Behavioral Health Department Alameda County Health	By: Signed by: BA167CA0C0D444A... **Karyn L. Tribble, PsyD, LCSW, Director**
POLICY TITLE **Notices of Adverse Benefit Determination for Medi-Cal Beneficiaries**	**Policy No:** 300-1-2 **Date of Original Approval**: 12-05-2016 **Date(s) of Revision(s):** 2-15-2019, 6/24/2025

PURPOSE

This policy ensures that Medi-Cal beneficiaries are provided written notification of when an Adverse Benefit Determination made by Alameda County Behavioral Health Department (ACBHDD) or an ACBHDD-contracted provider, collectively referred to as the Behavioral Health Plan (BHP), is made and informs the beneficiary of their right to request an appeal.

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

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

The beneficiary written notification of an Adverse Benefit Determination and the right to request an appeal, is referred to as a Notice of Adverse Benefit Determination (NOABD). Notices provide members with required information about their rights under the Medi-Cal program.

Additional guidance to provide members with required information about their rights under the Medi-Cal program including the Notice of Grievance Resolution (NGR), Notices of Appeal Resolution (NAR), a “Your Rights” attachment, a member non-discrimination notice, and language assistance taglines may be found in complimentary policies:

- Notice of Grievance Resolution (NGR)
- Notices of Appeal Resolution (NAR),
- a “Your Rights” attachment,
- a member non-discrimination notice, and language assistance taglines

AUTHORITY

- CMS Medicaid and CHIP Managed Care Final Rule (Final Rule)
- Title 42, Code of Federal Regulations (CFR), Part 438, Subpart F. Grievance and Appeal System
    - Title 22, California Code of Regulations (CCR), §51014.1. Fair Hearing Related to Denial, Termination or Reduction in Medical Services
- Title 22, CCR, §51014.2. Medical Assistance Pending Fair Hearing Decision
- Title 9, CCR, §1810.200. Action
- Title 9, CCR, §1850.210. Provision of Notice of Action
- Alameda County's MHP Contract #17-94572 with the California State Department of Health Care Services (DHCS)
- Alameda County's Intergovernmental Agreement (IA) 17-94062 (G)(2-8) with the State Department of Health Care Services (DHCS)
- MHSUDS Information Notice No: 18-010. Federal Grievance and Appeal System Requirements with Revised Beneficiary Notice Templates
- Behavioral Health Information No: 25-014 Mental Health Plan and Drug Medi-Cal Organized Delivery System Plan Grievance and Appeal Requirements with Revised Member Notice Templates

SCOPE

This policy applies to all ACBHD county-operated programs in addition to entities, individuals and programs providing Medi-Cal specialty mental health services or substance use disorder treatment services to Medi-Cal beneficiaries under a contract or subcontract with ACBHD.

BACKGROUND

On March 30, 2016, CMS issued the Parity Rule to strengthen access to mental health and substance use disorder services for Medi-Cal members. The Parity Rule aligned certain protections required of commercial health plans under the Mental Health Parity and Addiction Equity Act of 2008 to the Medicaid program.
On May 6, 2016, the Centers for Medicare and Medicaid Services (CMS) published the Medicaid and Children's Health Insurance Program Managed Care Final Rule, aimed at aligning the Medicaid managed care regulations with requirements for other major sources of coverage. BHPs are classified as Prepaid Inpatient Health Plans, and therefore, shall comply with all applicable federal managed care requirements. The Final Rule stipulates requirements for the handling of grievances and appeals that became effective July 1, 2017.

Effective July 1, 2017, the Centers for Medicare and Medicaid Services (CMS) 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.

In 2019 CMS finalized impactful changes to address concerns regarding the use of prior authorization's effect on a beneficiary and ensures timely access to care.

April 24, 2025, DHCS issued clarification regarding policy changes the Department of Health Care Services (DHCS) has made to ensure compliance with the Parity in Mental Health and Substance Use Disorder Services Final Rule (Parity Rule).

POLICY

I. Requirement for Providers Who Render Behavioral Health Services to Medi-Cal Beneficiaries to Issue Written Notification of an Adverse Benefit Determination (NOABD) to Beneficiaries:

All Medi-Cal beneficiaries must receive a written Notice of Adverse Benefit Determination (NOABD) informing them of any actions as defined above, their right to appeal to ACBHDD, and their right to a subsequent State Fair Hearing. All parts of the BHP acting as points of payment authorization and/or making decisions about access to care must comply with NOABD requirements outlined in this policy.

Beneficiaries must receive a written NOABD when the BHP makes any adverse benefit determination, as defined above. The BHP 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 the content of the NOABDs. The NOABD must explain all of the following:

A. The adverse benefit determination the BHP has made or intends to make;
B. A clear and concise explanation of the reason(s) for the decision. For determinations based on medical necessity criteria, the notice must include the clinical reasons for the decision. The BHP shall explicitly state why the beneficiary's condition does not meet specialty mental health services (SMHS) and/or DMC-ODS medical necessity criteria;
C. A description of the criteria used. This includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in making such determinations;
D. The beneficiary's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination.
E. The member's right to a second opinion from a network provider or for the BHP 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 beneficiary in writing. In addition, decisions may be communicated to the provider initially by telephone, and then in writing either by facsimile, mail, and/or secure electronic transmission. For written notification to the provider, the BHP must also include the name and direct telephone number or extension of the decision-maker (or the specific unit's telephone number).

II. Require Written NOABD Templates:

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

A. **Denial (of Authorization)**

Use this template when the BHP denies a request for a service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. For DMC-ODS pilot counties, also use this template for denied residential service requests.

B. **Payment Denial**

Use this template when the BHP denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a beneficiary.

C. **Delivery System**

Use this template when the BHP has determined that the beneficiary does not meet the criteria to be eligible for specialty mental health or substance use disorder services through the Plan. The beneficiary will be referred to the Managed Care Plan, or other appropriate systems, for mental health, substance use disorder, or other services.

D. **Modification**

Use this template when the BHP 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.

E. **Termination**

Use this template when the BHP terminates, reduces, or suspends a previously authorized service.

F. **Authorization Delay**
Use this template when there is a delay in processing a provider's request for authorization of specialty mental health services or substance use disorder residential services. When the BHP extends the timeframe to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the beneficiary or provider, and/or those granted when there is a need for additional information from the beneficiary or provider, when the extension is in the beneficiary's interest.

G. **Timely Access**
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.

H. **Financial Liability**
Use this template when the BHP denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities.

I. **Grievance and Appeal Timely Resolution**
Use this template when the BHP does not meet required timeframes for the standard resolution of grievances and appeals.

III. Timing of the Notice of Adverse Benefit Determination (NOABD)

The BHP must mail the notice (NOABD) to the beneficiary within the following timeframes:

A. For termination, suspension, or reduction of a previously authorized specialty mental health and/or DMC-ODS service, at least 10 days before the date of action, 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; or,
C. For decisions resulting in denial, delay, or modifications of all or part of the requested specialty mental health and/or DMC-ODS services, within two business days of the decision.

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

PROCEDURE

(See Attachment K: NOABD Table for a quick reference guide)

I. NOABD-Denial

A. The BHP shall issue a NOABD-Denial (of Authorization) (See Attachment A) in the following circumstance:
   1. When it denies a provider request for a service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. DMC-ODS Plans shall also use this template for denied residential service requests.
   2. When the BHP denies a beneficiary request for a specific type and/or level of service, but approves a different specialty mental health or substance use disorder treatment service type/level.

B. NOABD-Denial (of Authorization) shall be issued as follows:
   1. The beneficiary or the parent/ legal guardian will be sent a NOABD-Denial (of Authorization) via US Mail within two business days of the decision**.**
   2. The provider will receive communication of the decision via facsimile or secure electronic transmission within 24 hours of the BHP making the decision.

C. NOABD-Denial (of Authorization) are not required in the following circumstances:
   1. A NOABD-Denial (of Authorization) is not provided when the beneficiary disagrees with the services and interventions specified in the current Client Plan. In this case, the beneficiary shall be informed of their right to file a grievance using the consumer problem resolution process.
   2. The provider or clinical team bases the reduction or termination of service on a treatment decision responsive to the client's current clinical condition and the provider makes no service request to the BHP. Although NOABD is not issued to the consumer, they have a right to file an appeal with the BHP using the consumer problem resolution process.
   3. A NOABD-Denial (of Authorization) is not issued when the provider leaves the BHP as long as the beneficiary is provided with the same type and level of service.

II. **NOABD-Payment Denial**

A. ACBHD shall issue a NOABD-Payment Denial (See Attachment B) when a provider's request for payment for a service that has already been delivered to a beneficiary is denied, in whole or in part, for any reason. Reasons for denial may include, but are not limited to, denials based on documentation standards not being met.

B. SMHS acute psychiatric hospital services are emergency services, which do not require prior authorization. As such, issuance of the NOABD-Payment Denial is typically by the ACBHD Utilization Management Program (UM) for hospital service reimbursement denials.

C. Payment denials reasons are as follows:
   1. The beneficiary condition as described by provider does not meet the medical necessity criteria for SMHS hospital or non-hospital services or DMC-ODS services.

2. Services provided are not covered by the BHP.
3. ACBHD's request for additional information from the provider that was needed to approve payment was not received.

D. A NOABD-Payment Denial shall be issued as follows:
1. The beneficiary or the parent or legal guardian will be sent a NOABD-Payment Denial via US Mail at the time of any action denying the provider's claim.
2. If the beneficiary is currently homeless or out of contact, ACBHDD is expected to note on the NOABD why it could not be delivered.
3. The provider is separately notified of the payment denial within 24 hours of making the decision. The provider, not the beneficiary, has the right to appeal the payment denial to ACBHDD and subsequently to DHCS if ACBHD upholds the denial.

III. NOABD-Delivery System

A. A BHP shall issue a NOABD - Delivery System (See Attachment C) when it is determined, on the basis of screening/assessment, that the beneficiary does not meet medical necessity criteria or is otherwise not entitled to receive a specialty mental health service (SMHS) or a substance use disorder treatment service through the BHP: The screening /assessment shall consist of a telephone screening or face to face interview to determine whether client meets medical necessity for SMHS or DMC-ODS services.
1. If a beneficiary has been receiving services and has improved to the point of no longer meeting medical necessity criteria for SMHS or it's determined that the beneficiary cannot benefit from services, the provider may issue a NOABD-Delivery System to the beneficiary to inform them as such and their right to appeal the decision but is not required to appeal. It is best clinical practice to always keep beneficiaries informed of their progress in treatment and any plans for reduction or termination of services due to improvement in functioning.

B. A NOABD-Delivery System shall be issued as follows:
1. The NOABD-Delivery System shall be issued to the beneficiary and/or the parent or legal guardian.
2. The NOABD-Delivery System may be issued anytime preceding the end of an assessment.
3. The NOABD-Delivery System shall be hand delivered or mailed within two business days of the decision.
4. A copy of the NOABD-Delivery System will be placed in the beneficiary's chart if they were already receiving services from the provider issuing the NOABD-Delivery System.
5. The issuing provider shall send a copy of the NOABD-Delivery System to the ACBHD Quality Assurance Office via FAX or US Mail (do not send via e-mail) immediately upon issuance to the beneficiary:

US Mail: ACBHD Quality Assurance Office
2000 Embarcadero, Suite 400
Oakland, CA 94606

Fax: 510-639-1346

C. NOABD-Delivery System are not required in the following circumstances:
   1. The beneficiary's request is for a non-specialty mental health service (i.e. housing, transportation, or employment services).
   2. A beneficiary or potential consumer calls the ACCESS Unit or other point of entry to the MHP seeking only information about services.

IV. NOABD-Modification

A. The BHP shall issue a NOABD-Modification (See Attachment D) when the BHP 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.
B. A NOABD-Modification shall be issued as follows:
   1. The beneficiary or the parent/ legal guardian will be sent a NOABD-Modification via US Mail within two business days of the decision.
   2. The provider will be notified of the decision within 24 hours of the BHP making the decision.

V. NOABD Termination

A. The BHP shall issue a NOABD-Termination (See Attachment E) when the BHP terminates, reduces, or suspends a previously authorized specialty mental health and/or DMC-ODS service. A NOABD-Termination shall be issued as follows:
1. The beneficiary or the parent/legal guardian will be sent a NOABD Termination via US Mail, at least 10 days before the date of action, except as permitted under 42 CFR §431.213 and 431.214
2. The provider will be notified of the decision within 24 hours of the BHP making the decision.

VI. NOABD-Authorization Delay

A. The BHP shall issue a NOABD-Authorization Delay (See Attachment F) when there is a delay in processing a provider's request for authorization of specialty mental health services or substance use disorder residential services. When the BHP extends the timeframe to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the beneficiary or provider, and/or those granted when there is a need for additional information from the beneficiary or provider, when the extension is in the beneficiary's interest.

B. A NOABD-Authorization Delay shall be issued as follows:
   1. The beneficiary or the parent/ legal guardian will be sent a NOABD Authorization Delay via US Mail, within 2 days of decision.
   2. The provider will be notified of the decision within 24 hours of the BHP making the decision.

VII. NOABD-Timely Access

A. The BHP shall issue a NOABD-Timely Access (See Attachment G) when the provider responsible for providing services to the beneficiary has not provided services in a timely manner based on standards established by DHCS and ACBHDD's policy on timeliness standards.
B. NOABD-Timely Access shall be issued as follows:
   1. The beneficiary or the parent or legal guardian will be sent a NOABD-Timely Access by the provider responsible for providing the services.
   2. The issuing provider shall fax or send via US Mail -a copy of the NOABD-Timely Access to the ACBHDD Quality Assurance Office immediately upon issuance to the beneficiary:

      US Mail: ACBHD Quality Assurance Office
      2000 Embarcadero, Suite 400
      Oakland, CA 94606

      Fax: 510-639-1346

VIII. NOABD-Financial Liability

A. The BHP shall issue a NOABD-Financial Liability (See Attachment H) when the BHP denies a beneficiary's request to dispute financial liability, including cost- sharing and other beneficiary financial liabilities.
B. ACBHDD Provider Relations (PR) receives and makes reimbursement determinations for Conlan claims, which are beneficiary requests for reimbursement for their out-of-pocket expense(s) for Medi-Cal covered service(s). Beneficiaries may be able to receive reimbursement if:
   1. A Medi-Cal covered service was received on a date that the beneficiary was eligible for Medi-Cal. The three periods of eligibility that are included are the following:
      a. Retro: The 3-month period prior to the month the beneficiary applied for Medi-Cal. This period of eligibility is covered only when the beneficiary has requested, and it has been approved from the county representative or directly from Medi-Cal that specific dates and services before the beneficiary applied for Medi-Cal to be included in their period of eligibility.

b. Evaluation: From the date the beneficiary applied for the Medi-Cal program until the date the Medi-Cal card was issued. The provider must have been a Medi-Cal provider on the date the service(s) was provided.

c. Post Approval: After a beneficiary's Medi-Cal card was issued (including excess co-payment and excess share of cost charges). The provider must have been a Medi-Cal provider on the date the service(s) was provided.

2. The beneficiary paid for BHP covered services; or another person paid on the beneficiary's behalf.
3. After the beneficiary received their Medi-Cal card, they contacted and showed the BHP provider their Medi-Cal card and the provider would not reimburse.
4. The Provider was a contracted Medi-Cal provider at the time of service.

IX. Grievance and Appeal Timely Resolution

A. The BHP shall issue a NOABD-Grievance and Appeal Timely Resolution (See Attachment I) when the BHP fails to act within the required timeframes for standard resolution of grievances and appeals.

B. NOABD-Grievance and Appeal Timely Resolution shall be issued as follows:
   1. The beneficiary or the parent or legal guardian will be sent a NOABD-Grievance and Appeal Timely Resolution by the BHP entity responsible for resolving the grievance or appeal.
   2. The issuing entity shall fax or send via US Mail a copy of the NOABD-Grievance and Appeal Timely Resolution to the ACBHD Quality Assurance Office immediately upon issuance to the beneficiary:

US Mail: ACBHD Quality Assurance Office
2000 Embarcadero, Suite 400
Oakland, CA 94606

Fax: 510-639-1346

X. Notices to Beneficiaries Regarding Their Rights

Any provider in the BHP that issues a NOABD shall include the following written notice attachments to beneficiaries as indicated below.

A. The "NOABD Your Rights" attachment informs beneficiaries of critical appeal and State hearing rights with the following required information pertaining to NOABD (See Attachment J)
   1. The beneficiary's or provider's right to request an internal appeal with the Plan within 60 calendar days from the date on the NOABO;

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

The beneficiary's right to request a state hearing if ACBHDD fails to send a resolution notice in response to the appeal within the required timeframe; Procedures for exercising the beneficiary's rights to request an appeal; Circumstances under which an expedited review is available and how to request it; and

3. 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.

B. The **"Language Assistance"** taglines attachment (See Attachment J) informs beneficiaries of their right to translation services.
C. The **"Nondiscrimination Notice"** attachment (See Attachment J) informs beneficiaries that federal regulations prohibit discrimination on the basis of race, color, national origin, sex, age, or disability; how to request interpreter services and/or written information in other formats; how to file a grievance with ACBHDD or the U.S Department of Health and Human Services, office for Civil Rights, if a beneficiary believes that the BHP has failed to provide these services or discriminated against him/her.

XI. Translation of NOABDs

ACBHDD shall make all NOABD templates available in the BHP's threshold languages; the templates shall be posted in the ACBHDD Quality Assurance Manual on the Provider Website.

XII. Appeal of a NOABD by a Beneficiary

A. A beneficiary receiving a NOABD or experiencing a reduction or termination in service based on a clinical decision of the provider, may appeal the action by:
   1. Contacting Consumer Assistance at 1(800) 779-0787
   2. Submitting a letter or ACBHDD appeal form via US mail to: 2000 Embarcadero Cove, Suite 400 Oakland, CA 94606
   3. In Person: By visiting the provider site to obtain forms and assistance or by visiting consumer assistance at Mental Health Association, 2855 Telegraph Avenue, Suite 501 Berkeley, CA 94705

XIII. Aid Paid Pending (APP)

A. Beneficiaries who are issued a NOABD while they are receiving services, may request continuation of services, referred to as ''Aid Paid Pending," pending a resolution of an appeal to ACBHDD and any subsequent State Fair Hearing.

B. Upon receipt of an appeal to a NOABD from a beneficiary, the ACBHDD Quality Assurance Office will send via US Mail or hand deliver a written notice to the beneficiary informing them of their eligibility for Aid Paid Pending.

C. An Aid Paid Pending request must be made with the ACBHDD Quality Assurance Office within 10 days from the date the NOABD was mailed or given to the consumer, or before the effective date of the change in services, whichever is later.

D. ACBHD will notify the beneficiary's service provider that the beneficiary has requested and been approved for Aid Paid Pending and that the provider is obligated to provide the same level of services as beneficiary was receiving prior to the action until resolution of the appeal to ACBHDD or any subsequent State Fair Hearing.

XIV. Retention of Records

A. All NOABDs issued and/or received shall be placed by the provider in the beneficiary's chart. If there is no existing chart then the NOABD shall be retained by provider per ACBHDD's Record Retention policy.
B. NOABDs issued by ACBHDD units (i.e. ACCESS, UM, QA, PR) shall be retained per ACBHDD's Record Retention policy.
C. NOABDs received from providers by the Quality Assurance Office shall be retained per ACBHDD's Record Retention policy.

XV.

NON-COMPLIANCE

- Non-compliance with this policy refers to non-compliance with State and Federal regulations and guidelines, as well as with this ACBHD policy regarding written notification to a Beneficiary of when an Adverse Benefit Determination is made including, but not limited to, the right to appeal.
- Beneficiaries, Providers and Staff shall not face retribution for submitting a notice of non-compliance.
- Beneficiaries may report non-compliance through the ACBHD Consumer Grievance and Appeal process.
- Providers may report non-compliance through the ACBHDD Provider Problem and Resolution and Appeal process.
- Staff shall report any non-compliance to their immediate supervisor, who shall submit a Non-Compliance Report to ACBHDD QM. Staff may also notify the appropriate ACBHDD staff directly.
- Beneficiaries, Providers and Staff should report the non-compliance to ACBHDD QM as soon as possible. Non-Compliance Reports shall be submitted within fifteen (15) days of reasonable awareness of non-compliance.

- Any communication that contains protected health information (PHI) or otherwise confidential information (e.g., as defined by HIPPA, 42 CFR, Part 2, etc.) shall be sent through secure methods such as email with secure encryption.

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CONTACT

ACBHD Office	Current as of	Email
Quality Assurance Office	January 2025	QAOffice@acgov.org

DISTRIBUTION

This policy will be distributed to the following:

- ACBHD Staff
- ACBHD County and Contract Providers
- Public

ISSUANCE AND REVISION HISTORY

Authors: Donna Fone, MFT, LPCC, Quality Assurance Administrator and David Woodland, LPCC

Original Date of Approval: 12/5/16 by Karyn Tribble, PsyD, LCSW, Acting Behavioral Health Director

Revise Author	Reason for Revise	Date of Approval by (Name, Title)
Karen Capece, LCSW Division Diretor, UM; Donna Fone, MFT, **LPCC, QA** Administrator; Barbara Saler, LCSW, ACCESS Manager	Implementation of CMS Final Rule	2/15/2019 by Carol F. Burton, Acting Behavioral Health Director
Penny Bernhisel, Utilization Management Division Director, Karen Capece, LCSW Quality Management Director, David Woodland, Quality Assurance Clinical Review Specialist	• Triennial review • Update to new log • Approval from Director (no longer Acting) • Update content with new guidance from BHIN 25-014	6/24/2025 by Karyn Tribble, PsyD, LCSW, Behavioral Health Director

	• Update NOADBD templates	

DEFINITIONS

Term	Definition
Adverse Benefit Determination	California statute further clarifies that an Adverse Benefit Determination occurs when a BHP denies, modifies, or delays any health care service eligible for coverage and payment under the BHP's contract with DHCS13 . This includes a denial, modification, or delay of services requested by (1) a member seeking services from the BHP for the first time; (2) a member seeking continuation of services currently covered by a BHP; and (3) a member seeking new services in addition to services currently covered by the BHP. An Adverse Benefit Determination also occurs when the BHP fails to offer an appointment for a service eligible for coverage and payment within the appointment time standards set forth in subdivision (d)(1)(A) of section 14197 of the Welfare and Institutions Code, subject to authorized exceptions.
Aid Paid Pending (APP)	This term is used to refer to the continuation of services provided to a Medi-Cal beneficiary while waiting for a decision on an appeal to a Notice of Action or State Fair Hearing. To be eligible for APP, certain criteria must be met.
Beneficiary	Anyone currently receiving ACBHD care or services, or who has received ACBHD care or services in the last 12 months by the Behavioral Health Plan (BHP). The term 'beneficiary' is also synonymous with 'consumer,' 'patient,' or 'client'
Behavioral Health Plan (BHP)	Alameda County Behavioral Health (ACBHD) and ACBHD-contracted providers are collectively referred to as the Behavioral Health Plan (BHP). BHP providers and services are inclusive of both delivery systems: specialty mental health services (SMHS) and Drug Medi- Cal-Organized Delivery System (DMC-ODS).
Medi-Cal	The name of California's Medicaid program which provides health coverage to people with low-income, the aged or disabled and those with asset levels who meet certain eligibility requirements.
Medical Necessity	Per Medi-Cal, a service is medically necessary if it is needed to

	address a particular health condition and the following criteria are met: 1) the diagnosis is included/covered, 2) the condition results in a functional impairment, 3) the proposed intervention addresses the impairment, and 4) the condition would not be responsive to treatment by a physical health ·care provider.
NOABD-Delivery System	This Notice of Adverse Benefit Determination is used when ACBHD or its contracted provider has determined that the beneficiary does not meet the criteria to be eligible for specialty mental health or substance use disorder services through the BHP. The beneficiary is referred to the Managed Care Plan, or other appropriate system, for mental health, substance use disorder, or other services.
NOABD-Denial (of Authorization)	This Notice of Adverse Benefit Determination is used when the BHP denies a request for a service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. For DMC-ODS pilot counties, also use this template for denied residential service requests.
NOABD-Payment Denial	This Notice of Adverse Benefit Determination is used when the BHP denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a beneficiary.
NOABD-Modification	This Notice of Adverse Benefit Determination is used when the BHP 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.
NOABD-Termination	This Notice of Adverse Benefit Determination is used when the BHP terminates, reduces, or suspends a previously authorized service.
NOABD-Authorization Delay	This Notice of Adverse Benefit Determination is used when there is a delay in processing a provider's request for authorization of specialty mental health services or substance use disorder residential services. When the BHP extends the timeframe to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the beneficiary or provider, and/or those granted when there is a

	need for additional information from the beneficiary or provider, when the extension is in the beneficiary's interest.
NOABD-Timely Access	This Notice of Adverse Benefit Determination is used when there is a delay in providing the beneficiary with timely services, as required by the timely access standards applicable to the delayed service.
NOABD-Financial Liability	This Notice of Adverse Benefit Determination is used when the BHP denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities.
NOABD-Grievance and Appeal Timely Resolution	This Notice of Adverse Benefit Determination is used when the BHP does not meet the required timeframes for the standard resolution of grievances and appeals.
Specialty mental health services (SMHS)	Medi-Cal services provided under county Mental Health Plans (MHPs) by mental health specialists, both licensed and unlicensed, such as psychiatrists, psychologists, licensed clinical social workers, licensed marriage and family therapists, licensed professional clinical counselors, and peer support providers.
Substance use Disorder Treatment (SUD) services	Medi-Cal services provided under county Drug Medi-Cal-Organized Delivery System (DMC-ODS) Intergovernmental Agreement (IA) by substance use disorder treatment specialists, both licensed and unlicensed, such as Licensed Practitioners of the Healing Arts (LPHA) and SUD counselors.

Threshold language	Non-English languages spoken by Medi-Cal enrollees and potential enrollees based on a significant number or percentage of persons who speak each language as follows: • A population group of mandatory Medi-Cal beneficiaries residing in the Mental Health Plan's service area who indicate their primary language as other than English, and that meet a numeric threshold of 3,000 or five percent (5%) of the beneficiary population, whichever is lower; and • A population group of mandatory Medi-Cal beneficiaries residing in the Mental Health Plan's service area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes.

APPENDICES

A. NOABD- Denial (of Authorization) Template

B. NOABD- Payment Denial Template

C. NOABD- Delivery System Template

D. NOABD- Modification Template

E. NOABD- Termination Template

F. NOABD-Authorization Delay Template

G. NOABD- Timely Access Template

H. NOABD- Financial Liability Template

I. NOABD- Grievance & Appeal Timely Resolution Template

J. Beneficiary Enclosures:

- NOABD Your Rights Attachment
- Language Assistance Taglines Attachment
- Nondiscrimination Notice Attachment

K. NOABD Table