Glenn County

Mental Health Plan (MHP)

Beneficiary Handbook

Specialty Mental Health Services

Willows Office:
242 N Villa Avenue
Willows, CA 95988

Orland Offices:

CRWC
1187 E South St.
Orland, CA 95963

CSOC
604 E Walker St.
Orland, CA 95963

Published Date: 2022[1]

[1] The handbook must be provided at the time the beneficiary first accesses services.

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OTHER LANGUAGES AND FORMATS

Other Languages

You can get this Beneficiary Handbook and other materials for free in other languages. Call Glenn County Mental Health Plan at **1-800-500-6582** during office hours, and **1-800-507-3530** after hours, on holidays and weekends. The phone call is toll free.

Other Formats

You can get this information for free in other auxiliary formats, such as Braille, 18-point font large print, or audio. Call Glenn County Mental Health Plan at **1-800-500-6582** during office hours, and **1-800-507-3530** after hours, on holidays and weekends. The phone call is toll free.

Interpreter Services

You do not have to use a family member or friend as an interpreter. Free interpreter, linguistic, and cultural services are available 24 hours a day, 7 days a week. To get this handbook in a different language or to get an interpreter, linguistic, and cultural help, call the Glenn County Mental Health Plan at **1-800-500-6582** during office hours, and **1-800-507-3530** after hours, on holidays and weekends. The phone call is toll free.

GENERAL INFORMATION

Why Is It Important to Read This Handbook?

We welcome you to Glenn County Mental Health Service, we provide specialty mental health services for people who live in Glenn County and are eligible for Medi-Cal.

This handbook tells you how to get Medi-Cal specialty mental health services through your county mental health plan. This handbook explains your benefits and how to get care. It will also answer many of your questions.

You will learn:

- How to access specialty mental health services
- What benefits you have access to
- What to do if you have a question or problem
- Your rights and responsibilities as a Medi-Cal beneficiary

If you do not read this handbook now, you should keep this handbook so you can read it later. This handbook and other written materials are available either electronically at https://www.countyofglenn.net/dept/health-human-services/behavioral-health/welcome or in printed form from the mental health plan, free of charge. Call your mental health plan at 1-800-500-6582 if you would like a printed copy.

Use this handbook as an addition to the information you received when you enrolled in Medi-Cal.

Need This Handbook in Your Language or a Different Format?

If you speak a language other than English, free oral interpreter services are available to you. Call Glenn County Mental Health Plan **(800)-500-6582** during office hours, and **(800)-507-3530** after hours, holidays, and weekends. Your mental health plan is available 24 hours a day, seven days a week.

You can also contact your mental health plan at 1-800-507-3530 if you would like this handbook or other written materials in alternative formats such as large print, Braille, or audio. Your mental health plan will assist you.

If you would like this handbook or other written materials in a language other than English, call your mental health plan. Your mental health plan will assist you in your language over the phone.

This information is available in the languages listed below.

- English
- Spanish (Español)

What Is My Mental Health Plan Responsible For?

Your mental health plan is responsible for the following:

- Figuring out if you meet the criteria to access specialty mental health services from the county or its provider network.
- Providing an assessment to determine whether you need specialty mental 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 mental health plan. 1-800-500-6582 (Office Hours) and 1-800-507-3530 (After Hours).
- Having enough providers close to you to make sure that you can get the mental

health treatment services covered by the mental health plan if you need them.

- Informing and educating you about services available from your mental health 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 alternative forms like Braille or large-size print.
- Providing you with notice of any significant change in the information specified in this handbook at least 30 days before the intended effective date of the change. A change is considered significant when there is an increase or decrease in the amount or types of services that are available, or 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 through the mental health plan.
- Coordinate your care with other plans or delivery systems as needed to facilitate care transitions and guide referrals for beneficiaries, ensuring that the referral loop is closed, and the new provider accepts the care of the beneficiary.

INFORMATION ABOUT THE MEDI-CAL PROGRAM

Who Can Get Medi-Cal?

Many factors are used to decide what type of health coverage you can receive from Medi-Cal. They include:

- How much money you make
- Your age
- The age of any children you care for
- Whether you are pregnant, blind, or disabled
- Whether you are on Medicare

You also must be living in California to qualify for Medi-Cal. If you think you qualify for Medi-Cal, learn how to apply below.

How Can I Apply for Medi-Cal?

You can apply for Medi-Cal at any time of the year. You may choose one of the following ways to apply. Specific addresses and lines of contact for each of the options can be found at http://www.dhcs.ca.gov/services/medi-cal/Pages/CountyOffices.aspx.

- By Mail**:** Apply for Medi-Cal with a Single Streamlined Application, provided in English and other languages at https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/SingleStreamApps.aspx. Send completed applications to your local county office:

  Glenn County Health and Human Services Agency
  PO Box 611
  Willows, CA 95988

- By Phone**:** To apply over the phone, call your local county office at:

  Glenn County Health and Human Services Agency
  (530)934-6514

- In-Person**:** To apply in person, find your local county office at the local address listed below. Here, you can get help completing your application. Alternatively, if you reside in a different county, consult the website linked above.

  Glenn County Health and Human Services Agency
  420 East Laurel Street
  Willows, CA 95988

- Online**:** Apply online at www.benefitscal.com or www.coveredca.com. Applications are securely transferred directly to your local county social services office, since Medi-Cal is provided at the county level.

If you need help applying, or have questions, you can contact a trained Certified Enrollment Counselor (CEC) for free. Call **1-800-300-1506**, or search for a local CEC at https://apply.coveredca.com/hix/broker/search.

If you still have questions about the Medi-Cal program, you can learn more at http://www.dhcs.ca.gov/individuals/Pages/Steps-to-Medi-Cal.aspx.

What Are Emergency Services?

Emergency services are services for beneficiaries 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
- Serious problem(s) with bodily functions
- Serious problem(s) with any bodily 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 what seems like a mental health condition.

Emergency services are covered 24 hours a day, seven days a week for Medi-Cal beneficiaries. Prior authorization is not required for emergency services. The Medi-Cal program will cover emergency conditions, whether the condition is due to a medical or mental health condition (emotional or mental). 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.

Is Transportation Available?

Non-emergency medical transportation and non-medical transportation may be provided for Medi-Cal beneficiaries who are unable to provide transportation on their own and who have a medical necessity to receive certain Medi-Cal covered services. If you need assistance with transportation, contact your managed care plan for information and assistance.

If you have Medi-Cal but are not enrolled in a managed care plan, and you need non-medical transportation, you can contact your county mental health plan 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).

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

If you or someone you know is in crisis, please call the National Suicide Prevention Lifeline at **988** or **1-800-273-TALK (8255)**.
For local residents seeking assistance in a crisis and to access local mental health programs, please call 1-800-507-3530.

HOW TO TELL IF YOU OR SOMEONE YOU KNOW NEEDS HELP

How Do I Know When I Need Help?

Many people have difficult times in life and may experience mental health problems. The most important thing to remember is that help is available. If you or your family member are eligible for Medi-Cal and need mental health services, you should call your mental health plan access line at 1-800-500-6582 (Office Hours) and 1-800-507-3530 (After Hours). Your managed care plan can also help you contact your mental health plan if they believe you or a family member need mental health services that the managed care plan does not cover. The mental health plan will help you find a provider for services you may need.

You should call your mental health plan if you or a family member have one or more of the following signs:

- Depressed (or feeling hopeless, helpless, or very down) or feeling like you don't want to live
- Loss of interest in activities you generally like to do
- Significant weight loss or gain in a short period of time
- Sleeping too much or too little
- Slowed or excessive physical movements
- Feeling tired nearly every day
- Feelings of worthlessness or excessive guilt
- Difficulty thinking, concentrating, and/or making decisions
- Decreased need for sleep (feeling 'rested' after only a few hours of sleep)
- Racing thoughts too fast for you to keep up
- Talking very fast or cannot stop talking
- Believing that people are out to get you
- Hearing voices and/or sounds others do not hear
- Seeing things others do not see
- Unable to go to work or school due to feeling depressed (or feeling hopeless,

helpless, or very down)

- Prolong period of time of not caring about personal hygiene (being clean)
- Having trouble understanding and relating to people
- Pulling back or withdrawing from other people
- Crying frequently and for no reason
- Often angry and 'blow up' for no reason
- Having severe mood swings
- Feeling anxious or worried most of the time
- Having what others call strange or bizarre behaviors that are outside of the individual's cultural norm

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

You may contact your mental health plan access line at [mental health plan to insert phone number] or managed care plan for a screening and assessment for your child or teenager if you think they are showing any of the signs of a mental health problem. If your child or teenager qualifies for Medi-Cal and the mental health plan assessment indicates that specialty mental health services covered by the mental health plan are needed, the mental health plan will arrange for your child or teenager to receive the services. Your managed care plan can also help you contact your mental health plan if they believe your child or teenager needs mental health services that the managed care plan does not cover. There are also services available for parents who feel overwhelmed by being a parent or who have mental health problems.

The following checklist can help you assess if your child needs help, such as mental health services. If more than one sign is present or persists over a long period of time, it may indicate a more serious problem requiring professional help. Here are some signs to look out for:

- A lot of trouble concentrating or staying still, putting them in physical danger or causing school problems

- Intense worries or fears that get in the way of daily activities
- Sudden overwhelming fear without reason, sometimes with racing heart rate or fast breathing
- Feels very sad or withdraws from others for two or more weeks, causing problems with daily activities
- Extreme mood swings that cause problems in relationships
- Drastic changes in behavior
- Not eating, throwing up, or using laxatives 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, or use of a weapon, or serious plan to hurt others

ACCESSING SPECIALTY MENTAL HEALTH SERVICES

What Are Specialty Mental Health Services?

Specialty mental health services are services for people who have a mental health condition or emotional problems that a regular doctor cannot treat. These illnesses or problems are severe enough that they get in the way of a person's ability to carry on with their daily activities.

Specialty mental health services include:

- Mental health services
- Medication support services
- Targeted case management
- Crisis intervention services
- Crisis stabilization services
- Adult residential treatment services
- Crisis residential treatment services
- Day treatment intensive services
- Day rehabilitation
- Psychiatric inpatient hospital services
- Psychiatric health facility services
- Peer support services (only available for adults in certain counties, but minors may be eligible for the service under Early and Periodic Screening, Diagnostic, and Treatment regardless of their county of residence)

In addition to the specialty mental health services listed above, beneficiaries under age 21 have access to additional mental health services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Those services include:

- Intensive home-based services
- Intensive care coordination
- Therapeutic behavioral services

- Therapeutic foster care

If you would like to learn more about each specialty mental health service that may be available to you, see the “Scope of Services” section in this handbook.

How Do I Get Specialty Mental Health Services?

If you think you need specialty mental health services, you can call your mental health plan and ask for an appointment for an initial screening and assessment. You can call your county’s toll-free phone number. You can also request an assessment for mental health services from your managed care plan if you are a beneficiary. If the managed care plan determines that you meet the access criteria for specialty mental health services, the managed care plan will help you transition to receive mental health services through the mental health plan. There is no wrong door for accessing mental health services. You may even be able to receive non-specialty mental health services through your Medi-Cal Managed Care Plan in addition to specialty mental health services. You can access these services through your mental 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.

You may also be referred to your mental health plan for specialty mental health services by another person or organization, including your doctor, school, a family member, guardian, your Medi-Cal managed care plan, or other county agencies. Usually, your doctor or the Medi-Cal managed care plan will need your permission or the permission of the parent or caregiver of a child, to make the referral directly to the mental health plan, unless there is an emergency. Your mental health plan may not deny a request to do an initial assessment to determine whether you meet the criteria for receiving services from the mental health plan.

Specialty mental health services can be provided by the mental health plan (county) or other providers the mental health plan contracts with (such as clinics, treatment centers, community-based organizations, or individual providers).

Where Can I Get Specialty Mental Health Services?

You can get specialty mental health services in the county where you live, and outside of your county if necessary. Each county has specialty mental 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 (EPSDT).

Your mental health plan will determine if you meet the criteria to access specialty mental health services. If you do, the mental health plan will refer you to receive an assessment. If you do not meet the criteria to access specialty mental health services, you will be referred to your Medi-Cal managed care plan or a fee-for-service provider who can determine whether you need non-specialty mental health services. If your mental health plan or a provider on behalf of the mental health plan denies, limits, reduces, delays, or ends services you want or believe you should get, you have the right to receive a written Notice (called a “Notice of Adverse Benefit Determination”) from the mental health plan informing you of the reasons for denial, and your rights to file an appeal and/or State Hearing. You also have a right to disagree with the decision by asking for an appeal. You can find additional information below regarding your rights to a Notice and what to do if you disagree with your mental health plan’s decision.

Your mental health plan will help you find a provider who can get you the care you need. The mental health plan 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 Specialty Mental Health Services?

Your mental health plan has to meet the state's appointment time standards when scheduling an appointment for you to receive services from the mental health plan. The mental health plan 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 ongoing conditions.

However, these waiting times may be longer if your provider has determined that a longer waiting time is appropriate and not harmful.

Who Decides Which Services I Will Receive?

You, your provider, and the mental health plan are all involved in deciding what services you need to receive through the mental health plan. A mental health professional will talk with you and will help determine what kind of specialty mental health services are appropriate based on your needs.

You do not need to know if you have a mental health diagnosis or a specific mental health condition to ask for help. The mental health plan will conduct an assessment of your condition. The provider will evaluate whether you may have a mental health disorder that negatively affects your daily life or if you may have a mental health disorder or suspected mental health disorder that has the potential to negatively impact your life if you do not receive treatment. You will be able to receive the services you need while your provider conducts this assessment. You do not need

to have a mental health diagnosis or a specific mental health condition to receive services during the assessment period.

If you are under age 21, you may also be able to access specialty mental health services if you have a mental health condition due to trauma, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness. Additionally, if you are under age 21, the mental health plan must provide medically necessary services to correct or help your mental health condition. Services that sustain, support, improve, or make more tolerable a mental health condition are considered medically necessary.

Some services may require prior authorization from the mental health plan. The mental health plan must use a qualified professional to do the review for service authorization. This review process is called a prior authorization of specialty mental health services. The mental health plan's authorization process must follow specific timelines. For a standard prior authorization, the mental health plan must decide based on your provider's request as quickly as your condition requires. For example, your plan 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, but no longer than 14 calendar days after the mental health plan receives the request.

If you or your provider request it, or if the mental health plan needs to get more information from your provider and provides justification for it, the timeline can be extended for up to an additional 14 calendar days. An example of when an extension might be needed is when the mental health plan thinks it might be able to approve your provider's request for treatment if they get additional information from your provider. If the mental health plan extends the timeline for the provider's request, the county will send you a written notice about the extension.

Services that require prior authorization include: Intensive Home-Based Services, Day Treatment Intensive, Day Rehabilitation, Therapeutic Behavioral Services, and Therapeutic Foster Care. You may ask the mental health plan for more information about its prior authorization process. Call your mental health plan to request additional information.

If the mental health plan denies, delays, reduces, or terminates the services requested, the mental health plan must send you a Notice of Adverse Benefit Determination telling you that the services are denied, inform you that that you may file an appeal, and give you information on how to file an appeal. To find out more about your rights to file a grievance or appeal when you do not agree with your mental health plan's decision to deny your services or take other actions you do not agree with, refer to the Adverse Benefit Determinations by Your Mental Health section on page 32 in this handbook.

What Is Medical Necessity?

Services you receive must be medically necessary and appropriate to address your condition. For individuals 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 to alleviate severe pain.

For individuals under the age of 21, service is medically necessary if the service corrects, sustains, supports, improves, or makes more tolerable a mental health condition. Services that sustain, support, improve, or make more tolerable a mental 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 Mental Health Plan?

If you are enrolled in a Medi-Cal managed care plan, you have access to the following outpatient mental health services through your Medi-Cal 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.
- Outpatient laboratory, drugs (please note that most medications are covered under the Fee-For-Service Medi-Cal program), supplies, and supplements.

To get one of the above services, call your Medi-Cal managed care plan directly. If you are not in a Medi-Cal managed care plan, you may be able to get these services from individual providers and clinics that accept Medi-Cal. The mental health plan may be able to help you find a provider or clinic that can help you or may give you some ideas on how to 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 is covered under the Fee-For-Service Medi-Cal program, not your managed care plan.

How Do I Get Other Medi-Cal Services (Primary Care/Medi-Cal) That Are Not Covered by the Mental Health Plan?

If you are in a managed care plan, the plan is responsible to find 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 health plan for family planning services.

What If I Have an Alcohol or Drug Problem?

If you think that you need services to treat an alcohol or drug problem, contact your county at:

Orland Office:
1187 E. South Street Orland, CA 95963
(530) 685-6459
Willows Office:
242 N. Villa Avenue Willows, CA 95988
(530) 934-6582

Why might I need Psychiatric Inpatient Hospital Services?

You may be admitted to a hospital if you have a mental health condition or symptoms of a mental health condition that cannot 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 current danger to yourself or others, or significant property destruction
- Are unable to provide for or utilize 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 Specialty Mental Health Services I Need?

Your mental health plan is required to post a current provider directory online. If you have questions about current providers or would like an updated provider directory, visit your mental health plan website https://www.countyofglenn.net/dept/health-human-services/behavioral-health/behavioral-health-providers or call the mental health plan's toll-free phone number. You can get a list in writing or by mail if you ask for one.

The mental health plan may put some limits on your choice of providers. When you first start receiving specialty mental health services you can request that your mental health plan provide you with an initial choice of at least two providers. Your mental health plan must also allow you to change providers. If you ask to change providers, the mental health plan must allow you to choose between at least two providers to the extent possible.

Your mental health plan is responsible to ensure that you have timely access to care and that there are enough providers close to you to make sure that you can get the mental health treatment services covered by the mental health plan if you need them. Sometimes mental health plan's contracted providers choose to no longer provide specialty mental health services. Providers of the mental health plan may no longer contract with the mental health plan, or no longer accepts Medi-Cal specialty mental health services patients on their own or at the request of the mental health plan. When this happens, the mental health plan must make a good faith effort to give written notice to each person who was receiving specialty mental health services from the provider. The notice to the beneficiary shall be provided 30 calendar days prior to the effective date of the termination or 15 calendar days after the mental health plan knows the provider will stop working. When this happens, your mental health plan must allow you

to continue receiving services from the provider who left the mental health plan, if you and the provider agree. This is called “continuity of care” and is explained below.

Can I Continue To Receive Services From My Current Provider?

If you are already receiving mental health services from a Medi-Cal managed care plan, you may continue to receive care from that provider even if you receive mental health services from your mental health plan 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 specialty mental health 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, under certain conditions including, but not limited to, all of following:

- You have an existing relationship with the provider you are requesting;
- You need to stay with your current provider to continue ongoing treatment or because it would hurt your mental health condition to change to a new provider;
- The provider is qualified and meets Medi-Cal requirements; and
- The provider agrees to the mental health plan’s requirements for contracting with the mental health plan.

SCOPE OF SERVICES

If you meet the criteria for accessing specialty mental 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.

Mental Health Services

- Mental health services are an 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 the services. 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, over the phone or by telemedicine, or in your home or other community setting. [County] (to include any additional information regarding: the amount, duration, and scope of benefits available under the Contract in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled. (42 C.F.R. § 438.10(g)(2)(iii)).

Medication Support Services

- These services include the prescribing, administering, dispensing, and monitoring of psychiatric medicines; and education related to psychiatric medicines. Medication support services can be provided in a clinic or provider's office, over the phone or by telemedicine, or in the home or other community setting.

Targeted Case Management

- This service helps with getting 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 they don't end up in the hospital. Crisis intervention can last up to eight hours and can be provided in a clinic or provider's office, over the phone or by telemedicine, or in the home or other community setting.

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 crisis stabilization services.

Adult Residential Treatment Services

- These services provide mental health treatment and skill-building for people who are living in licensed facilities that 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 to be in the facility that offers adult residential treatment services.

Crisis Residential Treatment Services

- These services provide mental health treatment and skill-building for people having a serious mental or emotional crisis, but who do not need care in a psychiatric hospital. Services are available 24 hours a day, seven days a week in licensed facilities. Medi-Cal does not cover the room and board cost to be in the facility that offers crisis residential treatment services.

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 at least three hours a day. People can go to their own homes at night. The program includes skill-building activities and therapies as well as psychotherapy.

Day Rehabilitation

- This is a structured program designed to help people with a mental health condition learn and develop coping and life skills and to manage the symptoms of the mental health condition more effectively. The program lasts at least three hours per day. The program includes skill-building activities and therapies.

Psychiatric Inpatient Hospital Services

- These are services provided in a licensed psychiatric hospital based on the determination of a licensed mental health professional that the person requires intensive 24-hour mental health treatment.

Psychiatric Health Facility Services

- These services are provided in a licensed mental 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.

Are There Special Services Available for Children, and/or Young Adults under the age of 21?

Beneficiaries under age 21 are eligible to get additional Medi-Cal services through a benefit called Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).

To be eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, a beneficiary must be under the age of 21 and have full-scope Medi-Cal. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) cover services that are necessary to correct or help any behavioral health condition. Services that sustain, support, improve, or make more tolerable a behavioral health condition are considered to help the mental health condition and in turn, are medically necessary and covered as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services.

If you have questions about the Early and Periodic Screening, Diagnostic, and Treatment services, please call 1-800-500-6582 during office hours and 1-800-507-3530 after hours, holidays and weekends. Or visit the DHCS Early and Periodic Screening, Diagnostic, and Treatment webpage.

The following services are also available from the mental health plan for children, adolescents, and young adults under the age of 21: Therapeutic Behavioral Services, Intensive Care Coordination, Intensive Home-Based Services, and Therapeutic Foster Care Services.

Therapeutic Behavioral Services

Therapeutic Behavioral Services are intensive, individualized, short-term outpatient treatment interventions for beneficiaries up to age 21. Individuals receiving these services have serious emotional disturbances, are experiencing a stressful transition or

life crisis, and need additional short-term, specific support services to accomplish outcomes specified in their written treatment plan.

Therapeutic Behavioral Services is a type of specialty mental health service available through each mental health plan 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 reduce 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 a group home for children and young people under the age of 21 with very serious emotional problems, a Therapeutic Behavioral Services staff person can work with you so you may be able to move to a lower level of care, such as a foster home or back home.

Therapeutic Behavioral Services will help you and your family, caregiver, or guardian learn new ways of addressing problem behavior and ways of 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 Therapeutic Behavioral 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 during Therapeutic Behavioral Services, and when and where Therapeutic Behavioral Services will occur. The Therapeutic Behavioral Services staff person can work with you in most places where you are likely to need help with your problem behavior. This includes your home, foster home, group home, school, day treatment program, and other areas in the community.

Intensive Care Coordination

Intensive Care Coordination is a targeted case management service that facilitates the assessment of care planning for, and coordination of services to beneficiaries under age 21 who are eligible for the full-scope of Medi-Cal services and who meet medical necessity criteria for this service.

Intensive Care Coordination service components include assessing; service planning and implementation; monitoring and adapting; and transition. Intensive Care Coordination services are provided through the principles of the Integrated Core Practice Model, including the establishment of the Child and Family Team to ensure the facilitation of a collaborative relationship among a child, their family, and involved child-serving systems.

The Child and Family Team includes formal supports (such as the care coordinator, providers, and case managers from child-serving agencies), natural supports (such as family members, neighbors, friends, and clergy), and other individuals who work together to develop and implement the client plan and are responsible for supporting children and their families in attaining their goals. Intensive Care Coordination also provides an Intensive Care Coordination Coordinator who:

- Ensures that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, client-driven, and culturally and linguistically competent manner.
- Ensures that services and supports are guided by the needs of the child.
- Facilitates a collaborative relationship among the child, their family, and systems involved in providing services to them.
- Supports the parent/caregiver in meeting their child's needs.
- Helps establish the Child and Family Team and provides ongoing support.
- Organizes and matches care across providers and child serving systems to allow the child to be served in their community.

Intensive Home-Based Services

Intensive Home-Based Services are individualized, strength-based interventions designed to change or help mental health conditions that interfere with a child/youth's functioning and are aimed at helping the child/youth build skills necessary for successful functioning in the home and community and improving the child/youth's family's ability to help the child/youth successfully function in the home and community.

Intensive Home-Based Services services are provided according to an individualized treatment plan developed under the Integrated Core Practice Model by the Child and Family Team in coordination with the family's overall service plan, which may include, but are not limited to assessment, plan development, therapy, rehabilitation, and collateral. Intensive Home-Based Services are provided to beneficiaries under the age of 21 who are eligible for full-scope Medi-Cal services and who meet medical necessity criteria for this service.

Therapeutic Foster Care

The Therapeutic Foster Care service model allows for the provision of short-term, intensive, trauma-informed, and individualized specialty mental health services for children up to the age of 21 who have complex emotional and behavioral needs. Services include plan development, rehabilitation, and collateral. In Therapeutic Foster Care, children are placed with trained, intensely supervised, and supported Therapeutic Foster Care parents.

Available Services by Telephone or Telehealth

Services that can be provided by telephone or telehealth:

- Mental Health Services
- Medication Support Services
- Crisis Intervention Services

- Targeted Case Management
- Intensive Care Coordination
- Peer Support Services

Some service components may be delivered through telehealth or telephone:

- Day Treatment Intensive Services
- Day Rehabilitation
- Adult Residential Treatment Services
- Crisis Residential Treatment Services
- Crisis Stabilization Services

Services that cannot be provided by telephone or telehealth:

- Psychiatric Health Facility Services
- Psychiatric Inpatient Hospital Services
- Therapeutic Behavioral Services
- Intensive Home-Based Services
- Therapeutic Foster Care

ADVERSE BENEFIT DETERMINATIONS BY YOUR MENTAL HEALTH PLAN

What Rights Do I Have if the Mental Health Plan Denies the Services I Want or Think I Need?

If your mental health plan, or a provider on behalf of the mental health plan, denies, limits, reduces, delays, or ends services you want or believe you should get, you have the right to a written Notice (called a "Notice of Adverse Benefit Determination") from the mental health plan. You also have a right to disagree with the decision by asking for an appeal. The sections below discuss your right to a Notice and what to do if you disagree with your mental health plan's decision.

What Is an Adverse Benefit Determination?

An Adverse Benefit Determination is defined to mean any of the following actions taken by a mental health plan:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner;
5. The failure to act within the required timeframes for standard resolution of grievances and appeals (If you file a grievance with the mental health plan and the mental health plan does not get back to you with a written decision on your grievance within 90 days. If you file an appeal with the mental health plan and the mental health plan does not get back to you with a written decision on your appeal within 30 days, or if you filed an expedited appeal, and did not receive a response within 72 hours.); or
6. The denial of a beneficiary's request to dispute financial liability.

What Is a Notice of Adverse Benefit Determination?

A Notice of Adverse Benefit Determination is a letter that your mental health plan will send you if it makes a decision to deny, limit, reduce, delay, or end services you and your provider believe you should get. This includes a denial of payment for a service, a denial based on claiming the services are not covered, a denial based on claiming the services are not medically necessary, a denial that the service is for the wrong delivery system, or a denial of a request to dispute financial liability. 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 mental health plan's timeline standards for providing services.

Timing of the Notice

The Plan must mail the notice to the beneficiary at least 10 days before the date of action for termination, suspension, or reduction of a previously authorized specialty mental health service. The plan must also mail the notice to the beneficiary 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 specialty mental health services.

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

There are some cases where you may not receive a Notice of Adverse Benefit Determination. You may still file an appeal with the County Plan or if you have completed the appeal process, you can request a state hearing when these things happen. Information on how to file an appeal or request a fair hearing is included in this handbook. Information 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:

- The decision your mental health plan made 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 mental health plan's decision
- How to file an appeal with the mental health plan
- How to request a State Hearing if you are not satisfied with the mental health plan's decision on your appeal
- How to request an expedited appeal or an expedited State Hearing
- How to get help filing an appeal or requesting a State Hearing
- How long you have to file an appeal or request a State Hearing
- Your right to continue to receive services while you wait for an appeal or State Hearing decision, how to request for 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 Hearing request 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 on the notice carefully. If you don't understand the notice, your mental health plan can help you. You may also ask another person to help you.

If the mental health plan tells you your services will end or get reduced and you disagree with the decision, you have the right to file an appeal of that decision. You can continue getting services until your appeal or State Hearing is decided. You

must request the continuation of services no later than 10 days after receiving a Notice of Adverse Benefit Determination or before the effective date of the change.

THE PROBLEM RESOLUTION PROCESS: TO FILE A GRIEVANCE OR APPEAL

What If I Don't Get the Services I Want From My Mental Health Plan?

Your mental health plan must have a process for you to work out a complaint or problem about any issue related to the specialty mental health services you want or are receiving. This is called the problem resolution process and it could involve:

1. **The Grievance Process**: an expression of unhappiness about anything regarding your specialty mental health services or the mental health plan.
2. **The Appeal Process**: the review of a decision (e.g., denial, termination, or reduction to services) that was made about your specialty mental health services by the mental health plan or your provider.
3. **The State Hearing Process**: the process to request an administrative hearing before a state administrative law judge if the mental health plan denies your appeal.

Filing a grievance, appeal, or requesting a State 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 specialty mental health services. Grievances and appeals also help the mental health plan by giving them the information they can use to improve services. When your grievance or appeal is complete, your mental health plan will notify you and others involved, such as providers, of the final outcome. When your State Hearing is decided, the State Hearing Office will notify you and others involved of the final outcome. You can learn more about each problem resolution process below.

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

Your mental health plan will help explain these processes to you and must help you file a grievance, an appeal, or to request a State Hearing. The mental health plan 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 specialty mental health provider or advocate.
If you would like help, call 1-800-500-6582 during office hours and 1-800-507-3530 after hours, holidays and weekends. Your mental health plan 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.

Can The State Help Me with My Problem/Questions?

You may contact the Department of Health Care Services, Office of the Ombudsman, Monday through Friday, 8 a.m. to 5 p.m. (excluding holidays), by phone at **888-452-8609** or by e-mail at MMCDOmbudsmanOffice@dhcs.ca.gov. **Please note:** E-mail messages are not considered confidential. You should not include personal information in an e-mail message.

You may also get free legal help at your local legal aid office or other groups. You can also contact the California Department of Social Services (CDSS) to ask about your hearing rights by contacting their Public Inquiry and Response Unit by phone at **800-952-5253** (for TTY, call **800-952-8349**).

THE GRIEVANCE PROCESS

What Is a Grievance?

A grievance is an expression of dissatisfaction about anything regarding your specialty mental health services that are not one of the problems covered by the appeal and State Hearing processes.

What Is the Grievance Process?

The grievance process is the mental health plan's process for reviewing your grievance or complaint about your services or the mental health plan. A grievance can be made anytime orally or in writing, and making a grievance will not cause you to lose your rights or services. If you file a grievance, your provider will not get in trouble.

You can authorize another person, advocate, or your provider to act on your behalf. If you authorize another person to act on your behalf, the mental health plan might ask you to sign a form authorizing the mental health plan to release information to that person.

Any person who works for the mental health plan that decides the grievance must be qualified to make the decisions and not involved in any previous levels of review or decision-making.

When Can I File a Grievance?

You can file a grievance anytime with the mental health plan if you are unhappy with the specialty mental health services or have another concern regarding the mental health plan.

How Can I File a Grievance?

You may call your mental health plan 1-800-500-6582 during office hours and 1-800-507-3530 after hours, holidays and weekends, to get help with a grievance. Grievances can be filed orally or in writing. Oral grievances do not have to be followed up in writing. If you want to file your grievance in writing, the mental health plan will provide self-addressed envelopes at all provider sites for you to mail in your grievance. If you do not have a self-addressed envelope, you may mail your grievance directly to the address that is provided on the front of this handbook.

How Do I Know If the Mental Health Plan Received My Grievance?

Your mental health plan is required to let you know that it received your grievance by sending you a written confirmation.

When Will My Grievance Be Decided?

The mental health plan must make a decision about your grievance within 90 calendar days from the date you filed your grievance. The timeframes for making a decision may be extended by up to 14 calendar days if you request an extension, or if the mental health 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 mental health plan believes it might be able to resolve your grievance if they have more time to get information from you or other people involved.

How Do I Know If the Mental Health Plan Has Made a Decision About My Grievance?

When a decision has been made regarding your grievance, the mental health plan will notify you or your representative in writing of the decision. If your mental health plan

fails to notify you or any affected parties of the grievance decision on time, then the mental health plan will provide you with a Notice of Adverse Benefit Determination advising you of your right to request a State Hearing. Your mental health plan is required to provide you with a Notice of Adverse Benefit Determination on the date the timeframe expires. You may call the mental health plan 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.

THE APPEAL PROCESS (STANDARD AND EXPEDITED)

Your mental health plan must allow you to challenge a decision by your mental health plan that you do not agree with and request a review of certain decisions made by the mental health plan or your providers about your specialty mental health services. There are two ways you can request a review. One way is using the standard appeal process. The other way is by using the expedited appeal process. These two types 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 decision made by the mental health plan or your provider that involves a denial or changes to services you think you need. If you request a standard appeal, the mental health plan may take up to 30 days to review it. If you think waiting 30 days will put your health at risk, you should ask for an "expedited appeal."

The standard appeal process will:

- Allow you to file an appeal orally or in writing.
- 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 mental health plan might ask you to sign a form authorizing the mental health plan to release information to that person.
- Have your benefits continued upon request for an appeal within the required timeframe, which is 10 days from the date your Notice of Adverse Benefit Determination was mailed or personally given to you. You do not have to pay for continued services while the appeal is pending. However, if you do request continuation of the benefit, and the final decision of the appeal confirms the decision to reduce or discontinue the service you are receiving, you may be

required to pay the cost of services provided while the appeal was pending.

- Ensure that the individuals making the decision on your appeal 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.
- Allow you to have a reasonable opportunity to present evidence and testimony and make legal and factual arguments, in person, or in writing.
- Allow you, your representative, or the legal representative of a deceased beneficiary'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 Hearing, following the completion of the appeal process with the mental health plan.

When Can I File an Appeal?

You can file an appeal with your mental health plan in any of the following situations:

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

- Your grievance, appeal, or expedited appeal wasn't resolved in time.
- You and your provider do not agree on the specialty mental health services you need.

How Can I File an Appeal?

You may call your mental health plan [mental health plan to Insert Toll-Free Phone Number if Different Than the Footer] to get help filling an appeal. The mental health plan will provide self-addressed envelopes at all provider sites for you to mail in your appeal. 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 you may submit your appeal by e-mail or fax to problemresoultion@countyofglenn.net or (530) 934-6592.

How Do I Know If My Appeal Has Been Decided?

Your mental health 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 completely in your favor, the notice will also contain information regarding your right to a State Hearing and the procedure for filing a State Hearing

Is There a Deadline to File an Appeal?

You must file an appeal within 60 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 mental health plan must decide on your appeal within 30 calendar days from when the mental health plan receives your request for the appeal. The timeframes for making a decision may be extended up to 14 calendar days if you request an extension, or if the mental health 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 mental health plan believes it might be able to approve your appeal if it has more time to get information from you or your provider.

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

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

What Is an Expedited Appeal?

An expedited appeal is a faster way to decide on an appeal. The expedited appeal process follows a similar process to the standard appeal process. However, you must show that waiting for a standard appeal could make your mental health condition worse. The expedited appeal process also follows different deadlines than the standard appeal. The mental health plan 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 you think that 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. If the mental health plan agrees that your appeal meets the requirements for an expedited appeal, your mental health plan will resolve

your expedited appeal within 72 hours after the mental health plan receives the appeal. The timeframes for making a decision may be extended by up to 14 calendar days if you request an extension, or if the mental health plan shows that there is a need for additional information and that the delay is in your interest.

If your mental health plan extends the timeframes, the mental health plan will give you a written explanation as to why the timeframes were extended. If the mental health plan decides that your appeal does not qualify for an expedited appeal, the mental health plan must make reasonable efforts to give you prompt oral notice and will notify you in writing within two 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 mental health plan decision that your appeal doesn't meet the expedited appeal criteria, you may file a grievance.

Once your mental health plan resolves your request for an expedited appeal, the mental health plan will notify you and all affected parties orally and in writing.

THE STATE HEARING PROCESS

What Is a State Hearing?

A State Hearing is an independent review, conducted by an administrative law judge who works for the California Department of Social Services, to ensure you receive the specialty mental health services to which you are entitled under the Medi-Cal program. You may also visit the California Department of Social Services at https://www.cdss.ca.gov/hearing-requests for additional resources.

What Are My State Hearing Rights?

You have the right to:

- Have a hearing before an administrative law judge (also called a State Hearing)
- Be told about how to ask for a State Hearing
- Be told about the rules that govern representation at the State Hearing
- Have your benefits continued upon your request during the State Hearing process if you ask for a State Hearing within the required timeframes

When Can I File for a State Hearing?

You can file for a State Hearing in any of the following situations:

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

How Do I Request a State Hearing?

You can request a State Hearing:

- Online at: 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

  Or by Fax to: **916-651-5210** or **916-651-2789**.

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

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

Is There a Deadline to Ask for a State Hearing?

Yes, you only have 120 days to ask for a State Hearing. The 120 days start either the day after the mental health plan personally gives you its appeal decision notice or the day after the postmark date of the mental health plan appeal decision notice.

If you didn't receive a Notice of Adverse Benefit Determination, you may file for a State Hearing at any time.

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

If you are currently receiving authorized services and you want to continue receiving the services while you wait for the State Hearing decision, you must ask for a State Hearing within 10 days from the date of receiving the Notice of Adverse Benefit Determination,

or before the date your mental health plan says services will be stopped or reduced. When you ask for a State Hearing, you must say that you want to keep getting services during the State Hearing process.

If you do request continuation of services and the final decision of the State Hearing confirms the decision to reduce or discontinue the service you are receiving, you may be required to pay the cost of services provided while the State Hearing was pending.

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

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer.

Can I get a State 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. Ask your doctor or mental health professional to write a letter for you. You can also write a letter yourself. The letter must explain in detail how waiting for up to 90 days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, make sure you ask for an “expedited hearing” and provide the letter with your request for a hearing.

The Department of Social Services, State Hearings Division, will review your request for an expedited State 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 working days of the date your request is received by the State Hearings Division.

ADVANCE DIRECTIVE

What is an Advance Directive?

You have the right to have an advance directive. An advance directive is written instruction about your health care that is recognized under California law. It includes information that states 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. You may sometimes hear an advance directive described as a living will or durable power of attorney.

California law defines an advance directive as either an oral or written individual health care instruction or a power of attorney (a written document giving someone permission to make decisions for you). All mental health plans are required to have advance directive policies in place. Your mental health plan is required to provide written information on the mental health plan's advance directive policies and an explanation of state law, if asked for the information. If you would like to request the information, you should call your mental health plan for more information.

An advance directive is designed to allow people to have control over their own treatment, especially when they are unable to provide instructions about their own care. It is a legal document that allows people to say, in advance, what their wishes would be if they become unable to make health care decisions. 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

You may get a form for an advance directive from your mental health plan or online. In

California, you have the right to provide advance directive instructions to all of your health care 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

BENEFICIARY RIGHTS AND RESPONSIBILITIES

What Are My Rights as a Recipient of Specialty Mental Health Services?

As a person eligible for Medi-Cal, you have a right to receive medically necessary specialty mental health services from the mental health plan. When accessing these services, you have the right to:

- Be treated with personal respect and respect for your dignity and privacy.
- Receive information on available treatment choices and have them explained in a manner you can understand.
- Take part in decisions regarding your mental health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, punishment, or retaliation about the use of restraints and seclusion.
- Ask for and get a copy of your medical records, and request that they be changed or corrected, if needed.
- Receive the information in this handbook about the services covered by the mental health plan, other obligations of the mental health plan, and your rights as described here. You also have the right to receive this information and other information provided to you by the mental health plan in a form that is easy to understand and is compliant with the American Disabilities Act. This means, for example, that the mental health plan must make its written information available in the languages used by at least five percent or 3,000 of its mental health plan beneficiaries, whichever is less, and make oral interpreter services available free of charge for people who speak other languages. This also means that the mental health plan must provide different materials for people with special needs, such as people who are blind or have limited vision, or people who have trouble reading.
- Receive specialty mental health services from a mental health plan that follows

its contract with the state for the availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services. The mental health plan is required to:

- Employ or have written contracts with enough providers to make sure that all Medi-Cal eligible beneficiaries who qualify for specialty mental health services can receive them in a timely manner.
- Cover medically necessary services out-of-network for you in a timely manner, if the mental health plan does not have an employee or contract provider who can deliver the services. “Out-of-network provider” means a provider who is not on the mental health plan list of providers. The mental health plan must make sure you do not pay anything extra for seeing an out-of-network provider.
- Make sure providers are trained to deliver the specialty mental health services that the providers agree to cover.
- Make sure that the specialty mental health services the mental health plan covers are enough in amount, length of time, and scope to meet the needs of Medi-Cal eligible beneficiaries. This includes making sure the mental health plan’s system for approving payment for services is based on medical necessity and makes sure the medical necessity criteria is fairly used.
- Make sure that its providers do adequate assessments of people who may receive services and that they work with people who will receive services to develop goals for the treatment and services that will be given.
- Provide for a second opinion from a qualified health care professional within the mental health plan network, or one outside the network, at no additional cost to you if you request it.
- Coordinate the services it provides with services being provided to you through a Medi-Cal managed care plan or with your primary care provider, if necessary, and make sure your privacy is protected as specified in federal rules on the privacy of health information.

    - Provide timely access to care, including making services available 24 hours a day, seven days a week, when medically necessary to treat an emergency psychiatric condition or an urgent or crisis condition.
    - Participate in the state's efforts to encourage the delivery of services in a culturally competent manner to all people, including those with limited English proficiency and varied cultural and ethnic backgrounds.
- Your mental health plan is required to follow 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; as well as the rights described here. In other words, you should receive treatment, and must be free from discrimination.
- You may have additional rights under state laws about mental health treatment. If you wish to contact your county's Patients' Rights Advocate, you can do so by: calling (530) 934-6588.

What Are My Responsibilities as a Recipient of Specialty Mental Health Services?

As a recipient of specialty mental health services, it is your responsibility to:

- Carefully read this beneficiary handbook and other important informing materials from the mental health 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 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 mental health 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 mental health plan 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.