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DATE: March 27, 2018

MHSUDS INFORMATION NOTICE NO.: 18-010E

TO: COUNTY BEHAVIORAL HEALTH DIRECTORS
COUNTY DRUG & ALCOHOL ADMINISTRATORS
COUNTY BEHAVIORAL HEALTH DIRECTORS ASSOCIATION OF CALIFORNIA
CALIFORNIA COUNCIL OF COMMUNITY BEHAVIORAL HEALTH AGENCIES
COALITION OF ALCOHOL AND DRUG ASSOCIATIONS
CALIFORNIA ASSOCIATION OF ALCOHOL & DRUG PROGRAM EXECUTIVES, INC.
CALIFORNIA ALLIANCE OF CHILD AND FAMILY SERVICES
CALIFORNIA OPIOID MAINTENANCE PROVIDERS

SUBJECT: FEDERAL GRIEVANCE AND APPEAL SYSTEM REQUIREMENTS WITH REVISED BENEFICIARY NOTICE TEMPLATES

PURPOSE

The purpose of this Mental Health and Substance Use Disorder Services Information Notice (IN) is to provide Mental Health Plans (MHPs) and Drug Medi-Cal Organized Delivery System (DMC-ODS) pilot counties, herein referred to as Plans unless otherwise specified, with clarification and guidance regarding the application of revised federal regulations for processing grievances and appeals.

This IN provides guidance to Plans regarding federal grievance and appeal system requirements. In addition to clarifying the application of new federal regulations, this IN also includes uniform notice templates, including a Notice of Grievance Resolution (NGR), Notices of Adverse Benefit Determination (NOABD), Notices of Appeal Resolution (NAR), a “Your Rights” attachment, a beneficiary non-discrimination notice, and language assistance taglines. These uniform notices provide beneficiaries with required information about their rights under the Medi-Cal program.

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. MHPs and DMC-ODS pilot counties 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, 2017.²

This IN 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 in the Federal Register (81.Fed.Reg. 18390) to strengthen access to mental health and substance use disorder services for Medicaid beneficiaries. 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. As such, this IN largely mirrors the requirements outlined in [All Plan Letter 17-006](#) for managed care plans.

REVISED REQUIREMENTS

I. GRIEVANCES

The federal regulations³ redefined the term "grievance" to mean an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. The definition specifies that 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 beneficiary's rights regardless of whether remedial action is requested, and the beneficiary's right to dispute an extension of time proposed by the Plan to make an authorization decision.⁴ There is no distinction between an informal and formal grievance.

A complaint is the same as a formal grievance. A complaint shall be considered a grievance unless it meets the definition of an "adverse benefit determination" (see below).

The Plan shall not discourage the filing of grievances. A beneficiary need not use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and,

¹ 81 FR 27497

² Title 42, Code of Federal Regulations (CFR), Part 438, Subpart F

³ Title 42, CFR, Section 438.400(b)

⁴ Title 42, CFR, Section 438.400(b)

therefore, a grievance. Even if a beneficiary expressly declines to file a formal grievance, their complaint shall still be categorized as a grievance. As with other grievances, these grievance will be analyzed to monitor trends.

A. Timeframes for Filing

In accordance with 42 CFR §438.402, a beneficiary may file a grievance at any time.

B. Method of Filing

A beneficiary, or a provider and/or authorized representative, may file a grievance either orally or in writing.

C. Standard Grievances

1. Acknowledgment

The Plan shall provide to the beneficiary written acknowledgement of receipt of the 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.

2. Resolution

Each Plan must resolve grievances within the established timeframes. For standard resolution of a grievance and notice to affected parties, the timeframe is established by the State but may not exceed 90 calendar days from the day the Plan receives the grievance.⁵ Plans must comply with the following requirements for resolution of grievances:

- a. "Resolved" means that the Plan has reached a decision with respect to the beneficiary's grievance and notified the beneficiary of the disposition.
- b. Plans shall comply with the established timeframe of 90 calendar days for resolution of grievances, except as noted below.
- c. 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.⁶
- d. The Plan shall use the enclosed written 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 Title 42, CFR, Section 438.408(b)

⁶ Title 28, California Code of Regulations (CCR), Section 1300.68(a)

- e. Federal regulations⁷ 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.

D. 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.

Plans shall maintain a 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. Plans must transmit issues identified as a result of the grievance, appeal or expedited appeal processes to the Plan's Quality Improvement Committee, the Plan's administration or another appropriate body within the Plan's operations. The Plan shall ensure exempt grievances are included in its Beneficiary Grievance and Appeal Report that is submitted to DHCS.

⁷ Title 42, CFR, Sections 438.408(b) and (c)

II. ADVERSE BENEFIT DETERMINATIONS

A. Definition

The Final Rule replaced the term “Action” with “Adverse Benefit Determination”.⁸ 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.

B. Written Notice of Adverse Benefit Determination Requirements

Beneficiaries must receive a written NOABD when the Plan 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 regulations⁹ 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;

⁸ Title 42, CFR, Section 438.400(b)

⁹ Title 42, CFR, Section 438.404(b)

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.

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.

C. Timing of the Notice

The Plan must mail the notice to the beneficiary within the following timeframes:¹⁰

1. For termination, suspension, or reduction of a previously authorized specialty mental health and/or DMC-ODS service, at least 10 days before the date of action,¹¹ 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 and/or DMC-ODS 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.

¹⁰ Title 42, CFR, Section 438.404(c)

¹¹ Title 42, CFR, Section 431.211

D. Written NOABD Templates

In accordance with the federal requirements, Plans must 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.¹² 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. Denial of authorization for requested services
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. For DMC-ODS pilot counties, also use this template for denied residential service requests.
2. Denial of payment for a service rendered by provider
Use this template when the Plan denies, in whole or in part, for any reason,¹³ a provider's request for payment for a service that has already been delivered to a beneficiary.
3. Delivery system
Use this template when the Plan has determined that the beneficiary does not meet the criteria to be eligible for specialty mental health or substance use disorder services through the Plan. The beneficiary will be referred to the Managed Care Plan, or other appropriate system, for mental health, substance use disorder, or other services.
4. Modification of requested services
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. Termination of a previously authorized service
Use this template when the Plan terminates, reduces, or suspends a previously authorized service.
6. Delay in processing authorization of services
Use this template when there is a delay in processing a provider's request for authorization of specialty mental health services or substance use disorder residential services. When the Plan extends the timeframe to make an authorization decision, it is a delay in processing a provider's request. This

¹² Title 42, CFR, Section 438.10(b)(4)(ii)

¹³ Reasons for denials include, but are not limited, denials based on documentation standards

- 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. Failure to provide timely access to services
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. Dispute of financial liability
Use this template when the Plan denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities.
 9. Failure to timely resolve grievances and appeals
Use this template when the Plan does not meet required timeframes for the standard resolution of grievances and appeals.

E. 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 days¹⁴ from the date on the NOABD;¹⁵
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;¹⁶
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;¹⁷
4. Procedures for exercising the beneficiary's rights to request an appeal;¹⁸

¹⁴ Title 42, CFR, Section 438.402(c)(2)(ii)

¹⁵ Title 42, CFR, Section 438.404(b)(3)

¹⁶ Title 42, CFR, Section 438.404(b)(3)

¹⁷ Title 42, CFR, Section 438.408(c)(3)

¹⁸ Title 42, CFR, Section 438.404(b)(4)

5. Circumstances under which an expedited review is available and how to request it;¹⁹ 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 438.420.²⁰

Effective immediately, Plans shall utilize the revised NOABD templates and corresponding "Your Rights" attachments included in this IN, or the electronic equivalents of these templates and attachments generated from the Plan's Electronic Health Record System. Plans shall not make any changes to the NOABD templates or "Your Rights" attachments without prior review and approval from DHCS, except to insert information specific to beneficiaries as required.

III. APPEALS

Under new federal regulations, an "Appeal" is a review by the Plan of an Adverse Benefit Determination.²¹

A. Timeframes for Filing

Federal regulations²² require beneficiaries to file an appeal within 60 calendar days from the date on the NOABD. Plans 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.

B. Method of Filing

In accordance with federal regulations,²³ a beneficiary, or a provider and/or authorized representative, may request an appeal either orally or in writing. Appeals filed by the provider on behalf of the beneficiary require written consent from the beneficiary.²⁴

In addition, an oral appeal (excluding expedited appeals) shall be followed by a written appeal signed by the beneficiary.²⁵ The date of the oral appeal establishes the filing date for the appeal. Plans 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

¹⁹ Title 42, CFR, Section 438.404(b)(5)

²⁰ Title 42, CFR, Section 438.404(b)(6)

²¹ Title 42, CFR, Section 438.400(b)

²² Title 42, CFR, Section 438.402(c)(2)(ii)

²³ Title 42, CFR, Section 438.402(c)(3)(ii)

²⁴ Title 42, CFR, Sections 438.402(c)(1)(ii)

²⁵ Title 42, CFR, Sections 438.402(c)(3)(ii) and 438.406(b)(3)

accordance with federal regulations. Plans 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 form on the Plan's website or providing the form to the beneficiary upon request. Plans 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.²⁶ 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.

C. 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).

D. Standard Resolution of Appeals

1. Acknowledgment

The Plan 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.

2. Standard Resolution Timeframe

Federal regulations revised the timeline for the Plan to resolve an appeal to within 30 calendar days of receipt from 45 calendar days previously allowed.²⁷

3. Extension of Timeframes

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

- a. The beneficiary requests the extension;²⁸ or,
- b. 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.²⁹

²⁶ Title 42, CFR, Section 438.420

²⁷ Title 42, CFR, Section 438.408(b)(2)

²⁸ Title 42, CFR, Section 438.408(c)(1)(i)

²⁹ Title 42, CFR, Section 438.408(c)(1)(ii)

For any extension not requested by the beneficiary, Plans are required to provide the beneficiary with written notice of the reason for the delay. New federal regulations delineate the following additional requirements that Plans must comply with the following:

- a. The Plan shall make reasonable efforts to provide the beneficiary with prompt oral notice of the extension;³⁰
- 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;³¹
- 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;³² 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.³³

IV. EXPEDITED RESOLUTION OF APPEALS

The Plan must establish and maintain 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 or substance use disorder condition and/or 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 must 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.³⁴

A. General Requirements

If the Plan denies a request for expedited resolution of an appeal, it must transfer the appeal to the timeframe for standard resolution. In addition, the Plan must complete all of the following actions:³⁵

³⁰ Title 42, CFR, Section 438.408(c)(2)(i)

³¹ Title 42, CFR, Section 438.408(c)(2)(ii)

³² Title 42, CFR, Section 438.408(c)(2)(iii)

³³ Title 42, CFR, Section 438.408(c)(3)

³⁴ Title 42, CFR, Section 438.408(b)(3)

³⁵ Title 42, CFR, Section 438.410(c)

- a) 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;
- b) 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
- c) 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).

B. Timeframes for Resolving Expedited Appeals

For expedited resolution of an appeal and notice to the beneficiary and provider, Federal regulations³⁶ require the Plan to resolve the appeal within 72 hours from receipt of the appeal (this is a change from the 3 working days previously allowed). In addition to the other logging requirements delineated in federal regulations,³⁷ Plans 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. Plans may extend the timeframe for expedited appeals resolution by 14 calendar days in accordance with federal regulations.³⁸

C. Notice Requirements

In addition to the written NAR, Plans are required to make reasonable efforts to provide prompt oral notice to the beneficiary of the resolution.³⁹

V. NOTICE OF APPEAL RESOLUTION (NAR)

A NAR is a formal letter informing a beneficiary that an Adverse Benefit Determination has been overturned or upheld.

A. Adverse Benefit Determination Upheld

For appeals not resolved wholly in favor of the beneficiary, Plans shall utilize the DHCS template included with this IN, 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) Notice of Appeal Resolution and 2) "Your Rights" attachments. These documents are viewed as a "packet" and must be sent in conjunction to comply with all requirements of the NAR.

³⁶ Title 42, CFR, Section 438.408(b)(3)

³⁷ Title 42, CFR, Section 438.416(b)

³⁸ Title 42, CFR, Section 438.408(c)

³⁹ Title 42, CFR, Section 438.408(d)(2)(ii)

1. Notice of Appeal Resolution (NAR)

The Plans 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;⁴⁰
- b. The reasons for the Plan's determination, including the criteria, clinical guidelines, or policies used in reaching the determination;⁴¹
- 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.

2. NAR "Your Rights" Attachment

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;⁴² 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 438.420.⁴³

Plans shall use the appropriate NAR form and "Your Rights" attachments contained in this IN to notify beneficiaries of their rights.

B. Adverse Benefit Determination Overturned

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. Plans shall also ensure that the written response contains a clear and

⁴⁰ Title 42, CFR, Section 438.408(e)(1)

⁴¹ Title 42, CFR, Section 438.404(b)(2).

⁴² Title 42, CFR, Section 438.408(e)(2)(i); Title 22, CCR, Section 53858(e)(5)

⁴³ Title 42, CFR, Section 438.408(e)(2)(ii)

concise explanation of the reason, including why the decision was overturned. Plans 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. Plans shall authorize or provide services no later than 72 hours from the date and time it reverses the determination.⁴⁴

VI. STATE HEARINGS

Beneficiaries must exhaust the Plan'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.

A. Deemed Exhaustion of the Appeals Process

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.⁴⁵

B. Timeframes for Filing

New federal regulations⁴⁶ allow beneficiaries to request a State hearing within 120 calendar days from the date of the NAR, which informs the beneficiary that the Adverse Benefit Decision has been upheld by the Plan. DHCS has updated all "Your Rights" attachment templates so that beneficiaries are informed of the revised 120 calendar day requirement in accordance with new federal regulations.

The parties to State hearing include the Plan, as well as the beneficiary and his or her authorized representative or the representative of a deceased beneficiary's estate.

C. Standard Hearings

The Plan 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.⁴⁷

D. Expedited Hearings

⁴⁴ Title 42, CFR, Section 438.424(a)

⁴⁵ Title 42, CFR, Section 438.408(f)(1)

⁴⁶ Title 42, CFR, Sections 438.408(f)(1) and (2)

⁴⁷ Title 42, CFR, Section 431.244(f)(1)

The Plan 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.⁴⁸

E. Overturned Decisions

The Plan 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.⁴⁹

VII. LANGUAGE ASSISTANCE, 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, which must be made available to beneficiaries in threshold languages and alternative formats.⁵⁰ This translation requirement includes the individualized information described throughout this IN.

B. Nondiscrimination Notice and Language Assistance Taglines

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 Rule⁵¹ to implement Section 1557. Federal regulations⁵² require Plans to post nondiscrimination notice requirements and language assistance taglines in significant communications to beneficiaries.

DHCS has created sample "Nondiscrimination Notice" and "Language Assistance" taglines, which are available for Plan use. Plans may utilize the templates provided by DHCS, make modifications to the templates, or create new templates. If modifications or new templates are created, DHCS review and approval must be obtained prior to use.

These templates must be sent in conjunction with each of the following significant notices sent to beneficiaries: NOABD, grievance acknowledgment letter, appeal acknowledgment letter, grievance resolution letter, and NAR.

⁴⁸ Title 42, CFR, Section 431.244(f)(2)

⁴⁹ Title 42, CFR, Section 438.424(a)

⁵⁰ Title 42, CFR, Section 438.10(d)(3)

⁵¹ 81 FR 31375

⁵² Title 45, CFR, Section 92.8

VIII. GRIEVANCE AND APPEAL SYSTEM OVERSIGHT

Plans 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 regulations⁵³ and Plan contract requirements, as follows:

- A. The Plan shall have, and operate in accordance with, written policies and procedures regarding its grievance and appeal system.
- B. The Plan shall notify beneficiaries about its Grievance and Appeal System and shall include information on the Plan'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 Plan shall inform beneficiaries 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, that beneficiaries can access without making a verbal or written request to anyone must be available at all provider sites. A description of the procedure for filing grievances and appeals shall be readily available at each facility of the Plan, on the Plan's website, and at each contracting provider's office or facility, posted in a location that is accessible to beneficiaries. The Plan 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 Plan shall ensure adequate and appropriate consideration of grievances and appeals, as well as rectification when appropriate. If the beneficiary presents multiple issues, the Plan shall ensure that each issue is addressed and resolved.
- E. The Plan shall maintain a written record for each grievance and appeal received by the Plan. The record of each grievance and appeal shall be maintained in a log and include the following information:
 1. The date and time of receipt of the grievance or appeal;
 2. The name of the beneficiary 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 Plan or provider to investigate and resolve the grievance or appeal;
 6. The proposed resolution by the Plan or provider;
 7. The name of the Plan provider or staff responsible for resolving the grievance or appeal; and

⁵³ Title 42, CFR, Section 438

8. The date of notification to the beneficiary of the resolution.
- F. The written record of grievances and appeals shall be submitted at least quarterly to the Plan's 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. Appropriate action shall be taken to remedy any problems identified.⁵⁴
 - G. The Plan shall ensure decision-making by individuals with authority to require corrective action.⁵⁵
 - H. The Plan shall address the linguistic and cultural needs of its beneficiary population, as well as the needs of beneficiaries with disabilities. The Plan shall ensure all beneficiaries 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 Plan responses to grievances and appeals, as well as access to interpreters, telephone relay systems and other devices that aid individuals with disabilities to communicate.⁵⁶
 - I. The Plan shall ensure that there is no discrimination against a beneficiary because the beneficiary filed a grievance or appeal.
 - J. The Plan shall ensure that the person making the final decision for the proposed resolution of a grievance or appeal has not participated in any prior decisions related to the grievance or appeal. Additionally, the decision-maker shall be a health care professional with clinical expertise in treating a beneficiary's condition or disease if any of the following apply:⁵⁷
 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. Any grievance or appeal involving clinical issues.
 - K. The Plan shall ensure that individuals making decisions on clinical appeals take into account all comments, documents, records, and other information submitted

⁵⁴ Title 22, CCR, Sections 53858(e)(3) and (4)

⁵⁵ Title 22, CCR, Section 53858(e)(2)

⁵⁶ Title 22, CCR, Section 53858(e)(6)

⁵⁷ Title 42, CFR, Section 438.406(b)(2)

by the beneficiary or beneficiary's authorized representative, regardless of whether such information was submitted or considered in the initial Adverse Benefit Determination.⁵⁸

- L. The Plan shall provide the beneficiary or beneficiary's authorized representative the opportunity to review the beneficiary's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Plan in connection with any standard or expedited appeal of an Adverse Benefit Determination. This information must be provided free of charge and sufficiently in advance of the resolution timeframe.⁵⁹
- M. The Plan shall provide the beneficiary or authorized representative a reasonable opportunity, in person and in writing, to present evidence and testimony. The Plan must inform the beneficiary or authorized representative of the limited time available for this sufficiently in advance of the resolution timeframe for appeals, as specified, and in the case of expedited resolution.⁶⁰

Plans are responsible for ensuring that their delegates comply with all applicable state and federal laws and regulations, contract requirements, and other DHCS guidance, including INs. These requirements must be communicated by each Plan to all network providers and subcontractors.

For questions regarding this IN, please contact the Mental Health Services Division at (916) 322-7445 or MHSDFinalRule@dhcs.ca.gov or the Substance Use Disorder Program, Policy and Fiscal Division at (916) 327-8608 or DMCODSWaiver@dhcs.ca.gov.

Sincerely,

Original signed by

Brenda Grealish, Acting Deputy Director
Mental Health & Substance Use Disorder
Services

Enclosures:

- 1) Notice of Grievance Resolution (NGR)
- 2) Denial Notice (NOABD)
- 3) Payment Denial Notice (NOABD)

⁵⁸ Title 42, CFR, Section 438.406(b)(2)(iii)

⁵⁹ Title 42, CFR, Section 438.406(b)(5)

⁶⁰ Title 42, CFR, Section 438.406(b)(4)

- 4) Delivery System Notice (NOABD)
- 5) Modification Notice (NOABD)
- 6) Termination Notice (NOABD)
- 7) Timely Access Notice (NOABD)
- 8) Financial Liability Notice (NOABD)
- 9) NOABD Your Rights Attachment
- 10) Adverse Benefit Determination Upheld (NAR)
- 11) NAR Your Rights Attachment
- 12) Adverse Benefit Determination Overturned (NAR)
- 13) Beneficiary Non-Discrimination Notice
- 14) Language Assistance Taglines
- 15) Delay in processing authorization of services
- 16) Failure to timely resolve grievances and appeals