Fresno County Behavioral Health Member Handbook

Specialty Mental Health Services and Drug Medi-Cal Organized Delivery System

1925 E Dakota Ave

Fresno, CA 93726

FCMHP Access Line 1(800) 654-3937

This access line is available 24 hours a day, 7 days a week.

Effective Date: January 1, 2025[1]

[1] The handbook must be offered at the time the member first accesses services.

LANGUAGE TAGLINES

English Tagline

ATTENTION: If you need help in your language call 1(800) 654-3937 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call [1-xxx-xxx-xxxx] (TTY: 711). These services are free of charge.

الشعار بالعربية (Arabic)

يُرجى الانتباه: إذا احتجت إلى المساعدة بلغتك، فاتصل بـ [1-xxx-xxx-xxxx] (TTY: 711). تتوفر أيضًا المساعدات والخدمات للأشخاص ذوي الإعاقة، مثل المستندات المكتوبة بطريقة بريل والخط الكبير. اتصل بـ [1-xxx-xxx-xxxx] (TTY: 711). هذه الخدمات مجانية.

Հայերեն պիտակ (Armenian)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Եթե Ձեզ օգնություն է հարկավոր Ձեր լեզվով, զանգահարեք [1-xxx-xxx-xxxx] (TTY: 711): Կան նաև օժանդակ միջոցներ ու ծառայություններ հաշմանդամություն ունեցող անձանց համար, օրինակ՝ Բրայլի գրատիպով ու խոշորատառ տպագրված նյութեր: Զանգահարեք 1(800) 654-3937 (TTY: 711): Այդ ծառայություններն անվճար են:

ឃ្លាសម្គាល់ជាភាសាខ្មែរ (Cambodian)

ចំណាំ៖ បើអ្នក ត្រូវ ការជំនួយ ជាភាសា របស់អ្នក សូម ទូរស័ព្ទទៅលេខ 1(800) 654-3937 (TTY: 711)។ ជំនួយ និង សេវាកម្ម សម្រាប់ ជនពិការ ដូចជាឯកសារសរសេរជាអក្សរផុស សម្រាប់ជនពិការភ្នែក ឬឯកសារសរសេរជាអក្សរពុម្ពធំ ក៏អាចរកបានផងដែរ។ ទូរស័ព្ទមកលេខ [1-xxx-xxx-xxxx] (TTY: 711)។ សេវាកម្មទាំងនេះមិនគិតថ្លៃឡើយ។

简体中文标语 (Chinese)

请注意：如果您需要以您的母语提供帮助，请致电 [1-xxx-xxx-xxxx] (TTY: 711)。另外还提供针对残疾人士的帮助和服务，例如盲文和需要较大字体阅读，也是方便取用的。请致电 1(800) 654-3937 (TTY: 711)。这些服务都是免费的。

مطلب به زبان فارسی (Farsi)

توجه: اگر می‌خواهید به زبان خود کمک دریافت کنید، با [1-xxx-xxx-xxxx] (TTY: 711) تماس بگیرید. کمک‌ها و خدمات مخصوص افراد دارای معلولیت، مانند نسخه‌های خط بریل و چاپ با حروف بزرگ، نیز موجود است. با 1-] 1(800) 654-3937 (TTY: 711) تماس بگیرید. این خدمات رایگان ارائه می‌شوند.

हिंदी टैगलाइन (Hindi)

ध्यान दें: अगर आपको अपनी भाषा में सहायता की आवश्यकता है तो 1(800) 654-3937 (TTY: 711) पर कॉल करें। अशक्तता वाले लोगों के लिए सहायता और सेवाएं, जैसे ब्रेल और बड़े प्रिंट में भी दस्तावेज़ उपलब्ध हैं। 1(800) 654-3937 (TTY: 711) पर कॉल करें। ये सेवाएं नि: शुल्क हैं।

Nqe Lus Hmoob Cob (Hmong)
CEEB TOOM: Yog koj xav tau kev pab txhais koj hom lus hu rau 1(800) 654-3937 (TTY: 711). Muaj cov kev pab txhawb thiab kev pab cuam rau cov neeg xiam oob qhab, xws li puav leej muaj ua cov ntawv su thiab luam tawm ua tus ntawv loj. Hu rau (TTY: 711). Cov kev pab cuam no yog pab dawb xwb.

日本語表記 (Japanese)
注意日本語での対応が必要な場合は 1(800) 654-3937 (TTY: 711)へお電話ください。点字の資料や文字の拡大表示など、障がいをお持ちの方のためのサービスも用意しています。 (TTY: 711)へお電話ください。これらのサービスは無料で提供しています。

한국어 태그라인 (Korean)
유의사항: 귀하의 언어로 도움을 받고 싶으시면 1(800) 654-3937 (TTY: 711) 번으로 문의하십시오. 점자나 큰 활자로 된 문서와 같이 장애가 있는 분들을 위한 도움과 서비스도 이용 가능합니다. 1(800) 654-3937 (TTY: 711) 번으로 문의하십시오. 이러한 서비스는 무료로 제공됩니다.

ແທກໄລພາສາລາວ (Laotian)
ປະກາດ: ຖ້າທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາຂອງທ່ານໃຫ້ໂທຫາເບີ 1(800) 654-3937 (TTY: 711). ຍັງມີຄວາມຊ່ວຍເຫຼືອແລະການບໍລິການສໍາລັບຄົນພິການ
ຊຸ່ນເອກະສານທີ່ເປັນອັກສອນນູນແລະມີໂຕພິມໃຫຍ່ ໃຫ້ໂທຫາເບີ
1(800) 654-3937 (TTY: 711). ການບໍລິການເຫຼົ່ານີ້ບໍ່ຕ້ອງເສຍຄ່າໃຊ້ຈ່າຍໃດໆ.

Mien Tagline (Mien)
LONGC HNYOUV JANGX LONGX OC: Beiv taux meih qiemx longc mienh tengx faan benx meih nyei waac nor douc waac daaih lorx taux 1(800) 654-3937
(TTY: 711). Liouh lorx jauv-louc tengx aengx caux nzie gong bun taux ninh mbuo wuaaic fangx mienh, beiv taux longc benx nzangc-pokc bun hluo mbiutc aengx caux aamz mborqv benx domh sou se mbenc nzoih bun longc. Douc waac daaih lorx (TTY: 711). Naaiv deix nzie weih gong-bou jauv-louc se benx wang-henh tengx mv zuqc cuotv nyaanh oc.

ਪੰਜਾਬੀ ਟੈਗਲਾਈਨ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਮਦਦ ਦੀ ਲੋੜ ਹੈ ਤਾਂ ਕਾਲ ਕਰੋ 1(800) 654-3937 (TTY: 711). ਅਪਾਹਜ ਲੋਕਾਂ ਲਈ ਸਹਾਇਤਾ ਅਤੇ ਸੇਵਾਵਾਂ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ ਅਤੇ ਮੋਟੀ ਛਪਾਈ ਵਿੱਚ ਦਸਤਾਵੇਜ਼, ਵੀ ਉਪਲਬਧ ਹਨ| ਕਾਲ ਕਰੋ] (TTY: 711).
ਇਹ ਸੇਵਾਵਾਂ ਮੁਫਤ ਹਨ|

Русский слоган (Russian)

ВНИМАНИЕ! Если вам нужна помощь на вашем родном языке, звоните по номеру 1(800) 654-3937 (линия TTY: 711). Также предоставляются средства и услуги для людей с ограниченными возможностями, например документы крупным шрифтом или шрифтом Брайля. Звоните по номеру (линия TTY:711). Такие услуги предоставляются бесплатно.

Mensaje en español (Spanish)

ATENCIÓN: si necesita ayuda en su idioma, llame al 1(800) 654-3937 (TTY: 711). También ofrecemos asistencia y servicios para personas con discapacidades, como documentos en braille y con letras grandes. Llame al (TTY: 711). Estos servicios son gratuitos.

Tagalog Tagline (Tagalog)

ATENSIYON: Kung kailangan mo ng tulong sa iyong wika, tumawag sa 1(800) 654-3937 (TTY: 711). Mayroon ding mga tulong at serbisyo para sa mga taong may kapansanan,tulad ng mga dokumento sa braille at malaking print. Tumawag (TTY: 711). Libre ang mga serbisyong ito.

แท็กไลน์ภาษาไทย (Thai)

โปรดทราบ: หากคุณต้องการความช่วยเหลือเป็นภาษาของคุณ กรุณาโทรศัพท์ไปที่หมายเลข 1(800) 654-3937 (TTY: 711) **นอกจากนี้ ยังพร้อมให้ความช่วยเหลือและบริการต่าง ๆ สำหรับบุคคลที่มีความพิการ เช่น เอกสารต่าง ๆ ที่เป็นอักษรเบรลล์และเอกสารที่พิมพ์ด้วยตัวอักษรขนาดใหญ่ กรุณาโทรศัพท์ไปที่หมายเลข** (TTY: 711) **ไม่มีค่าใช้จ่ายสำหรับบริการเหล่านี้**

Примітка українською (Ukrainian)

УВАГА! Якщо вам потрібна допомога вашою рідною мовою, телефонуйте на номер 1(800) 654-3937 (TTY: 711). Люди з обмеженими можливостями також можуть скористатися допоміжними засобами та послугами, наприклад, отримати документи, надруковані шрифтом Брайля та великим шрифтом. Телефонуйте на номер (TTY: 711). Ці послуги безкоштовні.

Khẩu hiệu tiếng Việt (Vietnamese)

CHÚ Ý: Nếu quý vị cần trợ giúp bằng ngôn ngữ của mình, vui lòng gọi số 1(800) 654-3937 (TTY: 711). Chúng tôi cũng hỗ trợ và cung cấp các dịch vụ dành cho người khuyết tật, như tài liệu bằng chữ nổi Braille và chữ khổ lớn (chữ hoa). Vui lòng gọi số (TTY: 711). Các dịch vụ này đều miễn phí.

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OTHER LANGUAGES AND FORMATS

Other languages

If you need help in your language call 1(800) 654-3937 (TTY: 711). Aids and services for people with disabilities, like documents in braille and large print, are also available. Call 1(800) 654-3937 (TTY: 711). These services are free of charge.

Other formats

You can get this information in other formats, such as braille, 20-point font large print, audio, and accessible electronic formats at no cost to you. Call the county telephone number listed on the cover of this handbook (TTY: 711). The call is toll free.

Interpreter Services

The county provides oral interpretation services from a qualified interpreter, on a 24-hour basis, at no cost

to you. You do not have to use a family member or friend as an interpreter. We discourage the use of minors as interpreters, unless it is an emergency. Interpreter, linguistic and cultural services are available at no cost to you. Help is available 24 hours a day, 7 days a week. For language help or to get this handbook in a different language, call the county telephone number listed on the cover of this handbook (TTY: 711). The call is toll free.

COUNTY CONTACT INFORMATION

We are here to help. The following county contact information will help you get the services you need.

FCMHP Plan Administration 559-600-4645

24/7 Acess Line1(800) 654-3937

Mobile Crisis Response (559) 600-6000

CalHOPE Warm Line 1 833 317-HOPE(4673)

Fresno County Department of Behavioral Health webpage

https://www.fresnocountyca.gov/Departments/Behavioral-Health

FCMHP Provider Directory

https://www.fresnocountyca.gov/Departments/Behavioral-Health/Providers/Managed-Care/Provider-Directory

Who Do I Contact If I'm Having Suicidal Thoughts?

If you or someone you know is in crisis, please call the 988 Suicide and Crisis Lifeline at **988** or the National Suicide Prevention Lifeline at **1-800-273-TALK (8255)**. Chat is available at https://988lifeline.org/.

To access your local programs, please call the 24/7 Access Line listed above.

PURPOSE OF THIS HANDBOOK

Why is it important to read this handbook?

Your county has a mental health plan that offers mental health services known as “specialty mental health services”. Additionally, your county has a Drug Medi-Cal Organized Delivery System that provides services for alcohol or drug use, known as “substance use disorder services”. Together these services are known as ”behavioral health services”, and it is important that you have information about these services so that you can get the care you need. This handbook explains your benefits and how to get care. It will also answer many of your questions.

You will learn:

- How to receive behavioral health services through your county.

- What benefits you can access.
- What to do if you have a question or problem.
- Your rights and responsibilities as a member of your county.
- If there is additional information about your county, which may be indicated at the end of this handbook.

If you do not read this handbook now, you should hold on to it so you can read it later. This book is meant to be used along with the book you got when you signed up for your Medi-Cal benefits. If you have any questions about your Medi-Cal benefits, call the county using the phone number on the front of this book.

Where Can I Go for More Information About Medi-Cal?

Visit the Department of Health Care Services website at https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Beneficiaries.aspx for more information about Medi-Cal.

BEHAVIORAL HEALTH SERVICES INFORMATION

How to Tell if You or Someone You Know Needs Help?

Many people go through hard times in life and may experience mental health or substance use conditions. The most important thing to remember is that help is available. If you or your family member are qualified for Medi-Cal and need behavioral health services, you should call the 24/7 Access Line listed on the cover of this handbook. Your managed care plan can also help you contact your county if they believe you or a family member need behavioral health services that the managed care plan does not cover. Your county will help you find a provider for the services you may need.

The list below can help you decide if you or a family member needs help. If more than one sign is

present or happens for a long time, it may be a sign of a more serious problem that requires professional help. Here are some common signs you might need help with a mental health condition or substance use condition:

Thoughts and Feelings

- Strong mood changes, possibly with no reason, such as:
  - Too much worry, anxiety, or fear
  - Too sad or low
  - Too good, on top of the world
  - Moody or angry for too long
- Thinking about suicide
- Focusing only on getting and using alcohol or drugs
- Problems with focus, memory or logical thought and speech that are hard to explain
- Problems with hearing, seeing, or sensing things

that are hard to explain or that most people say don’t exist

Physical

- Many physical problems, possibly without obvious causes, such as:
  - Headaches
  - Stomach aches
  - Sleeping too much or too little
  - Eating too much or too little
  - Unable to speak clearly
- Decline in looks or strong concern with looks, such as:
  - Sudden weight loss or gain
  - Red eyes and unusually large pupils
  - Odd smells on breath, body, or clothing

Behavioral

- Having consequences from your behavior because of changes to your mental health or using alcohol or drugs, such as:
    - Having issues at work or school
    - Problems in relationships with other people, family, or friends
    - Forgetting your commitments
    - Not able to carry out usual daily activities
- Avoiding friends, family, or social activities
- Having secretive behavior or secret need for money
- Becoming involved with the legal system because of changes to your mental health or using alcohol or drugs

Members Under the Age of 21

How Do I Know When a Child or Teenager Needs Help?

You may contact your county or managed care plan for a screening and assessment for your child or teenager if you think they are showing signs of a behavioral health condition. If your child or teenager qualifies for Medi-Cal and the screening or assessment shows that behavioral health services are needed, then the county will arrange for your child or teenager to receive behavioral health services. Your managed care plan can also help you contact your county if they believe your child or teenager needs behavioral health services that the managed care plan does not cover. There are also services available for parents who feel stressed by being a parent.

Minors 12 years of age or older, may not need parental consent to receive outpatient mental health

services or residential shelter services if the attending professional person believes the minor is mature enough to participate in the behavioral health services or residential shelter services. Minors 12 years of age or older, may not need parental consent to receive medical care and counseling to treat a substance use disorder related problem. Parental or guardian involvement is required unless the attending professional person determines that their involvement would be inappropriate after consulting with the minor.

The list below can help you decide if your child or teenager needs help. If more than one sign is present or persists for a long time, it may be that your child or teenager has a more serious problem that requires professional help. Here are some signs to look out for:

- A lot of trouble paying attention or staying still, putting them in physical danger or causing school problems
- Strong worries or fears that get in the way of daily activities
- Sudden huge fear without reason, sometimes with racing heart rate or fast breathing
- Feels very sad or stays away from others for two or more weeks, causing problems with daily activities
- Strong mood swings that cause problems in relationships
- Big changes in behavior
- Not eating, throwing up, or using medicine to cause weight loss
- Repeated use of alcohol or drugs

- Severe, out-of-control behavior that can hurt self or others
- Serious plans or tries to harm or kill self
- Repeated fights, use of a weapon, or serious plan to hurt others

ACCESSING BEHAVIORAL HEALTH SERVICES

How Do I Get Behavioral Health Services?

If you think you need behavioral health services such as mental health services and/or substance use disorder services, you can call your county using the telephone number listed on the cover of this handbook. Once you contact the county, you will receive a screening and be scheduled for an appointment for an assessment.

You can also request behavioral health services from your managed care plan if you are a member. If the managed care plan determines that you meet the access criteria for behavioral health services, the managed care plan will help you to get an assessment to receive behavioral health services through your county. Ultimately, there is no wrong door for getting behavioral health services. You may

even be able to receive behavioral health services through your managed care plan in addition to behavioral health services through your county. You can access these services through your behavioral health provider if your provider determines that the services are clinically appropriate for you and as long as those services are coordinated and not duplicative.

In addition, keep the following in mind:

- You may be referred to your county for behavioral health services by another person or organization, including your general practitioner/doctor, school, a family member, guardian, your managed care plan, or other county agencies. Usually, your doctor or the managed care plan will need your consent or the permission of the parent or caregiver of a child, to make the referral directly to the county, unless

there is an emergency.

- Your county may not deny a request to do an initial assessment to determine whether you meet the criteria for receiving behavioral health services.
- Behavioral health services can be provided by the county or other providers the county contracts with (such as clinics, treatment centers, community-based organizations, or individual providers).

Where Can I Get Behavioral Health Services?

You can get behavioral health services in the county where you live, and outside of your county if necessary. Each county has behavioral health services for children, youth, adults, and older adults. If you are under 21 years of age, you are eligible for additional coverage and benefits under Early and Periodic Screening, Diagnostic, and Treatment. See

the “Early and Periodic Screening, Diagnostic, and Treatment” section of this handbook for more information.

Your county will help you find a provider who can get you the care you need. The county must refer you to the closest provider to your home, or within time or distance standards who will meet your needs.

When Can I Get Behavioral Health Services?

Your county has to meet appointment time standards when scheduling a service for you. For mental health services, the county must offer you an appointment:

- Within 10 business days of your non-urgent request to start services with the mental health plan;
- Within 48 hours if you request services for an urgent condition;

- Within 15 business days of your non-urgent request for an appointment with a psychiatrist; and,
- Within 10 business days from the prior appointment for nonurgent follow up appointments for ongoing conditions.

For substance use disorder services, the county must offer you an appointment:

- Within 10 business days of your non-urgent request to start services with a substance use disorder provider for outpatient and intensive outpatient services;
- Within 3 business days of your request for Narcotic Treatment Program services;
- A follow-up non-urgent appointment within 10 days if you're undergoing a course of treatment for an ongoing substance use disorder, except

for certain cases identified by your treating provider.

However, these times may be longer if your provider has determined that a longer waiting time is medically appropriate and not harmful to your health. If you have been told you have been placed on a waitlist and feel the length of time is harmful to your health, contact your county at the telephone number listed on the cover of this handbook. You have the right to file a grievance if you do not receive timely care. For more information about filing a grievance, see “The Grievance Process” section of this handbook.

What Are Emergency Services?

Emergency services are services for members experiencing an unexpected medical condition,

including a psychiatric emergency medical condition. An emergency medical condition has symptoms so severe (possibly including severe pain) that an average person could reasonably expect the following might happen at any moment:

- The health of the individual (or the health of an unborn child) could be in serious trouble
- Causes serious harm to the way your body works
- Causes serious damage to any body organ or part

A psychiatric emergency medical condition occurs when an average person thinks that someone:

- Is a current danger to himself or herself or another person because of a mental health condition or suspected mental health condition.
- Is immediately unable to provide or eat food, or

use clothing or shelter because of a mental health condition or suspected mental health condition.

Emergency services are covered 24 hours a day, seven days a week for Medi-Cal members. Prior authorization is not required for emergency services. The Medi-Cal program will cover emergency conditions, whether the condition is due to a physical health or mental health condition (thoughts, feelings, behaviors which are a source of distress and/or dysfunction in relation to oneself or others). If you are enrolled in Medi-Cal, you will not receive a bill to pay for going to the emergency room, even if it turns out to not be an emergency. If you think you are having an emergency, call **911** or go to any hospital or other setting for help.

Who Decides Which Services I Will Receive?

You, your provider, and the county are all involved in deciding what services you need to receive. A behavioral health professional will talk with you and will help determine what kind of services are needed.

You do not need to know if you have a behavioral health diagnosis or a specific behavioral health condition to ask for help. You will be able to receive some services while your provider completes an assessment.

If you are under the age of 21, you may also be able to access behavioral health services if you have a behavioral health condition due to trauma, involvement in the child welfare system, juvenile justice involvement, or homelessness. Additionally, if you are under age 21, the county

must provide medically necessary services to help your behavioral health condition. Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered medically necessary.

Some services may require prior authorization from the county. Services that require prior authorization include Intensive Home-Based Services, Day Treatment Intensive, Day Rehabilitation, Therapeutic Behavioral Services, Therapeutic Foster Care and Substance Use Disorder Residential Services. You may ask the county for more information about its prior authorization process. Call your county using the telephone number on the cover of this handbook to request additional information.

The county’s authorization process must follow specific timelines.

- For a standard substance use disorder authorization, the county must decide on your provider's request within 14 calendar days.
    - If you or your provider request, or if the county thinks it is in your interest to get more information from your provider, the timeline can be extended for up to another 14 calendar days. An example of when an extension might be in your interest is when the county thinks it might be able to approve your provider's request for authorization if the county had additional information from your provider and would have to deny the request without the information. If the county extends the timeline, the county will send you a written notice about the extension.
- For a standard prior mental health authorization, the county must decide based on your provider's request as quickly as your condition requires,

but not to exceed five (5) business days from when the county receives the request.

- For example, if following the standard timeframe could seriously jeopardize your life, health, or ability to attain, maintain, or regain maximum function, your county must rush an authorization decision and provide notice based on a timeframe related to your health condition that is no later than 72 hours after receipt of the service request. Your county may extend the time for up to 14 additional calendar days after the county receives the request if you or your provider request the extension or the county provides justification for why the extension is in your best interest.

In both cases, if the county extends the timeline for the provider's authorization request, the county will

send you a written notice about the extension. If the county does not make a decision within the listed timelines or denies, delays, reduces, or terminates the services requested, the county must send you a Notice of Adverse Benefit Determination telling you that the services are denied, delayed, reduced or terminated, inform you that you may file an appeal, and give you information on how to file an appeal.

You may ask the county for more information about its authorization process.

If you don’t agree with the county’s decision on an authorization process, you may file an appeal. For more information, see the "Problem Resolution” section of this handbook.

What Is Medical Necessity?

Services you receive must be medically necessary and clinically appropriate to address your condition. For members 21 years of age and older, a service is medically necessary when it is reasonable and necessary to protect your life, prevent significant illness or disability, or improve severe pain.

For members under the age of 21, a service is considered medically necessary if it corrects, sustains, supports, improves, or makes more tolerable a behavioral health condition. Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered medically necessary and covered as Early and Periodic Screening, Diagnostic, and Treatment services.

How Do I Get Other Mental Health Services That Are Not Covered by the County?

If you are enrolled in a managed care plan, you have access to the following outpatient mental health services through your managed care plan:

- Mental health evaluation and treatment, including individual, group and family therapy.
- Psychological and neuropsychological testing, when clinically indicated to evaluate a mental health condition.
- Outpatient services for purposes of monitoring prescription drugs.
- Psychiatric consultation.

To get one of the above services, call your managed care plan directly. If you are not in a managed care plan, you may be able to get these services from individual providers and clinics that accept Medi-Cal.

The county may be able to help you find a provider or clinic.

Any pharmacy that accepts Medi-Cal can fill prescriptions to treat a mental health condition. Please note that most prescription medication dispensed by a pharmacy, called Medi-Cal Rx, is covered under the Fee-For-Service Medi-Cal program, not your managed care plan.

What Other Substance Use Disorder Services Are Available from Managed Care Plans or the Medi-Cal "Fee for Service" Program?

Managed care plans must provide covered substance use disorder services in primary care settings and tobacco, alcohol, and illegal drug screening. They must also cover substance use disorder services for pregnant members and alcohol and drug use screening, assessment, brief

interventions, and referral to the appropriate treatment setting for members ages 11 and older. Managed care plans must provide or arrange services for Medications for Addiction Treatment (also known as Medication Assisted Treatment) provided in primary care, inpatient hospital, emergency departments, and other contracted medical settings. Managed care plans must also provide emergency services necessary to stabilize the member, including voluntary inpatient detoxification.

How Do I Get Other Medi-Cal Services (Primary Care/Medi-Cal)?

If you are in a managed care plan, the county is responsible for finding a provider for you. If you are not enrolled in a managed care plan and have "regular" Medi-Cal, also called Fee-For-Service Medi-Cal, then you can go to any provider that

accepts Medi-Cal. You must tell your provider that you have Medi-Cal before you begin getting services. Otherwise, you may be billed for those services. You may use a provider outside your managed care plan for family planning services.

Why Might I Need Psychiatric Inpatient Hospital Services?

You may be admitted to a hospital if you have a mental health condition or signs of a mental health condition that can't be safely treated at a lower level of care, and because of the mental health condition or symptoms of mental health condition, you:

- Represent a danger to yourself, others, or property.
- Are unable to care for yourself with food, clothing, or shelter.
- Present a severe risk to your physical health.

- Have a recent, significant deterioration in the ability to function as a result of a mental health condition.
- Need psychiatric evaluation, medication treatment, or other treatment that can only be provided in the hospital.

SELECTING A PROVIDER

How Do I Find a Provider For The Behavioral Health Services I Need?

Your county is required to post a current provider directory online. You can find the provider directory link in the County Contact section of this handbook. The directory contains information about where providers are located, the services they provide, and other information to help you access care, including information about the cultural and language services that are available from the providers.

If you have questions about current providers or would like an updated provider directory, visit your county's website or use the telephone number located on the cover of this handbook. You can get a list of providers in writing or by mail if you ask for one.

Note: The county may put some limits on your choice of providers. When you first start receiving behavioral health service services you can request that your county provide you with an initial choice of at least two providers. Your county must also allow you to change providers. If you ask to change providers, the county must allow you to choose between at least two providers when possible. Your county is responsible for ensuring that you have timely access to care and that there are enough providers close to you to make sure that you can get covered behavioral health services if you need them.

Sometimes the county's contracted providers choose to no longer provide behavioral health services because they may no longer contract with the county, or no longer accept Medi-Cal. When this happens, the county must make a good faith effort to

give written notice to each person who was receiving services from the provider. You are required to get a notice 30 calendar days prior to the effective date of the termination or 15 calendar days after the county knows the provider will stop working. When this happens, your county must allow you to continue receiving services from the provider who left the county, if you and the provider agree. This is called “continuity of care” and is explained below.

Note: American Indian and Alaska Native individuals who are eligible for Medi-Cal and reside in counties that have opted into the Drug Medi-Cal Organized Delivery System, can also receive Drug Medi-Cal Organized Delivery System services through Indian Health Care Providers that have the necessary Drug Medi-Cal certification.

Can I Continue To Receive Specialty Mental Health Services From My Current Provider?

If you are already receiving mental health services from a managed care plan, you may continue to receive care from that provider even if you receive mental health services from your mental health provider, as long as the services are coordinated between the providers and the services are not the same.

In addition, if you are already receiving services from another mental health plan, managed care plan, or an individual Medi-Cal provider, you may request “continuity of care” so that you can stay with your current provider, for up to 12 months. You may wish to request continuity of care if you need to stay with your current provider to continue your ongoing treatment or because it would cause serious harm to your mental health condition to change to a new

provider. Your continuity of care request may be granted if the following is true:

- You have an ongoing relationship with the provider you are requesting and have seen that provider in the last 12 months;
- You need to stay with your current provider to continue ongoing treatment to prevent serious detriment to the member's health or reduce the risk of hospitalization or institutionalization.
- The provider is qualified and meets Medi-Cal requirements;
- The provider agrees to the mental health plan’s requirements for contracting with the mental health plan and payment for services; and
- The provider shares relevant documentation with the county regarding your need for the services.

Can I Continue To Receive Substance Use Disorder Services From My Current Provider?

You may request to keep your out-of-network provider for a period of time if:

- You have an ongoing relationship with the provider you are requesting and have seen that provider prior to the date of your transition to the Drug Medi-Cal Organized Delivery System county.
- You need to stay with your current provider to continue ongoing treatment to prevent serious detriment to the member's health or reduce the risk of hospitalization or institutionalization.

YOUR RIGHT TO ACCESS BEHAVIORAL HEALTH RECORDS AND PROVIDER DIRECTORY INFORMATION USING SMART DEVICES

You can access your behavioral health records and/or find a provider using an application downloaded on a computer, smart tablet, or mobile device. Information to think about before choosing an application to get information this way can be found on your county's website listed in the County Contact section of this handbook.

SCOPE OF SERVICES

If you meet the criteria for accessing behavioral health services, the following services are available to you based on your need. Your provider will work with you to decide which services will work best for you.

Specialty Mental Health Services

Mental Health Services

- Mental health services are individual, group, or family-based treatment services that help people with mental health conditions to develop coping skills for daily living. These services also include work that the provider does to help make the services better for the person receiving care. These kinds of things include assessments to

see if you need the service and if the service is working; treatment planning to decide the goals of your mental health treatment and the specific services that will be provided; and “collateral”, which means working with family members and important people in your life (if you give permission) to help you improve or maintain your daily living abilities.

- Mental health services can be provided in a clinic or provider’s office, your home or other community setting, over the phone, or by telehealth (which includes both audio-only and video interactions). The county and provider will work with you to determine the frequency of your services/appointments.

Medication Support Services

- These services include prescribing, administering, dispensing, and monitoring of

psychiatric medicines. Your provider can also provide education on the medication. These services can be provided in a clinic, the doctor's office, your home, a community setting, over the phone, or by telehealth (which includes both audio-only and video interactions).

Targeted Case Management

- This service helps members get medical, educational, social, prevocational, vocational, rehabilitative, or other community services when these services may be hard for people with a mental health condition to get on their own. Targeted case management includes, but is not limited to:
    - Plan development;
    - Communication, coordination, and referral;
    - Monitoring service delivery to ensure the

person’s access to service and the service delivery system; and

- Monitoring the person’s progress.

Crisis Intervention Services

- This service is available to address an urgent condition that needs immediate attention. The goal of crisis intervention is to help people in the community so that they won’t need to go to the hospital. Crisis intervention can last up to eight hours and can be provided in a clinic or provider’s office, or in your home or other community setting. These services can also be done over the phone or by telehealth.

Crisis Stabilization Services

- This service is available to address an urgent condition that needs immediate attention. Crisis stabilization lasts less than 24 hours and must

be provided at a licensed 24-hour health care facility, at a hospital-based outpatient program, or at a provider site certified to provide these services.

Adult Residential Treatment Services

- These services provide mental health treatment to those with a mental health condition living in licensed residential facilities. They help build skills for people and provide residential treatment services for people with a mental health condition. These services are available 24 hours a day, seven days a week. Medi-Cal does not cover the room and board cost for staying at these facilities.

Crisis Residential Treatment Services

- These services provide mental health treatment

and skill building for people who have a serious mental or emotional crisis. This is not for people who need psychiatric care in a hospital. Services are available at licensed facilities for 24 hours a day, seven days a week. Medi-Cal does not cover the room and board cost for these facilities.

Day Treatment Intensive Services

- This is a structured program of mental health treatment provided to a group of people who might otherwise need to be in the hospital or another 24-hour care facility. The program lasts three hours a day. It includes therapy, psychotherapy and skill-building activities.

Day Rehabilitation

- This program is meant to help people with a mental health condition learn and develop

coping and life skills to better manage their symptoms. This program lasts at least three hours per day. It includes therapy and skill-building activities.

Psychiatric Inpatient Hospital Services

- These are services provided in a licensed psychiatric hospital. A licensed mental health professional decides if a person needs intensive around-the-clock treatment for their mental health condition. If the professional decides the member needs around-the-clock treatment, the member must stay in the hospital 24 hours a day.

Psychiatric Health Facility Services

- These services are offered at a licensed psychiatric health facility specializing in 24-hour rehabilitative treatment of serious mental health

conditions. Psychiatric health facilities must have an agreement with a nearby hospital or clinic to meet the physical health care needs of the people in the facility. Psychiatric health facilities may only admit and treat patients who have no physical illness or injury that would require treatment beyond what ordinarily could be treated on an outpatient basis.

Therapeutic Behavioral Services

Therapeutic Behavioral Services are intensive short-term outpatient treatment interventions for members up to age 21. These services are designed specifically for each member. Members receiving these services have serious emotional disturbances, are experiencing a stressful change or life crisis, and need additional short-term, specific support services.

These services are a type of specialty mental health service available through the county if you have serious emotional problems. To get Therapeutic Behavioral Services, you must receive a mental health service, be under the age of 21, and have full-scope Medi-Cal.

- If you are living at home, a Therapeutic Behavioral Services staff person can work one-to-one with you to decrease severe behavior problems to try to keep you from needing to go to a higher level of care, such as a group home for children and young people under the age of 21 with very serious emotional problems.
- If you are living in an out-of-home placement, a Therapeutic Behavioral Services staff person can work with you so you may be able to move back home or to a family-based setting, such as a foster home.

Therapeutic Behavioral Services will help you and your family, caregiver, or guardian learn new ways of addressing problem behavior and increasing the kinds of behavior that will allow you to be successful. You, the Therapeutic Behavioral Services staff person, and your family, caregiver, or guardian will work together as a team to address problematic behaviors for a short period until you no longer need the services. You will have a Therapeutic Behavioral Services plan that will say what you, your family, caregiver, or guardian, and the Therapeutic Behavioral Services staff person will do while receiving these services. The Therapeutic Behavioral Services plan will also include when and where services will occur. The Therapeutic Behavioral Services staff person can work with you in most places where you are likely to need help.

This includes your home, foster home, school, day treatment program, and other areas in the community.

Intensive Care Coordination

This is a targeted case management service that facilitates the assessment, care planning for, and coordination of services to beneficiaries under age 21. This service is for those that are qualified for the full-scope of Medi-Cal services and who are referred to the service on basis of medical necessity. This service is provided through the principles of the Integrated Core Practice Model. It includes the establishment of the Child and Family Team to help make sure there is a healthy communicative relationship among a child, their family, and involved child-serving systems.

The Child and Family Team includes professional support (for example: care coordinator, providers, and case managers from child-serving agencies), natural support (for example: family members, neighbors, friends, and clergy), and other people who work together to make and carry out the client plan. This team supports and ensures children and families reach their goals.

This service also has a coordinator that:

- Makes sure that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, client-driven,culturally and language appropriate manner.
- Makes sure that services and support are based on needs of child.
- Makes a way to have everyone work together for

the child, family, providers, etc.

- Supports parent/caregiver in helping meet child's needs
- Helps establish the Child and Family Team and provides ongoing support.
- Makes sure the child is cared for by other child-serving systems when needed.

Intensive Home-Based Services

- These services are designed specifically for each member. It includes strength-based interventions to improve mental health conditions that may interfere with the child/youth's functioning. These services aim to help the child/youth build necessary skills to function better at home and in the community and improve their family's ability to help them do so.

- Intensive Home-Based Services are provided under the Integrated Core Practice Model by the Child and Family Team. It uses the family's overall service plan. These services are provided to members under the age of 21 who are eligible for full-scope Medi-Cal services. A referral based on medical necessity is needed to receive these services.

Therapeutic Foster Care

- The Therapeutic Foster Care service model provides short-term, intensive, and trauma-informed specialty mental health services for children up to the age of 21 who have complex emotional and behavioral needs. These services are designed specifically for each member. In Therapeutic Foster Care, children are placed with trained, supervised, and supported Therapeutic Foster Care parents.

Justice-Involved Reentry

- Providing health services to justice-involved members up to 90 days prior to their incarceration release. The types of services available include reentry case management, behavioral health clinical consultation services, peer supports, behavioral health counseling, therapy, patient education, medication services, post-release and discharge planning, laboratory and radiology services, medication information, support services, and assistance to enroll with the appropriate provider, for example a Narcotic Treatment Program to continue with Medication Assisted Treatment upon release. To receive these services, individuals must be a Medi-Cal or CHIP member, and:
    - If under the age of 21 in custody at a Youth Correctional Facility.

    - If an adult, be in custody and meet one of the health care needs of the program.
- Contact your county using the telephone number on the cover of this handbook for more information on this service.

Medi-Cal Peer Support Services (varies by county)

- Medi-Cal Peer Support Services promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities. These services can be provided to you or your designated significant support person(s) and can be received at the same time as you receive other mental health services. The Peer Support Specialist in Medi-Cal Peer Support Services is an individual who has lived experience with behavioral health or

substance use conditions and is in recovery, who has completed the requirements of a county's State-approved certification program, who is certified by the county, and who provides these services under the direction of a Behavioral Health Professional who is licensed, waivered, or registered with the State.

- Medi-Cal Peer Support Services include individual and group coaching, educational skill-building groups, resource navigation, engagement services to encourage you to participate in behavioral health treatment, and therapeutic activities such as promoting self-advocacy.
- Members under age 21 may be eligible for the service under Early and Periodic Screening, Diagnostic, and Treatment regardless of which county they live in.

- Providing Medi-Cal Peer Support Services is optional for participating counties. Refer to the "Additional Information About Your County" section located at the end of this handbook to find out if your county provides this service.

Mobile Crisis Services

- Mobile Crisis Services are available if you are having a mental health crisis.
- Mobile Crisis Services are provided by health providers at the location where you are experiencing a crisis, including at your home, work, school, or other community locations, excluding a hospital or other facility setting. Mobile Crisis Services are available 24 hours a day, 7 days a week, and 365 days a year.
- Mobile Crisis Services include rapid response, individual assessment, and community-based

stabilization. If you need further care, the mobile crisis providers will also provide warm handoffs or referrals to other services.

Substance Use Disorder Services

What are Drug Medi-Cal Organized Delivery System County Services?

Drug Medi-Cal Organized Delivery System county services are for people who have a substance use condition, meaning they may be misusing alcohol or other drugs, or people who may be at risk of developing a substance use condition that a pediatrician or general practitioner may not be able to treat. These services also include work that the provider does to help make the services better for the person receiving care. These kinds of things include assessments to see if you need the service and if the service is working.

Drug Medi-Cal Organized Delivery System services can be provided in a clinic or provider's office, or your home or other community setting, over the phone, or by telehealth (which includes both audio-only and video interactions). The county and provider will work with you to determine the frequency of your services/appointments.

American Society of Addiction Medicine (ASAM)

Some of the Drug Medi-Cal Organized Delivery System services you may receive are based on the American Society of Addiction Medicine standards. The county or provider will use the American Society of Addiction Medicine tool to find the right type of services for you – if needed. These types of services are described as "levels of care," and are defined below.

Screening, Assessment, Brief Intervention, and Referral to Treatment (American Society of Addiction Medicine Level 0.5)

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT) is not a Drug Medi-Cal Organized Delivery System benefit. It is a benefit in Medi-Cal Fee-for-Service and Medi-Cal managed care delivery system for members that are aged 11 years and older. Managed care plans must provide covered substance use disorder services, including this service for members ages 11 years and older.

Early Intervention Services

Early intervention services are a covered Drug Medi-Cal Organized Delivery System service for members under age 21. Any member under age 21 who is screened and determined to be at risk of developing

a substance use disorder may receive any service covered under the outpatient level of service as early intervention services. A substance use disorder diagnosis is not required for early intervention services for members under age 21.

Early Periodic Screening, Diagnosis, and Treatment

Members under age 21 can get the services described earlier in this handbook as well as additional Medi-Cal services through a benefit called Early and Periodic Screening, Diagnostic, and Treatment.

To be able to get Early and Periodic Screening, Diagnostic, and Treatment services, a member must be under age 21 and have full-scope Medi-Cal. This benefit covers services that are medically necessary to correct or help physical and behavioral health

conditions. Services that sustain, support, improve, or make a condition more tolerable are considered to help the condition and are covered as Early and Periodic Screening, Diagnostic, and Treatment services. The access criteria for members under 21 are different and more flexible than the access criteria for adults accessing Drug Medi-Cal Organized Delivery System services, to meet the Early and Periodic Screening, Diagnostic, and Treatment requirement and the intent for prevention and early intervention of substance use disorder conditions.

If you have questions about these services, please call your county or visit the DHCS Early and Periodic Screening, Diagnostic, and Treatment webpage.

Outpatient Treatment Services (American Society of Addiction Medicine Level 1)

- Counseling services are provided to members up to nine hours a week for adults and less than six hours a week for members under age 21 when medically necessary. You might get more hours based on your needs. Services can be provided by someone licensed, like a counselor, in person, by telephone, or by telehealth.
- Outpatient Services include assessment, care coordination, counseling (individual and group), family therapy, medication services, Medications for Addiction Treatment for opioid use disorder, Medications for Addiction Treatment for alcohol use disorder and other non-opioid substance use disorders, patient education, recovery services, and substance use disorder crisis intervention services.

Intensive Outpatient Services (American Society of Addiction Medicine Level 2.1)

- Intensive Outpatient Services are given to members a minimum of nine hours with a maximum of 19 hours a week for adults, and a minimum of six hours with a maximum of 19 hours a week for members under age 21 when medically necessary. Services may exceed the maximum based on individual medical necessity. Services are mostly counseling and education about addiction-related issues. Services can be provided by a licensed professional or a certified counselor in a structured setting. Intensive Outpatient Treatment Services may be provided in person, by telehealth, or by telephone.
- Intensive Outpatient Services include the same things as Outpatient Services. More hours of service is the main difference.

Partial Hospitalization (varies by county) (American Society of Addiction Medicine Level 2.5)

- Members under age 21 may get this service under Early and Periodic Screening, Diagnostic, and Treatment regardless of the county where they live.
- Partial Hospitalization services include 20 or more hours of services per week, as medically necessary. Partial hospitalization programs have direct access to psychiatric, medical, and laboratory services and meet the identified needs which warrant daily monitoring or management but can be appropriately addressed in a clinic. Services may be provided in person, by telehealth, or by telephone.
- Partial Hospitalization services are similar to Intensive Outpatient Services, with an increase

in the number of hours and additional access to medical services being the main differences.

Residential Treatment (subject to authorization by the county) (American Society of Addiction Medicine Levels 3.1 – 4.0)

- Residential Treatment is a program that provides rehabilitation services to members with a substance use disorder diagnosis, when determined as medically necessary. The member shall live on the property and be supported in their efforts to change, maintain, apply interpersonal and independent living skills by accessing community support systems. Most services are provided in person; however, telehealth and telephone may also be used to provide services while a person is in residential treatment. Providers and residents work together to define barriers, set priorities,

establish goals, and solve substance use disorder-related problems. Goals include not using substances, preparing for relapse triggers, improving personal health and social skills, and engaging in long-term care.

- Residential services require prior authorization by the Drug Medi-Cal Organized Delivery System county.
- Residential Services include intake and assessment, care coordination, individual counseling, group counseling, family therapy, medication services, Medications for Addiction Treatment for opioid use disorder, Medications for Addiction Treatment for alcohol use disorder and other non-opioid substance use disorders, patient education, recovery services, and substance use disorder crisis intervention services.

- Residential Services providers are required to either offer medications for addiction treatment directly on-site or help members get medications for addiction treatment off-site. Residential Services providers do not meet this requirement by only providing the contact information for Medications for Addiction Treatment providers. Residential Services providers are required to offer and prescribe medications to members covered under the Drug Medi-Cal Organized Delivery System.

Inpatient Treatment Services (subject to authorization by the county) (varies by county) (American Society of Addiction Medicine Levels 3.1 – 4.0)

- Beneficiaries under age 21 may be eligible for the service under Early and Periodic Screening,

Diagnostic, and Treatment regardless of their county of residence.

- Inpatient services are provided in a 24-hour setting that provides professionally directed evaluation, observation, medical monitoring, and addiction treatment in an inpatient setting. Most services are provided in person; however, telehealth and telephone may also be used to provide services while a person is in inpatient treatment.
- Inpatient services are highly structured, and a physician is likely available on-site 24 hours daily, along with Registered Nurses, addiction counselors, and other clinical staff. Inpatient Services include assessment, care coordination, counseling, family therapy, medication services, Medications for Addiction Treatment for opioid use disorder, Medications for Addiction Treatment for Alcohol use disorder and other

non-opioid substance use disorders, patient education, recovery services, and substance use disorder crisis intervention services.

Narcotic Treatment Program

- Narcotic Treatment Programs are programs outside of a hospital that provide medications to treat substance use disorders, when ordered by a doctor as medically necessary. Narcotic Treatment Programs are required to give medications to members, including methadone, buprenorphine, naloxone, and disulfiram.
- A member must be offered, at a minimum, 50 minutes of counseling sessions per calendar month. These counseling services can be provided in person, by telehealth, or by telephone. Narcotic Treatment Services include assessment, care coordination, counseling, family therapy, medical psychotherapy,

medication services, care managment, Medications for Addiction Treatment for opioid use disorder, Medications for Addiction Treatment for alcohol use disorder and other non-opioid substance use disorders, patient education, recovery services, and substance use disorder crisis intervention services.

Withdrawal Management

- Withdrawal management services are urgent and provided on a short-term basis. These services can be provided before a full evaluation has been done. Withdrawal management services may be provided in an outpatient, residential, or inpatient setting.
- Regardless of the type of setting, the member shall be monitored during the withdrawal management process. Members receiving withdrawal management in a residential or

inpatient setting shall live at that location. Medically necessary habilitative and rehabilitative services are prescribed by a licensed physician or licensed prescriber.

- Withdrawal Management Services include assessment, care coordination, medication services, Medications for Addiction Treatment for opioid use disorder, Medications for Addiction Treatment for alcohol use disorder and other non-opioid substance use disorders, observation, and recovery services.

Medications for Addiction Treatment

- Medications for Addiction Treatment Services are available in clinical and non-clinical settings. Medications for Addiction Treatment include all FDA-approved medications and biological products to treat alcohol use disorder, opioid use disorder, and any substance use disorder.

Members have a right to be offered Medications for Addiction Treatment on-site or through a referral outside of the facility. A list of approved medications include:

  - Acamprosate Calcium
  - Buprenorphine Hydrochloride
  - Buprenorphine Extended-Release Injectable (Sublocade)
  - Buprenorphine/Naloxone Hydrochloride
  - Naloxone Hydrochloride
  - Naltrexone (oral)
  - Naltrexone Microsphere Injectable Suspension (Vivitrol)
  - Lofexidine Hydrochloride (Lucemyra)
  - Disulfiram (Antabuse)
  - Methadone (delivered by Narcotic Treatment Programs)

- Medications for Addiction Treatment may be provided with the following services:

assessment, care coordination, individual counseling, group counseling, family therapy, medication services, patient education, recovery services, substance use disorder crisis intervention services, and withdrawal management services. Medications for Addiction Treatment may be provided as part of all Drug Medi-Cal Organized Delivery System services, including Outpatient Treatment Services, Intensive Outpatient Services, and Residential Treatment, for example.

- Members may access Medications for Addiction Treatment outside of the Drug Medi-Cal Organized Delivery System county as well. For instance, Medications for Addiction Treatment, such as buprenorphine, can be prescribed by some prescribers in primary care settings that work with your managed care plan and can be dispensed or administered at a pharmacy.

Justice-Involved Reentry

- Providing health services to justice-involved members up to 90 days prior to their incarceration release. The types of services available include reentry case management, behavioral health clinical consultation services, peer supports, behavioral health counseling, therapy, patient education, medication services, post-release and discharge planning, laboratory and radiology services, medication information, support services, and assistance to enroll with the appropriate provider, for example a Narcotic Treatment Program to continue with Medication Assisted Treatment upon release. To receive these services, individuals must be a Medi-Cal or CHIP member, and:
    - If under the age of 21 in custody at a Youth Correctional Facility.

    - If an adult, be in custody and meet one of the health care needs of the program.
- Contact your county using the telephone number on the cover of this handbook for more information on this service.

Medi-Cal Peer Support Services (varies by county)

- Medi-Cal Peer Support Services promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities. These services can be provided to you or your designated significant support person(s) and can be received at the same time as you receive other Drug Medi-Cal Organized Delivery System services. The Peer Support Specialist in Medi-Cal Peer Support Services is an individual who has lived

experience with behavioral health or substance use conditions and is in recovery, who has completed the requirements of a county's State-approved certification program, who is certified by the counties, and who provides these services under the direction of a Behavioral Health Professional who is licensed, waivered, or registered with the State.

- Medi-Cal Peer Support Services include individual and group coaching, educational skill-building groups, resource navigation, engagement services to encourage you to participate in behavioral health treatment, and therapeutic activities such as promoting self-advocacy.
- Members under age 21 may be eligible for the service under Early and Periodic Screening, Diagnostic, and Treatment regardless of which county they live in.

- Providing Medi-Cal Peer Support Services is optional for participating counties. Refer to the “Additional Information About Your County” section located at the end of this handbook to find out if your county provides this service.

Recovery Services

- Recovery Services can be an important part of your recovery and wellness. Recovery services can help you get connected to the treatment community to manage your health and health care. Therefore, this service emphasizes your role in managing your health, using effective self-management support strategies, and organizing internal and community resources to provide ongoing self-management support.
- You may receive Recovery Services based on your self-assessment or your provider’s assessment of risk of relapsing. You may also

receive Recovery Services in person, by telehealth, or by telephone.

- Recovery Services include assessment, care coordination, individual counseling, group counseling, family therapy, recovery monitoring, and relapse prevention components.

Care Coordination

- Care Coordination Services consists of activities to provide coordination of substance use disorder care, mental health care, and medical care, and to provide connections to services and supports for your health. Care Coordination is provided with all services and can occur in clinical or non-clinical settings, including in your community.
- Care Coordination Services include coordinating with medical and mental health providers to monitor and support health conditions, discharge

planning, and coordinating with ancillary services including connecting you to community-based services such as childcare, transportation, and housing.

Contingency Management (varies by county)

- Members under age 21 may be eligible for the service under Early and Periodic Screening, Diagnostic, and Treatment regardless of their county of residence.
- Providing Contingency Management Services is optional for participating counties. Refer to the "Additional Information About Your County" section located at the end of this handbook to find out if your county provides this service.
- Contingency Management Services are an evidence-based treatment for stimulant use disorder where eligible members will participate in a structured 24 week outpatient Contingency

Management service, followed by six or more months of additional treatment and recovery support services without incentives.

- The initial 12 weeks of Contingency Management services include a series of incentives for meeting treatment goals, specifically not using stimulants (e.g., cocaine, amphetamine, and methamphetamine). Participants must agree to urine drug tests as often as determined by the Contingency Management services program. The incentives consist of cash equivalents (e.g., gift cards).
- Contingency Management Services are only available to members who are receiving services in a non-residential setting operated by a participating provider and are enrolled and participating in a comprehensive, individualized course of treatment.

Mobile Crisis Services

- Mobile Crisis Services are available if you are having a substance use crisis.
- Mobile Crisis Services are provided by health providers at the location where you are experiencing a crisis, including at your home, work, school, or other community locations, excluding a hospital or other facility setting. Mobile Crisis Services are available 24 hours a day, 7 days a week, and 365 days a year.
- Mobile Crisis Services include rapid response, individual assessment, and community-based stabilization. If you need further care, the mobile crisis providers will also provide warm handoffs or referrals to other services.

AVAILABLE SERVICES BY TELEPHONE OR TELEHEALTH

In-person, face-to-face contact between you and your provider is not always required for you to be able to receive behavioral health services. Depending on your services, you might be able to receive your services through telephone or telehealth. Your provider should explain to you about using telephone or telehealth and make sure you agree before beginning services via telephone or telehealth. Even if you agree to receive your services through telehealth or telephone, you can choose later to receive your services in-person or face-to-face. Some types of behavioral health services cannot be provided only through telehealth or telephone because they require you to be at a specific place for the service, such as residential treatment services or hospital services.

THE PROBLEM RESOLUTION PROCESS: TO FILE A GRIEVANCE, APPEAL, OR REQUEST A STATE FAIR HEARING

What If I Don't Get the Services I Want From My County?

Your county must have a way for you to work out any problems related to the services you want or are receiving. This is called the problem-resolution process and it could involve the following:

- The Grievance Process: A verbal or written expression of unhappiness about anything regarding your specialty mental health services, substance use disorder services, a provider, or the county. Refer to the Grievance Process section in this handbook for more information.
- The Appeal Process: An appeal is when you don't agree with the county's decision to change your services (e.g., denial, termination, or

reduction to services) or to not cover them. Refer to the Appeal Process section in this handbook for more information.

- The State Fair Hearing Process: A State Fair Hearing is a meeting with a judge from the California Department of Social Services (CDSS) if the county denies your appeal. Refer to the State Fair Hearing section in this handbook for more information.

Filing a grievance, appeal, or requesting a State Fair Hearing will not count against you and will not impact the services you are receiving. Filing a grievance or appeal helps to get you the services you need and to solve any problems you have with your behavioral health services. Grievances and appeals also help the county by giving them the information they can use to improve services. Your county will notify you, providers, and

parents/guardians of the outcome once your grievance or appeal is complete. The State Fair Hearing Office will notify you and the provider of the outcome once the State Fair Hearing is complete.

Note: Learn more about each problem resolution process below.

Can I Get Help With Filing an Appeal, Grievance, or State Fair Hearing?

Your county will help explain these processes to you and must help you file a grievance, an appeal, or to request a State Fair Hearing. The county can also help you decide if you qualify for what's called an "expedited appeal" process, which means it will be reviewed more quickly because your health, mental health, and/or stability are at risk. You may also authorize another person to act on your behalf, including your provider or advocate.

If you would like help, contact your county using the telephone number listed on the cover of this handbook. Your county must give you reasonable assistance in completing forms and other procedural steps related to a grievance or appeal. This includes, but is not limited to, providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.

If You Need Further Assistance

Contact the Department of Health Care Services, Office of the Ombudsman:

- Phone: # **1-888-452-8609**, Monday through Friday, 8 a.m. to 5 p.m. (excluding holidays).

OR

- E-mail: MMCDOmbudsmanOffice@dhcs.ca.gov. **Please note**: E-mail messages are not considered confidential (please do not include

personal information in the e-mail message).

You may also get free legal help at your local legal aid office or other groups. To ask about your State Fair Hearing rights, you can contact the California Department of Social Services Public Inquiry and Response Unit at this phone number: **1-800-952-5253** (for TTY, call **1-800-952-8349**).

Grievances

What Is a Grievance?

A grievance is a complaint regarding your unhappiness with any aspect of your behavioral health services or the county that is not covered by the appeal or State Fair Hearing processes.

What Is the Grievance Process?

The grievance process will:

- Involve simple steps to file your grievance orally or in writing.
- Not cause you to lose your rights or services or be held against your provider.
- Allow you to approve another person to act on your behalf. This could be a provider or an advocate. If you agree to have another person act on your behalf, you may be asked to sign an authorization form, which gives your county

permission to release information to that person.

- Make sure the approved person deciding on the grievance is qualified to make decisions and has not been a part of any previous level of review or decision-making.
- Determine the duties of your county, provider, and yourself.
- Make sure the results of the grievance are provided within the required timeline.

When Can I File a Grievance?

You can file a grievance at any time if you are unhappy with the care you have received or have another concern regarding your county.

How Can I File a Grievance?

You may call your county's 24/7 toll-free Access Line at any time to receive assistance with a grievance. Oral or written grievances can be filed. Oral grievances do not have to be followed up in writing. If you file your grievance in writing, please note the following: Your county supplies self-addressed envelopes at all provider sites. If you do not have a self-addressed envelope, mail your written grievances to the address provided on the front of this handbook.

How Do I Know If the County Received My Grievance?

Your county is required to provide you with a written letter to let you know your grievance has been received within five calendar days of receipt. A grievance received over the phone or in person, that

you agree is resolved by the end of the next business day, is exempt and you may not get a letter.

When Will My Grievance Be Decided?

A decision about your grievance must be made by your county within 30 calendar days from the date your grievance was filed.

How Do I Know If the County Has Made a Decision About My Grievance?

When a decision has been made about your grievance, the county will:

- Send you or your approved person a written notice of the decision;
- Send you or your approved person a Notice of Adverse Benefit Determination advising you of your right to request a State Fair Hearing if the

county does not notify you of the grievance decision on time;

- Advise you of your right to request a State Fair Hearing.

You may not get a written notice of the decision if your grievance was filed by phone or in person and you agree your issue has been resolved by the end of the next business day from the date of filing.

Note: Your county is required to provide you with a Notice of Adverse Benefit Determination on the date the timeframe expires. You may call the county for more information if you do not receive a Notice of Adverse Benefit Determination.

Is There a Deadline to File a Grievance?

No, you may file a grievance at any time.

Appeals

You may file an appeal when you do not agree with the county's decision for the behavioral health services you are currently receiving or would like to receive. You may request a review of the county's decision by using:

- The Standard Appeal Process.

OR

- The Expedited Appeal Process.

Note: The two types of appeals are similar; however, there are specific requirements to qualify for an expedited appeal (see below for the requirements).

The county shall assist you in completing forms and taking other procedural steps to file an appeal, including preparing a written appeal, notifying you of the location of the form on their website or providing you with the form upon your request. The county

shall also advise and assist you in requesting continuation of benefits during an appeal of the adverse benefit determination in accordance with federal regulations.

What Does the Standard Appeal Process Do?

The Standard Appeal Process will:

- Allow you to file an appeal orally or in writing.
- Make sure filing an appeal will not cause you to lose your rights or services or be held against your provider in any way.
- Allow you to authorize another person (including a provider or advocate) to act on your behalf. Please note: If you authorize another person to act on your behalf, the county might ask you to sign a form authorizing the county to release information to that person.
- Have your benefits continued upon request for

an appeal within the required timeframe. Please note: This is 10 days from the date your Notice of Adverse Benefit Determination was mailed or personally given to you.

- Make sure you do not pay for continued services while the appeal is pending and if the final decision of the appeal is in favor of the county's adverse benefit determination.
- Make sure the decision-makers for your appeal are qualified and not involved in any previous level of review or decision-making.
- Allow you or your representative to review your case file, including medical records and other relevant documents.
- Allow you to have a reasonable opportunity to present evidence, testimony, and arguments in person or in writing.
- Allow you, your approved person, or the legal

representative of a deceased member's estate to be included as parties to the appeal.

- Give you written confirmation from your county that your appeal is under review.
- Inform you of your right to request a State Fair Hearing, following the completion of the appeal process.

When Can I File an Appeal?

You can file an appeal with your county when:

- The county or the contracted provider determines that you do not meet the access criteria for behavioral health services .
- Your healthcare provider recommends a behavioral health service for you and requests approval from your county, but the county denies the request or alters the type or frequency of service.

- Your provider requests approval from the county, but the county requires more information and does not complete the approval process on time.
- Your county does not provide services based on its predetermined timelines.
- You feel that the county is not meeting your needs on time.
- Your grievance, appeal, or expedited appeal was not resolved in time.
- You and your provider disagree on the necessary behavioral health services.

How Can I File an Appeal?

- You may file an appeal via one of the following three methods:
    - Call your county's toll-free phone number listed on the cover of this handbook. After

calling, you will have to file a subsequent written appeal as well; or

- Mail your appeal (The county will provide self-addressed envelopes at all provider sites for you to mail in your appeal). Note: If you do not have a self-addressed envelope, you may mail your appeal directly to the address in the front of this handbook; or
- Submit your appeal by e-mail or fax. Refer to the “Additional Information About Your County” section located at the end of this handbook for more information.

How Do I Know If My Appeal Has Been Decided?

You or your approved person will receive written notification from your county of the decision on your appeal. The notification will include the following information:

- The results of the appeal resolution process.

- The date the appeal decision was made.
- If the appeal is not resolved in your favor, the notice will provide information regarding your right to a State Fair Hearing and how to request a State Fair Hearing.

Is There a Deadline to File an Appeal?

You must file an appeal within 60 calendar days of the date on the Notice of Adverse Benefit Determination. There are no deadlines for filing an appeal when you do not get a Notice of Adverse Benefit Determination, so you may file this type of appeal at any time.

When Will a Decision Be Made About My Appeal?

The county must decide on your appeal within 30 calendar days of receiving your request.

What If I Can't Wait 30 Days for My Appeal Decision?

If the appeal meets the criteria for the expedited appeal process, it may be completed more quickly.

What Is an Expedited Appeal?

An expedited appeal follows a similar process to the standard appeal but is quicker. Here is additional information regarding expedited appeals:

- You must show that waiting for a standard appeal could make your behavioral health condition worse.
- The expedited appeal process follows different deadlines than the standard appeal.
- The county has 72 hours to review expedited appeals.
- You can make a verbal request for an expedited appeal.

- You do not have to put your expedited appeal request in writing.

When Can I File an Expedited Appeal?

If waiting up to 30 days for a standard appeal decision will jeopardize your life, health, or ability to attain, maintain or regain maximum function, you may request an expedited resolution of an appeal.

Additional Information Regarding Expedited Appeals:

- If your appeal meets the requirements for an expedited appeal, the county will resolve it within 72 hours of receiving it.
- If the county determines that your appeal does not meet the criteria for an expedited appeal, they are required to provide you with timely verbal notification and will provide you with

written notice within two calendar days, explaining the reason for their decision. Your appeal will then follow the standard appeal timeframes outlined earlier in this section.

- If you disagree with the county's decision that your appeal does not meet the criteria for expedited appeal, you may file a grievance.
- After your county resolves your request for an expedited appeal, you and all affected parties will be notified both orally and in writing.

State Fair Hearings

What Is A State Fair Hearing?

A State Fair Hearing is an independent review conducted by an administrative law judge from the California Department of Social Services (CDSS) to ensure you receive the behavioral health services that you are entitled to under the Medi-Cal program.

Please visit the California Department of Social Services website https://www.cdss.ca.gov/hearing-requests for additional resources.

What Are My State Fair Hearing Rights?

You have the right to:

- Request a hearing before an administrative law judge, also known as a State Fair Hearing, to address your case.
- Learn how to request a State Fair Hearing.
- Learn about the regulations that dictate how representation works during the State Fair Hearing.
- Request to have your benefits continue during the State Fair Hearing process if you request for a State Fair Hearing within the required timeframes.
- Not pay for continued services while the State

Fair Hearing is pending and if the final decision is in favor of the county's adverse benefit determination.

When Can I File for a State Fair Hearing?

You can file for a State Fair Hearing if:

- You filed an appeal and received an appeal resolution letter telling you that your county denied your appeal request.
- Your grievance, appeal, or expedited appeal wasn't resolved in time.

How Do I Request a State Fair Hearing?

You can request a State Fair Hearing:

- Online: at the Department of Social Services Appeals Case Management website: https://acms.dss.ca.gov/acms/login.request.do
- In Writing: Submit your request to the county

welfare department at the address shown on the Notice of Adverse Benefit Determination, or mail it to:

California Department of Social Services

State Hearings Division

P.O. Box 944243, Mail Station 9-17-37

Sacramento, CA 94244-2430

- By Fax: 916-651-5210 or 916-651-2789

You can also request a State Fair Hearing or an expedited State Fair Hearing:

- By Phone:
  - *State Hearings Division*, toll-free, at **1-800-743-8525** or **1-855-795-0634**.
  - *Public Inquiry and Response*, toll-free, at **1-800-952-5253** or TDD at **1-800-952-8349**.

Is There a Deadline to Ask for a State Fair Hearing?

You have 120 days from the date of the county's written appeal decision notice to request a State Fair Hearing. If you didn't receive a Notice of Adverse Benefit Determination, you may file for a State Fair Hearing at any time.

Can I Continue Services While I'm Waiting for a State Fair Hearing Decision?

Yes, if you are currently receiving authorized services and wish to continue receiving the services while you wait for the State Fair Hearing decision, you must request a State Fair Hearing within 10 days from the date the appeal decision notice was postmarked or delivered to you. Alternatively, you can request the hearing before the date your county says that services will be stopped or reduced.

Note:

- When requesting a State Fair Hearing, you must indicate that you wish to continue receiving services during the State Fair Hearing process.
- If you request to continue receiving services and the final decision of the State Fair Hearing confirms the reduction or discontinuation of the service you are receiving, you are not responsible for paying the cost of services provided while the State Fair Hearing was pending.

When Will a Decision Be Made About My State Fair Hearing Decision?

After requesting a State Fair Hearing, it may take up to 90 days to receive a decision.

Can I Get a State Fair Hearing More Quickly?

If you think waiting that long will be harmful to your health, you might be able to get an answer within three working days. You can request for an Expedited State Fair Hearing by either writing a letter yourself or asking your general practitioner or mental health professional to write a letter for you. The letter must include the following information:

1. Explain in detail how waiting up to 90 days for your case to be decided can seriously harm your life, health, or ability to attain, maintain, or regain maximum function.
2. Ask for an “expedited hearing” and provide the letter with your request for a hearing.

The State Hearings Division of the Department of Social Services will review your request for an expedited State Fair Hearing and determine if it meets the criteria. If your request is approved, a hearing will be scheduled, and a decision will be

made within three working days from the date the State Hearings Division receives your request.

ADVANCE DIRECTIVE

What is an Advance Directive?

You have the right to an advance directive. An advance directive is a written document about your health care that is recognized under California law. You may sometimes hear an advance directive described as a living will or durable power of attorney. It includes information about how you would like health care provided or says what decisions you would like to be made, if or when you are unable to speak for yourself. This may include such things as the right to accept or refuse medical treatment, surgery, or make other health care choices. In California, an advance directive consists of two parts:

- Your appointment of an agent (a person) making decisions about your health care; and
- Your individual health care instructions.

Your county is required to have an advance directive program in place. Your county is required to provide written information on the advance directive policies and explain the state law if asked for the information. If you would like to request the information, you should call the telephone number on the cover of this handbook for more information.

You may get a form for an advance directive from your county or online. In California, you have the right to provide advance directive instructions to all of your healthcare providers. You also have the right to change or cancel your advance directive at any time.

If you have a question about California law regarding advance directive requirements, you may send a letter to:

California Department of Justice
Attn: Public Inquiry Unit
P. O. Box 944255
Sacramento, CA 94244-2550

RIGHTS AND RESPONSIBILITIES

County Responsibilities

What is my County Responsible for?

Your county is responsible for the following:

- Figuring out if you meet the criteria to access behavioral health services from the county or its provider network.
- Providing a screening or an assessment to determine whether you need behavioral health services.
- Providing a toll-free phone number that is answered 24 hours a day, seven days a week, that can tell you how to get services from the county. The telephone number is listed on the

cover of this handbook.

- Making sure there are sufficient behavioral health providers nearby so that you can access the services covered by your county when necessary.
- Informing and educating you about services available from your county.
- Providing services in your language at no cost to you, and if needed, providing an interpreter for you free of charge.
- Providing you with written information about what is available to you in other languages or alternative forms like Braille or large-size print. Refer to the “Additional Information About Your County” section located at the end of this handbook for more information.
- Informing you about any significant changes in the information mentioned in this handbook at

least 30 days before the changes take effect. A change is considered significant when there is an increase or decrease in the quantity or types of services offered, if there is an increase or decrease in the number of network providers, or if there is any other change that would impact the benefits you receive from the county.

- Making sure to connect your healthcare with any other plans or systems that may be necessary to help transition your care smoothly. This includes ensuring that any referrals for specialists or other providers are properly followed up on and that the new provider is willing to take care of you.
- Making sure you can keep seeing your current healthcare provider, even if they are not in your network, for a certain amount of time. This is important if switching providers would harm your health or raise the chance of needing to go to

the hospital.

Is Transportation Available?

If you struggle to attend your medical or behavioral health appointments, the Medi-Cal program helps in arranging transportation for you. Transportation must be provided for Medi-Cal members who are unable to provide transportation on their own and who have a medical necessity to receive Medi-Cal covered services. There are two types of transportation for appointments:

- Non-Medical: transportation by private or public vehicle for people who do not have another way to get to their appointment.
- Non-Emergency Medical: transportation by ambulance, wheelchair van, or litter van for those who cannot use public or private transportation.

Transportation is available for trips to the pharmacy or to pick up needed medical supplies, prosthetics, orthotics, and other equipment.

If you have Medi-Cal but are not enrolled in a managed care plan, and you need non-medical transportation to a health-related service, you can contact the non-medical transportation provider directly or your provider for assistance. When you contact the transportation company, they will ask for information about your appointment date and time.

If you need non-emergency medical transportation, your provider can prescribe non-emergency medical transportation and put you in touch with a transportation provider to coordinate your ride to and from your appointment(s).

For more information and assistance regarding transportation, contact your managed care plan.

Member Rights

What Are My Rights as a Recipient of Medi-Cal Behavioral Health Services?

As a Medi-Cal member, you have the right to receive medically necessary behavioral health services from your county. When accessing behavioral health services, you have the right to:

- Be treated with personal respect and respect for your dignity and privacy.
- Get clear and understandable explanations of available treatment options.
- Participate in decisions related to your behavioral health care. This includes the right to refuse any treatment that you do not wish to receive.
- Get this handbook to learn about county

services, county obligations, and your rights.

- Ask for a copy of your medical records and request changes, if necessary.
- Be free from any form of restraint or seclusion that is imposed as a means of coercion, discipline, convenience, or retaliation.
- Receive timely access to care 24/7 for emergency, urgent, or crisis conditions when medically necessary.
- Upon request, receive written materials in alternative formats such as Braille, large-size print, and audio format in a timely manner.
- Receive behavioral health services from the county that follows its state contract for availability, capacity, coordination, coverage, and authorization of care. The county is required to:
    - Employ or have written contracts with

enough providers to make sure that all Medi-Cal eligible members who qualify for behavioral health services can receive them in a timely manner.

- Cover medically necessary services out-of-network for you in a timely manner, if the county does not have an employee or contract provider who can deliver the services.

  Note: The county must make sure you do not pay anything extra for seeing an out-of-network provider. See below for more information:

  - *Medically necessary behavioral health services* for individuals 21 years of age or older are services that are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain. Medically

necessary behavioral health services for individuals under 21 years of age are services that sustain, support, improve, or make more tolerable a behavioral health condition.

- *Out-of-network provider* is a provider who is not on the county's list of providers.

- Upon your request, provide a second opinion from a qualified health care professional within or outside of the network at no extra cost.
- Make sure providers are trained to deliver the behavioral health services that the providers agree to cover.
- Make sure that the county's covered behavioral health services are enough in amount, length of time, and scope to meet the needs of Medi-Cal-eligible members.

This includes making sure that the county's method for approving payment for services is based on medical necessity and that the access criteria is fairly used.

  - Make sure that its providers conduct thorough assessments and collaborate with you to establish treatment goals.
  - Coordinate the services it provides with services being provided to you through a managed care plan or with your primary care provider, if necessary.
  - Participate in the state's efforts to provide culturally competent services to all, including those with limited English proficiency and diverse cultural and ethnic backgrounds.
- Express your rights without harmful changes to your treatment.
- Receive treatment and services in accordance with your rights described in this handbook and

with all 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 IX of the Education Amendments of 1972 (regarding education programs and activities).
  - Titles II and III of the Americans with Disabilities Act.
  - Section 1557 of the Patient Protection and Affordable Care Act.
- You may have additional rights under state laws regarding behavioral health treatment. To contact your county's Patients' Rights Advocate,

please contact your county by using the telephone number listed on the cover of the handbook.

Adverse Benefit Determinations

What Rights Do I Have if the County Denies the Services I Want or Think I Need?

If your county denies, limits, reduces, delays, or ends a service you think you need, you have the right to a written notice from the county. This notice is called a "Notice of Adverse Benefit Determination". You also have a right to disagree with the decision by asking for an appeal. The sections below inform you of the Notice of Adverse Benefit Determination and what to do if you disagree with the county's decision.

What Is an Adverse Benefit Determination?

An Adverse Benefit Determination is defined by any of the following actions
taken by the county:

- The denial or limited authorization of a requested service. This includes determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
- The reduction, suspension, or termination of a previously authorized service;
- The denial, in whole or in part, of payment for a service;
- The failure to provide services in a timely manner;
- The failure to act within the required timeframes for standard resolution of grievances and appeals. Required timeframes are as follows:

    - If you file a grievance with the county and the county does not get back to you with a written decision on your grievance within 30 days.
    - If you file an appeal with the county and the county does not get back to you with a written decision on your appeal within 30 days.
    - If you filed an expedited appeal and did not receive a response within 72 hours.
- The denial of a member's request to dispute financial liability.

What Is a Notice of Adverse Benefit Determination?

A Notice of Adverse Benefit Determination is a written letter that your county will send you if it decides to deny, limit, reduce, delay, or end services

you and your provider believe you should get. This includes denial of:

- A payment for a service.
- Claims for services that are not covered.
- Claims for services that are not medically necessary.
- Claims for services from the wrong delivery system.
- A request to dispute financial liability.

Note: A Notice of Adverse Benefit Determination is also used to tell you if your grievance, appeal, or expedited appeal was not resolved in time, or if you did not get services within the county's timeline standards for providing services.

Timing of the Notice

The county must mail the notice:

- To the member at least 10 days before the date

of action for termination, suspension, or reduction of a previously authorized behavioral health service.

- To the member within two business days of the decision for denial of payment or decisions resulting in denial, delay, or modification of all or part of the requested behavioral health services.

Will I Always Get A Notice Of Adverse Benefit Determination When I Don't Get The Services I Want?

Yes, you should receive a Notice of Adverse Benefit Determination. If you do not receive a notice, you may file an appeal with the county or if you have completed the appeal process, you can request a State Fair Hearing. When you contact your county, indicate you experienced an adverse benefit determination but did not receive a notice. Information on how to file an appeal or request a

State Fair Hearing is included in this handbook and should also be available in your provider's office.

What Will the Notice of Adverse Benefit Determination Tell Me?

The Notice of Adverse Benefit Determination will tell you:

- What your county did that affects you and your ability to get services.
- The date the decision will take effect and the reason for the decision.
- The state or federal rules the decision was based on.
- Your rights to file an appeal if you do not agree with the county's decision.
- How to receive copies of the documents, records, and other information related to the county's decision.

- How to file an appeal with the county.
- How to request a State Fair Hearing if you are not satisfied with the county's decision on your appeal.
- How to request an expedited appeal or an expedited State Fair Hearing.
- How to get help filing an appeal or requesting a State Fair Hearing.
- How long you have to file an appeal or request a State Fair Hearing.
- Your right to continue to receive services while you wait for an appeal or State Fair Hearing decision, how to request continuation of these services, and whether the costs of these services will be covered by Medi-Cal.
- When you have to file your appeal or State Fair Hearing request by if you want the services to continue.

What Should I Do When I Get a Notice of Adverse Benefit Determination?

When you get a Notice of Adverse Benefit Determination, you should read all the information in the notice carefully. If you don't understand the notice, your county can help you. You may also ask another person to help you.

You can request a continuation of the service that has been discontinued when you submit an appeal or request for a State Fair Hearing. You must request the continuation of services no later than 10 calendar days after the date the Notice of Adverse Benefit Determination was post-marked or delivered to you, or before the effective date of the change.

Member Responsibilities

What are my responsibilities as a Medi-Cal member?

It is important that you understand how the county services work so you can get the care you need. It is also important to:

- Attend your treatment as scheduled. You will have the best result if you work with your provider to develop goals for your treatment and follow those goals. If you do need to miss an appointment, call your provider at least 24 hours in advance, and reschedule for another day and time.
- Always carry your Medi-Cal Benefits Identification Card (BIC) and a photo ID when you attend treatment.
- Let your provider know if you need an oral interpreter before your appointment.

- Tell your provider all your medical concerns. The more complete information that you share about your needs, the more successful your treatment will be.
- Make sure to ask your provider any questions that you have. It is very important you completely understand the information that you receive during treatment.
- Follow through on the planned action steps you and your provider have agreed upon.
- Contact the county if you have any questions about your services or if you have any problems with your provider that you are unable to resolve.
- Tell your provider and the county if you have any changes to your personal information. This includes your address, phone number, and any other medical information that may affect your

ability to participate in treatment.

- Treat the staff who provide your treatment with respect and courtesy.
- If you suspect fraud or wrongdoing, report it:
  - The Department of Health Care Services asks that anyone suspecting Medi- Cal fraud, waste, or abuse to call the DHCS Medi-Cal Fraud Hotline at **1-800-822-6222**. If you feel this is an emergency, please call **911** for immediate assistance. The call is free, and the caller may remain anonymous.
  - You may also report suspected fraud or abuse by e-mail to fraud@dhcs.ca.gov or use the online form at http://www.dhcs.ca.gov/individuals/Pages/StopMedi-CalFraud.aspx.

Do I Have To Pay For Medi-Cal?

Most people in Medi-Cal do not have to pay anything for medical or behavioral health services. In some cases you may have to pay for medical and/or behavioral health services based on the amount of money you get or earn each month.

- If your income is less than Medi-Cal limits for your family size, you will not have to pay for medical or behavioral health services.
- If your income is more than Medi-Cal limits for your family size, you will have to pay some money for your medical or behavioral health services. The amount that you pay is called your ‘share of cost’. Once you have paid your ‘share of cost,’ Medi-Cal will pay the rest of your covered medical bills for that month. In the months that you don’t have medical expenses, you don’t have to pay anything.

- You may have to pay a ‘co-payment’ for any treatment under Medi-Cal. This means you pay an out-of-pocket amount each time you get a medical service or go to a hospital emergency room for your regular services.
- Your provider will tell you if you need to make a co-payment.

NONDISCRIMINATION NOTICE

Discrimination is against the law. The Fresno County Mental Health Plan (FCMHP) follows State and Federal civil rights laws. FCMHP does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

Fresno County provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, braille, audio or accessible electronic formats)

- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters

- Information written in other languages

If you need these services, contact the county between 8:00am and 5:00pm by calling 559-600-4645. Or, if you cannot hear or speak well, please call 711. Upon request, this document can be made available to you in braille, large print, audio, or accessible electronic formats.

HOW TO FILE A GRIEVANCE

If you believe that FCMHP has failed to provide these services or unlawfully discriminated in another way on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation, you can file a grievance with Plan Administration. You can file a grievance by phone, in writing, or in person:

- By phone: Contact Plan Adminstration between 8:00am and 5:00pm by calling 559-600-4645 Or, if you cannot hear or

speak well, please call 711.

- In writing: Fill out a complaint form or write a letter and send it to:
  1925 E Dakota Ave Suite G, Fresno CA 93726
- In person: Visit your doctor's office or FCMHP and say you want to file a grievance.

OFFICE OF CIVIL RIGHTS – CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

You can also file a civil rights complaint with the California Department of Health Care Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone: Call **916-440-7370**. If you cannot speak or hear well, please call **711 (California State Relay)**.
- In writing: Fill out a complaint form or send a letter to:

  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

Complaint forms are available at: https://www.dhcs.ca.gov/discrimination-grievance-procedures

- Electronically: Send an email to CivilRights@dhcs.ca.gov.

OFFICE OF CIVIL RIGHTS – U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

If you believe you have been discriminated against on the basis of race, color, national origin, age, disability or sex, you can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.
- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services

200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

- Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf