DHCS
CALIFORNIA DEPARTMENT OF
HEALTH CARE SERVICES
Michelle Baass | Director

DATE: April 24, 2025

Behavioral Health Information Notice No: 25-014
Supersedes MHSUD 18-010E

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: Mental Health Plan and Drug Medi-Cal Organized Delivery System Plan Grievance and Appeal Requirements with Revised Member Notice Templates

PURPOSE: The purpose of this Behavioral Health Information Notice (BHIN) is to provide Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Counties (hereafter collectively referred to as Behavioral Health Plans (BHPs)) with updated clarification and guidance regarding the application of federal regulations and state law for processing grievances and appeals.

This 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), Part 438, Subpart F; Welfare and Institutions Code Sections 14184.102, 14184.400, 14184.401, 14197.1, and 14197.3; MHP Contract, Exhibit A, Attachment 12; DMC-ODS Intergovernmental Agreement, Exhibit A, Attachment I.

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,[1] aimed at aligning the Medicaid managed care regulations with requirements for other major sources of coverage. BHPs are classified as Prepaid Inpatient Health Plans, and therefore, shall comply with all applicable federal managed care requirements. The Final Rule stipulates requirements for the handling of grievances and appeals that became effective July 1, 2017.[2]

This BHIN also includes policy changes the Department of Health Care Services (DHCS) has made to ensure compliance with the Parity in Mental Health and Substance Use Disorder Services Final Rule (Parity Rule). On March 30, 2016, CMS issued the Parity Rule[3] to strengthen access to mental health and substance use disorder services for Medi-Cal 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.

POLICY:
To ensure members are provided information of their rights, protections, and access to specialty mental health and substance use disorder services, BHPs shall establish and implement written policies and procedures for the notice requirements as described in this BHIN. BHPs shall also adhere to the recordkeeping, monitoring, and review requirements pertaining to the handling of grievances and appeals as described in this BHIN, the MHP contract, and DMC-ODS Intergovernmental Agreement. To the extent

[1] See "Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability," 81 Fed. Reg. 27498 (May 6, 2016), available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf.
[2] See Title 42 of the CFR, Part 438, Subpart F. The CFR is searchable at: https://www.ecfr.gov/cgi-bin/ECFR?page=browse.
[3] 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 CHIP, and Alternative Benefit Plans," 81 CFR 18390 (Mar. 30, 2016), available at: https://www.govinfo.gov/content/pkg/FR-2016-03-30/pdf/2016-06876.pdf.

that there is a conflict between this BHIN and the MHP contract or DMC-ODS Intergovernmental Agreement, the BHIN shall control.[4] To the extent that there is a conflict between this BHIN and any requirement set forth in California Code of Regulations, Title 9, Division 1, Chapter 11, Subchapter 5, this BHIN shall control.

I. GRIEVANCES

A. Definition

"Grievance" means an expression of dissatisfaction about any matter other than an Adverse Benefit Determination.[5] 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 BHP to make an authorization decision.[6] There is no distinction between an informal and formal grievance. A complaint shall be considered a grievance unless it meets the definition of an "Adverse Benefit Determination" (see below).

The BHPs 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 BHP. Even if a member expressly declines to file a grievance, the BHP shall process their complaint as a grievance.

B. Timeframes for Filing

A member may file a grievance at any time.[7]

C. Method of Filing

A member, a provider and/or authorized representative, may file a grievance either orally or in writing.[8]

D. Standard Grievances

1. Acknowledgement

The BHP shall provide to the member written acknowledgement of receipt of the grievance that is dated and postmarked within five calendar days of receipt of the grievance.[9] The acknowledgment

[4] 2022-2027 MHP Contract, Exh. E, Sec. 6(H); DMC-ODS Intergovernmental Agreement, Exh. A, Att. I, sec. I(B).
[5] *42 C.F.R.,* § 438.400(b).
[6] *Id.,* § 438.400(b).
[7] *Id.,* § 438.402(c)(2)(i).
[8] Id., § 438.402(c)(3)(i)-(ii); Cal. Code Regs. (CCR), tit. 9, § 1850.206(a).
[9] 42 C.F.R. § 438.406(b)(1); CCR, tit. 9, § 1850.205(d)(4).

letter shall include the date of receipt, and the name, telephone number, and address of the BHP representative who the member may contact about the grievance.

2. Resolution
   BHPs shall resolve grievances as expeditiously as the member's health condition requires, within established timeframes.[10] Federal regulations allow the state to establish a timeframe for grievance resolution that does not exceed 90 calendar days from the date of receipt of the grievance. DHCS' established timeframe is 30 calendar days.[11] BHPs shall comply with the following requirements for resolution of grievances:
   a. "Resolved" means that the BHP has reached a decision with respect to the member's grievance and notified the member of the disposition.
   b. BHPs shall resolve grievances within the established timeframe of 30 calendar days.
   c. The BHP 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 BHP's decision.

E. Grievance Process Exemptions
   BHPs are exempt from the requirement to send a written acknowledgment and disposition letter for grievances received over the telephone or in-person by the BHP, or a network provider of the BHP, that are 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 or email by the BHP, or a network provider of the BHP. If a BHP or a network provider of the BHP receives a complaint pertaining to an Adverse Benefit Determination,[12] the complaint is not considered a grievance, and the exemption also shall not apply.

[10] 42 C.F.R. § 438.408(a).
[11] *Id.,* § 438.408(b)(1).
[12] See *id.,* § 438.400 [defining "Adverse Benefit Determination"]; see also Welf. & Inst. Code, §§ 10950, subd. (g)(1) and 14197.3, subd. (a).

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II. ADVERSE BENEFIT DETERMINATIONS

A. Definition

For BHPs, an Adverse Benefit Determination is defined to mean any of the following actions taken by a BHP:

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.

California statute further clarifies that an Adverse Benefit Determination occurs when a BHP denies, modifies, or delays any health care service eligible for coverage and payment under the BHP's contract with DHCS[13]. This includes a denial, modification, or delay of services requested by (1) a member seeking services from the BHP for the first time; (2) a member seeking continuation of services currently covered by a BHP; and (3) a member seeking new services in addition to services currently covered by the BHP. An Adverse Benefit Determination also occurs when the BHP fails to offer an appointment for a service eligible for coverage and payment within the appointment time standards set forth in subdivision (d)(1)(A) of section 14197 of the Welfare and Institutions Code, subject to authorized exceptions.

B. Written NOABD Requirements

A BHP shall provide a member with a written NOABD when the BHP takes any of the actions described in Section II(A) above. A BHP shall give members timely and adequate notice of an Adverse Benefit Determination in writing, consistent with the requirements in CFR, Title 42, 438.10.[14] Regulations delineate the requirements for content of the NOABDs. The NOABD shall address all of the services regardless of whether the NOABD pertains to specialty mental health services (SMHS) or DMC-ODS services:

1. The Adverse Benefit Determination the BHP has made or intends to

[13] Welf. & Inst. Code, § 14197.3, subd. (a)(2).
[14] 42 C.F.R., § 438.404(b).

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 BHP shall explicitly state why the member's condition does not meet specialty mental health services or DMC-ODS medical necessity criteria;
3. A description of the criteria used. This includes medical necessity criteria; any processes, strategies, or evidentiary standards used in making such determinations; and reference to specific regulations or payment authorization procedures that support the decision;
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 specialty mental health or DMC-ODS services, and any processes, strategies, or evidentiary standards used in setting coverage limits; and
5. The member's right to a second opinion from a network provider, or for the BHP to arrange for the member to obtain a second opinion outside the network, at no cost to the member.

Decisions shall be communicated to the member in writing. In addition, BHPs 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 BHP shall include the name and direct telephone number or extension of the decision-maker.

If the BHP 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 BHP shall conduct ongoing oversight to monitor the effectiveness of this process.

C. Timing of the Notice
The BHP shall mail the NOABD to the member within the following timeframes:[15]

[15] *Id.,* § 438.404(c).

1. For termination, suspension, or reduction of a previously authorized specialty mental health service and/or DMC-ODS service, at least 10 days before the date of action,[16] 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 specialty mental health service and/or DMC-ODS service, within two business days of the decision.

The BHP shall also communicate the Adverse Benefit Determination to the affected provider within 24 hours of making the decision.

D. Written NOABD Templates

BHPs shall use DHCS' NOABD templates attached as enclosures to this BHIN, or the electronic equivalent of these templates generated from the BHP's Electronic Health Record System, when providing members with a written NOABD.[17] Electronic templates generated from the BHP's Electronic Health Record System shall contain the same information as the templates attached as enclosures to this BHIN. Additionally, BHPs shall use the enclosed NOABD and "Your Rights" templates to notify members of their rights in compliance with the federal regulations. BHPs shall not make any changes to the NOABD templates without prior review and approval from DHCS, except to insert the BHP's specific information or information specific to the members as required. The following is a description of Adverse Benefit Determinations and the corresponding NOABD template:

1. <u>Denial of authorization for requested services</u>
   BHPs shall use the Denial Notice template (*Enclosure 2*) when the BHP 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. DMC-ODS Plans shall also use this template for denied residential service requests.
2. <u>Denial of payment for a service rendered by a provider</u>
   BHPs shall use the Payment Denial Notice template (*Enclosure 3*) when the BHP 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.

[16] *Id.*, § 431.211.
[17] *Id.,* § 438.10(c)(4)(ii).

3. Delivery system
   BHPs shall use the Delivery System Notice template (*Enclosure 4*) when the BHP has determined that the member does not meet the criteria to be eligible for specialty mental health or substance use disorder services through the BHP. The BHP 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
   BHPs shall use the Modification Notice template (*Enclosure 5*) when the BHP 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
   BHPs shall use the Termination Notice template (*Enclosure 6*) when the BHP terminates, reduces, or suspends a previously authorized service.
6. Delay in processing authorization of services
   BHPs shall use the Authorization Delay Notice template (*Enclosure 7*) when there is a delay in processing a provider's request for authorization of specialty mental health services or substance use disorder residential and inpatient services. When the BHP extends the timeframe to make an authorization decision, it 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
   BHPs shall use the Timely Access Notice (*Enclosure 8*) template when there is a delay in providing the member with timely services, as required by the timely access standards applicable to the delayed service.
8. Dispute of financial liability
   BHPs shall use the Financial Liability Notice template (*Enclosure 9*) when the BHP 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
   BHPs shall use the Grievance and Appeal Timely Resolution Notice (*Enclosure 10*) template when the BHP does not meet required timeframes for the standard resolution of grievances and appeals.

E. "NOABD Your Rights" Template

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

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 BHP within 60 calendar days[18] from the date on the NOABD;
2. The member's right to request a State Hearing after filing an appeal with the BHP and receiving a notice that the Adverse Benefit Determination has been upheld;[19]
3. The member's right to request a State Hearing if the BHP fails to send a resolution notice in response to the appeal within the required timeframe;[20]
4. Procedures for exercising the member's rights to request an appeal or State Hearing;[21]
5. Circumstances under which an expedited review is available and how to request it;[22]
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 in accordance with Title 42, CFR, Section 438.420;[23] and
8. Notification that, if the final resolution of the appeal or State Hearing decision upholds the BHP'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.[24]
9. The member's right to a second opinion from a network provider, or for the BHP to arrange for the member to obtain a second opinion

[18] Id., § 438.402(c)(2)(ii).
[19] *Id.,* §§ 438.404(b)(3), 438.402(c)(1)(i).
[20] *Id.*, §§ 438.402(c)(1)(i)(A), 438.408(c)(3).
[21] *Id.*, § 438.404(b)(4).
[22] *Id.*, § 438.404(b)(5).
[23] *Id.*, § 438.404(b)(6).
[24] *Ibid.*

outside the network at no cost to the member.[25]

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

III. APPEALS

Per federal regulations, an "Appeal" is a review by the BHP of an Adverse Benefit Determination.[26]

A. Timeframes for Filing

Federal regulations[27] require members to file an appeal within 60 calendar days from the date on the NOABD. BHPs shall adopt the 60-calendar day timeframe in accordance with federal regulations. Members shall also exhaust the BHP's appeal process prior to requesting a State Hearing unless the member has been deemed to have exhausted that process.

B. Method of Filing

A member, or a provider and/or authorized representative, may request an appeal either orally or in writing.[28] Appeals filed by the provider on behalf of the member require written consent from the member.[29]

BHPs 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 BHP's website or providing the form to the member upon request. BHPs shall also advise and assist the member in requesting continuation of benefits during an appeal of the Adverse Benefit Determination in accordance with federal regulations.[30] Additionally, BHPs shall inform members that they shall not be held liable for the cost of these continued benefits.

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[25] *Id.*, § 438.206(b)(3)
[26] *Id.,* § 438.400(b).
[27] *Id.,* § 438.402(c)(2)(ii).
[28] *Id.*, § 438.402(c)(3)(ii).
[29] *Id.*, § 438.402(c)(1)(ii).
[30] See *id.,* § 438.420(a)-(c) [including requirements relating to continuation of benefits while an appeal or State Hearing is pending].

C. Authorized Representatives
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 as specified in CFR, Title 42, section 438.420(b)(5).[31]

D. Standard Resolution of Appeals
1. Acknowledgment
The BHP shall provide to the member written acknowledgement of receipt of the appeal.[32] In the acknowledgment letter, the BHP shall include the date of receipt, as well as the name, telephone number, and address of the BHP 's representative who the member may contact about the appeal. The written acknowledgement to the member shall be postmarked within five calendar days of receipt of the appeal.
2. Standard Resolution Timeframe
BHPs shall resolve an appeal within 30 calendar days of receipt.[33] In the event that the BHP fails to adhere to the noticing and timing requirements for resolving appeals, the member is deemed to have exhausted the BHP's appeal process and may initiate a State Hearing.

IV. EXPEDITED RESOLUTION OF APPEALS

The BHP shall establish and maintain an expedited review process for appeals when the BHP 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 mental health or substance use disorder condition and/or the member's ability to attain, maintain, or regain maximum function.[34]

A. General Requirements for Expedited Resolution of Appeals
If the BHP denies a request for expedited resolution of an appeal, it shall transfer the appeal to the timeframe for standard resolution. In addition, the BHP shall complete all of the following actions:[35]
a) The BHP 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;

[31] *Id.,* § 438.402(c)(1)(ii).
[32] *Id.*, § 438.406(b)(1).
[33] *Id.,* § 438.408(b)(2).
[34] *Id.,* § 438.410(a).
[35] *Id.,* § 438.410(c).

b) The BHP 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
c) The BHP 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 appeal).

B. Timeframes for Expedited Resolution of Appeals
For expedited resolution of an appeal and notice to affected parties (i.e., the member, authorized representative and/or provider), the BHP shall resolve the appeal, and provide notice, as expeditiously as the member's health condition requires, but no longer than 72 hours after the BHP receives the request for expedited resolution.[36] In addition to federal recordkeeping requirements,[37] BHPs shall log the time that the BHP received the appeal because the time of receipt dictates the timeframe for resolution.

C. Oral Notice Requirements
In addition to providing a written Notice of Appeal Resolution, BHPs shall make reasonable efforts to provide prompt oral notice to the member of the resolution.[38]

V. 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. BHPs shall use the appropriate NAR notice templates and "NAR Your Rights" attachments contained in this BHIN as enclosures to notify members of their rights. BHPs 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.

A. Adverse Benefit Determination Upheld
For appeals not resolved wholly in favor of the member, BHPs shall utilize DHCS' Adverse Benefit Determination Upheld notice template included with this BHIN as *Enclosure 12*, or the electronic equivalent of that template generated from the BHP's Electronic Health Record System. BHPs shall also provide the NAR "Your Rights" attachment with the notice

[36] *Id.*, § 438.408(b)(3).
[37] *Id.,* § 438.416(b)
[38] *Id.,* § 438.408(d)(2)(ii).

template. These documents are viewed as a "packet" and BHPs shall send the documents in conjunction to comply with all requirements of the NAR.

1. Notice of Appeal Resolution (NAR)
   BHPs shall send written NARs to members. The written NAR shall include the following:
   a. The results of the resolution and the date it was completed;[39]
   b. The reasons for the BHP's determination, including the criteria, clinical guidelines, or policies used in reaching the determination;[40]
   c. For appeals not resolved wholly in the favor of the member:
      - the right to request a State Hearing and how to request it;[41] the right to request and receive benefits while the State Hearing is pending and how to make the request;42 and,
      - notification that the member shall not be held liable for the cost of those benefits if the State Hearing decision upholds the BHP's Adverse Benefit Determination.43
2. NAR "Your Rights" Attachment
   The "NAR Your Rights" attachment that is included in this BHIN as *Enclosure 13* provides members with the following required information pertaining to the NAR:
   a. The member's right to request a State Hearing no later than 120 calendar days from the date of the BHP's written appeal resolution and instructions on how to request a State Hearing;[44]
   b. 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)[45; and,
   c. Notification that the member shall not be held liable for the

[39] *Id.,* § 438.408(e)(1).
[40] See *id.,* § 438.404(b)(2).
[41] *Id.,* § 438.408(e)(2)(i).
[42] *Id.,* 438.408(e)(2)(ii).
[43] *Id.*, 438.408(e)(2)(iii).
[44] *Id.,* § 438.408(e)(2)(i).
[45] *Id.,* § 438.408(e)(2)(ii); see *id.,* § 438.420 [including requirements relating to continuation of benefits while an appeal or State Hearing is pending].

cost of those benefits if the State Hearing decision upholds the BHP's Adverse Benefit Determination.

B. Adverse Benefit Determination Overturned

For appeals resolved wholly in favor of the member, BHPs 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. BHPs shall also ensure that the written response contains a clear and concise explanation of the reason the decision was overturned.

BHPs shall authorize or provide the disputed services promptly and as expeditiously as the member's condition requires if the BHP reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending. BHPs shall authorize or provide services no later than 72 hours from the date and time it reverses the determination.[46]

VI. STATE HEARINGS

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

A. Exhaustion of the Appeals Process

Members shall exhaust the BHP'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 BHP is upholding an Adverse Benefit Determination.[47]

However, if the BHP fails to adhere to the notice and timing requirements in CFR, Title 42, section 438.408, including the BHP's failure to provide a NOABD or a NAR as stated in this BHIN, the member is deemed to have exhausted the BHP's appeals process. The member may then initiate a State Hearing.[48]

B. Timeframes for Filing

Members may request a State Hearing within 120 calendar days from the date of the NAR upholding the Adverse Benefit Determination.[49] The NOABD and NAR "Your Rights" templates inform members of this requirement.

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[46] *Id.,* § 438.424(a).
[47] *Id.*, § 438.408(f)(1).
[48] *Id.,* § 438.408(f)(1)(i); see also Welf. & Ins. Code, § 10951, subd. (b)(1)(B).
[49] *Id.,* § 438.408(f)(2).

The BHP shall participate in the State Hearing, as well as the member and their authorized representative or the representative of a deceased member's estate.[50]

C. Standard Resolution
The BHP shall notify members that the State must reach its decision on the State Hearing within 90 calendar days of the date of the request for the State Hearing.[51]

D. Expedited Resolution
The BHP 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 hearing appealing a denial of a service that meets the criteria for expedited resolution.[52]

E. Overturned Decisions
If services were not provided while the State Hearing was pending, the BHP 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 BHP's adverse benefit determination.[53]

VII. 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 BHP 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);[54]
2. The appeal involves the termination, suspension, or reduction of a previously authorized service;[55]
3. The member's services were ordered by an authorized provider;[56]
4. The period covered by the original authorization has not expired;[57] and,

[50] *Id.,* § 438.408(f)(3).
[51] See *id.,* § 431.244(f)(1).
[52] *Id.,* § 431.244(f)(2).
[53] *Id.,* § 438.424(a).
[54] Id., § 438.420(b)(1).
[55] *Id.*, § 438.420(b)(2).
[56] *Id.*, § 438.420(b)(3).
[57] *Id.*, § 438.420(b)(4).

5. The request for continuation of benefits is filed on or before the later of the following:[58]
    i. Within ten (10) calendar days of the BHP sending the notice of Adverse Benefit Determination;[59] or
    ii. The intended effective date of the Adverse Benefit Determination.[60]

If a member has been receiving disputed services during the BHP's appeal process and requests a State Hearing, the BHP shall continue to provide APP to the member.[61] If the BHP 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 BHP sends the notice of an adverse appeal resolution; or
3. A State Hearing decision adverse to the beneficiary is issued.[62]

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

VIII. NOTICE OF AVAILABILITY, NONDISCRIMINATION NOTICE AND TAGLINES

A. Translation of Notices
Written materials that are critical to obtaining services including, at a minimum, appeal and grievance notices, and denial and termination notices, shall be made available to members in prevalent non-English languages and alternative formats.[63] This translation requirement includes the individualized information described throughout this BHIN.

B. Nondiscrimination Notice and Notice of Availability Taglines
DHCS has included the "Non-discrimination Notice" and "Notice of Availability" (formerly known as "Language Assistance") taglines templates as enclosures to this BHIN (*Enclosure 15 and Enclosure 16, respectively*). BHPs shall send the Non-discrimination Notice andNotice of Availability Taglines templates in conjunction with each of the

[58] *Id.*, § 438.420(b)(5).
[59] *Id.*, § 438.420(a).
[60] *Id.*, § 438.420(a).
[61] See *id.*, § 438.420(b).
[62] *Id.*, § 438.420(c)(1)-(3).
[63] *Id.,* § 438.10(d)(3).

following significant notices sent to members: NOABD, grievance acknowledgment letter, appeal acknowledgment letter, grievance resolution letter, and NAR.

BHPs shall utilize the templates provided by DHCS. BHPs shall not make any changes to the templates without prior review and approval from DHCS, except to insert BHP's specific information.

IX. GRIEVANCE AND APPEAL SYSTEM OVERSIGHT

BHPs 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,[64] the MHP contract and DMC-ODS Intergovernmental Agreement requirements, and any other relevant DHCS guidance, including the following:

A. The BHP shall have, and operate in accordance with, written policies and procedures regarding its grievance and appeal system.
B. The BHP shall notify members about its Grievance and Appeal System and shall include information on the BHP'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.
C. The BHP shall inform members of the process for obtaining grievance and appeals forms. The forms that may be used to file grievances, appeals and 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 BHP shall ensure that a description of the procedure for filing grievances and appeals is readily available at each facility of the BHP, on the BHP's website, and at each contracting provider's office or facility, and posted in a location that is accessible to members. The BHP 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.
D. The BHP 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 BHP shall ensure that each issue is addressed and resolved.
E. The BHP shall maintain a grievance and appeal log and written record for each grievance, appeal, and expedited appeals received by the BHP.

[64] Including regulations included in Title 42, CFR, Part 438.

The BHP 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 BHP 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:

1. The date and time of receipt of the grievance or appeal;
2. The name of the member filing the grievance or appeal;
3. The name of the representative recording the grievance or appeal;
4. A description of the complaint or problem;
5. A description of the action taken by the BHP or provider to investigate and resolve the grievance or appeal;
6. The proposed and final resolution by the BHP or provider;
7. The name of the BHP provider or staff responsible for resolving the grievance or appeal; and
8. The date of notification to the member of the resolution.[65]

F. The BHP 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 BHP shall take appropriate action to remedy any problems identified by this review and shall ensure members of its quality improvement committee have the authority to require corrective action[66]

G. The BHP shall address the linguistic and cultural needs of its member population, as well as the needs of members with disabilities. The BHP 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 the BHP's responses to grievances and appeals, as well as access to interpreters, telephone relay systems and other devices that aid individuals with disabilities to communicate.[67]

H. The BHP shall ensure that there is no discrimination against a member because the member filed a grievance or appeal.

I. The BHP shall ensure that the person making the final decision for the proposed resolution of a grievance or appeal has not participated in any

[65] 42 C.F.R., § 438.416(b).
[66] See CCR, tit. 22, § 53858(e)(3)-(4).
[67] *See id.,* § 53858(e)(6).

prior decisions related to the grievance or appeal, nor is a subordinate of any such individual.[68] 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:[69]

1. An appeal of an Adverse Benefit Determination that is based on lack of medical necessity;
2. A grievance regarding denial of an expedited resolution of an appeal; or
3. A grievance or appeal involving clinical issues.

J. The BHP 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.[70]

K. The BHP 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 BHP (or at the direction of the BHP) 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.[71]

L. The BHP 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 BHPs 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.[72]

[68] 42 C.F.R., § 438.406(b)(2)(i).
[69] *Id.,* § 438.406(b)(2)(ii).
[70] *Id.,* § 438.406(b)(2)(iii).
[71] *Id.,* § 438.406(b)(5).
[72] *Id.,* § 438.406(b)(4).

BHPs 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. BHPs shall transmit issues identified as a result of the member's filed grievance, appeal, or expedited appeal to the BHP's Quality Improvement Committee, the BHP's administration or another appropriate body within the BHP's operations. BHPs shall adhere to the grievance and appeal reporting requirements as described in BHIN 22-036 and any subsequent guidance issued by DHCS.

BHPs shall ensure that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including BHINs. Each BHP shall communicate these requirements to all network providers and subcontractors.

COMPLIANCE:
BHPs are required to implement the specified requirements within 90 calendar days following the publication date of this BHIN and ensure compliance with this policy. DHCS may impose Corrective Action Plans (CAP), as well as administrative and/or monetary sanctions for non-compliance with the terms of this BHIN. For additional information regarding administrative and monetary sanctions, see BHIN 22-045, and any subsequent DHCS guidance on this topic.

If you have any questions regarding this BHIN, please contact DHCS at CountySupport@dhcs.ca.gov.

Sincerely,

Original signed by

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)
Enclosures: Continued on next page

Enclosures: 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 - Notice of Availability Taglines