DHCS
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES
Michelle Baass | Director

DATE: November XX, 2024

Behavioral Health Information Notice No: 24-XXX
Supersedes Behavioral Health Information Notice 22-070

TO: California Alliance of Child and Family Services
California Association for Alcohol/Drug Educators
California Association of Alcohol & Drug Program Executives, Inc.
California Association of DUI Treatment Programs
California Association of Social Rehabilitation Agencies
California Consortium of Addiction Programs and Professionals
California Council of Community Behavioral Health Agencies
California Hospital Association
California Opioid Maintenance Providers
California State Association of Counties
Coalition of Alcohol and Drug Associations
County Behavioral Health Directors
County Behavioral Health Directors Association of California
County Drug & Alcohol Administrators

SUBJECT: Parity Requirements for Drug Medi-Cal (DMC) State Plan Counties

PURPOSE: To provide updated guidance and clarification to DMC counties on parity requirements regarding Discrimination, Grievances, Adverse Benefit Determinations, Appeals, State Hearings, Provider Directories, Timely Access Standards, and Provider Credentialing.

This Behavioral Health Information Notice (BHIN) also encloses several notice templates, including the Notice of Grievance Resolution (NGR), Notices of Adverse Benefit Determination (NOABD), Notices of Appeal Resolution (NAR), a "Your Rights" attachment, a member non-discrimination notice, and language assistance taglines. These notices provide members with required information about their rights under the Medi-Cal program.

REFERENCE: Title 42, Code of Federal Regulations (CFR), Section 431.244(f); Welfare and Institutions (W&I) Code Section 14197; California Code of Regulations (CCR), Title 22, Section 51341.1(p); W&I Code Section 14197.1; DMC Contract, Exhibit A, Attachment 1.

BACKGROUND:
On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Final Rule (Managed Care Rule), which revised Title 42 of the CFR. These changes aimed to align Medicaid managed care regulations with the requirements of other major sources of coverage. On March 30, 2016, CMS issued the Parity Rule[1] to strengthen access to mental health and substance use disorder services for Medicaid members. The Parity Rule aligned certain protections required of commercial health plans under the Mental Health Parity and Addiction Equity Act of 2008 to the Medicaid program.

The Department of Health Care Services (DHCS) is required to ensure that all covered mental health benefits and substance use disorder benefits, including those provided via a fee-for-service delivery system, are in compliance with the Parity Rule.[2] This BHIN supersedes BHIN 22-070 and includes DHCS policy intended to ensure that the delivery of covered substance use disorder benefits complies with the Parity Rule.

POLICY:
To ensure DMC members are provided information on their rights, protections, and access to services comparable to Medi-Cal physical health and mental health and substance use disorder services as members receiving care through a managed care plan or Prepaid Inpatient Health Plans (PIHPs) delivery system, DMC Counties (hereinafter referred to as "County" or "Counties") shall establish and implement written policies and procedures for the following parity requirements. Counties shall adhere to the recordkeeping, monitoring, and review requirements pertaining to the handling of grievances and appeals.

Counties may claim for administrative costs to implement and maintain timely access standards, the grievance and appeal processes, and to develop and maintain provider directories using the "MC 5312: Drug Medi-Cal (DMC) Services Claim for Reimbursement of County Administrative Expenses" form (DMC Admin claim form). Counties may claim for provider credentialing costs using the DMC Quality Assurance Utilization (QAUR) claim form. Counties shall submit claims for administrative costs on the DMC Admin Claim form or the QAUR claim form on the line titled "Prop 30 Federal" because the Parity Rule is a federal mandate. The DMC Admin and QAUR claim forms

[1] See "Medicaid and Children's Health Insurance Programs; Mental Health Parity and Addiction Equity Act of 2008; the Application of Mental Health Parity Requirements to Coverage Offered by Medicaid Managed Care Organizations, the Children's Health Insurance Program (CHIP), and Alternative Benefit Plans," 81 Fed.Reg. 18390 (Mar. 30, 2016), available at: https://www.govinfo.gov/content/pkg/FR-2016-03-30/pdf/2016-06876.pdf.
[1] See 42 C.F.R. § 438.420(b)(1).
[2] See 42 C.F.R. Part 438, subpart K.

can be found on the Drug Medi-Cal Treatment Program Forms page on the DHCS webpage.

A. DISCRIMINATION GRIEVANCE REQUIREMENTS:

The County shall adopt discrimination grievance[3] procedures that ensure prompt and equitable resolution of discrimination-related complaints. The County shall not require a member to file a discrimination grievance with the County before filing the grievance directly with the DHCS Office of Civil Rights or the U.S. Health and Human Services Office for Civil Rights.

Discrimination Grievance Coordinator

1. The County shall designate a Discrimination Grievance Coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements and investigating discrimination grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law.
2. The Discrimination Grievance Coordinator shall be available to:
    a. Answer questions and provide appropriate assistance to the county's staff, providers, and members regarding the state and federal nondiscrimination legal obligations.
    b. Advise the County about nondiscrimination best practices and accommodating persons with disabilities.
    c. Investigate and process any Americans with Disabilities Act, Section 504 of the Rehabilitation Act, Section 1557 of the Affordable Care Act, and/or Government Code section 11135 grievances received by the County.

Discrimination Grievances Reporting Requirements

Within ten (10) calendar days of mailing a discrimination grievance resolution letter to a member, the County shall submit detailed information regarding the grievance to the DHCS Office of Civil Rights' designated discrimination grievance email box. The County shall submit the following detailed information via secured email to: DHCS.DiscriminationGrievances@dhcs.ca.gov.

1. The original complaint;
2. The provider's or other accused party's response to the grievance;
3. The County's personnel contact information responsible for the County's investigation and response to the grievance;

[3] "Discrimination grievance" means a complaint concerning the unlawful discrimination on the basis of any characteristic protected under federal or state law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

4. Contact information for the member filing the grievance and for the provider or other accused party that is the subject of the grievance;
5. All correspondence with the member regarding the grievance, including, but not limited to, the discrimination grievance acknowledgment and resolution letter(s) sent to the member; and
6. The results of the County's investigation, including, but not limited to, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

B. GRIEVANCES:

The County shall have in effect a documented grievance process for its members that complies with the following requirements.

"Grievance" means an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a provider or employee, failure to respect the member's rights regardless of whether remedial action is requested, and the member's right to dispute an extension of time proposed by the County to make an authorization decision. There is no distinction between an informal and formal grievance.

A complaint is the same as a grievance. If the County is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance. An inquiry is a request for information that does not include an expression of dissatisfaction. Inquiries may include but are not limited to, questions pertaining to eligibility, benefits, or other fee-for-service processes. A complaint shall be considered a grievance unless it meets the definition of an "Adverse Benefit Determination" (see below).

The County shall not discourage the filing of grievances. A member need not use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and processed as a grievance by the County. Even if a member expressly declines to file a grievance, the County shall process the complaint as a grievance.

At any time, the member, an authorized provider, or an authorized representative acting on behalf of the member may file a grievance with the County either orally or in writing. In handling grievances, the County shall reasonably assist members with completing forms and taking other procedural steps related to a grievance. This assistance includes, but is not limited to, providing auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate Teletypewriters/Telecommunications Devices for the Deaf and interpreter capability.

The County's process for handling member grievances shall:

1. Acknowledge receipt of each grievance within five calendar days.
2. Ensure that the individuals who make decisions on grievances are individuals who:
    a. Were neither involved in any previous level of review/decision-making nor a subordinate of any such individual.
    b. When handling a grievance regarding denial of expedited resolution of an appeal or a grievance that involves clinical issues, have appropriate clinical expertise in treating the member's condition or disease.

Standard Grievance Acknowledgment

The County shall provide the member with a written acknowledgment of receipt of the grievance that is dated and postmarked within five calendar days of receipt of the grievance. The acknowledgment letter shall include the date of receipt, and the name, telephone number, and address of the County representative who the member may contact about the grievance.

Standard Grievance Resolution

Each County shall resolve grievances as expeditiously as the member's health condition requires, within the timeframes outlined in this BHIN. For standard resolution of a grievance and notice to affected parties, the State establishes the timeframe; however, the timeframe may not exceed 90 calendar days from the day the County receives the grievance. Counties shall comply with the following requirements for resolution of grievances:

"Resolved" means that the County has reached a decision with respect to the member's grievance and notified the member of the disposition. Counties shall resolve grievances within the established timeframe of 30 calendar days for resolution of grievances.

The County shall use the enclosed written NGR template (*Enclosure 1*) to notify members of the results of the grievance resolution. The NGR shall contain a clear and concise explanation of the County's decision.

Grievance Process Exemptions

Counties are exempt from the requirement to send a written acknowledgement and disposition letter for grievances received over the telephone or in-person by the County, or a DMC-certified provider, that is resolved to the member's satisfaction by the close of the next business day following receipt.

This exemption shall not apply for grievances received via mail by the County, or a DMC-certified provider. If a County or DMC-certified provider receives a complaint pertaining to an Adverse Benefit Determination, the complaint is not considered a grievance and the exemption also shall not apply.

C. ADVERSE BENEFIT DETERMINATIONS:

The NOABD and NAR templates are included as Enclosures in this BHIN.
An Adverse Benefit Determination is defined to mean any of the following actions taken by a County:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner;
5. The failure to act within the required timeframes for standard resolution of grievances and appeals; or
6. The denial of a member's request to dispute financial liability.

Written Notice of Adverse Benefit Determination (NOABD) Requirements

A County shall provide a member with a written NOABD notice when the County takes any of the actions described immediately above in Section (B). The County shall give members timely and adequate notice of an Adverse Benefit Determination in writing. The NOABD shall explain all of the following:

1. The Adverse Benefit Determination the County has made or intends to make;
2. A clear and concise explanation of the reason(s) for the decision. For determinations based on medical necessity criteria, the notice shall include the clinical reasons for the decision. The County shall explicitly state why the member's condition does not meet medical necessity criteria;
3. A description of the criteria used. This includes medical necessity criteria; and any processes, strategies, or evidentiary standards used in making such determinations; and reference to specific regulations that support the decision; and,
4. The member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member's Adverse Benefit Determination. Such information includes criteria to access substance use disorder services, and any processes, strategies, or evidentiary standards used in setting coverage limits.

5. The member's right to a second opinion from a network provider, or for the Plan to arrange for the member to obtain a second opinion outside the network, at no cost to the member.

Counties shall communicate decisions to the provider initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively. For written notification to the provider, the County shall also include the name and direct telephone number or extension of the decision-maker.

If the County can substantiate through documentation that effective processes are in place to allow the provider to easily contact the decision-maker through means other than a direct phone number (e.g., telephone number to the specific unit of the Utilization Management Department that handles provider appeals directly), a direct telephone number or extension is not required. However, the County shall conduct ongoing oversight to monitor the effectiveness of this process.

Timing of the Notice

The County shall mail the notice to the member within the following timeframes:

1. For termination, suspension, or reduction of a previously authorized service, at least 10 days before the date of action, except as permitted under CFR, Title 42, Sections 431.213 and 431.214;
2. For denial of payment, at the time of any action affecting the claim; or,
3. For decisions resulting in denial, delay, or modification of all or part of the requested services, within two (2) business days of the decision.

The County shall also communicate the decision to the affected provider within 24 hours of making the decision.

Written NOABD Templates

Counties shall use DHCS' NOABD templates attached as enclosures to this BHIN, or the electronic equivalent of these templates generated from the County's Electronic Health Record System, when providing members with a written NOABD. Electronic templates generated from the County's Electronic Health Record System shall contain the same information as the templates attached as enclosures to this BHIN. Additionally, Counties shall use the enclosed NOABD and "Your Rights" templates to notify members of their rights. The following is a description of Adverse Benefit Determinations and the corresponding NOABD template:

1. Denial of authorization for requested services
   Counties shall use the Denial Notice template (*Enclosure 2*) when the County denies a request for a service. Denials include determinations based on type or

level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

2. Denial of payment for a service rendered by a provider
   Counties shall use the Payment Denial Notice template (*Enclosure 3*) when the County denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a member.
3. Delivery system
   Counties shall use the Delivery System Notice template (*Enclosure 4*) when the County has determined that the member does not meet the criteria to be eligible for substance use disorder services through the County. The County shall refer the member to the appropriate health care delivery system (i.e., Managed Care Plan, Medi-Cal Fee-for-Service, mental health, substance use disorder), or other services.
4. Modification of requested services
   Counties shall use the Modification Notice template (*Enclosure 5*) when the County modifies or limits a provider's request for a service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services.
5. Termination of a previously authorized service
   Counties shall use the Termination Notice template (*Enclosure 6*) when the County terminates, reduces, or suspends a previously authorized service.
6. Delay in processing authorization of services
   Counties shall use the Authorized Delay Notice template (*Enclosure 7*) when there is a delay in processing a provider's request for authorization of substance use disorder residential services that are requested as part of the "Expanded Substance Disorder Services"[4]. When the County extends the timeframe to make an authorization decision, there is a delay in processing a provider's request. This includes extensions granted at the request of the member or provider, and/or those granted when there is a need for additional information from the member or provider when the extension is in the member's interest.
7. Failure to provide timely access to services
   Counties shall use the Timely Access Notice template (*Enclosure 8*) when there is a delay in providing the member with timely services, as required by the timely access standards applicable to the delayed service.

[4] Supplement 3 to Attachment 3.1-A

8. Dispute of financial liability
   Counties shall use the Financial Liability Notice template (*Enclosure 9*) when the County denies a member's request to dispute financial liability, including cost-sharing and other member financial liabilities.
9. Failure to timely resolve grievances and appeals
   Counties shall use the Grievance and Appeal Timely Resolution Notice template (*Enclosure 10*) when the County does not meet the required timeframes for the standard resolution of grievances and appeals.

"NOABD Your Rights" Template

The NOABD "Your Rights" template (*Enclosure 11*) is a notice that informs members of critical appeal and State Hearing rights. Counties shall send the "NOABD Your Rights" template with each NOABD template as described above.

Counties shall utilize the enclosed "NOABD Your Rights" template, or the electronic equivalent of this template generated from the County's Electronic Health Record System. Electronic templates generated from the County's Electronic Health Record System shall contain the same information as the templates attached as enclosures to this BHIN. Counties shall not make any changes to the NOABD templates or "NOABD Your Rights" template without prior review and approval from DHCS, except to insert the County's specific information or information specific to members as required.

The "NOABD Your Rights" template provides members with the following required information pertaining to the NOABD:

1. The member's or provider's right to request an internal appeal with the County within 60 calendar days from the date on the NOABD;
2. The member's right to request a State Hearing only after filing an appeal with the County and receiving a notice that the Adverse Benefit Determination has been upheld;
3. The member's right to request a State Hearing if the County fails to send a resolution notice in response to the appeal within the required timeframe;
4. Procedures for exercising the member's rights to request an appeal;
5. Circumstances under which an expedited review is available and how to request it;
6. The member's right to be either self-represented or represented by an authorized third party (including legal counsel, relative, friend, or any other person) in a State Hearing;
7. The member's right to have benefits continue pending resolution of the appeal and how to request continuation of benefits;

8. Notification that, if the final resolution of the appeal or State Hearing decision upholds the County's Adverse Benefit Determination, the member shall not be held liable for the cost of continued services provided to the member while the appeal or State Hearing was pending; and,
9. The member's right to a second opinion from a network provider, or for the County to arrange for the member to obtain a second opinion outside the network at no cost to the member.

D. APPEALS:

The County shall have in effect, a documented appeals process for its members that complies with the following requirements. An "Appeal" means a review by the County of an Adverse Benefit Determination.

Timeframes for Filing

Members shall file an appeal within 60 calendar days from the date on the NOABD, and counties shall adopt this 60-calendar day timeframe. Members shall also exhaust the County's appeal process prior to requesting a State Hearing unless the member has been deemed to have exhausted that process.

Method of Filing

A member, or a provider and/or authorized representative, may request an appeal either orally or in writing. Appeals filed by the provider on behalf of the member require written consent from the member. Counties shall assist the member in completing forms and taking other procedural steps to file an appeal, including preparing a written appeal, notifying the member of the location of the form on the County's website, or providing the form to the member upon request. Counties shall also advise and assist the member in requesting continuation of benefits during an appeal of the Adverse Benefit Determination. Additionally, the County shall inform members that they shall not be held liable for the cost of these continued benefits.

Authorized Representative

With written consent of the member, a provider or authorized representative may file a grievance, request an appeal, or request a State Hearing on behalf of the member. Providers cannot request continuation of benefits.

Standard Resolution of Appeals:

Acknowledgment

The County shall provide the member with a written acknowledgment of receipt of the appeal. In the acknowledgment letter, the County shall include the date of receipt, as well as the name, telephone number, and address of the County representative who the

member may contact about the appeal. The written acknowledgment to the member shall be postmarked within five calendar days of receipt of the appeal.

Standard Resolution Timeframe
The County shall resolve an appeal within 30 calendar days of receipt of the written or oral appeal, whichever is received first. In the event that the County fails to adhere to the noticing and timing requirements for resolving appeals, the member is deemed to have exhausted the County's appeal process and may initiate a State Hearing.

E. EXPEDITED RESOLUTION OF APPEALS:

The County shall establish and maintain an expedited review process for appeals when the County determines (from a member request) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking time for a standard resolution could seriously jeopardize the member's substance use disorder condition and/or the member's ability to attain, maintain, or regain maximum function.

General Requirements for Expedited Resolution of Appeals
If the County denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution. In addition, the County shall complete all of the following actions:

1. The County shall make reasonable efforts to provide the member with prompt oral notice of the decision to transfer the appeal to the timeframe for standard resolution;
2. The County shall notify the member in writing of the decision to transfer the appeal to the timeframe for standard resolution within two (2) calendar days of making the decision and notify the member of the right to file a grievance if they disagree with the decision; and,
3. The County shall resolve the appeal as expeditiously as the member's health condition requires and within the timeframe for standard resolution of an appeal (i.e., within 30 days of receipt of the written or oral appeal, whichever is received first).

Timeframes for Resolving Expedited Appeals
For expedited resolution of an appeal and notice to the affected parties (i.e., the member, authorized representative and/or provider), the County shall resolve the appeal, and provide notice, as expeditiously as the member's health condition requires, but no longer than 72 hours after the Plan receives the request for expedited resolution. In addition to federal record-keeping requirements, Counties shall log the time that the County received the expedited appeal because the time of receipt dictates the timeframe for resolution.

Oral Notice Requirements
In addition to providing a written NAR, Counties shall make reasonable efforts to provide prompt oral notice to the member of the resolution.

F. NOTICE OF APPEAL RESOLUTION (NAR):

A NAR is a formal letter informing a member that an Adverse Benefit Determination has been overturned or upheld. The NAR templates are included as Enclosures in this BHIN. Plans shall use the appropriate NAR notice templates and "NAR Your Rights" attachments contained in this BHIN as enclosures to notify members of their rights. Plans shall not make any changes to the NAR notice or "NAR Your Rights" templates without prior review and approval from DHCS, except to insert the Plan's specific information or information specific to the members as required.

Adverse Benefit Determination Upheld
For appeals not resolved wholly in favor of the member, Counties shall utilize DHCS' template included with this BHIN as *Enclosure 12*, or the electronic equivalent of that template generated from the County's Electronic Health Record System Counties shall also provide the "NAR Your Rights" attachment with the notice template. These documents are viewed as a "packet" and Counties shall send the documents together to comply with all requirements of the NAR.

Notice of Appeal Resolution
The County shall send written NARs to members. The written NAR shall include the following:

1. The results of the resolution and the date it was completed;
2. The reasons for the County's determination, including the criteria, clinical guidelines, or policies used in reaching the determination;
3. For appeals not resolved wholly in the favor of the member:
    a. The right to request a State Hearing and how to request it;
    b. The right to request and receive benefits while the State Hearing is pending and how to make the request; and,
    c. Notification that the member shall not be held liable for the cost of those benefits if the State Hearing decision upholds the County's Adverse Benefit Determination.

"NAR Your Rights" Template
The "NAR Your Rights" template that is included in this BHIN as *Enclosure 13* provides members with the following required information pertaining to the NAR:

1. The member's right to request a State Hearing no later than 120 calendar days from the date of the County's written appeal resolution and instructions on how to request a State Hearing;
2. The member's right to request and receive continuation of benefits while the State Hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made (i.e., within ten days from the date the letter was post-marked or delivered to the member); and,
3. Notification that the member shall not be held liable for the cost of those benefits if the State Hearing decision upholds the County's Adverse Benefit Determination.

Adverse Benefit Determination Overturned

For appeals resolved wholly in favor of the member, Counties shall use the Adverse Benefit Determination Overturned (NAR) notice template (*Enclosure 14*) as a written notice to the member that includes the results of the resolution and the date it was completed. Counties shall also ensure that the written response contains a clear and concise explanation of the reason the decision was overturned.

Counties shall authorize or provide the disputed services promptly and as expeditiously as the member's condition requires if the County reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending. Counties shall authorize or provide services no later than 72 hours from the date and time it reverses the determination.

G. STATE HEARINGS:

The County shall have in effect, a documented State Hearings process for its members that complies with the following requirements.

Exhaustion of the Appeals Process

Members shall exhaust the County's appeal process prior to requesting a State Hearing. A member has the right to request a State Hearing only after receiving notice that the County is upholding an Adverse Benefit Determination.

However, if the County fails to adhere to the notice and timing requirements, including the County's failure to provide a NOABD or a NAR to a member as stated in this BHIN, the member is deemed to have exhausted the County's appeals process. The member may then initiate a State Hearing.

Timeframes for Filing
Members may request a State Hearing within 120 calendar days from the date of the NAR upholding the Adverse Benefit Determination. The NOABD and "NAR Your Rights" templates inform members of this requirement.

The County shall participate in the State Hearing, as well as the member and his or her authorized representative or the representative of a deceased member's estate.

Standard Resolution
The County shall notify members that the State must reach its decision on the hearing within 90 calendar days of the date of the request for the State Hearing.[5]

Expedited Resolution
The County shall notify members that the State must reach its decision on the State Hearing within three working days of the date of the request for the State Hearing appealing a denial of a service that meets the criteria for expedited resolution.[6]

Overturned Decisions
If services were not provided while the State Hearing was pending, the County shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than 72 hours from the date it receives notice reversing the County's Adverse Benefit Determination.

H. CONTINUATION OF SERVICES

Members have the right to keep receiving approved services while waiting for a final decision from an appeal or State Hearing. This request is called Aid Paid Pending (APP). If a member requests an appeal, the County shall continue to provide APP to the member while the appeal is pending if all of the following conditions are met:

1. The member timely files a request for an appeal in accordance with Title 42, CFR, sections 438.402(c)(1)(ii) and (c)(2)(ii);
2. The appeal involves the termination, suspension, or reduction of a previously authorized service;
3. The member's services were ordered by an authorized provider;
4. The period covered by the original authorization has not expired; and,
5. The request for continuation of benefits is filed on or before the later of the following:
    a. Within ten (10) calendar days of the County sending the NOABD; or
    b. The intended effective date of the adverse benefit determination.

[5] Title 42, CFR, Section 431.244(f)(1)
[6] See 42 C.F.R. § 431.244(f)(2).

If a member has been receiving disputed services during the County's appeal process and requests a State Hearing, the County shall continue to provide APP to the member. If the County continues to provide APP to the member while the appeal or State Hearing is pending, the services shall be continued until:

1. The member withdraws the appeal or request for State Hearing;
2. The member does not request a State Hearing and continuation of benefits within 10 calendar days from the date the County sends the notice of an adverse appeal resolution; or
3. A State Hearing decision adverse to the member is issued.

If the final resolution of the appeal or State hearing upholds the County's Adverse Benefit Determination, the County shall not recover the cost of continued services provided to the member while the appeal or State Hearing was pending.

I. LANGUAGE ASSISTANCE, NONDISCRIMINATION NOTICE AND TAGLINES:

The County shall have in effect a documented process that complies with the following requirements.

Translation of Notices

Written materials that are critical to obtaining services include, at a minimum, appeal and grievance notices, and denial and termination notices, which shall be made available to members in prevalent non-English languages and alternative formats. This translation requirement includes the individualized information described throughout this BHIN.

Nondiscrimination Notice and Language Assistance Taglines

DHCS has included the "Nondiscrimination Notice" and "Language Assistance" tagline templates as enclosures to this BHIN (*Enclosure 15 and 16, respectively*). Counties shall send the Non-discrimination Notice and Language Assistance Taglines templates in conjunction with each of the following significant notices sent to members: NOABD, grievance acknowledgment letter, appeal acknowledgment letter, grievance resolution letter, and NAR. Counties shall utilize the templates provided by DHCS. Counties shall not make any changes to the templates without prior review and approval from DHCS, except to insert County's specific information.

J. GRIEVANCE AND APPEAL SYSTEM OVERSIGHT:

Counties shall establish, implement, and maintain a Grievance and Appeal System to ensure the receipt, review, and resolution of grievances and appeals. The Grievance and Appeal System shall operate in accordance with all applicable federal regulations

and County contract requirements, and any other relevant DHCS guidance, including the following:

1. The County shall have, and operate in accordance with, written policies and procedures regarding its grievance and appeal system.
2. The County shall notify members about its Grievance and Appeal System and shall include information on the County's procedures for filing and resolving grievances and appeals, a toll-free telephone number or a local telephone number, and the address for mailing grievances and appeals.
3. The County shall inform members of the process for obtaining grievance and appeals forms. The forms that may be used to file grievances, appeals, expedited appeals, and self-addressed envelopes, shall be available at all provider sites for members to access without the member having to request the forms or envelopes. The County shall ensure that a description of the procedure for filing grievances and appeals is readily available to all DMC-certified providers, on the County's website, and at each contracting provider's office or facility, posted in a location that is accessible to members. The County shall ensure that assistance in filing grievances and appeals will be provided at each location where grievances and appeals are submitted. Grievance and appeal forms shall be provided promptly upon request.
4. The County shall ensure that grievances and appeals are adequately, and appropriately considered, and appropriate remedies are provided when necessary. If the member presents multiple issues, the County shall ensure that each issue is addressed and resolved.
5. The County shall maintain a grievance and appeal log and written record for each grievance, appeal, and expedited appeals received by the County. The County shall log within one working day of the date of receipt of the grievance or appeal. DHCS reserves the right to request any data pertaining to filed grievances and appeals at any time. The County shall maintain a record of each grievance and appeal in a log that is accessible to the state and available upon request to CMS, and that includes the following information:
    a. The date and time of receipt of the grievance or appeal;
    b. The name of the member filing the grievance or appeal;
    c. The name of the representative recording the grievance or appeal;
    d. A description of the complaint or problem;
    e. A description of the action taken by the County or provider to investigate and resolve the grievance or appeal;
    f. The proposed and final resolution by the County or provider;
    g. The name of the County provider or staff responsible for resolving the grievance or appeal; and
    h. The date of notification to the member of the resolution.

6. The County shall, at least quarterly, submit the written record of grievances and appeals to its quality improvement committee for systematic aggregation and analysis for quality improvement. Grievances and appeals reviewed shall include, but not be limited to, those related to access to care, quality of care, and denial of services. The County shall take appropriate action to remedy any problems identified by its review and shall ensure members of its quality improvement committee have the authority to require corrective action.
7. The County shall address the linguistic and cultural needs of its member population, as well as the needs of members with disabilities. The County shall ensure all members have access to and can fully participate in the Grievance and Appeal System by assisting those with limited English proficiency or with a visual or other communicative impairment. Such assistance shall include but is not limited to, translations of grievance and appeal procedures, forms, and County responses to grievances and appeals, as well as access to interpreters, telephone relay systems, and other devices that aid individuals with disabilities to communicate.
8. The County shall ensure that there is no discrimination against a member because the member filed a grievance or appeal.
9. The County shall ensure that the person making the final decision for the proposed resolution of a grievance or appeal has not participated in any prior decisions related to the grievance or appeal, nor is a subordinate of any such individual. Additionally, the decision-maker shall be a health care professional with clinical expertise in treating a member's condition or disease if deciding any of the following:
    a. An appeal of an Adverse Benefit Determination that is based on lack of medical necessity;
    b. A grievance regarding the denial of an expedited resolution of an appeal; or
    c. Any grievance or appeal involving clinical issues.
10. The County shall ensure that individuals making decisions on grievances and appeals take into account all comments, documents, records, and other information submitted by the member or member's authorized representative, regardless of whether such information was submitted or considered in the initial Adverse Benefit Determination.
11. The County shall provide the member or member's authorized representative the opportunity to review the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the County (or at the direction of the County) in connection with any standard or expedited appeal of an Adverse Benefit Determination. This

information shall be provided free of charge and sufficiently in advance of the resolution timeframe.

12. The County shall provide the member or authorized representative a reasonable opportunity, in person and in writing, to present evidence and testimony, and make legal and factual arguments. The County shall inform the member or authorized representative of the limited time available for this sufficiently in advance of the resolution timeframes for standard and expedited appeals.

Counties shall maintain a log of all grievances containing the date of receipt of the grievance, the name of the member, member identification number, nature of the grievance, the resolution, and the representative's name who received and resolved the grievance. Counties shall transmit issues identified as a result of the member's filed grievance, appeal or expedited appeal to the County's Quality Improvement Committee, the County's administration, or another appropriate body within the County's operations.

K. SERVICE ACCESS REQUIREMENTS:

The following items address parity requirements pertaining to service access requirements for members. The County shall have in effect a documented process that complies with the following requirements.

Provider Directory

1. The County shall make available in electronic form and, upon request, in paper form, the following information about its DMC-certified providers:
    a. The provider's name and group affiliation (if any);
    b. Provider's business address(es) (e.g., physical location of the clinic or office);
    c. Telephone number(s);
    d. Email address(es), as appropriate;
    e. Website URL, as appropriate;
    f. Specialty, in terms of training, experience, and specialization, including board certification (if any);
    g. Services/modalities provided, including information about populations served;
    h. Whether the provider accepts new members;
    i. The provider's cultural capabilities (e.g., veterans, older adults, Transition Age Youth, Lesbian, Gay, Bisexual, Transgender);
    j. The provider's linguistic capabilities including languages offered (e.g., Spanish, Tagalog, American Sign Language) by the provider or a skilled medical interpreter at the provider's office; and,

k. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment.

In addition to the information listed above, the provider directory shall also include the following information for each rendering provider:

i. Type of practitioner, as appropriate;
ii. National Provider Identifier number;
iii. California license number and type of license; and
iv. An indication of whether the provider has completed cultural competence training.

2. The County shall include the following provider types covered under the DMC contract in the provider directory:
   a. Physicians, including specialists;
   b. Hospitals;
   c. Pharmacies; and
   d. Behavioral health providers.
3. The provider directory shall include a statement that affirms a DMC county member's right to obtain covered services from any enrolled and DMC-certified provider, even if that provider is not listed in the provider directory.[7]
4. Information included in a paper provider directory shall be updated at least monthly and electronic provider directories shall be updated no later than 30 calendar days after the County receives updated provider information.
5. Provider directories shall be made available on the County's website in a machine-readable file and format as specified by the Secretary of Health and Human Services.

L. TIMELY ACCESS

To ensure DMC members have the same access to substance use disorder services as members receiving care through a managed care or PIHP delivery system, Counties shall comply with California's timely access standards. W&I Code section 14197, subdivision (d), sets forth timely access standards and requires compliance with the appointment time standards set forth in Health and Safety Code section 1367.03 and Title 28, CCR, section 1300.67.2.2. The specific appointment wait time standards for which DHCS is currently collecting data are detailed in the Timely Access Data Tool (TADT) Attachment D.3 (*Enclosure 17*) and are referenced in the table below.

[7] Consistent with 42 CFR § 431.51(a)(1) and Section 1902(a)(23) of the Social Security Act and Exhibit A, Attachment 1 of the DMC contract, DMC counties do not operate closed networks. Members are not limited to only those providers included in the County's current directory and may access covered services from other enrolled and certified providers who enter into agreements with the county for reimbursement.

Table 1: Timely Access Standards

Modality Type	Standard
Outpatient Services – Substance Use Disorder Services	Offered an appointment within 10 business days of request for services
Residential	Offered an appointment within 10 business days of request for services
Narcotic Treatment Program (NTP)[1]	Offered an appointment within 3 business days of request for services

1 For NTP patients, the NTP standards apply equally to both buprenorphine and methadone where applicable. Buprenorphine is not specified in several areas of the current regulations, so we default to the federal regulations. (For example, with take home medication, time in treatment requirements are not applicable to buprenorphine patients.) 28 CCR § 1300.67.2.2, subd. (b)(7)

Timely Access Data Tool (TADT)

To ensure Counties provide timely access to services, Counties shall have a system in place for tracking and measuring the timeliness of care, which includes timeliness in receiving the first appointment for outpatient or NTP services. The TADT, provided as an enclosure to this BHIN, is a uniform data collection tool developed by DHCS to collect timely access data as part of the DMC State Plan Annual Certification.

Counties' Reporting Requirement

Counties shall use the TADT to submit timely access data for new members who request services during the reporting period. Counties shall report the following timely access data elements:

1. Client Identification Number
2. Date of First Contact to Request Services
3. Assessment Appointment First Offer Date
4. Assessment Appointment Second Offer Date
5. Assessment Appointment Third Offer Date
6. Assessment Appointment Accepted Date
7. Assessment Start Date
8. Assessment End Date
9. Treatment Appointment First Offer Date
10. Treatment Appointment Second Offer Date
11. Treatment Appointment Third Offer Date
12. Treatment Appointment Accepted Date
13. Treatment Start Date
14. Closure Reason
15. Close out Date
16. Referred to

Reporting Period: February 1, through April 30. The data submitted for the reporting period will be used to determine compliance for Fiscal Year (FY) 2024-25.

Beginning with FY 2024-25 DMC State Plan Annual Certification, DHCS shall place Counties on a Corrective Action Plan for deficiencies identified by DHCS related to the timeliness standard. Counties that do not meet the timeliness standard shall receive technical assistance along with their findings.

Compliance with Timely Access Standards

Counties shall report timely access data regarding all new members that are requesting outpatient, perinatal residential, and NTP services. The definition of what constitutes a new member is at the discretion of the Counties. The data will be used to determine the timeliness in accordance with timely access standards.

The Date of First Contact to Request Services and the number of days between that date and the Assessment Appointment First Offer Date determines compliance with timely access standards. Counties shall demonstrate that at least eighty percent of members have been offered an appointment within the appropriate standard of time. Counties shall separately achieve this eighty percent standard.

If Counties are not meeting timely access standards and available providers are unable to provide timely access to necessary services, Counties shall adequately and timely cover these services for the member.

All future guidance on Timely Access compliance and TADT submission for DMC State Plan counties subsequent to FY 2024-25 will be accessible in the annual Network Adequacy Behavioral Health Information Notice on Network Certification Requirements

M. PROVIDER CREDENTIALING AND RE-CREDENTIALING:

The County shall establish a credentialing and re-credentialing process.

For all licensed, waivered, registered, and/or certified providers[8], the County shall verify and document the following items through a primary source,[9] as applicable. The listed requirements are not applicable to all provider types. When applicable to the provider type, the information shall be verified by the County unless the County can demonstrate

[8] For substance use disorder services, providers delivering covered services are defined in Title 22 of the CCR, Section 51051.

[9] "Primary source" refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.

the required information has been previously verified by the applicable licensing, certification, and/or registration board.

1. The appropriate license and/or board certification or registration, as required for the particular provider type;
2. Evidence of graduation or completion of any required education, as required for the particular provider type;
3. Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type; and
4. Satisfaction of any applicable continuing education requirements, as required for the particular provider type.

In addition, the County shall verify and document the following information from each provider located within their geographical boundaries, as applicable,

1. Work history;
2. Hospital and clinic privileges in good standing;
3. History of any suspension or curtailment of hospital and clinic privileges;
4. Current Drug Enforcement Administration identification number;
5. National Provider Identifier number;
6. Current malpractice insurance in an adequate amount, as required for the particular provider type;
7. History of liability claims against the provider;
8. Provider information, if any, entered in the National Practitioner Data Bank, when applicable[10];
9. History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal: providers terminated from either Medicare or Medicaid/Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the County's provider network.[11]; and
10. History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards.

Attestation for Prospective Providers

For all prospective providers who want to deliver Medi-Cal-covered services, each provider's application to contract with the County shall include a signed and dated statement attesting to the following:

1. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
2. A history of loss of license or felony conviction;
3. A history of loss or limitation of privileges or disciplinary activity;

[10] See https://www.npdb.hrsa.gov/.
[11] This list is available at: https://files.medi-cal.ca.gov/pubsdoco/SandILanding.aspx.

4. A lack of present illegal drug use; and
5. The application's accuracy and completeness.

Provider Re-Credentialing

Counties shall verify and document at a minimum every three years that each provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements listed above. The County shall require each provider to submit any updated information needed to complete the re-credentialing process, as well as a newly signed attestation. In addition to the initial credentialing requirements, when completing the re-credentialing process, Counties shall document that they have considered information from other sources pertinent to the credentialing process, such as quality improvement activities, member grievances, and medical record reviews.

Provider Credentialing and Re-Credentialing Procedures

A County may delegate its authority to perform credentialing reviews to a professional credentialing verification organization; nonetheless, the County remains contractually responsible for the completeness and accuracy of these activities. If the County delegates credential verification activities to a subcontractor, it shall establish a formal and detailed agreement with the entity performing those activities. To ensure accountability for these activities, the County shall establish a system that:

1. Evaluates the subcontractor's ability to perform these activities and includes an initial review to assure that the subcontractor has the administrative capacity, experience, and budgetary resources to fulfill its responsibilities;
2. Ensures that the subcontractor meets the County's and DHCS' standards; and
3. Continuously monitors, evaluates, and approves delegated functions.

Each County shall maintain a system for reporting serious quality deficiencies that result in the suspension or termination of a provider to DHCS, and other authorities as appropriate.

Each County shall maintain policies and procedures for disciplinary actions, including reducing, suspending, or terminating a provider's privileges. Counties shall implement and maintain a process by which providers may appeal credentialing decisions, including decisions to deny a provider's credentialing application, or suspend or terminate a provider's previously approved credentialing approval.

Counties are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS

guidance, including BHINs. These requirements shall be communicated by each County to all providers and subcontractors.

Questions regarding this BHIN may be directed to the County/Provider Operations and Monitoring Branch at CountySupport@dhcs.ca.gov.

Sincerely,

Michele Wong, Chief
Behavioral Health Oversight and Monitoring Division

Enclosures:
Enclosure 1 - Notice of Grievance Resolution (NGR)
Enclosure 2 - Denial Notice (NOABD)
Enclosure 3 - Payment Denial Notice (NOABD)
Enclosure 4 – Delivery System Notice (NOABD)
Enclosure 5 - Modification Notice (NOABD)
Enclosure 6 - Termination Notice (NOABD)
Enclosure 7 – Delay in processing authorization of services (NOABD)
Enclosure 8 - Timely Access Notice (NOABD)
Enclosure 9 - Financial Liability Notice (NOABD)
Enclosure 10 – Failure to timely resolve grievances and appeals (NOABD)
Enclosure 11 - NOABD Your Rights Attachment
Enclosure 12 - Adverse Benefit Determination Upheld (NAR)
Enclosure 13 - NAR Your Rights Attachment
Enclosure 14 - Adverse Benefit Determination Overturned (NAR)
Enclosure 15 - Non-Discrimination Notice
Enclosure 16 - Language Assistance Taglines
Enclosure 17 - Timely Access Data Tool
Enclosure 18 - Certification of Data and Documentation Submissions