2020

DMC-ODS Beneficiary Handbook

Napa County Health and Human Services Drug Medi-Cal Organized Delivery System (DMC-ODS)

Alcohol & Drug Services Division

LANGUAGE ASSISTANCE

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-707-253-4063 (TTY: 711).

ATTENTION: Auxiliary aids and services, including but not limited to large print documents and alternative formats, are available to you free of charge upon request. Call 1-707-253-4063 (TTY: 711).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-707-253-4063 (TTY: 711).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-707-253-4063 (TTY: 711).

Tagalog (Tagalog/Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-707-253-4063 (TTY: 711).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-707-253-4063 (TTY: 711).번으로 전화해 주십시오.

繁體中文(Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-707-253-4063 (TTY: 711).

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-707-253-4063 (TTY: 711). (հեռատիպ)՝

Русский (Russian)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-707-253-4063 (TTY: 711).

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شمافراهم می باشد. با 1-707-253-4063 (TTY: 711)تماس بگیری.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-707-253-4063 (TTY: 711).まで、お電話にてご連絡ください。

Hmoob (Hmong)
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-707-253-4063 (TTY: 711).

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-707-253-4063 (TTY: 711). 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-707-253-4063 (رقم هاتف الصم والبكم:TTY-711).

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-707-253-4063 (TTY: 711). पर कॉल करें।

ภาษาไทย (Thai)
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-707-253-4063 (TTY: 711).

ខ្មែរ (Cambodian)
ប្រយ័ត្ន៖ រ សើ 	នជាអ្នកនិយាយ ភាសាខ្មែ , រសវាជំនួយមននកភាសា រោយមិនគិត្ច ្ចនគឺអាចមានសំវា ់ ់រ អ្ើ នក។ ចូ ទូ ស័ព្ 1-707-253-4063 (TTY: 711). ។

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-707-253-4063 (TTY: 711).

Table of Contents

GENERAL INFORMATION 7
Emergency Services 7
Who Do I Contact If I'm Having Suicidal Thoughts? 7
Why Is It Important To Read This Handbook? 7
Information For Members Who Need Materials In A Different Language 9
Information For Members Who Have Trouble Reading, are Hearing Impaired or Vision Impaired 9
Notice Of Privacy Practices 9
What if I Need After Hours Substance Use Services? 10
Who Do I Contact If I Feel That I Was Discriminated Against? 10
SERVICES 11
What Are DMC-ODS Services? 11
How Do I Get DMC-ODS Services? 16
Where Can I Get DMC-ODS Services? 17
How Do I Know When I Need Help? 17
How to Get Mental Health Services 18
Where Can I Get Specialty Mental Health Services? 18
How Do I Know When A Child or Teenager Needs Help? 18
MEDICAL NECESSITY 19
What Is Medical Necessity And Why Is It So Important? 19
What Are The 'Medical Necessity' Criteria For Coverage Of Substance Use Disorder Treatment Services? 19
NOTICE OF ADVERSE BENEFIT DETERMINATION 21
What is a Notice of Adverse Benefit Determination? 21
When Will I Get A Notice Of Adverse Benefit Determination? 21
Will I Always Get A Notice of Adverse Benefit Determination When I Don't Get The Services I Want? 22
What Will The Notice of Adverse Benefit Determination Tell Me? 22
What Should I Do When I Get A Notice Of Adverse Benefit Determination? 22
PROBLEM RESOLUTION PROCESSES 22
What If I Don't Get the Services I Want From My County DMC-ODS Plan? 22
Can I Get Help To File An Appeal, Grievance Or State Fair Hearing? 23
What If I Need Help To Solve A Problem With My County DMC-ODS Plan But Don't Want to File A Grievance Or Appeal? 23

THE GRIEVANCE PROCESS 23
What Is A Grievance? 23
When Can I File A Grievance? 24
How Can I File A Grievance? 24
How Do I Know If The County Plan Received My Grievance? 24
When Will My Grievance Be Decided? 24
How Do I Know If The County Plan Has Made a Decision About My Grievance? 24
Is There A Deadline To File To A Grievance? 25
THE APPEAL PROCESS (Standard and Expedited) 25
What Is A Standard Appeal? 25
When Can I File An Appeal? 26
How Can I File An Appeal? 26
How Do I Know If My Appeal Has Been Decided? 26
Is There A Deadline To File An Appeal? 27
When Will A Decision Be Made About My Appeal? 27
What If I Can't Wait 30 Days For My Appeal Decision? 27
What Is An Expedited Appeal? 27
When Can I File an Expedited Appeal? 27
THE STATE FAIR HEARING PROCESS 28
What is a State Fair Hearing? 28
What Are My State Fair Hearing Rights? 28
When Can I File For A State Fair Hearing? 28
How Do I Request A State Fair Hearing? 29
Is There a Deadline for Filing For A State Fair Hearing? 29
Can I Continue Services While I'm Waiting For A State Fair Hearing Decision? 29
What Do I Need To Do if I Want to Continue Services While I'm Waiting For A State Fair Hearing Decision? 29
What If I Can't Wait 90 Days For My State Fair Hearing Decision? 29
IMPORTANT INFORMATION ABOUT THE STATE OF CALIFORNIA MEDI-CAL PROGRAM 30
Who Can Get Medi-Cal? 30
Do I Have To Pay For Medi-Cal? 30
Does Medi-Cal Cover Transportation? 31
MEMBER RIGHTS AND RESPONSIBILITIES 31
What Are My Rights As A Recipient of DMC-ODS Services? 31

What Are My Responsibilities As A Recipient of DMC-ODS Services? 32
PROVIDER DIRECTORY 33
TRANSITION OF CARE REQUEST 33
When can I request to keep my previous, and now out-of-network, provider?..... 33
How do I request to keep my out-of-network provider? 33
What if I continued to see my out-of-network provider after transitioning to the County Plan?..... 34
Why would the County Plan deny my transition of care request?..... 34
What happens if my transition of care request is denied? 34
What happens if my transition of care request is approved? 34
How quickly will my transition of care request be processed? 34
What happens at the end of my transition of care period? 34
APPENDIX A **35**

GENERAL INFORMATION

Emergency Services

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

Emergency Services are services provided for an unexpected medical condition, including a psychiatric emergency medical condition.

An emergency medical condition is present when you have symptoms that cause severe pain or a serious illness or an injury, which a prudent layperson (a careful or cautious non-medical person) believes, could reasonably expect without medical care could:

- Put your health in serious danger, or
- If you are pregnant, put your health or the health of your unborn child in serious danger,
- Cause serious harm to the way your body works, or
- Cause serious damage to any body organ or part.

You have the right to use any hospital in the case of emergency. Emergency services never require authorization.

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 1-800-273-TALK (8255).

For local residents seeking assistance in a crisis and to access local mental health programs, please call: (707) 253-4711.

Why Is It Important To Read This Handbook?

Welcome! Napa County HHSA Alcohol and Drug Services (ADS) encourages you to learn about the services and benefits that are covered by the Drug Medi-Cal Organized Deliver System (DMC-ODS). This is a delivery system of healthcare services for Medi-Cal eligible individuals with substance use disorder (SUD). Substance use treatment services are part of your managed care benefits. This delivery system is required to provide a continuum of services to all eligible beneficiaries modeled after the American Society of Addiction Medicine (ASAM) Criteria. ASAM criteria provides a way to match individuals suffering from addiction with the services and tools they need for a successful and long-term recovery. Services required to participate in the DMC-ODS include:

Early Intervention (overseen through the managed care system)
Outpatient Services
Intensive Outpatient Services

Short-Term Residential Services (up to 90 days)
Withdrawal Management
Opioid/Narcotic Treatment Program Services
Recovery Services
Case Management
Physician Consultation

It is important that you understand how the Drug Medi-Cal Organized Delivery System (DMC-ODS) plan works so you can get the care you need. This handbook explains your benefits and how to get care. This handbook is available in the ADS waiting area lobby, at the ADS website on line and/or a hardcopy will be offered and supplied for your personal use during the ADS intake process. In addition, the Provider Directory is online at the Napa County Health and Human Services website. The link is www.countyofnapa.org/HHSA/ADS.

You will learn:

- How to receive substance use disorder (SUD) treatment services through your county DMC-ODS plan
- What benefits you have access to
- What to do if you have a question or problem
- Your rights and responsibilities as a member of your county DMC-ODS plan

If you don't read this handbook now, you should keep this handbook so you can read it later. Use this handbook as an addition to the member handbook that you received when you enrolled in your current Medi-Cal benefit. That could be with a Medi-Cal managed care plan or with the regular Medi-Cal "Fee for Service" program.

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

- Figuring out if you are eligible for DMC-ODS services from the county or its provider network.
- Coordinating your care.
- Providing a toll-free phone number that is answered 24 hours a day and 7 days a week that can tell you about how to get services from the County Plan. You can also contact the County Plan at this number to request availability of after-hours care.
- Having enough providers to make sure that you can get the SUD treatment services covered by the County Plan if you need them.
- Informing and educating you about services available from your County Plan.
- Providing you services in your language or by an interpreter (if necessary) free of charge and letting you know that these interpreter services are available.
- Providing you with written information about what is available to you in other languages or forms. Translation services and materials are available in Spanish.
- All Beneficiary informing materials, including this Handbook and Grievance/Appeal Forms are available at DMC-ODS provider sites in English

and Spanish. ADS supplies a reference list for alternate languages outside the County's threshold languages on page 4 of this booklet. In addition, ADS uses the Language Line Services for over-the-phone interpretation needs.

- If you require this document in an alternate format (example: Braille, Large Print, Audiotape, CD-ROM), you may request an alternate format by calling ADS Access (707) 253-4063 or (855) 753-5247 toll free. Hearing and/or speech impaired members can call the California Relay Service by dialing 711.
- 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 would be considered significant when there is an increase or decrease in the amount or type 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 County Plan.
- Informing you if any contracted provider refuses to perform or otherwise support any covered service due to moral, ethical, or religious objections and informing you of alternative providers that do offer the covered service.
- Ensuring that you have continued access to your previous, and now out-of-network, provider for a period of time if changing providers would cause your health to suffer or increase your risk of hospitalization.

Napa County HHSA ADS Access: (707) 253-4063
Napa County HHSA Alcohol & Drug Services Toll Free Number: (855) 753-5247
Napa County HHSA ADS Utilization Management: (707) 253-4774
Medical Emergency 911

Information for Members Who Need Materials In A Different Language

All Beneficiary informing materials, including this Handbook and Grievance/Appeal Forms are available at DMC-ODS provider sites in English and Spanish. ADS supplies a reference list for alternate languages outside the County's threshold languages on page 4 of this booklet. In addition, ADS uses the Language Line Services for over-the-phone interpretation needs.

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

If you require this document in an alternate format (example: Braille, Large Print, Audiotape, CD-ROM), you may request an alternate format by calling ADS Access (707) 253-4063 or (855) 753-5247 toll free. Hearing and/or speech impaired members can call the California Relay Service by dialing 711.

Notice of Privacy Practices

A copy of the Notice of Privacy Practices is included at the end of this handbook as Appendix A. If you have any questions about this notice, please contact the County Privacy Officer at (707)

253-4715 or you may also obtain a copy of the Notice of Privacy Practices from the program staff where you receive services from the Napa County Health and Human Services Agency. You may also obtain a copy of the Notice of Privacy Practices online at https://www.countyofnapa.org/hhsa/ads/.

What if I Need After Hours Substance Use Services?

If you have questions or need to speak to someone after normal business hours, call the HHSA Napa County Alcohol & Drug Services toll free number (855) 753-5247. This number will provide linkages to the Detox center and give general information about Napa County Alcohol and Drug Services which includes outpatient and residential services. The number will
Also maintain a log of call backs which will be relayed to the ADS Access office the following business day.

Who Do I Contact If I Feel That I Was Discriminated Against?

Discrimination is against the law. The State of California and DMC-ODS follows state and federal civil rights laws and do not discriminate, exclude people, or treat them differently because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. The Napa County DMC-ODS provides:

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

- Free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact the Napa County ADS between 8am and 5pm Monday through Friday at (707) 253-4063. Or, if you cannot hear or speak well, please call 711.

If you believe that the State of California or DMC-ODS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Vincent James, Deputy Director of HHSA-Civil Rights Coordinator
2751 Napa Valley Corporate Drive, Napa, CA 94559
Phone: 707-253-4173, TTY-299-1770 Fax: 707-253-4880
HHSACivilRightsCoordinator@countyofnapa.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance,

Vincent James, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint directly with the U.S. Department of Health and Human Services, Office of Civil Rights by phone, in writing, or electronically:

- By phone:
  Call 1 (800) 368-1019.
  If you cannot speak or hear well, please call TTY/TDD 1 (800) 537-7697.

- In writing:
  Fill out a complaint form or send a letter to:

  OFFICE OF CIVIL RIGHTS
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

Complaint forms are available at https://www.hhs.gov/ocr/complaints/index.html.

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

SERVICES

What Are DMC-ODS Services?

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

DMC-ODS services include:

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

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

- **Outpatient Services**
  - Counseling services are provided to members up to nine hours a week for adults and less than six hours a week for adolescents when determined to be medically necessary and in accordance with an individualized client plan. Services can be provided by a licensed professional or a certified counselor in any appropriate setting in the community.
  - Outpatient Services includes intake and assessment, treatment planning, individual counseling, group counseling, family therapy, collateral services, member education, medication services, crisis intervention services, and discharge planning.
  - Outpatient treatment services are offered for adolescents at a provider based clinic as well as at particular school sites throughout Napa County. Outpatient sites offer adolescent services up to six hours per week based on beneficiary needs. Outpatient treatment services are offered for adults at Napa County Health and Human Services – Alcohol Drug Services adults consists of up to nine (9) hours per week.

- **Intensive Outpatient Treatment**
  - Intensive Outpatient Treatment services are provided to members (a minimum of nine hours with a maximum of 19 hours a week for adults and a minimum of six hours with a maximum of 19 hours a week for adolescents) when determined to be medically necessary and in accordance with an individualized client plan. Services consist primarily of counseling and education about addiction-related problems. Services can be provided by a certified counselor in a designated setting in the community
  - Intensive Outpatient Treatment Services include the same components as Outpatient Services. The increased number of hours of service are the main difference.
  - Napa County ADS provides adult Outpatient and Intensive Treatment services for DMC-ODS Beneficiaries. Typically these services are provided 3-5 hours per day, 3-4 times per week.

- **Partial Hospitalization** (only available in some counties)
  - Partial Hospitalization services feature 20 or more hours of clinically intensive programming per week, as specified in the member's treatment plan. Partial hospitalization programs typically have direct access to psychiatric, medical, and laboratory services, and are to meet the identified needs which warrant daily monitoring or management but which can be appropriately addressed in a structured outpatient setting.
  - Partial Hospitalization services are similar to Intensive Outpatient Treatment services, with an increase in number of hours and additional access to medical services being the main differences.
  - <u>Napa County ADS does not currently provide Partial Hospitalization services.</u>

- **Residential Treatment** (subject to authorization by the county)
  - Residential Treatment is a non-institutional, 24-hour non-medical, short-term residential program that provides rehabilitation services to members with a SUD diagnosis when determined as medically necessary and in accordance with an individualized treatment plan. Each member shall live on the premises and shall be supported in their efforts to restore, maintain and apply interpersonal and independent living skills and access community support systems. Providers and residents work collaboratively to define barriers, set priorities, establish goals, create treatment plans, and solve SUD related problems. Goals include sustaining abstinence, preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care.
  - Residential services require prior authorization by the County Plan. Each authorization for residential services can be for a maximum of 90 days for adults and 30 days for youth. Only two authorizations for residential services are allowed in a one-year-period. It is possible to have one 30-day extension per year based on medical necessity. Pregnant women can receive residential services through the last day of the month that the 60th day after delivery occurs. Early Periodic Screening, Diagnosis, and Treatment (EPSDT) eligible members (under the age of 21) will not have the authorization limits described above as long as medical necessity establishes the need for ongoing residential services.
  - Residential Services includes intake and assessment, treatment planning, individual counseling, group counseling, family therapy, collateral services, member education, medication services, safeguarding medications (facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication), crisis intervention services, transportation (provision of or arrangement for transportation to and from medically necessary treatment) and discharge planning.

- **Withdrawal Management**
  - Withdrawal Management services are provided when determined as medically necessary and in accordance with an individualized client plan. Each member shall reside at the facility if receiving a residential service and will be monitored during the detoxification process. Medically necessary habilitative and rehabilitative services are provided in accordance with an individualized client plan prescribed by a licensed physician, or licensed prescriber and approved and authorized according to the State of California requirements.
  - Withdrawal Management Services include intake and assessment, observation (to evaluate health status and response to any prescribed medication), medication services, and discharge planning.
  - Napa County provides two levels of withdrawal management, ambulatory withdrawal management for mild withdrawal with daily or less than daily outpatient supervision and clinically-managed residential withdrawal management for moderate withdrawal which involves 24-hour support to

complete withdrawal to increase likelihood of continuing treatment or recovery.

- **Opioid Treatment**
  - Opioid (Narcotic) Treatment Program (OTP/NTP) services are provided in NTP licensed facilities. Medically necessary services are provided in accordance with an individualized client plan determined by a licensed physician or licensed prescriber, and approved and authorized according to the State of California requirements. OTPs/NTPs are required to offer and prescribe medications to members covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone, and disulfiram.
  - A member must receive, at a minimum, 50 minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity.
  - Opioid Treatment Services include the same components as Outpatient Treatment Services, with the inclusion of medical psychotherapy consisting of a face-to-face discussion conducted by a physician on a one-on-one basis with the member.
  - NTP services can be accessed through the MedMark Treatment Center in neighboring Solano County.

- **Medication Assisted Treatment** (varies by county)
  - Medication Assisted Treatment (MAT) Services are available outside of the OTP clinic. MAT is the use of prescription medications, in combination with counseling and behavioral therapies, to provide a whole-person approach to the treatment of SUD. Providing this level of service is optional for participating counties.
  - MAT services includes the ordering, prescribing, administering, and monitoring of all medications for SUD. Opioid and alcohol dependence, in particular, have well established medication options. Physicians and other prescribers may offer medications to members covered under the DMC-ODS formulary including buprenorphine, naloxone, disulfiram, Vivitrol, or any FDA approved medication for the treatment of SUD.
  - Napa County ADS provides MAT services for DMC-ODS Beneficiaries meeting medical necessity for Outpatient level of care for opioid and alcohol dependency. Services include a medical exam and evaluation, lab work, random urinalysis screens and medications which may include buprenorphine (Suboxone) or naltrexone (Vivitrol).

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

- Recovery Services include individual and group counseling; recovery monitoring/substance abuse assistance (recovery coaching, relapse prevention, and peer-to-peer services); and case management (linkages to educational, vocational, family supports, community-based supports, housing, transportation, and other services based on need).
- Napa County ADS provides Recovery Services Case Management for DMC-ODS Beneficiaries meeting medical necessity. ADS supplies Recovery Case Management Services. This service is available as a preventive and supportive component. The Recovery Services Case Manager will coordinate resources and monitor progress in recovery. This includes coaching in recovery and providing linkages to life skills, employment services, job training and education services, parent education transportation and housing.

- **Case Management**
  - Case Management Services assist a member to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. These services focus on coordination of SUD care, integration around primary care especially for members with a chronic SUD, and interaction with the criminal justice system, if needed.
  - Case Management Services include a comprehensive assessment and periodic reassessment of individual needs to determine the need for continuation of case management services; transitions to higher or lower levels of SUD care; development and periodic revision of a client plan that includes service activities; communication, coordination, referral and related activities; monitoring service delivery to ensure member access to service and the service delivery system; monitoring the member's progress; and, member advocacy, linkages to physical and mental health care, transportation and retention in primary care services.
  - Case management shall be consistent with and shall not violate confidentiality of any member as set forth in Federal and California law.
  - Napa County ADS provides Case Management Services for DMC-ODS Beneficiaries meeting medical necessity.

- **Language Line Solutions**
  - ADS has Language Identification posters and language identification cards which are located in the waiting areas.
  - ADS provides an interpreter for all languages spoken by clients including American Sign Language when requested by client. ADS provides this service through Certified Bilingual staff, Language Line Services and/or contracted interpreters and/or translators.
  - Interpretation Services have a three step process:
    1. ADS uses internal Certified Bilingual Staff for interpretation.
    2. If identified staff is not fluent in non-threshold language, the Language Line Services is used. ADS staff follow the Language Line Services Instruction sheet to obtain services.
    3. When the Language Line Services is not appropriate for the situation, and

advance notice of the need for language services is provided, ADS may use the services of contracted interpreters and/or translators.

- Interpreters are offered and provided at no cost to the individual.
- A beneficiary may request to use their own interpreter but ADS will let them know that they have the option of having a certified interpreter and get arelease of information signed before services.
- ADS prohibits the use of minors as interpreters.
- Vital documents are translated into any non-English "threshold" language needed.
- Translated versions are available within 30 days of the publication ofthe document in English.
- If a translation of vital documents is not required, ADS will provide written notice, in the primary language of the beneficiary, of their right to oral interpretation of written materials.
- All written translations are reviewed in-house and through contracts. This is completed by Certified Bilingual staff members, independently, to verify quality of translations.

Early Periodic Screening, Diagnosis, and Treatment (EPSDT)

If you are under 21 years of age, you may receive additional medically necessary services under Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). EPSDT services include screening, vision, dental, hearing and all other medically necessary mandatory and optional services listed in federal law 42 U.S.C. 1396d(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening whether or not the services are covered for adults. The requirement for medical necessity and cost effectiveness are the only limitations or exclusions that are applicable to EPSDT services.

For a more complete description of the EPSDT services that are available and to have your questions answered, please call Napa County HHSA Children Mental Health 707-259-8151 or 800- 648-8650 Member Services.

HOW TO GET DMC-ODS SERVICES

How Do I Get DMC-ODS Services?

If you think you need substance use disorder (SUD) treatment services, you can get services by asking the County Plan for them yourself. You can call your county toll-free phone number listed in the front section of this handbook. You may also be referred to your County Plan for SUD treatment services in other ways. Your County Plan is required to accept referrals for SUD treatment services from doctors and other primary care providers who think you may need these services and from your Medi-Cal managed care health plan, if you are a member. Usually the provider or the Medi- Cal managed care health plan will need your permission or the permission of the parent or caregiver of a child to make the referral, unless there is an

emergency. Other people and organizations may also make referrals to the county, including schools; county welfare or social services departments; conservators, guardians or family members; and law enforcement agencies.

The covered services are available through Napa County's' provider network. If any contracted provider raises an objection to performing or otherwise supporting any covered service, Napa County will arrange for another provider to perform the service. Napa County will respond with timely referrals and coordination in the event that a covered service is not available from a provider because of religious, ethical or moral objections to the covered service.

You may also be referred to your county for SUD treatment services in other ways. Your County Plan is required to accept referrals for SUD treatment services from doctors and other primary care providers who think you may need these services and from your Medi-Cal Managed Care Health plan, if you are a member. Usually the provider or the Medi-Cal Managed Care Health Plan will need your permission or the permission of the parent or caregiver of a child to make the referral, unless there is an emergency. Other people and organizations may also make referrals to the county (Ex. county welfare or social services departments, law enforcement agencies). Upon receipt of a referral, a DMC-ODS provider will perform an assessment to determine medical necessity based by the American Society of Addiction Medicine (ASAM) criteria. The ASAM criteria is an assessment tool used to determine a person's level of care needed for SUD treatment.

Where Can I Get DMC-ODS Services?

Napa County HHSA ADS Division is participating in the DMC-ODS pilot program. Since you are a resident of Napa County, you can get DMC-ODS services in the county where you live through the DMC-ODS County Plan. Your County Plan has SUD treatment providers available to treat conditions that are covered by the plan. Other counties that provide Drug Medi-Cal services that are not participating in the DMC-ODS pilot will be able to provide regular DMC services to you if needed. If you are under 21 years of age, you are also eligible for EPSDT services in any other county across the state.

After Hours Care

Napa County has 24/7 toll free number for prospective beneficiaries to call to access DMC-ODS services. The After Hours telephone number is (855) 753-5247. This line will collect pertinent information needed for services and supply the appropriate connection and referral. If there is an emergency, please call 911 immediately.

How Do I Know When I Need Help?

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

currently reside in a DMC-ODS participating county.

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

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

HOW TO GET MENTAL HEALTH SERVICES

How to Get Mental Health Services

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

The covered specialty mental health services are available through an MHP provider (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. 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 EPSDT.
Your MHP will determine if you need specialty mental health services. If you do, the MHP will refer you to a mental health provider that provides the services you need.
The MHP has to make sure they refer you to a provider who will meet your needs and who is the closest provider to your home.

Your MHP has to meet the state's appointment time standards when scheduling an appointment for you to receive services from the MHP. The MHP must offer you an appointment that meets the following appointment time standards:

- Within 10 business days of your non-urgent request to start services with the MHP;
- Within 48 hours if you request services for an urgent condition;
- Within 15 business days of your request for an appointment with a psychiatrist; and,

For ongoing services (following the initial appointment), in a timely manner based on your condition

and need for services.

MEDICAL NECESSITY

What Is Medical Necessity And Why Is It So Important?

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

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

What Are the 'Medical Necessity' Criteria for Coverage of Substance Use Disorder Treatment Services?

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

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

- You must be enrolled in Medi-Cal.
- You must reside in a county that is participating in the DMC-ODS.
- You must have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for a Substance-Related and Addictive Disorder. Any adult, or youth under the age of 21, who is assessed to be "at-risk" for developing a SUD will be eligible for Early Intervention services if they do not meet medical necessity criteria.
- You must meet the American Society of Addiction Medicine (ASAM) definition of medical necessity for services based on the ASAM Criteria (ASAM Criteria are national treatment standards for addictive and substance-related conditions).

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

SELECTING A PROVIDER

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

The County Plan may put some limits on your choice of providers. Your county DMC-ODS plan must give you a chance to choose between at least two providers when you first start services, unless the County Plan has a good reason why it can't provide a choice, for example, there is

only one provider who can deliver the service you need. Your County Plan must also allow you to change providers. When you ask to change providers, the county must allow you to choose between at least two providers, unless there is a good reason not to do so.

Sometimes county contract providers leave the county network on their own or at the request of the County Plan. When this happens, the County Plan must make a good faith effort to give written notice of termination of a county contracted provider within 15 days after receipt or issuance of the termination notice, to each person who was receiving SUD treatment services from the provider.

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

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

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

If the county doesn't make a decision within the timeline required for a standard or an expedited authorization request, the County Plan must send you a Notice of Adverse Benefit Determination telling you that the services are denied and that you may file an appeal or ask for a State Fair Hearing.

You may ask the County Plan for more information about its authorization process. Check the front section of this handbook to see how to request the information.

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

Which Providers Does My DMC-ODS Plan Use?

If you are new to the County Plan, information about obtaining a complete list of providers in

your County Plan can be found at the end of this handbook and contains information about where providers are located, the SUD treatment services they provide, and other information to help you access care, including information about the cultural and language services that are available from the providers. If you have questions about providers, call your county toll-free phone number located in the front section of this handbook.

NOTICE OF ADVERSE BENEFIT DETERMINATION

What is a Notice of Adverse Benefit Determination?

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

When Will I Get A Notice Of Adverse Benefit Determination?

You will get a Notice of Adverse Benefit Determination:

- If your County Plan or one of the County Plan providers decides that you do not qualify to receive any Medi-Cal SUD treatment services because you do not meet the medical necessity criteria.
- If your provider thinks you need a SUD service and asks the County Plan for approval, but the County Plan does not agree and denies your provider's request, or changes the type or frequency of service. Most of the time you will receive a Notice of Adverse Benefit Determination before you receive the service, but sometimes the Notice of Adverse Benefit Determination will come after you already received the service, or while you are receiving the service. If you get a Notice of Adverse Benefit Determination after you have already received the service you do not have to pay for the service.
- If your provider has asked the County Plan for approval, but the County Plan needs more information to make a decision and doesn't complete the approval process on time.
- If your County Plan does not provide services to you based on the timelines the County Plan has set up. Call your County Plan to find out if the County Plan has set up timeline standards.
- If you file a grievance with the County Plan and the County Plan does not get back to you with a written decision on your grievance within 90 calendar days. If you file an appeal with the County Plan and the County Plan does not get back to you with a written decision on your appeal within 30 calendar days or, if you filed an expedited appeal and did not receive a response within 72 hours.

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 fair 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:

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

What Should I Do When I Get A Notice Of Adverse Benefit Determination?

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

You can request a continuation of the service that has been discontinued when you submit an appeal or a request for State Fair Hearing. 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.

PROBLEM RESOLUTION PROCESSES

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

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

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

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

Learn more about each problem resolution process below.

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

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

If you would like help, call Napa County Alcohol & Drug Services Division Access line at (Toll Free) 855-753-5247 or (707) 253-4063.

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

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

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

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

THE GRIEVANCE PROCESS

What Is A Grievance?

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

The grievance process will:

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

When Can I File A Grievance?

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

How Can I File A Grievance?

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

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

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

When Will My Grievance Be Decided?

The County Plan must make a decision about your grievance within 90 calendar days from the date you filed your grievance. Timeframes may be extended by up to 14 calendar days if you request an extension, or if the County Plan believes that there is a need for additional information and that the delay is for your benefit. An example of when a delay might be for your benefit is when the county believes it might be able to resolve your grievance if the County Plan had a little more time to get information from you or other people involved.

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

When a decision has been made regarding your grievance, the County Plan will notify you or your representative in writing of the decision. If your County Plan fails to notify you or any

affected parties of the grievance decision on time, then the County Plan will provide you with a Notice of Adverse Benefit Determination advising you of your right to request a State Fair Hearing. Your County Plan will provide you with a Notice of Adverse Benefit Determination on the date the timeframe expires.

Is There A Deadline To File To A Grievance?

You may file a grievance at any time.

THE APPEAL PROCESS (Standard and Expedited)

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

What Is A Standard Appeal?

A standard appeal is a request for review of a problem you have with the plan or your provider that involves a denial or changes to services you think you need. If you request a standard appeal, the County Plan may take up to 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 appeals process will:

- Allow you to file an appeal in person, on the phone, or in writing. If you submit your appeal in person or on the phone, you must follow it up with a signed written appeal. You can get help to write the appeal. If you do not follow-up with a signed written appeal, your appeal will not be resolved. However, the date that you submitted the oral appeal is the filing date.
- Ensure filing an appeal will not count against you or your provider in any way.
- Allow you to authorize another person to act on your behalf, including a provider. If you authorize another person to act on your behalf, the plan might ask you to sign a form authorizing the plan to release information to that person.
- Have your benefits continued upon request for an appeal within the required timeframe, which is 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. 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 furnished while the appeal was pending;
- Ensure that the individuals making the decisions are qualified to do so and not involved in any previous level of review or decision-making.
- Allow you or your representative to examine your case file, including your medical

record, and any other documents or records considered during the appeal process, before and during the appeal process.

- Allow you to have a reasonable opportunity to present evidence and allegations of fact or law, in person or in writing.
- Allow you, your representative, or the legal representative of a deceased member's estate to be included as parties to the appeal.
- Let you know your appeal is being reviewed by sending you written confirmation.
- Inform you of your right to request a State Fair Hearing, following the completion of the appeal process.

When Can I File An Appeal?

You can file an appeal with your county DMC-ODS Plan:

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

How Can I File An Appeal?

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

How Do I Know If My Appeal Has Been Decided?

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

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

Is There A Deadline To File An Appeal?

You must file an appeal within 60 days of the date of the action you're appealing when you get a Notice of Adverse Benefit Determination. Keep in mind that you will not always get a Notice of Adverse Benefit Determination. There are no deadlines for filing an appeal when you do not get a Notice of Adverse Benefit Determination; so you may file this type of appeal at any time.

When Will A Decision Be Made About My Appeal?

The County Plan must decide on your appeal within 30 calendar days from when the County Plan receives your request for the appeal. Timeframes may be extended by up to 14 calendar days if you request an extension, or if the County Plan believes that there is a need for additional information and that the delay is for your benefit. An example of when a delay is for your benefit is when the county believes it might be able to approve your appeal if the County Plan had a little more time to get information from you or your provider.

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

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

What Is An Expedited Appeal?

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

- Your appeal must meet certain requirements.
- The expedited appeals process also follows different deadlines than the standard appeals.
- You can make a verbal request for an expedited appeal. You do not have to put your expedited appeal request in writing.

When Can I File an Expedited Appeal?

If you think that waiting up to 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 County Plan agrees that your appeal meets the requirements for an expedited appeal, your county will resolve your expedited appeal within 72 hours after the County Plan receives the appeal. Timeframes may be extended by up to 14 calendar days if you request an extension, or if the County Plan shows that there is a need for additional information and that the delay is in your interest. If your County Plan extends the timeframes, the plan will give you a written explanation as to why the timeframes were extended.

If the County Plan decides that your appeal does not qualify for an expedited appeal, the County Plan must make reasonable efforts to give you prompt oral notice and will notify you in writing within 2 calendar days giving you the reason for the decision. Your appeal will then

follow the standard appeal timeframes outlined earlier in this section. If you disagree with the county's decision that your appeal doesn't meet the expedited appeal criteria, you may file a grievance.

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

THE STATE FAIR HEARING PROCESS

What is a State Fair Hearing?

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

What Are My State Fair Hearing Rights?

You have the right to:

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

When Can I File For A State Fair Hearing?

You can file for a State Fair Hearing:

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

How Do I Request A State Fair Hearing?

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

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

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

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

You only have 120 days to ask for a State Fair Hearing. The 120 days start either the day after the County Plan personally gave you its appeal decision notice, or the day after the postmark date of the county appeal decision notice.

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

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

Yes, if you are currently receiving treatment and you want to continue your treatment while you appeal, you must ask for a State Fair Hearing within 10 days from the date the appeal decision notice was postmarked or delivered to you OR before the date your County Plan says services will be stopped or reduced. When you ask for a State Fair Hearing, you must say that you want to keep receiving your treatment. Additionally, you will not have to pay for services received while the State Fair Hearing is pending.

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

What Do I Need To Do if I Want to Continue Services While I'm Waiting for a State Fair Hearing Decision?

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

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

You may ask for an expedited (quicker) State Fair Hearing if you think the normal 90-calendar day time frame will cause serious problems with your health, including problems with your

ability to gain, maintain, or regain important life functions. The Department of Social Services, State Hearings Division, will review your request for an expedited State Fair Hearing and decide if it qualifies. If your expedited hearing request is approved, a hearing will be held and a hearing decision will be issued within 3 working days of the date your request is received by the State Hearings Division.

IMPORTANT INFORMATION ABOUT THE STATE OF CALIFORNIA MEDI-CAL PROGRAM

Who Can Get Medi-Cal?

You may qualify for Medi-Cal if you are in one of these groups:

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

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

Do I Have To Pay For Medi-Cal?

You may have to pay for Medi-Cal depending on the amount of money you get or earn each month.

- If your income is less than Medi-Cal limits for your family size, you will not have to pay for Medi-Cal services.
- If your income is more than Medi-Cal limits for your family size, you will have to pay some money for your medical or SUD treatment services. The amount that you pay is called your 'share of cost.' Once you have paid your 'share of cost,' Medi-Cal will pay the rest of your covered medical bills for that month. In the months that you don't have medical expenses, you don't have to pay anything.
- You may have to pay a 'co-payment' for any treatment under Medi-Cal. This means you pay an out of pocket amount each time you get a medical or SUD treatment service or a prescribed drug (medicine) and a co-payment if you go to a hospital emergency room for your regular services.

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

Does Medi-Cal Cover Transportation?

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

- For children, the county Child Health and Disability Prevention (CHDP) program can help. You may also wish to contact your county social services office at 1-800-464-4214. You can also get information online by visiting www.dhcs.ca.gov, then clicking on 'Services' and then 'Medi-Cal.'
- For adults, your county social services office can help at 1-800-464-4214. Or you can get information online by visiting www.dhcs.ca.gov, then clicking on 'Services' and then 'Medi-Cal.'
- If you are enrolled in a Medi-Cal Managed Care Plan (MCP), the MCP is required to assist with transportation according to Section 14132 (ad) of the Welfare and Institutions Code. Transportation services are available for all service needs, including those that are not included in the DMC-ODS program.

MEMBER RIGHTS AND RESPONSIBILITIES

What Are My Rights As A Recipient of DMC-ODS Services?

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

- Be treated with respect, giving due consideration to your right to privacy and the need to maintain confidentiality of your medical information.
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.
- Participate in decisions regarding your SUD care, including the right to refuse treatment.
- Receive timely access to care, including services available 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-network provider" means a provider who is not on the County Plan's list of providers. You may contact member services at Napa County Alcohol & Drug Services Divisions Access line at (Toll Free) 855-753-5247 or (707) 253-4063 for information on how to receive services from an out-of-network provider.
- The county must make sure you don't pay anything extra for seeing an out-of-network provider.
- Request a second opinion from a qualified health care professional within the county network, or one outside the network, at no additional cost to you.
- 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.

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

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

- Carefully read the member informing materials that you have received from the County Plan. These materials will help you understand which services are available and how to get treatment if you need it.
- Attend your treatment as scheduled. You will have the best result if you follow your treatment plan. If you do need to miss an appointment, call your provider at least 24 hours in advance and reschedule for another day and time.
- Always carry your Medi-Cal (County Plan) ID card and a photo ID when you attend treatment.
- Let your provider know if you need an interpreter before your appointment.
- Tell your provider all your medical concerns in order for your plan to be accurate. The more complete information that you share about your needs, the more successful your treatment will be.
- Make sure to ask your provider any questions that you have. It is very important you completely understand your treatment plan and any other information that you receive during treatment.

- Follow the treatment plan you and your provider have agreed upon.
- Be willing to build a strong working relationship with the provider that istreating you.
- Contact the County Plan if you have any questions about your services or if you have any problems with your provider that you are unable to resolve.
- Tell your provider and the County Plan if you have any changes to your personal information. This includes address, phone number, and any other medical information that can affect your ability to participate in treatment.
- Treat the staff who provide your treatment with respect and courtesy.
- If you suspect fraud or wrongdoing, report it. If you suspect Medi-Cal fraud, waste or abuse, call the DHCS Medi-Cal Fraud Hotline at 1-800-822-6222 or email DHCS at fraud@dhcs.ca.gov. You may also contact Napa County HHSA (707)251-1099 for assistance.

PROVIDER DIRECTORY

A current Provider Directory is available at all DMC-ODS provider sites and at
https://www.countyofnapa.org/DocumentCenter/View/5992/Provider-Directory-English-PDF
https://www.countyofnapa.org/DocumentCenter/View/5990/Directorio-de-Proveedores-PDF

The Provider Directory includes:

- the categories of service available from each provider;
- the names locations, telephone number and websites of current contracted providers by category;
- options for services in languages other than English and services that are designed to address cultural differences;
- whether the providers are not accepting new beneficiaries; and
- whether the providers have accommodations for people with physical disabilities.

TRANSITION OF CARE REQUEST

When can I request to keep my previous, and now out-of-network, provider?

- After joining the County Plan, you may request to keep your out-of-network provider if:
    - Moving to a new provider would result in a serious detriment to your health or would increase your risk of hospitalization or institutionalization; and
    - You were receiving treatment from the out-of-network provider prior to the date of your transition to the County Plan.

How do I request to keep my out-of-network provider?

- You, your authorized representatives, or your current provider, may submit a request in writing to the County Plan. You can also contact member services at 1-888-818-1115 for information on how to request services from an out-of-network provider.
- The County Plan will send written acknowledgement of receipt of your request and begin to

process your request within three (3) working days.

What if I continued to see my out-of-network provider after transitioning to the County Plan?

- You may request a retroactive transition of care request within thirty (30) calendar days of receiving services from an out-of-network provider.

Why would the County Plan deny my transition of care request?

- The County Plan may deny your request to retain your previous, and now out-of-network provider, if:
    - The County Plan has documented quality of care issues with the provider

What happens if my transition of care request is denied?

- If the County Plan denies your transition of care it will:
    - Notify you in writing;
    - Offer you at least one in-network alternative provider that offers the same level of services as the out-of-network provider; and
    - Inform you of your right to file a grievance if you disagree with the denial.
    - If the County Plan offers you multiple in-network provider alternatives and you do not make a choice, then the County Plan will refer or assign you to an in-network provider and notify you of that referral or assignment in writing.

What happens if my transition of care request is approved?

- Within seven (7) calendar days of approving your transition of care request the County Plan will provide you with:
    - The request approval;
    - The duration of the transition of care arrangement;
    - The process that will occur to transition your care at the end of the continuity of care period; and
    - Your right to choose a different provider from the County Plan's provider network.

How quickly will my transition of care request be processed?

- The County Plan will completed its review of your transition of care request within thirty (30) calendar days from the date the County Plan received your request.

What happens at the end of my transition of care period?

- The County Plan will notify you in writing thirty (30) calendar days before the end of the transition of care period about the process that will occur to transition your care to an in-network provider at the end of your transition of care period.

APPENDIX A

Effective Date: 9/23/13

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the County Privacy Officer or the program staff where you receive services from the Napa County Health and Human Services Agency (the "Agency"). The contact information for the County Privacy Officer is on the last page of this notice.

WHO WILL FOLLOW THIS NOTICE

This notice describes our Agency's practices and that of:

- Any health care professional authorized to enter information into your Agency medical record.
- Any member of a volunteer group we allow to help you while you are a health care client of the agency.
- All employees, staff, and other Agency personnel in health care related departments.

All those identified above may share health information with each other for treatment, payment or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH CARE INFORMATION

We understand that information about you and your health is personal. We are committed to protecting your health information. We create a record of the care and services you receive as a health care client of our Agency. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by the Agency, whether made by Agency personnel, a provider or a business associate with whom we contract.

This notice will tell you about the ways in which we may use and disclose your health information. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

We are required by law to:

- Make sure that health information that identifies you is kept private (with certain exceptions);
- Give you this notice of our legal duties and privacy practices with respect to your health information; and follow the terms of the notice that is currently in effect
- Notify you of any breaches of your health information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment.

We may use your health information to provide you with health treatment or services. We may disclose your health information to doctors, nurses, counselors, health care students, or other persons providing health services to you. For example, a doctor who is treating you may need to know if you have had a history of adverse side effects to a particular class of medication prior to prescribing a similar one. This information would be useful in selecting the most appropriate medication or course of treatment for you. Different programs of the agency may share your health information in order to coordinate the different things you need, such as prescriptions and lab work. We also may disclose your health information to people outside the agency who may be involved in your health, e.g., home health agencies or your private physician.

For the disclosure of your health information outside a particular Behavioral Health program, and for some Health programs, your authorization will always be obtained.

For Payment

We may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payer, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For Health Care Operations

We may use and disclose your health information for operational purposes. These uses and disclosures are necessary to operate the agency and make sure that all of our health care clients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many agency health care clients to decide what additional services the agency should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, counselors, health care students, and other Agency personnel for review and continuous quality improvement purposes. We may also combine the health information we have with health information from other agencies to compare how we are doing and see where we can make improvements in the care and services we offer.

Appointment Reminders

We may use your health information to contact you as a reminder that you have an appointment for treatment or health care at the agency.

Treatment Alternatives

We may use your health information to provide you with information about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services.

We may use your health information to provide you with information about our health-related products or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care

We may disclose your health information to a friend, family member or other person you identify as being involved in your health care or who helps pay for your care. You may inform us verbally or in writing if you object to any such disclosures.

Research

We may disclose your protected health information to researchers when their research has been approved by our institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

As Required By Law

We may disclose your health information when required to do so by federal, state or local law. For example, the agency may disclose information for the following purposes:

- Court orders and court-ordered warrants;
- Subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information;
- A civil or an authorized investigative demand;
- Medicare conditions of participation relating to health care provider participation in the program;
- Statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

To Avert A Serious Threat to Health or Safety

We may disclose your health information when necessary to prevent a serious and imminent danger of violence to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to the target of the threat or to someone able to help prevent the threat.

Military and Veterans

If you are a member of the armed forces, we may disclose your health information as required by military command authorities. We may also disclose health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation

We may disclose your health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Related Activities

We may disclose your health information for public health activities. These activities generally include the following:

- To prevent or control disease;
- To report the abuse or neglect of children, elders, and dependent adults;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.

Immunization Records

We may disclose your child's proof of immunization to their school, if State or other law requires the school to have such information prior to admitting your child as a student. We will obtain the parent's or guardian's authorization before making such a disclosure, though this may be done informally without a written authorization.

Victims of Abuse, Neglect or Domestic Violence

We may disclose your health information to a government authority if asked to do so by a law enforcement official and the disclosure is required by law, necessary to prevent serious harm to the individual or other potential victims, or if you agree. If such a disclosure is made, we will make every effort to promptly inform you, with certain exceptions.

Health Oversight Activities

We may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights law.

Law Enforcement

We may disclose your health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the Agency;
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the persons who committed the crime.

Coroners, Medical Examiners and Funeral Directors

We may disclose your health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose your health information to funeral directors as necessary to carry out their duties.

Specialized Governmental Functions

We may disclose your health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

We may disclose your health information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct authorized investigations.

OTHER USES OF YOUR HEALTH INFORMATION

Other uses and disclosures of your health information not covered by this notice or the laws that apply to us will be made only with your written authorization. **Most uses and disclosures of psychotherapy notes and of your health information for marketing purposes and the sale of health information require your authorization.** If you provide us with authorization to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, this will stop any further use or disclosure of your health information for the purposes covered by your written authorization, except if we have already acted in reliance on your authorization.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the following rights regarding your health information that we maintain:

Right to Inspect and Copy

You have the right to inspect and copy your health information that is used to make decisions about your care. Usually, this includes health and billing records, but may not include some mental health information. This health information that we maintain is known as your designated record set.

To inspect and/or copy health information in your designated record set you must submit your request in writing on the Agency's **Inspect/Copy Request Form**. That form can be obtained from and submitted to the program or division of the Agency where you receive services. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or supplies associated with your request. If we maintain any part of your designated record set in an electronic health record or other electronic format, you have the right to obtain copies of your information in electronic form unless the Agency is unable to readily produce the copies in the requested format, in which case we will give you hard copies of the health information you have requested.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your health information you may request that the denial be reviewed. Another licensed health care professional chosen by the Agency will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend

If you feel that your health information is incorrect or incomplete, you may ask us to amend the record. You have the right to request an amendment for as long as the information is kept by or for the Agency.

To request an amendment, your request must be made in writing on the Agency's **Amendment Request Form**. This form can be obtained from and then submitted to the program or division of the Agency where you receive services. You must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for the agency, i.e., not part of your medical record;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a written addendum, of reasonable length, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want the addendum to be made part of your medical record we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect. If you do not submit an addendum you may request that we provide, with any future disclosure, your request for amendment and our denial.

Right to an Accounting of Disclosures

You have the right to request an accounting of disclosures. This is a list of the disclosures we have made of your health information for reasons other than our own uses for treatment, payment and health care operations, (as those functions are described above), disclosures that you have authorized, and disclosures made more than six years prior to the date of your request.

To request this list or accounting of disclosures, you must submit your request in writing on the Agency's **Accounting of Disclosures Request Form**. This form can be obtained from and then submitted to the program or division of the Agency where you receive services. The first list you request within a 12-month period will be free. For additional lists, we will charge you for the costs of providing the list. We will notify

you of the approximate cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request a restriction of the use or disclosure of your heath information to carry out treatment, payment or health care operations. We are not, however, required to agree to your request except if you request that we not disclose your health information to your health plan with respect to healthcare for which you have paid for in full out of pocket. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request a restriction, you must make your request in writing on the Agency's **Restricting Uses/Disclosures Request Form**. This form can be obtained from and then submitted to the program or division of the Agency where you receive services. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing on the Agency's **Restricting Communications Request Form**. This form can be obtained from and then submitted to the program or division of the Agency where you receive services. We will not ask you the reason for your request and we will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to Receive Notice of a Breach

We will notify you of any breach of your unsecured protected health information.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice contact the program or division of the Agency where you receive services.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the agency.

COMPLAINTS

If you believe your privacy rights have been violated you may file a complaint with the County Privacy Officer or the Secretary of the United States Department of Health and Human Services. To file a complaint with the County Privacy Officer please call 707-259-8349 or address a written complaint to 1195 Third Street Suite 301, Napa, CA 94559. **You will not be penalized for filing a complaint.**