State of California—Health and Human Services Agency
Department of Health Care Services

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DATE: December 30, 2022

Behavioral Health Information Notice No.: 22-070

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

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

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

REFERENCE: Title 42, Code of Federal Regulations (CFR), Section 431.244(f); Welfare and Institutions Code (W&I) Section 14197, subdivision (c), (e); 22 CCR Section 54341(p); W&I Section 14197.1; Drug Medi-Cal Contract Exhibit A, Attachment 1

BACKGROUND:
On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Final Rule (Managed Care Rule), which revised Title 42 of the Code of Federal Regulations (CFR). These changes aimed to align Medicaid managed care regulations with the requirements of other major sources of coverage.

On March 30, 2016, CMS issued the Parity in Mental Health and Substance Use Disorder (SUD) Services Final Rule (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 (42 CFR Part 438, subpart K).

The Department of Health Care Services (DHCS) is required to ensure that all covered mental health benefits and substance use disorder benefits, including those provided via a fee-for-service delivery system, are in compliance with the Parity Rule. This Behavioral Health Information Notice (BHIN) includes policy changes DHCS has made to ensure that the delivery of covered substance use disorder benefits complies with the Parity Rule. In accordance with the Parity Rule, the following parity requirements are effective January 1, 2023.

POLICY:
To ensure DMC beneficiaries have the same rights, protections, and accessibility to services comparable to Medi-Cal physical health and mental health and substance use disorder services as beneficiaries receiving care through a managed care or Prepaid Inpatient Health Plans (PIHPs) delivery system, DMC counties shall establish and implement written policies and procedures for the following parity requirements. The requirements specified in this BHIN will be effective January 1, 2023. DHCS will monitor compliance starting Fiscal Year (FY) 2023-2024. For FY 2023-2024, DHCS will provide feedback and technical assistance on the status and effectiveness of the county's implementation and compliance with these new requirements.

Claiming for administrative costs should be included on the DMC Admin Claim form and the Quality Assurance Utilization (QAUR) claim form on the line titled Prop 30 Federal, since Parity Rule is a federal mandate.

Administrative costs to implement and maintain timely access standards, the grievance and appeal processes, and to develop and maintain provider directories can be claimed on the DMC Admin claim form. Provider credentialing costs can be claimed using the DMC QAUR claim form.

Claim forms for DMC Admin and QAUR can be found on the Drug Medi-Cal Treatment Program Forms page on the DHCS web page.

A. **DISCRIMINATION GRIEVANCE REQUIREMENTS:**

The following items, which have been added to the DMC contract, address parity requirements pertaining to allegations of discrimination from beneficiaries.
The County shall adopt Discrimination Grievance procedures that ensure prompt and equitable resolution of discrimination-related complaints. The County shall not require a beneficiary to file a Discrimination Grievance with the County before filing the grievance directly with DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights.

Discrimination Grievance Coordinator

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

Discrimination Grievances Reporting Requirements

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

1. The original complaint;
2. The provider's or other accused party's response to the grievance;
3. The County's personnel contact information responsible for the County's investigation and response to the grievance;
4. Contact information for the beneficiary filing the grievance and for the provider or other accused party that is the subject of the grievance;
5. All correspondence(s) with the beneficiary regarding the grievance, including, but not limited to, the Discrimination Grievance acknowledgment and resolution letter(s) sent to the beneficiary; and

6. The results of the County's investigation, including, but not limited to, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

A. GRIEVANCES:

The following items address parity requirements pertaining to grievances from beneficiaries. The County shall have in effect, a documented grievance process for its beneficiaries that complies with the following requirements.

Federal regulations define the term "grievance" to mean an expression of dissatisfaction about any matter other than an Adverse Benefit Determination (ABD). 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 County to make an authorization decision. There is no distinction between an informal and formal grievance.

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

The County shall not discourage the filing of grievances. A beneficiary need not use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance. Even if a beneficiary expressly declines to file a formal grievance, their complaint shall still be categorized as a grievance.

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

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

Standard Grievance Acknowledgment
The County shall provide the beneficiary with a written acknowledgment 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 County representative who the beneficiary may contact about the grievance. The written acknowledgment to the beneficiary must be postmarked within five calendar days of receipt of the grievance.

Standard Grievance Resolution
Each County must resolve grievances within the timeframes outlined in this BHIN. 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 County receives the grievance. Counties must comply with the following requirements for resolution of grievances:

1. "Resolved" means that the County has reached a decision with respect to the beneficiary's grievance and notified the beneficiary of the disposition.
2. Counties 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 County's decision to extend the timeframe for making an authorization decision shall not exceed 30 calendar days.
4. The County shall use the enclosed written 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 County's decision.
5. Federal regulations allow the County to extend the timeframe for an additional 14 calendar days if the beneficiary requests the extension or if the County shows (to the satisfaction of DHCS, upon request) that there is a 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 County shall provide the beneficiary with the applicable Notice of Adverse Benefit Determination (NOABD), and include the status of the grievance

and the estimated date of resolution, which shall not exceed 14 additional calendar days.

If the County 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 County, or a DMC-certified provider, that is 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 County, or a DMC-certified provider, are not exempt from the requirement to send an acknowledgment and disposition letter in writing. If a County or DMC-certified provider receives a complaint pertaining to an ABD, the complaint is not considered a grievance and the exemption does not apply.

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

B. ADVERSE BENEFIT DETERMINATIONS:

The following items address parity requirements concerning ABD and notice requirements to beneficiaries. The Notices of Adverse Benefit Determination (NOABD) and Notices of Appeal Resolution (NAR) templates are included as Enclosures in this BHIN.

The Final Rule replaced the term "Action" with "Adverse Benefit Determination". The definition of an ABD 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 ABD is defined to mean any of the following actions taken by a County:

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

Written Notice of Adverse Benefit Determination Requirements
Beneficiaries must receive a written NOABD when the County takes any of the actions described above. The County must give beneficiaries timely and adequate notice of an ABD in writing. The NOABD must explain all of the following:

1. The ABD the County has made or intends to make;
2. A clear and concise explanation of the reason(s) for the decision. For determinations based on medical necessity criteria, the notice must include the clinical reasons for the decision. The County shall explicitly state why the beneficiary's condition does not meet medical necessity criteria;
3. A description of the criteria used. This includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in making such determinations;
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 ABD.

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 County must also include the name and direct telephone number or extension of the decision-maker.

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

Timing of the Notice
The County must mail the notice to the beneficiary within the following timeframes:

1. For termination, suspension, or reduction of a previously authorized service, at least 10 days before the date of action; except as permitted under 42 CFR §§ 431.213 and 431.214 or,
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 services, within two business days of the decision.

The County 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, Counties must use DHCS' uniform notice templates, or the electronic equivalent of these templates generated from the County'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 federal regulations. The following is a description of ABDs 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 County denies a request for a service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
2. Denial of payment for a service rendered by a provider
   Use this template when the County denies, in whole or in part, for any reason,[1] a provider's request for payment for a service that has already been delivered to a beneficiary.
3. Modification of requested services
   Use this template when the County modifies or limits a provider's request for a service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services.
4. Termination of a previously authorized service
   Use this template when the County terminates, reduces, or suspends a previously authorized service.
5. Delay in processing authorization of services

[1] Reasons for denials include, but are not limited, denials based on documentation standards

Use this template when there is a delay in processing a provider's request for authorization of perinatal substance use disorder residential services. When the County 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.

6. 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.
7. Dispute of financial liability
   Use this template when the County denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities.
8. Failure to timely resolve grievances and appeals
   Use this template when the County does not meet the required timeframes for the standard resolution of grievances and appeals.

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 NAR. These attachments must be sent to beneficiaries with each NOABD or NAR.

Effective January 1, 2023, Counties shall utilize the revised NOABD templates and corresponding "Your Rights" attachments included in this BHIN, or the electronic equivalents of these templates and attachments generated from the County's Electronic Health Record System. The corresponding "Your Rights" attachments must be included when issuing a NOABD to a beneficiary. Counties 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.

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 County 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 ABD has been upheld;
3. The beneficiary's right to request a State hearing if the County fails to send a resolution notice in response to the appeal within the required timeframe;

4. Procedures for exercising the 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.

C. APPEALS:

The following items address parity requirements pertaining to appeals from beneficiaries. The County shall have in effect, a documented appeals process for its beneficiaries that complies with the following requirements. Under federal regulations, an "Appeal" is a review by the County of an ABD.

Timeframes for Filing

Federal regulations require beneficiaries to file an appeal within 60 calendar days from the date on the NOABD. Counties shall adopt the 60 calendar day timeframe in accordance with the federal regulations. Beneficiaries must also exhaust the County's appeal process prior to requesting a State hearing.

Method of Filing

In accordance with federal regulations, 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. 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. Counties 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. Counties 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 County's website, or providing the form to the beneficiary upon request. Counties shall also advise and assist the beneficiary in requesting the continuation of benefits during an appeal of the ABD in accordance with federal regulations. In the event that the County does not receive a written, signed appeal from the beneficiary, the County shall neither dismiss nor delay the resolution of the appeal.

Authorized Representative

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.

Standard Resolution of Appeals:
Acknowledgement
The County shall provide to the beneficiary with a written acknowledgment 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 County representative who the beneficiary may contact about the appeal. The written acknowledgment to the beneficiary must be postmarked within five calendar days of receipt of the appeal.

Standard Resolution Timeframe
The County shall resolve an appeal within 30 calendar days of receipt of the written or oral appeal, whichever is received first.

Extension of Timeframes
Counties 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 County 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, Counties are required to provide the beneficiary with written notice of the reason for the delay. Federal regulations delineate the following additional requirements that Counties must comply with the following:

1. The County shall make reasonable efforts to provide the beneficiary with prompt oral notice of the extension;
2. The County 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;
3. The County 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,
4. In the event that the County fails to adhere to the notice and timing requirements, the beneficiary is deemed to have exhausted the County's appeal process and may initiate a State hearing.

D. <u>Expedited Resolution of Appeals:</u>
The County must establish and maintain an expedited review process for appeals when the County 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

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 County must resolve the appeal, and provide notice, as expeditiously as the beneficiary's health condition requires, no longer than 72 hours after the County receives the expedited appeal request.

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

1. The County 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 County 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 County 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 written or oral appeal, whichever is received first).

Timeframes for Resolving Expedited Appeals
For expedited resolution of an appeal and notice to the beneficiary and provider, the County shall resolve the appeal within 72 hours from receipt of the appeal. In addition to the other logging requirements delineated in federal regulations, Counties 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. Counties may extend the timeframe for expedited appeals resolution by 14 calendar days in accordance with federal regulations.

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

E. NOTICE OF APPEAL RESOLUTION (NAR):

A NAR is a formal letter informing a beneficiary that an ABD has been overturned or upheld. The NAR templates are included as Enclosures in this BHIN.

Adverse Benefit Determination Upheld
For appeals not resolved wholly in favor of the beneficiary, Counties shall utilize the DHCS template included with this BHIN, or the electronic equivalent of that template generated from the County'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.

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

1. The results of the resolution and the date it was completed;
2. The reasons for the Plan's determination, including the criteria, clinical guidelines, or policies used in reaching the determination;
3. For appeals not resolved wholly in the favor of the beneficiary, the right to request a State hearing and how to request it;
4. 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,
5. Notification that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the Plan's ABD.

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

1. 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,
2. 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).

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

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. Counties shall

also ensure that the written response contains a clear and concise explanation of the reason, including why the decision was overturned. Counties shall utilize the DHCS template packet for appeals, which contains the NAR for overturned decisions. Counties must authorize or provide the disputed services promptly and as expeditiously as the beneficiary's condition requires if the County reverses the decision to deny, limit, or delay services that were not furnished while the appeal was pending. Counties shall authorize or provide services no later than 72 hours from the date and time it reverses the determination.

F. STATE HEARINGS:

The following items address parity requirements pertaining to State hearings. The County shall have in effect, a documented State hearings process for its beneficiaries that complies with the following requirements.

Beneficiaries must exhaust the County'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 County is upholding an ABD.

Deemed Exhaustion of the Appeals Process

If the County fails to adhere to the notice and timing requirements, the beneficiary is deemed to have exhausted the County's appeals process. The enrollee may then initiate a State hearing.

Timeframes for Filing

New federal regulations 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 County. 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 the State hearing include the County, as well as the beneficiary and his or her authorized representative or the representative of a deceased beneficiary's estate.

Standard Hearings

The County 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.[2]

[2] Title 42, CFR, Section 431.244(f)(1)

Expedited Hearings
The County 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.[3]

Overturned Decisions
The County 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 County's adverse benefits determination.

G. LANGUAGE ASSISTANCE, NONDISCRIMINATION NOTICE AND TAGLINES:

The following items address parity requirements pertaining to language assistance, nondiscrimination notice, and taglines. The County shall have in effect, a documented process that complies with the following requirements.

Translation of Notices
Written materials that are critical to obtaining services include, at a minimum, appeal and grievance notices, and denial and termination notices, which must be made available to beneficiaries in threshold languages and alternative formats. This translation requirement includes the individualized information described throughout this BHIN.

Nondiscrimination Notice and Language Assistance Taglines
Section 1557 of the Affordable Care Act 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[4] to implement Section 1557. Federal regulations[5] require Counties to post nondiscrimination notice requirements and language assistance taglines in significant communications to beneficiaries.

DHCS has created sample "Nondiscrimination Notice" and "Language Assistance Tagline" templates that are included as Enclosures in this BHIN. Counties may utilize the templates provided by DHCS, make modifications to the templates, or create new templates. If modifications or new templates are created, DHCS shall review and approve the modified templates prior to County's use.

[3] Title 42, CFR, Section 431.244(f)(2)
[4] 81 FR 31375
[5] Title 45, CFR, Section 92.8

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.

H. GRIEVANCE AND APPEAL SYSTEM OVERSIGHT:

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

1. The County shall have, and operate in accordance with, written policies and procedures regarding its grievance and appeal system.
2. The County shall notify beneficiaries about its Grievance and Appeal System and shall include information on the County's procedures for filing and resolving grievances and appeals, a toll-free telephone number or a local telephone number, and the address for mailing grievances and appeals.
3. The County shall inform 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, must be available at all provider sites so that beneficiaries can access without making a verbal or written request to anyone. A description of the procedure for filing grievances and appeals shall be readily available to all DMC-certified providers, on the County's website, and at each contracting provider's office or facility, posted in a location that is accessible to beneficiaries. The County shall ensure that assistance in filing grievances and appeals will be provided at each location where grievances and appeals are submitted. Grievance and appeal forms shall be provided promptly upon request.
4. The County shall ensure adequate and appropriate consideration of grievances and appeals, as well as rectification when appropriate. If the beneficiary presents multiple issues, the County shall ensure that each issue is addressed and resolved.
5. The County shall maintain a written record for each grievance and appeal received by the County. DHCS reserves the right to request any data reporting pertaining to filed grievances and appeals. The record of each grievance and appeal shall be maintained in a log and include the following information:

    a. The date and time of receipt of the grievance or appeal;
    b. The name of the beneficiary filing the grievance or appeal;
    c. The name of the representative recording the grievance or appeal;
    d. A description of the complaint or problem;

e. A description of the action taken by the County or provider to investigate and resolve the grievance or appeal;
f. The proposed resolution by the County or provider;
g. The name of the County provider or staff responsible for resolving the grievance or appeal; and
h. The date of notification to the beneficiary of the resolution.

6. The written record of grievances and appeals shall be submitted at least quarterly to the County'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.
7. The County shall ensure decision-making by individuals with authority to require corrective action.
8. The County shall address the linguistic and cultural needs of its beneficiary population, as well as the needs of beneficiaries with disabilities. The County 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 County responses to grievances and appeals, as well as access to interpreters, telephone relay systems, and other devices that aid individuals with disabilities to communicate.
9. The County shall ensure that there is no discrimination against a beneficiary because the beneficiary filed a grievance or appeal.
10. The County shall ensure that the person making the final decision for the proposed resolution of a grievance or appeal has not participated in any prior decisions related to the grievance or appeal. 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:

    a. An appeal of an ABD that is based on lack of medical necessity;
    b. A grievance regarding the denial of an expedited resolution of an appeal; or
    c. Any grievance or appeal involving clinical issues.

11. The County shall ensure that individuals making decisions on clinical appeals take into account all comments, documents, records, and other information submitted by the beneficiary or beneficiary's authorized representative, regardless of whether such information was submitted or considered in the initial ABD.

12. The County 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 County in connection with any standard or expedited appeal of an ABD. This information must be provided free of charge and sufficiently in advance of the resolution timeframe.
13. The County shall provide the beneficiary or authorized representative a reasonable opportunity, in person and in writing, to present evidence and testimony. The County 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.

I. SERVICE ACCESS REQUIREMENTS:

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

Provider Directory

1. The County shall make available in electronic form and, upon request, in paper form, the following information about its DMC-certified providers:
    a. The provider's name and group affiliation (if any)
    b. Provider's business address(es) (e.g., physical location of the clinic or office)
    c. Telephone number(s)
    d. Email address(es), as appropriate
    e. Website URL, as appropriate
    f. Specialty, in terms of training, experience and specialization, including board certification (if any)
    g. Services/modalities provided, including information about populations served
    h. Whether the provider accepts new beneficiaries
    i. The provider's cultural capabilities (e.g., veterans, older adults, Transition Age Youth, Lesbian, Gay, Bisexual, Transgender)
    j. The provider's linguistic capabilities including languages offered (e.g., Spanish, Tagalog, American Sign Language) by the provider or a skilled medical interpreter at the provider's office
    k. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment
    l. In addition to the information listed above, the provider directory must also include the following information for each rendering provider:

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

2. The County shall include the following provider types covered under this Agreement in the provider directory:
    a. Physicians, including specialists
    b. Hospitals
    c. Pharmacies
    d. Behavioral health providers

3. The provider directory shall include a statement that affirms a DMC county beneficiary's right to obtain covered services from any enrolled and DMC certified provider, even if that provider is not listed in the provider directory.[6]
4. Information included in a paper provider directory shall be updated at least monthly and electronic provider directories shall be updated no later than 30 calendar days after the County receives updated provider information.
5. Provider directories shall be made available on the County's website in a machine-readable file and format as specified by the Secretary of Health and Human Services.

J. TIMELY ACCESS

In order to ensure that DMC beneficiaries have the same access to SUD services as beneficiaries receiving care through a managed care or PIHP delivery system, DMC Counties shall comply with California's timely access standards. Welfare & Institutions Code section 14197, subdivision (d), sets forth timely access standards and requires compliance with the appointment time standards set forth in Health & Safety Code section 1367.03 and Title 28, California Code of Regulations, section 1300.67.2.2. The specific appointment time standards for which DHCS is currently collecting data are detailed in the Timely Access Data Tool (TADT) Attachment D.3, and are referenced in the table below.

[6] Consistent with 42 CFR Part 2 § 431.51 subd. (a)(1) and Section 1902(a)(23) of the Social Security Act and Exhibit A, Attachment 1 of the Drug Medi-Cal contract, DMC counties do not operate closed networks. Beneficiaries are not limited to only those providers included in the county's current directory and may access covered services from other enrolled and certified providers who enter into agreements with the county for reimbursement.

Timely Access Standards	
Modality Type	**Standard**
Outpatient Services – Substance Use Disorder Services	Offered an appointment within 10 business days of request for services
Residential	Offered an appointment within 10 business days of request for services
Narcotic Treatment Program (NTP)[1]	Offered an appointment within 3 business days of request for services
[1] For NTP patients, the NTP standards apply equally to both buprenorphine and methadone where applicable. Buprenorphine is not specified in several areas of the current regulations so we default to the federal regulations. (For example, with take home medication, time in treatment requirements are not applicable to buprenorphine patients.) 28 CCR § 1300.67.2.2, subd. (b)(7)	

Timely Access Data Tool (TADT)
To ensure that Counties provide timely access to services, DHCS requires Counties to have a system in place for tracking and measuring timeliness of care, which includes timeliness to receiving the first appointment for Outpatient or NTP services. For this purpose, DHCS developed the TADT, a uniform data collection tool that is included as Enclosures in this BHIN. Counties are required to submit timeliness data as part of the DMC State Plan Annual Certification.

Counties' Reporting Requirement
Counties must use the TADT to submit timely access data for new beneficiaries who request services during the reporting period, and are required to report the following timely access data elements:

1. Client Identification Number
2. Date of First Contact to Request Services
3. Assessment Appointment First Offer Date
4. Assessment Appointment Second Offer Date
5. Assessment Appointment Third Offer Date
6. Assessment Appointment Accepted Date
7. Assessment Start Date
8. Assessment End Date
9. Treatment Appointment First Offer Date

10. Treatment Appointment Second Offer Date
11. Treatment Appointment Third Offer Date
12. Treatment Appointment Accepted Date
13. Treatment Start Date
14. Closure Reason
15. Close out Date
16. Referred to

Reporting Period: February 1, 2023, through April 30, 2023. The data submitted for the reporting period will be used to determine compliance for the certification period.

Counties will not be placed on a Corrective Action Plan (CAP) for timely access standards for the FY 2023-2024 DMC State Plan Annual Certification. However, they will receive findings from DHCS regarding the percentage of requests meeting the standard. Counties that do not meet the timely access standard will receive technical assistance accompanying their findings. Compliance monitoring for Counties' Timely Access standards will commence in FY 2024-2025.

Methodology for Determining Counties Compliance with Timely Access Standards
DHCS requests that Counties submit data for all new beneficiaries that are requesting outpatient, perinatal residential, and NTP services. The definition of what constitutes a new beneficiary is at the discretion of the Counties. The data will be used to determine the timeliness in accordance with timely access standards.

DHCS calculates compliance using the Date of First Contact to Request Services and the number of days between that date and the Assessment Appointment First Offer Date, wherein, 80% of beneficiaries must have been offered an appointment within the appropriate standard (for example, when a client calls on the 1st of the month and is offered an appointment on the 11th of the month, the client was offered an appointment within 10 days).

Furthermore, if Counties are found to not meet timely access standards and available providers are unable to provide timely access to necessary services, Counties must adequately and timely cover these services for the beneficiary.

K. PROVIDER CREDENTIALING AND RE-CREDENTIALING:

The Parity Rule requires the State to establish a uniform credentialing and re-credentialing policy that addresses DMC-certified providers. The County shall establish a credentialing and re-credentialing process.

For all licensed, waivered, registered, and/or certified providers[7], the County must verify and document the following items through a primary source,[8] as applicable. The listed requirements are not applicable to all provider types. When applicable to the provider type, the information must be verified by the County unless the County can demonstrate the required information has been previously verified by the applicable licensing, certification, and/or registration board.

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

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

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

[7] For SUD, providers delivering covered services are defined in Title 22 of the California Code of Regulations, Section 51051.
[8] "Primary source" refers to an entity, such as a state licensing agency, with legal responsibility for originating a document and ensuring the accuracy of the document's information.

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

1. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
2. A history of loss of license or felony conviction;
3. A history of loss or limitation of privileges or disciplinary activity;
4. A lack of present illegal drug use; and
5. The application's accuracy and completeness.

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

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

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

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

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

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

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

Sincerely,

Original signed by

Ivan Bhardwaj, Acting Chief
Medi-Cal Behavioral Health Division

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