Disability Rights California

California's Protection & Advocacy System
Toll-Free (800) 776-5746

Medi-Cal Managed Care Health Plans What are they? What do I need to know about them?

Updated September 2017, Pub #5495.01

1. What is managed care?

Managed care is a system for providing and paying for health care services. Managed care means that you receive most of your health care from a managed care plan. A managed care plan is an organized network of health care providers that emphasizes primary and preventive care. Hospitals, physicians and other health care providers are members of the network. The managed care plan can be public or private.

Many well-known companies offer managed care plans such as Kaiser Permanente or Anthem Blue Cross. Other managed care plans are offered by individual county health care systems or by a combination of counties. There are a wide variety of plans. Over 80% of Medi-Cal beneficiaries are enrolled in a managed care plan.

2. How is managed care different from traditional medical care?

At one time, most private health insurance companies and many government programs such as Medi-Cal and Medicare paid health care providers on a "fee-for-service" (FFS) basis. That means that after a health care provider provides a service, the provider sends a bill to someone for that particular service. For example, if your doctor charges $40 for an office visit, and you went to the doctor, the doctor would send a bill for $40

after the visit. The bill could be sent to you, to a private insurance company, or to a government health care program such as Medi-Cal or Medicare, depending on who is responsible for payment. The only limit is that a provider who wishes to bill a program such as Medi-Cal or Medicare for your care has to be enrolled in the program as a provider.

Managed care is different. People who receive medical care through managed care plans must sign up for a plan. When people do this, they are “members” or “enrollees” of the plan. Under the typical managed care arrangement, the managed care plan is paid a flat fee in advance to provide health care for each member of the plan. This is called a capitation payment or capitated rate. If the cost of the care provided by the plan is less than its monthly capitation rate, the plan makes a profit; if the cost is more, the plan incurs a loss. The managed care contracts with providers to provide the care its members need. For the most part, the plan will only pay for care when members see a provider who contracts with their plan.

All of this means that managed care plans must have adequate provider networks to provide all of their members with services when the services are needed. This means having enough hospitals, primary care physicians, specialists and other health care providers in the geographical area where the managed care plan provides services, and where the members of the plan live. It also means that the providers have to be located in different places around that geographical area so that the members won’t have to travel too far to get services. As a rule, primary care providers should not be more than 30 minutes away. Finally, it means that providers must be able to deliver services to each member without discrimination. This includes having facilities that are physically accessible to people with disabilities such as mobility impairments, providing culturally competent services, and ensuring language access, including access to people who are limited-English-proficient or who need sign language interpreters or materials in alternative formats.

3. Are there any advantages to managed care?

Yes. Managed care plans can provide you with the following:

- Help coordinating your care

- Help finding primary care doctors and specialists
- Help finding a pharmacy
- Ongoing referrals to specialists
- Telephone advice nurses
- Customer service centers
- Support groups
- Health education programs to help you:
    - Quit smoking
    - Prevent and deal with drug and alcohol problems
    - Manage chronic pain
    - Eat well and exercise safely
- Help getting to and from medical appointments (transportation assistance)

4. Are there any drawbacks to managed care?

Yes. The main one is that managed care plans usually require you to get your health care from the managed care network of providers. Not all doctors, hospitals, or other providers are members of the network. If you are joining a managed care plan for the first time, or switching plans, you may have to change doctors or other providers.

Another drawback to managed care is that there may not be enough providers in the network to provide with you with all of the services you need at a time or a location that is convenient to you. Managed care plans are supposed to have adequate provider networks, but there are sometimes gaps. Also, some managed care plans may have networks in a relatively small geographic area, such as only one county, so it can sometimes be a challenge to get services from providers in a nearby county. However, if the network is not adequate to meet your needs, the managed care plan has an obligation to expand the network so that it is

adequate, or to provide you with out-of-network services if necessary to meet your needs.

5. Under managed care do I have a right to make my own health care decisions?

Yes. Under managed care you have the same right to make informed choices about your health care that you do under the fee-for-service system. Managed care plans may require you to get your health care services from a certain network of providers, but those providers cannot take away your right to make your own decisions about your health care. No one can deny you the right to make your own decisions about your health care unless a court has decided that you do not have the capacity to make choices for yourself.

6. Is managed care the same as case management?

No. Managed care has to do with how health care services are delivered and paid for. Under managed care you join a managed care plan so that you can receive your health care services from the managed care plan's network of providers. In contrast, case management has to do with help in accessing or utilizing services. However, your managed care plan must provide you with case management if you need it.

7. What kinds of managed care plans are available under Medi-Cal?

All counties now have Medi-Cal managed care plans sometimes also called Medi-Cal health care plans. These types of Medi-Cal managed care plans are a type of Managed Care Organization. You may see these terms in various places. Medi-Cal managed care plans will be used in this memo to describe the types of plans listed below.

There are two basic types of Medi-Cal managed care plans: COHS (County-Organized Health Systems) model plans and non-COHS model plans. General information about Medi-Cal managed care can be found on the California Department of Health Care Services website here: http://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx.

Under the COHS model, there is only one managed care plan available in the county where the beneficiary lives, and almost all Medi-Cal beneficiaries in those counties must enroll. For the most part, there is no fee-for-service Medi-Cal system in COHS model counties. The following is a list of the COHS plans and the counties which they serve. Almost all Medi-Cal beneficiaries living on one of those counties must enroll in the COHS plan, and receive many, but not all, of their Medi-Cal services from the plan.

COHS Plans and Counties

CalOptima: Orange

CenCal Health: Santa Barbara, San Luis Obispo

Central California Alliance for Health: Santa Cruz, Monterey, Merced

Gold Coast Health Plan: Ventura

Health Plan of San Mateo: San Mateo

Partnership HealthPlan of California: Solano, Napa, Yolo, Sonoma, Mendocino, Marin, Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, Trinity

Non-COHS Models

Under the non-COHS models, there are at least two plans available in each county (except that San Benito County has only one plan). The Non-COHS plans fall into the following three categories:

1. Two-plan model
2. GMC (Geographic Managed Care) model
3. Regional model

Counties with two-plan model managed care offer a choice of only two plans. One plan is a commercial plan (CP), such as Anthem Blue Cross, Health Net, or Molina Healthcare. The other plan is a local initiative (LI),

which is established by the county board of supervisors. Local initiatives are publicly operated partnerships that include county health systems, other safety net providers, and private providers (except for Tulare County where the LI is operated by a commercial plan, Anthem Blue Cross).

The GMC model is used only in Sacramento and San Diego Counties. It operates much like the two-plan model. There are two main differences. First, there is no local initiative (LI) under the GMC model—all of the plans are commercial plans. Second, there is a choice among more than two commercial plans (CP)—four in Sacramento County and five in San Diego County.

The regional model is used in counties that are primarily rural. Medi-Cal beneficiaries in regional model counties can choose between two commercial plans (except in San Benito County where there is a choice between one plan and fee-for-service Medi-Cal). Regional model counties do not have local initiative plans. Regional model plans follow GMC model rules.

Two-Plan/GMC Managed Care Counties and Plans

The following is a list of the 16 counties with two-plan or GMC model managed care. The list includes the local initiative (LI) plans and commercial plans (CP) available in each county. In addition, local initiative plans often subcontract with commercial plans, such as Kaiser Permanente, Health Net, Anthem Blue Cross, or Molina Healthcare, to provide services to some members.

Contra Costa: Contra Costa Health Plan (LI), Anthem Blue Cross (CP)

Fresno/Kings/Madera: CalViva Health (LI), Anthem Blue Cross (CP)

Kern: Kern Family Health Care (LI), Health Net (CP)

Los Angeles: LA Care (LI), Health Net (CP)

Riverside/San Bernardino: Inland Empire Health Plan (LI), Molina Healthcare (CP)

Sacramento (GMC): Anthem Blue Cross (CP), Health Net (CP), Kaiser Permanente (CP), Molina Healthcare (CP)

San Diego (GMC): Care 1st (CP), Community Health Group (CP), Health Net (CP), Kaiser Permanente (CP), Molina Healthcare (CP)

San Francisco: San Francisco Health Plan (LI), Anthem Blue Cross (CP)

San Joaquin/Stanislaus: Health Plan of San Joaquin (LI), Health Net (CP)

Santa Clara: Santa Clara Family Health Plan (LI), Anthem Blue Cross (CP)

Tulare: Anthem Blue Cross (LI), Health Net (CP)

Regional Managed Care Counties and Plans

The following is a list of the Regional Managed Care Counties and Plans.

Anthem Blue Cross (CP), California Health and Wellness (CP): Alpine, Amador, Butte, Calaveras, Colusa, El Dorado, Glenn, Inyo, Mariposa, Mono, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Tuolumne, Yuba.

Molina Healthcare (CP), California Health and Wellness (CP): Imperial

Anthem Blue Cross (CP), Medi-Cal fee-for-service (Regular Medi-Cal): San Benito.

Also, there is a contract between the state and Kaiser Permanente to provide managed care to certain former Healthy Families beneficiaries who have been transitioned into the Medi-Cal program.

8. Do I have to enroll in Medi-Cal managed care?

It depends on the county where you live. There are different rules for COHS model and non-COHS model counties.

If you live in a COHS model county, you have to enroll in Medi-Cal managed care with few exceptions.

If you live in a two-plan, GMC, or regional model county, you generally have to enroll in a Medi-Cal managed care plan but there are a number of exceptions. You do not have to enroll in a Medi-Cal managed care plan if:

1. You have Medicare as well as Medi-Cal ("dual-eligible")
   Note: Beginning in 2014, most dual-eligible beneficiaries in 7 counties have to enroll in Medi-Cal managed care—these counties are San Mateo, San Diego, Orange, Riverside/San Bernardino, Los Angeles, and Santa Clara
2. You receive foster care or adoption assistance benefits
3. You are enrolled in a private health care plan (other health coverage, or "OHC")
4. You are in a long-term care facility (LTC) such as a nursing home or intermediate care facility
5. You have a share of cost for Medi-Cal
6. You receive services from the California Children's Services (CCS) program
7. You are enrolled in a Program of All-Inclusive Care for the Elderly (PACE)

A complete list of the categories of beneficiaries who are exempt from enrollment in Medi-Cal managed care can be found on the managed care aid code chart, located here: http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/Aid_Code_Master_Chart%203-8-17.pdf. The aid code chart also lists the categories of Medi-Cal beneficiaries who can voluntarily enroll in Medi-Cal managed care.

Note: Even if you are not required to enroll in Medi-Cal managed care, you may have to in order to get certain services that are available only through Medi-Cal managed care plans. In most counties, this includes Community-Based Adult Services (CBAS). In 7 counties it also includes other Long-Term Services and Supports (LTSS), such as In-Home Supportive Services (IHSS). These 7 counties are San Mateo, San Diego, Orange, Riverside/San Bernardino, Los Angeles, and Santa Clara.

9. Do the Medi-Cal managed care plans provide all Medi-Cal services?

No. Not all Medi-Cal services are provided through Medi-Cal managed care plans. Services that are not provided through Medi-Cal managed care are said to be “carved out” of managed care. Most carved-out services are provided under the traditional fee-for-service system. However, some carved out services are provided through other types of Medi-Cal managed care plans. For example, Medi-Cal specialty mental health services are provided by county “mental health plans” or “MHPs.” Some of the carved-out services are listed below.

Mental Health

Medi-Cal specialty mental health services are provided through county mental health plans (MHPs). Medi-Cal beneficiaries who are entitled to specialty mental health services must receive those services through the county MHP. This means that Medi-Cal beneficiaries who receive specialty mental health services and are enrolled in one of the four types of Medi-Cal managed care plans listed above will receive Medi-Cal services through two separate plans—one plan will be a Medi-Cal managed care plan and the other plan will be the county MHP. The Medi-Cal managed care plan and the MHP must have a memorandum of understanding (MOU) for coordination of care. In addition, psychiatric medications will be provided through the Medi-Cal managed care plan even if the medications are prescribed by the MHP.

This does not mean that all Medi-Cal mental health services are provided through county MHPs. First, mental health conditions that would be responsive to physical-health-care-based treatment are not provided by the county MHP. This allows primary care physicians, for example, to prescribe psychiatric medications, such as antidepressants and anti-anxiety medications, if the physician chooses to do so. Second, beginning in January 2014, non-specialty mental health treatment is available through the Medi-Cal managed care plan. Medi-Cal managed care plans will provide the following non-specialty mental health services when needed:

1. Individual and group mental health evaluation and treatment (psychotherapy)
2. Psychological testing when clinically indicated to evaluate a mental health condition
3. Outpatient services for the purposes of monitoring medication treatment
4. Outpatient laboratory, medications, supplies and supplements
5. Psychiatric consultation

Note: If the Medi-Cal beneficiary is not enrolled in a Medi-Cal managed care plan, psychiatric medications and the non-specialty mental health services listed above are provided through the Medi-Cal fee-for-service system.

In-Home Supportive Services (IHSS)

In-Home Supportive Services (IHSS) are not provided through Medi-Cal managed care except in the 7 counties that enroll beneficiaries who receive both Medicare and Medi-Cal. IHSS is offered through Medi-Cal managed care in those counties for all Medi-Cal beneficiaries, whether or not they also receive Medicare.

Home and Community-Based Waiver Services (HCBS)

Home and Community-Based Waiver Services (HCBS) provide home and community-based services to qualified individuals. HCBS are not provided through Medi-Cal managed care. Different HCBS Waivers are administered by different agencies. For example, the Nursing Facility/Acute Hospital Waiver is administered by In-Home Operations, a division within the Department of Health Care Services. The HCBS for the Developmentally Disabled Waiver is administered by regional centers. However, Medi-Cal beneficiaries who receive services under an HCBS waiver are not necessarily exempt from enrollment in Medi-Cal managed care.

Dental

Dental services are not provided through the Medi-Cal managed care plans listed above. Dental services are generally provided through the Medi-Cal fee-for-service system (commonly known as “Denti-Cal”). However, there are separate dental managed care (DMC) plans in Sacramento and Los Angeles Counties. Enrollment in dental managed care is mandatory for some Medi-Cal beneficiaries in Sacramento County. There is no mandatory enrollment in Los Angeles County. In addition, some Medi-Cal beneficiaries who also receive Medicare and are enrolled in Medicare managed care plans (Medicare Advantage) may be able to obtain some dental services through their Medicare managed care plan.

California Children’s Services (CCS)

Services provided under the California Children’s Services (CCS) program are not provided through Medi-Cal managed care (except in San Mateo, Santa Barbara, Solano, Yolo, Marin, and Napa Counties). However, managed care plans have a duty to coordinate EPSDT (Early Periodic Screening, Diagnostic, and Treatment) services for children under age 21. For more information, refer to All Plan Letter 14-017 here: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-017.pdf.

Local Education Agency (LEA)

Services provided by school districts for the purpose of enabling students to obtain free appropriate public educations, and which are paid for by Medi-Cal, are not provided through the Medi-Cal managed care system. However, school districts can contract with various Medi-Cal managed care organizations for provision of services. This is particularly common in the case of county mental health plans. For more information, refer to All Plan Letter 14-017 here: http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2014/APL14-017.pdf.

Special Programs

Some special Medi-Cal programs are not provided through Medi-Cal managed care. These include tuberculosis treatment, pregnancy-only services, minor-consent services, and emergency-care or limited-scope Medi-Cal for undocumented residents. People who are enrolled in these special programs receive their services on a fee-for-service basis.

10. If I'm in managed care, can I keep the same doctors I have now?

It depends. Ordinarily, your doctor must be part of the managed care network. However, the managed care network must provide you with "continuity of care." What this means is that if you now have a doctor who is *not* part of the managed care network, you can keep that doctor for up to 12 months after you have been enrolled in a Medi-Cal managed care plan; but only if the doctor is both willing to keep seeing you and willing to accept either the managed care network's payment rate or the Medi-Cal fee-for-service rate, whichever is higher. The doctor becomes a part of the managed care network just for purposes of caring for you. The doctor will have access to network providers for purposes of referrals, etc. There may be other situations where your plan is required to provide you with "continuity of care," too.

For more information about this important continuity of care right, go to the Medi-Cal managed care website:
http://www.dhcs.ca.gov/services/Pages/ContinuityOfCare.aspx

11. If I don't already have doctors I like, will the health plan provide ones who know about my disability?

The Medi-Cal managed care plan can help you find a doctor's office that will meet your special needs. Your doctor and the health plan will be responsible for helping to coordinate your care. This includes helping you find the specialists you need. In addition, the managed care plan has telephone advice nurses to answer your health questions and customer service call centers to answer questions about your benefits. If you don't

like your primary care doctor or other provider, you may be able to change your primary care doctor or other provider.

12. What if I don't like managed care – can I get out?

Maybe. You may be able to get an "exemption" to stay in fee-for-service Medi-Cal for all of your care for up to 12 months if you have a complex or progressive medical condition that requires ongoing medical supervision or medical treatment which cannot be interrupted. This exemption will have to be renewed at least every 12 months. You are not eligible for an exemption if your doctor is in a Medi-Cal managed care plan.

If you want an exemption from enrolling in managed care, you and your doctor have to fill out the Medical Exemption Request (MER) form. Call Health Care Options (HCO) at 1-800-430-4263 to get a copy of the MER form or download and print the form here: https://www.healthcareoptions.dhcs.ca.gov/sites/default/files/Documents/MU_0003383_ENG_TempMedExemptionWEB.pdf. It is important for your doctor to include information describing the ongoing medical supervision and/or complex medical treatment you receive, and why this prevents you from transferring into managed care right now. Call HCO if you have any questions. You or your doctor can also get help with your medical exemption request by calling the Medi-Cal managed care ombudsman at 1-888-452-8609, or sending an email to the following address: merhelp@dhcs.ca.gov.

If your request is denied, you can file a request for Medi-Cal fair hearing and stay in fee-for-service Medi-Cal pending the hearing. Be sure to ask to stay in fee-for-service Medi-Cal in your request for hearing.

13. How do I choose a health plan?

The rules are different depending on whether you live in a COHS county, or a non-COHS county.

In COHS counties, you will be enrolled in the COHS plan when you apply for Medi-Cal. If you move into a COHS county from another county, you

will be enrolled in the COHS plan when you notify the county Medi-Cal office of your change of address.

In two-plan, GMC, and regional model counties, you enroll in a plan by sending a choice enrollment form to the enrollment broker, Health Care Options (HCO). You will receive an enrollment packet when you enroll in Medi-Cal or move to a new county. You will then need to choose a plan and send the enrollment choice form to HCO. You will receive a reminder notice at least 30 days before you are required to enroll. If you do not enroll, you will be enrolled automatically by default in one of the plans.

If you move into a two-plan, GMC, or regional model county from another county, you will need to submit a new choice enrollment form to HCO. You need to do this in addition to notifying the county Medi-Cal office of your change of address.

You can get general information about enrollment on the HCO website here: https://www.healthcareoptions.dhcs.ca.gov/enroll. You can get a choice enrollment form on the HCO website here: https://www.healthcareoptions.dhcs.ca.gov/download-forms.

14. Can I change to a different Medi-Cal managed care plan? If so, how?

You can change to a different Medi-Cal managed care plan once per month (except in COHS plan counties). You change plans by submitting a choice enrollment form to HCO. The change is effective the first of the month after HCO receives the form. You can get general information about changing plans on the HCO website here: http://www.healthcareoptions.dhcs.ca.gov. You can get a choice enrollment form on the HCO website here: https://www.healthcareoptions.dhcs.ca.gov/download-forms.

15. I am dissatisfied with a decision of the managed care plan. What can I do?

Starting July 1, 2017, the rules for grievances and appeals changed. The following is a brief description of the process. For more detailed

information see: All Plan Letter 17-006 at http://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2017/APL17-006.pdf. You can also read our publication on this subject at: http://www.disabilityrightsca.org/pubs/560601.pdf.

Grievances

You can file a grievance, also known as a complaint, if you are unhappy with something your health plan or a health plan provider did, not related to an Adverse Benefit Determination. If you want to challenge an Adverse Benefit Determination, you need to file an appeal, which is explained below. A grievance may include the quality of care you received from a doctor, or if a doctor or other staff was rude to you. Sometimes, it may not be obvious if you should file a grievance or an appeal. In those cases, if you file a grievance where you should have filed an appeal, your managed care plan should identify which is should be and proceed accordingly.

You can file a grievance with your Medi-Cal managed care plan orally or in writing. If you are in a Knox-Keene licensed plan, you must file your grievance within 180 days of the incident giving rise to the grievance if you want to seek external review by the Department of Managed Health Care. If you are not in a Knox-Keene licensed plan, you can file your grievance at any time. Your Medi-Cal managed care plan must generally resolve a grievance within 30 days. You can also file for an expedited grievance if you think you are at risk of imminent and serious threat to your health, such as severe pain or potential loss of life, limb, or major bodily function. In those cases, your health plan must respond to your grievance within 72 hours.

If you don't like how your managed care plan resolved your grievance or the time for it to respond has passed, you can file a complaint with the Department of Managed Health Care (DMHC) at (888) 466-2219 or TDD: (877) 688-989. You must file your complaint within 180 days of the incident giving rise to the grievance. Also see https://www.dmhc.ca.gov/FileaComplaint.aspx#.WBJ8JY3FA3E.

NOTE: You can only submit a complaint to DMHC if you are in a health plan that is licensed under the Knox-Keene Act. The five plans that are

NOT Knox-Keene licensed are: CalOptima – Orange; CenCal Health - Santa Barbara and San Luis Obispo; Central California Alliance for Health - Santa Cruz, Monterey, Merced; Gold Coast Health Plan – Ventura; and Partnership HealthPlan of California - Solano, Napa, Yolo, Sonoma, Mendocino, Marin, Del Norte, Humboldt, Lake, Lassen, Modoc, Shasta, Siskiyou, Trinity. If you have one of these plans, you cannot ask for an DMHC to review your grievance. See: http://healthconsumer.org/wp/wp-content/uploads/2016/10/County-Organized-Health-System-Medi-Cal-Plans.pdf or http://wpso.dmhc.ca.gov/hpsearch/viewall.aspx.

If you are in a plan that is not licensed under the Knox-Keene Act, you can contact the Department of Health Care Services (DHCS) Medi-Cal Managed Care Office of the Ombudsman. You can call them at 1-888-452-8609 or by email at MMCDOmbudsmanOffice@dhcs.ca.gov. For more information, visit http://www.dhcs.ca.gov/services/medi-cal/Pages/MMCDOfficeoftheOmbudsman.aspx.

You can also file for a Medi-Cal Fair Hearing if you have a grievance against your health plan. You must file your hearing within 90 days from the date of the situation giving rise to the grievance. You do not need to exhaust your plan's internal grievance procedure before going to a hearing for something other than an Adverse Benefit Determination (explained below), so you might want to file a grievance and a hearing request at the same time. However, this does not always mean that the Administrative Law Judge (ALJ) who decides your case will have the power to correct the problem. For example, if you file a grievance because a staff member was rude to you, and you do not like how your managed care plan resolved your grievance, the ALJ cannot correct that problem. However, the ALJ might be able to help you if, for instance, your managed care plan never answers the phone. The CDSS hearing website is here: http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx. Information about requesting a fair hearing is here: https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx.

Appeals

If your managed care plan sends you an Adverse Benefit Determination (also known as Notice of Action) you can file an appeal to your Medi-Cal

managed care plan. An Adverse Benefit Determination is an action taken by your managed care plan that affects your care, such as delay, modification, denial or reduction of services, denial or only partial payment for a service, or the determination that the requested service was not a covered benefit. You must file your appeal within 60 days after you receive the Adverse Benefit Determination. You can file your appeal either orally or in writing, but if you file it orally, you will need to send in a signed, written appeal to managed care plan. Within 5 days of submitting your appeal, your Medi-Cal managed care plan must send you a letter letting you know that it got your appeal. It must respond to your appeal within 30 days of receipt of your appeal however, under certain circumstances, it can extend the due date by 14 calendar days.

You can also file for an expedited appeal if you think you are at risk of imminent and serious threat to your health, such as severe pain or potential loss of life, limb, or major bodily function. In those cases, your health plan must respond to your appeal within 72 hours. Here again, an extension of 14 days to respond may apply. The response is called a Notice of Appeal Resolution (NAR). The NAR will provide you with information on your right to request a state fair hearing, your timeline for doing so, and how to request a state fair hearing.

Once you have exhausted your plan's internal appeals procedures, you can request a Medi-Cal fair hearing with the California Department of Social Services (CDSS). You can also request a Medi-Cal fair hearing if your managed care plan did not send you a NAR within the required timeframe You must request a state hearing no later than 120 calendar days from the date of your managed care plan's NAR. You can also ask for an expedited review.

The CDSS hearing website is here: http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx. Information about requesting a fair hearing is here: https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx.

Aside from requesting a fair hearing, if you don't like how your managed care plan resolved your appeal or the time for it to respond has passed, you can also file what is called a "complaint" with the Department of Managed Health Care at (888) 466-2219 or TDD: (877) 688-989. The

complaint you file with DMHC is different from filing an appeal or grievance with your health plan. You must file your complaint within 180 days of the incident giving rise to the complaint. NOTE: If you have already attended a fair hearing on your case, you can no longer file a complaint with DMHC. Also see https://www.dmhc.ca.gov/FileaComplaint.aspx#.WBJ8JY3FA3E.

Independent Medical Review

If your issue is denial, reduction, or delay of a service/device/supply because your managed care plan does not think that it is medically necessary, or they say it is experimental or investigational, and you have exhausted your appeal process, under most managed care plans, you can file a request for independent medical review (IMR) with the DMHC. You have 6 months from receiving the NAR to request an IMR.

IMPORTANT: If you choose to ask for an IMR/Complaint first, the 120 days to request a state fair hearing continues to run. Also, you cannot ask for an IMR if you have already attended a state fair hearing. It is very important that you keep this in mind.

See our publication on independent medical reviews at http://www.disabilityrightsca.org/pubs/553401.pdf.

NOTE: You can only ask for an IMR if you are in a health plan that is licensed under the Knox-Keene Act. See above for non-Knox-Keene licensed health plans.

16. Can I get aid paid pending my appeal?

Yes, but only if you request an appeal or a Medi-Cal fair hearing before your services are reduced, suspended or terminated. (Note: you can also get your services reinstated pending the hearing if you were not given proper written notice of the reduction, suspension or termination.)

If you want an IMR and a Medi-Cal fair hearing with aid paid pending the hearing, you must request the fair hearing before your services are reduced, suspended or terminated. To ensure you continue receiving services, you may want to request an IMR and request a fair hearing with aid paid pending at the same time. You can then request postponement of

the fair hearing pending resolution of the IMR. That way, you can get aid paid pending the hearing while you wait for the resolution of the IMR.

17. I don't have to enroll in managed care but I want to. Is it possible for me to enroll voluntarily?

Yes, most Medi-Cal beneficiaries can voluntarily enroll in Medi-Cal managed care. A complete list of the categories of beneficiaries who can voluntarily enroll in Medi-Cal managed care can be found on the managed care aid code chart, located here: http://www.dhcs.ca.gov/services/MH/Documents/MedCCC/Library/Aid_Code_Master_Chart%203-8-17.pdf.

18. How can I find out more about the managed care plans in my area and pick the best one for me?

You can find information about all of the Medi-Cal managed care plans available in each county here: http://www.dhcs.ca.gov/individuals/Pages/MMCDHealthPlanDir.aspx.

You can find general information about two-plan, GMC and regional model Medi-Cal managed care plans on the Health Care Options (California Department of Health Care Services) website here: https://www.healthcareoptions.dhcs.ca.gov/learn.

You can compare plans here: https://www.healthcareoptions.dhcs.ca.gov/choose.

General enrollment information for two-plan, GMC and regional model Medi-Cal managed care plans can be found here: https://www.healthcareoptions.dhcs.ca.gov/enroll.

Specific enrollment information, including enrollment notices and specific informing materials for each plan (such as evidence of coverage), can be found here: https://www.healthcareoptions.dhcs.ca.gov/learn/health-plan-materials.

Specific enrollment forms for two-plan, GMC and regional model Medi-Cal managed care plans can be found here: https://www.healthcareoptions.dhcs.ca.gov/enroll. Instructions for completing the form are here: https://www.healthcareoptions.dhcs.ca.gov/enroll.

You can also find out about two-plan, GMC and regional model plans by contacting Health Care Options directly. You can call Health Care Options directly at: 1-800-430-4263. More Health Care Options contact information can be found here: https://www.healthcareoptions.dhcs.ca.gov/contact-us. There are also Health Care Options contact numbers for languages other than English. The following is the list of telephone numbers.

Health Care Options
(California Department of Health Care Services)
Contact Numbers

Language	Phone Number
Arabic	1-800-576-6881
Armenian	1-800-840-5032
Cambodian	1-800-430-5005
Cantonese	1-800-430-6006
English	1-800-430-4263
Farsi	1-800-840-5034
Hmong	1-800-430-2022
Korean	1-800-576-6883
Laotian	1-800-430-4091
Mandarin	1-800-576-6885
Russian	1-800-430-7007
Spanish	1-800-430-3003
Tagalog	1-800-576-6890

Vietnamese	1-800-430-8008
TDD	1-800-430-7077

We want to hear from you! Please complete the following survey about our publications and let us know how we are doing! [Take the Survey]

For legal assistance call 800-776-5746 or complete a request for assistance form. For all other purposes call 916-504-5800 (Northern CA); 213-213-8000 (Southern CA).

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