Contra Costa County

Drug Medi-Cal Organized Delivery System (DMC-ODS) Program

BENEFICIARY HANDBOOK

CONTRA COSTA
ALCOHOL & OTHER DRUGS SERVICES
A Program of Behavioral Health Services

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GENERAL INFORMATION

Emergency Services

Emergency services are covered 24 hours a day and 7 days a week. If you think you are having a health related emergency, call 911 or go to the nearest emergency room for help.

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

- The health of the individual (or, with respect to a pregnant women, the health of the woman or her unborn child) could be seriously in trouble,
- Serious problems with bodily functions
- Serious problems with any bodily organ or part

Contra Costa Regional Medical Center (CCRM) Emergency Room is located at 2500 Alhambra Ave., Martinez, CA 94553 or it can be reached by calling (925) 370-5170. Under 42CFR 438.10 (f) (6) the beneficiary has a right to use any hospital or other setting for emergency care. The hospital does not need to get prior authorization from the DMC-ODS Plan for emergency services the hospital provides to you.

Post Stabilization care services are covered services that are needed after an emergency. These services are provided after the emergency is over to continue to improve or resolve the condition.

Important Telephone Numbers

Contra Costa County Behavioral Health Access Line..... 1-800-846-1652

Why is it Important to Read this Handbook?

Welcome to Contra Costa County's Drug Medi-Cal Organized Delivery System (DMC-ODS) Plan!

As your DMC-ODS Plan, we have the responsibility to ensure that Substance Use Disorders (SUD) treatment services are readily available for you. As a member, you have certain rights and responsibilities, which are described in this Handbook.

The DMC-ODS Plan is a Medi-Cal benefit provided by, and within Contra Costa through a county-operated Prepaid Inpatient Hospital (PIHP) as defined in 42CFR 438.2. The DMC-ODS waiver Plan covers only Drug Medi-Cal (DMC) services and is limited to the coverage of DMC-ODS benefits. The DMC-ODS Plan provides for automatic mandatory enrollment of all Medi-Cal beneficiaries in the single PIHP operating in the county in which the beneficiary resides.

Contra Costa County, as a participant in the DMC-ODS Waiver Pilot program, is considered a managed care plan, which means that you will receive part, or all, of your

benefits from SUD providers who have a contract with the County. Services provided under the DMC-ODS Plan are possible through a contract between Behavioral Health's Alcohol and Other Drug Services and the California Department of Health Care Services (DHCS). The service area covered by this DMC-ODS plan is Contra Costa County.

It is important that you understand how the Drug Medi-Cal Organized Delivery System (DMC-ODS) plan works so 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 substance use disorder (SUD) treatment services through your county DMC-ODS plan
- What benefits you have access to
- What to do if you have a question or problem
- Your rights and responsibilities as a member of your county DMC-ODS plan

If you don't read this handbook now, you should keep this handbook so you can read it later.

Use this handbook as an addition to the member handbook that you received when you enrolled in your current Medi-Cal benefit. That could be with a Medi-Cal managed care plan or with the regular Medi-Cal "Fee for Service" program.

As A Member Of Your County DMC-ODS Plan, Your County Plan Is Responsible For

- Figuring out if you are eligible for DMC-ODS services from the county or its provider network.
- Coordinating your care.
- Providing a toll-free phone number that is answered twenty-four (24) hours a day and seven (7) days a week that can tell you about how to get services from the county plan.
- Having enough providers to make sure that you can get the SUD treatment services covered by the county plan if you need them.
- Informing and educating you about services available from your county plan.
- Providing you services in your language or by an interpreter (if necessary) free of charge and letting you know that these interpreter services are available.
- Providing you with written information about what is available to you in other languages or forms.

If you have additional questions regarding your benefits under the DMC-ODS Plan, please call the Behavioral Health Access Line at 1-800-846-1652 toll free.

Information For Members Who Need Materials In A Different Language

All beneficiary informing materials, including this Handbook, Grievance and Appeal Forms, are available at DMC-ODS provider sites in English and Spanish.

For any other language, please contact the Behavioral Health Access Line at 1-800-846-1652.

Information For Members Who Have Trouble Reading, are Hearing Impaired or Vision Impaired

If you require this document in a different format (example: Braille, Large Print, Audiotape, CD-ROM) you may request an alternate format by calling **the Behavioral Health Access Line at 1-800-846-1652 (toll free).** Hearing and/or speech impaired members can call the California Relay Service by dialing 711.

Notice Of Privacy Practices

You may obtain a copy of the Notice of Privacy Practices from the front desk at any DMC-ODS provider site.

SERVICES

What Are DMC-ODS Services?

DMC-ODS services are health care services for people who have at least one SUD that the regular doctor cannot treat.

DMC-ODS services include:

- Outpatient Services
- Intensive Outpatient Treatment
- Partial Hospitalization (only available in some counties)
- Residential Treatment (subject to prior authorization by the county)
- Withdrawal Management
- Opioid Treatment
- Medication Assisted Treatment (varies by county)
- Recovery Services
- Case Management

If you would like to learn more about each DMC-ODS service that may be available to you, see the descriptions below:

- **Outpatient Services**
  - Counseling services are provided to members up to nine (9) hours a week for adults and less than six (6) hours a week for adolescents when determined to be medically necessary and in accordance with an individual client plan. Services can be provided by a licensed professional or a certified counselor in any appropriate setting in the community.

- Outpatient Services includes intake and assessment, treatment planning, individual counseling, group counseling, family therapy, collateral services, member education, medication services, crisis intervention services, and discharge planning.

- **Intensive Outpatient Treatment**
  - Intensive Outpatient Treatment services are provided to members (a minimum of nine (9) hours with a maximum of nineteen (19) hours a week for adults and a minimum of six (6) hours with a maximum of nineteen (19) hours a week for adolescents) when determined to be medically necessary and in accordance with an individualized client plan. Services consist primarily of counseling and education about addiction-related problems. Services can be provided by a certified counselor in any appropriate setting in the community.

  - Intensive Outpatient Treatment Services include the same components as Outpatient Services. The increased number of hours of service are the main difference.

- **Partial Hospitalization** (only available in some counties)
  - Partial Hospitalization services feature twenty (20) or more hours of clinically intensive programming per week, as specified in the member's treatment plan. Partial hospitalization programs typically have direct access to psychiatric, medical, and laboratory services, and are to meet the identified needs which warrant daily monitoring or management but which can be appropriately addressed in a structured outpatient setting.

  - Partial Hospitalization services are similar to Intensive Outpatient Treatment services, with the increase in number of hours and the additional access to medical services being the main difference.

- **Residential Treatment** (subject to authorization by the county)
  - Residential Treatment is a non-institutional, twenty-four (24)-hour non-medical, short-term residential program that provides rehabilitation services to members with a SUD diagnosis when determined as medically necessary and in accordance with an individualized treatment plan. Each member shall live on the premises and shall be supported in their efforts to restore, maintain and apply interpersonal and independent living skills and access community support systems. Providers and residents work

collaboratively to define barriers, set priorities, establish goals, create treatment plans, and solve SUD related problems. Goals include sustaining abstinence, preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care.

- Residential services require prior authorization by the county plan. Each authorization for residential services can be for a maximum of ninety (90) days for adults and thirty (30) days for youth. Only two authorizations for residential services are allowed in a one-year-period. It is possible to have one thirty (30) day extension per year based on medical necessity. Pregnant women can receive residential services through the last day of the month that the sixtieth (60^{th}) day after delivery occurs. Early Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible members (under the age of twenty-one (21) will not have the authorization limits described above as long as medically necessity establishes the need for ongoing residential services.

- Residential Services includes intake and assessment, treatment planning, individual counseling, group counseling, family therapy, collateral services, member education, medication services, safeguarding medications (facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication), crisis intervention services, transportation (provision of or arrangement for transportation to and from medically necessary treatment) and discharge planning.

- **Withdrawal Management**
  - Withdrawal Management services are provided when determined as medically necessary and in accordance with an individualized client plan. Each member shall reside at the facility if receiving a residential service and will be monitored during the detoxification process. Medically necessary habilitative and rehabilitative services are provided in accordance with an individualized client plan prescribed by a license physician, or licensed prescriber and approved and authorized according to the State of California requirements.

  - Withdrawal Management Services include intake and assessment, observation (to evaluate health status and response to any prescribed

medication), medication services, and discharged planning.

- **Opioid Treatment**
  - Opioid (Narcotic) Treatment Program (OTP/NTP) services are provided in NTP licensed facilities. Medically necessary services are provided in accordance with an individualized client plan determined by a licensed physician or licensed prescriber, and approved and authorized according to the State of California requirements. OTPs/NTPs are required to offer and prescribe medications to members covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone, and disulfiram.

  - A member must receive at minimum fifty (50) minutes of counseling sessions with a therapist or counselor for up to two hundred (200) minutes per calendar month, although additional services may be provided based on medical necessity.

  - Opioid Treatment Services include the same components as Outpatient Treatment Services, with the inclusion of medical psychotherapy consisting of a face-to-face discussion conducted by a physician on a one-on-one basis with the member.

- **Medication Assisted Treatment** (varies by county)
  - Medication Assisted Treatment (MAT) Services are available outside of the OTP clinic. MAT is the use of prescription medications, in combination with counseling and behavioral therapies, to provide a whole-person approach to the treatment of SUD. Providing this level of service is optional for participating counties.

  - MAT services include the ordering, prescribing, administering, and monitoring of all medications for SUD. Opioid and alcohol dependence, in particular, have well established medication options. Physicians and other prescribers may offer medications to members covered under the DMC-ODS formulary including buprenorphine, naloxone, disulfiram, Vivitrol, Acamprosate, or any FDA approved medication for the treatment of SUD.

- **Recovery Services**

  - Recovery Services are important to the member's recovery and wellness. The treatment community becomes a therapeutic agent through which members are empowered and prepared to manage their health and health care. Therefore, treatment must emphasize the member's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to members.

  - Recovery Services include individual and group counseling; recovery monitoring/substance abuse assistance (recovery coaching, relapse prevention, and peer-to-peer services); and case management (linkages to educational, vocational, family supports, community-based supports, housing, transportation, and other services based on need).

- **Case Management**
  - Case Management Services assist a member to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services focus on coordination of SUD care, integration around primary care especially for members with a chronic SUD, and interaction with the criminal justice system, if needed.

  - Case Management Services include a comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services; transitions to higher or lower levels of SUD care; development and periodic revision of a client plan that includes service activities; communication, coordination, referral and related activities; monitoring service delivery to ensure member access to service and the service delivery system; monitoring the member's progress; and, member advocacy, linkages to physical and mental health care, transportation and retention in primary care services.

  - Case management shall be consistent with and shall not violate confidentiality of any member as set forth in Federal and California law.

HOW TO GET DMC-ODS SERVICES

How Do I Get DMC-ODS Services?

If you think you need substance use disorder (SUD) treatment services, you can get services by asking the county plan for them yourself. You can call your county toll-free

phone number listed in the front section of this handbook. You may also be referred to your county plan for SUD treatment services in other ways. Your county plan is required to accept referrals for SUD treatment services from doctors and other primary care providers who think you may need these services and from your Medi-Cal managed care health plan, if you are a member. Usually the provider or the Medi-Cal managed care health plan will need your permission or the permission of the parent or caregiver of a child to make the referral, unless there is an emergency. Other people and organizations may also make referrals to the county, including schools; county welfare or social services departments; conservators, guardians or family members; and law enforcement agencies.

Where Can I Get DMC-ODS Services?

Contra Costa County is participating in the DMC-ODS pilot program. Since you are a resident of Contra Costa County, you can get DMC-ODS services through the Contra Costa DMC-ODS county plan. Your county plan has SUD treatment providers available to treat conditions that are covered by the plan.

How Do I Know When I Need Help?

Many people have difficult times in life and may experience SUD problems. The most important thing to remember when asking yourself if you need professional help is to trust yourself. If you are eligible for Medi-Cal, and you think you may need professional help, you should request an assessment from your county plan to find out for sure since you currently reside in a DMC-ODS participating county.

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

You may contact your participating county DMC-ODS plan for an assessment for your child or teenager if you think he or she is showing any of the signs of a SUD. If your child or teenager qualifies for Medi-Cal and the county assessment indicates that drug and alcohol treatment services covered by the participating county are needed, the county will arrange for your child or teenager to receive the services.

MEDICAL NECESSITY

What is Medical Necessity and Why Is It So Important?

One of the conditions necessary for receiving SUD treatment services through your county's DMC-ODS plan is something called 'medical necessity.' This means a doctor or other licensed professional will talk with you to decide if there is a medical need for services, and if you can be helped by services if you receive them.

The term medical necessity is important because it will help decide if you are eligible for DMC-ODS service, and what kind of DMC-ODS services are appropriate. Deciding medical necessity is a very important part of the process of getting DMC-ODS services.

What Are The 'Medical Necessity' Criteria For Coverage Of Substance Use Disorder Treatment Services?

As part of deciding if you need SUD treatment services, the county DMC-ODS plan will work with you and your provider to decide if the services are a medical necessity, as explained above. This section explains how your participating county will make that decision.

In order to receive services through the DMC-ODS, you must meet the following criteria:

- You must be enrolled in Medi-Cal
- You must reside in a county that is participating in the DMC-ODS.
- You must have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for a Substance-Related and Addictive Disorder with certain exceptions for the youth under 21, be assessed as 'at risk' for developing a SUD.
- You must meet the American Society of Addiction Medicine (ASAM) definition of medical necessity for services based on the ASAM Criteria (ASAM Criteria are national treatment standards for addictive and substance-related conditions).

You don't need to know if you have a diagnosis to ask for help. Your county DMC-ODS plan will help you get this information and will determine medical necessity with an assessment.

SELECTING A PROVIDER

How Do I Find A Provider For The Substance Use Disorder Treatment Services I Need?

The county plan may put some limits on your choice of providers. Your county DMC-ODS plan must give you a chance to choose between at least two providers when you first start services, unless the county plan has a good reason why it can't provide a choice, for example, there is only one provider who can deliver the service you need. Your county plan must also allow you to change providers. When you ask to change providers, the county must allow you to choose between at least two providers, unless there is a good reason not to do so.

Sometimes county contract providers leave the county network on their own or at the request of the county plan. When this happens, the county plan must make a good faith

effort to give written notice of termination of a county contracted provider within fifteen (15) days after receipt or issuance of the termination notice, to each person who was receiving SUD treatment services from the provider.

Once I Find a Provider, can The County Plan Tell the Provider What Services I Get?

You, your provider, and the county plan are all involved in deciding what services you need to receive through the county by following the medical necessity criteria and the list of covered services. Sometimes the county will leave the decision to you and the provider. Other times, the county plan may require your provider to ask the county to review the reasons the provider thinks you need a service before the service is provided. The county plan must use a qualified professional to do the review. This review process is called a plan payment authorization process.

The county plan's authorization process must follow specific timelines. For a standard authorization, the plan must make a decision on your provider's request within fourteen (14) calendar days. If you or your provider request or if the county plan thinks it is in your interest to get more information from your provider, the timeline can be extended for up to another fourteen (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 plan had additional information from your provider and would have to deny the request without the information. If the county plan extends the timeline, the county will send you a written notice about the extension.

If the county doesn't make a decision within the timeline requires for a standard or an expedited authorization request, the county plan must send you a Notice of Action telling you that the services are denied and that you may file an appeal or ask for a State Fair Hearing. You may ask the county plan for more information about its authorization process. Check the front section of this handbook to see how to request the information.

If you don't agree with the county plan's decision on an authorization process, you may file an appeal with the county or ask for a State Fair Hearing.

Which Providers Does My DMC-ODS Plan Use?

If you are new to the county plan, a complete list of providers in your county plan can be found at the end of this handbook and contains information about where providers are located, the SUD treatment 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 providers, call your county toll-free phone number located in the front section of this handbook.

NOTICE OF ACTION (NOA)

What is a Notice of Action (NOA)

A Notice of Action, sometimes called a (NOA), is a form that your county DMC-ODS plan uses to tell you when the plan makes a decision about whether or not you will get Medi-Cal SUD treatment services. A Notice of Action (NOA) is also used to tell you if your grievance, appeal or expedited appeal was not resolved in time, or if you didn't get services within the county plan's timeline standards for providing services.

When Will I Get A Notice of Action (NOA)?

You will get a Notice of Action (NOA):

- If your county plan or one of the county plan providers decides that you do not qualify to receive any Medi-Cal SUD treatment services because you do not meet the medical necessity criteria.
- If your provider thinks you need a SUD service and asks the county plan for approval, but the county plan does not agree and denies your provider's request, or changes the type or frequency of service. Most of the time you will receive a Notice of Action (NOA) before you receive the service, but sometimes the Notice of Action (NOA) will come after you already received the service, or while you are receiving the service. If you get a Notice of Action (NOA) after you have already received the service you do not have to pay for the service.
- If your provider has asked the county plan for approval, but the county plan needs more information to make a decision and doesn't complete the approval process on time.
- If your county plan does not provide services to you based on the timelines the county plan has set up. Call your county plan to find out if the county plan has set up timeline standards.
- If you file a grievance with the county plan and the county plan does not get back to you with a written decision on your grievance within sixty (60) days. If you file an appeal with the county plan and the county plan does not get back to you with a written decision on you appeal within forty-five (45) days or, if you filed an expedited appeal, and did not receive a response within three (3) working days.

Will I Always Get A Notice Of Action (NOA) When I Don't Get The Services I Want?

There are some cases where you may not receive a Notice of Action (NOA). You may still file an appeal with the county plan or if you have completed the appeal process, you can request a state fair hearing when these things happen. Information on how to file an appeal or request a fair hearing is included in the handbook. Information should also be available in your provider's office.

What Will The Notice of Action (NOA) Tell Me?

The Notice of Adverse Benefit Determination will tell you:

- What your county plan did that affects you and your ability to get services.
- The effective date of the decision and the reason the plan made its decision.
- The state or federal rules the county was following when it made the decision.
- What your rights are if you do not agree with what the plan did.
- How to file an appeal with the plan.
- How to request a State Fair Hearing.
- How to request an expedited appeal or an expedited 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.
- If you are eligible to continue to receive services while you wait for an Appeal or State Fair Hearing decision.
- When you have to file your Appeal or State Fair Hearing request if you want the services to continue.

What Should I Do When I Get A Notice Of Action (NOA)?

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

If the Notice of Action (NOA) form tells you that you can continue services while you are waiting for a State Fair Hearing decision, you must request the state fair hearing within ten (10) days from the date the Notice of Action (NOA) was mailed or personally given to you, or if the Notice of Action (NOA) is sent more than ten (10) days before the effective date for the change in services, before the effective date of the change.

PROBLEM RESOLUTION PROCESSES

What if I Don't Get the Services I Want From My County DMC-ODS Plan?

Your county plan has a way for you to work out a problem about any issue related to the SUD treatment services you are receiving. This is called the problem resolution process and it could involve the following processes.

1. The Grievance Process – an expression of unhappiness about anything regarding your SUD treatment services.
2. The Appeal Process – review of a decision (denial or changes to services) that was made about your SUD treatment services by county plan or your provider
3. The State Fair Hearing Process – review to make sure you receive the SUD treatment services which you are entitled to under the Medi-Cal program.

Filing a grievance of appeal or a State Fair Hearing will not count against you and will not impact the services you are receiving. When your grievance or appeal is complete, your county plan will notify you and others involved of the final outcome. When your State Fair Hearing is complete, the State Hearing Office will notify you and others involved of the final outcome.

Learn more about each problem resolution process below.

Can I Get Help To File An Appeal, Grievance Or State Fair Hearing?

Your county plan will have people available to explain these processes to you and to help you report a problem either as a grievance, an appeal, or as a request for State Fair Hearing. They may also help you decide if you qualify for what's called an 'expedited' process, which means it will be reviewed more quickly because your health or stability are at risk. You may also authorize another person to act on your behalf, including your SUD treatment provider.

If you would like help, call the Contra Costa County Behavioral Health Access Line at 1- 800-846-1652.

What If I Need To Solve A Problem With My County DMC-ODS Plan But Don't Want To File A Grievance Or Appeal?

You can get help from the State if you are having trouble finding the right people at the county to help you find your way through the system.

You may get free legal help at your local legal aid office or other groups. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:

Call toll free: 1-800-952-5253
If you are deaf and use TDD, call: 1-800-952-8349

THE GRIEVANCE PROCESS

What Is A Grievance?

A grievance is an expression of unhappiness about anything regarding your SUD treatment services that are not one of the problems covered by the appeal and State Fair Hearing processes.

The grievance process will:

- Involve simple, and easily understood procedures that allow you to present your grievance orally or in writing.
- Not count against you or your provider in any way.
- Allow you to authorize another person to act on your behalf, including a provider. If you authorize another person to act on your behalf, the county plan might ask you to sign a form authorizing the plan to release information to that person.
- Ensure that the individuals making the decisions are qualified to do so and not involved in any previous levels of review or decision-making.
- Identify the roles and responsibilities of you, your county plan and your provider.
- Provide resolution for the grievance in the required timeframes.

When Can I File A Grievance?

You can file a grievance with the county plan if you are unhappy with the SUD treatment services you are receiving from the county plan or have another concern regarding the county plan.

How Can I File A Grievance?

You may call your county plan's toll-free phone number to get help with your grievance. The county will provide self-addressed envelopes at all the providers' sites for you to mail in your grievance. Grievances can be filed orally or in writing. Oral grievances do not have to be followed up in writing.

How Do I Know If The County Plan Received My Grievance?

Your county plan will let you know that it received your grievance by sending you a written confirmation.

When Will My Grievance Be Decided?

The county plan must make a decision about your grievance within sixty (60) calendar days from the date you filed your grievance. Timeframes may be extended by up to fourteen (14) calendar days if you request an extension, or if the county plan believes that there is a need for additional information and that the delay is for your benefit. An example of when a delay might be for your benefit is when the county believes it might be able to resolve your grievance if the county plan had a little more time to get information from you or other people involved.

How Do I Know If The County Plan Has Made A Decision About My Grievance?

When a decision has been made regarding your grievance, the county plan will notify you or your representative in writing of the decision. If your county plan fails to notify you or any affected parties of the grievance decision on time, then the county plan will provide you with a Notice of Action advising you of your right to request a State Fair Hearing. Your county plan will provide you with a Notice of Action on the date the timeframe expires.

Is There A Deadline To File A Grievance?

You may file a grievance at any time.

THE APPEAL PROCESS

(Standard and Expedited)

Your county plan is responsible for allowing you to request a review of a decision that was made about your SUD treatment services by the plan or your providers. There are two ways you can request a review. One way is using the standard appeals process. The second way is by using the expedited appeals process. These two forms of appeals are similar; however, there are specific requirements to qualify for an expedited appeal. The specific requirements are explained below.

What Is A Standard Appeal?

A standard appeal is a request for review of a problem that you have with the plan or your provider that involves a denial or changes to services you think you need. If you request a standard appeal, the county plan may take up to forty-five (45) days to review it. If you think waiting forty-five (45) days will put your health at risk, you should ask for an 'expedited appeal.'

The standard appeals process will:

- Allow you to file an appeal in person, on the phone, or in writing. If you submit your appeal in person or on the phone, you must follow it up with a signed written appeal. You can get help to write the appeal. If you do not follow-up with a signed written appeal, your appeal will not be resolved. However, the date that you submitted the oral appeal is the filing date.
- Ensure filing an appeal will not count against you or your provider in any way.
- Allow you to authorize another person to act on your behalf, including a provider. If you authorize another person to act on your behalf, the plan might ask you to sign a form authorizing the plan to release information to that person.
- Have your benefits continued upon request for an appeal within the required timeframe, which is ten (10) days from the date your Notice of Action was

mailed or personally given to you. You do not have to pay for continued services while the appeal is pending.

- Ensure that the individuals making the decisions are qualified to do so and not involved in any previous level of review or decision-making.
- Allow you or your representative to examine your case file, including your medical record, and any other documents or records considered during the appeal process, before and during the appeal process.
- Allow you to have a reasonable opportunity to present evidence and allegations of fact or law, in person or in writing.
- Allow you, your representative, or the legal representative of a deceased member's estate to be included as parties to the appeal.
- Let you know your appeal is being reviewed by sending you written confirmation.
- 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 DMC-ODS Plan:

- If your county or one of the county contracted providers decides that you do not qualify to receive any Medi-Cal SUD treatment services because you do not meet the medical necessity criteria.
- If your provider thinks you need a SUD treatment service and asks the county for approval, but the county does not agree and denies your provider's request, or changes the type or frequency of service.
- If your provider has asked the county plan for approval, but the county needs more information to make a decision and doesn't complete the approval process on time.
- If your county plan doesn't provide services to you based on the timelines the county plan has set up.
- If you don't think the county plan is providing services soon enough to meet your needs.
- If your grievance, appeal or expedited appeal wasn't resolved in time.
- If you and your provider do not agree on the SUD services you need.

How Can I File An Appeal?

See the front part of this handbook for information on how to file an appeal with your county plan. You may call your county plan's toll-free phone number to get help with filing an appeal. The plan will provide self-addressed envelopes at all provider sites for you to mail in your appeal.

How Do I Know If My Appeal Has Been Decided?

Your county DMC-ODS plan will notify you or your representative in writing about their decision for your appeal. The notification will have the following information:

- The results of the appeal resolution process.
- The date the appeal decision was made.
- If the appeal is not resolved wholly in your favor, the notice will also contain information regarding your right to a State Fair Hearing and the procedure for filing a State Fair Hearing.

Is There a Deadline To File An Appeal?

You must file an appeal within ninety (90) days of the date of the action you're appealing when you get a notice of action. Keep in mind that you will not always get a notice of action. There are no deadlines for filing an appeal when you do not get a notice of action; so you may file this type of appeal at any time.

When Will A Decision Be Made About My Appeal?

The county plan must decide on your appeal within forty-five (45) calendar days from when the county plan receives your request for the appeal. Timeframes may be extended by up to fourteen (14) calendar days if you request an extension, or if the county plan believes that there is a need for additional information and that the delay is for your benefit. An example of when a delay is for your benefit is when the county believes it might be able to approve your appeal if the county plan had a little more time to get information from you or your provider.

What If I Can't Wait Forty-five (45) Days For My Appeal Decision?

The appeal process may be faster if it qualifies for the expedited appeals process.

What Is An Expedited Appeal?

An expedited appeal is a faster way to decide an appeal. The expedited appeals process follows a similar process to the standard appeals process. However,

- Your appeal must meet certain requirements.
- The expedited appeals process also follows different deadlines than the standard 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 you think that waiting up to forty-five (45) 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. If the county pan agrees that your appeal meets the requirements for an expedited appeal, your county will resolve your expedited appeal within seventy-two (72) hours after the county plan receives the appeal. Timeframes may be extended by up to fourteen (14) calendar days if you request an extension, or if the county plan shows that there is a need for additional information and that the delay is in your interest. If your county plan extends the timeframes, the plan will give you a written explanation as to why the timeframes were extended.

If the county plan decides that your appeal does not qualify for an expedited appeal, the county plan must make reasonable efforts to give you prompt oral notice and will notify you in writing within two (2) calendar days giving you the reason for the 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 doesn't meet the expedited appeal criteria, you may file a grievance.

Once your county plan resolves your expedited appeal, the plan will notify you and all affected parties orally and in writing.

THE STATE FAIR HEARING PROCESS

What is a State Fair Hearing?

A State Fair Hearing is an independent review conducted by the California Department of Social Services to ensure you receive the SUD treatment services to which you are entitled under the Medi-Cal program.

What Are My State Fair Hearing Rights?

You have the right to:

- Have a hearing before the California Department of Social Services (also called a State Fair Hearing).
- Be told about how to ask for a State Fair Hearing.
- Be told about the rules that govern representation at the State Fair Hearing.
- Have your benefits continued upon your request during the State Fair Hearing process if you ask for a State Fair Hearing within the required timeframes.

When Can I File For A State Fair Hearing?

You can file for a State Fair Hearing:

- If you have completed the county plan's appeal process.

- If your county or one of the county contracted providers decides that you do not qualify to receive any Medi-Cal SUD treatment services because you do not meet the medical necessity criteria.
- If your provider thinks you need a SUD treatment service and asks the county plan for approval, but the county plan does not agree and denies your provider's request, or changes the type or frequency of service.
- If your provider has asked the county plan for approval, but the county needs more information to make a decision and doesn't complete the approval process on time.
- If your county plan doesn't provide services to you based on the timelines the county has set up.
- If you don't think the county plan is providing services soon enough to meet your needs.
- If your grievance, appeal or expedited appeal wasn't resolved in time.
- If you and your provider do not agree on the SUD treatment service you need.

How Do I Request A State Fair Hearing?

You can request a State Fair Hearing directly from the California Department of Social Services. You can ask for a State Fair Hearing by writing to:

State Hearings Division
California Department of Social Services
744 P Street, Mail Station 9-17-37
Sacramento, California 95814

You can also call 1-800-952-8349 or for TDD 1-800-952-8349.

Is There A Deadline For Filing For A State Fair Hearing?

You only have ninety (90) days to ask for a State Fair Hearing. The ninety (90) days start either the day after the county plan personally gave you its appeal decision notice, or the day after the postmark date of the county appeal decision notice.

If you didn't receive a Notice of Action (NOA), 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?

You can continue treatment services while you're waiting for a State Fair Hearing decision if your provider thinks SUD treatment service you are already receiving needs to continue and asks the county plan for approval to continue, but the county does not agree and denies your provider's request, or changes the type or frequency of service the provider requested. You will always receive a Notice of Action (NOA) from the

county plan when this happens. Additionally, you will not have to pay for services received while the State Fair Hearing is pending.

What Do I Need To Do If I Want To Continue Services While I'm Waiting For A State Fair Hearing Decision?

If you want services to continue during the State Fair Hearing process, you must request a State Fair Hearing within one hundred twenty (120) days from the date of the county notice of resolution.

What If I Can't Wait 90 Days For My State Fair Hearing Decision?

You may ask for an expedited (quicker) State Fair Hearing if you think the normal ninety (90) day time frame will cause serious problems with your health, including problems with your ability to gain, maintain, or regain important life functions. The Department of Social Services, State Hearing Division, will review your request for an expedited State Fair Hearing and decide if it qualifies. If your expedited hearing request is approved, a hearing will be held and a hearing decision will be issued within three (3) working days of the date your request is received by the State Hearing Division.

IMPORTANT INFORMATION ABOUT MEDI-CAL

Who Can Get Medi-Cal?

You May Qualify for Medi-Cal if you are in one of these groups:

- 65 years old, or older
- Under 21 years of age
- An adult, between 21 and 65 based on income eligibility
- Blind or disabled
- Pregnant
- Certain refugees, or Cuban/Haitian immigrants
- Receiving care in a nursing home

You must be living in California to qualify for Medi-Cal. Call or visit your local county social services office to ask for a Medi-Cal application, or get one on the internet at http://www.dhcs.ca.gov/services/medi-cal/pages/MediCalApplications.aspx

Do I Have To Pay For Medi-Cal?

You may have to pay for Medi-Cal depending 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 Medi-Cal 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 SUD treatment 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. You may have to pay an out of pocket amount each time you get a medical or SUD treatment service or prescribed drug (medicine) and a co-payment if you go to a hospital emergency room for your regular services.

Your provider will tell you if you need to make a co-payment.

Does Medi-Cal Cover Transportation?

If you have trouble getting to your medical appointments or drug and alcohol treatment appointments, the Medi-Cal program can help you find transportation.

- For children, the county Child Health and Disability Prevention (CHDP) program can help. Or, you may wish to contact your county social services office. These phone numbers can be found in your local telephone book in the 'County Government' pages. You can also get information online by visiting **www.dhcs.ca.gov.,** then clicking on 'Services' and then 'Medi-Cal.'
- For adults, your county social services office can help. You can get information about your county social services office by checking your local telephone book. Or you can get information online by visiting www.dhcs.ca.gov, then clicking on 'Services' and then 'Medi-Cal.'

MEMBER RIGHTS AND RESPONSIBILITIES

What Are My Rights As A Recipient Of DMS-ODS Services?

As a person eligible for Medi-Cal and residing in a DMC-ODS pilot program county, you have a right to receive medically necessary SUD treatment services from the county plan. You have the right to:

- Be treated with respect, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
- Participate in decisions regarding your SUD care, including the right to refuse treatment.
- Receive timely access to care, including services available twenty-four (24) hours a day, seven (7) days a week, when medically necessary to treat an emergency condition or an urgent or crisis condition.

- Receive the information in this handbook about the SUD treatment services covered by the county DMS-ODS plan, other obligations of the county plan and your rights as described here.
- Have your confidential health information protected.
- Request and receive a copy of your medical records, and request that they be amended or corrected as specified in 45 CFR 164.524 and 164.526.
- Receive written materials in alternative formats (including Braille, large size print, and audio format) upon request and in a timely fashion appropriate for the format being requested.
- Receive oral interpretation services for your preferred language.
- Receive SUD treatment services from a county plan that follows the requirements of its contract with the State in the areas of availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.
- Access Minor Consent Services, if you are a minor.
- Access medically necessary services out-of-network in a timely manner, if the plan doesn't have an employee or contract provider who can deliver the services. "Out-of-network provider" means a provider who is not on the county plan's list of providers. The county must make sure you don't pay anything extra for seeing an out-of-network provider.
- Request a second opinion from a qualified health care professional within the county network, or one outside the network, at no additional cost to you.
- Voice grievances, either verbally or in writing, about the organization of the care received.
- Request a State Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Freedom to exercise these rights without adversely affecting how you are treated by the county plan, providers, or the State.

What Are My Responsibilities As A Recipient of DMS-ODS Services?

As a recipient of DMC-ODS service, it is your responsibility to:

- Carefully read the member informing materials that you have received from the county plan. These materials will help you understand which services are available and how to get treatment if you need it.
- Attend your treatment as scheduled. You will have the best result if you follow your treatment plan. If you do need to miss an appointment, call your provider

at least twenty-four (24) hours in advance and reschedule for another day and time.

- Always carry your Medi-Cal (county plan) ID card and a photo ID when you attend treatment.
- Let your provider know if you need an interpreter before your appointment.
- Tell you provider all your medical concerns in order for your plan to be accurate. 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 your treatment plan and any other information that you receive during treatment.
- Follow the treatment plan you and your provider have agreed upon.
- Be willing to build a strong working relationship with the provider that is treating you.
- Contact the county plan 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 plan if you have any changes to your personal information. This includes address, phone number, and any other medical information that can 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.

PROVIDER DIRECTORY

If you are a Contra Costa County Medi-Cal beneficiary and if you think you or a family member needs substance use services, call the Access Line at (800) 846-1652 (toll free). For those who are hearing/speech impaired, call the California Relay Service (CRS) at 711 (TTH/TDD). The Behavioral Health Access Line will conduct a screening and referral to a DMC-ODS Plan provider who will perform an assessment to determine medical necessity based on the American Society of Addiction Medicine (ASAM) criteria. If necessary, the Access Line provides authorization for residential treatment.