F. BENEFICIARY RIGHTS, GRIEVANCE AND APPEALS

Client Rights and Protections: Code of Federal Regulations (CFR)

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

On January 1, 2022, the Department of Health Care Services (DHCS) initiates the implementation of the California Advancing & Innovating Medi-Cal (CalAIM) initiative. The MHP will implement CalAIM and applicable updates to specialty mental health medical necessity criteria for beneficiaries 21+ and applicable updates to specialty mental health medical necessity criteria for beneficiaries under 21. The MHP will implement Medi-Cal recoupment requirements as indicated by the CalAIM initiative.

According to Title 9 and 42 CFR 438.1000, the MHP is responsible for ensuring compliance with client rights and protections. Providers, as contractors of the MHP, must comply with applicable federal and state laws (such as Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CRF, Part 80), the Age Discrimination Act of 1975 as implemented by regulations at 45 CRF, part 91; the Rehabilitation Act of 1973; Titles II and III of the Americans with Disabilities Act, Section 1557 of the Patient Protection and Affordable Care Act (ACA), and other laws regarding privacy and confidentiality. These rights and protections can be summarized as follows:

- *Easily understandable information.* Each managed care enrollee is guaranteed the right to receive all enrollment notices, information materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.
- *Dignity, respect, and privacy*. Each managed care enrollee is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
- *Receive information on the managed care plan and available treatment options*. Each managed care enrollee is guaranteed the right to receive information on the managed care plan and its benefits, enrollee rights and protections, and emergency care, as well as available treatment options and alternatives. The information should be presented in a manner appropriate to the enrollee's condition and ability to understand.
- *Participate in decisions*. Each managed care enrollee is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
- *Free from restraint or seclusion*. Each managed care enrollee is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulation on the use of restraints and seclusion.

- *Copy of medical records*. Each managed care enrollee is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR, 164.524 and 164.526.
- *Right to health care services*. Each enrollee has the right to be furnished health care services in accordance with CFR, Title 42, Sections 438.206-210.
- *Free exercise of rights*. Each managed care enrollee is guaranteed the right to free exercise of his/her rights in such a way that those rights do not adversely affect the way the MHP and its providers treat the enrollee.

In accordance with 42 CFR and Title 9, the MHP Quality Assurance Unit distributes the Guide to Medi-Cal Mental Health Services, which contains information on client rights, as well as a description of the services available through the MHP, and the avenues to obtain resolution of dissatisfaction with MHP services.

Note: *New clients must receive a copy of the Guide to Medi-Cal Mental Health Services when they first obtain services from the provider and upon request, thereafter. (Handbooks are available in threshold languages.) Additional copies may be obtained from the MHP Behavioral Health Services Division at (619) 563-2700. To receive the materials in the audio or large print format contact QIMatters.HHSA@sdcounty.ca.gov*

Process Definitions (Title 42 CFR § 438.400 (b))

- Grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination as defined below (under appeal). Grievances may include but are not limited to: the quality of care of services provided, aspects of interpersonal relationships, such as rudeness of a provider or employee, failure to respect the rights of the client regardless of what remedial action is requested, including the client's right to dispute an extension of time proposed by the plan to make an authorization decision. A grievance can be filed at any time, orally or in writing. (42 CFR § 438.402)

- Discrimination Grievance is when a client believes they have been unlawfully discriminated against, they have the right to file a Discrimination Grievance with the county plan, the Department's Office of Civil Rights, and the United States Department of Health and Human Services, Office for Civil Rights. San Diego County complies with all State and Federal civil rights laws. (45 CFR §§ 92.7 and 92.8; WIC§14029.91). Discrimination Grievance posters can be found in the Beneficiary Handbook and printed for posting.

- Grievance Exemption is when grievances are received over the telephone or in-person that are resolved to the client's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written acknowledgment and disposition letter. Note: Grievances received via mail are not exempt from the requirement to send an acknowledgment and disposition letter in writing. If a complaint is received pertaining to an Adverse Benefit

Determination, as defined under 42 CFR Section 438.400, the complaint is not considered a grievance and the exemption does not apply.

- Appeal means a review of an adverse benefit determination or "action" which may include:
    - Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
    - The reduction, suspension, or termination of a previously authorized service.
    - The denial, in whole or in part, of payment for a service.
    - The failure to act within the timeframes regarding the standard resolution of grievances and appeals.
    - The failure to provide services in a timely manner.
    - The denial of a client's request to dispute financial liability.

- Grievance and appeal system are the processes the county and providers implement to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

- State Fair Hearing is a legal process that includes an impartial hearing and ruling by an administrative law judge. A Medi-Cal beneficiary is required to exhaust the MHP problem resolution process prior to requesting a State Fair Hearing and only a Medi-Cal beneficiary may request a state fair hearing.

Additional Client Rights

- **Provider Selection**

  In accordance with 42 CFR 438.6 and Title 9, providers are reminded that clients have the right to obtain a list of MHP providers, including information on their location, type of services offered, and areas of cultural and linguistic competence.

- **Second Opinion**

  If the MHP or its designee determines that a client does not meet Medical Necessity Criteria for inpatient or outpatient mental health services, a client or someone on behalf of the client, may request a second opinion. A second opinion from a mental health clinician provides the client with an opportunity to receive additional input on his or her mental health care at no extra cost. As the MHP designee, Optum is responsible for informing the treating provider of the second opinion request and for coordinating the second opinion with an MHP contracted individual provider.

The second opinion provider is required to obtain a release of information from the client in order to review the client's medical record and discuss the client's treatment. After the second opinion evaluation is completed, the second opinion provider forwards a report to the MHP Program Monitor/COR for review. If a second opinion request occurs as the result of a denial of authorization for payment, the MHP Medical Director may uphold the original denial decision or may reverse it and authorize payment.

- **Transfer from One Provider to Another**

  Clients have a right to request a transfer from one Medi-Cal provider to another within or outside of a program. These transfer requests shall be recorded on the Client Suggestions and Provider Transfer Request tab of the Monthly/Quarterly Status Report. Documentation in the Log shall include the date the transfer request was received, whether the request was to a provider within or outside of the program, and the relevant code showing the reason for transfer if specified by the client. The Log shall be submitted with the provider's Monthly/Quarterly Status Report.

- **Right to Language, Visual and Hearing Impairment Assistance**

  Clients shall be routinely informed about the availability of free language assistance at the time of accessing services. The MHP prohibits the expectation that the client use family or friends for interpreter services. However, if the client so chooses, this choice should be documented in the client record. Providers must also be able to provide persons with visual or hearing impairment, or other disability, with information on Mental Health Plan Services, making every effort to accommodate individual's preferred method of communication, in accordance again with Title 9 and Behavioral Health Services policy.

- **Right to a Patient Advocate**

  A client pursuant to W&I Code 5325 (h) has a right to see and receive the services of a patient advocate who has no direct or indirect clinical or administrative responsibility for the person receiving mental health services.

The rights specified in this section may not be waived by the person's parent, guardian, or conservator.

The Patient Advocate does not need to have access to the entire chart, but rather, the portions that have to do with the potential denial of rights.

- **Open Payments Database Physician's Notice to Clients**

  As required by State Assembly Bill AB1278, physicians are required to provide notice to patients regarding the Open Payments Database which is managed by the U.S. Centers for Medicare and Medicaid Services (CMS). The federal Physician Payments Sunshine Act

requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public. The Open Payments Database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. If can be found at https://openpaymentsdata.cms.gov

Advance Health Care Directive Information

Federal Medicaid regulations (42 CFR 422.128) require the MHP to ensure that all adults and emancipated minor Medi-Cal beneficiaries are provided with information about the right to have an Advance Health Care Directive. In order to be in full compliance with this regulation, it is necessary that all eligible clients be informed of the right to have an Advance Health Care Directive at their first face-to-face contact for services, or when they become eligible (upon their 18 birthday or emancipation). An Advance Health Care Directive is defined in the 42 CFR, Chapter IV, Part 489.100 as "a written instruction such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." Generally, Advance Health Care Directives deal with how physical health care should be provided when an individual is incapacitated by a serious physical health care condition, such as a stroke or coma, and unable to make medical treatment decisions for himself/herself.

In order to comply with the Federal regulations (42 CFR, Chapter IV, Section 422-128), providers shall do the following for new adult or emancipated clients:

1. Provide written information on the client right to make decisions concerning medical treatment, including the right to accept or refuse medical care and the right to formulate Advance Directives, at the first face-to-face contact with a new client, and thereafter, upon request.
2. Document in the client's medical record that this information has been given and whether or not the client has an existing Advance Directive.
3. If the client who has an Advance Directive wishes to bring in a copy, the provider shall add it to the client's current medical record.
4. If a client is incapacitated at the time of initial enrollment and unable to receive information, the provider will have a follow-up procedure in place to ensure that, the information on the right to an Advance Directive is given to the client at the appropriate time. In the interim, the provider may choose to give a copy of the information to the client's family or surrogate.
5. Not condition the provision of care or otherwise discriminate against an individual based on whether or not he or she has an Advance Directive.
6. Should the situation ever arise, provide information about the State contact point to clients who wish to complain about non-compliance with an Advance Directive.

The MHP is providing an informational brochure on Advance Directives, available in the threshold languages, which can be given out to new clients or members of the community who request it. All brochures are available on the Optum website at www.optumsandiego.com under the County Staff and

Providers tab, under Organizational Provider Documents. *To receive the materials in the audio or large print format contact* QIMatters.HHSA@sdcounty.ca.gov, or providers may duplicate their own copies. The MHP will also be responsible for notifying providers of any changes in State law regarding Advance Directives within 90 days of the law change.

Providers are expected to formulate their own policies and procedures on Advance Health Care Directives and educate staff. Because of the legal nature of Advance Directives, providers may wish to consult with their own legal counsel regarding federal regulations.

Periodic Notice of Clients' Rights

In accordance with DHCS regulations, written and oral information explaining the grievance/appeal process and the availability of a State Fair Hearing for Medi-Cal beneficiaries shall be provided to new clients upon first admission to Mental Health Services, along with the Guide to Medi-Cal Mental Health Services. The date of this activity shall be reflected on the Behavioral Health Assessment signature page. Information on the Beneficiary and Client Problem Resolution Process and State Fair Hearing Rights must be provided annually and documented on the Behavioral Health Assessment signature page.

BENEFICIARY GRIEVANCE AND APPEAL PROCESS

San Diego County Mental Health Services is committed to honoring the rights of every client to have access to a fair, impartial, effective process through which the client can seek resolution of a grievance or adverse benefit determination by the MHP. All county operated and contracted providers are required to participate fully in the Beneficiary and Appeal Process. Providers shall comply with all aspects of the process, including the distribution and display of the appropriate beneficiary protection materials, including posters, brochures and grievance/appeal forms as described in the process. (Beneficiary Packet Materials Order Form and Grievance/Appeal Forms are available on the Optum website: https://www.optumsandiego.com).

The MHP has delegated the roles and responsibilities of managing the grievance and appeal resolution process for beneficiaries to contracted advocacy organizations. When one of the contracted advocacy organizations notifies a provider of a grievance or appeal, the provider shall cooperate with the investigation and resolution of the grievance or appeal in a timely manner.

At all times, Grievance and Appeal information must be readily available for clients to access without the need for request. Each provider site shall have posters, brochures, and grievance/appeal forms in threshold languages, and addressed envelopes available to clients. These materials shall be displayed in a prominent public place. Clients shall not be subject to any discrimination, penalty, sanction or restriction for filing a grievance/appeal. The client shall not be discouraged, hindered or otherwise interfered with in seeking or attempting to register a grievance/appeal. Additionally, the client shall be assisted in preparing a written grievance/appeal, if requested.

Written materials that are critical to obtaining services including, at a minimum, appeal and grievance notices, and denial and termination notices, shall be available to beneficiaries in threshold languages and alternative formats. These materials are available on the Optum website.

Grievance Resolution at Provider Sites

Clients are encouraged to direct their grievances directly to program staff or management for the most efficient way to resolve problems. This may be done orally or in writing at the program. In accordance with 42 CFR §438.402, a beneficiary may file a grievance at any time. The Plan shall provide to the beneficiary written acknowledgement of receipt of grievance. The acknowledgment letter shall include the date of receipt, as well as the name, telephone number, and address of the Plan representative who the beneficiary may contact about the grievance. The written acknowledgement to the beneficiary must be postmarked within five calendar days of receipt of the grievance.

Providers shall log of all grievances containing the date of receipt of the grievance, the name of the beneficiary, nature of the grievance, the resolution, and the representative's name who received and resolved the grievance in the Client Suggestions and Provider Transfer Request Log. The log shall be secured to protect client confidentiality. This log shall be submitted with the provider's Monthly/Quarterly Status Report.

Providers shall inform all clients about their right to file a grievance with one of the MHP's contracted advocacy organizations if the client has an expression of dissatisfaction about any matter, is uncomfortable approaching program staff, or the dissatisfaction has not been successfully resolved at the program. Clients should feel equally welcomed to bring their concerns directly to the program's attention or to seek the assistance of one of the advocacy organizations.

Complaints to Board of Behavioral Sciences (AB 630)

Effective on or after 7/1/20, mental health professionals licensed or registered with the Board of Behavioral Sciences (BBS), prior to providing psychotherapy, must give clients a notice in at least 12-point font telling them that BBS receives and responds to complaints about licensees and tells clients how to contact BBS to file complaints.

Providers should have a Policy and Procedure in place addressing this regulation and QA will be monitoring this during the Medi-Cal site visits.

Grievance Process

A "grievance" is defined as an expression of dissatisfaction about any matter other than an adverse benefit determination. There is no distinction between an informal and formal grievance. A compliant is the same as a formal grievance. A compliant shall be considered a grievance unless it meets the

definition of an "adverse benefit determination". Even if a beneficiary expressly declines to file a formal grievance, their complaint shall be categorized as a grievance.

JFS Patient Advocacy facilitates the grievance process for clients in inpatient and other 24-hour residential facilities. CCHEA facilitates the grievance process for outpatient and all other mental health services. These advocacy services will contact providers within two (2) business days of receiving written permission from the client to represent him/her. Securing this permission can be difficult and time consuming. To ensure compliance with the mandated federal timeline, providers shall work closely with the Advocacy organization to find a mutually agreeable solution to resolve the grievance quickly.

If a grievance or appeal is about a clinical issue, CCHEA and JFS Patient Advocacy Program, as required by 42 CFR, will be utilizing a clinician with appropriate clinical expertise in treating the client's condition to review and make a decision about the case.

Grievance Resolution

Timeline: 90 days from receipt of grievance to resolution, with a possible 14-day extension for good cause.

The MHP must resolve grievances within the established timeframes. The Plan must comply with the following requirements for resolution of grievances:

1. "Resolved" means that the Plan has reached a decision with respect to the beneficiary's grievance and notified the beneficiary of the disposition.
2. Plans shall comply with the established timeframe of 90 calendar days for resolution of grievances, except as noted below.
3. The timeframe for resolving grievances related to disputes of a Plan's decision to extend the timeframe for making an authorization decision shall no exceed 30 calendar days.
4. The Plan shall use the Notice of Grievance Resolution (NGR) to notify beneficiaries of the results of the grievance resolution. The NGR shall contain a clear and concise explanation of the Plan's decision.
5. Federal regulations allow the Plan to extend the timeframe for an additional 14 calendar days if the beneficiary requests the extension or the Plan shows (to the satisfaction of DHCS, upon request) that there is need for additional information and how the delay is in the beneficiary's interest. In the event that resolution of a standard grievance is not reached within 90 calendar days as required, the Plan shall provide the beneficiary with the applicable NOABD, and include the status of the grievance and the estimated date of resolution, which shall not exceed 14 additional calendar days. If the Plan extends the timeframe, not at the request of the beneficiary, it must complete all of the following: (a) give the beneficiary prompt oral notice of the delay, (b) within two calendar days of making the decision, give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he/she disagrees with that decision, and (c) resolve the grievance no later than the date the extension expires.

Grievance Process Exemptions

Grievances received over the telephone or in-person by the Plan, or a network provider of the Plan, that are resolved to the beneficiary's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written acknowledgment and disposition letter.

Grievances received via mail by the Plan, or a network provider of the Plan, are not exempt from the requirement to send an acknowledgment and disposition letter in writing. If a Plan or a network provider of the Plan receives a complaint pertaining to an Adverse Benefit Determination, as defined under 42 CFR Section 438.400, the complaint is not considered a grievance and the exemption does not apply.

Advocacy Services and Records Requests

In accordance with the Code of Federal Regulation (CFR) Title 42, Part 438, Subpart F – Grievance System, the JFS Patient Advocacy Program and CCHEA are required to conduct grievance investigations and appeals pursuant to State and Federal law. These processes may include, but are not limited to, consulting with facility administrators, interviewing staff members, requesting copies of medical records, submitting medical records to independent clinical consultants for review of clinical issues, conducting staff member trainings, suggesting policy changes, submitting requests for Plans of Correction (POC), and preparing resolution letters.

There are mandated timelines for grievances and appeals. Providers' quick and efficient cooperation will ensure compliance with these requirements. When requested, MHP providers shall provide copies of medical records to the JFS Patient Advocacy Program and CCHEA within seven (7) calendar days from the date of the medical record request. The Advocacy Agencies will provide the program with a signed release of information from the client with the request.

ADVERSE BENEFIT DETERMINATION (ABD)

The definition of an "Adverse Benefit Determination" encompasses all previous elements of "Action" under federal regulations with the addition of language that clarifies the inclusion of determinations involving medical necessity, appropriateness and setting of covered benefits, and financial liability.

An Adverse Benefit Determination is defined to mean any of the following actions taken by a Plan:

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 beneficiary's request to dispute financial liability.

Written Notice of Adverse Benefit Determination (NOABD) Requirements

Beneficiaries must receive a written NOABD when the MHP takes any of the actions described above. The Plan must give beneficiaries timely and adequate notice of an adverse benefit determination in writing, consistent with the requirements in 42 CFR §438.10. The federal regulations delineate the requirements for content of the NOABDs. The NOABD must explain all of the following:

1. The adverse benefit determination the Plan 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 must include the clinical reasons for the decision. The Plan shall explicitly state why the beneficiary's condition does not meet specialty mental health services and/or DMC-ODS 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;
4. The beneficiary'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 beneficiary's adverse benefit determination.

Decisions shall be communicated to the beneficiary in writing. In addition, decisions shall be communicated to the provider initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively. For written notification to the provider, the Plan must also include the name and direct telephone number or extension of the decision-maker. Programs shall review the client's chart for an emergency contact. If the program has a Release of Information on file for the individual, they are to send the NOABD to the emergency contact. If not, document the inability to reach client on the NOABD log and place a copy of the NOABD in the log as well.

If the Plan 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 Plan must conduct ongoing oversight to monitor the effectiveness of this process.

Timing of the Notice

The MHP shall mail the notice to the beneficiary within the following timeframes:

1. For termination, suspension, or reduction of a previously authorized specialty mental health service, at least 10 days before the date of action, except as permitted under 42 CFR §§ 431.213

and 431.214;
2. For denial of payment, at the time of any action denying the provider's claim; or,
3. For decisions resulting in denial, delay, or modification of all or part of the requested specialty mental health services, within two business days of the decision.

The Plan must also communicate the decision to the affected provider within 24 hours of making the decision.

Written NOABD Templates

In accordance with the federal requirements, the MHP (providers) shall use DHCS' uniform notice templates, or the electronic equivalent of these templates generated from the Plan's Electronic Health Record System, when providing beneficiaries with a written NOABD. The notice templates include both the enclosed NOABD and **"Your Rights"** documents to notify beneficiaries of their rights in compliance with the federal regulations. The following is a description of adverse benefit determinations and the corresponding NOABD template, as well as instructions related to the timeframes for sending the NOABD to the beneficiary:

1. **NOABD Denial of Authorization Notice** - Use this template when the Plan 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. **NOABD Payment Denial Notice** - Use this template when the Plan 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 beneficiary.
3. **NOABD Delivery System Notice** - Use this template when the Plan has determined that the beneficiary does not meet the criteria to be eligible for specialty mental health through the Plan. The beneficiary shall be referred to the Managed Care Plan, or other appropriate system, for mental health, substance use disorder, or other services.
4. **NOABD Modification Notice** - Use this template when the Plan 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. **NOABD Termination Notice** - Use this template when the Plan terminates, reduces, or suspends a previously authorized service. This notice is also required for all clients who have unsuccessfully discharged. Unsuccessful discharge includes, but is not limited to, client AWOL, client unwilling to continue with services, client terminates services AMA, etc.
6. **NOABD Delay Notice** - Use this template when there is a delay in processing a provider's request for authorization of specialty mental health service. When the Plan 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 beneficiary or provider, and/or those granted when there is a need for additional information from the beneficiary or provider, when the extension is in the beneficiary's interest.
7. **NOABD Timely Access Notice** - Use this template when there is a delay in providing the

beneficiary with timely services, as required by the timely access standards applicable to the delayed service.

8. **NOABD Financial Liability Notice** - Use this template when the Plan denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities.
9. **NOABD "Your Rights" Attachment -** the "Your Rights" attachment is a new form that informs beneficiaries of critical appeal and State hearing rights. There are two types of "Your Rights" attachments. One accompanies the NOABD and the other accompanies the Notice of Appeals Resolution. These attachments must be sent to beneficiaries with each NOABD or NAR.

The "**NOABD Your Rights**" attachment provides beneficiaries with the following required information pertaining to NOABD:

1. The beneficiary's or provider's right to request an internal appeal with the Plan within 60 calendar days from the date on the NOABD;
2. The beneficiary's right to request a State hearing only after filing an appeal with the Plan and receiving a notice that the Adverse Benefit Determination has been upheld;
3. The beneficiary's right to request a State hearing if the Plan fails to send a resolution notice in response to the appeal within the required timeframe;
4. Procedures for exercising the beneficiary's rights to request an appeal;
5. Circumstances under which an expedited review is available and how to request it; and,
6. The beneficiary'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.

The MHP programs shall have a written policy and procedure addressing the collecting, storing, filing, and mailing of Notice of Adverse Benefit Determinations. It is recommended that programs maintain all Notice of Adverse Benefit Determinations in a confidential location at the program site for no less than ten (10) years after discharge for adults. For minors, records are to be kept until they have reached the age of 18, plus seven (7) years.

- All MHP programs shall maintain on site a monthly NOABD Log.
- Programs shall include the following in their NOABD Logs:
    - Date NOABD was issued.
    - Beneficiary identification number/CCBH case number.
    - Mode of NOABD Delivery
    - Beneficiary response, requests, provisions for second opinions, initiation of grievance/appeal procedure, and/or request for a State Fair Hearing if known.
        - Logs to contain copies of each NOABD and "Your Rights" forms attached.
        - Logs to contain documentation of inability to contact the client, if applicable.
        - Log to reflect "NO NOABD ISSUED" if none are issued within a month.
        - NOABD Logs must be available for review at COR or QA request.
- Monthly logs are to be submitted to QA on a quarterly basis, along with Medication Monitoring Reports. Dates for submission are as follows:

- Quarter One: October 15th
- Quarter Two: January 15th
- Quarter Three: April 15th
- Quarter Four: July 15th

- QA has developed an Excel NOABD Log that programs can use to track monthly NOABD's. The NOABD log can be accessed at https://www.optumsandiego.com . If programs choose to create their own log, it must contain all the same elements listed above. All NOABD's will be stored in the Logbook, therefore not being stored in the beneficiary's individual chart.

APPEAL PROCESS

Timeline.: 30 calendar days from receipt of appeal to resolution, with a possible 14-day extension for good cause.

An "Appeal" is a review by the MHP of an Adverse Benefit Determination regarding provision of services through an authorization process, including:

1. 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. Reduction, suspension or termination of a previously authorized service;
3. Denial of, in whole or in part, of payment for a service;
4. Failure to provide services in a timely manner;
5. Failure to act within the required timeframes of a standard resolution of grievances and appeals; or
6. Denial of a beneficiary's request to dispute financial liability.

Federal regulations require beneficiaries to file an appeal within 60 calendar days from the date on the NOABD. The MHP shall adopt the 60-calendar day timeframe in accordance with the federal regulations. Beneficiaries must also exhaust the Plan's appeal process prior to requesting a State hearing. A beneficiary, or provider and/or authorized representative, may request an appeal either orally or in writing. Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary.

In addition, an oral appeal (excluding expedited appeals) shall be followed by a written appeal signed by the beneficiary. The date of the oral appeal establishes the filing date for the appeal. The MHP shall request that the beneficiary's oral request for a standard appeal be followed by written confirmation unless the beneficiary or provider requests expedited resolution in accordance with federal regulations.

The MHP and its providers shall assist the beneficiary in completing forms and taking other procedural steps to file an appeal, including preparing a written appeal, notifying the beneficiary of the location of the forms on the Optum website or providing the form to the beneficiary upon request. The MHP shall also advise and assist the beneficiary in requesting continuation of benefits during an appeal of the

adverse benefit determination in accordance with federal regulations. In the event that the Plan does not receive a written, signed appeal from the beneficiary, the Plan shall neither dismiss nor delay resolution of the appeal.

Authorized Representatives

With written consent of the beneficiary, a provider or authorized representative may file a grievance, request an appeal, or request a State hearing on behalf of the beneficiary. Providers and authorized representatives cannot request continuation of benefits, as specified in 42 CFR §438.420(b)(5).

Standard Resolution of Appeals

The MHP shall provide to the beneficiary written acknowledgement of receipt of the appeal. The acknowledgment letter shall include the date of receipt, as well as the name, telephone number, and address of the Plan representative who the beneficiary may contact about the appeal. The written acknowledgement to the beneficiary must be postmarked within five calendar days of receipt of the appeal.

Extension of Timeframes

The MHP may extend the resolution timeframes for appeals by up to 14 calendar days if either of the following two conditions applies:

1. The beneficiary requests the extension; or,
2. The Plan demonstrates, to the satisfaction of DHCS upon request, that there is a need for additional information and how the delay is in the beneficiary's best interest.

For any extension not requested by the beneficiary, the Plan is required to provide the beneficiary with written notice of the reason for the delay. Federal regulations delineate the following additional requirements:

a. The Plan shall make reasonable efforts to provide the beneficiary with prompt oral notice of the extension;
b. The Plan shall provide written notice of the extension within two calendar days of making the decision to extend the timeframe and notify the beneficiary of the right to file a grievance if the beneficiary disagrees with the extension;
c. The Plan shall resolve the appeal as expeditiously as the beneficiary's health condition requires and in no event extend resolution beyond the 14-calendar day extension; and,
d. In the event that the Plan fails to adhere to the notice and timing requirements, the beneficiary is deemed to have exhausted the Plan's appeal process and may initiate a State hearing.

Expedited Resolution of Appeals

Timeline: 72 hours from receipt of expedited appeal request

In addition to the other logging requirements delineated in federal regulations, the MHP must log the time and date of appeal receipt when expedited resolution is requested as the specific time of receipt drives the timeframe for resolution. The Plan may extend the timeframe for expedited appeals resolution by 14 calendar days in accordance with federal regulations.

The MHP maintains an expedited review process for appeals when the Plan determines (from a beneficiary request) or the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) that taking time for a standard resolution could seriously jeopardize the beneficiary's mental health of the beneficiary's ability to attain, maintain, or regain maximum function. For expedited resolution of an appeal and notice to affected parties (i.e., the beneficiary, legal representative and/or provider), the Plan shall resolve the appeal, and provide notice, as expeditiously as the beneficiary's health condition requires, no longer than 72 hours after the Plan receives the expedited appeal request.

General Expedited Requirements

If the MHP denies a request for expedited resolution of an appeal, it must transfer the appeal to the timeframe for standard resolution. In addition, the Plan shall complete all of the following actions:

1. The Plan shall make reasonable efforts to provide the beneficiary with prompt oral notice of the decision to transfer the appeal to the timeframe for standard resolution;
2. The Plan shall provide written notice of the decision to transfer the appeal to the timeframe for standard resolution within two calendar days of making the decision and notify the beneficiary of the right to file a grievance if the beneficiary disagrees with the extension; and
3. The Plan shall resolve the appeal as expeditiously as the beneficiary's health condition requires and within the timeframe for standard resolution of an appeal (i.e., within 30 days of receipt of the appeal).

Notice of Appeal Resolution (NAR) Requirements

A NAR is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld. In addition to the written NAR, the MHP is required to make reasonable efforts to provide prompt oral notice to the beneficiary of the resolution.

NAR Adverse Benefit Determination Upheld Notice

For appeals not resolved wholly in favor of the beneficiary, the MHP shall utilize the DHCS template or the electronic equivalent of that template generated from the Plan's Electronic Health Record System, for upheld decisions, which is comprised of two components:

1. NAR Adverse Benefit Determination Upheld Notice, and

2. "Your Rights" attachment.

These documents are a **"packet"** and shall be sent together to comply with all requirements of the NAR. The MHP shall send written NARs to beneficiaries. The written NAR shall include the following:

a. The results of the resolution and the date it was completed;
b. The reasons for the Plan's determination, including the criteria, clinical guidelines, or policies used in reaching the determination;
c. For appeals not resolved wholly in the favor of the beneficiary, the right to request a State hearing and how to request it;
d. For appeals not resolved wholly in the favor of the beneficiary, the right to request and receive benefits while the hearing is pending and how to make the request; and,
e. Notification that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the Plan's adverse benefit determination.

NAR "Your Rights" Notice

The NAR "Your Rights" attachment provides beneficiaries with the following required information pertaining to NAR:

a. The beneficiary's right to request a State hearing no later than 120 calendar days from the date of the Plan's written appeal resolution and instructions on how to request a State hearing; and,
b. The beneficiary'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 beneficiary) in accordance with Title 42, CFR, Section 438.420.

The MHP shall use the appropriate NAR form and "Your Rights" attachments.

NAR Adverse Benefit Determination Overturned Notice

For appeals resolved wholly in favor of the beneficiary, written notice to the beneficiary shall include the results of the resolution and the date it was completed. The MHP shall also ensure that the written response contains a clear and concise explanation of the reason, including why the decision was overturned. The MHP shall utilize the DHCS template packet for appeals, which contains the NAR for overturned decisions.

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

Note: A decision by a therapist to limit, reduce, or terminate a client's service is considered a clinical decision and cannot be the subject of an appeal; however, it can be grieved.

STATE FAIR HEARING (SFH)

Beneficiaries must exhaust the MHP's appeal process prior to requesting a State hearing. A beneficiary has the right to request a State hearing only after receiving notice that the Plan is upholding an adverse benefit determination. If the Plan fails to adhere to the notice and timing requirements in 42 CFR§438.408, the beneficiary is deemed to have exhausted the Plan's appeals process. The enrollee may then initiate a State hearing. Beneficiaries may request a State hearing within 120 calendar days from the date of the Notice of Appeal Resolution (NAR), which informs the beneficiary that the Adverse Benefit Decision has been upheld by the Plan.

For **Standard Hearings,** the MHP shall notify beneficiaries that the State must reach its decision on the hearing within 90 calendar days of the date of the request for the hearing. For **Expedited Hearings,** the MHP shall notify beneficiaries that the State must reach its decision on the state fair hearing within three working days of the date of the request for the hearing. For **Overturned Decisions,** the MHP shall authorize or provide the disputed services promptly and as expeditiously as the beneficiary's health condition requires, but no later than 72 hours from the date it receives notice reversing the Plan's adverse benefits determination.

NON-DISCRIMINATION AND LANGUAGE ASSISTANCE NOTICES

Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. On May 18, 2016, the United States Department of Health and Human Services, Office for Civil Rights issued the Nondiscrimination in Health Program and Activities Final Rule to implement Section 1557. Federal regulations require the MHP (and providers) to post nondiscrimination and language assistance notices in significant communications to beneficiaries.

The MHP has created a "Beneficiary Non-Discrimination Notice" and "Language Assistance Notice", which shall be sent along with each of the following significant notices sent to beneficiaries:

- NOABD,
- Grievance Acknowledgment Letter,
- Appeal Acknowledgment Letter,
- Grievance Resolution Letter, and
- Notice of Appeal Resolution Letter.

Provider Appeal Process

If the provider and advocacy organization cannot successfully resolve the client's grievance or appeal, the advocacy organization will issue a finding, to be sent to the client, provider and Mental Health Director, which may include the need for a Plan of Correction to be submitted by the provider to the Mental Health Director or designee in 10 days. In the rare instances when the provider disagrees with the disposition of the grievance/appeal and/or does not agree to write a Plan of Correction, the provider

may write to the Mental Health Director within 10 days, requesting an administrative review. The Mental Health Director or his designee shall have the final decision about needed action. Please see the Beneficiary and Client Problem Resolution Process for details of this portion of the process.

Considerations for Minors

If the client is a minor, unless it is a minor consent case, the original should be sent to the minor and a copy should be sent to the minor's parent(s) or legal guardian.

In minor consent cases, only the minor shall receive the NOABD. The minor's parent/guardian shall not receive a copy or be otherwise notified of the adverse benefit determination.

Monitoring the Beneficiary Grievance and Appeal Resolution Process

The MHP, operating from a shared concern with providers about improving the quality of care and experience of beneficiaries, will monitor feedback from the grievance/appeal process to identify potential deficiencies and take actions for continuous improvement. Data is collected, analyzed and shared with the BHS System of Care and stakeholder thru system-wide meetings and councils.