representation, and your right to continued benefits.[82] The NOABD must be written in plain

[77] Cal. Welf. & Inst. Code § 10960(e).

[78] Cal. Welf. & Inst. Code § 10962.

[79] Cal. Welf. & Inst. Code § 10962.

[80] Cal. Welf. & Inst. Code § 10950(a); Cal. Gov't Code § 100506.4(a)(1); 22 C.C.R. § 50951.

[81] 42 C.F.R. §§ 431.206(b), 431.210, 435.912, 435.917(a); 22 C.C.R. § 51014.1.

[82] 42 C.F.R. §§ 431.206(b), 431.210; 22 C.C.R. § 51014.1.

language and be accessible to individuals with disabilities and persons with limited English proficiency.[83] The NOABD must provide you a choice to receive notices in an electronic format or by regular mail.[84] When the intended action involves termination of eligibility or suspension, termination or reduction of services, a NOABD generally must be sent at least 10 days before the date of the action.[85] The NOABD may be mailed no later than the day of the action in exceptional circumstances, including instances when your physician prescribes a change in the level of medical care.[86]

b. Continuing Benefits: Aid Paid Pending

As mentioned earlier, if a service you are currently receiving is being terminated, reduced, suspended, or modified, you may be able to keep receiving the service while the hearing is pending through Aid Paid Pending. To receive Aid Paid Pending, you must file the request for a state fair hearing within 10 days of receiving the NOABD or before the effective date of action.[87] Once this request is filed, your benefits will continue until a hearing decision is issued or until the authorization period expires, whichever occurs first.[88]

c. External Review: State Fair Hearing

You have the right to appeal the adverse benefit determination at a state fair hearing, even if you do not receive a NOABD.[89] You must file a request for a state fair hearing within 90 days of the date of the NOABD or the adverse benefit determination if no NOABD was issued, which can be extended to 180 days upon a showing of good cause—a "substantial and a compelling reason beyond the [your] control," like being hospitalized or seriously ill.[90]

You can request an expedited hearing if the 90-day timeframe for a standard hearing would "seriously jeopardize your life, health, or ability to attain, maintain, or regain maximum

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[83] 42 C.F.R. §§ 435.916(g), 435.917(a), 431.206(e), 435.905(b).

[84] 42 C.F.R. § 435.918(a).

[85] 42 C.F.R. § 431.206; 22 C.C.R. § 51014.1.

[86] 42 C.F.R. § 431.213; 22 C.C.R. § 51014.1.

[87] 42 C.F.R. § 431.230; 22 C.C.R. §§ 51334(c), 51014.2(a), (c).

[88] 42 C.F.R. § 431.230; 22 C.C.R. §§ 51334(c), 51014.2(a), (c).

[89] Cal. Welf. & Inst. Code § 10950(a); Cal. Gov. Code § 100506.4(a)(1); 22 C.C.R. § 50951.

[90] Cal. Welf. & Inst. Code § 10951(a)(1)(2); Cal. Gov. Code § 100506.4(a)(1). Cal. Welf. & Inst. Code § 10951(c). Other factors considered when determining whether there is "good cause" include the length of the delay, the diligence of the party making the request, and the potential prejudice to the other party. An instance that would not be considered "good cause" is a person's inability to understand an adequate and language-compliant notice.

function."[91] If the request for an expedited hearing is granted, the case must be calendared on an expedited basis and you must be given at least 10 days advance notice detailing the time, date, and type of hearing to be conducted.[92] The Administrative Law Judge's decision must be issued as expeditiously as possible, but no more than 5 working days after the hearing, unless you agree to a delay to submit additional documents for the appeals record.[93] If the request is denied, you must be notified of the denial and the case must be set for a regular state hearing.[94]

There are various ways to request a state fair hearing. You may request a state fair hearing with California's Department of Social Services:

- By calling (800) 743-8525
- Online at https://acms.dss.ca.gov/acms/login.request.do
- By faxing your completed form on the NOABD back to (916) 229-4110
- By mailing your completed form on the NOABD back to:

  California Department of Social Services
  State Hearings Division
  P.O. Box 944243
  Mail Station 9-17-442
  Sacramento, California 94244-2430

ADVOCACY TIP # 5.7: If you paid out of pocket for a service because of a barrier or denial and wish to seek reimbursement for those costs, you will need to submit a Conlan reimbursement packet first, before you may request a state fair hearing. For additional information on how to submit a Conlan reimbursement, see: https://www.dhcs.ca.gov/services/medi-cal/Pages/Online-Conlan-Claim-Forms.aspx.

1. Informal Resolutions: Conditional & Unconditional Withdrawals

After your hearing request is filed, DHCS may offer to resolve the matter informally, without need for the hearing.[95] In that case, the appeal is withdrawn in writing, either conditionally or unconditionally.[96] A conditional withdrawal is a retraction of your hearing request based on the

[91] 42 C.F.R. § 431.224; 9 C.C.R. § 1810.216.4; CDSS ACL 13-40 at 1-3.

[92] 42 C.F.R. § 431.224; 9 C.C.R. § 1810.216.4; CDSS ACL 13-40 at 2.

[93] Cal. Gov. Code § 100506.4(a)(2)

[94] 42 C.F.R. § 431.224; 9 C.C.R. § 1810.216.4; CDSS ACL 13-40 at 2.

[95] CDSS ACL 23-82 at 2.

[96] CDSS ACL 23-82 at 2.

DHCS's agreement to take further actions to resolve the issue.[97] Conditional withdrawals are documented with a written agreement between you and DHCS, requiring that a party (or both parties) complete the actions agreed upon during the informal resolution process within 30 days.[98] If the conditions are met, the appeal is dismissed.[99] Unconditional withdrawals immediately dismiss the appeal without prejudice, meaning you may file a new hearing request on that same issue as long as it is timely.[100]

2. Formal Resolution: Administrative Law Judge's Decision

If your case proceeds to a formal hearing, the State Hearings Division must set the hearing within 30 working days after the request is filed.[101] The date of the hearing request is the date the CDSS receives the request. CDSS must send you a written notice of the date, time, and location of the hearing at least 10 days before the hearing.[102] The notice must explain how the hearing will take place, either by telephone, video conference, or in person.

DHCS' hearing representative must send you a copy of their position statement, at least 2 working days before the hearing, setting forth the issues in question at the Fair Hearing.[103] You may receive the position statement by mail or upon request by electronic communications.[104] If DHCS does not make the position statement available in the required time period or if DHCS modifies it within the 2 days before the hearing, you have the right to ask for postponement, or to move forward with the hearing anyway.[105]

All state fair hearings must be decided or dismissed within 90 days from when the hearing was requested.[106] Once the Administrative Law Judge has issued a proposed decision, it must be sent to you (or your authorized representative) and the Director of DHCS.[107] The Director of DHCS has 30 days from receipt of the Judge's proposed decision, or within 3 business days for an

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[97] CDSS ACL 23-82 at 4.

[98] CDSS ACL 23-82 at 7.

[99] CDSS ACL 23-82 at 4.

[100] CDSS ACL 23-82 at 3.

[101] Cal. Welf. & Inst. Code § 10952(a).

[102] Cal. Welf. & Inst. Code § 10952(a).

[103] Cal. Welf. & Inst. Code § 10952.5 (this applies to State Fair Hearings for both Medi-Cal eligibility and Medi-Cal scope of benefits).

[104] Cal. Welf. & Inst. Code § 10952.5(a).

[105] Cal. Welf. & Inst. Code § 10952.5(c).

[106] 42 C.F.R. 431.244(f); CDSS MPP § 22-060.

[107] Cal. Welf. & Inst. Code § 10959(a).

expedited resolution, to accept or change the decision, or to set another hearing date.[108] If the Director does not do anything with the proposed decision, then the proposal is accepted.[109] If the decision is in your favor, then DHCS must implement the Judge's orders within 30 days from when the hearing decision is received by DHCS.[110]

If the decision is not in your favor, or if you are otherwise dissatisfied with the decision, you have a right to seek a rehearing.[111] You can request a rehearing by sending a written request to the State Hearings Division Rehearing unit within 30 days after receiving the decision.[112] The rehearing request must be in writing and state the date of the adverse decision. It must also list any reasons for why a rehearing should be granted, e.g. the adopted decision not being supported by the parties. The Director of DHCS must take action to grant or deny the request for rehearing within 15 days of receiving it; otherwise, the request will be deemed denied.[113] The hearing decision remains final until a rehearing is granted.[114]

You may also, with or without requesting a rehearing, file a writ of mandamus in state court.[115] The deadline to file a petition for writ of mandamus is one year from receiving notice of the Director's final decision.[116] There is no filing fee and, if you prevail, you are entitled to attorney fees and costs.[117]

C. MEDI-CAL RX COMPLAINT PROCESS

In 2022, Governor Gavin Newsom created a new program within Medi-Cal, called Medi-Cal Rx,[118] in an effort to lower the cost of prescription drugs for Medi-Cal beneficiaries. To learn more about Medi-Cal Rx, please also review Chapter 3: Types of Coverage of this Guide.

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[108] Cal. Welf. & Inst. Code § 10959(a).

[109] Cal. Welf. & Inst. Code § 10959(b).

[110] Cal. Welf. & Inst. Code § 10961.

[111] Cal. Welf. & Inst. Code § 10960.

[112] Cal. Welf. & Inst. Code § 10960.

[113] 42 C.F.R. § 431.232(b); Cal. Welf. & Inst. Code § 10960.

[114] Cal. Welf. & Inst. Code § 10960(d).

[115] Cal. Welf. & Inst. Code § 10960(e).

[116] Cal. Welf. & Inst. Code § 10962.

[117] Cal. Welf. & Inst. Code § 10962.

[118] Cal. Dep't of Health Care Servs., *Welcome to Medi-Cal Rx*, https://medi-calrx.dhcs.ca.gov/home/ (last visited Feb. 22, 2025).

Medi-Cal Rx has adopted an informal complaint process when you have concerns with a decision about a prescription, in addition to the existing state fair hearing process.[119] This informal complaint process does not replace the State Fair Hearing process. To appeal the adverse benefit determination, you must go through the state fair hearing process, as discussed in this Chapter's section B. Medi-Cal Fee-For-Service, above.

The Medi-Cal Rx Consumer Service Center (CSC) administers the complaint (sometimes also called grievance) processes for Medi-Cal pharmacy benefits. Complaints can be filed at any time and there are no time restrictions based on the date the incident occurred. The complaint may be filed by yourself or an authorized representative and may be submitted in person, in writing, or by phone. The Customer Service Representatives (CSR) process the complaints/grievances in all threshold languages and a TTY option using the 711 National Service.[120]

A complaint would include situations such as:

- Dissatisfaction due to Medi-Cal Rx coverage policy, quality of care, and/or timeliness of care;
- Dissatisfaction due to inaccuracies and/or omissions relative to services/information being provided; and/or
- Dissatisfaction due to aspects of interpersonal relationships such as rudeness of a provider or employee (inclusive of discriminatory practices pursuant to applicable state/federal law).[121]

Once a complaint is received, the CSR will determine whether the complaint can be resolved immediately (no further research is required). If the complaint can be resolved immediately, the complaint is "exempt" and will be resolved via the communication it was submitted and then closed.[122] Medi-Cal Rx usually will not send an acknowledgement letter for exempt complaints, but the CSR will generate a closeout communication and maintain a log of the complaint with

[119] Complaint and grievance are used interchangeably in this section, which is also in accordance with Medi-Cal Rx policy. *See* Cal. Dep't of Health Care Servs., *Medi-Cal Rx Complaints/Grievances Policy Version 6* (April 7, 2021), https://www.dhcs.ca.gov/provgovpart/pharmacy/Documents/Complaints-and-GrievanceV6.0-04072021.pdf (last visited Feb. 22, 2025) [hereinafter DHCS *Medi-Cal Rx Complaints/Grievances Policy*].

[120] DHCS' existing threshold languages (17 total) are Arabic, Armenian, Cambodian, Chinese, English, Farsi, Hindi, Hmong, Japanese, Korean, Laotian, Punjabi, Russian, Spanish, Tagalog - Filipino, Thai, and Vietnamese.

[121] *See also* DHCS *Medi-Cal Rx Complaints/Grievances Policy* at 2-4 (reasons that would not be considered a complaint).

[122] DHCS *Medi-Cal Rx Complaints/Grievances Policy* at 5-6.

important information (e.g., date of the call, your name, identification number, nature of the complaint, nature of the resolution, name of the CSR).[123]

If the complaint cannot be resolved immediately and further research is required, an acknowledgement letter of receipt of the complaint will be sent to you within 1 business day.[124] The CSR will conduct an initial investigation and will determine within 3 days if the complaint needs to go to DHCS to be resolved.[125] Typically, DHCS resolves complaints involving discriminatory practices, policy disagreements, and legal threats.[126] If the complaint does not need to be sent to DHCS, the CSR will conduct an investigation to determine whether the complaint can be resolved within 10 business days.[127] The investigation may include listening to calls, reviewing your history related to the complaint, contacting the prescriber or pharmacy, and interviewing CSRs who may have been involved with a previous interaction. Once an investigation is conducted, the CSR will create an action plan to resolve the complaint.[128]

If within this period the CSR determines that your complaint cannot be resolved within 10 days, the CSR will send you a notice, documenting the status of your complaint. Your complaint should be resolved within 30 business days and the CSC will send you a final notice, summarizing the resolution, either through mail or electronically.[129] The resolution must include the outcome of the complaint, your name, date of the initial complaint submission, the Case ID, date of complaint resolution, and summary of complaint resolution.[130] If you submitted a complaint anonymously, communication letters will not be generated. If the case requires more than 30 days to resolve, the CSR will document the reason for the extension and communicate the reason to DHCS; the CSR and DHCS will then develop a resolution plan and execute.[131]

If the complaint involves an urgent matter, it can be escalated by the agent for immediate attention and action, which you can request by yourself or the CSR can flag the complaint as urgent on their own.[132]

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[123] DHCS *Medi-Cal Rx Complaints/Grievances Policy* at 6.

[124] DHCS *Medi-Cal Rx Complaints/Grievances Policy* at 6.

[125] DHCS *Medi-Cal Rx Complaints/Grievances Policy* at 6.

[126] DHCS *Medi-Cal Rx Complaints/Grievances Policy* at 7.

[127] DHCS *Medi-Cal Rx Complaints/Grievances Policy* at 7.

[128] DHCS *Medi-Cal Rx Complaints/Grievances Policy* at 7.

[129] DHCS *Medi-Cal Rx Complaints/Grievances Policy* at 7.

[130] DHCS *Medi-Cal Rx Complaints/Grievances Policy* at 7.

[131] DHCS *Medi-Cal Rx Complaints/Grievances Policy* at 7.

[132] DHCS *Medi-Cal Rx Complaints/Grievances Policy* at 6.

D. MEDI-MEDI PLANS

In California, people who have both Medicare and Medi-Cal have the choice to remain in Original Medicare, enroll in a regular Medicare Advantage Plan (referred to as "MA" or "MAP"), enroll in PACE,[133] or enroll in one of the Medi-Medi plans (referred to as "integrated dual special needs plans" or "D-SNP"). To determine whether you are enrolled in Medi-Medi plan, please refer to Chapter 3: Types of Coverage of this Guide.

The majority of people in California who choose a Medi-Medi plan enroll in either an D-SNP or a FIDE-SNP (e.g. SCAN Connections). Both of these plans are considered an "applicable integrated plan" under federal law and regulation, requiring the Medi-Medi plan evaluate claims and pre-authorization requests for needed services under both the Medicare and Medi-Cal coverage criteria.[134] Moreover, as a result of federal law, these Medi-Medi plans must provide you with integrated notices and integrated grievance and appeals processes.

For a general overview of the differences between these different D-SNP plans, please see Justice in Aging's advocate resource.[135]

a. Integrated Grievances & Appeals

Those D-SNPs designated as applicable integrated plans must establish and oversee an integrated grievance and appeal system to ensure you have the opportunity to submit grievances and appeals, and receive timely adjudication.[136] D-SNPs conduct both grievances and plan coverage determination appeals, called Integrated Organizational Determinations. We will discuss each below and their respective rights and timelines, as well as things to consider when pursuing them.

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[133] For an overview of PACE (Program of All-Inclusive Care for the Elderly) *see* U.S. Ctr. for Medicare and Medicaid Servs., Medicare, *PACE*, https://www.medicare.gov/health-drug-plans/health-plans/your-coverage-options/other-medicare-health-plans/PACE (last visited Feb. 12, 2025).

[134] 42 C.F.R. § 422.629(k)(3).

[135] Rachel Gershon & Tiffany Huyenh-Cho, Justice In Aging, *Dual Eligible Special Needs Plans (D-SNPs): What Advocates Need to Know* (Feb. 28, 2024), https://justiceinaging.org/dual-eligible-special-needs-plans-d-snps-what-advocates-need-to-know/ (last visited Feb. 12, 2025) [hereinafter *D-SNPs: What Advocates Needs to Know*].

[136] 42 C.F.R. § 422.629(k)(3).

1. Grievances

As in the Medi-Cal managed care plan context, a grievance (or complaint) is any expression of dissatisfaction about a matter other than an adverse benefit determination.

You may file a grievance at any time. Within 5 calendar days of receiving your grievance, your D-SNP must send you a written acknowledgement of the grievance that is dated and postmarked.[137] Your D-SNP must resolve standard grievances and send you a written resolution as expeditiously as you health condition requires, but no later than 30 calendar days from receipt of the grievance. Expedited grievances are those that involve imminent and serious health risks and must be resolved in 24 hours.[138]

ADVOCACY TIP # 5.8: Always request a written notice of grievance resolution because there are scenarios in which only an oral notification is required.[139]

2. Pre-authorization coverage determinations & appeals

Your D-SNP may require a prior authorization process for certain services, equipment, and supplies. In D-SNPs these coverage determinations are referred to as Integrated Organizational Determinations under federal law.[140] Given that D-SNPs have integrated both the Medicare and Medi-Cal benefits, they must make coverage determinations using the coverage determination or medical necessity standards under both Medicare and Medi-Cal.[141] Denials for these Integrated Organizational Determinations are issued either as full or partial denials.

D-SNPs must make coverage determinations within 5 business days from the D-SNP receipt of information reasonably necessary to make the determination, but no later than 14 calendar days from when the D-SNP receives the request.[142] If there is an expedited request for coverage determination, your D-SNP must provide you notice as expeditiously as your condition requires but no later than 72 hours from receipt of the request.[143]

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[137] 42 C.F.R. § 422.631(d)(2)(i)(B); Cal. Health & Safety Code § 1367.01(h)(1).

[138] Cal. Health & Safety Code § 1368.01(b); 28 C.C.R. § 1300.68.01.

[139] 42 C.F.R. § 422.630.

[140] The terms "coverage determination" and "Integrated Organizational Determinations" are used interchangeably in this section.

[141] *See* 42 C.F.R. § 422.629(k)(3).

[142] 42 C.F.R. § 422.631(d)(2)(i)(B); Cal. Health & Safety Code § 1367.01(h)(1).

[143] 42 C.F.R. § 422.631(d)(2)(iv); Cal. Health & Safety Code § 1367.01(h)(2).

3. Integrated reconsiderations / Internal plan appeals

If your D-SNP's initial coverage determination is not favorable, you have similar appeal rights to those articulated above for Medi-Cal managed care members. D-SNPs must use the same federal definition of "appeal" and "adverse beneficiary determination." Note that federal regulations extended the time to request an appeal with a Medicare managed care plan to 65 days (originally it was 60 days).[144]

Prior to terminating, suspending, or reducing a previously authorized gender-affirming service, D-SNPs must provide an integrated coverage determination notice at least 10 calendar days in advance of the effective date of the action.[145] To continue services pending appeal or review, you must request "continuation of benefits" within 10 calendar days of the postmark date on the notice or prior to the intended effective date of the action, whichever is later.[146]

When you request a reconsideration, your D-SNP must provide you the reasonable opportunity to present evidence and testimony and make legal and factual arguments for integrated grievances and integrated reconsiderations.[147] You must be notified of the limited time available for presenting evidence sufficiently in advance of the resolution timeframe.

Your D-SNP must complete the reconsideration process as expeditiously as the your health condition requires, but no later than 30 calendar days from the date of request and, in response to an expedited appeal, no more than 72 hours.[148] Your D-SNP must send you a reconsideration decision in writing when they send you a full or partial denial of an integrated organizational determination (i.e. pre-authorization determination). [149] The notice will explain the secondary external review process.

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[144] 42 C.F.R. § 422.633(d)(1); U.S. Ctr. for Medicare and Medicaid Servs., *Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* at § 50.9.1 (Nov. 18, 2024), https://www.cms.gov/medicare/appeals-and-grievances/mmcag/downloads/parts-c-and-d-enrollee-grievances-organization-coverage-determinations-and-appeals-guidance.pdf (last visited Feb. 12, 2025) [hereinafter *Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*].

[145] 42 C.F.R. § 422.631(d)(2)(i)(A).

[146] 42 C.F.R. § 422.632(a).

[147] 42 C.F.R. § 422.629 (d).

[148] 42 C.F.R. §§ 422.633(f)(1), (2).

[149] 42 C.F.R. § 422.633(f)(4).

4. Second level or external agency appeal

After the internal integrated appeal options are completed, secondary and external appeal options branch out depending on the source of coverage for the service or item.[150] Services or items in dispute that are primarily covered by Medicare may be pursued through typical Medicare managed care appeal processes. Services or items in dispute that are primarily covered by Medi-Cal may be pursued through the Medi-Cal managed care external review processes.

For decisions relating to Medi-Cal covered services (e.g. long-term care, certain equipment, etc.), external review occurs in accordance with DMHC's Independent Medical Review / Complaint processes and/or the associated state fair hearing process as described above in the section relating to Medi-Cal managed care appeal options. For determining Medi-Cal scope of coverage please refer to the medical necessity and prior authorization process discussion in Chapter 4.

For decisions relating to Medicare covered services, external review of D-SNP reconsideration determinations is handled as they are by Medicare Advantage plans. Specifically, D-SNPs must automatically forward any full or partial denial of an integrated organizational decision for a review by an external Independent Review Entity (IRE; Maximus is the IRE in California).[151] You may also request a second level review within 65 days of the post mark of the Integrated Organizational Determination.[152] The IRE will then issue a decision within 30 days for pre-service coverage determinations, 60 days for coverage determinations relating to payment for services already provided, and 7 days for Medicare Part B drug related decisions.[153]

Beyond the second level appeal, you have further rights to appeal unfavorable determinations through the Administrative Law Judge hearing level (request within 65 days),[154] then appeal

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[150] To identify Medicare coverage determination guidance for particular services or items using National level, *see* U.S. Ctr. for Medicare and Medicaid Servs., *Medicare Coverage Database*, https://www.cms.gov/medicare-coverage-database/search.aspx (last visited Feb. 12, 2025). To identify Medicare coverage determination guidance for particular services or items using Local levels, *see* Noridian Healthcare Solutions, *Medicare*, https://med.noridianmedicare.com/ (last visited Feb. 22, 2025) (for California local coverage determinations information); U.S. Ctr. for Medicare and Medicaid Servs., *National Government Services*, https://www.ngsmedicare.com/web/ngs/home?lob=93618&state=97162&rgion=93624 (last visited Feb. 22, 2025) (for Home Health and Hospice).

[151] *See* 42 C.F.R. § 422.592.

[152] *See Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* at § 50.2.1.

[153] 42 C.F.R. § 422.590.

[154] *See Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* at § 70.1; *see* § 70.2 (regarding the amount in controversy requirements).

through the Medicare Appeals Council (request within 65 days),[155] and then by filing a lawsuit in Federal District Court (file your petition within 60-days).[156] Detailed discussion of these appeals procedures may be found on the National Center on Law and Elder Rights (NCLER's) website.[157]

E. Civil Rights Complaints

If you believe your civil rights have been violated, there are several state and federal complaint processes available to enforce those rights.

a. DHCS Office of Civil Rights: Discrimination Complaint

If you believe you have been subjected to unlawful discrimination in the Medi-Cal program, you can file a complaint with the Department of Health Care Services' Office of Civil Rights if the discrimination was on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or any other basis protected by federal or State civil rights laws.[158]

1. Procedure & Policy

You must complete the DHCS 1044 Discrimination Complaint Form[159] and can include additional sheets of paper if needed to fully describe your discrimination complaint. You must include on the form:

- Name & address of medical administrator/provider;
- Date of occurrence;

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[155] *Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* at § 70.1 (except there are no amount in controversy requirements).

[156] *Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* at § 70.1 (note the 2025 amount in controversy requirement for Federal District Court review is $1,900).

[157] *See* U.S. Dep't of Health & Human Servs., Administration for Community Living, *National Center on Law and Elder Rights*, https://ncler.acl.gov/medicare#gsc.tab=0 (last visited Feb. 22, 2025).

[158] Cal. Dep't of Health Care Servs., *Discrimination Grievance Policies and Procedures*, https://www.dhcs.ca.gov/discrimination-grievance-procedures (last visited Feb. 22, 2025).

[159] Cal. Dep't of Health Care Servs., *DHCS Discrimination Complaint Form (Title VI and ADA)*, https://www.dhcs.ca.gov/Documents/1044-DHCS-DISCRIMINATION-COMPLAINT-FORM.pdf (last visited Feb. 22, 2025).

- The basis of discrimination: sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation, or any other basis protected by federal or State civil rights laws;
- A description of the incident that occurred; and
- The resolution or outcome you are seeking.

Once you complete the discrimination complaint form, you may be file it:

- By mailing it to: Office of Civil Rights,
  Department of Health Care Services
  PO Box 997413, MS 0009
  Sacramento, CA 95899-7413
- By emailing it to CivilRights@dhcs.ca.gov
- By calling DHCS's Office of Civil Rights at (916) 440-7370.

DHCS provides free assistance and services to people with disabilities to communicate effectively with DHCS.

You have 365 days from the day of the discriminatory action to submit a complaint to the DHCS Office of Civil Rights.[160] DHCS will send you a written notification within 10 days that your complaint has been received and will let you know if more information is needed.[161] DHCS will begin an investigation within 30 days of receiving the discrimination complaint to determine if the complaint is within its jurisdiction.[162] During the investigation, DHCS may share information about your complaint with your Medi-Cal MCP, the health care provider, or entity that committed the discriminatory action.[163] In accordance with applicable law, DHCS will take appropriate steps to preserve the confidentiality of your records relating to complaints and will share them only with those who have a need to know.[164]

If the discrimination complaint is within DHCS' jurisdiction, DHCS will issue a written determination explaining its findings (or if the investigation is ongoing), provide an update on the status of the investigation, and the expected date of completion within 90 days of receipt.[165] Once the investigation is completed, DHCS will issue a written determination. The written determination will be based on a preponderance of the evidence and will include a notice of your

[160] Cal. Dep't of Health Care Servs., *DHCS Discrimination Grievance Policies and Procedures*, https://www.dhcs.ca.gov/discrimination-grievance-procedures (last visited Aug. 14, 2025) [hereinafter *DHCS Discrimination Grievance Policies and Procedures*].

[161] *DHCS Discrimination Grievance Policies and Procedures.*
[162] *DHCS Discrimination Grievance Policies and Procedures.*
[163] *DHCS Discrimination Grievance Policies and Procedures.*
[164] *DHCS Discrimination Grievance Policies and Procedures.*
[165] *DHCS Discrimination Grievance Policies and Procedures.*

right to pursue further administrative or legal remedies.[166] If the discrimination complaint is not within DHCS' jurisdiction, DHCS will notify you of its determination in writing within 90 days of receipt of the discrimination complaint.[167]

2. Appeal

You may appeal DHCS' written determination within 15 days of receiving it.[168] The written determination will be deemed received 5 days after mailing or immediately received if faxed or emailed.[169] Appeals must identify the written determination being appealed or include a copy of the written determination and an explanation of the reason you are appealing the determination.[170] Appeals may be filed:

- By mailing it to: Office of Civil Rights
  Department of Health Care Services
  PO Box 997413, MS 0009
  Sacramento, CA 95899-7413
- By emailing it to CivilRights@dhcs.ca.gov

The DHCS Director, or their representative, will issue a written determination of an appeal no later than 60 days after DHCS receives the appeal.[171] The determination on appeal will not be decided upon by any person who participated in the determination of the discrimination complaint that is being appealed.[172]

ADVOCACY TIP # 5.9: The availability and use of the DHCS discrimination grievance procedure does not prevent you from pursuing other legal or administrative remedies, including filing a discrimination grievance with a Medi-Cal managed care plan, or filing a complaint of discrimination in California state court.

[166] *DHCS Discrimination Grievance Policies and Procedures.*
[167] *DHCS Discrimination Grievance Policies and Procedures.*
[168] *DHCS Discrimination Grievance Policies and Procedures.*
[169] *DHCS Discrimination Grievance Policies and Procedures.*
[170] *DHCS Discrimination Grievance Policies and Procedures.*
[171] *DHCS Discrimination Grievance Policies and Procedures.*
[172] *DHCS Discrimination Grievance Policies and Procedures.*

b. California Civil Rights Department (CRD) Complaint

If you are in California and believe you have been subjected to discrimination, harassment, or retaliation, you can file a complaint with the California Civil Rights Department. [173]

1. Procedure & Policy

The first step is to submit an intake form. This form may be submitted:[174]

- Online through the California Civil Rights System (CCRS) portal,
- By mailing it to 651 Bannon Street, Suite 200 Sacramento, CA 95811,
- By emailing it to contact.center@calcivilrights.ca.gov ,
- By calling (800) 884-1684 (voice), (800) 700-2320 (TTY), or California's Relay Service at 711, or
- In person by visiting one of their office locations.[175]

It is important to have the following information to provide to CRD:[176]

- The specific facts and any records about the incident(s), including the name and contact information of the person or entity you believe harmed you (if known);
- Copies of any documents or other evidence related to your complaint; and
- The names and contact information of any witnesses (if known).

If you are unable to gather all the required information at the time you file, you can still begin the filing process through the CCRS portal and add additional information as you acquire it.[177] Your unfiled complaint will remain available in the system for 30 days.[178]

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[173] *See generally* State of California, Civil Rights Department, *Complaint Process*, https://calcivilrights.ca.gov/complaintprocess (last visited Aug. 14, 2025) [hereinafter CRD, *Complaint Process*].

[174] Instructions on how to create an account and upload documents can be found at State of California, Civil Rights Department, *How to File a Complaint*, https://calcivilrights.ca.gov/complaintprocess/how-to-file-a-complaint/# (last visited Aug. 14, 2025).

[175] State of California, Civil Rights Department, *Office Locations*, https://calcivilrights.ca.gov/locations/ (last visited Feb. 24, 2025).

[176] CRD, *Complaint Process.*

[177] CRD, *Complaint Process.*

[178] CRD, *Complaint Process.*

You must submit a complaint within 1 year of the date you were last harmed.[179] When you file a discrimination complaint, it will initiate an intake interview with a CRD representative. The representative will evaluate the allegations and decide whether to accept your case for investigation.[180] CRD can only investigate violations of civil rights laws that the CRD enforces.[181]

ADVOCACY TIP # 5.10: There are several ways to file a complaint with the CRD. The fastest and easiest way is online via the California Civil Rights System (CCRS) portal. It offers many benefits, such as self-service appointment scheduling; a list of upcoming appointments; the ability to upload files to your case as needed; and the ability to pause filing and resume at a later time if more information is needed (within 30 days of complaint creation). However, if the CCRS portal is not the best way for you, you can file by email, mail, phone, or in-person.

Some of those laws include:

- Laws that prohibit discrimination in state-funded programs[182]
- Disabled Persons Act[183]
- Ralph Civil Rights Act[184]

If your complaint is accepted for investigation, CRD will prepare a complaint form for your signature.[185] When you submit the complaint, it will be sent to the person or entity that you believe discriminated against you. If CRD files your complaint, it means that it has preliminarily determined that the allegations are covered by a law that the department enforces—it does not determine whether there is reasonable cause to believe any laws have been violated.[186] If your

[179] CRD, *Complaint Process.*

[180] CRD, *Complaint Process.*

[181] *See* Cal. Gov. Code § 11135 [laws that prohibit discrimination in state-funded programs]; Cal. Civil Code § 54 [Disabled Persons Act]; Cal. Civil Code § 51.7 [Ralph Civil Rights Act (prohibits hate violence or threat of hate violence)]; Cal. Gov. Code §§ 12900-12999 [Fair Employment and Housing Act]; Cal. Gov. Code § 12945.2 [Cal. Family Rights Act (CFRA)]; Cal. Civil Code § 51 [Unruh Civil Rights Act (requires business establishments to provide equal accommodations)]; Cal. Civil Code § 51.9 [prohibits sexual harassment in business, service or professional contexts outside of traditional employment relationships]; Cal. Civil Code § 52.5 [Cal. Trafficking Victims Protection Act].

[182] *See* Cal. Gov. Code § 11135.

[183] *See* Cal. Civil Code § 54.

[184] *See* Cal. Civil Code § 51.7.

[185] CRD, *Complaint Process.*

[186] CRD, *Complaint Process.*

complaint is not accepted for investigation, it is likely because your complaint, if proven, would not have violated the civil rights laws that CRD enforces.[187]

If it accepts your case, CRD will independently investigate the facts and the legal issues.[188] This involves reviewing your responses in the complaint and other information and evidence that you and the opposing entity submit.[189] CRD uses the facts obtained through its investigation to determine if there is reasonable cause to believe a law the department enforces has been violated; if not, the case is closed.[190] If there is reasonable cause, CRD notifies the parties of this determination and may notify them that the department intends to file a lawsuit in court.[191] Prior to filing a lawsuit, CRD typically requires the parties to go to mediation to attempt to reach an agreement to resolve the dispute through conciliation or by referring your case to CRD's Dispute Resolution Division when appropriate or required by law.[192]

Here are some possible outcomes from the complaint: (1) Recovery of out-of-pocket losses; (2) An injunction prohibiting the unlawful practice; (3) Access to housing or a job opportunity; (4) Policy changes; (5) Training; (6) Reasonable accommodation(s); Damages for emotional distress; and (7) Civil penalties and punitive damages.[193]

2. Appeal

If you are dissatisfied with the outcome of CRD's investigation, and the case has not been settled or accepted by CRD to file a lawsuit in court, you may appeal CRD's closure of the case.[194] You have 10 days from receipt of the closure letter to submit an appeal.[195] The closure letter will provide instructions on what the appeal should contain. It is important that your appeal clearly states what specifically you would like reviewed during the appeal.[196] For example, if CRD was

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[187] CRD, *Complaint Process.*

[188] CRD, *Complaint Process.*

[189] CRD, *Complaint Process.*

[190] CRD, *Complaint Process.*

[191] CRD, *Complaint Process.*

[192] CRD, *Complaint Process.*

[193] CRD, *Complaint Process.*

[194] CRD, *Complaint Process.*

[195] CRD, *Complaint Process.*

[196] CRD, *Complaint Process.*

unable to interview all of your witnesses or gather certain evidence, your appeal should identify the name of the witness and provide their contact information or specify the evidence that you believe was overlooked. Another example: if you believe that CRD misapplied the law, your appeal should describe what you understand the law to be. Since an appeal is narrower than the investigation, it is important that you provide all relevant information during the investigation.[197]

The closure letter will direct you to submit your appeal to either (1) the investigator's supervisor (the closure letter will contain the supervisor's contact information); or (2) the Appeals Unit.[198] It is very important that you follow the instructions in the closure letter to ensure that you file your appeal in a timely manner to the correct person or unit.

If you submitted your **appeal to the investigator's supervisor**, the supervisor will respond to your appeal by sending you a letter informing you of the reasons for upholding the closure letter or contacting you to inform you that your case will be reopened.[199]

If you submitted your **appeal to the Appeals Unit**, the Appeals Unit will send you a letter informing you the appeal has been either accepted for review or rejected.[200] If you receive a letter informing you the appeal was accepted for review, no immediate action is needed. Once an appeal reviewer has had an opportunity to review your case file and appeal, they will contact you if more information is needed to decide your appeal.[201] Appeals are processed by the Appeals Unit in the order they are received.[202] The Appeals Unit does not have a deadline by which to decide an appeal. However, the Appeals Unit processes appeals as quickly as possible without sacrificing the quality of its work.[203] You can check on the status of your appeal by contacting the person or unit you submitted your appeal to and include your assigned CRD case number on all correspondence.[204]

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[197] CRD, *Complaint Process.*

[198] CRD, *Complaint Process.*

[199] CRD, *Complaint Process.*

[200] CRD, *Complaint Process.*

[201] CRD, *Complaint Process.*

[202] CRD, *Complaint Process.*

[203] For additional information please refer to 2 C.C.R. §§ 10033, 10065.

[204] CRD, *Complaint Process.*

ADVOCACY TIP # 5.11: If you filed an appeal, we strongly encourage you to seek additional legal advice and not wait until the appeal process is over to decide if you will file a civil lawsuit. There are statutory time limits for filing civil lawsuits in court and this appeal process does not pause the statutory time limit.

c. U.S. Department of Health & Human Services, Office for Civil Rights (OCR) Complaint

The U.S. Department of Health and Human Services, Office for Civil Rights can receive complaints regarding violations of your rights of nondiscrimination, conscience, religious freedom, and health information privacy.[205] You can file a complaint of discrimination form:[206]

- Electronically through the Office for Civil Rights Complaint Portal,[207]
- By mailing the Complaint form to:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW., Room 509F, HHH Building,
  Washington, DC 20201
- By faxing the Complaint form to (202) 619-3818
- By emailing the Complaint form to ocrmail@hhs.gov

Complaints must be filed within 180 days of when you knew the alleged discriminatory act occurred.[208] OCR may extend the 180-day period if you can show good cause.[209] The complaint must also include the name of the health care or social service provider involved, and describe

[205] *See* U.S. Dep't of Health and Human Servs., *How to File a Civil Rights Complaint*, https://www.hhs.gov/civil-rights/filing-a-complaint/complaint-process/index.html (last visited Aug. 14, 2025) [hereinafter HHS, *How to File a Civil Rights Complaint*].

[206] U.S. Dep't of Health and Human Servs., Office for Civil Rights, *Civil Rights and Conscience Complaint*, https://www.hhs.gov/sites/default/files/ocr-cr-complaint-form-package.pdf (last visited Feb. 24, 2025).

[207] U.S. Dep't of Health and Human Servs., Office for Civil Rights, *Complaint Portal Assistant*, https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf (last visited Feb. 24, 2025).

[208] HHS, *How to File a Civil Rights Complaint*.

[209] HHS, *How to File a Civil Rights Complaint*.

the acts or omissions you believe violated civil rights laws or regulations.[210] OCR typically aims to resolve complaints within 180 days, but may take more time if determined necessary.

ADVOCACY TIP # 5.12: Under this current Presidential Administration, the OCR has changed its discrimination language to only include violations of rights of nondiscrimination, conscience, religious freedom, and health information privacy. The removal of language concerning discrimination violations of race, color, national origin, sex, age, or disability indicates OCR is not interested in enforcing complaints of discrimination based on sex, gender identity, gender expression, or sexual orientation. Due to the ongoing attacks on access to GAC federally, we highly encourage that TGI individuals accessing GAC in California utilize DHCS and California state civil rights complaints to address any discriminatory actions they may be experiencing from plans, health care providers, and other entities, rather than filing complaints with OCR.

[210] HHS, *How to File a Civil Rights Complaint*.