COUNTY OF YOLO

HEALTH AND HUMAN SERVICES AGENCY

POLICIES AND PROCEDURES

SECTION 5, CHAPTER 9, POLICY 016

NOTICES OF ADVERSE BENEFIT DETERMINATION, APPEALS, AND STATE HEARINGS

POLICY NUMBER:	5-9-016
SYSTEM OF CARE:	BEHAVIORAL HEALTH
FINALIZED DATE:	03.22.2021
EFFECTIVE:	07.01.2020
SUPERSEDES # :	Supersedes Policy #'s: 6-9-003 Beneficiary Appeal and State Fair Hearing Procedure 6-9-004 Beneficiary Expedited Appeal and State Fair Hearing 6-9-005 Grievance and Appeal Recordkeeping Policy 6-9-006 Notice of Adverse Beneficiary Determination Policy 5-9-003 Beneficiary Appeal and State Fair Hearing Procedure 5-9-004 Beneficiary Expedited Appeal and State Fair Hearing 5-9-005 Grievance and Appeal Recordkeeping Policy Executed 5-9-006 Notice of Adverse Beneficiary Determination Executed 5-9-011 Request for Second Opinion Executed PP 306 Request for Second Opinion (10-16-08) PP 503 Notices of Action PP 1100 Beneficiary Protection Problem Resolution Process (12-22-08)

A. PURPOSE: To establish a uniform policy to ensure that Yolo County Health and Human Services (HHSA) Behavioral Health (BH) Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Substance Use Disorder (SUD) Service providers are in compliance with State and Federal regulatory requirements regarding Notices of Adverse Benefit Determination (NOABD), beneficiary Appeals and State Hearing processes.

B. RELATED DOCUMENTS:

1. Denial Notice (NOABD)
2. Payment Denial Notice (NOABD)
3. Delivery System Notice (NOABD)
4. Modification Notice (NOABD)
5. Termination Notice (NOABD)
6. Timely Access Notice (NOABD)
7. Financial Liability Notice (NOABD)
8. NOABD Your Rights Attachment
9. Language Assistance Taglines
10. Beneficiary Non- Discrimination Notice
11. Action Appeal Form
12. Adverse Benefit Determination Upheld (NAR)
13. Adverse Benefit Determination Overturned (NAR)
14. NAR Your Rights Attachment
15. Authorization Delay Notice
16. NOABD Grievance and Appeal Timely Resolution Notice

C. DEFINITIONS:

1. **Administrator**: Yolo County HHSA BH is the administrator of the Mental Health Plan (MHP) and Drug Medi-Cal Organized Delivery System (DMC-ODS) Plan, hereby referred to as the "Administrator".

2. **Network Providers:** Any provider, group of providers, or entity that has a network provider agreement with the Administrator and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the contract (Title 42 Code of Federal Regulations [42 CFR] § 438.2)

3. **Notice of Adverse Beneficiary Determination (NOABD):** The Final Rule replaced the term "Action" with "Adverse Benefit Determination". 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.

4. **Appeal:** A review by the Administrator or Network Provider of an Adverse Benefit Determination.

5. **Expedited Appeal:** An expedited appeals process where there is an immediate need for health services because a standard appeal could jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function. This determination is made after a beneficiary requests or a provider indicates (in making the request on

beneficiary's behalf or in support of the beneficiary's request) a need for expedited appeal (45 CFR § 155.540).

6. **Authorized Representative:** An individual or provider, with written consent by the beneficiary, assisting with requesting an appeal or State hearing on behalf of the beneficiary. Providers and authorized representatives cannot request continuation of benefits, as specified in 42 CFR Section 438.420(b)(5).

7. **State Hearing:** Part of the appeal process available to Medi-Cal beneficiaries who have concerns about DMC-ODS or Medi-Cal SMHS. A beneficiary does not have access to the State Fair Hearing process until the appeal process has been exhausted.

D. POLICY: The Administrator and its Network Providers' shall ensure eligible beneficiaries have adequate information about adverse benefit determination, appeals, expedited appeals and state fair hearings systems and processes, and provide any written materials that are critical to obtaining services including, at a minimum, appeal notices, denials and termination notices. These materials shall be made available to beneficiaries in threshold languages and alternative formats in accordance with state, federal and Yolo County HHSA policies. Additionally, Network Providers shall adhere to any further requirements outlined within their contracts with Yolo County HHSA BH.

1. **Notice of Adverse Benefit Determinations (NOABDs):** An Adverse Benefit Determination or NOABD shall be provided to a beneficiary when there is a:
    a. 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;

    b. Reduction, suspension, or termination of a previously authorized service;

    c. Denial, in whole or in part, of payment for a service;

    d. Failure to provide services in a timely manner;

    e. Failure to act within the required timeframes for standard resolution of grievances and appeals; or

    f. Denial of a beneficiary's request to dispute financial liability.

2. **Written NOABD Templates:** In accordance with federal requirements, the Administrator and Network Providers shall use the Department of Health Care Services (DHCS) uniform notice templates, or the electronic equivalent of these templates generated from an 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. No changes shall be made to any of the templates or attachments without prior review and approval from DHCS, except to insert information specific to beneficiaries as required**.** Network provider NOABD logs and associated records shall be made available to the Administrator and DHCS upon request or as defined in the provider's contract.

3. **NOABD "Your Rights":** 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 (NAR). These attachments shall be sent to beneficiaries with each NOABD or NAR issued.

4. **Appeals:** The Administrator shall have an appeal system in place for beneficiaries. (42 C.F.R. §§ 438.228(a), 438.402(a); Cal. Code Regs., tit. 9, § 1850.205; MHSUDS IN No. 18-101E). The appeal system shall be implemented to handle appeals of adverse benefit determinations and grievances, and shall include processes to collect and track information about them. The Administrators beneficiary problem resolution processes shall include:
    a. A grievance process;
    b. An appeal process; and,
    c. An expedited appeal process. (MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9, § 1850.205(b)(1)- (b)(3).)

    In accordance with federal regulations, a beneficiary, or a provider and/or authorized representative, may request an appeal or expedited 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 shall establish the filing date for the appeal so that the earliest possible filing date is established. In the event that a written, signed appeal is not received from the beneficiary, the appeal shall neither be dismissed nor delayed for any resolution of the appeal. Network provider shall notify Yolo County HHSA BH Quality Management (QM) regarding any appeals and/or expedited appeal requests received. Any logs and associated records shall be made available to the Administrator and DHCS upon request.

    The Administrator or Network Provider 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. Beneficiaries shall be assisted 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 Administrator's website or providing the form to the beneficiary upon request. The Administrator and Network Providers 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.

A beneficiary shall have 60 calendar days from the date on the NOABD to file an appeal in accordance with federal regulations. Beneficiaries shall exhaust the Administrator's appeal process prior to requesting a State hearing.

5. **Expedited Appeals:** The Administrator shall establish and maintain an expedited review process for appeals when a determination (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 Administrator shall resolve the appeal, and provide notice, as expeditiously as the beneficiary's health condition requires. For expedited resolution of an appeal and notice to the beneficiary and any affected parties, the Administrator shall follow federal regulation, that requires the appeal to be resolved within 72 hours from receipt of the appeal.

6. **Appeal System Oversight:** The Administrator shall establish, implement, and maintain an appeal system to ensure the receipt, review, and resolution of appeals. The appeal system shall operate in accordance with all applicable federal regulations and DHCS contract requirements, and shall include at minimum, the following:
    a. The Administrator shall have, and operate in accordance with, written policies and procedures regarding its appeal system.

    b. The Administrator shall notify beneficiaries about its Appeal System and shall include information on the procedures for filing and resolving appeals, a toll-free telephone number or a local telephone number, and the address for mailing appeals.

    c. The Administrator shall inform beneficiaries of the process for obtaining appeals forms. The forms that may be used to file appeals and expedited appeals, and self-addressed envelopes, that beneficiaries can access without making a verbal or written request to anyone shall be available at all provider sites.

    d. The Administrator shall ensure adequate and appropriate consideration of appeals, as well as rectification when appropriate. If the beneficiary presents

multiple issues, the Administrator shall ensure that each issue is addressed and resolved.

e. The Administrators shall maintain a written record for each appeal received within one (1) working day of the date of receipt of the appeal or expedited appeal. The record of each appeal shall be maintained in a log and include the following information:
    i. The date and time of receipt of the appeal;
    ii. The name of the beneficiary filing the appeal;
    iii. The name of the representative recording the appeal;
    iv. A description of the complaint or problem;
    v. A description of the action taken;
    vi. Investigate and resolve the appeal;
    vii. The proposed resolution by the Administrator;
    viii. The name of the Administrator staff responsible for resolving the appeal; and
    ix. The date of notification to the beneficiary of the resolution.

f. The written record of appeals shall be submitted at least quarterly to the Administrators quality improvement committee for systematic aggregation and analysis for quality improvement. 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.

g. The Administrator shall ensure decision-making by individuals with authority to require corrective action and shall ensure that decision makers on appeals of adverse benefit determinations were not involved in any previous level of review or decision-making, and were not subordinates of any individual who was involved in a previous level of review or decision-making. (MHP Contract, Ex. A, Att. 12; 42 C.F.R. § 438.406(b)(2)(i); 42 C.F.R. § 438.228(a).)

h. The Administrator shall address the linguistic and cultural needs of its beneficiary population, as well as the needs of beneficiaries with disabilities. The Administrator shall ensure all beneficiaries have access to and can fully participate in the 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 appeal procedures, forms, and responses to appeals, as well as access to interpreters, telephone relay systems and other devices that aid individuals with disabilities to communicate.

i. The Administrator shall not subject a beneficiary or any party filing on behalf of a beneficiary to discrimination or any other penalty/punitive action for filing

or supporting an appeal or expedited appeal. (MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9,§ 1850.205(c)(5).)

j. The Administrator shall maintain the confidentiality of each beneficiary's information for beneficiary problem resolution. (MHP Contract, Ex. A, Att. 12; Cal. Code Regs., tit. 9, § 1850.205(c)(6).)

k. The Administrator shall ensure that the person making the final decision for the proposed resolution of an appeal has not participated in any prior decisions related to the appeal. Additionally, the decision-maker shall be a health care professional with clinical expertise, as determined by DHCS, in treating a beneficiary's condition or disease if any of the following apply:
    i. An appeal of an Adverse Benefit Determination that is based on lack of medical necessity;
    ii. A grievance regarding denial of an expedited resolution of an appeal; or
    iii. appeal involving clinical issues.

l. The Administrator 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 Adverse Benefit Determination.

m. The Administrator 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 Administrator in connection with any standard or expedited appeal of an Adverse Benefit Determination provided that there is no disclosure of the protected health information of any individual other than the beneficiary (42 C.F.R. § 438.406(b)(5).). This information shall be provided free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions.

n. The Administrator shall provide the beneficiary or authorized representative a reasonable opportunity, in person and in writing, to present evidence and testimony and make arguments of fact or law, in person and in writing for any appeals or expedited appeals.

o. The Administrator shall 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.

p. The Administrator will allow the beneficiary, his or her representative, or the legal representative of a deceased beneficiary's estate, to be included as parties to the appeal.

7. **State Hearings:** Beneficiaries shall exhaust the appeal process prior to requesting a State hearing. A beneficiary has the right to request a State hearing only after receiving notice that the Administrator is upholding an adverse benefit determination. For standard hearings, the Administrator shall notify beneficiaries that the State shall reach its decision on the hearing within 90 calendar days of the date of the request for the hearing. For expedited hearings, the Administrator shall notify beneficiaries that the State shall reach its decision on the state fair hearing within three (3) working days of the date of the request for the hearing.

8. **Continuation of Services:** The Administrator and Network Providers shall continue the beneficiary's benefits if all of the following occur:
    a. The beneficiary files the request of an appeal timely in accordance with 42 C.F.R. § 438.402(c)(1)(ii) and (c)(2)(ii);

    b. The appeal involves the termination, suspension, or reduction of previously authorized services;

    c. The services were ordered by an authorized provider;

    d. The period covered by the original authorization has not expired; and,

    e. The beneficiary timely files for continuation of benefits. (42 C.F.R. § 438.420(b).)

    If, at the beneficiary's request, the Administrator continues or reinstates the beneficiary's benefits while the appeal or State Hearing is pending, the benefits shall be continued until one of the following occurs:
    a. The beneficiary withdraws the appeal or request for a State Hearing;

    b. The beneficiary fails to request a State Hearing and continuation of benefits within 10 calendar days after the MHP sends the notice of adverse resolution (i.e., NAR) to the beneficiary's appeal;

    c. A State Hearing office issues a hearing decision adverse to the beneficiary.(42 C.F.R. § 438.420(c).)

E. PROCEDURE:

1. **Notices of Adverse Benefit Determinations:** Upon determination that a NOABD should be issued to a beneficiary, the following shall be completed:
    a. Beneficiaries must receive a written NOABD, using DHCS approved templates, when the Administrators determines a NOABD is warranted. Beneficiaries shall receive a timely and adequate notice of an adverse benefit determination

in writing, consistent with the requirements in 42 CFR §438.10. The federal regulations delineate the requirements for content of the NOABDs. The NOABD must explain all of the following:

i. The adverse benefit determination the Provider has made or intends to make;
ii. A clear and concise explanation of the reason(s) for the decision;
iii. For determinations based on medical necessity criteria, the notice must include the clinical reasons for the decision. The Provider shall explicitly state why the beneficiary's condition does not meet SMHS and/or DMC-ODS medical necessity criteria;
iv. The right of the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits. (42 C.F.R. § 438.404(b)(2)).
v. The beneficiary's right to file, and the procedures for exercising, an appeal or an expedited appeal with the MHP, including information about exhausting the MHPs one level of appeal and the right to request a State fair hearing after receiving notice that the adverse benefit determination is upheld. (42 C.F.R. § 438.404(b)(3)- (b)(4))
vi. The circumstances under which an appeal process can be expedited and how to request it. (42 C.F.R. § 438.404(b)(5)).
vii. The beneficiary's right to have benefits continue pending resolution of the appeal and how to request that benefits be continued, and the circumstances under which a beneficiary may be required to pay the costs of those services. (42 C.F.R. § 438.404(b)(6))(MHSUDS IN No. 18-010E).

b. In addition, decisions shall be communicated initially by telephone or facsimile, and then in writing, except for decisions rendered retrospectively. For written notification, the Issuing Provider shall include the name and direct telephone number or extension of the decision-maker. If the Issuing Provider can substantiate through documentation that effective processes are in place 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 ongoing oversight shall be conducted to monitor the effectiveness of this process.

c. All written notification should include:
    i. A NOABD letter developed from the appropriate template
    ii. NOABD "Your Rights" Attachment

iii. Nondiscrimination Notice
iv. Language Assistance Taglines

d. All NOABD's shall be tracked in a log and shall be made available to Yolo County HHSA BH QM at a minimum quarterly or upon request.

2. **NOABD Templates and Timeframes:** Beneficiaries shall be provided adequate notice of an adverse benefit determination in writing within the following timelines:
   a. For termination, suspension, or reduction of a previously authorized SMHS and/or DMC-ODS service: at least 10 days before the date of action, except as permitted under 42 CFR §§ 431.213 and 431.214;

   b. For denial of payment: at the time of any action denying the provider's claim;

   c. For decisions resulting in denial, delay, or modification of all or part of the requested SMHS and/or DMC-ODS services: within two (2) business days of the decision.

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

   e. 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:
      i. **Denial of authorization for requested services:** Use this template when a request for a service is denied. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. DMC-ODS Residential Network Providers should use this template for denied DMC-ODS residential service requests.
      ii. **Denial of payment for a service rendered by provider:** Use this template when a service is denied, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a beneficiary.
      iii. **Delivery system**: Use this template when there is a determination that the beneficiary does not meet the criteria to be eligible for SMHS or SUD services. The beneficiary shall be referred to the Managed Care Plan, or other appropriate system, for mental health, substance use disorder, or other services.
      iv. **Modification of requested services:** Use this template when requested services will be modified or limited including reductions in frequency and/or duration of services, and approval of alternative treatments and services.

v. **Termination of a previously authorized service**: Use this template when the services will be/are terminated, reduced, or suspended for a previously authorized service.

vi. **Delay in processing authorization of services**: Use this template when there is a delay in processing a provider's request for authorization of SMHS or SUD residential services. When a timeframe is extended 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.

vii. **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.

viii. **Dispute of financial liability**: Use this template when a beneficiary's request to dispute financial liability is denied, including cost-sharing and other beneficiary financial liabilities.

ix. **Failure to timely resolve grievances and appeals:** Use this template when required timeframes for the standard resolution of grievances and appeals are not met.

x. **Nondiscrimination Notice:** Use this template to provide beneficiaries information regarding Section 1557 of the Affordable Care ACT (ACA) which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability.

xi. **Language Assistance Taglines:** Use this template provide beneficiaries information regarding Section 1557 of the Affordable Care ACT (ACA) which provides a Language Tagline for threshold languages in California.

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

   a. The beneficiary's or provider's right to request an internal appeal with Administrator within 60 calendar days from the date on the NOABD;

   b. The beneficiary's right to request a State hearing only after filing an appeal with the Administrator and receiving a notice that the Adverse Benefit Determination has been upheld;

   c. The beneficiary's right to request a State hearing if the Administrator fails to send a resolution notice in response to the appeal within the required timeframe;

d. Procedures for exercising the beneficiary's rights to request an appeal;

e. Circumstances under which an expedited review is available and how to request it; and,

f. 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.

4. **Second Opinion:**
   a. At the request of the beneficiary, when the Administrator or its Network Provider has determined that the beneficiary is not entitled to SMHS or SUD services due to not meeting the medical necessity criteria, the Administrator shall provide for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse). (MHP Contract, Ex. A, Att.2; CCR, title 9, § 1810.405(e)).

   b. The Administrator may provide a second opinion from a network provider, or arrange for the beneficiary to obtain a second opinion outside the network at no cost to the beneficiary. (MHP Contract, Ex. A, Att.2; 42 C.F.R. § 438.206(b)).

5. **Appeals:** Adequate information about procedures for filing and resolving appeals, a toll-free telephone number or a local telephone number, and the address for mailing appeals shall be provided to beneficiaries upon access or request. The Administrator and Network Providers shall take, at minimum, the following actions:
   a. Include information describing the appeal / expedited appeal processes in the beneficiary handbook, which shall be provided to beneficiaries.

   b. Post notices explaining the appeal and expedited appeal process and procedures in locations at all offices or facilities owned or operated by the Administrator or Network Provider at which beneficiaries may obtain SMHS or SUD services. Notices shall be sufficient to ensure that the information is readily available to both beneficiaries and provider staff.

   c. Make forms available that may be used to file appeals and self-addressed envelopes that beneficiaries can access at all Administrator and Network Provider site locations without having to make a verbal or written request to anyone.

   d. Give beneficiaries reasonable assistance in completing the appeal form and in taking any procedural steps towards filing the appeal or requesting a state fair hearing, including but not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

e. At the request of the beneficiary, the Administrator and its network providers shall identify staff or another individual, such as a legal guardian, to be responsible for assisting a beneficiary with these processes, including providing assistance in writing the appeal.

f. The Administrator and its Network Providers shall allow a beneficiary, provider, or authorized representative, acting on behalf of the beneficiary and with the beneficiary's written consent to file an appeal or request a state fair hearing. The Administrator shall have only one level of appeal for beneficiaries, therefore Network Providers shall notify Yolo County HHSA BH Quality Management (QM) within one (1) business day following receipt of a request for an appeal or expedited appeal.

g. Provide a staff person or other individual with responsibility to provide information requested by the beneficiary or the beneficiary's representative regarding the status of the beneficiary's appeal.

h. Identify the roles and responsibilities of the Administrator, the provider, and the beneficiary in the appeal documentation.

i. Make written materials that are critical to obtaining services, including appeal notices, available in the prevalent non-English languages in the county.

6. **Appeal Acknowledgement:** The Administrator shall provide to the beneficiary written acknowledgement of receipt of an appeal or expedited appeal. The written acknowledgement to the beneficiary shall be postmarked within five (5) calendar days of receipt of the appeal. The acknowledgment letter shall include:
   i. The date of receipt;

   ii. The name, telephone number, and address of the representative who the beneficiary may contact about the appeal.

7. **Standard Resolution of Appeals:**
   a. Appeals shall be resolved as expeditiously as the beneficiary's health condition requires, within 30 calendar days, in accordance with federal regulations (Title 42, CFR, Section 438.408(b)(2)).

   b. Resolution timeframes for appeals may be extended by up to 14 calendar days if either of the following two conditions apply:
      i. The beneficiary requests the extension; or,
      ii. The Administrator 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.

c. For any extension not requested by the beneficiary, the Administrator shall provide the beneficiary with written notice of the reason for the delay. New federal regulations delineate the following:
    i. The Administrator shall make reasonable efforts to provide the beneficiary with prompt oral notice of the extension;
    ii. The Administrator shall provide written notice of the extension within two (2) 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;
    iii. The Administrator 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,
    iv. In the event that the Administrator fails to adhere to the notice and timing requirements, the beneficiary is deemed to have exhausted the appeal process and may initiate a State hearing.

d. If a request for an expedited resolution of an appeal is denied, the timeframes shall follow the standard resolution timeframe outlined above. In addition, the Administrator shall:
    i. make reasonable efforts to provide the beneficiary with prompt oral notice of the decision to transfer the appeal to the timeframe for standard resolution;
    ii. provide written notice of the decision to transfer the appeal to the timeframe for standard resolution within two (2) calendar days of making the decision and notify the beneficiary of the right to file a grievance if the beneficiary disagrees with the extension; and
    iii. 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).

e. The Administrator shall provide notice, in writing, to any provider identified by the beneficiary or involved in appeal, or expedited appeal of the final disposition of the beneficiary's appeal, or expedited appeal. (Cal. Code Regs., tit. 9, § 1850.205(d)(6).)

f. In addition to the other logging requirements delineated in federal regulations, for expedited appeals the time and date of appeal receipt shall be logged. The timeframe for expedited appeals resolution may be extended by 14 calendar days in accordance with federal regulations.

g. In addition to the written NAR, the Administrator shall make reasonable efforts to provide prompt oral notice to the beneficiary of the resolution.

8. **Notice of Appeal Resolution (NAR):** Upon resolution of an appeal, the Administrator shall issue a NAR to beneficiaries. The written NAR shall include:
    a. The results of the resolution and the date it was completed:

    b. The reasons for the determination, including the criteria, clinical guidelines, or policies used in reaching the determination;

    c. For appeals not resolved wholly in the favor of the beneficiary, the right to request a State hearing and how to request it;

    d. For appeals not resolved wholly in the favor of the beneficiary, the right to request and receive benefits while the hearing is pending and how to make the request; and,

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

    f. Notification that the beneficiary may be held liable for the cost of those benefits if the hearing decision upholds the adverse benefit determination.

    g. The Administrator shall authorize or provide the disputed services promptly and as expeditiously as the beneficiary's condition requires if the NAR resulted in favor of the beneficiary. Services shall be authorized or provided no later than 72 hours from the date and time the determination was reversed.

9. **NAR "Your Rights" Attachment:** The appropriate NAR form and attachments shall be provided to notify beneficiaries of their rights. 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 written appeal resolution and instructions on how to request a State hearing; and,

    b. The beneficiary's right to request and receive continuation of benefits while the State hearing is pending and instructions on how to request continuation of benefits, including the timeframe in which the request shall be made (i.e., within ten days from the date the letter was post-marked or delivered to the beneficiary) in accordance with Title 42, CFR, Section 438.420.

10. <u>State Hearings:</u>

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

b. A beneficiary may request a State hearing with the California Department of Social Services, State Hearings Division within 120 calendar days from the date of the NAR, which informs the beneficiary that the Adverse Benefit Decision has been upheld.

c. The Administrator shall check the CA Department of Social Services Appeals Case Management System daily in order to determine if any State Hearings have been filed which involve a Yolo County beneficiary.

d. Upon completion of a State hearing, if a decision is overturned, the Administrator 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 adverse benefit determination.

F. REFERENCES:

1. DHCS MHSUDS INFORMATION NOTICE 18-010E
2. 9 CCR § 1810.440
3. 9 CCR § 1850.205
4. 42 C.F.R § 438.402
5. 42 C.F.R § 438.406
6. 42 C.F.R. § 438.408
7. 42 C.F.R. § 438.410

Approved by:

Karen Larsen

3/24/2021

Karen Larsen, Director **Date**
Yolo County Health and Human Services Agency