F. Member Rights, Grievance and Appeals

San Diego County Behavioral Health Services is committed to honoring the rights of every member to have access to a fair, impartial, effective process through which the member can seek resolution of a grievance or adverse benefit determination by the BHP. All county operated and contracted providers are required to participate fully in the Member Grievance and Appeal Process. Providers shall comply with all aspects of the process.

According to Title 9 and 42 CFR 438.1000, the BHP is responsible for ensuring compliance with member rights and protections. The BHP, operating from a shared concern with providers about improving the quality of care and experience of members, will monitor feedback from the grievance/appeal process to identify potential deficiencies and take actions for continuous improvement. Data is collected, analyzed and shared with the BHS System of Care and stakeholders through system-wide meetings and councils

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

- *Easily understandable information*- Each managed care enrollee is guaranteed the right to receive all enrollment notices, information materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood.

- *Dignity, respect, and privacy*- Each managed care enrollee is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.

- *Receive information on the managed care plan and available treatment options*. Each managed care enrollee is guaranteed the right to receive information on the managed care plan and its benefits, enrollee rights and protections, and emergency care, as well as available treatment options and alternatives. The information should be presented in a manner appropriate to the enrollee's condition and ability to understand.

- *Participate in decisions*. Each managed care enrollee is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.

- *Free from restraint or seclusion*. Each managed care enrollee is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in federal regulation on the use of restraints and seclusion.

- *Copy of medical records*. Each managed care enrollee is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR, 164.524 and 164.526.

- *Right to health care services*. Each enrollee has the right to be furnished health care services in accordance with CFR, Title 42, Sections 438.206-210.

- *Free exercise of rights*. Each managed care enrollee is guaranteed the right to free exercise of his/her rights in such a way that those rights do not adversely affect the way the BHP and its providers treat the enrollee.

More information about Beneficiary Materials and Processes can be found on the Optum Website> *Beneficiary* tab.

Definitions (Title 42 CFR § 438.400 (b)

- The Grievance and Appeal System includes the processes the County and providers implement to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them

- A Grievance means an expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Grievances may include, but are not limited to, the quality of care of services provided, aspects of interpersonal relationships (i.e. rudeness of a provider or employee), failure to respect the rights of the member, and the member's right to dispute an extension of time proposed by the Plan to make an authorization decision.

    - There is no distinction between an informal and formal grievance. A complaint is the same as a grievance- a compliant shall be considered a grievance unless it meets the definition of an "Adverse Benefit Determination".

- An Inquiry is a request for information that does not include expression of dissatisfaction. Inquiries may include questions pertaining to eligibility, benefits, or other fee-for-service- processes. If the Plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

- A Discrimination Grievance-is filed when a member believes they have been unlawfully discriminated against. Discrimination Grievance posters can be found

in the Beneficiary Handbook and printed for posting. The member has a right to file a Discrimination Grievance with the county Plan, the Department's Office of Civil Rights, and the United States Department of Health and Human Services, Office for Civil Rights. San Diego County complies with all State and Federal civil rights laws. (45 CFR §§ 92.7 and 92.8; WIC§14029.91).

- A Grievance Exemption is a grievance received over the telephone or in-person by the Plan, or a network provider of the Plan, that are resolved to the beneficiary's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written acknowledgment and disposition letter. Grievances received via mail by the Plan, or a network provider of the Plan, are not exempt from the requirement to send an acknowledgment and disposition letter in writing. If a Plan or a network provider of the Plan receives a complaint pertaining to an Adverse Benefit Determination, as defined under 42 CFR Section 438.400, the complaint is not considered a grievance, and the exemption does not apply.

- An Appeal is a review of an adverse benefit determination or "action" which may include:

    - Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medically necessary specialty mental health services, appropriateness, setting, or effectiveness of a covered benefit.

    - Reduction, suspension, or termination of a previously authorized service.

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

    - Failure act within the timeframes regarding the standard resolution of grievances and appeals.

    - Failure to provide services in a timely manner.

    - Denial of a member's request to dispute financial liability.

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

Authorized Representatives

With written consent of the member, a provider or authorized representative may file a grievance, request an appeal, or request a State hearing on behalf of the

beneficiary. Providers and authorized representatives cannot request continuation of benefits, as specified in 42 CFR §438.420(b)(5).

Advocacy Services and Records Requests

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

There are mandated timelines for grievances and appeals. Providers' quick and efficient cooperation will ensure compliance with these requirements. When requested, BHP providers shall provide copies of medical records to the JFS Patient Advocacy Program and CCHEA within 3 business days from the date of the medical record request. The Advocacy Agencies will provide the program with a signed release of information from the member with the request if the member has not signed the Coordinated Care Consent form in the EHR.

Members should feel equally welcomed to bring their concerns directly to the program's attention or to seek the assistance of one of the advocacy organizations. If the member is uncomfortable approaching program staff or feels that the expressed grievance has not been successfully resolved at the program level, the member is welcome to contact an advocacy agency. The member shall not be discouraged, hindered, or otherwise interfered with when seeking or attempting to file a grievance/appeal. The member is also not required to present a grievance/appeal in writing and shall be assisted in preparing a written grievance/appeal, if requested.

Providers shall inform members, their authorized representative, or the provider acting on behalf of the member, about their right to file a grievance with assistance from one of the County's contracted advocacy organizations listed below (42 CFR §438.406):

Jewish Family Services, Patient Advocacy Program (JFS)
(For inpatient or residential services)
1-800-479-2233 or 619-282-1134
Email: jfsonline@jfssd.org

Consumer Center for Health, Education, and Advocacy (CCHEA)
(For outpatient services)
1-877-734-3258
TTY-1-800-735-2929

JFS Patient Advocacy facilitates the grievance process for members in inpatient and other 24-hour residential facilities. **CCHEA** facilitates the grievance process for outpatient and all other mental health services. These advocacy services will contact providers within two (2) business days of receiving written permission from the member to represent him/her. Securing this permission can be difficult and time consuming. To ensure compliance with the mandated federal timeline, providers shall work closely with the Advocacy organization to find a mutually agreeable solution to resolve the grievance quickly. If a grievance or appeal is about a clinical issue, CCHEA and JFS Patient Advocacy Program, as required by 42 CFR, will be utilizing a clinician with appropriate clinical expertise in treating the member's condition to review and make a decision about the case.

Providing Beneficiary Materials

Please use the Beneficiary Packet Materials Order Form to request hard copies of brochures and posters related to the Member Grievance and Appeal Processes as well as other Beneficiary Materials. Electronic versions of all materials are available to print on the Optum Website> *Beneficiary* tab. The order form also includes information on where to access grievance and appeal forms and how to request required postage paid envelopes for members to mail grievances and appeals. To receive the materials in the audio or large print format contact QIMatters.HHSA@sdcounty.ca.gov, or providers may duplicate their own copies. The BHP will also be responsible for notifying providers of any changes in State law regarding Advance Directives within ninety (90) days of the law change.

Member Grievance and Appeals Process

Members are encouraged to direct their grievances directly to program staff or management (either orally or via writing) for the most efficient way to resolve problems. In accordance with 42 CFR §438.402, a beneficiary may file a grievance at any time. The Plan shall provide to the beneficiary written acknowledgement of receipt of the grievance. The acknowledgment letter shall include the date of receipt, as well as the name, telephone number, and address of the Plan representative who the beneficiary may contact about the grievance. The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the grievance.

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

Providers shall have self-addressed stamped envelopes (CCHEA and JFS will provide upon request), posters, brochures, grievance/appeal forms in all threshold languages to

include interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. These materials shall be displayed in a prominent public place. When one of the contracted advocacy organizations notifies a provider of a grievance or appeal, the provider shall cooperate with the investigation and resolution of the grievance or appeal in a timely manner.

ASCMI Form

As of 3/31/26 the Coordinated Care Consent form will be deactivated and replaced with the Authorization to Share Confidential Member Information (ASCMI) Form to share information within SmartCare and "drop or raise" the CDAG wall. If members choose to sign, this form allows the member to provide consent to share sensitive physical health, behavioral health, housing, and social services information across providers outside of the electronic health record. The Grievance process can be facilitated via member signing of this form as it will grant permission for advocacy agencies to access needed information in the member's chart which can reduce coordination time in the event that the member files a grievance during his/her time in treatment.

Although this form is required to be offered to all members, signing the form is optional. Member denial to sign the form can be documented on the form itself within the EHR. All paper downtime forms must eventually be entered into the EHR for the form to be effective. Details on how to use the form, FAQs, and additional information can be found at ASCMI – CalAIM.

Transgender, Gender Diverse or Intersex Grievances

Per BHIN 25-019 if a member submits a grievance against a BHP, its subcontractors, or staff for failure to provide trans-inclusive health care, the BHP is required to submit quarterly reports to DHCS. BHPs are also required to submit additional information when the outcomes of the grievance reported are resolved in a member's favor. If the grievance is resolved in the member's favor, then the individual named in that grievance must complete a refresher course by retaking the trans-inclusive health cultural competency training (outlined within BHIN 25-019) within 45 days of the resolution of the grievance and before they have direct contact with members again. BHPs are required to submit to DHCS verification of the completed refresher training quarterly as well as a reporting template to be submitted within quarterly submission timelines outlined in the BHIN.

Grievance Resolution

Timeline: Thirty (30) days from receipt of grievance to resolution. The BHP must resolve grievances within the established timeframes.

The Plan must comply with the following requirements for resolution of grievances:

1. "Resolved" means that the Plan has reached a decision with respect to the member's grievance and notified the member of the disposition.

2. Plans shall comply with the established timeframe of thirty (30) calendar days for resolution of grievances. The timeframe for resolving grievances related to disputes of a Plan's decision to extend the timeframe for making an authorization decision shall not exceed thirty (30) calendar days.

3. The Plan shall use the Notice of Grievance Resolution (NGR) to notify beneficiaries of the results of the grievance resolution. The NGR shall contain a clear and concise explanation of the Plan's decision.

    a. In the event that resolution of a standard grievance is not reached within thirty (30) calendar days as required, the Plan shall provide the beneficiary with the applicable NOABD and include the status of the grievance and the estimated date of resolution.

Adverse Benefit Determination (ABD)

The definition of an "Adverse Benefit Determination" encompasses all previous elements of "Action" under federal regulations with the addition of language that clarifies the inclusion of determinations involving access to medically necessary services, appropriateness and setting of covered benefits, and financial liability. An Adverse Benefit Determination is defined to mean any of the following actions taken by a Plan:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, meeting criteria for 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.

Beneficiaries must receive a written Notice of Adverse Benefit Determination (NOABD) when the BHP takes any of the actions described above. The Plan must give beneficiaries timely and adequate notice of an adverse benefit determination in writing,

consistent with the requirements in 42 CFR §438.10. The federal regulations delineate the requirements for content of the NOABDs.

The NOABD must explain all of the following:

1. The adverse benefit determination the Plan has made or intends to make.

2. A clear and concise explanation of the reason(s) for the decision. For determinations based on criteria for access to medically necessary SMHS, the notice must include the clinical reasons for the decision. The Plan shall explicitly state why the member's condition does not meet specialty mental health services and/or DMC-ODS criteria for access to medically necessary services criteria.

3. A description of the criteria used. This includes criteria for access to medically necessary SMHS, and processes, strategies, or evidentiary standards used in making such determinations; and reference to specific regulations or payment authorization procedures that support the decision.

4. The member's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination.

5. The member's right to a second opinion from a network provider, or for the Plan to arrange for the member to obtain a second opinion outside the network, at no cost to the member.

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

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

Timing of the Notice

The Plan must also communicate the decision to the affected provider within

twenty- four (24) hours of making the decision. The BHP shall mail the notice to the member within the following timeframes:

1. For termination, suspension, or reduction of a previously authorized specialty mental health service, at least ten (10) days before the date of action, except as permitted under 42 CFR §§ 431.213 and 431.214.

2. For denial of payment, at the time of any action denying the provider's claim; or,

3. For decisions resulting in denial, delay, or modification of all or part of the requested specialty mental health services, within two (2) business days of the decision.

NOABD Considerations for Minors

If the member is a minor (unless it is a minor consent case) the original should be sent to the minor and a copy should be sent to the minor's parent(s) or legal guardian. Where involvement of the parent or guardian is determined to be inappropriate, BHPs and providers shall establish and ensure safeguards are in place to suppress confidential information and prevent appointment notifications, NOABD documents, and any other communications that would violate the minor's confidentiality from being inappropriately delivered to the minor's parent or guardian. (BHIN 24-046)

NOABD Templates

All templates are located on the Optum Website > SMH & DMC-ODS Health Plans> > *NOABD* tab. In accordance with the federal requirements, the BHP (providers) shall use DHCS' uniform notice templates, or the electronic equivalent of these templates generated from the Plan's EHR when providing members with a written NOABD. The notice templates include both the enclosed NOABD and **"Your Rights"** documents to notify members of their rights in compliance with the federal regulations. Below are descriptions of the different adverse benefit determinations and corresponding templates:

1. **NOABD Denial of Authorization Notice** - When the Plan denies a request for a service. Denials include determinations based on type or level of service, requirements for criteria for access to medically necessary services, appropriateness, setting or effectiveness of a covered benefit.

2. **NOABD Denial of Payment for a Service Rendered by a Provider** - When the Plan denies, in whole or in part, a provider's request for payment for a service that has already been delivered to a member.

3. **NOABD Delivery System Notice** - Wehn the Plan has determined that the member does not meet the criteria to be eligible for specialty mental health through

the Plan. The member shall be referred to the Managed Care Plan, or other appropriate system, for mental health, substance use disorder, or other services.

4. **NOABD Modification of Requested Services Notice** - When the Plan modifies or limits a provider's request for a service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services.

5. **NOABD Termination of Previously Authorized Services Notice** - When the Plan terminates, reduces, or suspends a previously authorized service. This notice is also required for all members who have unsuccessfully discharged. Unsuccessful discharge includes, but is not limited to: AWOL, unwillingness to continue with services, member terminated services AMA, etc.

6. **NOABD Delay in Processing Authorization of Services Notice** - When there is a delay in processing a provider's request for authorization of specialty mental health service. When the Plan extends the timeframe to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the member or provider, when the extension is in the beneficiary's interest.

7. **NOABD Failure to Provide Timely Access Notice** – When there is a delay in providing the member with timely services, as required by the timely access standards applicable to the delayed service.

8. **NOABD Dispute of Financial Liability Notice** - When the Plan denies a member's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities.

9. **NOABD Failure to timely Resolve Grievances and Appeals** – When the Plan does not meet required timeframes for the standard resolution of grievances and appeals.

10. **The "NOABD Your Rights" Attachment -** A notice that informs members of critical appeal and State Hearing rights. There are two types of "Your Rights" attachments- one accompanies the NOABD, and the other accompanies the Notice of Appeals Resolution. These attachments must be sent to beneficiaries with each NOABD or NAR.

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

        i. The member's or provider's right to request an internal appeal with the Plan within sixty (60) calendar days from the date on the NOABD;

ii. The member's right to request a State Hearing only after filing an appeal with the Plan and receiving a notice that the Adverse Benefit Determination has been upheld;
iii. The member's right to request a State Hearing if the Plan fails to send a resolution notice in response to the appeal within the required timeframe;

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

v. The member's right to be either self-represented or represented by an authorized third party (including legal counsel, relative, friend, or any other person) in a State Hearing;

vi. The member's right to have benefits continue pending resolution of the appeal and how to request continuation of benefits in accordance with Title 42, CFR, Section 438.420, and

vii. Notification that, if the final resolution of the appeal or State Hearing decision upholds the Plans' Adverse Benefit Determination, the member shall not be held liable for the cost of continued services provided to the member while the appeal or State Hearing was pending.

The member's right to a second opinion from a network provider, or the Plan to arrange for the member to obtain a second opinion outside the network at no cost to the member.

Non- Discrimination and Language Assistance Notices

Section 1557 of the Affordable Care Act (ACA) prohibits discrimination on the basis of race, color, national origin, sex, age, or disability. On May 18, 2016, the United States Department of Health and Human Services, Office for Civil Rights issued the Nondiscrimination in Health Program and Activities Final Rule to implement Section 1557. Federal regulations require the BHP (and providers) to post nondiscrimination and language assistance notices in significant communications to beneficiaries. The BHP has created a "Member Non-Discrimination Notice" and "Language Assistance Notice", which shall be sent along with each of the following significant notices sent to beneficiaries:

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

Appeal Process

Federal regulations require members to file an appeal within sixty (60) calendar days from the date on the NOABD. Members must also exhaust the Plan's appeal process prior to requesting a State Hearing unless the member has been deemed to have exhausted that process. A member, 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 member require written consent from the member.

BHPs shall assist the member in completing forms and taking other procedural steps to file an appeal, including preparing a written appeal, notifying the member of the location of the form on the BHP's website or providing the form to the member upon request. BHPs shall advise and assist the member in requesting continuation of benefits during an appeal of the Adverse Benefit Determination in accordance with federal regulations. BHPs shall inform members that they shall not be held liable for the cost of these continued benefits

Standard Resolution of Appeals

The BHP shall provide to the beneficiary written acknowledgement of receipt of the appeal. The letter of acknowledgment shall include the date of receipt and name, telephone number, and address of the Plan representative who the beneficiary may contact about the appeal. The written acknowledgement to the beneficiary must be postmarked within five (5) calendar days of receipt of the appeal. The BHP shall resolve an appeal within thirty (30) calendar days of receipt. In addition to providing a written Notice of Appeal Resolution, the BHP shall make reasonable efforts to provide prompt oral notice to the member of the resolution. In the event that the Plan fails to adhere to the noticing and timing requirements for resolving appeals, the member is deemed to have exhausted the BHP's appeal process and may initiate a State Hearing.

Expedited Resolution of Appeals

The BHP maintains an expedited review process for appeals when the Plan determines (from a member's request) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking time for a standard resolution could seriously jeopardize the member's mental health and/or the member's ability to attain, maintain, or regain maximum function. If the BHP denies a request for expedited resolution of an appeal, it must transfer the appeal to the timeframe for standard resolution.

In addition, the Plan shall complete all of the following actions:

1. The Plan shall make reasonable efforts to provide the member with prompt oral notice of the decision to transfer the appeal to the timeframe for standard

resolution;

2. The Plan shall notify the member in writing of the decision to transfer the appeal to the timeframe for standard resolution within two calendar days of making the decision and notify the member of the right to file a grievance if they disagree with the decision; and

3. The Plan shall resolve the appeal as expeditiously as the member's health condition requires and within the timeframe for standard resolution of an appeal (i.e., within thirty (30) days of receipt of the appeal).

4. For expedited resolution of an appeal and notice to affected parties (i.e., the member, legal representative and/or provider), the Plan shall resolve the appeal, and provide notice, as expeditiously as the member's health condition requires, no longer than seventy- two (72) hours after the Plan receives the expedited appeal request.

Notice of Appeal Resolution (NAR) Requirements

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

NAR "Your Rights" Notice

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

- The member's right to request a State hearing no later than one hundred and twenty (120) calendar days from the date of the Plan's written appeal resolution and instructions on how to request a State hearing; and,

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

- Notification that the member shall not be held liable for the cost of those benefits if the State Hearing decision upholds the Plan's Adverse Benefit Determination.

NAR Adverse Benefit Determination Upheld Notice

For appeals not resolved wholly in favor of the member, the BHP shall utilize the DHCS template, or the electronic equivalent of that template generated from the Plan's

Electronic Health Record System, for upheld decisions, which is comprised of two components:

1. NAR Adverse Benefit Determination Upheld Notice, and

2. "Your Rights" attachment.

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

- The results of the resolution and the date it was completed;

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

- For appeals not resolved wholly in the favor of the member, the right to request a State Hearing and how to request it, the right to request and receive benefits while the State Hearing is pending and how to make the request; and,

- notification that the member shall not be held liable for the cost of those benefits if the State Hearing decision upholds the Plan's Adverse Benefit Determination

NAR Adverse Benefit Determination Overturned Notice

For appeals resolved wholly in favor of the member, the Plan shall use the Adverse Benefit Determination Overturned (NAR) notice template as a written notice to the member that includes the results of the resolution and the date it was completed. The BHP shall also ensure that the written response contains a clear and concise explanation of the reason, including why the decision was overturned.

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

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

Provider Appeal Process

If the provider and advocacy organization cannot successfully resolve the member's grievance or appeal, the advocacy organization will issue a finding, to be sent

to the member, provider and Behavioral Health Director, which may include the need for a Plan of Correction to be submitted by the provider to the Behavioral Health Director or designee in ten (10) days. In the rare instances when the provider disagrees with the disposition of the grievance/appeal and/or does not agree to write a Plan of Correction, the provider may write to the Behavioral Health Director within ten (10) days, requesting an administrative review. The Behavioral Health Director or his designee shall have the final decision about needed action.

State Fair Hearing (SFH)

Members must exhaust the BHP's appeal process prior to requesting a State Hearing. A member has the right to request a State Hearing only after receiving notice that the Plan has upheld an Adverse Benefit Determination. If the Plan fails to adhere to the notice and timing requirements in 42 CFR§438.408, including the BHP's failure to provide a NOABD or a NAR the member is deemed to have exhausted the Plan's appeals process. The member may then initiate a State Hearing. Members may request a State Hearing within one hundred and twenty (120) calendar days from the date of the NAR which informs the member the Adverse Benefit Decision has been upheld by the Plan.

The Grievance/Appeals and State Fair Hearing process is designed to:

- Provide a grievance/appeals and State Fair Hearing process adhering to Federal and State regulations
- Provide straightforward member /provider access
- Support and honor the rights of every member
- Be action-oriented
- Provide resolution within State established timeframes
- Encourage effective grievance resolution at program level
- Improve the quality of Behavioral Health services for all County of San Diego residents

- For **Standard Hearings,** the BHP shall notify members that the State must reach its decision on the hearing within ninety (90) calendar days of the date of the request for the hearing.

- For **Expedited Hearings,** the BHP shall notify members that the State must reach its decision on the state fair hearing within three (3) working days of the date of the request for the hearing.

- For **Overturned Decisions,** the BHP shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires, but no later than seventy- two (72) hours from the date it receives notice reversing the Plan's adverse benefits determination.

Continuation of Services

Members have the right to keep receiving approved services while waiting for a final decision from an appeal or State Hearing. This request is called *Aid Paid Pending* (APP). If a member requests an appeal, the BHP shall continue to provide APP to the member while the appeal is pending if all of the following conditions are met:

- The member timely files a request for an appeal in accordance with Title 42, CFR, sections 438.402(c)(1)(ii) and (c)(2)(ii)

- The appeal involves the termination, suspension, or reduction of a previously authorized service,

- The member's services were ordered by an authorized provider;

- The period covered by the original authorization has not expired, and,

- The request for continuation of benefits is filed on or before the following: Within ten(10) calendar days of the BHP sending the NOABD, or the intended effective date of the Adverse Benefit Determination.

If a member has been receiving disputed services during the BHP's appeal process and requests a State Hearing, the BHP shall continue to provide APP to the member. If the BHP continues to provide APP to the member while the appeal or State Hearing is pending, the services shall be continued until:

- The member withdraws the appeal or request for State Hearing;

- The member does not request a State Hearing and continuation of benefits within ten (10) calendar days from the date the BHP sends the notice of an adverse appeal resolution; or

- A State Hearing decision adverse to the member is issued.

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

Member's Rights

Member Notification of Rights

In accordance with DHCS regulations, written and oral information explaining the grievance/appeal process and the availability of a State Fair Hearing for Medi-Cal members shall be provided/made available to new members upon first admission to Behavioral Health Services, along with the Integrated Behavioral Member Handbook. Programs attest to this during the "Program Compliance" portion of the QAPR that they are in compliance with applicable Federal and State laws by providing the Handbook information and materials to members. Additionally, programs submit a signed "*Client Notification of Significant Changes for the Integrated Behavioral Health Member Handbook Attestation*" annually to QI Matters.

Right to Provider Selection

In accordance with 42 CFR 438.10 and Title 9, enrollees (all members) have the right to choose and obtain a list of BHP providers, including name/group affiliation, location, telephone number, specialties, hours of operation, type of services, cultural and linguistic capabilities, ADA accommodation, and whether provider is accepting new enrollees.

When feasible and/or upon request, enrollees shall be provided with their initial choice of provider. Each enrollee shall be offered a paper copy of the BHP Provider Directory and/or instructions in their threshold language of how to access the Provider Directory at the time of enrollment and anytime at enrollee's request within (5) five business days. If requested, staff shall assist the member or responsible adult, in reviewing the list of available options and/or obtaining an appointment. Providers shall log all requests for services prior to the onset of services on the Request for Service Log.
The BHP Provider Directory is available on the County's website or by calling Behavioral Health Services at (619) 563-2788. The Fee-for-Service Provider Directory is available by calling Optum at 1-888-724-7240 and online at the Optum website.

Right to a Second Opinion

If the MHP or its designee determines that a member does not meet criteria for access to inpatient or outpatient specialty mental health services, a member or someone on behalf of the member, may request a second opinion. A second opinion from a mental health clinician provides the member with an opportunity to receive additional input on his

or her mental health care at no extra cost. As the BHP designee, Optum is responsible for informing the treating provider of the second opinion request and for coordinating the second opinion with an BHP contracted individual provider.

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

Right to Transfer

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

Right to Language, Visual and Hearing Impairment Assistance

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

Right to a Patient Advocate

A member pursuant to W&I Code 5325 (h) has a right to see and receive the services of a patient advocate who has no direct or indirect clinical or administrative responsibility for the person receiving mental health services. The rights specified in this section may not be waived by the person's parent, guardian, or conservator. The Patient Advocate does not need to have access to the entire chart, but rather, the portions that have to do with the potential denial of rights.

Right to Access Health Information (45 CFR § 164.524)

The Privacy Rule

The Privacy Rule generally requires HIPAA covered entities (health plans and most health care providers) to provide individuals, upon request, with access to the protected health information (PHI) about them in one or more "designated record sets" maintained by or for the covered entity. A "designated record set" is defined at 45 CFR 164.501 as a group of records maintained by or for a covered entity that comprises the:

- Medical records and billing records about individuals maintained by or for a covered health care provider;
- Enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or
- Other records that are used

This includes the right to inspect or obtain a copy, or both, of the PHI, as well as to direct the covered entity to transmit a copy to a designated person or entity of the individual's choice. Individuals have a right to access this PHI for as long as the information is maintained by a covered entity, or by a business associate on behalf of a covered entity, regardless of the date the information was created; whether the information is maintained in paper or electronic systems onsite, remotely, or is archived; or where the PHI originated (e.g., whether the covered entity, another provider, the patient, etc.).

For more information, please see: US Dept. HHS- Individuals' Right Under HIPAA to Access their Health Information.

Personal Representatives

An individual's personal representative (generally, a person with authority under State law to make health care decisions for the individual) also has the right to access PHI about the individual in a designated record set (as well as to direct the covered entity to transmit a copy of the PHI to a designated person or entity of the individual's choice), upon request. See 45 CFR 164.502(g) and HHS.GOV- Personal Representatives for more information .

Information Excluded from the Right of Access

An individual does not have a right to access PHI that is not part of a designated record set. For example, a hospital's peer review files or practitioner or provider performance evaluations, or a health plan's quality control records that are used to improve customer service or formulary development records, may be generated from

and include an individual's PHI but might not be in the covered entity's designated record set and subject to access by the individual.

In addition, two categories of information are expressly excluded from the right of access:

- Psychotherapy notes, which are the personal notes of a mental health care provider documenting or analyzing the contents of a counseling session, that are maintained separate from the rest of the member's medical record. See 45 CFR 164.524(a)(1)(i) and 164.501.

- Information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative action or proceeding. See 45 CFR 164.524(a)(1)(ii).

Right to Direct PHI to Another Person

An individual also has a right to direct the covered entity to transmit the PHI about the individual directly to another person or entity designated by the individual. This request must be in writing, signed by the individual, and clearly identify the designated person and where to send the PHI. A covered entity may accept an electronic copy of a signed request (i.e. PDF), as well as an electronically executed request (i.e. via a secure web portal) that includes an electronic signature. The same requirements for providing the PHI to the individual, such as the fee limitations and requirements for providing the PHI in the form and format and manner requested by the individual, apply when an individual directs that the PHI be sent to another person. (45 CFR 164.524(c)(3).

Right to Request Materials in Alternative Formats

Clients reserve the right to request written information in their preferred formats (large print, braille, audio or other accessible electronic formats). Requests for alternative formats may be made with directly to programs or through Optum's Access & Crisis Line. Programs are expected to address and assist clients with these requests. Below are the steps to follow if a program or Optum ACL receives a request.

Process for Requests Made to the Program

- If materials requested are not already available on the Optum website, programs shall contact QI Matters (qimatters.hhsa@sdcounty.ca.gov) with the following information:

    - Client name and contact information (address, phone number, email address)

- Preferred method of delivery (mail, email (if applicable), pick up at program)
- QA will coordinate directly with the program once materials are ready

Process for Requests made to Optum's ACL

- If materials requested are not already available on the Optum website, ACL staff shall contact QI Matters (qimatters.hhsa@sdcounty.ca.gov) with the following information:
  - Client name and contact information (address, phone number, email address)
  - Preferred method of delivery (mail, email (if applicable), pick up at a program)
- QA will coordinate directly with the client once the materials are ready

For additional information on these rights and for items that are readily available in alternative format, programs may refer clients to the Optum Beneficiary & Families page.

Advance Health Care Directive Information

Federal Medicaid regulations (42 CFR 422.128) require the BHP to ensure that all adults and emancipated minor Medi-Cal beneficiaries are provided with information about the right to have an Advance Health Care Directive at their first face-to-face contact for services, or when they become eligible (upon their 18 birthday or emancipation).

An Advance Health Care Directive is defined in the 42 CFR, Chapter IV, Part 489.100 as "a written instruction such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated." Generally, Advance Health Care Directives deal with how physical health care should be provided when an individual is incapacitated by a serious physical health care condition, such as a stroke or coma, and unable to make medical treatment decisions for himself/herself.

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

1. Provide written information on the member right to make decisions concerning medical treatment, including the right to accept or refuse medical care and the right to formulate Advance Directives, at the first face-to-face contact with a new member, and thereafter, upon request.

2. Document in the member's medical record that this information has been given and whether or not the member has an existing Advance Directive.

3. If the member who has an Advance Directive wishes to bring in a copy, the provider shall add it to the member's current medical record.

4. If a member is incapacitated at the time of initial enrollment and unable to receive information, the provider will have a follow-up procedure in place to ensure that the information on the right to an Advance Directive is given to the member at the appropriate time. In the interim, the provider may choose to give a copy of the information to the member's family or surrogate.

5. Not condition the provision of care or otherwise discriminate against an individual based on whether or not he or she has an Advance Directive.

6. Should the situation ever arise, provide information about the State contact point to members who wish to complain about non-compliance with an Advance Directive.

The BHP is required to provide brochure on Advance Directives to new members or members of the community who request it. All brochures are available on the Optum website >*Beneficiary* tab. Providers are expected to formulate their own policies and procedures on Advance Health Care Directives and educate staff. Because of the legal nature of Advance Directives, providers may wish to consult with their own legal counsel regarding federal regulations.

Guidance on Service and Support Animals

Service Animals

"Service animals" are animals that are trained to perform specific tasks to assist individuals with disabilities, including individuals with mental health disabilities. Service animals do not need to be professionally trained or certified. Under the Americans with Disabilities Act, service animals can only be dogs or miniature horses. Staff members are not permitted to request documentation for a service animal. Service animals are not required to be formally trained, nor must they wear a special tag or vest. Unless there is a reason to believe that an animal poses a threat to others, facility representatives can only ask two questions to determine whether an animal qualifies as a service animal:

1. Is the animal required because of the handler's disability?

2. What work or task the animal has been trained to perform?

If the member affirmatively answers the two questions above, the animal would be considered a service animal under the law and should be allowed in the facility unless one of the legal justifications (described below) for denial applies.

Support Animals

"Support animals" are animals that provide emotional, cognitive, or other similar support to an individual with a disability. A support animal does not need to be trained or certified. The current Fair Housing Act (and regulations) indicate that support animals should be allowed in any dwelling or housing accommodation, subject to limited exceptions. If a facility has a “no pets” policy, any member may request a “reasonable accommodation” to allow their support animal in the facility. Requests for a reasonable accommodation do not have to be in writing. Evaluating reasonable accommodation(s) should be an interactive process between the requester and the facility staff. If the facility staff members do not understand the initial request, they should continue to work with the requester until they can understand how the support animal will assist with the requester’s disability-related need.

Staff can request documentation regarding the member’s disability and the need for the support animal. This documentation should only be requested if the disability and/or need for the animal are not already apparent. Facility staff can also require that emotional support animals be licensed and/or vaccinated according to state and local laws that apply to all other animals. If the connection between the disability-related need and the support animal is readily apparent, or if the requester submits appropriate documentation establishing this connection, staff members should allow the support animal, unless one of the legal justifications for denial applies (see below). If the connection is not readily apparent, and the requester does not submit appropriate documentation, then the individual’s request could possibly be denied (pending submission of documentation).

Denial of a Service or Support Animal

Staff are not permitted to preemptively deny a service animal or deny based solely on the animal’s breed. In all cases, facilities need to and document case-by-case determinations via an “individualized assessment” of a service animal’s behavior and its handler’s ability to care for it. Facility staff are only authorized to deny service animals in limited circumstances. If facility staff decide to deny a reasonable accommodation for a support animal or deny access to a service animal, they must provide a specific legal justification to the member.

Examples of specific legal justifications include the following:

1. Fundamental Alteration - Permitting the animal would alter the essential nature of the program.

2. Undue Burden - Permitting the animal would cause significant difficulty or expense.

3. Direct Threat - Permitting the animal would lead to significant risk of substantial bodily harm to the health or safety of others or would cause substantial physical damage to the property of others, and that harm cannot be sufficiently mitigated or eliminated by a reasonable accommodation.

The reasons for denial of a service animal should be carefully documented by facility staff and clearly communicated to the handler. For any non-English speaking individuals, the facility should attempt to provide this information in the individual's preferred language. Facilities should also consider consulting their own legal counsel or risk management coordinator as appropriate.

In cases when facility staff are denying an animal because the requester fails to establish the connection between their disability-related need and the support animal, facility staff should explain why they believe the connection was not established but would not be required to cite one of the specific legal justifications above. Also, to the extent practical, if an animal requires removal, efforts should be made to ensure that it is retrievable by the owner.

Individuals who feel they have been wrongfully denied a service or support animal can file complaints with the U.S. Department of Justice, the U.S. Department of Housing and Urban Development, the California Department of Fair Employment and Housing, and the California Civil Rights Department. They may also file suit in state, federal, or small claims court or seek other legal representation. Additionally, individuals can choose to file a grievance or complaint through the appropriate patient advocacy agency

The information provided above is a summary of applicable law, regulations, and is intended as guidance. In developing policies and procedures, it is recommended that facility representatives utilize the legal guidelines that can be found in Cal. Code Regs. Title 2 § 12005, Cal. Code Regs. tit. 2 § 12176-12181, Cal. Code Regs. Title 2, § 12185, Cal. Code Regs. Title 2 § 14020, Cal. Code Regs. Title 2 § 14331, 28 C.F.R. § 36.104, 28 C.F.R. § 36.302, 28 C.F.R. § 36 app A to Part 36, 28 C.F.R. § 36 app C to Part 36.

For more information please see: ADA Requirements: Service Animals and FAQs about Service Animals and the ADA.