Residential Treatment Residents' Rights (SUDs)

(The information below is not an exhaustive list. For a complete list of resident rights, please contact the Patient Advocacy Program at (619) 282-1134.)

From Behavioral Health Services Drug Medi-Cal Organized Delivery System (DMC-ODS) Beneficiary Handbook:

- Be treated with respect, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
- Participate in decisions regarding your SUD care, including the right to refuse treatment.
- Receive timely access to care, including services available 24 hours a day, 7 days a week, when medically necessary to treat an emergency condition or an urgent or crisis condition.
- Receive the information in this handbook about the SUD treatment services covered by the county DMC-ODS plan, other obligations of the county plan and your rights as described here.
- Have your confidential health information protected.
- Request and receive a copy of your medical records, and request that they be amended or corrected as specified in 45 CFR §164.524 and 164.526.
- Receive written materials in alternative formats (including Braille, large size print, and audio format) upon request and in a timely fashion appropriate for the format being requested.
- Receive oral interpretation services for your preferred language.
- Receive SUD treatment services from a county plan that follows the requirements of its contract with the State in the areas of availability of services, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.
- Access Minor Consent Services, if you are a minor.
- Access medically necessary services out-of-network in a timely manner, if the plan doesn't have an employee or contract provider who can deliver the services. "Out-of-Substance Use Disorder Provider" means a provider who is not on the county plan's list of providers. The county must make sure you don't pay anything extra for seeing an out-of-Substance Use Disorder Provider. You can contact the Access and Crisis Line at (888) 724-7240 for information on how to receive services from an out-of-Substance Use Disorder Provider.
- Request a second opinion from a qualified health care professional within the county network, or one outside the network, at no additional cost to you.
- File grievances, either verbally or in writing, about the organization or the care received.
- Request an appeal, either verbally or in writing, upon receipt of a notice of adverse benefit determination.
- Request a State Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible.
- Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
- Be free to exercise these rights without adversely affecting how you are treated by the county plan, providers, or the State.

From The Personal Rights at an AOD Certified Program form:

YOUR PERSONAL RIGHTS AT AN AOD CERTIFIED PROGRAM

In accordance with Alcohol and/or Other Drug (AOD) Program Certification Standards, the Client Personal Rights include, but are not limited to, the following:

- The right to confidentiality as provided for in HIPAA and Title 42, Code of Federal Regulations, part 2.
- The right to be accorded dignity in contact with staff, volunteers, board members, and other individuals.
- The right to be accorded safe, healthful and comfortable accommodations to meet his or her needs.
- The right to be free from verbal, emotional, physical abuse and/or inappropriate sexual behavior.
- The right to be informed by the program of the procedures to file a grievance or appeal discharge.
- The right to be free from discrimination based on ethnic group identification, religion, age, gender, race, sexual orientation, or disability.
- The right to be accorded access to his or her file.

42 CFR § 438.100 Enrollee rights.

(a) *General rule.* The State must ensure that:

(1) Each MCO, PIHP, PAHP, PCCM and PCCM entity has written policies regarding the enrollee rights specified in this section; and

(2) Each MCO, PIHP, PAHP, PCCM and PCCM entity complies with any applicable Federal and State laws that pertain to enrollee rights, and ensures that its employees and contracted providers observe and protect those rights.

(b) *Specific rights* -

(1) *Basic requirement.* The State must ensure that each managed care enrollee is guaranteed the rights as specified in paragraphs (b)(2) and (3) of this section.

(2) An enrollee of an MCO, PIHP, PAHP, PCCM, or PCCM entity has the following rights: The right to -

(i) Receive information in accordance with § 438.10.

(ii) Be treated with respect and with due consideration for his or her dignity and privacy.

(iii) Receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand. (The information requirements for services that are not covered under the contract because of moral or religious objections are set forth in § 438.10(g)(2)(ii)(A) and (B).)

(iv) Participate in decisions regarding his or her health care, including the right to refuse treatment.

(v) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

(vi) If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.

(3) An enrollee of an MCO, PIHP, or PAHP (consistent with the scope of the PAHP's contracted services) has the right to be furnished health care services in accordance with §§ 438.206 through 438.210.
(c) *Free exercise of rights.* The State must ensure that each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the MCO, PIHP, PAHP, PCCM or PCCM entity and its network providers or the State agency treat the enrollee.
(d) *Compliance with other Federal and State laws.* The State must ensure that each MCO, PIHP, PAHP, PCCM and PCCM entity complies with any other applicable Federal and State laws (including: 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; and section 1557 of the Patient Protection and Affordable Care Act.

CFR › Title 42 › Chapter IV › Subchapter C › Part 438 › Subpart D › Section 438.206
42 CFR § 438.206 Availability of services.
(a) *Basic rule.* Each State must ensure that all services covered under the State plan are available and accessible to enrollees of MCOs, PIHPs, and PAHPs in a timely manner. The State must also ensure that MCO, PIHP and PAHP provider networks for services covered under the contract meet the standards developed by the State in accordance with § 438.68.
(b) *Delivery network.* The State must ensure, through its contracts, that each MCO, PIHP and PAHP, consistent with the scope of its contracted services, meets the following requirements:
(1) Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all enrollees, including those with limited English proficiency or physical or mental disabilities.
(2) Provides female enrollees with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a women's health specialist.
(3) Provides for a second opinion from a network provider, or arranges for the enrollee to obtain one outside the network, at no cost to the enrollee.
(4) If the provider network is unable to provide necessary services, covered under the contract, to a particular enrollee, the MCO, PIHP, or PAHP must adequately and timely cover these services out of network for the enrollee, for as long as the MCO, PIHP, or PAHP's provider network is unable to provide them.
(5) Requires out-of-network providers to coordinate with the MCO, PIHP, or PAHP for payment and ensures the cost to the enrollee is no greater than it would be if the services were furnished within the network.
(6) Demonstrates that its network providers are credentialed as required by § 438.214.
(7) Demonstrates that its network includes sufficient family planning providers to ensure timely access to covered services.
(c) *Furnishing of services.* The State must ensure that each contract with a MCO, PIHP, and PAHP complies with the following requirements.
(1) *Timely access.* Each MCO, PIHP, and PAHP must do the following:

(i) Meet and require its network providers to meet State standards for timely access to care and services, taking into account the urgency of the need for services.
(ii) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid FFS, if the provider serves only Medicaid enrollees.
(iii) Make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.
(iv) Establish mechanisms to ensure compliance by network providers.
(v) Monitor network providers regularly to determine compliance.
(vi) Take corrective action if there is a failure to comply by a network provider.
(2) *Access and cultural considerations.* Each MCO, PIHP, and PAHP participates in the State's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.
(3) *Accessibility considerations.* Each MCO, PIHP, and PAHP must ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities.
(d) *Applicability date.* This section applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2018. Until that applicability date, states are required to continue to comply with § 438.206 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.

42 CFR Section 438.10(g)(2)(ii)(A) and (B)
(g) *Information for enrollees of MCOs, PIHPs, PAHPs and PCCM entities - Enrollee handbook.*
(1) Each MCO, PIHP, PAHP and PCCM entity must provide each enrollee an enrollee handbook, within a reasonable time after receiving notice of the beneficiary's enrollment, which serves a similar function as the summary of benefits and coverage described in 45 CFR 147.200(a).
(2) The content of the enrollee handbook must include information that enables the enrollee to understand how to effectively use the managed care program. This information must include at a minimum:
(i) Benefits provided by the MCO, PIHP, PAHP or PCCM entity.
(ii) How and where to access any benefits provided by the State, including any cost sharing, and how transportation is provided.
(A) In the case of a counseling or referral service that the MCO, PIHP, PAHP, or PCCM entity does not cover because of moral or religious objections, the MCO, PIHP, PAHP, or PCCM entity must inform enrollees that the service is not covered by the MCO, PIHP, PAHP, or PCCM entity.
(B) The MCO, PIHP, PAHP, or PCCM entity must inform enrollees how they can obtain information from the State about how to access the services described in paragraph (g)(2)(i)(A) of this section.