MASTER ADMINISTRATION SERVICES AGREEMENT
Between
PARTNERSHIP HEALTHPLAN OF CALIFORNIA
And SISKIYOU COUNTY

This Behavioral Health Services Agreement (Agreement) is entered into by and between PARTNERSHIP HEALTHPLAN OF CALIFORNIA (Plan), a County Organized Health System Medi-Cal Managed Care Plan, with its principal offices at 4665 Business Center Drive, Fairfield, CA, 94534, and the SISKIYOU COUNTY (County), a political subdivision of the State of California, effective as of July 1, 2020 (Effective Date).

RECITALS

WHEREAS, Plan is a licensed health care service plan in California and;

WHEREAS, County has contracted with the State of California, Department of Health Care Services for the purpose of identifying and providing covered Drug Medi-Cal Organized Delivery System (DMC-ODS) services for substance use disorder (SUD) treatment in the County's service area pursuant to Sections 11848.5(a) and (b) of the Health and Safety Code, Sections 14021.51-14021.53 and 14124.20-14124.25 of the Welfare and Institutions Code, Part 438 of the Code of Federal Regulations and the Specialty Terms and Conditions of the State of California DMC ODS waiver (State-County Intergovernmental Agreement; Attachment A); and,

WHEREAS, this Agreement is further controlled by applicable provisions of (a) the Welfare and Institutions Code Chapter 7, Sections 14000 et seq. in particular but not limited to Sections 14100.2, 14021, 14021.5, 140211.6, 14043, et seq., and (b) Division 4 of Title 9 of the California Code of Regulations (hereinafter referred to as Title 9); and,

WHEREAS, the objective of this Agreement is to make substance use treatment services available to Medi-Cal beneficiaries through utilization of federal and state funds available pursuant to Title XIX and Title XXI of the Social Security Act (hereinafter referred to as the Act) for reimbursable covered services rendered by certified DMC providers; and,

WHEREAS, County wishes to delegate to Plan the carrying out of the provisions of the State-County Intergovernmental Agreement; and,

WHEREAS, this Agreement requires the Plan, on behalf of the County, to ensure the availability and accessibility of adequate numbers of facilities, service locations, service sites and professional, allied and supportive personnel to provide medically necessary services, and ensure the authorization of services for urgent conditions: now,

THEREFORE, be it resolved that Plan and County agree to be legally bound as follows.

I. DEFINITIONS

Beneficiary: Individual enrolled in Siskiyou County Medi-Cal program.
Contractor: Service provider contracting with Plan to provide ODS waiver services.
County: Siskiyou County
Department or DHCS: the California State Department of Health Care Services.
Plan: Partnership HealthPlan of California.
Provider: service provider contracted with Plan for the delivery of substance use or other health care services.
State: State of California.

II. RESPONSIBILITIES OF PLAN

a. **General Obligation:** Plan shall provide the services set forth in Attachment A, the State-County Intergovernmental Agreement, attached hereto and incorporated by reference, and Attachment B – Delegated Service Standards/Delegation Agreement set forth in Attachment B, attached hereto and incorporated by reference. Plan shall perform its duties under this Agreement in a manner consistent with all applicable laws and regulations.

b. **Compliance with State and Federal Requirements**: Plan shall comply with all applicable requirements. Plan shall comply with County's contracting and oversight processes as outlined in Exhibit B.

c. **Collaboration:** Plan shall identify the personnel and processes to collaborate with County for the purposes of program oversight; individual case collaboration; and other responsibilities necessary for County to oversee this Agreement.

d. **Reports**: Plan shall provide regular reports, as outlined in Attachment B, to designated County staff to enable County oversight and monitoring of this Agreement.

III. RESPONSIBILITIES OF COUNTY

a. **General Obligation:** County shall provide the oversight activities set forth in Attachment B and the payments and services set forth in Attachment C.

b. **Compliance with State and Federal Requirements:** County shall comply with all applicable requirements.

c. **Collaboration:** County shall identify the personnel and processes to collaborate with Plan for the purposes of program oversight; individual case collaboration; and other responsibilities necessary for County to oversee this Agreement.

IV. TERMS AND TERMINATION

a. **Term:** This Agreement is effective, unless otherwise terminated in accordance with the Agreement.

b. **Termination for Cause**: If one party believes there is a material breach of Agreement, such non-breaching party may terminate Agreement upon sixty (60) days' written notice to the other Party. The party alleged to be in breach shall have thirty (30) days from receipt of such notice to cure the breach or provide a reasonable plan for the cure of the breach as quickly as possible; otherwise the non-breaching party may terminate the Agreement upon the conclusion of the thirty (30) days' notice period.

Notwithstanding the above, subject to all continuity of care obligations applicable by law or contract, this Agreement may be terminated by one party upon notice to the other: (i) in case of a suspension or revocation of the party's license, certificate, or other legal credential authorizing the activity contemplated hereunder; (ii) in the event of fraud or misrepresentation by the other party in entering in to this Agreement or otherwise; or (iii) the other party makes an assignment for the benefit of creditors, becomes insolvent or bankrupt, or is subject to a bankruptcy petition or petition for dissolution, liquidation, or the winding up of business affairs, or for the appointment of a trustee or receiver to take possession of assets.

c. **Termination without Cause:** Notwithstanding any other provisions to the contrary, a party may terminate this Agreement upon at least ninety (90) days prior written notice to the other party, subject to al continuity of care obligations imposed by law or government contract.

d. **Upon Termination/Expiration:** In the event that this Agreement expires, is not renewed or is terminated, the parties shall work together in good faith to effect an orderly transfer of Plan's obligations hereunder to County.

V. OTHER PROVISIONS

a. **Performance Review and Oversight:** County shall provide oversight activities to ensure that Plan is properly performing all delegated functions and meeting all Service Standards as outlined in Attachment B. The parties agree to meet on a quarterly basis, or as needed, to review and evaluate the delivery of services under this Agreement.

b. **Each Party Responsible for its Own Acts:** Each party shall be responsible for its own acts or omissions and for any and all claims, liabilities, injuries, suits, demands and expenses of all kinds which may result or arise out of any alleged malfeasance or neglect caused or alleged to have been caused by that party or its employees or representatives in the performance or omission of any act or responsibility of that party under this Agreement.

c. **Amendments:** This Agreement may be amended only by written agreement executed by the parties. If either party believes that amendment of this Agreement is necessary to comply with applicable federal or state law or applicable government pronouncements, it shall notify the other party and the parties shall negotiate promptly and in good faith an amendment to this Agreement to allow this Agreement to be in compliance. Shall any new requirements result in material changes to the cost of providing services under the revised scope of work, the parties will work in good faith to reach agreement on revised compensation. If the parties do not amend this Agreement as necessary, either party may

terminate this agreement for cause pursuant to the termination provisions set forth herein.

d. **Assignment:** Except as provided in this Agreement, a Party may not assign its rights under this Agreement without prior written consent of the other Parties. Any attempted assignment of rights under this Agreement or any attempted delegation of this Agreement without the prior written consent of the other party shall be null and void.

e. **Indemnification:** Each Party ("Indemnifying Party") shall indemnify and hold harmless the other party and its directors, officers, affiliates, representatives and employees ("Indemnified Party") against any and all claims, losses, costs, expenses, liabilities and damages (including attorney fees and legal costs) arising out of obligations under this Agreement or out of a failure to perform any obligation under this Agreement or out of any negligence or gross or reckless misconduct of the Indemnifying Party, its trustees, officers, shareholders, directors, managers, members, employees or agents; provided that the foregoing indemnity obligations will not apply to any loss that arises in whole or in part from the negligence or intentional misconduct of the Indemnified Party or where the Indemnified Party has been reimbursed for the loss under the insurance required under this Agreement. A Party seeking indemnification under this Agreement shall give prompt notice to the Indemnifying Party of any Claim for which the notifying Party seeks indemnification hereunder. The Indemnifying party shall have the right to defend any claim made against the Indemnified Party, to retain counsel of its choice (subject to the Indemnified party's approval, which will not be unreasonably withheld) and to settle any such claim at its expense. This provision shall survive termination of this Agreement.

f. **Waiver:** Waiver of, or failure of a party to enforce the terms of this Agreement in one instance shall not constitute a waiver of such party's rights under the Agreement in any other respect.

g. **No Third Party Rights:** No provision in this Agreement shall create any rights in any person or entity not a party hereto.

h. **Actions:** Each party shall notify the other parties as soon as reasonably possible, as but no later than fifteen (15) days after receipt, of any legal or regulatory action related to this Agreement.

i. **Severability:** If any part of this Agreement is determined to be invalid, illegal or unenforceable, such part shall be reformed, if possible, to conform with applicable law and the remaining parts of this Agreement shall be in full force and effect so far as reasonably possible to carry out the contractual purposes and terms set forth herein. If the arrangement contemplated by this Agreement is determined impermissible, the Parties shall negotiate in good faith to enter into a new agreement which, to the extent possible, reflects the arrangement contemplated hereunder while conforming to the applicable laws or regulations deemed violated by the present agreement.

j. **Entire Agreement:** This Agreement, with the attached exhibits, is the sole agreement between the Parties relating to the subject matter hereof and supersedes all prior agreement, oral or written, relating to the subject matter hereof.

k. **Consent of the Parties:** Whenever the consent of a Party hereto is required hereunder, such consent shall not be unreasonably withheld, delayed or conditioned.

l. **Notices:** Any notice, demand or communication required, permitted or desired to be given hereunder shall be deemed given when personally delivered or the next day if sent by a national overnight delivery service or three (3) days after deposited in the U.S. mail, postage prepared, to the addresses set forth herein, or to such other address as the parties may designate in writing:

If sent to the Plan, to:

Elizabeth Gibboney, CEO
Partnership HealthPlan of California
4665 Business Center Drive
Fairfield, CA 94534

If sent to the County, to:

IN WITNESS WHEREOF, the Parties have executed this Agreement by their duly authorized representatives as of the Effective Date.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA "PHC"	**SISKIYOU COUNTY**
By: Elizabeth Gibboney	By:
Name: Elizabeth Gibboney	Name: Michael N. Kobseff
Title: CEO	Title: Chair, Board of Supervisors
Date: 5/21/2020	Date: 5/5/2020

Accounting:
2134 401100 723000
2135 401130 723000

ATTEST:
LAURA BYNUM
County Clerk & Ex-Officio
Clerk of the Board

By: _______________
Deputy

5

ATTACHMENTS

Attachment A:	Intergovernmental Agreement between the California Department of Health Services and Siskiyou County
Attachment B:	Delegated Service Standards/Delegation Agreement
Attachment C:	Other Fiscal Provisions
Attachment D:	Memorandum of Understanding Outlining Shared Responsibilities between Partnership HealthPlan of California and Siskiyou County
Attachment E:	Business Associate Agreement between Partnership HealthPlan of California and the Siskiyou County
Attachment F:	Services to Non Medi-Cal Clients

Exhibit A
Scope of Work

1. Service Overview

This Intergovernmental Agreement (hereinafter referred to as Agreement) is entered into by and between the California Department of Health Care Services (DHCS) and the Contractor for the purpose of identifying and providing covered Drug Medi-Cal Organized Delivery System (DMC-ODS) services for substance use disorder treatment in the Contractor's service area pursuant to Sections 11848.5(a) and (b) of the Health and Safety Code, Sections 14021.51–14021.53 and 14124.20–14124.25 of the Welfare and Institutions Code (hereinafter referred to as W&I Code), Part 438 of the Code of Federal Regulations, and the Special Terms and Conditions of the DMC-ODS waiver.

It is further agreed this Agreement is controlled by applicable provisions of: (a) W&I Code, Chapter 7, Sections 14000, *et seq.*, in particular, but not limited to, Sections 14100.2, 14021, 14021.5, 14021.6, 14043, *et seq.* and (b) Division 4 of Title 9 of the California Code of Regulations.

It is understood and agreed that nothing contained in this Agreement shall be construed to impair the single state agency authority of DHCS.

The objective of this Agreement is to make DMC-ODS services available to Medi-Cal beneficiaries through utilization of federal and state funds available pursuant to Title XIX or Title XXI of the Social Security Act for reimbursable covered services rendered by network providers.

2. Service Location

The services shall be performed at facilities in the County of Siskiyou.

3. Service Hours

The services shall be provided during the working hours and days as defined by the Contractor.

4. Project Representatives

A. The project representatives during the term of this Agreement will be:

Department of Health Care Services	**County of Siskiyou**
Contract/Grant Manager: Robert Strom Telephone: (916) 713-8553 Fax: (916) 322-1176 Email: Robert.Strom@dhcs.ca.gov	Sarah Collard, Ph.D., Director Telephone: (530) 841-4816 Fax: (530) 841-2790

Exhibit A
Scope of Work

B. Direct all inquiries to:

Department of Health Care Services	**County of Shasta**
Department of Health Care Services MCBHD – Program Policy Section Attention: Sandra Vallejo 1500 Capitol Avenue, MS 2702 Sacramento, CA 95814 Telephone: (916) 713-8558 Fax: (916) 322-1176 Email: sandra.vallejo@dhcs.ca.gov	Siskiyou County Health and Human Services Agency, BH Disivion Attention: Sarah Collard, Ph.D., Director 2060 Campus Drive Yreda, CA 96097 Telephone: (530) 841-4816 Fax: (530) 841-2790

C. Either party may make changes to the information above by giving written notice to the other party. Said changes shall not require an amendment to this Agreement.

5. Americans with Disabilities Act

Contractor agrees to ensure that deliverables developed and produced, pursuant to this Agreement shall comply with the accessibility requirements of the Americans with Disabilities Act of 1990, Section 508 of the Rehabilitation Act of 1973 as amended (Rehabilitation Act) (29 U.S.C. § 794d), and regulations implementing the Rehabilitation Act as set forth in Part 1194 of Title 36 of the Federal Code of Regulations. In 1998, Congress amended the Rehabilitation Act to require Federal agencies to make their electronic and information technology accessible to people with disabilities. California Government Code Section 7405 codifies Section 508 of the Rehabilitation Act requiring accessibility of electronic and information technology.

6. See Exhibit A, Attachment I, for a detailed description of the services to be performed.

7. Reference Documents

All DMC-ODS documents incorporated by reference into this Agreement may not be physically attached to the Agreement, but can be found at DHCS' website: https://www.dhcs.ca.gov/provgovpart/Pages/DMC-ODS-Contracts.aspx.

Document 1F(a): Reporting Requirement Matrix – County Submission Requirements for the Department of Health Care Services

Document 1G: Perinatal Practice Guidelines

Exhibit A
Scope of Work

Document 1J: Attachment Y of the DMC-ODS Special Terms and Conditions

Document 1K: Drug and Alcohol Treatment Access Report (DATAR)

Document 1P: Alcohol and/or Other Drug Program Certification Standards

Document 1V: Youth Treatment Guidelines

Document 2A: Sobky v. Smoley, Judgment, Signed February 1, 1995

Document 2G Drug Medi-Cal Billing Manual

Document 2L(a): Good Cause Certification (6065A)

Document 2L(b): Good Cause Certification (6065B)

Document 2P: County Certification - Cost Report Year-End Claim For Reimbursement

Document 2P(a): DMC-ODS Cost Report Excel Workbook

Document 3G: California Code of Regulations, Title 9 – Rehabilitation and Developmental Services, Division 4 – Department of Alcohol and Drug Programs, Chapter 4 – Narcotic Treatment Programs

Document 3H: California Code of Regulations, Title 9 – Rehabilitation and Developmental Services, Division 4 – Department of Alcohol and Drug Programs, Chapter 8 – Certification of Alcohol and Other Drug Counselors

Document 3J: CalOMS Treatment Data Collection Guide

Document 3S CalOMS Treatment Data Compliance Standards

Document 3V Culturally and Linguistically Appropriate Services (CLAS) National Standards

Document 4D : Drug Medi-Cal Certification for Federal Reimbursement (DHCS 100224A)

Document 4F : Drug Medi-Cal (DMC) MC # 5312 Services Quarterly Claim for Reimbursement of County Administrative Expenses

Document 5A : Confidentiality Agreement

Exhibit A, Attachment I
Program Specifications

I. Preamble

A. This Intergovernmental Agreement (hereinafter referred to as Agreement) is entered into by and between the Department of Health Care Services (hereinafter referred to as DHCS, The Department, or the state) and the Contractor for the purpose of identifying and providing covered Drug Medi-Cal Organized Delivery System (DMC-ODS) services for substance use disorder (SUD) treatment in the Contractor's service area pursuant to Sections 11848.5(a) and (b) of the Health and Safety Code (hereinafter referred to as HSC), Sections 14021.51–14021.53 and 14124.20–14124.25 of the Welfare and Institutions Code (hereinafter referred to as WIC), Part 438 of the Code of Federal Regulations (hereinafter referred to as 42 CFR 438), and the Special Terms and Conditions (STCs) of the DMC-ODS waiver.

B. It is further agreed this Agreement is controlled by applicable provisions of: (a) the WIC, Chapter 7, Sections 14000, et seq., in particular, but not limited to, Sections 14100.2, 14021, 14021.5, 14021.6, 14043, et seq. and (b) Division 4 of Title 9 of the California Code of Regulations (hereinafter referred to as Title 9).

C. It is understood and agreed that nothing contained in this Agreement shall be construed to impair the single state agency authority of DHCS.

D. The objective of this Agreement is to make DMC-ODS services available to Medi-Cal beneficiaries through utilization of federal and state funds available pursuant to Title XIX or Title XXI of the Social Security Act (hereinafter referred to as the Act) for reimbursable covered services rendered by certified DMC providers.

E. DMC-ODS services shall be provided though a Prepaid Inpatient Health Plan (PIHP) as defined in 42 CFR §438.2.

F. This Agreement requires the Contractor to ensure the availability and accessibility of adequate numbers of facilities, service locations, service sites, and professional, allied, and supportive personnel to provide medically necessary services, and ensure the authorization of services for urgent conditions. The DMC-ODS provides for automatic mandatory enrollment of all Medi-Cal beneficiaries in the single PIHP operating in the county in which the beneficiary resides. PIHPs in a very small county or in any one geographic area may have a limited number of providers for a particular service. Except as required by 42 CFR 438.206(b)(4), if

additional providers are not needed to meet general access requirements, the Contractor is not obligated to subcontract with additional providers to provide more choices for an individual beneficiary.

II. Federal Requirements

A. Waived and Inapplicable Federal Requirements

1. The Contractor is operating as a PIHP. Accordingly, the following provisions of 42 CFR §438 are not applicable to this Intergovernmental Agreement: 42 CFR §438.3(s)(t) – Standard Contract Requirements; 42 CFR §438.4 – Actuarial Soundness; 42 CFR §438.5 – Rate Development Standards; 42 CFR §438.6 – Special Contract Provisions Related to Payment; 42 CFR §438.7 – CMS Review and Approval of the Rate Certifications; 42 CFR §438.8 - Medical loss ratio (MLR) standards; 42 CFR §438.9 - Provisions that apply to non-emergency medical transportation PAHPs; 42 CFR 438.10(g)(2)(ii)(A) and (B) – Information Requirements; 42 CFR §438.50 – State Plan Requirements; 42 CFR §438.54(c) – Voluntary Managed Care Enrollment; 42 CFR §438.71(b)(1)(i&iii)(c)(d) – Beneficiary Support System; 42 CFR §438.74 – State Oversight of Minimum MLR Requirements; 42 CFR §438.104 - Marketing Activities; 42 CFR §438.108 – Cost Sharing; 42 CFR §438.110 - Member Advisory Committee; 42 CFR §438.114 – Emergency and Poststabilization Services; 42 CFR §438.116 – Solvency Standards; 42 CFR §438.206(b)(2) – Women's Health Services (No women's health services are provided through the DMC-ODS Waiver); 42 CFR §438.208(c)(1) – Identification of Individuals with Special Health Care Needs; 42 CFR §§438.700-730 – Sanctions; 42 CFR §438.802 – Basic Requirements; 42 CFR §438.808 – Exclusion of Entities; 42 CFR §438.810 – Expenditures for Enrollment Broker Services; 42 CFR §431.51(b)(2) and §441.202 (No family planning services, including abortion procedures, are provided through the DMC-ODS Waiver); and 42 CFR §§455.100-104 – Disclosure Requirements.
2. Under this DMC-ODS, free choice of providers is restricted. That is, beneficiaries enrolled in this program shall receive DMC-ODS services through the Contractor, operating as a PIHP. Based on this service delivery model, the Department has requested, and Centers for Medicare & Medicaid Services (CMS) has granted

approval to waive the following 42 CFR §438 provisions for this Agreement: 42 CFR §438.10(f)(3) – Notice Requirements; 42 CFR §438.52 - Choice of MCOs, PIHPs, PAHPs, PCCMs, and PCCM Entities; 42 CFR §438.56 – Disenrollment: Requirements and Limitations.

B. General Provisions

1. Standard Contract Requirements (42 CFR §438.3).

i. CMS shall review and approve this Agreement.

ii. Enrollment discrimination is prohibited.

a. The Contractor shall accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under this Agreement.
b. Enrollment is mandatory.
c. The Contractor shall not, based on health status or need for health care services, discriminate against individuals eligible to enroll.
d. The Contractor shall follow all Federal and State civil rights laws. The Contractor shall not unlawfully discriminate, exclude people, or treat them differently, on any ground protected under Federal or State law, including 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.
e. The Contractor will not use any policy or practice that has the effect of discriminating on the basis 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.
f. The Contractor shall ensure the posting of a Department-approved nondiscrimination notice and language taglines in at least the top 16 non-English languages in the State, as determined by the Department, in a conspicuously visible font size, in

conspicuous physical locations where the Contractor interacts with the public, in a conspicuous location on the Contractor's website that is accessible on the Contractor's home page, and in significant communications and significant publications targeted to beneficiaries, enrollees, applicants, and members of the public, as required by 45 CFR § 92.8.

g. The Contractor shall provide information on how to file a Discrimination Grievance with:
    i. The Contractor and the Department if there is a concern of discrimination based on 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.
    ii. The United States Department of Health and Human Services Office of Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability.

iii. Services that may be covered by the Contractor.

a. The Contractor may cover, for beneficiaries, services that are in addition to those covered under the State Plan as follows:
    i. Any services that the Contractor voluntarily agrees to provide.
    ii. Any services necessary for compliance by the Contractor with the parity requirements set forth in 42 CFR §438.900 et. al and only to the extent such services are necessary for the Contractor to comply with 42 CFR §438.910.

iv. Compliance with applicable laws and conflict of interest safeguards.

a. The Contractor shall comply with all applicable Federal and state laws and regulations including:
    i. Title VI of the Civil Rights Act of 1964.
    ii. Title IX of the Education Amendments of 1972 (regarding education programs and activities).

iii. The Age Discrimination Act of 1975; the Rehabilitation Act of 1973.
iv. The Americans with Disabilities Act of 1990 as amended.
v. Section 1557 of the Patient Protection and Affordable Care Act.

b. The Contractor shall comply with the conflict of interest safeguards described in 42 CFR §438.58 and with the prohibitions described in section 1902(a)(4)(C) of the Act applicable to contracting officers, employees, or independent Contractors.
c. Provider-preventable condition requirements:
    i. The Contractor shall comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions. The Contractor shall report all identified provider-preventable conditions to the Department.
    ii. The Contractor shall not make payments to a provider for provider-preventable conditions that meet the following criteria:
        1. Is identified in the state plan.
        2. Has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
        3. Has a negative consequence for the beneficiary.
        4. Is auditable.
    iii. The Contractor shall ensure the use and submission of the report using the DHCS Drug Medi-Cal Organized Delivery System Provider Preventable Conditions (PPC) Reporting Form at the time of discovery of any provider

preventable conditions that are covered under this provision to:

Department of Health Care Services
Medi-Cal Behavioral Health Division
1500 Capitol Avenue, MS-2623
Sacramento, CA 95814

Or by secure, encrypted email to:
ODSSubmissions@dhcs.ca.gov

v. Inspection and audit of records and access to facilities.

a. The Department, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the Contractor, the subcontractor, and any network providers, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted. The right to audit under this section exists for 10 years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.

vi. Subcontracts.

a. All subcontracts shall fulfill the requirements or activity delegated under the subcontract in accordance with 42 CFR §438.230.

b. The Contractor shall require that subcontractors not bill beneficiaries for covered services under a contractual, referral, or other arrangement with the Contractor in excess of the amount that would be owed by the individual if the Contractor had directly provided the services. (42 U.S.C. 1396u–2(b)(6)(C))

vii. Choice of network provider.

a. The Contractor shall allow each beneficiary to choose his or her network provider to the extent possible and appropriate.

viii. Audited financial reports.

a. The Contractor shall ensure submission of audited financial reports specific to this Agreement on an

annual basis. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

ix. Recordkeeping requirements.

a. The Contractor shall retain, and require the subcontractor and network providers to retain, as applicable, the following information: beneficiary grievance and appeal records in 42 CFR §438.416, and the data, information, and documentation specified in 42 CFR §§438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

2. Information Requirements (42 CFR §438.10).

i. Basic Rules

a. The Contractor shall ensure all required information in this section is provided to beneficiaries and potential beneficiaries in a manner and format that may be easily understood and is readily accessible by such beneficiaries and potential beneficiaries.

b. The Department shall operate a website that provides the content, either directly or by linking to the Contractor's website.

ii. For consistency in the information provided to beneficiaries, the Contractor shall ensure the use of:

a. The Department developed definitions for managed care terminology, including appeal, emergency medical condition, emergency services, excluded services, grievance, health insurance, hospitalization, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services, and urgent care.

b. The Department developed model beneficiary handbooks and beneficiary notices.

iii. The Contractor shall ensure the required information in this section is provided to each beneficiary.

iv. Beneficiary information required in this section may not be provided electronically by the Contractor or subcontractor unless all of the following are met:

a. The format is readily accessible.
b. The information is placed in a location on the Department or the Contractor and subcontractor's website that is prominent and readily accessible.
c. The information is provided in an electronic form, which can be electronically retained and printed.
d. The information is consistent with the content and language requirements of this section.
e. The beneficiary is informed that the information is available in paper form without charge upon request and provides it upon request within five business days.

v. The Contractor shall have in place mechanisms to help beneficiaries and potential beneficiaries understand the requirements and benefits of the plan.

vi. Language and format:

a. The Department shall use the methodology below for identifying the prevalent non–English languages spoken by beneficiaries and potential beneficiaries throughout the state, and in the Contractor's service area.
    i. A population group of mandatory Medi-Cal beneficiaries residing in the service area who indicate their primary language as other than English and that meet a numeric threshold of 3,000 or five percent of the beneficiary population, whichever is lower.
    ii. A population group of mandatory Medi-Cal beneficiaries residing in the Contractor's service area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes.

vii. The Department shall make oral interpretation available in all languages and written translation available in each prevalent non–English language. All written materials for potential beneficiaries shall include language taglines in at least the top 16 non-English languages spoken by individuals with limited English proficiency of the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information. Large print means printed in a font size no smaller than 18 point.

viii. The Contractor shall ensure its written materials that are critical to obtaining services, including, at a minimum, provider directories, beneficiary handbooks, appeal and grievance notices, and denial and termination notices, are made available in the prevalent non–English languages in its particular service area. Written materials shall also be made available in alternative formats upon request of the potential beneficiary or beneficiary at no cost. Auxiliary aids and services shall also be made available upon request of the potential beneficiary or beneficiary at no cost. Written materials shall include taglines in the prevalent non–English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the Contractor's member/customer service unit. Large print means printed in a font size no smaller than 18 point.

ix. Pursuant to WIC 14029.91(e)(1), the Contractor shall ensure interpretation services are made available free of charge and in a timely manner to each beneficiary. This includes oral interpretation and the use of auxiliary aids (e.g. TTY/TDY and American Sign Language) and services, including qualified interpreters for individuals with disabilities (WIC 14029.91(e)(2)). Oral interpretation requirements apply to all non–English languages, not just those that the Department identifies as prevalent.

   a. Pursuant to WIC 14029.91(a)(1)(B), Oral interpretation services shall be provided by an

interpreter that, at a minimum, meets all of the following qualifications:

i. Demonstrated proficiency in speaking and understanding both spoken English and the language spoken by the limited-English-proficient beneficiary.
ii. The ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from the language spoken by the limited-English-proficient beneficiary and English, using any necessary specialized vocabulary, terminology, and phraseology.
iii. Adherence to generally accepted interpreter ethics principles, including client confidentiality.

x. Pursuant to WIC Section 14029.91(a)(1)(C), the Contractor shall not require a beneficiary with limited English proficiency to provide his or her own interpreter or rely on a staff member who does not meet the qualifications described in WIC 14029.91(a)(1)(B).

xi. The Contractor shall not rely on an adult or minor child accompanying the limited-English-proficient beneficiary to interpret or facilitate communication except under the circumstances described in WIC Section 14029.91 (a)(1)(D).

xii. The Contractor shall ensure its beneficiaries are notified:

a. That oral interpretation is available for any language and written translation is available in prevalent languages to individuals whose primary language is not English. This may include, but is not limited to:
   i. Qualified interpreters;
   ii. Information written in other languages.
b. That auxiliary aids and services are available upon request and at no cost for beneficiaries with disabilities. Free aids and services to people with disabilities to help them communicate better may include, but are not limited to:
   i. Qualified sign language interpreters;

ii. Written information in other formats (large print, audio, accessible electronic formats, other formats.)

c. How to access services.

xiii. Pursuant to 45 CFR §92.201, the Contractor shall not require a beneficiary with limited English proficiency to accept language assistance services.

xiv. The Contractor shall ensure all written materials for potential beneficiaries and beneficiaries are provided consistent with the following:

a. Use easily understood language and format.

b. Use a font size no smaller than 12 point.

c. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of beneficiaries or potential beneficiaries with disabilities or limited English proficiency.

d. Include a large print tagline in at least the top 16 non-English languages and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 point.

xv. Information for potential beneficiaries.

a. The Contractor shall ensure the information specified in this section is provided to each potential beneficiary, either in paper or in electronic format, at the time that the potential beneficiary is first required to enroll in the Contractor's program.

b. The information for potential beneficiaries shall include, at a minimum, all of the following:

i. The basic features of managed care.

ii. Which populations are subject to mandatory enrollment and the length of the enrollment period.

iii. The service area covered.

iv. Covered benefits including:

1. Which benefits are provided by the Contractor.
2. Which, if any, benefits are provided directly by the Department.

v. The provider directory and formulary information.

vi. The requirements for each Contractor to provide adequate access to covered services, including the network adequacy standards established in 42 CFR §438.68.

vii. The Contractor's entities responsible for coordination of beneficiary care.

viii. To the extent available, quality and performance indicators for the Contractor, including beneficiary satisfaction.

xvi. Information for all beneficiaries of the Contractor.

a. The Contractor shall make a good faith effort to give written notice of termination of a network provider, within 15 calendar days after receipt or issuance of the termination notice, to each beneficiary who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

xvii. Beneficiary handbook.

a. The Contractor shall utilize, and require its subcontractor and network providers to utilize, the state developed model beneficiary handbook.

b. The Contractor shall ensure each beneficiary is provided a beneficiary handbook, within a reasonable time after receiving notice of the beneficiary's enrollment, which serves as the summary of benefits and coverage described in 45 CFR § 147.200(a).

c. The content of the beneficiary handbook shall include information that enables the beneficiary to understand how to effectively use the managed care program. This information shall include at a minimum:

i. Benefits provided by the Contractor, including Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefits.

ii. How and where to access any benefits, including EPSDT benefits, provided by the state and how transportation is provided.

iii. The amount, duration, and scope of benefits available under the Agreement in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled.

iv. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the Contractor, the subcontractor, or network provider.

v. The extent to which, and how, after-hours care is provided.

vi. Any restrictions on the beneficiary's freedom of choice among network providers.

vii. The extent to which, and how, beneficiaries may obtain benefits from out-of-network providers.

viii. Beneficiary rights and responsibilities, including:

1. The beneficiary's right to receive beneficiary and plan information.
2. The elements specified in 42 CFR §438.100, and outlined in Article II.D.1 of this Agreement.

ix. Grievance, appeal, and fair hearing procedures and timeframes, consistent with Article II.G of this Agreement, in a state-developed or state-approved description (WIC 14029.91(e)(4)). Such information shall include:

1. The right to file grievances and appeals.
    a. The Contractor shall ensure information is included on filing a Discrimination Grievance with the Contractor, the subcontractor, the DHCS Office of Civil Rights and the U.S. Health and Human

Services Office for Civil Rights, and shall specifically include information stating that the Contractor complies with all State and Federal civil rights laws. If a beneficiary believes they have been unlawfully discriminated against, they have the right to file a Discrimination Grievance with the Contractor, the subcontractor, the Department's Office of Civil Rights, and the United States Department of Health and Human Services, Office for Civil Rights.

2. The requirements and timeframes for filing a grievance or appeal.
3. The availability of assistance in the filing process.
4. The right to request a state fair hearing after the Contractor's subcontractor has made a determination on a beneficiary's appeal, which is adverse to the beneficiary.
5. The fact that, when requested by the beneficiary, benefits that the subcontractor seeks to reduce or terminate will continue if the beneficiary files an appeal or a request for state fair hearing within the timeframes specified for filing, and that the beneficiary may, consistent with state policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the beneficiary.

x. How to access auxiliary aids and services, including additional information in alternative formats or languages. The Contractor shall

ensure the specific information is included regarding:
1. The provision of cost free aids and services to individuals with disabilities (qualified sign language interpreters, written information in other formats).
2. The provision of cost free language services to individuals whose primary language is not English (qualified interpreters, information written in other languages).

xi. The toll-free telephone number for member services, medical management, and any other unit providing services directly to beneficiaries.

xii. Information on how to report suspected fraud or abuse.

d. The beneficiary handbook will be considered to be provided if the Contractor ensures the subcontractor:

i. Mails a printed copy of the information to the beneficiary's mailing address.

ii. Provides the information by email after obtaining the beneficiary's agreement to receive the information by email.

iii. Posts the information on the Contractor's website and advises the beneficiary, in paper or electronic form, that the information is available on the Internet and includes the applicable Internet address, provided that beneficiaries with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.

iv. Provides the information by any other method that can reasonably be expected to result in the beneficiary receiving that information.

e. The Contractor shall ensure each beneficiary is given notice of any significant change in the information

specified above, at least 30 days before the intended effective date of the change.

xviii. Provider Directory.

a. The Contractor shall ensure, in electronic form and, upon request, in paper form, the following information is made available about its network providers:
   i. The provider's name as well as any group affiliation.
   ii. Street address(es).
   iii. Telephone number(s).
   iv. Website URL, as appropriate.
   v. Specialty, as appropriate.
   vi. Whether the provider will accept new beneficiaries.
   vii. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.
   viii. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

b. The Contractor shall ensure the following provider types covered under this Agreement are included in the provider directory:
   i. Physicians, including specialists
   ii. Hospitals
   iii. Pharmacies
   iv. Behavioral health providers

c. Information included in a paper provider directory shall be updated at least monthly and electronic provider directories shall be updated no later than 30 calendar days after the Contractor receives updated provider information.

d. Provider directories shall be made available on the Contractor and subcontractor's website in a machine-

readable file and format as specified by the Secretary of Health and Human Services.

xix. Formulary.

a. The Contractor shall ensure, in electronic or paper form, the following information about its formulary is made available:
   i. Which medications are covered (both generic and name brand).
   ii. What tier each medication resides.
b. Formulary drug lists shall be made available on the Contractor's website in a machine-readable file and format as specified by the Secretary.

3. Provider Discrimination Prohibited (42 CFR § 438.12).

i. The Contractor and subcontractor shall not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

ii. If the Contractor or subcontractor declines to include individual or groups of providers in its provider network, it shall give the affected providers written notice of the reason for its decision.

iii. In all contracts with network providers, the Contractor shall ensure compliance with the requirements specified in 42 CFR §438.214.

iv. This section may not be construed to:

a. Require the Contractor to subcontract with providers beyond the number necessary to meet the needs of its beneficiaries.
b. Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.
c. Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to beneficiaries.

4. **Requirements that Apply to Indians, Indian Health Care Providers (IHCPs), and Indian Managed Care Entities (IMCEs) (42 CFR §438.14).**

   i. The Contractor shall demonstrate that there are sufficient IHCPs participating in the Contractor's provider network to ensure timely access to services available under this Agreement from such providers for Indian beneficiaries who are eligible to receive services.

   ii. The Contractor shall require that IHCPs, whether participating or not, be paid for covered services provided to Indian beneficiaries who are eligible to receive services from such providers as follows:

      a. At a rate negotiated between the Contractor's subcontractor and the IHCP.
      b. In the absence of a negotiated rate, at a rate not less than the level and amount of payment that Contractor would make for the services to a participating provider, which is not an IHCP.
      c. Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR 447.45 and 447.46.

   iii. The Contractor shall permit Indian beneficiaries to obtain services covered under this Agreement between the State and the Contractor from out-of-network IHCPs from whom the beneficiary is otherwise eligible to receive such services.

   iv. If timely access to covered services cannot be ensured due to few or no IHCPs, the Contractor will be considered to have demonstrated that there are sufficient IHCPs participating in the Contractor's provider network to ensure timely access to services by permitting Indian beneficiaries to access out-of-state IHCPs.

   v. The Contractor shall permit an out-of-network IHCP to refer an Indian beneficiary to a network provider.

   vi. Payment requirements.

      a. When an IHCP is enrolled in Medicaid as a Federally Qualified Health Center (FQHC) but not a participating provider of the Contractor, it shall be paid

an amount equal to the amount the Contractor would pay a FQHC that is a network provider but is not an IHCP, including any supplemental payment from the Department to make up the difference between the amount the Contractor's subcontractor pays and what the IHCP FQHC would have received under fee-for-service (FFS).

b. When an IHCP is not enrolled in Medicaid as an FQHC, regardless of whether it participates in the network of the Contractor or not, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State plan's FFS payment methodology.

c. When the amount an IHCP receives from the Contractor's subcontractor is less than the amount required by paragraph (vi)(b) above, the Department shall make a supplemental payment to the IHCP to make up the difference between the amounts the Contractor entity pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

C. State Responsibilities

1. Conflict of Interest Safeguards (42 CFR §438.58).

i. The Department shall have in effect safeguards against conflict of interest on the part of Department and local officers and employees and agents of the Department who have responsibilities relating to this Agreement. These safeguards shall be at least as effective as the safeguards specified in section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

2. Prohibition of Additional Payments (42 CFR §438.60).

i. The Department shall ensure that no payment is made to a network provider other than by the Contractor's subcontractor for services covered under this Agreement, except when these payments are specifically required to be

made by the Department in Title XIX of the Act, in 42 CFR chapter IV.

3. **Continued Services to Beneficiaries (42 CFR §438.62).**
   - **i.** The Department shall arrange for Medicaid services to be provided without delay to any Medicaid beneficiary of the Contractor if this Agreement is terminated.
   - **ii.** The Department shall have in effect a transition of care policy to ensure continued access to services during a transition from FFS to the Contractor or transition from one Contractor to another when a beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.
   - **iii.** The Contractor shall implement a transition of care policy consistent with the requirements of the Department's transition of care policy.
   - **iv.** The Department shall make its transition of care policy publicly available and provide instructions on how beneficiaries and potential beneficiaries access continued services upon transition. At a minimum, the Contractor shall ensure the transition of care policy is provided to beneficiaries and potential beneficiaries in the beneficiary handbook and notices.
4. **State Monitoring Requirements (42 CFR §438.66).**
   - **i.** The Department shall have in effect a monitoring system for the Contractor.
   - **ii.** The Department's monitoring system is outlined in Article III.DD of this Agreement.
   - **iii.** The Department shall use data collected from its monitoring activities to improve the performance of the Contractor. That data shall include, at minimum:
     - a. Beneficiary grievance and appeal logs
     - b. Provider complaint and appeal logs
     - c. Findings from the State's External Quality Review process
     - d. Results from any beneficiary or provider satisfaction survey conducted by the State or the Contractor
     - e. Performance on required quality measures
     - f. Medical management committee reports and minutes

g. The annual quality improvement plan for the Contractor
h. Customer service performance data submitted by the Contractor and performance data submitted by the beneficiary support system

5. Network Adequacy Standards (42 CFR §438.68).

i. The Contractor shall adhere to, in all geographic areas within the county, all applicable time and distance standards for network providers developed by the Department, including those set forth in WIC Section 14197 and any Information Notices issued pursuant to that section.

a. Pursuant to WIC Section 14197(d)(1)(A), the Contractor shall ensure that all beneficiaries seeking outpatient and intensive outpatient (non-OTP) services be provided with an appointment within 10 business days of a non-OTP service request.
b. Pursuant to WIC Section 14197(d)(3) the Contractor shall ensure that all beneficiaries seeking OTP services are provided with an appointment within three business days of an OTP service request.
c. If the Contractor cannot meet the time and distance standards set forth in this section, the Contractor shall submit a request for alternative access standards to the Department.
d. Pursuant to WIC Section 14197(e), DHCS may grant requests for alternative access standards if the Contractor has exhausted all other reasonable options to obtain providers to meet the applicable standard or if DHCS determines that the Contractor has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.
    i. The Contractor shall include a description of the reasons justifying the alternative access standards.
        1. Requests for alternative access standards shall be approved or denied on a zip code and service type basis.
e. Requests for alternative access standards may include seasonal considerations (e.g. winter road

conditions), when appropriate. Furthermore, the Contractor shall include an explanation about gaps in the county's geographic service area, including information about uninhabitable terrain within the county (e.g., desert, forestland), as appropriate. The use of clinically appropriate telecommunications technology may be considered in determining compliance with the applicable standards established in the DHCS Information Notice 18-011 and/or for approving an alternative access request.

f. DHCS will make a decision to approve or deny the request within 90 days of submission by the Contractor. DHCS may stop the 90-day timeframe, on one or more occasions as necessary, in the event of an incomplete submission or to obtain additional information from the Contractor. (WIC 14197(e)(3))

g. If the Contractor does not comply with the applicable standards at any time, DHCS may impose additional corrective actions, including fines, penalties, the withholding of payments, special requirements, probationary or corrective actions, or any other actions deemed necessary to ensure compliance.

h. Fines and penalties imposed by the Department shall be in the amounts specified below:
   i. First violation: $500, plus $25 per day for each day that the Contractor continues to be out of compliance.
   ii. Second and subsequent violation: $500, plus $25 per day for each day that the Contractor continues to be out of compliance.

ii. The Department shall monitor beneficiary access to each provider type on an ongoing basis and communicate the findings to CMS in the managed care program assessment report required under 42 CFR §438.66.

D. Beneficiary Rights and Protections

1. Beneficiary Rights (42 CFR §438.100).

i. The Contractor shall have written policies guaranteeing the beneficiary's rights specified in 42 CFR 438.100.

ii. The Contractor shall comply with any applicable Federal and state laws that pertain to beneficiary rights, and ensures that its employees, the subcontractor, and network providers observe and protect those rights.

iii. Specific rights.

a. The Contractor shall ensure that its beneficiaries have the right to:
   i. Receive information regarding the Contractor's PIHP and plan in accordance with 42 CFR §438.10.
   ii. Be treated with respect and with due consideration for his or her dignity and privacy.
   iii. Receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand.
   iv. Participate in decisions regarding his or her health care, including the right to refuse treatment.
   v. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
   vi. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR § 164.524 and 164.526.

b. The Contractor shall ensure that its beneficiaries have the right to be furnished health care services in accordance with 42 CFR §§438.206 through 438.210.

iv. Free exercise of rights.

a. The Contractor shall ensure that each beneficiary is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the

Contractor, the subcontractor, and network providers treat the beneficiary.

v. Compliance with other Federal and state laws.

a. The Contractor shall comply with any other applicable Federal and state laws, including, but not limited to:
   i. Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80.
   ii. The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91.
   iii. The Rehabilitation Act of 1973.
   iv. Title IX of the Education Amendments of 1972 (regarding education programs and activities).
   v. Titles II and III of the Americans with Disabilities Act.
   vi. Section 1557 of the Patient Protection and Affordable Care Act.

2. Provider-Beneficiary Communications (42 CFR §438.102).

i. The Contractor or subcontractor shall not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a beneficiary who is his or her patient, for the following:

a. The beneficiary's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
b. Any information the beneficiary needs to decide among all relevant treatment options.
c. The risks, benefits, and consequences of treatment or non-treatment.
d. The beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3. Liability for Payment (42 CFR §438.106).

i. The Contractor shall ensure that its beneficiaries are not held liable for any of the following:

a. The Contractor's debts, in the event of the Contractor's insolvency.

b. Covered services provided to the beneficiary, for which:
    i. The state does not pay the Contractor; or
    ii. The Contractor or the Department does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.

c. Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the beneficiary would owe if the Contractor covered the services directly.

E. Contractor Standards as a PIHP

1. Availability of Services (42 CFR §438.206).

i. The Contractor shall ensure that all services covered under the State Plan are available and accessible to its beneficiaries in a timely manner. Covered services delivered by network providers under this Agreement shall meet the standards developed by the Department in accordance with 42 CFR §438.68.

ii. The Contractor shall, consistent with the scope of its contracted services, ensure the following requirements are met:

a. Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under this Agreement for all beneficiaries, including those with limited English proficiency or physical or mental disabilities.

b. Provide for a second opinion from a network provider, or arranges for the beneficiary to obtain one outside the network, at no cost to the beneficiary.

c. If the provider network is unable to provide necessary services, covered under this Agreement, to a particular beneficiary, the Contractor shall adequately and timely cover these services out-of-network for the beneficiary, for as long as the Contractor's provider network is unable to provide them.

d. Require out-of-network providers to coordinate with the Contractor for payment and ensures the cost to the beneficiary is no greater than it would be if the services were furnished within the network.
e. Demonstrate that its network providers are credentialed as required by 42 CFR §438.214.

iii. The Contractor shall comply with the following timely access requirements:

a. Meet and require its network providers to meet Department standards for timely access to care and services, taking into account the urgency of the need for services.
b. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid FFS, if the provider serves only Medicaid beneficiaries.
c. Make services included in this Agreement available 24 hours a day, 7 days a week, when medically necessary.
d. Establish mechanisms to ensure compliance by network providers.
e. Monitor network providers regularly to determine compliance.
f. Take corrective action if there is a failure to comply by a network provider.

iv. Access and cultural considerations (WIC §14029.91).

a. The Contractor shall participate in the Department's efforts to promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

v. Accessibility considerations (45 CFR §§ 92.204 & 92.205).

a. The Contractor shall ensure that their health programs or activities provided through electronic and information technology are accessible to individuals

with disabilities, unless doing so would result in undue financial and administrative burdens or a fundamental alteration in the nature of the health programs or activities. When undue financial and administrative burdens or a fundamental alteration exist, the covered entity shall provide information in a format other than an electronic format that would not result in such undue financial and administrative burdens or a fundamental alteration but would ensure, to the maximum extent possible, that individuals with disabilities receive the benefits or services of the health program or activity that are provided through electronic and information technology

b. The Contractor shall ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid beneficiaries with physical or mental disabilities. The Contractor and its network providers shall make reasonable modifications to policies, practices, or procedures when such modifications are necessary to avoid discrimination on the basis of disability, unless the Contractor or its network providers can demonstrate that making the modifications would fundamentally alter the nature of the health program or activity. For the purposes of this section, the term ‘‘reasonable modifications’’ shall be interpreted in a manner consistent with the term as set forth in the ADA Title II regulation at 28 CFR 35.130(b)(7).

2. **Assurances of Adequate Capacity and Services (42 CFR §438.207).**

   i. The Contractor shall give assurances to the Department and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the Department’s standards for access and timeliness of care under this part, including the standards at 42 CFR §438.68 and 42 CFR §438.206(c)(1).

ii. The Contractor shall ensure submission of documentation to the Department to demonstrate that it complies with the following requirements:
  a. Offers an appropriate range of specialty services that are adequate for the anticipated number of beneficiaries in compliance with applicable network adequacy standards.
  b. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in compliance with applicable network adequacy standards.

iii. The Contractor shall ensure submission of network adequacy documentation to the Medi-Cal Behavioral Health Division (MCBHD) via email to ODSSubmissions@dhcs.ca.gov:
  a. Upon entering into this Agreement with the Department.
  b. On an annual basis, on or before April 1.
  c. Within 10 business days of a significant change in the Contractor's operations that would affect the adequacy and capacity of services, including composition of the Contractor's provider network.
  d. As requested by the Department.

iv. The Contractor's failure to submit network adequacy documentation in a timely manner shall subject the Contractor to fines, sanctions and penalties as described in this Agreement (Article II.C.5.ii.i and Article II.C.5.ii.j.)

v. Upon receipt of the Contractor's network adequacy documentation, the Department shall either certify the Contractor's network adequacy documentation or inform the Contractor that its documentation does not meet applicable time and distance standards, or Department approved alternate access standard.

vi. Upon receipt of the Department's determination that the Contractor does not meet the applicable time and distance standards, or a DHCS approved alternate access standard, the Contractor shall submit a Corrective Action Plan (CAP)

for approval to DHCS that describes action steps that the Contractor will immediately implement to ensure compliance with applicable network adequacy standards within the Department's approved timeframe.

vii. The Contractor shall ensure submission of updated network adequacy documentation as requested by the Department.

viii. If the Department determines that the Contractor does not comply with the applicable standards at any time, the Department may require a CAP, impose fines, or penalties, withhold payments, or any other actions deemed necessary by the Department to ensure compliance with network adequacy standards.

a. Fines and penalties imposed by the Department for late submissions shall be in the amounts specified below:

i. First violation: $500, plus $25 per day for each day that the item to be submitted is late.

ii. Second and subsequent violation: $500, plus $25 per day for each day that the item to be submitted is late.

3. Coordination and Continuity of Care (42 CFR §438.208).

i. The Contractor shall comply with the care and coordination requirements of this section.

ii. As all beneficiaries receiving DMC-ODS services have special health care needs, the Contractor shall implement mechanisms for identifying, assessing, and producing a treatment plan for all beneficiaries that have been assessed to need a course of treatment, and as specified below.

iii. The Contractor shall implement procedures to deliver care to and coordinate services for all of its beneficiaries. These procedures shall meet Department requirements and shall do the following:

a. Ensure that each beneficiary has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary. The beneficiary shall be provided

information on how to contact their designated person or entity.

b. Coordinate the services the Contractor furnishes to the beneficiary:
   i. Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays;
   ii. With the services the beneficiary receives from any other managed care organization;
   iii. With the services the beneficiary receives in FFS Medicaid; and
   iv. With the services the beneficiary receives from community and social support providers.
c. Make a best effort to conduct an initial screening of each beneficiary's needs, within 90 calendar days of the effective date of enrollment for all new beneficiaries, including subsequent attempts if the initial attempt to contact the beneficiary is unsuccessful.
d. Share with the Department or other managed care organizations serving the beneficiary, the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities.
e. Ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards.
f. Ensure that in the process of coordinating care, each beneficiary's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E and 42 CFR Part 2, to the extent that they are applicable.

iv. The Contractor shall implement mechanisms to comprehensively assess each Medicaid beneficiary identified by the Department as having special health care needs to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care

monitoring. The assessment mechanisms shall use appropriate providers.

v. The Contractor shall ensure a treatment or service plan is produced meeting the criteria below for beneficiaries with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan shall be:

a. Developed with beneficiary participation, and in consultation with any providers caring for the beneficiary.
b. Developed by a person trained in person-centered planning using a person-centered process and plan, as defined in 42 CFR §441.301(c)(1) and (2).
c. Approved by the Contractor in a timely manner, if the Contractor requires this approval.
d. In accordance with any applicable Department quality assurance and utilization review standards.
e. Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the beneficiary's circumstances or needs change significantly, or at the request of the beneficiary per 42 CFR §441.301(c)(3).

vi. For beneficiaries with special health care needs, determined through an assessment to need a course of treatment or regular care monitoring, the Contractor shall have a mechanism in place to allow beneficiaries to directly access a specialist as appropriate for the beneficiary's condition and identified needs.

4. Coverage and Authorization of Services (42 CFR §438.210).

i. The Contractor shall furnish medically necessary services covered by this Agreement in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in 42 CFR §440.230, and for beneficiaries under the age of 21, as set forth in 42 CFR §441, subpart B.

ii. The Contractor:

a. Shall ensure that the medically necessary services provided are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
b. Shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of diagnosis, type of illness, or condition of the beneficiary.

iii. The Contractor may place appropriate limits on a service based on criteria applied under the State Plan, such as medical necessity.

iv. The Contractor may place appropriate limits on a service for the purpose of utilization control, provided that:

a. The services furnished can reasonably achieve their purpose.
b. The services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services and supports.

v. Authorization of services.

a. The Contractor and its subcontractor shall have in place, and follow, written authorization policies and procedures.
b. The Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.
c. The Contractor shall consult with the requesting provider for medical services when appropriate.
d. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by an individual who has appropriate expertise in addressing the beneficiary's medical and behavioral health.
e. Notice of adverse benefit determination.
    i. The Contractor's subcontractor shall notify the requesting provider, and give the beneficiary written notice of any decision by the Contractor

or subcontractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The beneficiary's notice shall meet the requirements of 42 CFR §438.404.

vi. Standard authorization decisions.

a. For standard authorization decisions, the Contractor shall ensure notice is provided as expeditiously as the beneficiary's condition requires, not to exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days when:
   i. The beneficiary, or the provider, requests extension; or
   ii. The Contractor or subcontractor justifies (to the Department, upon request) a need for additional information and how the extension is in the beneficiary's interest.

vii. Expedited authorization decisions.

a. For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires, and no later than 72 hours after receipt of the request for service.
b. The Contractor may extend the 72-hour time period by up to 14 calendar days if the beneficiary requests an extension, or if the Contractor justifies (to the Department, upon request) a need for additional information and how the extension is in the beneficiary's interest.

viii. Compensation for utilization management activities.

a. Consistent with 42 CFR §438.3(i) and 42 CFR §422.208, compensation to individuals or entities that conduct utilization management activities shall not be

structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

5. **Provider Selection (42 CFR §438.214).**
   - **i.** The Contractor shall implement written policies and procedures for selection and retention of network providers and the implemented policies and procedures, at a minimum, meet the following requirements:
     - a. Credentialing and re-credentialing requirements.
       - i. The Contractor shall follow the state's established uniform credentialing and re-credentialing policy that addresses behavioral and substance use disorders, outlined in DHCS Information Notice 18-019.
       - ii. The Contractor shall follow a documented process for credentialing and re-credentialing of network providers.
     - b. Nondiscrimination.
       - i. The Contractor's network provider selection policies and procedures, consistent with 42 CFR §438.12, shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
     - c. Excluded providers.
       - i. The Contractor shall not employ or subcontract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.
     - d. Additional Department requirements.
       - i. The Contractor shall comply with any additional requirements established by the Department.

6. **Confidentiality (42 CFR §438.224).**
   - **i.** For medical records and any other health and enrollment information that identifies a particular beneficiary, the Contractor shall use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and

E and 42 CFR Part 2, to the extent that these requirements are applicable.

7. **Grievance and Appeal Systems (42 CFR §438.228).**
   - **i.** The Contractor shall have in effect, a grievance and appeal system that meets the requirements outlined in Article II.G of this Agreement.
   - **ii.** The Contractor shall ensure the issuance any Notice of Adverse Benefit Determination (NOABD) under 42 CFR Part 431, subpart E. The Department shall conduct random reviews of the Contractor, network providers and subcontractor to ensure that they are notifying beneficiaries in a timely manner.
8. **Subcontractual Relationships and Delegation (42 CFR §438.230).**
   - **i.** The requirements of this section apply to any contract or written arrangement between the Contractor and subcontractor, or subcontractor and providers.
   - **ii.** Unless specifically prohibited by this Agreement or by federal or state law, the Contractor may delegate duties and obligations of the Contractor under this Agreement to a subcontractor if the Contractor determines that the subcontractor selected is able to perform the delegated duties in an adequate manner in compliance with the requirements of this Agreement. The Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Agreement.
   - **iii.** All contracts or written arrangements between the Contractor and subcontractor, or subcontractor and providers, shall specify the following:
     a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.
     b. The subcontractor or provider agrees to perform the delegated activities and reporting responsibilities specified in compliance with the Contractor's Agreement obligations.

c. The contract or written arrangement shall either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the Department or the Contractor determine that the subcontractor or network provider has not performed satisfactorily.
d. The subcontractor or network provider agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.
e. The subcontractor or network provider agrees that—
    i. The Department, CMS, the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or network providers, that pertain to any aspect of services and activities performed, or determination of amounts payable under this Agreement at any time.
    ii. The subcontractor or network provider shall make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid beneficiaries.
    iii. The Department, CMS, the HHS Inspector General, the Comptroller General, or their designees' right to audit the subcontractor and network providers shall exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
    iv. If the Department, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the Department, CMS, or the HHS Inspector

General may inspect, evaluate, and audit the subcontractor and network providers at any time.

9. **Practice Guidelines (42 CFR §438.236).**
   - **i.** The Contractor shall adopt practice guidelines that meet the following requirements:
     - a. Are based on valid and reliable clinical evidence or a consensus of providers in the particular field.
     - b. Consider the needs of the Contractor's beneficiaries.
     - c. Are adopted in consultation with contracting health care professionals.
     - d. Are reviewed and updated periodically as appropriate.
   - **ii.** The Contractor shall ensure dissemination of the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.
   - **iii.** The Contractor shall ensure that all decisions for utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

10. **Health Information Systems (42 CFR §438.242).**
    - **i.** The Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this part. The systems shall provide information on areas including, but not limited to, utilization, claims, and grievances and appeals.
    - **ii.** The Contractor shall comply with Section 6504(a) of the Affordable Care Act.
    - **iii.** The Contractor shall ensure data on beneficiary and provider characteristics are collected, as specified by the Department, and on all services furnished to beneficiaries through an encounter data system or other methods as may be specified by the Department.
    - **iv.** The Contractor shall ensure that data received from providers is accurate and complete by—
      - a. Verifying the accuracy and timeliness of reported data, including data from network providers the Contractor is compensating.

b. Screening the data for completeness, logic, and consistency.
c. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for Department Medicaid quality improvement and care coordination efforts.

v. The Contractor shall make all collected data available to the Department and upon request to CMS.

vi. The Contractor shall ensure sufficient beneficiary encounter data is collected and maintained to identify the provider who delivers any item(s) or service(s) to beneficiaries.

vii. The Contractor shall ensure the submission of beneficiary encounter data to the Department, annually and upon request, as specified by CMS and the Department, based on program administration, oversight, and program integrity needs.

viii. The Contractor shall ensure the submission of all beneficiary encounter data that the Department is required to report to CMS under 42 CFR §438.818.

ix. The Contractor shall ensure the submission of encounter data to the Department in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate.

F. Quality Measurement and Improvement External Quality Review

1. Quality Assessment and Performance Improvement Program (PIP) (42 CFR §438.330).

i. The Contractor shall ensure the establishment and implementation of an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its beneficiaries.

ii. After consulting with states and other stakeholders and providing public notice and opportunity to comment, CMS may specify performance measures and performance improvement projects (PIPs), which shall be included in the standard measures identified and PIPs required by the Department. The Department may request an exemption from including the performance measures or PIPs

established under this section by submitting a written request to CMS explaining the basis for such request.

iii. The Contractor’s comprehensive quality assessment and performance improvement program shall include at least the following elements:

a. Performance improvement projects.
b. Collection and submission of performance measurement.
c. Mechanisms to detect both underutilization and overutilization of services.
d. Mechanisms to assess the quality and appropriateness of care furnished to beneficiaries with special health care needs, as defined by the Department in the quality strategy under 42 CFR §438.340.

iv. The Department shall identify standard performance measures, including those performance measures that may be specified by CMS, relating to the performance of the Contractor.

v. Annually, the Contractor shall ensure the following:

a. Measure and report to the Department on its performance, using the standard measures required by the Department.
b. Submit to the Department data, specified by the Department, which enables the Department to calculate Contractor’s performance using the standard measures identified by the Department.
c. Perform a combination of the activities described above.

vi. Performance improvement projects.

a. The Contractor shall ensure performance improvement projects, including any performance improvement projects required by CMS that focus on both clinical and nonclinical areas are conducted.
b. Each performance improvement project shall be designed to achieve significant improvement, sustained over time, in health outcomes and

beneficiary satisfaction, and shall include the following elements:

i. Measurement of performance using objective quality indicators.
ii. Implementation of interventions to achieve improvement in the access to and quality of care.
iii. Evaluation of the effectiveness of the interventions based on the performance measures.
iv. Planning and initiation of activities for increasing or sustaining improvement.

c. The Contractor shall ensure the status and results of each project conducted are reported to the Department as requested, but not less than once per year.

2. Department Review of the Contractor's Accreditation Status (42 CFR §438.332).

i. The Contractor shall inform the Department if it has been accredited by a private independent accrediting entity. The Contractor is not required to obtain accreditation by a private independent accrediting entity.

ii. If the Contractor has received accreditation by a private independent accrediting entity, then the Contractor shall authorize the private independent accrediting entity to provide the Department a copy of its most recent accreditation review, including:

a. Accreditation status, survey type, and level (as applicable).
b. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings.
c. Expiration date of the accreditation.

iii. The Department shall:

a. Make the accreditation status for the Contractor available on the website required under 42 CFR §438.10(c)(3), including whether the Contractor has been accredited and, if applicable, the name of the

accrediting entity, accreditation program, and accreditation level.

b. Update this information at least annually.

G. Grievance and Appeal System

1. General Requirements (42 CFR §438.402).

i. The Contractor shall have a grievance and appeal system in place for beneficiaries.

ii. The Contractor shall have only one level of appeal for beneficiaries.

iii. Filing requirements:

a. Authority to file.

i. A beneficiary may file a grievance and request an appeal with the Contractor. A beneficiary may request a state fair hearing after receiving notice under 42 CFR §438.408 that the adverse benefit determination is upheld.

1. In the case that the Contractor fails to adhere to the notice and timing requirements in 42 CFR §438.408, the beneficiary is deemed to have exhausted the Contractor's appeals process. The beneficiary may initiate a state fair hearing.
2. The Department may offer and arrange for an external medical review if the following conditions are met.
   a. The review shall be at the beneficiary's option and shall not be required before, or used as a deterrent to, proceeding to the state fair hearing.
   b. The review shall be independent of both the Department and the Contractor.
   c. The review shall be offered without any cost to the beneficiary.

d. The review shall not extend any of the timeframes specified in 42 CFR §438.408 and shall not disrupt the continuation of benefits in 42 CFR §438.420.

ii. With the written consent of the beneficiary, a provider or an authorized representative may request an appeal or file a grievance, or request a state fair hearing, on behalf of a beneficiary, with the exception that providers cannot request continuation of benefits as specified in 42 CFR §438.420(b)(5).

b. Timing:
   i. Grievance:
      1. The beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, may file a grievance with the Contractor at any time.
   ii. Appeal:
      1. The Contractor shall allow the beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, to file a request for an appeal to the Contractor within 60 calendar days from the date on the adverse benefit determination notice.

c. Procedures:
   i. Grievance:
      1. The beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, may file a grievance either orally or in writing and, as determined by the Department, either with the Department or with the Contractor.
   ii. Appeal:

1. The beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, may request an appeal either orally or in writing. Further, unless an expedited resolution is requested, an oral appeal shall be followed by a written, signed appeal.

2. Timely and Adequate Notice of Adverse Benefit Determination (42 CFR §438.404).

i. Notice.

a. The Contractor shall ensure beneficiaries receive timely and adequate notice of an adverse benefit determination, in writing, consistent with the requirements below and in 42 CFR §438.10.

ii. Content of notice.

a. The notice shall explain the following:

i. The adverse benefit determination the Contractor has made or intends to make.

ii. The reasons for the adverse benefit determination, including the right of the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

iii. The beneficiary's right to request an appeal of the Contractor's adverse benefit determination, including information on exhausting the Contractor's one level of appeal described at 42 CFR §438.402(b) and the right to request a state fair hearing consistent with 42 CFR §438.402(c).

iv. The procedures for exercising these appeal rights.

v. The circumstances under which an appeal process can be expedited and how to request it.
vi. The beneficiary's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the beneficiary may be required to pay the costs of these services.

iii. Timing of notice.

a. The Contractor shall ensure the notice is mailed within the following timeframes:
   i. At least 10 days before the date of the adverse benefit determination, when the adverse benefit determination is a termination, suspension, or reduction of previously authorized Medicaid-covered services.
   ii. For denial of payment, at the time of any adverse benefit determination affecting the claim.
   iii. For standard authorization decisions that deny or limit services, as expeditiously as the beneficiary's condition requires within state-established timeframes that shall not exceed 14 calendar days following receipt of the request for service.
      1. The Contractor shall be allowed to extend the 14 calendar day NOABD timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the beneficiary or the provider requests an extension.
      2. The Contractor shall be allowed to extend the 14 calendar day NOABD timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the

Contractor justifies a need (to the Department, upon request) for additional information and shows how the extension is in the beneficiary's best interest. Consistent with 42 CFR §438.210(d)(1)(ii), the Contractor shall:

a. Give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he or she disagrees with that decision.
b. Issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

iv. For service authorization decisions not reached within the timeframes specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.
v. For expedited service authorization decisions, within the timeframes specified in 42 CFR §438.210(d)(2).

b. The Contractor shall be allowed to mail the NOABD as few as five days prior to the date of action if the Contractor has facts indicating that action should be taken because of probable fraud by the beneficiary, and the facts have been verified, if possible, through secondary sources.
c. The Contractor shall mail the NOABD by the date of the action when any of the following occur:
    i. The recipient has died.
    ii. The beneficiary submits a signed written statement requesting service termination.
    iii. The beneficiary submits a signed written statement including information that requires

service termination or reduction and indicates that he understands that service termination or reduction will result.

iv. The beneficiary has been admitted to an institution where he or she is ineligible under the plan for further services.

v. The beneficiary's address is determined unknown based on returned mail with no forwarding address.

vi. The beneficiary is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.

vii. A change in the level of medical care is prescribed by the beneficiary's physician.

viii. The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act.

ix. The transfer or discharge from a facility will occur in an expedited fashion.

3. Discrimination Grievances (45 CFR § 92.7; WIC §14029.91(e)(4))

i. For Discrimination Grievances, the Contractor shall designate a Discrimination Grievance Coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law.

ii. The Contractor shall adopt Discrimination Grievance procedures that ensure the prompt and equitable resolution of discrimination-related complaints. The Contractor shall not require a beneficiary to file a Discrimination Grievance with the Contractor before filing the grievance directly with DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights.

iii. Within ten (10) calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary, the Contractor

shall submit the following information regarding the Discrimination Grievance to the DHCS Office of Civil Rights:

a. The original complaint.
b. The provider's or other accused party's response to the complaint.
c. Contact information for the Contractor's personnel responsible for investigating and responding to the complaint.
d. Contact information for the beneficiary filing the complaint.
e. Contact information for the provider or other accused party that is the subject of the complaint.
f. All correspondence with the beneficiary regarding the complaint, including, but not limited to, the Discrimination Grievance acknowledgment and resolution letter(s) sent to the beneficiary.
g. The results of the Contractor's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

4. Handling of Grievances and Appeals (42 CFR §438.406).

i. In handling grievances and appeals, the Contractor shall give beneficiaries any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

ii. The Contractor's process for handling beneficiary grievances and appeals of adverse benefit determinations shall:

a. Acknowledge receipt of each grievance and appeal within five calendar days.
b. Ensure that the individuals who make decisions on grievances and appeals are individuals—
    i. Who, were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.
    ii. Who, if deciding any of the following, are individuals who have the appropriate clinical

expertise, as determined by the Department, in treating the beneficiary's condition or disease.

1. An appeal of a denial that is based on lack of medical necessity.
2. A grievance regarding denial of expedited resolution of an appeal.
3. A grievance or appeal that involves clinical issues.

iii. Who, take into account all comments, documents, records, and other information submitted by the beneficiary or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

c. Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and shall be confirmed in writing, unless the beneficiary or the provider requests expedited resolution.

d. Provide the beneficiary a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor shall inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution.

e. Provide the beneficiary and his or her representative the beneficiary's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor (or at the direction of the Contractor) in connection with the appeal of the adverse benefit determination. This information shall be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c).

f. Include, as parties to the appeal:
   i. The beneficiary and his or her representative.
   ii. The legal representative of a deceased beneficiary's estate.

5. **Resolution and Notification: Grievances and Appeals (42 CFR §438.408).**

i. The Contractor shall resolve each grievance and appeal, and provide notice, as expeditiously as the beneficiary's health condition requires, within the following timeframes:
   a. Standard resolution of grievances: 90 calendar days from the day the Contractor receives the grievance.
   b. Standard resolution of appeals: 30 calendar days from the day the Contractor receives the appeal. This timeframe may be extended in the manner described below.
   c. Expedited resolution of appeals: 72 hours after the Contractor receives the appeal. This timeframe may be extended under in the manner described below.

ii. Extension of timeframes.
   a. The Contractor may extend the timeframes for standard and expedited resolution of grievances and appeals by up to 14 calendar days if:
      i. The beneficiary requests the extension; or
      ii. The Contractor shows (to the satisfaction of the Department, upon its request) that there is need for additional information and how the delay is in the beneficiary's interest.

iii. If the Contractor extends the timeframes not at the request of the beneficiary, it shall complete all of the following:
   a. Make reasonable efforts to give the beneficiary prompt oral notice of the delay.
   b. Within two calendar days, give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he or she disagrees with that decision.
   c. Resolve the appeal as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

Exhibit A, Attachment I
Program Specifications

iv. If the Contractor fails to adhere to the notice and timing requirements in this section, the beneficiary is deemed to have exhausted the Contractor's appeals process. The beneficiary may initiate a state fair hearing.

v. Format of notice:

a. Grievances.
   i. The Contractor shall notify the beneficiary of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR §438.10.

b. Appeals.
   i. For all appeals, the Contractor shall provide written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR §438.10.
   ii. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice.

vi. The written notice of the resolution shall include the following:

a. The results of the resolution process and the date it was completed.

b. For appeals not resolved wholly in favor of the beneficiaries—
   i. The right to request a state fair hearing.
   ii. How to make the request a state fair hearing.
   iii. The right to request and receive benefits, while the hearing is pending and how to make the request.
   iv. That the beneficiary may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the Contractor's adverse benefit determination.

vii. Requirements for state fair hearings—

a. A beneficiary may request a state fair hearing only after receiving notice that the Contractor is upholding the adverse benefit determination.

b. If the Contractor fails to adhere to the notice and timing requirements in 42 CFR §438.408, then the beneficiary is deemed to have exhausted the Contractor's appeals process. The beneficiary may initiate a state fair hearing.
c. The Department shall offer and arrange for an external medical review when the following conditions are met:
    i. The review shall be at the beneficiary's request and shall not be required before, or used as a deterrent to, proceeding to the state fair hearing
    ii. The review shall be independent of both the Department and the Contractor.
    iii. The review shall be offered without any cost to the beneficiary.
    iv. The review shall not extend any of the timeframes specified in 42 CFR §438.408 and shall not disrupt the continuation of benefits in 42 CFR §438.420.
d. State fair hearing.
    i. The beneficiary shall request a state fair hearing no later than 120 calendar days from the date of the Contractor's Notice of Appeal Resolution.
    ii. The parties to the state fair hearing include the Contractor, as well as the beneficiary and his or her representative or the representative of a deceased beneficiary's estate.

6. **Expedited Resolution of Appeals (42 CFR §438.410).**
    i. The Contractor shall establish and maintain an expedited review process for appeals when the Contractor determines (for a request from the beneficiary) or the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

- **ii.** The Contractor shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's appeal.
- **iii.** If the Contractor denies a request for expedited resolution of an appeal, it shall:
  - a. Transfer the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2).
  - b. Follow the requirements in 42 CFR §438.408(c)(2).

7. Information About the Grievance and Appeal System to Providers and Subcontractors (42 CFR §438.414).

- **i.** The Contractor shall provide the information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all network providers and the subcontractor at the time they enter into a contract.

8. Recordkeeping Requirements (42 CFR §438.416).

- **i.** The Contractor shall ensure records of grievances and appeals are maintained and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the Department quality strategy.
- **ii.** The record of each grievance or appeal shall contain, at a minimum, all of the following information:
  - a. A general description of the reason for the appeal or grievance.
  - b. The date received.
  - c. The date of each review or, if applicable, review meeting.
  - d. Resolution at each level of the appeal or grievance, if applicable.
  - e. Date of resolution at each level, if applicable.
  - f. Name of the covered person for whom the appeal or grievance was filed.
- **iii.** The record shall be accurately maintained in a manner accessible to the Department and available upon request to CMS.

9. Continuation of Benefits While the Contractor's Appeal and the State Fair Hearing Are Pending (42 CFR §438.420).

- **i.** Timely files mean files for continuation of benefits on or before the later of the following:

a. Within 10 calendar days of Contractor sending the NOABD.
b. The intended effective date of the Contractor's proposed adverse benefit determination.

ii. The Contractor shall continue the beneficiary's benefits if all of the following occur:

a. The beneficiary files the request for an appeal timely in accordance with 42 CFR §438.402(c)(1)(ii) and (c)(2)(ii).
b. The appeal involves the termination, suspension, or reduction of previously authorized services.
c. An authorized provider ordered the services.
d. The period covered by the original authorization has not expired.
e. The beneficiary timely files for continuation of benefits.

iii. At the beneficiary's request, the Contractor shall continue or reinstate the beneficiary's benefits while the appeal or state fair hearing is pending, the benefits shall be continued until one of following occurs:

a. The beneficiary withdraws the appeal or request for state fair hearing.
b. The beneficiary fails to request a state fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the beneficiary's appeal under 42 CFR §438.408(d)(2).
c. A state fair hearing officer issues a hearing decision adverse to the beneficiary.

iv. If the final resolution of the appeal or state fair hearing is adverse to the beneficiary, that is, upholds the Contractor's adverse benefit determination, the Contractor may, consistent with the Department's usual policy on recoveries under 42 CFR §431.230(b) and as specified in this Agreement, recover the cost of services furnished to the beneficiary while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

10. **Effectuation of Reversed Appeal Resolutions (42 CFR §438.424).**
    - **i.** The Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires (but no later than 72 hours from the date it receives notice reversing the determination) if the services were not furnished while the appeal was pending and if the Contractor or state fair hearing officer reverses a decision to deny, limit, or delay services.
    - **ii.** The Contractor shall pay for disputed services received by the beneficiary while the appeal is pending, unless state policy and regulations provide for the state to cover the cost of such services, when the Contractor or state fair hearing officer reverses a decision to deny authorization of the services.

H. Additional Program Integrity Safeguards

1. **Basic Rule (42 CFR §438.600).**
    - **i.** As a condition for receiving payment under a Medicaid managed care program, the Contractor shall comply with the requirements in 42 CFR §§438.604, 438.606, 438.608 and 438.610, as applicable and as outlined below.
2. **State Responsibilities (42 CFR §438.602).**
    - **i. Monitoring Contractor compliance.**
        - a. Consistent with 42 CFR §438.66, the Department shall monitor the Contractor’s compliance, as applicable, with 42 CFR §§438.604, 438.606, 438.608, 438.610, 438.230, 438.808, 438.900 et seq.
    - **ii. Screening, enrollment, and revalidation of providers.**
        - a. The Department shall screen and enroll, and revalidate every five years, all of the Contactor’s network providers, in accordance with the requirements of 42 CFR, Part 455, Subparts B and E. This provision does not require the network provider to render services to FFS beneficiaries.
    - **iii. Ownership and control information.**
        - a. The Department shall review the ownership and control disclosures submitted by the Contractor, and

any subcontractors as required in 42 CFR §438.608(c).

iv. **Federal database checks.**

a. Consistent with the requirements in 42 CFR §455.436, the Department shall confirm the identity and determine the exclusion status of the Contractor, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the Contractor through routine checks of Federal databases. This includes the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases as the state or Secretary may prescribe. These databases shall be consulted upon contracting and no less frequently than monthly thereafter. If the Department finds a party that is excluded, it shall promptly notify the Contractor and take action consistent with 42 CFR §438.610(c).

v. **Periodic audits.**

a. The Department shall periodically, but no less frequently than once every three years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, the Contractor.

vi. **Whistleblowers.**

a. The Department shall receive and investigate information from whistleblowers relating to the integrity of the Contractor, subcontractors, or network providers receiving Federal funds under 42 CFR, Part 438.

vii. **Transparency.**

a. The Department shall post on its website, as required in 42 CFR §438.10(c)(3), the following documents and reports:

i. This Agreement.

Exhibit A, Attachment I
Program Specifications

ii. The data at 42 CFR §438.604(a)(5).
iii. The name and title of individuals included in 42 CFR §438.604(a)(6).
iv. The results of any audits performed pursuant Article II, Section H, Paragraph (v) of this Agreement.

viii. Contracting integrity.

a. The Department shall have in place conflict of interest safeguards described in 42 CFR §438.58 and shall comply with the requirement described in section 1902(a)(4)(C) of the Act applicable to contracting officers, employees, or independent Contractors.

ix. Entities located outside of the U.S.

a. The Department shall ensure that the Contractor is not located outside of the United States and that no claims paid by the Contractor to a network provider, out-of-network provider, subcontractor, or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates.

3. Data, Information, and Documentation that shall be submitted (42 CFR §438.604).

i. The Contractor shall ensure the submission to the Department the following data:

a. Encounter data in the form and manner described in 42 CFR §438.818.
b. Documentation described in 42 CFR §438.207(b) on which the Department bases its certification that the Contractor has complied with the Department's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR §438.206.
c. Information on ownership and control described in 42 CFR §455.104 from the Contractor's subcontractors as governed by 42 CFR §438.230.
d. The annual report of overpayment recoveries as required in 42 CFR §438.608(d)(3).

ii. In addition to the data, documentation, or information above, the Contractor shall ensure the submission of any other data, documentation, or information relating to the performance of the Contractor's program integrity safeguard obligations required by the Department or the Secretary.

4. **Source, Content, and Timing of Certification (42 CFR §438.606).**
   i. The data, documentation, or information specified in 42 CFR §438.604, shall be certified by the Contractor's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.
   ii. The certification shall attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR §438.604 is accurate, complete, and truthful.
   iii. The Contractor shall ensure the submission of the certification concurrently with the submission of the data, documentation, or information required in 42 CFR §438.604(a) and (b).

5. **Program Integrity Requirements (42 CFR §438.608).**
   i. The Contractor, and its subcontractor, to the extent that the subcontractor are delegated responsibility by the Contractor for coverage of services and payment of claims under this Agreement, shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse.
   ii. The arrangements or procedures shall include the following:
      a. A compliance program that includes, at a minimum, all of the following elements:
         i. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the

contract, and all applicable Federal and state requirements.

ii. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Agreement and who reports directly to the County Behavioral Health Director and the Board of Supervisors.
iii. The establishment of a Regulatory Compliance Committee on the Board of Supervisors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under this Agreement.
iv. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and state standards and requirements under this Agreement.
v. Effective lines of communication between the compliance officer and the organization's employees.
vi. Enforcement of standards through well-publicized disciplinary guidelines.
vii. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement.

b. Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the Department.
c. Provision for prompt notification to the Department when it receives information about changes in a beneficiary's circumstances that may affect the beneficiary's eligibility including all of the following:
    i. Changes in the beneficiary's residence.
    ii. The death of a beneficiary.
d. Provision for notification to the Department when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor.
e. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by beneficiaries and the application of such verification processes on a regular basis.
f. If the Contractor makes or receives annual payments under this Agreement of at least $5,000,000, provision for written policies for all employees of the entity, and of any subcontractor or agent, that provide detailed information about the False Claims Act and other Federal and state laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers
g. Provision for the prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the Department Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.
h. Provision for the Contractor's suspension of payments to a network provider for which the Department determines there is a credible allegation of fraud in accordance with 42 CFR §455.23.

iii. The Contractor shall ensure that all network providers are enrolled with the Department as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 CFR part 455, subparts B and E. This provision does not require the network provider to render services to FFS beneficiaries.

iv. The Contractor and subcontractor shall provide reports to the Department within 60 calendar days when it has identified payments in excess of amounts specified in this Contract.

v. Treatment of recoveries made by the Contractor of overpayments to providers.

a. The Contractor shall specify in accordance with this Exhibit A, Attachment I and Exhibit B of this Agreement:
    i. The retention policies for the treatment of recoveries of all overpayments from the Contractor to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.
    ii. The process, timeframes, and documentation required for reporting the recovery of all overpayments.
    iii. The process, timeframes, and documentation required for payment of recoveries of overpayments to the state in situations where the Contractor is not permitted to retain some or all of the recoveries of overpayments.
    iv. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

b. The Contractor shall have a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days after the date on which the overpayment was identified, and to

notify the Contractor in writing of the reason for the overpayment.

c. The Contractor shall annually report to the Department on their recoveries of overpayments.

6. **Prohibited Affiliations (42 CFR §438.610).**

   i. The Contractor, subcontractor, and network providers shall not knowingly have a relationship of the type described in paragraph (iii) of this subsection with the following:

      a. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

      b. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in paragraph (a)(1) of this section.

   ii. The Contractor, subcontractor, and network providers shall not have a relationship with an individual or entity that is excluded from participation in any Federal Health Care Program under section 1128 or 1128A of the Act.

   iii. The relationships described in paragraph (i) of this section, are as follows:

      a. A director, officer, or partner of the Contractor.

      b. A subcontractor of the Contractor, as governed by 42 CFR §438.230.

      c. A person with beneficial ownership of five percent or more of the Contractor's equity.

      d. A network provider or person with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Agreement.

   iv. If the Department finds that the Contractor is not in compliance, the Department:

      a. Shall notify the Secretary of the noncompliance.

b. May continue an existing Agreement with the Contractor unless the Secretary directs otherwise.
c. May not renew or otherwise extend the duration of an existing Agreement with the Contractor unless the Secretary provides to the state and to Congress a written statement describing compelling reasons that exist for renewing or extending the Agreement despite the prohibited affiliations.
d. Nothing in this section shall be construed to limit or otherwise affect any remedies available to the U.S. under sections 1128, 1128A or 1128B of the Act.

v. The Contractor shall provide the Department with written disclosure of any prohibited affiliation under this section by the Contractor, subcontractor, or network provider.

7. **Disclosures on Information and Ownerships Control (42 CFR §455.104)**

i. The Contractor, subcontractor, and network providers shall provide the following disclosures through the DMC certification process described in Article III.J:

a. The name and address of any person (individual or corporation) with an ownership or control interest in the Contractor. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
b. Date of birth and Social Security Number (in the case of an individual).
c. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a five percent or more interest.
d. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or

corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a five percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

e. The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.
f. The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

ii. Disclosures are due at any of the following times:

a. Upon the Contractor submitting the proposal in accordance with the Department's procurement process.
b. Upon the Contractor executing this Agreement with the Department.
c. Upon renewal or extension of this Agreement.
d. Within 35 days after any change in ownership of the Contractor.

iii. The Contractor shall provide all disclosures to the Department.

iv. Federal financial participation (FFP) shall be withheld from the Contractor if it fails to disclose ownership or control information as required by this section.

v. For the purposes of this section “person with an ownership or control interest” means a person or corporation that -

a. Has an ownership interest totaling five percent or more in a disclosing entity.
b. Has an indirect ownership interest equal to five percent or more in a disclosing entity.
c. Has a combination of direct and indirect ownership interests equal to five percent or more in a disclosing entity.
d. Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation

secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of the disclosing entity.

e. Is an officer or director of a disclosing entity that is organized as a corporation.

f. Is a partner in a disclosing entity that is organized as a partnership.

I. Conditions for FFP

1. Costs under this Nonrisk Contract (42 CFR §438.812).

i. The amount the Department pays for the furnishing of medical services to eligible beneficiaries is a medical assistance cost.

ii. The amount the Department pays for the Contractor's performance of other functions is an administrative cost.

J. Parity in Mental Health and Substance Use Disorder Benefits (42 CFR §438.900 et seq.)

1. General Parity Requirement

i. To ensure compliance with the parity requirements set forth in 42 CFR §438.900 et seq., the Contractor shall not impose, or allow any of its subcontractors to impose any financial requirements, Quantitative Treatment Limitations, or Non-Quantitative Treatment Limitations in any classification of benefit (inpatient, outpatient, emergency care, or prescription drugs) other than those limitations permitted and outlined in this Agreement.

ii. The Contractor shall not apply any financial requirement or treatment limitation to substance use disorder services in any classification of benefit that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification of benefit furnished to beneficiaries (whether or not the benefits are furnished by the Contractor). (42 CFR 438.910(b)(1))

iii. The Contractor shall provide substance use disorder services to beneficiaries in every classification in which medical/surgical benefits are provided. (42 CFR 438.910(b)(2))

2. Quantitative Limitations

i. The Contractor shall not apply any cumulative financial requirement for substance use disorder services in a classification that accumulates separately from any established for medical/surgical services in the same classification. (42 CFR 438.910(c)(3))

3. **Non-Quantitative Limitations**

   i. The Contractor shall not impose a non-quantitative treatment limitation for substance use disorder benefits in any classification unless, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. (42 CFR §438.910(d))

   ii. The Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for substance use disorder services that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits. (42 CFR §438.910(d)(3))

III. Program Specifications

A. Provision of Services

1. Provider Specifications

i. The following requirements shall apply to the Contractor, subcontractor, network providers, and network provider's staff:

   a. Professional staff shall be licensed, registered, certified, or recognized under California scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioners of the Healing Arts (LPHA) include:

      i. Physician

ii. Nurse Practitioners
iii. Physician Assistants
iv. Registered Nurses
v. Registered Pharmacists
vi. Licensed Clinical Psychologists
vii. Licensed Clinical Social Worker
viii. Licensed Professional Clinical Counselor
ix. Licensed Marriage and Family Therapists
x. Licensed Eligible Practitioners working under the supervision of Licensed Clinicians

ii. Non-professional staff shall receive appropriate onsite orientation and training prior to performing assigned duties. A professional and/or administrative staff shall supervise non-professional staff.

iii. Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring. Documentation of trainings, certifications and licensure shall be contained in personnel files.

iv. Physicians shall receive a minimum of five hours of continuing medical education related to addiction medicine each year.

v. Professional staff (LPHAs) shall receive a minimum of five hours of continuing education related to addiction medicine each year.

vi. Registered and certified SUD counselors shall adhere to all requirements in CCR Title 9, §13000 et seq.

2. Services for Adolescents and Youth

i. Assessment and services for adolescents will follow the American Society of Addiction Medicine (ASAM) adolescent treatment criteria.

B. Organized Delivery System (ODS) Timely Coverage

1. Non-Discrimination - Member Discrimination Prohibition

i. Contractor shall accept individuals eligible for enrollment in the order in which they apply without restriction in accordance with this Agreement. Contractor shall take affirmative action to ensure that beneficiaries are provided covered services and will not discriminate against individuals eligible to enroll under the laws of the United States and the

State of California. Contractor shall not unlawfully discriminate against any person pursuant to:

a. Title VI of the Civil Rights Act of 1964.
b. Title IX of the Education Amendments of 1972 (regarding education and programs and activities).
c. The Age Discrimination Act of 1975.
d. The Rehabilitation Act of 1973.
e. The Americans with Disabilities Act.

2. DMC-ODS services shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in this opt-in County. Determination of who may receive the DMC-ODS benefits shall be performed in accordance with DMC-ODS Special Terms and Conditions (STC) 132(d), Article II.E.4 of this Agreement, and as follows:

i. The Contractor, subcontractor, or network providers shall verify the Medicaid eligibility determination of an individual. When the network providers conduct the initial eligibility verification, that verification shall be reviewed and approved by the Contractor prior to payment for services. If the individual is eligible to receive services from tribal health programs operating under the Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), then the determination shall be conducted as set forth in the Tribal Delivery System - Attachment BB to the STCs.

ii. All beneficiaries shall meet the following medical necessity criteria:

a. The individual shall have received a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.
b. The individual shall meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.
c. For beneficiaries in treatment prior to implementation of the DMC-ODS, the provider must conduct an ASAM assessment by the due date of the next

updated treatment plan or continuing services justification, whichever occurs first.

i. If the assessment determines a different level of care, the provider shall refer the beneficiary to the appropriate level of care.

iii. Adolescents are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under the age of 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Nothing in the DMC-ODS overrides any EPSDT requirements.

iv. In addition to Article III.B.2.ii, the initial medical necessity determination for an individual to receive a DMC-ODS benefit shall be performed by a Medical Director or an LPHA. If a beneficiary's assessment and intake information are completed by a counselor through a face-to-face review or telehealth, the Medical Director or LPHA shall evaluate each beneficiary's assessment and intake information with the counselor to establish whether that beneficiary meets medical necessity criteria. The ASAM Criteria shall be applied to determine placement into the level of assessed services.

v. For an individual to receive ongoing DMC-ODS services, the Medical Director or LPHA shall reevaluate that individual's medical necessity qualification at least every six months through the reauthorization process and document their determination that those services are still clinically appropriate for that individual. For an individual to receive ongoing Opioid Treatment Program/Narcotic Treatment Program (OTP/NTP) services, the Medical Director or LPHA shall reevaluate that individual's medical necessity qualification within two years from admission and annually thereafter through the reauthorization process and determine that those services are still clinically appropriate for that individual.

Exhibit A, Attachment I
Program Specifications

C. Covered Services

1. In addition to the coverage and authorization of services requirements set forth in Article II.E.4 of this Agreement, the Contractor shall:
   - **i.** Identify, define, and specify the amount, duration, and scope of each medically necessary service that the Contractor is required to offer.
   - **ii.** Require that the medically necessary services identified be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in 42 CFR 440.230.
   - **iii.** Specify the extent to which the Contractor is responsible for covering medically necessary services related to the following:
     - a. The prevention, diagnosis, and treatment of health impairments.
     - b. The ability to achieve age-appropriate growth and development.
     - c. The ability to attain, maintain, or regain functional capacity.
2. The Contractor shall ensure the delivery of the DMC-ODS Covered Services within a continuum of care as defined in the ASAM criteria.
3. Mandatory DMC-ODS Covered Services include:
   - **i.** Withdrawal Management (minimum one level)
   - **ii.** Intensive Outpatient
   - **iii.** Outpatient
   - **iv.** Opioid (Narcotic) Treatment Programs
   - **v.** Recovery Services
   - **vi.** Case Management
   - **vii.** Physician Consultation
   - **viii.** Perinatal Residential Treatment Services (excluding room and board)
     - a. Room and board shall not be a covered expenditure under the DMC-ODS. Room and board may be paid with funding sources unrelated to the DMC-ODS.

ix. Non-perinatal Residential Treatment Services (excluding room and board)
   a. Room and board shall not be a covered expenditure under the DMC-ODS. Room and board may be paid with funding sources unrelated to DMC-ODS.

4. The Contractor is responsible for ensuring that its beneficiaries are able to receive all medically necessary DMC-ODS services. If the Contractor's provider network is unable to provide necessary services to a particular beneficiary, the Contractor shall adequately and timely cover these services out-of-network for as long as the Contractor's network is unable to provide them.

5. According to STC 147(c), the Contractor shall ensure that a beneficiary that resides in a county that does not participate in DMC-ODS does not experience a disruption of OTP/NTP services. The Contractor shall require all OTP/NTP subcontractors to provide any medically necessary NTP services covered by the California Medi-Cal State Plan to beneficiaries that reside in a county that does not participate in DMC-ODS. The Contractor shall require all OTP/NTP subcontractors that provide services to an out-of-county beneficiary to submit the claims for those services to the county in which the beneficiary resides (according to MEDS).

6. Contractor, to the extent applicable, shall comply with "Sobky v. Smoley" (Document 2A), 855 F. Supp. 1123 (E.D. Cal 1994), incorporated by this reference.

7. Contractor shall comply with federal and state mandates to provide SUD treatment services deemed medically necessary for Medi-Cal eligible pregnant and postpartum women.

8. In accordance with the EPSDT mandate under 1905(r) of the Social Security Act, the Contractor shall ensure that all beneficiaries under age 21 receive all applicable medically necessary services needed to correct and ameliorate health conditions that are coverable under Section 1905(a) of the Social Security Act.

D. Financing

1. Payment for Services

i. The Contractor shall pay the subcontractor the per utilizer per month (PUPM) rate identified in Exhibit B, Part V,

Exhibit A, Attachment I
Program Specifications

Provision A for each beneficiary who receives at least one service in a month. This PUPM rate is an interim reimbursement rate subject to reconciliation.

ii. The Contractor or its subcontractor shall submit a claim to the Department's Short-Doyle Medi-Cal claiming system for each DMC ODS service the subcontractor provides to a Medi-Cal beneficiary.

iii. The Contractor shall certify the public expenditures incurred to provide all DMC-ODS services for Medi-Cal beneficiaries.

iv. DHCS shall reimburse the Contractor in accordance with the sharing ratios identified in Exhibit B, Part V, Provision C to this Agreement.

v. The Contractor shall attest to the accuracy, completeness, and truthfulness of claims and payment data, under penalty of perjury.

vi. DHCS shall establish a CMS-approved Certified Public Expenditure (CPE) protocol before reimbursing the Contractor for any FFP associated with DMC-ODS services. This CMS-approved CPE protocol (Attachment AA of the STCs) shall define the process by which DHCS will reimburse the Contractor.

vii. The Contractor shall only provide State Plan DMC services until DHCS and CMS approve of this Agreement and the approved Agreement is executed by the Contractor's County Board of Supervisors. During this time, State Plan DMC services shall be reimbursed pursuant to the State Plan reimbursement methodologies.

viii. Pursuant to Title 42 CFR 433.138 and 22 CCR 51005(a), if a beneficiary has Other Heath Coverage (OHC), then the Contractor shall bill that OHC prior to billing DMC to receive either payment from the OHC, or a notice of denial from the OHC indicating that:

a. The recipient's OHC coverage has been exhausted, or
b. The specific service is not a benefit of the OHC.

ix. If the Contractor or subcontractor submits a claim for OHC and receives partial payment of the claim, the Contractor may submit the claim to the Department's Short-Doyle Medi-

Cal claiming system. DHCS will reduce Contractor's certified public expenditures by the amount of the payment made by the OHC.

2. **Rate Setting**
   - **i.** The Contractor shall obtain DHCS' approval of the PUPM rate the Contractor pays the subcontractor.
   - **ii.** DHCS, pursuant to the process set forth in WIC 14021.51 shall set the OTP/NTP reimbursement rate. The Contractor shall require the subcontractor to reimburse all OTP/NTP providers at this rate.
   - **iii.** The Contractor shall require the subcontractor to reimburse county-operated non-OTP/NTP providers no more than the providers' allowable costs and to reimburse non-county-operated non-OTP/NTP providers no more than the prevailing charges in the locality for comparable services under comparable circumstances.

E. Availability of Services

1. In addition to the availability of services requirements set forth in Article II.E.1 of this Agreement, the Contractor shall:
   - **i.** Consider the number and types (in terms of training, experience, and specialization) of providers required to ensure the availability and accessibility of medically necessary services.
   - **ii.** Maintain and monitor a network of appropriate providers that is supported by written agreements for subcontractors, and that is sufficient to provide its beneficiaries with adequate access to all services covered under this Agreement.
   - **iii.** In establishing and monitoring the network, document the following:
     - a. The anticipated number of Medi-Cal eligible beneficiaries.
     - b. The expected utilization of services, taking into account the characteristics and SUD treatment needs of beneficiaries.
     - c. The expected number and types of providers in terms of training and experience needed to meet expected utilization.

d. The number of network providers who are not accepting new beneficiaries.
e. The geographic location of providers and their accessibility to beneficiaries, considering distance, travel time, means of transportation ordinarily used by Medi-Cal beneficiaries, and physical access for disabled beneficiaries.

F. Access to Services

1. Subject to DHCS provider enrollment certification requirements, the Contractor shall maintain continuous availability and accessibility of covered services and facilities, service sites, and personnel to provide the covered services through use of DMC certified providers. Such services shall not be limited due to budgetary constraints.
2. When a beneficiary makes a request for covered services, the Contractor shall require services to be initiated with reasonable promptness. Contractor shall have a documented system for monitoring and evaluating the quality, appropriateness, and accessibility of care, including a system for addressing problems that develop regarding waiting times and appointments.
3. In addition to the coverage and authorization of service requirements set forth in Article II.E.4 of this Agreement, the Contractor shall:
   - **i.** Authorize DMC-ODS services in accordance with the medical necessity requirements specified in Title 22, Section 51303 and the coverage provisions of the approved State Medi-Cal Plan.
   - **ii.** Inform the beneficiary in accordance with Article II.G.2 of this Agreement if services are denied.
   - **iii.** Provide prior authorization for residential services within 24 hours of the prior authorization request being submitted by the provider.
     - a. Prior authorization is prohibited for non-residential DMC-ODS services.
     - b. The Contractor's prior authorization process shall comply with the parity requirements set forth in 42 CFR §438.910(d).

iv. Review the DSM and ASAM Criteria documentation to ensure that the beneficiary meets the requirements for the service.
v. Have written policies and procedures for processing requests for initial and continuing authorization of services.
vi. Have a mechanism in place to ensure that there is consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate.
vii. Track the number, percentage of denied, and timeliness of requests for authorization for all DMC-ODS services that are submitted, processed, approved, and denied.
viii. Pursuant to 42 CFR 438.3(l), allow each beneficiary to choose his or her health professional to the extent possible and appropriate.
ix. Require that treatment programs are accessible to people with disabilities in accordance with CFR Title 45, Part 84 and the Americans with Disabilities Act.
x. Have a 24/7 toll free number for prospective beneficiaries to call to access DMC-ODS services and make oral interpretation services available for beneficiaries, as needed.
xi. Must guarantee that it will not avoid costs for services covered in this Agreement by referring enrollees to publicly supported health care resources.

4. Covered services, whether provided directly by the Contractor, through the subcontractor, or network providers , shall be provided to beneficiaries in the following manner:
   i. DMC-ODS services approved through the Special Terms and Conditions shall be available to all beneficiaries that reside in the ODS County and enrolled in the ODS Plan.
   ii. Access to State Plan services shall remain at the current, pre-implementation level or expand upon implementation.

G. Coordination of Care

1. In addition to meeting the coordination and continuity of care requirements set forth in Article II.E.3, the Contractor shall develop a care coordination plan that provides for seamless transitions of care for beneficiaries with the DMC-ODS system of care. Contractor is responsible for developing a structured

approach to care coordination to ensure that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient) without disruptions to services.

2. In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, the Contractor shall ensure that beneficiaries have access to recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.
3. The Contractor shall require the subcontractor to include in its contracts with all network providers the following elements which should be implemented at the point of care to ensure clinical integration:
   i. Comprehensive substance use, physical, and mental health screening.
   ii. Beneficiary engagement and participation in an integrated care program as needed.
   iii. Shared development of care plans by the beneficiary, caregivers, and all providers.
   iv. Collaborative treatment planning with managed care.
   v. Delineation of case management responsibilities.
   vi. A process for resolving disputes between the Contractor and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved.
   vii. Availability of clinical consultation, including consultation on medications.
   viii. Care coordination and effective communication among providers including procedures for exchanges of medical information.
   ix. Navigation support for patients and caregivers.
   x. Facilitation and tracking of referrals between systems including bidirectional referral protocol.

H. Authorization of Services – Residential Programs

Exhibit A, Attachment I
Program Specifications

1. The Contractor shall implement residential treatment program standards that comply with the authorization of services requirements set forth in Article II.E.4 and shall:

- **i.** Establish, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services for residential programs.
- **ii.** Ensure that residential services are provided in DHCS or Department of Social Services (DSS) licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.
- **iii.** Ensure that residential services may be provided in facilities with no bed capacity limit.
- **iv.** Ensure that the length of residential services comply with the following time restrictions:
  - a. Adults, ages 21 and over, may receive up to two non-continuous short-term residential regimens per 365-day period. A short-term residential regimen is defined as one residential stay in a DHCS licensed facility for a maximum of 90 days per 365-day period.
    - i. An adult beneficiary may receive one 30-day extension, if that extension is medically necessary, per 365-day period.
  - b. Adolescents, under the age of 21, may receive up to two 30-day non-continuous regimens per 365-day period. Adolescent beneficiaries receiving residential treatment shall be stabilized as soon as possible and moved down to a less intensive level of treatment.
    - i. Adolescent beneficiaries may receive a 30-day extension if that extension is determined to be medically necessary. Adolescent beneficiaries are limited to one extension per 365-day period.
  - c. Nothing in the DMC-ODS overrides any EPSDT requirements. EPSDT beneficiaries may receive a longer length of stay based on medical necessity.

d. If determined to be medically necessary, perinatal beneficiaries may receive a longer lengths of stay than those described above.

v. Ensure that at least one ASAM level of Residential Treatment Services is available to beneficiaries in the first year of implementation.

vi. Demonstrate ASAM levels of Residential Treatment Services (Levels 3.1-3.5) within three years of CMS approval of the county implementation plan and state-county Agreement and describe coordination for ASAM Levels 3.7 and 4.0.

vii. Enumerate the mechanisms that the Contractor has in effect that ensure the consistent application of review criteria for authorization decisions, and require consultation with the requesting provider when appropriate.

viii. Require written notice to the beneficiary of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the beneficiary's condition or disease.

2. Pursuant to 42 CFR 431.201, the Contractor shall define service authorization request in a manner that at least includes a beneficiary's request for the provision of a service.

I. Provider Selection and Certification

1. In addition to complying with the provider selection requirements set forth in Article II.E.5 and the provider discrimination prohibitions in Article II.B.3, the Contractor:

i. Shall have written policies and procedures for selection and retention of providers that comply with the terms and conditions of this Agreement and applicable federal and state laws and regulations.

ii. Shall apply those policies and procedures equally to all providers regardless of public, private, for-profit or non-profit status, and without regard to whether a provider treats persons who require high-risk or specialized services.

iii. Shall not discriminate against persons who require high-risk or specialized services.

iv. Shall subcontract with providers in another state where out-of-state care or treatment is rendered on an emergency basis or is otherwise in the best interests of the person under the circumstances.

v. Shall select only providers that have a license and/or certification issued by the state that is in good standing.

vi. Shall select only providers that, prior to the furnishing of services under this Agreement, have enrolled with, or revalidated their current enrollment with, DHCS as a DMC provider under applicable federal and state regulations.

vii. Shall select only providers that have been screened in accordance with 42 CFR 455.450(c) (“high” categorical risk) prior to furnishing services under this Agreement, have signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107, and have complied with the ownership and control disclosure requirements of 42 CFR 455.104. DHCS shall deny enrollment and DMC certification to any provider (as defined in Welfare & Institutions Code section 14043.1), or a person with ownership or control interest (as defined in 42 CFR 455.101) in the provider, that, at the time of application, is under investigation for fraud or abuse pursuant to Part 455 of Title 42 of the Code of Federal Regulations, unless DHCS determines that there is good cause not to deny enrollment upon the same bases enumerated in 42 CFR 455.23(e). If a provider is under investigation for fraud or abuse, that provider shall be subject to temporary suspension pursuant to Welfare & Institutions Code section 14043.36. Upon receipt of a credible allegation of fraud, a provider shall be subject to a payment suspension pursuant to Welfare & Institutions Code section 14107.11 and DHCS may thereafter collect any overpayment identified through an audit or examination. During the time a provider is subject to a temporary suspension pursuant to Welfare & Institutions Code section 14043.36, the provider, or a person with ownership or control interest (as defined in 42 CFR 455.101), in the provider may not receive reimbursement for services provided to a DMC-ODS beneficiary. A provider shall be subject to suspension

pursuant to WIC 14043.61 if claims for payment are submitted for services provided to a Medi-Cal beneficiary by an individual or entity that is ineligible to participate in the Medi-Cal program. A provider will be subject to termination of provisional provider status pursuant to WIC 14043.27 if the provider has a debt due and owing to any government entity that relates to any federal or state health care program, and has not been excused by legal process from fulfilling the obligation. Only providers newly enrolling or revalidating their current enrollment on or after January 1, 2015 would be required to undergo fingerprint- based background checks required under 42 CFR 455.434.

2. **Disclosures that shall be provided.**
   - **i.** A disclosure from any provider or disclosing entity is due at any of the following times:
     - a. Upon the provider or disclosing entity submitting the provider application.
     - b. Upon the provider or disclosing entity executing the provider agreement.
     - c. Upon request of the Medicaid agency during the re-validation of enrollment process under 42 CFR 455.414.
     - d. Within 35 days after any change in ownership of the disclosing entity.
   - **ii.** All disclosures shall be provided to the Medicaid agency.
   - **iii.** Consequences for failure to provide required disclosures.
     - a. FFP is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.
3. The Contractor or subcontractor shall only select providers that have a Medical Director who, prior to the delivery of services under this Agreement, has enrolled with DHCS under applicable state regulations, has been screened in accordance with 42 CFR 455.450(a) as a “limited” categorical risk within a year prior to serving as a Medical Director under this Agreement, and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107.

4. The Contractor or subcontractor may contract individually with LPHAs to provide DMC-ODS services in the network.
5. The Contractor shall have a protest procedure for providers that are not awarded a contract. The Contractor's protest procedure shall ensure that:
   i. Providers that submit a bid to be a subcontracted provider, but are not selected, shall exhaust the Contractor's protest procedure if a provider wishes to appeal to DHCS.
   ii. If the Contractor does not render a decision within 30 calendar days after the protest was filed with the Contractor, then the protest shall be deemed denied and the provider may appeal the failure to DHCS.

J. DMC Certification and Enrollment

1. DHCS shall certify eligible providers to participate in the DMC program.
2. The DHCS shall certify any network providers. This certification shall be performed prior to the date on which the Contractor begins to deliver services under this Agreement at these sites.
3. Contractor shall require that providers of perinatal DMC services are properly certified to provide these services and comply with the applicable requirements contained in Article III.PP of this Exhibit A, Attachment I.
4. Contractor shall require all the network providers of services to be licensed, registered, DMC certified and/or approved in accordance with applicable laws and regulations. Contractor's subcontracts shall require that providers comply with the following regulations and guidelines:
   i. Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8
   ii. Title 22, Section 51490.1(a)
   iii. Exhibit A, Attachment I, Article III.PP – Requirements for Services
   iv. Title 9, Division 4, Chapter 4, Subchapter 1, Sections 10000, et. seq
   v. Title 22, Division 3, Chapter 3, sections 51000 et. seq
5. In the event of conflicts, the provisions of Title 22 shall control if they are more stringent.
6. The Contractor shall ensure the Provider Enrollment Division (PED) is notified of an addition or change of information in a

providers pending DMC certification application within 35 days of receiving notification from the provider. The Contractor shall ensure that a new DMC certification application is submitted to PED reflecting the change.

7. The Contractor shall be responsible for ensuring that any reduction of covered services or relocations by providers are not implemented until the approval is issued by DHCS. Within 35 days of receiving notification of a provider's intent to reduce covered services or relocate, the Contractor shall submit, or require the provider to submit, a DMC certification application to PED. The DMC certification application shall be submitted to PED 60 days prior to the desired effective date of the reduction of covered services or relocation.
8. The Contractor shall notify DHCS PED by e-mail at DHCSDMCRecert@dhcs.ca.gov within two business days of learning that a subcontractor's license, registration, certification, or approval to operate an SUD program or provide a covered service is revoked, suspended, modified, or not renewed by entities other than DHCS.
   i. A provider's certification to participate in the DMC program shall automatically terminate in the event that the provider, or its owners, officers or directors are convicted of Medi-Cal fraud, abuse, or malfeasance. For purposes of this section, a conviction shall include a plea of guilty or nolo contendere.

K. Continued Certification

1. All DMC certified providers shall be subject to continuing certification requirements at least once every five years. DHCS may allow the Contractor to continue delivering covered services to beneficiaries at a site subject to on-site review by DHCS as part of the recertification process prior to the date of the on-site review, provided the site is operational, the certification remains valid, and has all required fire clearances.
2. DHCS shall conduct unannounced certification and recertification on-site visits at clinics pursuant to WIC 14043.7.

L. Laboratory Testing Requirements

1. 42 CFR Part 493 sets forth the conditions that all laboratories shall meet to be certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988

(CLIA). Except as specified in paragraph (2) of this section, a laboratory will be cited as out of compliance with section 353 of the Public Health Service Act unless it:

- **i.** Has a current, unrevoked or unsuspended certificate of waiver, registration certificate, certificate of compliance, certificate for PPM procedures, or certificate of accreditation issued by HHS applicable to the category of examinations or procedures performed by the laboratory; or
- **ii.** Is CLIA-exempt.

2. These rules do not apply to components or functions of:

- **i.** Any facility or component of a facility that only performs testing for forensic purposes;
- **ii.** Research laboratories that test human specimens but do not report patient specific results for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of individual patients; or
- **iii.** Laboratories certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), in which drug testing is performed which meets SAMHSA guidelines and regulations. However, all other testing conducted by a SAMHSA-certified laboratory is subject to this rule.

3. Laboratories under the jurisdiction of an agency of the Federal Government are subject to the rules of 42 CFR 493, except that the Secretary may modify the application of such requirements as appropriate.

M. Recovery from Other Sources or Providers

1. The Contractor or subcontractor shall recover the value of covered services rendered to beneficiaries whenever the beneficiaries are covered for the same services, either fully or partially, under any other state or federal medical care program or under other contractual or legal entitlement including, but not limited to, a private group or indemnification program, but excluding instances of the tort liability of a third party or casualty liability insurance.

2. The monies recovered are retained by the Contractor. However, Contractor's claims for FFP for services provided to beneficiaries under this Agreement shall be reduced by the amount recovered.

3. The Contractor shall maintain accurate records of monies recovered from other sources.
4. Nothing in this section supersedes the Contractor's obligation to follow federal requirements for claiming FFP for services provided to beneficiaries with other coverage under this Agreement.

N. Early Intervention (ASAM Level 0.5)

1. Contractor shall ensure beneficiaries at risk of developing a substance use disorder or those with an existing substance use disorder are identified and offer those beneficiaries: screening for adults and youth, brief treatment as medically necessary, and, when indicated, a referral to treatment with a formal linkage.

O. Outpatient Services (ASAM Level 1.0)

1. Outpatient services consist of up to nine hours per week of medically necessary services for adults and less than six hours per week of services for adolescents. Group size is limited to no less than two (2) and no more than twelve (12) beneficiaries.
2. Outpatient services includes: assessment, treatment planning, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, and discharge planning and coordination.
3. Services may be provided in-person, by telephone, or by telehealth, and in any appropriate setting in the community.

P. Intensive Outpatient Services (ASAM Level 2.1)

1. Intensive outpatient services involves structured programming provided to beneficiaries as medically necessary for a minimum of nine hours and a maximum of 19 hours per week for adult perinatal and non-perinatal beneficiaries. Adolescents are provided a minimum of six and a maximum of 19 hours per week. Group size is limited to no less than two (2) and no more than twelve (12) beneficiaries.
   - **i.** Network providers may provide more than 19 hours per week to adults when determined by a Medical Director or an LPHA to be medical necessary, and in accordance with the individualized treatment plan.
   - **ii.** Network providers may extend a beneficiary’s length of treatment when determined by a Medical Director or an LPHA to be medically necessary, and in accordance with the individualized treatment plan.

2. Intensive outpatient services includes: assessment, treatment planning, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, and discharge planning and coordination.
3. Services may be provided in-person, by telephone, or by telehealth, and in any appropriate setting in the community.

Q. Residential Treatment Services

1. Residential services are provided in DHCS or DSS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.
2. Residential services can be provided in facilities with no bed capacity limit.
3. The length of residential services range from one to 90 days with a 90-day maximum for adults and 30-day maximum for adolescents per 365-day period, unless medical necessity warrants a one-time extension of up to 30 days per 365-day period.
   - **i.** Only two non-continuous 30-day (adolescents) or 90-day (adults) regimens may be authorized in a one-year period (365 days). The average length of stay for residential services is 30 days.
   - **ii.** Perinatal beneficiaries shall receive a length of stay for the duration of their pregnancy, plus 60 days postpartum.
   - **iii.** EPSDT adolescent beneficiaries shall receive a longer length of stay, if found to be medically necessary.

R. Case Management

1. Case management services are defined as a service that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.
2. The Contractor shall ensure that case management services focus on coordination of SUD care, integration around primary care especially for beneficiaries with a chronic substance use disorder, and interaction with the criminal justice system, if needed.
3. The Contractor shall be responsible for determining which entity monitors the case management activities.

4. Case management services may be provided by an LPHA or a registered or certified counselor.
5. The Contractor shall coordinate a system of case management services with physical and/or mental health in order to ensure appropriate level of care.
6. Case management services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.

S. Physician Consultation Services

1. Physician Consultation Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are designed to assist DMC physicians by allowing them to seek expert advice when developing treatment plans for specific DMC-ODS beneficiaries. Physician consultation services may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.
2. Contractor's subcontractor may contract with one or more physicians or pharmacists in order to provide consultation services.
3. The Contractor or subcontractor shall only allow DMC providers to bill for physician consultation services.

T. Recovery Services

1. Recovery Services includes:
   - **i.** Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care.
   - **ii.** Recovery Monitoring: Recovery coaching, monitoring via telephone and internet.
   - **iii.** Substance Abuse Assistance: Peer-to-peer services and relapse prevention.
   - **iv.** Education and Job Skills: Linkages to life skills, employment services, job training, and education services.
   - **v.** Family Support: Linkages to childcare, parent education, child development support services, and family/marriage education.

vi. Support Groups: Linkages to self-help and support, spiritual and faith-based support.

vii. Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

2. Recovery services shall be utilized when the beneficiary is triggered, when the beneficiary has relapsed, or simply as a preventative measure to prevent relapse. As part of the assessment and treatment needs of Dimension 6, Recovery Environment of the ASAM Criteria and during the transfer/transition planning process, the Contractor shall provide beneficiaries with recovery services.

3. Additionally, the Contractor shall:
   - i. Ensure delivery of recovery services to beneficiaries as medically necessary.
   - ii. Ensure beneficiaries have access to recovery services after completing their course of treatment.
   - iii. Ensure delivery of recovery services either face-to-face, by telephone, or by telehealth, and in any appropriate setting in the community with the beneficiary.

U. Withdrawal Management

1. The Contractor shall ensure network providers deliver, at a minimum, one of the five levels of withdrawal management (WM) services according to the ASAM Criteria, when determined by a Medical Director or LPHA as medically necessary, and in accordance with the beneficiary's individualized treatment plan.
2. The Contractor shall ensure that all beneficiaries receiving both residential services and WM services are monitored during the detoxification process.
3. The Contractor shall ensure delivery of medically necessary habilitative and rehabilitative services in accordance with an individualized treatment plan prescribed by a licensed physician or licensed prescriber.

V. Opioid (Narcotic) Treatment Program Services (OTP/NTP)

1. Pursuant to WIC 14124.22, an OTP/NTP provider who is also enrolled as a Medi-Cal provider may provide medically necessary treatment of concurrent health conditions to Medi-Cal beneficiaries who are not enrolled in managed care plans as long

as those services are within the scope of the provider's practice. OTP/NTP providers shall refer all Medi-Cal beneficiaries that are enrolled in managed care plans to their respective managed care plan to receive medically necessary medical treatment of their concurrent health conditions.

2. The diagnosis and treatment of concurrent health conditions of Medi-Cal beneficiaries that are not enrolled in managed care plans by an OTP/NTP provider may be provided within the Medi-Cal coverage limits. When the services are not part of the SUD treatment reimbursed pursuant to WIC 14021.51, the services rendered shall be reimbursed in accordance with the Medi-Cal program. Services reimbursable under this section shall include all of the following:
   - **i.** Medical treatment visits
   - **ii.** Diagnostic blood, urine, and X-rays
   - **iii.** Psychological and psychiatric tests and services
   - **iv.** Quantitative blood and urine toxicology assays
   - **v.** Medical supplies
3. An OTP/NTP provider who is enrolled as a Medi-Cal fee-for-service provider shall not seek reimbursement from a beneficiary for SUD treatment services, if the OTP/NTP provider bills the services for treatment of concurrent health conditions to the Medi-Cal fee-for-service program.
4. The Contractor's subcontractor shall subcontract with licensed NTPs to offer services to beneficiaries who meet medical necessity criteria requirements.
5. Services shall be provided in accordance with an individualized beneficiary plan determined by a licensed prescriber.
6. Offer and prescribe medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone, and disulfiram.
7. Services provided as part of an OTP/NTP includes assessment, treatment planning, individual and group counseling, patient education, medication services, collateral services, crisis intervention services, treatment planning, medical psychotherapy, and discharge services.
   - **i.** Beneficiaries shall receive between 50 and 200 minutes of counseling per calendar month with a therapist or counselor,

and, when medically necessary, additional counseling services may be provided.

W. Cultural Competence Plan

1. The Contractor shall ensure the development of a cultural competency plan and subsequent plan updates.
2. Contractor shall promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

X. Implementation Plan

1. The Contractor shall comply with the provisions of the Contractor's Implementation Plan (IP) as approved by DHCS.
2. The Contractor shall not provide DMC-ODS services without: 1) an approved IP approved by DHCS and CMS, and 2) a CMS approved Intergovernmental Agreement executed by DHCS and the Contractor's Board of Supervisors.
3. The Contractor shall obtain written approval by DHCS prior to making any changes to the IP.

Y. Additional Provisions

1. **Additional Intergovernmental Agreement Restrictions**
   i. This Agreement is subject to any additional restrictions, limitations, conditions, or statutes enacted or amended by the federal or state governments, which may affect the provisions, terms, or funding of this Agreement in any manner.
2. **Voluntary Termination of DMC-ODS Services**
   i. The Contractor may terminate this Agreement at any time, for any reason, by giving 60 days written notice to DHCS. The Contractor shall be paid for DMC-ODS services provided to beneficiaries up to the date of termination. Upon termination, the Contractor shall immediately begin providing DMC services to beneficiaries in accordance with the State Plan.
3. **Nullification of DMC-ODS Services**
   i. The parties agree that failure of the Contractor, or its subcontractor, to comply with W&I section 14124.24, the Special Terms and Conditions, and this Agreement, shall be deemed a breach that results in the termination of this Agreement for cause.

ii. In the event of a breach, DMC-ODS services shall terminate. The Contractor shall immediately begin providing DMC services to the beneficiaries in accordance with the State Plan.

4. **Hatch Act**
   i. Contractor agrees to comply with the provisions of the Hatch Act (Title 5 USC, Sections 1501-1508), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.
5. **No Unlawful Use or Unlawful Use Messages Regarding Drugs**
   i. Contractor agrees that information produced through these funds, and which pertains to drug and alcohol related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug or alcohol related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (HSC Section 11999-11999.3). By signing this Agreement, Contractor agrees that it shall enforce, and shall require its subcontractors to enforce, these requirements.
6. **Noncompliance with Reporting Requirements**
   i. Contractor agrees that DHCS has the right to withhold payments until Contractor has submitted any required data and reports to DHCS, as identified in this Exhibit A, Attachment I or as identified in Document 1F(a), Reporting Requirement Matrix for Counties.
7. **Limitation on Use of Funds for Promotion of Legalization of Controlled Substances**
   i. None of the funds made available through this Agreement may be used for any activity that promotes the legalization of any drug or other substance included in Schedule I of Section 202 of the Controlled Substances Act (21 USC 812).
8. **Health Insurance Portability and Accountability Act (HIPAA) of 1996**
   i. If any of the work performed under this Agreement is subject to the HIPAA, Contractor shall ensure the work is performed in compliance with all applicable provisions of HIPAA. As identified in Exhibit F, DHCS and the Contractor shall

cooperate to ensure mutual agreement as to those transactions between them, to which this Provision applies. Refer to Exhibit F for additional information.

ii. **Trading Partner Requirements**

a. No Changes. Contractor hereby agrees that for the personal health information (Information), it shall not change any definition, data condition or use of a data element or segment as proscribed in the federal HHS Transaction Standard Regulation. (45 CFR Part 162.915 (a))
b. No Additions. Contractor hereby agrees that for the Information, it shall not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation. (45 CFR Part 162.915 (b))
c. No Unauthorized Uses. Contractor hereby agrees that for the Information, it shall not use any code or data elements that either are marked "not used" in the HHS Transaction's Implementation specification or are not in the HHS Transaction Standard's implementation specifications. (45 CFR Part 162.915 (c))
d. No Changes to Meaning or Intent. Contractor hereby agrees that for the Information, it shall not change the meaning or intent of any of the HHS Transaction Standard's implementation specification. (45 CFR Part 162.915 (d))

iii. **Concurrence for Test Modifications to HHS Transaction Standards**

a. Contractor agrees and understands that there exists the possibility that DHCS or others may request an extension from the uses of a standard in the HHS Transaction Standards. If this occurs, Contractor agrees that it shall participate in such test modifications.

iv. **Adequate Testing**

a. Contractor is responsible to adequately test all business rules appropriate to their types and

specialties. If the Contractor is acting as a clearinghouse for enrolled providers, Contractor has obligations to adequately test all business rules appropriate to each and every provider type and specialty for which they provide clearinghouse services.

v. **Deficiencies**

a. The Contractor agrees to cure transactions errors or deficiencies identified by DHCS, and transactions errors or deficiencies identified by an enrolled provider if the Contractor is acting as a clearinghouse for that provider. If the Contractor is a clearinghouse, the Contractor agrees to properly communicate deficiencies and other pertinent information regarding electronic transactions to enrolled providers for which they provide clearinghouse services.

vi. **Code Set Retention**

a. Both DHCS and the Contractor understand and agree to keep open code sets being processed or used in this Agreement for at least the current billing period or any appeal period, whichever is longer.

vii. **Data Transmission Log**

a. Both DHCS and the Contractor shall establish and maintain a Data Transmission Log, which shall record any and all data transmissions taking place between the Parties during the term of this Agreement. Each Party shall take necessary and reasonable steps to ensure that such Data Transmission Logs constitute a current, accurate, complete, and unaltered record of any and all Data Transmissions between the Parties, and shall be retained by each Party for no less than 24 months following the date of the Data Transmission. The Data Transmission Log may be maintained on computer media or other suitable means provided that, if necessary to do so, the information contained in the Data Transmission Log may be retrieved in a timely manner and presented in readable form.

Exhibit A, Attachment I
Program Specifications

9. **Counselor Certification**
   i. Any counselor or registrant providing intake, assessment of need for services, treatment or recovery planning, individual or group counseling to participants, patients, or residents in a DHCS licensed or certified program is required to be certified as defined in CCR Title 9, Division 4, Chapter 8. (Document 3H)
10. **Cultural and Linguistic Proficiency**
    i. To ensure equal access to quality care by diverse populations, each service provider receiving funds from this Agreement shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards (Document 3V) and comply with 42 CFR 438.206(c)(2).
11. **Trafficking Victims Protection Act of 2000**
    i. Contractor, its subcontractor, and network providers that provide services covered by this Agreement shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(g)) as amended by section 1702. For full text of the award term, go to: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title22-section7104d&num=0&edition=prelim
12. **Participation in the County Behavioral Health Director's Association of California.**
    i. The Contractor's County AOD Program Administrator shall participate and represent the county in meetings of the County Behavioral Health Director's Association of California for the purposes of representing the counties in their relationship with DHCS with respect to policies, standards, and administration for SUD services.
    ii. The Contractor's County AOD Program Administrator shall attend any special meetings called by the Director of DHCS.
13. **Youth Treatment Guidelines**
    i. Contractor shall follow the guidelines in Document 1V, incorporated by this reference, "Youth Treatment Guidelines," in developing and implementing adolescent treatment programs funded under this Exhibit, until such time new Youth Treatment Guidelines are established and

adopted. No formal amendment of this Agreement is required for new guidelines to be incorporated into this Agreement.

14. Nondiscrimination in Employment and Services

- **i.** By signing this Agreement, Contractor certifies that under the laws of the United States and the State of California, incorporated into this Agreement by reference and made a part hereof as if set forth in full, Contractor shall not unlawfully discriminate against any person.

15. Federal Law Requirements:

- **i.** Title VI of the Civil Rights Act of 1964, Section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in federally funded programs.
- **ii.** Title IX of the Education Amendments of 1972 (regarding education and programs and activities), if applicable.
- **iii.** Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.
- **iv.** Age Discrimination Act of 1975 (45 CFR Part 90), as amended (42 USC Sections 6101 – 6107), which prohibits discrimination on the basis of age.
- **v.** Age Discrimination in Employment Act (29 CFR Part 1625).
- **vi.** Title I of the Americans with Disabilities Act (29 CFR Part 1630) prohibiting discrimination against the disabled in employment.
- **vii.** Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities.
- **viii.** Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.
- **ix.** Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.
- **x.** Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than $10,000 funded by federal financial assistance.

xi. Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.

xii. The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.

xiii. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism.

16. State Law Requirements:

i. Fair Employment and Housing Act (Government Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (California Administrative Code, Title 2, Section 7285.0 et seq.).

ii. Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135.

iii. Title 9, Division 4, Chapter 8, commencing with Section 10800.

iv. No state or Federal funds shall be used by the Contractor, or its subcontractors, for sectarian worship, instruction, and/or proselytization. No state funds shall be used by the Contractor, or its subcontractors, to provide direct, immediate, or substantial support to any religious activity.

v. Noncompliance with the requirements of nondiscrimination in services shall constitute grounds for state to withhold payments under this Agreement or terminate all, or any type, of funding provided hereunder.

17. Investigations and Confidentiality of Administrative Actions

i. Contractor acknowledges that if a DMC provider is under investigation by DHCS or any other state, local or federal law enforcement agency for fraud or abuse, DHCS may temporarily suspend the provider from the DMC program, pursuant to WIC 14043.36(a). Information about a provider's administrative sanction status is confidential until such time as the action is either completed or resolved. DHCS may also issue a Payment Suspension to a provider pursuant to WIC 14107.11 and Code of Federal Regulations, Title 42, section 455.23. The Contractor or subcontractor is to

withhold payments from a DMC provider during the time a Payment Suspension is in effect.

ii. Contractor shall execute the Confidentiality Agreement, attached as Document 5A. The Confidentiality Agreement permits DHCS to communicate with Contractor concerning network providers that are subject to administrative sanctions.

18. Subcontract Provisions

i. Contractor shall include all the foregoing provisions in all of its subcontracts.

ii. Contractor must ensure the subcontractor includes all the foregoing provisions in its contracts with providers.

Z. Beneficiary Problem Resolution Process

1. The Contractor shall establish and comply with a beneficiary problem resolution process.

2. Contractor shall inform the subcontractor and network providers at the time they enter into a subcontract about:

i. The beneficiary's right to a state fair hearing, how to obtain a hearing and the representation rules at the hearing.

ii. The beneficiary's right to file grievances and appeals and the requirements and timeframes for filing.

iii. The beneficiary's right to give written consent to allow a provider, acting on behalf of the beneficiary, to file an appeal. A provider may file a grievance or request a state fair hearing on behalf of a beneficiary, if the state permits the provider to act as the beneficiary's authorized representative in doing so.

iv. The beneficiary may file a grievance, either orally or in writing, and, as determined by DHCS, either with DHCS or with the Contractor.

v. The availability of assistance with filing grievances and appeals.

vi. The toll-free number to file oral grievances and appeals.

vii. The beneficiary's right to request continuation of benefits during an appeal or state fair hearing filing although the beneficiary may be liable for the cost of any continued benefits if the action is upheld.

viii. Any state determined provider's appeal rights to challenge the failure of the Contractor to cover a service.

3. The Contractor shall represent the Contractor's position in fair hearings, as defined in 42 CFR 438.408 dealing with beneficiaries' appeals of denials, modifications, deferrals or terminations of covered services. The Contractor shall carry out the final decisions of the fair hearing process with respect to issues within the scope of the Contractor's responsibilities under this Agreement. Nothing in this section is intended to prevent the Contractor from pursuing any options available for appealing a fair hearing decision.
   i. Pursuant to 42 CFR 438.228, the Contractor shall develop problem resolution processes that enable beneficiary to request and receive review of a problem or concern he or she has about any issue related to the Contractor's performance of its duties, including the delivery of SUD treatment services.
4. The Contractor's beneficiary problem resolution processes shall include:
   i. A grievance process
   ii. An appeal process
   iii. An expedited appeal process

AA. Subcontracts

1. In addition to complying with the subcontractual relationship requirements set forth in Article II.E.8 of this Agreement, the Contractor shall ensure that all subcontracts require that the Contractor oversee and is held accountable for any functions and responsibilities that the Contractor delegates to any subcontractor.
2. Each subcontract shall:
   i. Fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract.
   ii. Ensure that the Contractor evaluates the prospective subcontractor's ability to perform the activities to be delegated.
   iii. Require a written agreement between the Contractor and the subcontractor that specifies the activities and report

responsibilities delegated to the subcontractor, and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

iv. Ensure the Contractor monitors the subcontractor's performance on an ongoing basis and subject it to an annual onsite review, consistent with statutes, regulations, and Article III.PP.

v. Ensure the Contractor identifies deficiencies or areas for improvement, the subcontractor shall take corrective actions and the Contractor shall ensure that the subcontractor implements these corrective actions.

3. The Contractor shall ensure the following provider requirements are included in all subcontracts with providers:

i. Culturally Competent Services: Providers are responsible to provide culturally competent services. Providers shall ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations. Translation services shall be available for beneficiaries, as needed.

ii. Medication Assisted Treatment: Providers will have procedures for linkage/integration for beneficiaries requiring medication assisted treatment. Provider staff will regularly communicate with physicians of beneficiaries who are prescribed these medications unless the beneficiary refuses to consent to sign a 42 CFR part 2 compliant release of information for this purpose.

iii. Evidence Based Practices (EBPs): Providers will implement at least two of the following EBPs based on the timeline established in the county implementation plan. The two EBPs are per provider per service modality. The Contractor will ensure the providers have implemented EBPs. The state will monitor the implementation and regular training of EBPs to staff during reviews. The required EBPs include:

a. Motivational Interviewing: A beneficiary-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other

problem solving or solution-focused strategies that build on beneficiaries' past successes.

b. Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
c. Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.
d. Trauma-Informed Treatment: Services shall take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.
e. Psycho-Education: Psycho-educational groups are designed to educate beneficiaries about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries' lives, to instill self-awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

BB. Program Integrity Requirements

1. Service Verification. To assist DHCS in meeting its obligation under 42 CFR 455.1(a)(2), the Contractor shall establish a mechanism to verify whether services were actually furnished to beneficiaries.
2. **DMC Claims and Reports**

   i. The Contractor, subcontractor, or network providers that bill DHCS or the Contractor for DMC-ODS services shall submit claims in accordance with Department of Health Care Service's DMC Provider Billing Manual.

ii. The Contractor, subcontractor, or network providers that provide DMC services shall be responsible for verifying the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for DMC services to that beneficiary for that month. Medi-Cal eligibility verification should be performed prior to rendering service, in accordance with and as described in the DHCS DMC Provider Billing Manual. Options for verifying the eligibility of a Medi-Cal beneficiary are described in the Department of Health Care Services DMC Provider Billing Manual.

iii. Claims for DMC reimbursement shall include DMC-ODS services covered under the Special Terms and Conditions of this Agreement, and any State Plan services covered under CCR Title 22, Section 51341.1(c-d) and administrative charges that are allowed under WIC, Sections 14132.44 and 14132.47.

a. Contractor shall ensure submission to DHCS the "Certified Expenditure" form reflecting either: 1) the approved amount of the 837P claim file, after the claims have been adjudicated, or 2) the claimed amount identified on the 837P claim file, which could account for both approved and denied claims. Contractor shall ensure submission to DHCS the Drug Medi-Cal Certification Form DHCS 100224A (Document 4D) for each 837P transaction approved for reimbursement of the federal Medicaid funds.

b. DMC service claims shall be submitted electronically in a HIPAA-compliant format (837P). All adjudicated claim information shall be retrieved by the Contractor or subcontractor via an 835 HIPAA compliant format (Health Care Claim Payment/Advice).

iv. The following forms shall be prepared as needed and retained by the provider for review by state staff:

a. Good Cause Certification (6065A), Document 2L(a)
b. Good Cause Certification (6065B), Document 2L(b)
c. In the absence of good cause documented on the Good Cause Certification (6065A or 6065B) form, claims that are not submitted within six months of the

end of the month of service shall be denied. The existence of good cause shall be determined by DHCS in accordance with CCR Title 22, Sections 51008 and 51008.5.

3. **Certified Public Expenditure - County Administration**
   i. Separate from direct service claims as identified above, the Contractor may submit an invoice for administrative costs for administering the DMC-ODS program on a quarterly basis. The form requesting reimbursement shall be submitted to DHCS via email to: sudfmab@dhcs.ca.gov .
4. **Certified Public Expenditure – Quality Assurance and Utilization Review (QA/UR)**
   i. Separate from direct service claims as identified above, the Contractor may submit an invoice for QA/UR for administering the DMC-ODS quality management program on a quarterly basis. The form requesting reimbursement shall be submitted to DHCS via email to: sudfmab@dhcs.ca.gov .

CC. Quality Management (QM) Program

1. The Contractor's QM Program shall improve Contractor's established treatment outcomes through structural and operational processes and activities that are consistent with current standards of practice.
2. The Contractor shall have a written description of the QM Program, which clearly defines the QM Program's structure and elements, assigns responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement.
3. Annually, each Contractor shall:
   i. Measure and report to DHCS its performance using standard measures required by DHCS including those that incorporate the requirements set forth in Article II.F.1 of this Agreement.
   ii. Submit to DHCS data specified by DHCS that enables DHCS to measure the Contractor's performance.
   iii. Perform a combination of the activities described above.
   iv. Evaluate and update the QM Program annually, as necessary, as set forth in Article II.F.1 of this Agreement.

4. During the Triennial Reviews, DHCS shall review the status of the Quality Improvement Plan and the Contractor's monitoring activities.
   i. This review shall include the counties service delivery system, beneficiary protections, access to services, authorization for services, compliance with regulatory and contractual requirements of the waiver, and a beneficiary records review.
   ii. This triennial review shall provide DHCS with information as to whether the counties are complying with their responsibility to monitor their service delivery capacity.
   iii. The counties shall receive a final report summarizing the findings of the triennial review, and if out of compliance, the Contractor shall submit a CAP within 60 days of receipt of the final report. DHCS shall follow-up with the CAP to ensure compliance.
5. The QM Program shall conduct performance-monitoring activities throughout the Contractor's operations. These activities shall include, but not be limited to, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, and resolution of beneficiary grievances.
6. The Contractor shall ensure continuity and coordination of care with physical health care providers. The Contractor shall coordinate with other human services agencies used by its beneficiaries.
7. The Contractor shall have mechanisms to detect both underutilization of services and overutilization of services, as required by Article II.F.1 of this Agreement.
8. The Contractor shall implement mechanisms to assess beneficiary/family satisfaction. The Contractor shall assess beneficiary/family satisfaction by:
   i. Surveying beneficiary/family satisfaction with the Contractor's services at least annually.
   ii. Evaluating beneficiary grievances, appeals and fair hearings at least annually.
   iii. Evaluating requests to change persons providing services at least annually.

iv. The Contractor shall inform providers of the results of beneficiary/family satisfaction activities.

9. The Contractor shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. Monitoring shall occur at least annually.
10. The Contractor shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The Contractor shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the Contractor at least annually.
11. The Contractor shall have a QM Work Plan covering the current Agreement cycle with documented annual evaluations and documented revisions as needed. The Contractor's QM Work Plan shall evaluate the impact and effectiveness of its quality assessment and performance improvement program. The QM Work Plan shall include:
    i. Evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Article II.F.1 and Article II.G.8 of this Agreement.
    ii. Evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service.
    iii. A description of completed and in-process QM activities, including performance improvement projects. The description shall include:
        a. Monitoring efforts for previously identified issues, including tracking issues over time.
        b. Objectives, scope, and planned QM activities for each year.
        c. Targeted areas of improvement or change in service delivery or program design.
    iv. A description of mechanisms the Contractor has implemented to assess the accessibility of services within its

service delivery area. This shall include goals for responsiveness for the Contractor's 24-hour toll-free telephone number, timeliness for scheduling of routine appointments, timeliness of services for urgent conditions, and access to after-hours care.

12. Evidence of compliance with the requirements for cultural competence and linguistic competence specified in Article II.B.2 of this Agreement and Article II.E.1 of this Agreement.

DD. State Monitoring - Postservice Postpayment and Postservice Prepayment Utilization Reviews

1. DHCS shall conduct Postservice Postpayment and Postservice Prepayment (PSPP) Utilization Reviews of the network providers to determine whether the DMC services were provided in accordance with Article III.PP of this exhibit. DHCS shall issue the PSPP report to the Contractor with a copy to the subcontractor and network provider. The Contractor shall be responsible for their subcontractor and network providers to ensure any deficiencies are remediated pursuant to Article III.DD.2. The Contractor shall attest the deficiencies have been remediated and are complete, pursuant to Article III.EE.5 of this Agreement.

2. The Department shall recover payments made if subsequent investigation uncovers evidence that the claim(s) should not have been paid, DMC-ODS services have been improperly utilized, and requirements of Article III.PP were not met.

i. All deficiencies identified by PSPP reports, whether or not a recovery of funds results, shall be corrected and the Contractor shall submit a Contractor-approved CAP. The CAP shall be submitted to the DHCS Analyst that conducted the review, within 60 days of the date of the PSPP report.

a. The CAP shall:

i. Be documented on the DHCS CAP template.

ii. Provide a specific description of how the deficiency shall be corrected.

iii. Identify the title of the individual(s) responsible for:

1. Correcting the deficiency.
2. Ensuring on-going compliance.

iv. Provide a specific description of how the provider will ensure on-going compliance.
v. Specify the target date of implementation of the corrective action.

b. DHCS shall provide written approval of the CAP to the Contractor with a copy to the provider. If DHCS does not approve the CAP, DHCS shall provide guidance on the deficient areas and request an updated CAP from the Contractor with a copy to the provider. Contractor shall submit an updated CAP to the DHCS Analyst that conducted the review, within 30 days of notification.
c. If a CAP is not submitted, or, the provider does not implement the approved CAP provisions within the designated timeline, then DHCS may withhold funds from the Contractor until the entity that provided the services complies with this Exhibit A, Attachment I. DHCS shall inform the Contractor when funds shall be withheld.

3. The Contractor may appeal DMC dispositions concerning demands for recovery of payment and/or programmatic deficiencies of specific claims. Such appeals shall be handled as follows:

i. Requests for first-level appeals:

a. The Contractor shall initiate action by submitting a letter to:

Division Chief
DHCS MCBHD
1500 Capitol Avenue, MS-2623
Sacramento, CA 95814

i. The Contractor shall submit the letter on the official stationery of the Contractor and it shall be signed by an authorized representative of the Contractor.
ii. The letter shall identify the specific claim(s) involved and describe the disputed (in)action regarding the claim.

b. The letter shall be submitted to the address listed in Subsection (a) above within 90 calendar days from the date the Contractor received written notification of the decision to disallow claims.
c. The MCBHD shall acknowledge Contractor letter within 15 calendar days of receipt.
d. The MCBHD shall inform the Contractor of MCBHD's decision and the basis for the decision within 15 calendar days after the MCBHD's acknowledgement notification. The MCBHD shall have the option of extending the decision response time if additional information is required from the Contractor. The Contractor will be notified if the MCBHD extends the response time limit.

4. A Contractor may initiate a second level appeal to the Office of Administrative Hearings and Appeals (OAHA).

i. The second level process may be pursued only after complying with first-level procedures and only when:
   a. The MCBHD has failed to acknowledge the grievance or complaint within 15 calendar days of its receipt, or
   b. The Contractor is dissatisfied with the action taken by the MCBHD where the conclusion is based on the MCBHD's evaluation of the merits.

ii. The second-level appeal shall be submitted to the Office of Administrative Hearings and Appeals within 30 calendar days from the date the MCBHD failed to acknowledge the first-level appeal or from the date of the MCBHD's first-level appeal decision letter.

iii. All second-level appeals made in accordance with this section shall be directed to:

Office of Administrative Hearings and Appeals
1029 J Street, Suite 200, MS 0016
Sacramento, CA 95814

iv. In referring an appeal to the OAHA, the Contractor shall submit all of the following:
   a. A copy of the original written appeal sent to the MCBHD.
   b. A copy of the MCBHD's report to which the appeal applies.

Exhibit A, Attachment I
Program Specifications

If received by the Contractor, a copy of the MCBHD's specific finding(s), and conclusion(s) regarding the appeal with which the Contractor is dissatisfied.

5. The appeal process listed here shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of DHCS pursuant to Exhibit B of this Agreement.
6. State shall monitor the subcontractor's compliance with Contractor utilization review requirements, as specified in Article III.EE. Counties are also required to monitor the subcontractor's compliance pursuant to Article III.AA of this Agreement. The federal government may also review the existence and effectiveness of DHCS' utilization review system.
7. Contractor shall, at a minimum, implement and maintain compliance with the requirements described in Article III.PP for the purposes of reviewing the utilization, quality, and appropriateness of covered services and ensuring that all applicable Medi-Cal requirements are met.
8. Contractor shall ensure that subcontractor's sites shall keep a record of the beneficiaries/patients being treated at that location. Contractor shall retain beneficiary records for a minimum of 10 years, in accordance with 42 CFR 438.3(h), from the finalized cost settlement process with the Department. When an audit by the Federal Government or DHCS has been started before the expiration of the 10-year period, the beneficiary records shall be maintained until completion of the audit and the final resolution of all issues.

EE. Contractor Monitoring

1. Contractor shall conduct, at least annually, a utilization review of network providers to ensure covered services are being appropriately rendered. The annual review shall include an on-site visit of the service provider. Reports of the annual review shall be provided to DHCS at:

Department of Health Care Services
Medi-Cal Behavioral Health Division
1500 Capitol Avenue, MS-2623
Sacramento, CA 95814

Or by secure, encrypted email to: SUDCountyReports@dhcs.ca.gov

The Contractor's reports shall be provided to DHCS within 2 weeks of completion.

Technical assistance is available to counties from MCBHD.

2. If significant deficiencies or significant evidence of noncompliance with the terms of the DMC-ODS waiver, or this Agreement, are found in a county, DHCS shall engage the Contractor to determine if there are challenges that can be addressed with facilitation and technical assistance. If the Contractor remains noncompliant, the Contractor shall submit a CAP to DHCS. The CAP shall detail how and when the Contractor shall remedy the issue(s). DHCS may remove the Contractor from participating in the Waiver if the CAP is not promptly implemented.
3. If the Contractor is removed from participating in the Waiver, the county shall provide DMC services in accordance with the California Medi-Cal State Plan.
4. Contractor shall ensure that DATAR submissions, detailed in Article III.FF of this Exhibit, are complied with by the subcontractor and network providers. Contractor shall attest that each network provider is enrolled in DATAR at the time of execution of the subcontract.
5. The Contractor shall monitor and attest compliance and/or completion by providers with CAP requirements (detailed in Article III.DD) of this Exhibit as required by any PSPP review. The Contractor shall attest to DHCS, using the form developed by DHCS that the requirements in the CAP have been completed by the Contractor and/or the provider. Submission of DHCS Form 8049 by Contractor shall be accomplished within the timeline specified in the approved CAP, as noticed by DHCS.
6. Contractor shall attest that DMC claims submitted to DHCS have been subject to review and verification process for accuracy and legitimacy. (45 CFR 430.30, 433.32, 433.51). Contractor shall not knowingly submit claims for services rendered to any beneficiary after the beneficiary's date of death, or from uncertified or decertified providers.

FF. Reporting Requirements

Exhibit A, Attachment I
Program Specifications

1. Contractor agrees that DHCS has the right to withhold payments until Contractor has submitted any required data and reports to DHCS, as identified in this Exhibit A, Attachment I or as identified in Document 1F(a), Reporting Requirement Matrix for Counties.
2. Contractor shall submit documentation to DHCS in a format specified by DHCS that complies with the following requirements:
   - **i.** Offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service area,
   - **ii.** Maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of beneficiaries in the area, and
   - **iii.** Demonstrates the Contractor’s compliance with the parity requirements set forth in 42 CFR §438.900 et seq.
3. The Contractor shall submit the documentation described in paragraph (2) of this section as specified by DHCS, but no less frequently than the following:
   - **i.** At the time it enters into this Agreement with DHCS.
   - **ii.** At any time there has been a significant change in the Contractor’s operations that would affect adequate capacity, services, and parity, including:
     - a. Changes in Contractor services, benefits, geographic service area or payments.
     - b. Enrollment of a new population in the Contractor.
     - c. Changes in a quantitative limitation or non-quantitative limitation on a substance use disorder benefit.
   - **iii.** After DHCS reviews the documentation submitted by the Contractor, DHCS shall certify to CMS that the Contractor has complied with the state's requirements for availability of services, as set forth in 42 CFR 438.206, and parity requirements, as set forth in 42 CFR 438.900 et seq.
   - **iv.** CMS' right to inspect documentation. DHCS shall make available to CMS, upon request, all documentation collected by DHCS from the Contractor.
4. **California Outcomes Measurement System (CalOMS) for Treatment (CalOMS-Tx)**
   - **i.** The CalOMS-Tx business rules and requirements are:

Exhibit A, Attachment I
Program Specifications

a. Contractor shall contract with a software vendor that complies with the CalOMS-Tx data collection system requirements for submission of CalOMS-Tx data. A Business Associate Agreement (BAA) shall be established between the Contractor and the software vendor. The BAA shall state that DHCS is allowed to return the processed CalOMS-Tx data to the vendor that supplied the data to DHCS.
b. Contractor shall conduct information technology (IT) systems testing and pass state certification testing before commencing submission of CalOMS-Tx data. If the Contractor subcontracts with vendor for IT services, Contractor is responsible for ensuring that the subcontracted IT system is tested and certified by the DHCS prior to submitting CalOMS-Tx data. If Contractor changes or modifies the CalOMS-Tx IT system, then Contractor shall re-test and pass state re-certification prior to submitting data from new or modified system.
c. Electronic submission of CalOMS-Tx data shall be submitted by Contractor within 45 days from the end of the last day of the report month.
d. Contractor shall comply with data collection and reporting requirements established by the DHCS CalOMS-Tx Data Collection Guide (Document 3J) and all former Department of Alcohol and Drug Programs Bulletins and DHCS Information Notices relevant to CalOMS-Tx data collection and reporting requirements.
e. Contractor shall submit CalOMS-Tx admission, discharge, annual update, resubmissions of records containing errors or in need of correction, and “provider no activity” report records in an electronic format approved by DHCS.
f. Contractor shall comply with the CalOMS-Tx Data Compliance Standards established by DHCS identified in (Document 3S) for reporting data content,

data quality, data completeness, reporting frequency, reporting deadlines, and reporting method.

g. Contractor shall participate in CalOMS-Tx informational meetings, trainings, and conference calls.
h. Contractor shall implement and maintain a system for collecting and electronically submitting CalOMS-Tx data.
i. Contractor and their software vendor shall meet the requirements as identified in Exhibit F, Privacy and Information Security Provisions.

5. CalOMS-Tx General Information

i. If the Contractor experiences system or service failure or other extraordinary circumstances that affect its ability to timely submit CalOMS-Tx data, and or meet other CalOMS-Tx compliance requirements, Contractor shall report the problem in writing by secure, encrypted e-mail to DHCS at: ITServiceDesk@dhcs.ca.gov, before the established data submission deadlines. The written notice shall include a remediation plan that is subject to review and approval by DHCS. A grace period of up to 60 days may be granted, at DHCS' sole discretion, for the Contractor to resolve the problem before non-DMC payments are withheld.

ii. If DHCS experiences system or service failure, no penalties shall be assessed to the Contractor for late data submission.

iii. Contractor shall comply with the treatment data quality standards established by DHCS. Failure to meet these standards on an ongoing basis may result in withholding non-DMC funds.

iv. If the Contractor submits data after the established deadlines, due to a delay or problem, the Contractor shall still be responsible for collecting and reporting data from time of delay or problem.

6. Drug and Alcohol Treatment Access Report (DATAR)

i. The DATAR business rules and requirements:

a. The Contractor shall be responsible for ensuring that the subcontractor or network providers submit a

monthly DATAR report in an electronic copy format as provided by DHCS.

b. In those instances where the Contractor maintains, either directly or indirectly, a central intake unit or equivalent, which provides intake services including a waiting list, the Contractor shall identify and begin submitting monthly DATAR reports for the central intake unit by a date to be specified by DHCS.
c. The Contractor shall ensure that all DATAR reports are submitted to DHCS by the 10th of the month following the report activity month.
d. The Contractor shall ensure that all applicable providers are enrolled in DHCS' web-based DATAR program for submission of data, accessible on the DHCS website when executing the subcontract.
e. If the Contractor or its subcontractor experiences system or service failure or other extraordinary circumstances that affect its ability to timely submit a monthly DATAR report, and/or to meet data compliance requirements, the Contractor shall report the problem in writing before the established data submission deadlines. The written notice shall include a CAP that is subject to review and approval by DHCS. A grace period of up to 60 days may be granted, at DHCS' sole discretion, for the Contractor to resolve the problem before non-DMC payments are withheld (See Exhibit B, Part II, Section 2).
f. If DHCS experiences system or service failure, no penalties shall be assessed to Contractor for late data submission.
g. The Contractor shall be considered compliant if a minimum of 95% of required DATAR reports from the network providers are received by the due date.

7. Year-End Cost Settlement Reports

i. The Contractor shall submit the following year-end cost settlement data for the previous fiscal year to DHCS, no later than November 1 of each year:

Exhibit A, Attachment I
Program Specifications

a. County Certification form (MC 6229): Submit via regular mail or overnight services. DHCS needs original signatures, not a copy.
b. Regional County DMC-ODS Cost Report for county-operated providers Report: Submit the individual provider Excel files via email.
c. PUPM Reconciliation Report: Submit the CMS approved PUPM Reconciliation Report to DHCS via e-mail by December 31 following the close of the fiscal year.

8. Failure to Meet Reporting Requirements

i. Failure to meet required reporting requirements shall result in:

a. DHCS shall issue a Notice of Deficiency to Contractor regarding specified providers with a deadline to submit the required data and a request for a CAP to ensure timely reporting in the future. DHCS shall approve or reject the CAP or request revisions to the CAP, which shall be resubmitted to DHCS within 30 days.
b. If the Contractor has not ensured compliance with the data submission or CAP request within the designated timeline, then DHCS may withhold funds until all data is submitted. DHCS shall inform the Contractor when funds shall be withheld.

GG. Training

1. MCBHD shall provide mandatory annual DMC-ODS training to the Contractor or subcontractor.

2. The Contractor may request additional Technical Assistance or training from MCBHD on an ad hoc basis.

3. Training to DMC Subcontractors

i. The Contractor shall ensure that the subcontractor and network providers receive training on the DMC-ODS requirements, at least annually. The Contractor shall report compliance with this section to DHCS annually as part of the DHCS County Monitoring process.

ii. The Contractor shall require the subcontractor and network providers to be trained in the ASAM Criteria prior to providing services.

a. The Contractor shall ensure that, at minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled “ASAM Multidimensional Assessment” and “From Assessment to Service Planning and Level of Care”. A third module entitled, “Introduction to The ASAM Criteria” is recommended for all county and provider staff participating in the Waiver. With assistance from the state, counties will facilitate ASAM provider trainings.

b. The Contractor shall ensure that all residential service providers meet the established ASAM criteria for each level of residential care they provide and receive an ASAM Designation prior to providing DMC-ODS services.

HH. Program Complaints

1. The Contractor shall be responsible for investigating complaints and providing the results of all investigations to DHCS by secure, encrypted e-mail to SUDCountyReports@dhcs.ca.gov within two business days of completion.
2. Complaints for Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities, and counselor complaints may be made by using:
   The Complaint Form available, and may be submitted, online: http://www.dhcs.ca.gov/individuals/Pages/Sud-Complaints.aspx
3. Suspected Medi-Cal fraud, waste, or abuse must be reported to:
   DHCS Medi-Cal Fraud: (800) 822-6222 or
   Fraud@dhcs.ca.gov

II. Record Retention

1. Contractor shall include instructions on record retention and include in any subcontract with providers the mandate to keep and maintain records for each service rendered, to whom it was rendered, and the date of service, pursuant to WIC 14124.1 and 42 CFR 438.3(h) and 438.3(u).

JJ. Subcontract Termination

1. The Contractor shall notify the Department of the termination of any subcontract, or subcontractor's agreement with a network provider, and the basis for termination of the subcontract or agreement, within two business days. The Contractor shall submit the notification by secure, encrypted email to: SUDCountyReports@dhcs.ca.gov

KK. Corrective Action Plan

1. If the Contractor fails to ensure any of the foregoing oversight through an adequate system of monitoring, utilization review, and fiscal and programmatic controls, DHCS may request a CAP from the Contractor to address these deficiencies and a timeline for implementation. Failure to submit a CAP or adhere to the provisions in the CAP can result in a withholding of funds allocated to Contractor for the provision of services, and/or termination of this Agreement for cause.
2. Failure to comply with Monitoring requirements shall result in:
   - **i.** DHCS shall issue a report to Contractor after conducting monitoring or utilization reviews of the Contractor. When the DHCS report identifies non-compliant services or processes, it shall require a CAP. The Contractor shall submit a CAP to DHCS within the timeframes required by DHCS.
     - a. The CAP shall:
       - i. Be documented on the DHCS CAP template.
       - ii. Provide a specific description of how the deficiency shall be corrected.
       - iii. Identify the title of the individual(s) responsible for:
         1. Correcting the deficiency
         2. Ensuring on-going compliance
       - iv. Provide a specific description of how the provider will ensure on-going compliance.
       - v. Specify the target date of implementation of the corrective action.
   - **ii.** DHCS shall provide written approval of the CAP to the Contractor. If DHCS does not approve the CAP submitted by the Contractor, DHCS shall provide guidance on the deficient areas and request an updated CAP from the Contractor with a new deadline for submission.

iii. If a CAP is not submitted, or, the Contractor does not implement the approved CAP provisions within the designated timeline, then DHCS may withhold funds until the Contractor is in compliance. DHCS shall inform the Contractor when funds shall be withheld.

LL. Quality Improvement (QI) Program

1. Contractor shall establish an ongoing quality assessment and performance improvement program consistent with Article II.F.1 of this Agreement.
2. CMS, in consultation with DHCS and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by DHCS in this Agreement.
3. Performance improvement projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and beneficiary satisfaction.
4. The monitoring of accessibility of services outlined in the Quality Improvement (QI) Plan will at a minimum include:
   i. Timeliness of first initial contact to face-to-face appointment.
   ii. Frequency of follow-up appointments in accordance with individualized treatment plans.
   iii. Timeliness of services of the first dose of OTP/NTP services.
   iv. Access to after-hours care.
   v. Responsiveness of the beneficiary access line.
   vi. Strategies to reduce avoidable hospitalizations.
   vii. Coordination of physical and mental health services with waiver services at the provider level.
   viii. Assessment of the beneficiaries' experiences.
   ix. Telephone access line and services in the prevalent non-English languages.
5. The Contractor's QI program shall monitor the Contractor's service delivery system with the aim of improving the processes of providing care and better meeting the needs of its beneficiaries. The QI Program shall be accountable to the Contractor's Director.
6. The Contractor shall establish a QI Committee to review the quality of SUD treatment services provided to beneficiaries. The QI Committee shall recommend policy decisions; review and

evaluate the results of QI activities, including performance improvement projects; institute needed QI actions; ensure follow-up of QI processes; and document QI Committee meeting minutes regarding decisions and actions taken.

7. The Contractor's QI Committee shall review the following data at a minimum on a quarterly basis since external quality review (EQR) site reviews will begin after county implementation. The External Quality Review Organization (EQRO) shall measure defined data elements to assess the quality of service provided by the Contractor. These data elements shall be incorporated into the EQRO protocol:

- **i.** Number of days to first DMC-ODS service at appropriate level of care after referral.
- **ii.** Existence of a 24/7 telephone access line with prevalent non-English language(s).
- **iii.** Access to DMC-ODS services with translation services in the prevalent non-English language(s).

8. Operation of the QI program shall include substantial involvement by a licensed SUD staff person.

9. The QI Program shall include active participation by the Contractor's practitioners and providers, as well as beneficiaries and family members, in the planning, design and execution of the QI Program.

10. The Contractor shall maintain a minimum of two active Performance Improvement Projects (PIPs) that meet the criteria in 42 CFR 438.330(b)(1) and (d). Performance improvement projects shall focus on a clinical area, as well as one non-clinical area.

11. PIPs shall:

- **i.** Measure performance using required quality indicators.
- **ii.** Implement system interventions to achieve improvement in quality.
- **iii.** Evaluate the effectiveness of interventions.
- **iv.** Plan and initiate activities for increasing or sustaining improvement.

12. The Contractor shall report the status and results of each PIP to DHCS, as requested.

13. Each PIP shall be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care annually.

MM. Utilization Management (UM) Program

1. The Contractor shall have a Utilization Management (UM) Program assuring that beneficiaries have appropriate access to SUD services, medical necessity has been established, the beneficiary is at the appropriate ASAM level of care, and that the interventions are appropriate for the diagnosis and level of care. The Contractor shall have a documented system for collecting, maintaining and evaluating accessibility to care and waiting list information, including tracking the number of days to first DMC-ODS service at an appropriate level of care following initial request or referral for all DMC-ODS services.

NN. Formation and Purpose

1. **Authority**
   - **i.** The state and the Contractor enter into this Agreement, by authority of Chapter 3 of Part 1, Division 10.5 of the Health and Safety Code (HSC) and with approval of Contractor's County Board of Supervisors (or designee) for the purpose of providing alcohol and drug services, which shall be reimbursed pursuant to Exhibit B. The state and the Contractor identified in the State Standard (STD) Form 213 are the only parties to this Intergovernmental Agreement. This Agreement is not intended, nor shall it be construed, to confer rights on any third party.
2. **Control Requirements**
   - **i.** Performance under the terms of this Exhibit A, Attachment I, is subject to all applicable federal and state laws, regulations, and standards. The Contractor shall:
     - a. Require its subcontractor to establish written policies and procedures consistent with the requirements listed in 2(c).
     - b. Monitor for compliance with the written procedures.
     - c. Be held accountable for audit exceptions taken by DHCS against the Contractor and its subcontractor for any failure to comply with these requirements:

i. HSC, Division 10.5, commencing with Section 11760
ii. Title 9, Division 4, Chapter 8, commencing with Section 13000
iii. Government Code Section 16367.8
iv. Title 42, CFR, Sections 8.1 through 8.6
v. Title 21, CFR, Sections 1301.01 through 1301.93, Department of Justice, Controlled Substances
vi. State Administrative Manual (SAM), Chapter 7200 (General Outline of Procedures)

3. The Contractor shall be familiar with the above laws, regulations, and guidelines and shall ensure that its subcontractors are also familiar with such requirements.

4. The provisions of this Exhibit A, Attachment I are not intended to abrogate any provisions of law or regulation, or any standards existing or enacted during the term of this Agreement.

OO. Performance Provisions

1. Monitoring

i. The Contractor's performance under this Exhibit A, Attachment I, shall be monitored by DHCS annually during the term of this Agreement. Monitoring criteria shall include, but not be limited to:

a. Whether the quantity of work or services being performed conforms to this Exhibit.
b. Whether the Contractor has established and is monitoring appropriate quality standards.
c. Whether the Contractor is abiding by all the terms and requirements of this Agreement.
d. The Contractor shall conduct annual onsite monitoring reviews of services and subcontracted services for programmatic and fiscal requirements. Contractor shall submit copy of their monitoring and audit reports to DHCS within two weeks of issuance. Reports shall be sent by secure, encrypted e-mail to:

SUDCountyReports@dhcs.ca.gov

Alternatively, mail to:

Department of Health Care Services
Medi-Cal Behavioral Health Division
1500 Capitol Avenue, MS-2623
Sacramento, CA 95814

- **ii.** Failure to comply with the above provisions shall constitute grounds for DHCS to suspend or recover payments, subject to the Contractor's right of appeal, or may result in termination of this Agreement or both.

2. Performance Requirements

- **i.** The Contractor shall provide services based on funding set forth in Exhibit B, Attachment I, and under the terms of this Agreement.
- **ii.** The Contractor shall provide services to all eligible persons in accordance with federal and state statutes and regulations.
- **iii.** The Contractor shall ensure that in planning for the provision of services, the following barriers to services are considered and addressed:
  - a. Lack of educational materials or other resources for the provision of services.
  - b. Geographic isolation and transportation needs of persons seeking services or remoteness of services.
  - c. Institutional, cultural, and/or ethnicity barriers.
  - d. Language differences.
  - e. Lack of service advocates.
  - f. Failure to survey or otherwise identify the barriers to service accessibility.
  - g. Needs of persons with a disability.

3. The Contractor shall comply with any additional requirements of the documents that have been incorporated by reference, including, but not limited to, those in the Exhibit A – Statement of Work.

4. Amounts awarded pursuant to Exhibit B, Attachment I shall be used exclusively for costs associated with providing DMC-ODS services consistent with the purpose of the funding.

5. DHCS shall issue a report to the Contractor after conducting monitoring or utilization reviews of the subcontractor or network providers. When the DHCS report identifies non-compliant

services or processes, it shall require a CAP. The Contractor, or in coordination with its subcontractor , shall submit a CAP to the DHCS Analyst that conducted the review, within 60 calendar days from the date of the report. The CAP shall be electronically submitted, directly to the DHCS analyst who conducted the review.

6. The CAP shall follow the requirements in Article III.KK.2.

PP. Requirements for Services

1. **Confidentiality.**
   i. All SUD treatment services shall be provided in a confidential setting in compliance with 42 CFR, Part 2 requirements.
2. **Perinatal Services.**
   i. Perinatal services shall address treatment and recovery issues specific to pregnant and postpartum women, such as relationships, sexual and physical abuse, and development of parenting skills.
   ii. Perinatal services shall include:
      a. Mother/child habilitative and rehabilitative services (i.e., development of parenting skills, training in child development, which may include the provision of cooperative child care pursuant to Health and Safety Code Section 1596.792).
      b. Service access (i.e., provision of or arrangement for transportation to and from medically necessary treatment).
      c. Education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant.
      d. Coordination of ancillary services (i.e., assistance in accessing and completing dental services, social services, community services, educational/vocational training and other services which are medically necessary to prevent risk to fetus or infant).
   iii. Medical documentation that substantiates the beneficiary's pregnancy and the last day of pregnancy shall be maintained in the beneficiary record.
   iv. Contractor shall comply with the perinatal program requirements as outlined in the Perinatal Practice Guidelines. The Perinatal Practice Guidelines are attached to this Agreement as Document 1G, incorporated by

reference. The Contractor shall comply with the current version of these guidelines until new Perinatal Practice Guidelines are established and adopted. The incorporation of any new Perinatal Practice Guidelines into this Agreement shall not require a formal amendment.

3. **Narcotic Treatment Programs.**
   - **i.** OTP/NTP services and regulatory requirements shall be provided in accordance with CCR Title 9, Chapter 4.
4. **Naltrexone Treatment Services.**
   - **i.** For each beneficiary, all of the following shall apply:
     - a. The provider shall confirm and document that the beneficiary meets all of the following conditions:
       - i. Has a documented history of opiate addiction.
       - ii. Is at least 18 years of age.
       - iii. Has been opiate free for a period of time to be determined by a physician based on the physician's clinical judgment. The provider shall administer a body specimen test to confirm the opiate free status of the beneficiary.
       - iv. Is not pregnant and is discharged from the treatment if she becomes pregnant.
     - b. The physician shall certify the beneficiary's fitness for treatment based upon the beneficiary's physical examination, medical history, and laboratory results.
     - c. The physician shall advise the beneficiary of the overdose risk should the beneficiary return to opiate use while taking Naltrexone and the ineffectiveness of opiate pain relievers while on Naltrexone.
5. **Substance Use Disorder Medical Director.**
   - **i.** The SUD Medical Director's responsibilities shall, at a minimum, include all of the following:
     - a. Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
     - b. Ensure that physicians do not delegate their duties to non-physician personnel.
     - c. Develop and implement written medical policies and standards for the provider.

d. Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
e. Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
f. Ensure that provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries, and determine the medical necessity of treatment for beneficiaries.
g. Ensure that provider's physicians are adequately trained to perform other physician duties, as outlined in this section.

ii. The SUD Medical Director may delegate his/her responsibilities to a physician consistent with the provider's medical policies and standards; however, the SUD Medical Director shall remain responsible for ensuring all delegated duties are properly performed.

6. Provider Personnel.

i. Personnel files shall be maintained on all employees, contracted positions, volunteers, and interns, and shall contain the following:

a. Application for employment and/or resume
b. Signed employment confirmation statement/duty statement
c. Job description
d. Performance evaluations
e. Health records/status as required by the provider, AOD Certification or CCR Title 9
f. Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries)
g. Training documentation relative to substance use disorders and treatment
h. Current registration, certification, intern status, or licensure
i. Proof of continuing education required by licensing or certifying agency and program
j. Provider's Code of Conduct.

ii. Job descriptions shall be developed, revised as needed, and approved by the provider's governing body. The job descriptions shall include:

a. Position title and classification
b. Duties and responsibilities
c. Lines of supervision
d. Education, training, work experience, and other qualifications for the position

iii. Written provider code of conduct for employees and volunteers/interns shall be established which addresses at least the following:

a. Use of drugs and/or alcohol
b. Prohibition of social/business relationship with beneficiaries or their family members for personal gain
c. Prohibition of sexual contact with beneficiaries
d. Conflict of interest
e. Providing services beyond scope
f. Discrimination against beneficiaries or staff
g. Verbally, physically, or sexually harassing, threatening or abusing beneficiaries, family members or other staff
h. Protection of beneficiary confidentiality
i. Cooperate with complaint investigations

iv. If a provider utilizes the services of volunteers and/or interns, written procedures shall be implemented which address:

a. Recruitment
b. Screening and Selection
c. Training and orientation
d. Duties and assignments
e. Scope of practice
f. Supervision
g. Evaluation
h. Protection of beneficiary confidentiality

v. Written roles and responsibilities and a code of conduct for the Medical Director shall be clearly documented, signed and dated by a provider representative and the physician.

7. Beneficiary Admission.

i. Each provider shall include in its policies, procedures, and practice, the written admission and readmission criteria for determining beneficiary’s eligibility and the medical necessity for treatment. These criteria shall include, at a minimum:

a. DSM diagnosis
b. Use of alcohol/drugs of abuse
c. Physical health status

d. Documentation of social and psychological problems.

ii. If a potential beneficiary does not meet the admission criteria, the beneficiary shall be referred to an appropriate service provider.

iii. If a beneficiary is admitted to treatment, the beneficiary shall sign a consent to treatment form.

iv. The Medical Director or LPHA shall document the basis for the diagnosis in the beneficiary record.

v. All referrals made by the provider staff shall be documented in the beneficiary record.

vi. Copies of the following documents shall be provided to the beneficiary upon admission:

a. Beneficiary rights, share of cost if applicable, notification of DMC funding accepted as payment in full, and consent to treatment.

vii. Copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries:

a. A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay.
b. Complaint process and grievance procedures.
c. Appeal process for involuntary discharge.
d. Program rules and expectations.

viii. Where drug screening by urinalysis is deemed medically appropriate the program shall:

a. Establish written procedures, which protect against the falsification and/or contamination of any urine sample.
b. Document urinalysis results in the beneficiary's file.

8. Assessment.

i. The provider shall ensure a counselor or LPHA completes a personal, medical, and substance use history for each beneficiary upon admission to treatment.

a. Assessment for all beneficiaries shall include at a minimum:

i. Drug/Alcohol use history
ii. Medical history
iii. Family history
iv. Psychiatric/psychological history
v. Social/recreational history
vi. Financial status/history
vii. Educational history

viii. Employment history
ix. Criminal history, legal status, and
x. Previous SUD treatment history

b. The Medical Director or LPHA shall review each beneficiary's personal, medical, and substance use history if completed by a counselor within 30 calendar days of each beneficiary's admission to treatment date.

9. Beneficiary Record.

i. In addition to the requirements of 22 CCR § 51476(a), the provider shall:

a. Establish, maintain, and update as necessary, an individual beneficiary record for each beneficiary admitted to treatment and receiving services.
b. Each beneficiary's individual beneficiary record shall include documentation of personal information.
c. Documentation of personal information shall include all of the following:
   i. Information specifying the beneficiary's identifier (i.e., name, number).
   ii. Date of beneficiary's birth, the beneficiary's sex, race and/or ethnic background, beneficiary's address and telephone number, and beneficiary's next of kin or emergency contact.

ii. Documentation of treatment episode information shall include documentation of all activities, services, sessions, and assessments, including, but not limited to all of the following:

a. Intake and admission data including, a physical examination, if applicable.
b. Treatment plans.
c. Progress notes.
d. Continuing services justifications.
e. Laboratory test orders and results.
f. Referrals.
g. Discharge plan.
h. Discharge summary.
i. Contractor authorizations for Residential Services.
j. Any other information relating to the treatment services rendered to the beneficiary.

Exhibit A, Attachment I
Program Specifications

10. Diagnosis Requirements.

i. The Medical Director or LPHA shall evaluate each beneficiary's assessment and intake information if completed by a counselor through a face-to-face review or telehealth with the counselor to establish a beneficiary meets the medical necessity criteria in Article III.B.2.ii.

a. The Medical Director or LPHA shall document separately from the treatment plan the basis for the diagnosis in the beneficiary's record within 30 calendar days of each beneficiary's admission to treatment date.

i. The basis for the diagnosis shall be a narrative summary based on DSM-5 criteria, demonstrating the Medical Director or LPHA evaluated each beneficiary's assessment and intake information, including their personal, medical, and substance use history.

ii. The Medical Director or LPHA shall type or legibly print their name, and sign and date the diagnosis narrative documentation. The signature shall be adjacent to the typed or legibly printed name.

11. Physical Examination Requirements.

i. If a beneficiary had a physical examination within the twelve-month period prior to the beneficiary's admission to treatment date, the physician or registered nurse practitioner or physician's assistant (physician extenders) shall review documentation of the beneficiary's most recent physical examination within 30 calendar days of the beneficiary's admission to treatment date.

a. If a provider is unable to obtain documentation of a beneficiary's most recent physical examination, the provider shall describe the efforts made to obtain this documentation in the beneficiary's individual patient record.

ii. As an alternative to complying with paragraph (i) above or in addition to complying with paragraph (i) above, the physician or physician extender may perform a physical examination of the beneficiary within 30 calendar days of the beneficiary's admission to treatment date.

iii. If the physician or a physician extender, has not reviewed the documentation of the beneficiary's physical examination as provided for in paragraph (i), or the provider does not perform a physical examination of the beneficiary as provided for in paragraph (ii), then the LPHA or counselor shall include in the beneficiary's initial and updated treatment plans the goal of obtaining a physical examination, until this goal has been met and the physician has reviewed the physical examination results. The physician shall type or legibly print their name, sign, and date documentation to support they have reviewed the physical examination results. The signature shall be adjacent to the typed or legibly printed name.

12. Treatment Plan.

i. For each beneficiary admitted to treatment services, the LPHA or counselor shall prepare an individualized written initial treatment plan, based upon the information obtained in the intake and assessment process.

a. The LPHA or counselor shall attempt to engage the beneficiary to meaningfully participate in the preparation of the initial treatment plan and updated treatment plans.

i. The initial treatment plan and updated treatment plans shall include all of the following:

1. A statement of problems identified through the ASAM, other assessment tool(s) or intake documentation.
2. Goals to be reached which address each problem.
3. Action steps that will be taken by the provider and/or beneficiary to accomplish identified goals.
4. Target dates for the accomplishment of action steps and goals.
5. A description of the services, including the type of counseling, to be provided and the frequency thereof.
6. The assignment of a primary therapist or counselor.

7. The beneficiary's diagnosis as documented by the Medical Director or LPHA.
8. If a beneficiary has not had a physical examination within the 12-month period prior to the beneficiary's admission to treatment date, a goal that the beneficiary have a physical examination.
9. If documentation of a beneficiary's physical examination, which was performed during the prior 12 months, indicates a beneficiary has a significant medical illness, a goal that the beneficiary obtain appropriate treatment for the illness.

b. The provider shall ensure that the initial treatment plan meets all of the following requirements:
   i. The LPHA or counselor shall complete, type or legibly print their name, and sign and date the initial treatment plan within 30 calendar days of the admission to treatment date. The signature shall be adjacent to the typed or legibly printed name.
   ii. The beneficiary shall review, approve, type, or legibly print their name, sign and date the initial treatment plan, indicating whether the beneficiary participated in preparation of the plan, within 30 calendar days of the admission to treatment date.
      1. If the beneficiary refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment.
   iii. If a counselor completes the initial treatment plan, the Medical Director or LPHA shall review the initial treatment plan to determine whether services are medically necessary (as defined in Article IV) and appropriate for the beneficiary.

Exhibit A, Attachment I
Program Specifications

1. If the Medical Director or LPHA determines the services in the initial treatment plan are medically necessary, the Medical Director or LPHA shall type or legibly print their name, and sign and date the treatment plan within 15 calendar days of signature by the counselor. The signature shall be adjacent to the typed or legibly printed name.

ii. The provider shall ensure that the treatment plan is reviewed and updated as described below:

a. The LPHA or counselor shall complete, type, or legibly print their name, sign and date the updated treatment plan no later than 90 calendar days after signing the initial treatment plan, and no later than every 90 calendar days thereafter, or when there is a change in treatment modality or significant event, whichever comes first. The signature shall be adjacent to the typed or legibly printed name. The updated treatment plan shall be updated to reflect the current treatment needs of the beneficiary.

b. The beneficiary shall review, approve, type, or legibly print their name and, sign and date the updated treatment plan, indicating whether the beneficiary participated in preparation of the plan, within 30 calendar days of signature by the LPHA or counselor.

   i. If the beneficiary refuses to sign the updated treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment.

c. If a counselor completes the updated treatment plan, the Medical Director or LPHA shall review each updated treatment plan to determine whether continuing services are medically necessary (as defined in Article IV) and appropriate for the beneficiary.

   i. If the Medical Director or LPHA determines the services in the updated treatment plan are medically necessary, they shall type or legibly print their name and, sign and date the updated treatment plan, within 15 calendar days of

signature by the counselor. The signature shall be adjacent to the typed or legibly printed name.

13. Sign-in Sheet.

i. Establish and maintain a sign-in sheet for every group counseling session, which shall include all of the following:

a. The LPHA(s) and/or counselor(s) conducting the counseling session shall type or legibly print their name(s), sign, and date the sign-in sheet on the same day of the session. The signature(s) must be adjacent to the typed or legibly printed name(s). By signing the sign-in sheet, the LPHA(s) and/or counselor(s) attest that the sign-in sheet is accurate and complete.
b. The date of the counseling session.
c. The topic of the counseling session.
d. The start and end time of the counseling session.
e. A typed or legibly printed list of the participants' names and the signature of each participant that attended the counseling session. The participants shall sign the sign-in sheet at the start of or during the counseling session.

14. Progress Notes.

i. Progress notes shall be legible and completed as follows:

a. For outpatient services, Naltrexone treatment services, and recovery services, each individual and group session, the LPHA or counselor who conducted the counseling session or provided the service shall record a progress note for each beneficiary who participated in the counseling session or treatment service.
    i. The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven calendar days of the counseling session. The signature shall be adjacent to the typed or legibly printed name.
    ii. Progress notes are individual narrative summaries and shall include all of the following:
        1. The topic of the session or purpose of the service.

2. A description of the beneficiary's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals.
3. Information on the beneficiary's attendance, including the date, start and end times of each individual and group counseling session or treatment service.
4. Identify if services were provided in-person, by telephone, or by telehealth.
5. If services were provided in the community, identify the location and how the provider ensured confidentiality.

b. For intensive outpatient services and residential treatment services, the LPHA or counselor shall record, at a minimum, one progress note, per calendar week, for each beneficiary participating in structured activities including counseling sessions or other treatment services.
   i. The LPHA or counselor shall type or legibly print their name, and sign and date progress notes within the following calendar week. The signature shall be adjacent to the typed or legibly printed name.
   ii. Progress notes are individual narrative summaries and shall include all of the following:
      1. A description of the beneficiary's progress on the treatment plan, problems, goals, action steps, objectives, and/or referrals.
      2. A record of the beneficiary's attendance at each counseling session including the date, start and end times and topic of the counseling session.
      3. Identify if services were provided in-person, by telephone, or by telehealth.
      4. If services were provided in the community, identify the location and how the provider ensured confidentiality.

c. For each beneficiary provided case management services, the LPHA or counselor who provided the treatment service shall record a progress note.

i. The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven calendar days of the case management service. The signature shall be adjacent to the typed or legibly printed name.

ii. Progress notes shall include all of the following:
1. Beneficiary's name.
2. The purpose of the service.
3. A description of how the service relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referrals.
4. Date, start and end times of each service.
5. Identify if services were provided in-person, by telephone, or by telehealth.
6. If services were provided in the community, identify the location and how the provider ensured confidentiality.

d. For physician consultation services, additional medication assisted treatment, and withdrawal management, the Medical Director or LPHA working within their scope of practice who provided the treatment service shall record a progress note and keep in the beneficiary's file.

i. The Medical Director or LPHA shall type or legibly print their name, and sign and date the progress note within seven calendar days of the service. The signature shall be adjacent to the typed or legibly printed name.

ii. Progress notes shall include all of the following:
1. Beneficiary's name.
2. The purpose of the service.
3. Date, start and end times of each service.
4. Identify if services were provided face-to-face, by telephone or by telehealth.

15. Continuing Services.

i. Continuing services shall be justified as shown below:

a. For outpatient services, intensive outpatient services, Naltrexone treatment, and case management:

i. For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or

the date of completion of the most recent justification for continuing services, the LPHA or counselor shall review the beneficiary's progress and eligibility to continue to receive treatment services, and recommend whether the beneficiary should or should not continue to receive treatment services at the same level of care.

ii. For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the Medical Director or LPHA shall determine medical necessity for continued services for the beneficiary. The determination of medical necessity shall be documented by the Medical Director or LPHA in the beneficiary's individual patient record and shall include documentation that all of the following have been considered:
   1. The beneficiary's personal, medical and substance use history.
   2. Documentation of the beneficiary's most recent physical examination.
   3. The beneficiary's progress notes and treatment plan goals.
   4. The LPHA’s or counselor's recommendation pursuant to Paragraph (i) above.
   5. The beneficiary's prognosis.
      i. The Medical Director or LPHA shall type or legibly print their name, and sign and date the continuing services information when completed. The signature shall be adjacent to the typed or legibly printed name.

iii. If the Medical Director or LPHA determines that continuing treatment services for the beneficiary is not medically necessary, the provider shall discharge the beneficiary from

the current LOC and transfer to the appropriate services.

b. Residential services length of stay shall be in accordance with Article III.H of this Agreement.

16. Discharge.

i. Discharge of a beneficiary from treatment may occur on a voluntary or involuntary basis. For outpatient services, intensive outpatient services and residential services, in addition to the requirements of this subsection, an involuntary discharge is subject to the requirements set forth in Article II.G.2 of this Agreement.

ii. An LPHA or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom the provider loses contact.

a. The discharge plan shall include, but not be limited to, all of the following:
   i. A description of each of the beneficiary's relapse triggers.
   ii. A plan to assist the beneficiary to avoid relapse when confronted with each trigger.
   iii. A support plan.

b. The discharge plan shall be prepared within 30 calendar days prior to the scheduled date of the last face-to-face treatment with the beneficiary.
   i. If a beneficiary is transferred to a higher or lower level of care based on ASAM criteria within the same DMC certified program, they are not required to be discharged unless there has been more than a 30-calendar day lapse in treatment services.

c. During the LPHA's or counselor's last face-to-face treatment with the beneficiary, the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. The signatures shall be adjacent to the typed or legibly printed name. A copy of the discharge plan shall be provided to the beneficiary and documented in the beneficiary record.

iii. The LPHA or counselor shall complete a discharge summary, for any beneficiary with whom the provider lost contact, in accordance with all of the following requirements:

a. The LPHA or counselor shall complete the discharge summary within 30 calendar days of the date of the last face-to-face treatment contact with the beneficiary.
b. The discharge summary shall include all of the following:
    i. The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment.
    ii. The reason for discharge.
    iii. A narrative summary of the treatment episode.
    iv. The beneficiary's prognosis.

17. Reimbursement of Documentation.

i. If the Contractor allows for the inclusion of the time spent documenting when billing for a unit of service delivered, the Contractor shall require its subcontractor to require providers to include the following information in their progress notes:
  a. The date the progress note was completed.
  b. The start and end time of the documentation of the progress note.

ii. Documentation activities shall be billed as a part of the covered service unit.

IV. Definitions

A. The words and terms of this Intergovernmental Agreement are intended to have their usual meaning unless a specific or more limited meaning is associated with their usage pursuant to the HSC, Title 6.

1. ***"Abuse"*** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

2. ***"Adolescents"*** means beneficiaries between the ages of twelve and under the age of twenty-one.

3. ***"Administrative Costs"*** means the Contractor's actual direct

costs, as recorded in the Contractor's financial records and supported by source documentation, to administer the program or an activity to provide service to the DMC-ODS program. Administrative costs do not include the cost of treatment or other direct services to the beneficiary. Administrative costs may include, but are not limited to, the cost of training, programmatic and financial audit reviews, and activities related to billing. Administrative costs may include Contractor's overhead per the approved indirect cost rate proposal pursuant to OMB Omni-Circular and the State Controller's Office Handbook of Cost Plan Procedures.

4. ***"Adverse benefit determination"*** means, in the case of an MCO, PIHP, or PAHP, any of the following:
   (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
   (2) The reduction, suspension, or termination of a previously authorized service.
   (3) The denial, in whole or in part, of payment for a service.
   (4) The failure to provide services in a timely manner, as defined by the state.
   (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.
   (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network.
   (7) The denial of an enrollee's request to dispute a financial liability, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

5. ***"Appeal"*** is the request for review of an adverse benefit determination.

6. ***"ASAM Assessment"*** means an assessment that utilizes the published ASAM criteria for the purpose of determining a level of care.

Exhibit A, Attachment I
Program Specifications

7. ***"ASAM Criteria-Medical Necessity"*** pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. It should not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs (as in Dimension 2); or Dimension 3 psychiatric issues (such as imminent suicidality). Rather, "medical necessity" encompasses all six assessment dimensions so that a more holistic concept would be "Clinical Necessity," "necessity of care," or "clinical appropriateness."
8. ***"Authorization"*** is the approval process for DMC-ODS Services prior to the submission of a DMC claim.
9. ***"Available Capacity"*** means the total number of units of service (bed days, hours, slots, etc.) that a Contractor actually makes available in the current fiscal year.
10. ***"Beneficiary"*** means a person who: (a) has been determined eligible for Medi-Cal; (b) is not institutionalized; (c) has a substance-related disorder per the current "Diagnostic and Statistical Manual of Mental Disorders (DSM)" criteria; and (d) meets the admission criteria to receive DMC covered services.
11. ***"Beneficiary/Enrollee Encounter Data"*** means the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a state and a MCO, PIHP, or PAHP that is subject to the requirements of §§438.242 and 438.818.
12. ***"Beneficiary Handbook"*** is the state developed model enrollee handbook.
13. ***"Calendar Week"*** means the seven-day period from Sunday through Saturday.
14. ***"Case Management"*** means a service to assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.
15. ***"Certified Provider"*** means a substance use disorder clinic location that has received certification to be reimbursed as a DMC clinic by the state to provide services as described in Title 22, California Code of Regulations, Section 51341.1.

16. ***"Collateral Services"*** means sessions with therapists or counselors and significant persons in the life of a beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.

17. ***"Complaint"*** means requesting to have a problem solved or have a decision changed because you are not satisfied. A complaint is sometimes called a grievance or an appeal.

18. ***"Contractor"*** means the county identified in this Agreement and responsible for adhering to and ensuring full compliance with all terms and conditions of this Agreement.

19. ***"Corrective Action Plan (CAP)"*** means the written plan of action document which the Contractor, or its subcontractor develops and submits to DHCS to address or correct a deficiency or process that is non-compliant with laws, regulations or standards.

20. ***"County"*** means a county that participates in DMC-ODS.

21. ***"County Realignment Funds"*** means Behavioral Health Subaccount funds received by the County as per California Code Section 30025.

22. ***"Crisis Intervention"*** means a contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance, which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the beneficiary's emergency.

23. ***"Days"*** means calendar days, unless otherwise specified.

24. ***"Dedicated Capacity"*** means the historically calculated service capacity, by modality, adjusted for the projected expansion or reduction in services, which the Contractor agrees to make available to provide DMC-ODS services to persons eligible for Contractor services.

25. ***"Discharge services"*** means the process to prepare the beneficiary for referral into another level of care, post treatment

return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

26. ***"Discrimination Grievance"*** means a complaint concerning the unlawful discrimination on the basis of any characteristic protected under federal or state law, including 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.

27. ***"DMC-ODS Services"*** means those DMC services authorized by Title XIX or Title XXI of the Social Security Act; Title 22 Section 51341.1; WIC 14124.24; and California's Medicaid State Plan, including the DMC ODS 1115 Demonstration Waiver special terms and conditions.

28. ***"Drug Medi-Cal Organized Delivery System"*** is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program. DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a county that opts into the Pilot program. Upon approval of an implementation plan, the state shall contract with the county to provide DMC-ODS services. The county shall, in turn, contract with DMC certified providers or provide county-operated services to provide all services outlined in the DMC-ODS. Counties may also contract with a managed care plan to provide services. Participating counties with the approval from the state may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design or comparability of services. Counties may act jointly in order to deliver these services.

29. ***"Drug Medi-Cal Program"*** means the state system wherein beneficiaries receive covered services from DMC-certified substance use disorder treatment providers.

30. ***"Drug Medi-Cal Termination of Certification"*** means the provider is no longer certified to participate in the Drug Medi-Cal program upon the state's issuance of a Drug Medi-Cal certification termination notice.

31. ***"Early Periodic Screening, Diagnosis, and Treatment Program***

(EPSDT)" means the federal mandate under Section 1905(r) of the Social Security Act, which requires the Contractor to ensure that all beneficiaries under age 21 receive all applicable medically necessary services needed to correct and ameliorate health conditions that are coverable under Section 1905(a) of the Social Security Act.

32. ***"Education and Job Skills"*** means linkages to life skills, employment services, job training, and education services.

33. ***"Emergency medical condition"*** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:
(1) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
(2) Serious impairment to bodily functions.
(3) Serious dysfunction of any bodily organ or part.

34. ***"Emergency services"*** means covered inpatient and outpatient services that are as follows:
(1) Furnished by a provider that is qualified to furnish these services under Title 42.
(2) Needed to evaluate or stabilize an emergency medical condition.

35. ***"Excluded Services"*** means services that are not covered under this Agreement.

36. ***"Face-to-Face"*** means a service occurring in person.

37. ***"Family Support"*** means linkages to childcare, parent education, child development support services, and family and marriage education.

38. ***"Family Therapy"*** means including a beneficiary's family members and loved ones in the treatment process, and education about factors that are important to the beneficiary's recovery as well as their own recovery can be conveyed. Family members may provide

social support to beneficiaries, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

39. ***"Fair Hearing"*** means the state hearing provided to beneficiaries upon denial of appeal pursuant to 22 CCR 50951 and 50953 and 9 CCR 1810.216.6. Fair hearings shall comply with 42 CFR 431.220(a)(5), 438.408(f), 438.414, and 438.10(g)(1).

40. ***"Federal Financial Participation (FFP)"*** means the share of federal Medicaid funds for reimbursement of DMC services.

41. ***"Final Settlement"*** means permanent settlement of the Contractor's actual allowable costs or expenditures as determined at the time of audit, which shall be completed within three years of the date the year-end cost settlement report was accepted for interim settlement by the state. If the audit is not completed within three years, the interim settlement shall be considered as the final settlement.

42. ***"Fraud"*** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or state law.

43. ***"Grievance"*** means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.

44. ***"Grievance and Appeal System"*** means the processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

45. ***"Group Counseling"*** means contacts in which one or more therapists or counselors treat two or more clients at the same time

with a maximum of 12 in the group, focusing on the needs of the individuals served. A beneficiary that is 17 years of age or younger shall not participate in-group counseling with any participants who are 18 years of age or older. However, a beneficiary who is 17 years of age or younger may participate in group counseling with participants who are 18 years of age or older when the counseling is at a provider's certified school site.

46. ***"Hospitalization"*** means that a patient needs a supervised recovery period in a facility that provides hospital inpatient care.

47. ***"Individual Counseling"*** means contact between a beneficiary and a therapist or counselor. Services provided in-person, by telephone or by telehealth qualify as Medi-Cal reimbursable units of service, and are reimbursed without distinction.

48. ***"Intake"*** means the process of determining whether a beneficiary meets the medical necessity criteria and whether a beneficiary is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for substance use disorder treatment and evaluation.

49. ***"Intensive Outpatient Services"*** means (ASAM Level 2.1) structured programming services consisting primarily of counseling and education about addiction-related problems a minimum of nine (9) hours with a maximum of 19 hours per week for adults, and a minimum of six (6) hours with a maximum of 19 hours per week for adolescents. Services may be provided in any appropriate setting in the community. Services may be provided in-person, by telephone or by telehealth. Also known as Intensive Outpatient Treatment.

50. ***"Interim Settlement"*** means temporary settlement of actual allowable costs or expenditures reflected in the Contractor's year-end cost settlement report.

51. ***"Key Points of Contact"*** means common points of access to substance use treatment services from the county, including but not limited to the county's beneficiary problem resolution process,

county owned or operated or contract hospitals, and any other central access locations established by the county.

52. ***"Long-Term Services and Supports (LTSS)"*** means services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

53. ***"Licensed Practitioners of the Healing Arts (LPHA)"*** includes Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

54. ***"Managed Care Organization (MCO)"*** means an entity that has, or is seeking to qualify for, comprehensive risk contract under 42 CFR part 438, and that is-
    (1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of Title 20 Chapter 4; or
    (2) Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:
        (i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.
        (ii) Meets the solvency standards of the §438.116.

55. ***"Managed Care Program"*** means a managed care delivery system operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act.

56. ***"Maximum Payable"*** means the encumbered amount reflected on the Standard Agreement of this Agreement and supported by Exhibit B, Attachment I.

57. ***"Medical Necessity" and "Medically Necessary Services"*** means those SUD treatment services that are reasonable and

necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of a disease, illness, or injury consistent with 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Section 1905(r) of the Social Security Act.

58. ***"Medical Necessity Criteria"*** means adult beneficiaries must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, and must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria. Adults shall meet the ASAM Adult Dimensional Admission Criteria. Beneficiaries under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health.

59. ***"Medical psychotherapy"*** means a type of counseling service that has the same meaning as defined in 9 CCR § 10345.

60. ***"Medication Services"*** means the prescription or administration of medication related to substance use disorder treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services.

61. ***"Modality"*** means those necessary overall general service activities to provide substance use disorder services as described in Division 10.5 of the HSC.

62. ***"Opioid (Narcotic) Treatment Program"*** means an outpatient clinic licensed by the state to provide narcotic replacement therapy directed at stabilization and rehabilitation of persons who are opiate-addicted and have a substance use diagnosis.

63. ***"Naltrexone Treatment Services"*** means an outpatient treatment service directed at serving detoxified opiate addicts by using the drug Naltrexone, which blocks the euphoric effects of opiates and helps prevent relapse to opiate addiction.

Exhibit A, Attachment I
Program Specifications

64. ***"Network"*** means the group of entities that have been contracted to provide services under this Agreement.

65. ***"Network Provider"*** means any provider, group of providers, or entity that has a network provider agreement with the Subcontractor, Partnership HealthPlan of California, to provide covered services to beneficiaries, and receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the State's agreement with the Contractor.

66. ***"Non-participating provider"*** means a provider that is not engaged in the continuum of services under this Agreement.

67. ***"Non-Perinatal Residential Program"*** services are provided in DHCS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria. These residential services are provided to the non-perinatal population and do not require the enhanced services found in the perinatal residential programs.

68. ***"Non-Quantitative Treatment Limitation (NQTL)"*** means a limit on the scope or duration of benefits that is not expressed numerically. Non-quantitative treatment limitations include:

    a. Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
    b. Formulary design for prescription drugs;
    c. Network tier design;
    d. Standards for provider admission to participate in a network, including reimbursement rates;
    e. Methods for determining usual, customary, and reasonable charges;
    f. Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
    g. Exclusions based on failure to complete a course of treatment;

h. Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services; and
i. Standards for providing access to out-of-network providers.

69. ***“Nonrisk Contract”*** means a contract between the state and a PIHP or PAHP under which the Contractor-
    (1) Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR 447.362, and
    (2) May be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits

70. ***“Notice of Adverse Benefit Determination (NOABD)”*** means a formal communication of any action and consistent with 42 CFR 438.404 and 438.10.

71. ***“Observation”*** means the process of monitoring the beneficiary’s course of withdrawal. It is to be conducted as frequently as deemed appropriate for the beneficiary and the level of care the beneficiary is receiving. This may include but is not limited to observation of the beneficiary’s health status.

72. ***“Outpatient Services”*** means (ASAM Level 1.0) outpatient service directed at stabilizing and rehabilitating persons up to nine hours of service per week for adults, and less than six hours per week for adolescents.

73. ***“Overpayment”*** means any payment made to a subcontractor or network provider by a MCO, PIHP, or PAHP to which the subcontractor or network provider is not entitled to under Title XIX of the Act or any payment to a MCO, PIHP, or PAHP by a state to which the MCO, PIHP, or PAHP is not entitled to under Title XIX of the Act.

74. ***“Patient Education”*** means providing research based education on addiction, treatment, recovery and associated health risks.

75. ***“Participating provider”*** means a provider that is engaged in the continuum of services under this Agreement.

76. ***“Payment Suspension”*** means the Drug Medi-Cal certified provider has been issued a notice pursuant to WIC 14107.11 and is

not authorized to receive payments after the payment suspension date for DMC services, regardless of when the service was provided.

77. ***"Performance"*** means providing the dedicated capacity in accordance with Exhibit B, Attachment I, and abiding by the terms of this Exhibit A, including all applicable state and federal statutes, regulations, and standards, including Alcohol and/or Other Drug Certification Standards (Document 1P), if applicable, in expending funds for the provision of SUD services hereunder.

78. ***"Perinatal DMC Services"*** means covered services as well as mother/child habilitative and rehabilitative services; services access (i.e., provision or arrangement of transportation to and from medically necessary treatment); education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant; and coordination of ancillary services (Title 22, Section 51341.1(c)(4)).

79. ***"Physician"*** as it pertains to the supervision, collaboration, and oversight requirements in sections 1861(aa)(2)(B) and (aa)(3) of the Act, a doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the State in which the function is performed.

80. ***"Physician Consultation"*** services are to support DMC physicians with complex cases, which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

81. ***"Physician services"*** means services provided by an individual licensed under state law to practice medicine.

82. ***"Plan"*** means any written arrangement, by one or more entities, to provide health benefits or medical care or assume legal liability for injury or illness.

83. ***"Postpartum"*** as defined for DMC purposes, means the 60-day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility for perinatal services shall end on the last day of the calendar month in which the 60th day occurs.

84. ***"Postservice Postpayment (PSPP) Utilization Review"*** means

the review for program compliance and medical necessity, conducted by the state after service was rendered and paid. The Department may recover prior payments of Federal and state funds if such a review determines that the services did not comply with the applicable statutes, regulations, or terms as specified in Article III.PP of this Agreement.

85. ***"Potential Beneficiary/Enrollee"*** means a Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given MCO, PIHP, PAHP, PCCM or PCCM entity, but is not yet an enrollee of a specific MCO, PIHP, PAHP, PCCM, or PCCM entity.

86. ***"Preauthorization"*** means approval by the Plan that a covered service is medically necessary.

87. ***"Prepaid Ambulatory Health Plan (PAHP)"*** means an entity that:
(1) Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State Plan payment rates.
(2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and
(3) Does not have a comprehensive risk contract.

88. ***"Prepaid Inpatient Health Plan (PIHP)"*** means an entity that:
(1) Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State Plan payment rates.
(2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and
(3) Does not have a comprehensive risk contract.

89. ***"Prescription drugs"*** means simple substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are:
(1) Prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law;
(2) Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and

(3) Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist or practitioner's records.

90. ***"Primary Care"*** means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

91. ***"Primary Care Case Management Entity (PCCM entity)"*** means an organization that provides any of the following functions, in addition to primary care case management services, for the state:

(1) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line.
(2) Development of enrollee care plans.
(3) Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program.
(4) Provision of payments to FFS providers on behalf of the state.
(5) Provision of enrollee outreach and education activities.
(6) Operation of a customer service call center.
(7) Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement.
(8) Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.
(9) Coordination with behavioral health systems/providers.
(10) Coordination with long-term services and supports systems/providers.

92. ***"Primary Care Case Manager (PCCM)"*** means a physician, a physician group practice or, at State option, any of the following:

(1) A physician assistant
(2) A nurse practitioner
(3) A certified nurse-midwife

93. ***"Primary care physician (PCP)"*** means a Physician responsible for supervising, coordinating, and providing initial and Primary Care to patients and serves as the medical home for Members. The PCP

is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist.

94. ***"Primary care provider"*** means a person responsible for supervising, coordinating, and providing initial and Primary Care to patients, for initiating referrals, and for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.

95. ***"Projected Units of Service"*** means the number of reimbursable DMC units of service, based on historical data and current capacity, the Contractor expects to provide on an annual basis.

96. ***"Provider"*** means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services.

97. ***"Provider-preventable condition"*** means a condition that meets the definition of a health care-acquired condition — a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary under section 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State Plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients — or an "other provider-preventable condition," which is defined as a condition occurring in any health care setting that meets the following criteria:
(1) Is identified in the State Plan.
(2) Has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
(3) Has a negative consequence for the beneficiary.
(4) Is auditable.
(5) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

98. **"Quality Assurance/Utilization Review (QA/UR)"** activities are

reviews of physicians, health care practitioners and providers of health care services in the provision of health care services and items for which payment may be made to determine whether:

(1) Such services are or were reasonable and medically necessary and whether such services and items are allowable.

(2) The quality of such services meets professionally recognized standards of health care.

99. ***"Quantitative Treatment Limitation (QTL)"*** means a limit on the scope or duration of a benefit that is expressed numerically.

100. ***"Re-certification"*** means the process by which the DMC certified clinic is required to submit an application and specified documentation, as determined by DHCS, to remain eligible to participate in and be reimbursed through the DMC program. Re-certification shall occur no less than every five years from the date of previous DMC certification or re-certification.

101. ***"Recovery monitoring"*** means recovery coaching, monitoring via telephone and internet. Recovery monitoring is only available in Recovery services.

102. ***"Recovery Services"*** are available after the beneficiary has completed a course of treatment. Recovery services emphasize the patient'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 patients.

103. ***"Rehabilitation Services"*** includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.

104. ***"Relapse"*** means a single instance of a beneficiary's substance use or a beneficiary's return to a pattern of substance use.

105. ***"Relapse Trigger"*** means an event, circumstance, place or person that puts a beneficiary at risk of relapse.

Exhibit A, Attachment I
Program Specifications

106. ***"Residential Treatment Services"*** means a non-institutional, 24-hour non-medical, short-term residential program of any size that provides rehabilitation services to beneficiaries. Each beneficiary 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. Programs shall provide a range of activities and services. Residential treatment shall include 24-hour structure with available trained personnel, seven days a week, including a minimum of five hours of clinical service a week to prepare beneficiary for outpatient treatment.

107. ***"Revenue"*** means Contractor's income from sources other than the state allocation.

108. ***"Safeguarding medications"*** means facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.

109. ***"Service Area"*** means the geographical area under the jurisdiction of this Agreement.

110. ***"Service Authorization Request"*** means a beneficiary's request for the provision of a service.

111. ***"Short-Term Resident"*** means any beneficiary receiving residential services pursuant to DMC-ODS, regardless of the length of stay, is a "short-term resident" of the residential facility in which they are receiving the services.

112. ***"State"*** means the Department of Health Care Services or DHCS.

113. ***"Subcontract"*** means an agreement between the Contractor and its subcontractors.

114. ***"Subcontractor"*** means an individual or entity that has a contract with the Contractor that relates directly or indirectly to the performance of the Contractor's obligations under its agreement with the State. For the purposes of this Agreement, Partnership HealthPlan of California is the sole subcontractor.

115. ***"Substance Abuse Assistance"*** means peer-to-peer services and relapse prevention. Substance abuse assistance is only available in Recovery services.

116. ***"Substance Use Disorder Diagnoses"*** are those set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.

117. ***"Substance Use Disorder Medical Director"*** has the same meaning as in 22 CCR § 51000.24.4.

118. ***"Support Groups"*** means linkages to self-help and support, spiritual and faith-based support.

119. ***"Support Plan"*** means a list of individuals and/or organizations that can provide support and assistance to a beneficiary to maintain sobriety.

120. ***"Telehealth between Provider and Beneficiary"*** means office or outpatient visits via interactive audio and video telecommunication systems.

121. ***"Telehealth between Providers"*** means communication between two providers for purposes of consultation, performed via interactive audio and video telecommunications systems.

122. ***"Temporary Suspension"*** means the provider is temporarily suspended from participating in the DMC program as authorized by WIC 14043.36(a). The provider cannot bill for DMC services from the effective date of the temporary suspension.

123. ***"Threshold Language"*** means a language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

124. ***"Transportation Services"*** means provision of or arrangement for transportation to and from medically necessary treatment.

125. ***"Unit of Service"*** means:
(A) For case management, intensive outpatient treatment, outpatient services, Naltrexone treatment services, and recovery services contact with a beneficiary in 15-minute increments on a calendar day.
(B) For additional medication assisted treatment, physician services that includes ordering, prescribing, administering, and monitoring of all medications for substance use disorders per visit

or in 15-minute increments.
(C) For narcotic treatment program services, a calendar month of treatment services provided pursuant to this section and Chapter 4 commencing with 9 CCR § 10000.
(D) For physician consultation services, consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists in 15-minute increments.
(E) For residential services, providing 24-hour daily service, per beneficiary, per bed rate.
(F) For withdrawal management per beneficiary per visit/daily unit of service.

126. ***"Urgent care"*** means a condition perceived by a beneficiary as serious, but not life threatening. A condition that disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 24-72 hours.

127. ***"Utilization"*** means the total actual units of service used by beneficiaries and participants.

128. ***"Withdrawal Management"*** means detoxification services provided in either an ambulatory or non-ambulatory setting consistent with the ASAM level of care criteria to DMC ODS beneficiaries.

V. Contractor Specific Requirements

The Contractor shall contract with the Subcontractor, Partnership HealthPlan of California, to deliver DMC-ODS services using network providers as outlined in Exhibit A, Attachment I.

Beginning July 1, 2020 and ending June 30, 2023, in addition to the general requirements outlined in Exhibit A, Attachment I, the Contractor agrees to the following Contractor specific requirements:

A. Covered Services

In addition to the Mandatory DMC-ODS Covered Services outlined in Article III.C of Exhibit A, Attachment I, the Contractor shall establish assessment and referral procedures and shall arrange, provide, or subcontract for medically necessary

Contractor specific covered services in the service area in compliance with 42 CFR 438.210(a)(1), 438.210(a)(2), and 438.210(a)(3).

1. The Contractor shall ensure delivery of the Contractor specific covered services within a continuum of care as defined in the American Society of Addiction Medicine (ASAM) criteria.

2. Contractor specific covered services include:

   i. Additional Medication Assisted Treatment (MAT)

B. Access to Services

In addition to the general access to services requirements outlined in Article III.F of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific access to services requirements:

1. Beneficiary Access Line (BAL) also known as the Central Access Line

   i. The Contractor shall provide a toll-free 24/7 BAL to beneficiaries seeking access to Substance Use Disorder (SUD) services.

   ii. The Contractor's BAL shall provide oral and audio-logical (TTY/TDY) translations in the beneficiary's primary language.

   iii. The Contractor shall publish the BAL information on the Contractor's web page, on all information brochures, and prevention materials in all threshold languages.

   iv. The BAL shall provide 24/7 referrals to services for urgent conditions and medical emergencies.

   v. The Contractor shall ensure an "after hours" phone line is available to address urgent situations and to facilitate links to DMC-ODS services.

2. The Contractor shall allow the beneficiary point of entry through the BAL. Alternatively, the Contractor shall allow beneficiaries to appear in person at any network provider.

   i. The Contractor shall ensure a brief screening to beneficiaries through the BAL to determine whether there is sufficient information to make a referral to the provisional ASAM Level of Care (LOC) or whether a face-to-face

Exhibit A, Attachment I
Program Specifications

ASAM assessment is necessary to determine the beneficiary's appropriate LOC.

ii. Beneficiaries screened as having an urgent need (non-emergency) shall be referred for an appointment with a qualified staff within 48 hours.

iii. The BAL shall be staffed by registered/certified counselors or LPHAs during normal business hours. These staff shall work with beneficiaries and supervise and support non-clinical BAL staff.

iv. The Contractor shall allow beneficiaries to appear in person at any network provider and provide same-day ASAM assessments, if available.

a. The Contractor shall ensure network providers facilitate a call to the BAL, if the network providers do not have qualified (LPHA or LPHA-supervised and ASAM trained) staff available for beneficiary screening and assessment.

v. For beneficiaries scheduled for a face-to-face assessment, the Contractor shall ensure the network providers use a biopsychosocial and comprehensive ASAM assessment to confirm the beneficiary's medical necessity and appropriate ASAM LOC.

vi. The Contractor shall ensure that assessments are conducted by an LPHA or by a registered/certified alcohol and drug counselor and reviewed by the LPHA or Medical Director.

vii. The Contractor shall ensure staff performing the ASAM criteria interviews must, at a minimum, have completed ASAM training Modules 1 (Multidimensional Assessment) and 2 (From Assessment to Service Planning) and provide evidence of successful completion prior to claiming for reimbursement for assessment services.

viii. The Medical Director, a licensed physician, or a LPHA must diagnose the beneficiary as having at least one DSM 5 substance use disorder.

ix. Medical necessity for DMC-ODS services shall be determined as part of the assessment process and shall be performed through a face-to-face interview or via telehealth.

x. In the event that the comprehensive ASAM assessment yields an ASAM LOC recommendation that does not agree with the screening assessment

result, the Contractor shall ensure transition of the beneficiary to the appropriate LOC.

xi. The Contractor shall ensure the initial network provider facilitates a "warm hand-off" to support completion of the full ASAM assessment and enrollment in DMC-ODS services, if the brief screening assessment and the full ASAM assessment involve different providers.

xii. If the entity screening or assessing the beneficiary determines that the medical necessity criteria, pursuant to DMC-ODS Special Terms and Conditions (STCs) 132 (e), has not been met, then a written Notice of Adverse Benefit Determination shall be issued in accordance with 42 CFR 438.404.

C. Timely Access

In addition to the general timely access requirements outlined in Article II.E of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific timely access requirements:

1. Time and Distance Requirements

i. The Contractor shall adhere to, in all geographic areas within the county, all applicable time and distance standards for network providers developed by the Department, including those set forth in WIC Section 14197 and any Information Notices pursuant to that section.

2. Timely Access Requirements

i. For outpatient and intensive outpatient services, the Contractor shall ensure a face-to-face appointment within ten business days of the service authorization request.

ii. For OTP, the Contractor shall ensure a face-to-face appointment within three business days of the service authorization request.

iii. The Contractor shall have policies and procedures in place to screen for emergency medical conditions and immediately refer beneficiaries to emergency medical care. The Contractor shall ensure that the subcontractor and network providers comply with the Contractor's policies and procedures.

3. Network Adequacy

i. The Contractor shall comply with the Department's network adequacy standards outlined in Article II.C of this Exhibit A, Attachment I.

4. Non-Compliance

i. In the event of non-compliance with network adequacy requirements, the Contractor shall provide the subcontractor or network providers technical assistance to adhere to the requirements. Contractor shall also issue a written report documenting the non-compliance and require the network provider or the subcontractor to submit a Corrective Action Plan (CAP) within 30 days of the report. The Contractor shall be responsible for approving the CAP and verifying corrections have been made to resolve the applicable network adequacy requirements.

D. Coordination of Care

In addition to the general coordination and continuity of care requirements outlined in Article III.G of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific coordination and continuity of care requirements:

1. The Contractor shall ensure all beneficiaries are reassessed, as often as necessary.

i. Comprehensive ASAM assessments are generally valid for 180 days.

ii. The Contractor shall require reassessments for those who return to the DMC-ODS following a break in treatment (discharge).

iii. Treatment Plans shall be reevaluated, at a minimum, every 90 days, unless there are significant changes warranting reassessments. Changes that could warrant a reassessment and possibly a transfer to a higher or lower LOC include, but are not limited to, the following:

a. Achieving treatment plan goals.
b. Inability to achieve treatment plan goals despite amendments to the treatment plan.
c. Identification of intensified or new problems that cannot adequately be addressed in the current level of care.
d. Lack of beneficiary capacity to resolve problems.

e. At the request of the beneficiary.

2. The Contractor shall ensure the Contractor's and network providers' Case Managers transition the beneficiaries to appropriate LOC. This may include step-up or step-down in SUD treatment services. Case managers shall provide warm hand-offs and arrange for transportation to the new LOC, when medically necessary and documented in the individualized treatment plan.

3. The Contractor shall ensure all Case Managers transition beneficiaries to the appropriate LOC, within 10 business days from the time of assessment or reassessment, with no interruption of current treatment services.

4. The Contractor shall ensure a beneficiary's transition of care to a network provider when that beneficiary has received, and no longer requires, inpatient SUD services (ASAM level 3.7 and 4.0 services) in an acute care hospital, or another Fee for Service (FFS) facility, when the network provider is notified by the facility.

5. The Contractor shall ensure a beneficiary's transition of care to a network provider when that beneficiary has received, and no longer requires, inpatient SUD services (ASAM level 3.7 and 4.0 services) in a Chemical Dependency Recovery Hospital (CDRH) or Acute Freestanding Psychiatric hospital, when the network provider is notified by the facility.

E. Authorization of Services – Residential Programs

In addition to the general authorization of residential services requirements outlined in Article III.H of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific authorization of residential services requirements

1. The Contractor shall ensure prior authorization determinations for residential treatment are processed within 24 hours of the service authorization request.

2. The Contractor shall ensure the beneficiaries meet the DSM and ASAM criteria requirements to receive residential services.

3. Either a Medical Director or an LPHA shall determine medical necessity for beneficiaries presenting for residential treatment.

4. The Contractor shall ensure beneficiaries are continually assessed throughout treatment and prior to the end of the initial authorization period.
   i. Lengths of stay shall vary according to the assessed medical need for each beneficiary.
   ii. The provider shall submit either a discharge plan or a request for continued residential services to the Contractor.
5. The Contractor shall ensure written notice is given to the beneficiary of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, determined by medical necessity.

F. Outpatient Services (ASAM Level 1)

In addition to the general outpatient services requirements outlined in Article III. O of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific outpatient services requirements:

1. The Contractor shall ensure the network providers deliver outpatient services (ASAM Level 1) to beneficiaries (up to nine hours a week for adults, and less than six hours a week for adolescents) when determined by a Medical Director or an LPHA to be medically necessary, and in accordance with an individualized treatment plan.
2. The network providers may deliver outpatient services in-person or by telephone by a licensed professional or a registered or certified counselor in any appropriate setting in the community, in accordance with HIPAA and 42 CFR Part 2.
3. The components of outpatient services include intake, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, treatment planning and discharge services.
4. The Contractor shall ensure case management services are provided to beneficiaries receiving outpatient services to coordinate care with ancillary service providers and facilitate transitions between LOC.

G. Intensive Outpatient Services (ASAM Level 2.1)

Exhibit A, Attachment I
Program Specifications

In addition to the general intensive outpatient services requirements outlined in Article III.P of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific intensive outpatient services requirements:

1. The Contractor shall ensure the network providers deliver intensive outpatient services (ASAM Level 2.1) to adult beneficiaries a minimum of nine hours with a maximum of 19 hours a week, when determined by a Medical Director or an LPHA to be medically necessary, and in accordance with an individualized treatment plan.

i. The network providers may provide more than 19 hours per week to adults when determined by a Medical Director or an LPHA to be medical necessary, and in accordance with the individualized treatment plan.

ii. The network providers may extend a beneficiary's length of treatment when determined by a Medical Director or an LPHA to be medically necessary, and in accordance with the individualized treatment plan.

2. The Contractor shall ensure the network providers deliver intensive outpatient services (ASAM Level 2.1) to adolescent beneficiaries a minimum of six hours with a maximum of 19 hours a week, when determined by a Medical Director or an LPHA to be medically necessary, and in accordance with an individualized treatment plan.

i. The network providers may provide more than 19 hours per week to adolescents when determined by a Medical Director or an LPHA to be medical necessary, and in accordance with the individualized treatment plan.

ii. The network providers may extend a beneficiary's length of treatment when determined by a Medical Director or an LPHA to be medically necessary, and in accordance with the individualized treatment plan.

3. The network providers may deliver intensive outpatient services in-person or by telephone by a licensed professional or a certified counselor in any appropriate setting in the community in accordance with HIPAA and 42 CFR Part 2.

4. Intensive outpatient services include counseling and education about addiction-related problems, with specific components including intake, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, treatment planning, and discharge services.

5. The Contractor shall ensure case management services are available for beneficiaries receiving intensive outpatient services to facilitate help with coordination of care with ancillary service providers and facilitate transitions between LOCs.

H. Residential Treatment Services

In addition to the general residential treatment services requirements outlined in Article III.Q of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific residential treatment services requirements:

1. The Contractor shall ensure the network providers deliver residential services to non-perinatal and perinatal beneficiaries in DHCS licensed residential facilities that have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.

2. The Contractor shall make ASAM LOC Designations for 3.1 (Clinically Managed Low-Intensity Residential Services) and 3.5 (Clinically Managed High-Intensity Residential Services) available for adult and adolescent (18 and over) beneficiaries.

3. The Contractor shall make available to adolescent beneficiaries (ages 17 and under) ASAM LOC designations for 3.1 (Clinically Managed Low-Intensity Residential Services).

   i. The Contractor shall make available ASAM LOC 3.1 for adolescent beneficiaries (ages 17 and under) with a network provider by or before the end of the second year of this Intergovernmental Agreement. In the interim, the Contractor shall ensure beneficiaries are referred to an out-of-network provider.

4. The Contractor shall make ASAM LOC Designation for 3.3 (Clinically Managed Population-Specific High-Intensity Residential Services) available for beneficiaries by or before the end of year three of this Intergovernmental Agreement.

5. For ASAM LOC 3.7 (Medically Monitored Intensive Inpatient Services) and ASAM LOC 4.0 (Medically Managed Intensive Inpatient Services), the Contractor shall coordinate care. In all instances, the Contractor shall ensure

42 CFR Part 2 compliant releases are in place to coordinate care with inpatient and out-of-county facilities accepting DMC beneficiaries.

6. The length of residential services ranges from one to 90 days with a 90-day maximum for adults, unless medical necessity authorizes a one-time extension of up to 30 days on an annual basis.

7. For adult beneficiaries, only two non-continuous 90-day regimens shall be authorized in a one-year period.

8. Pursuant to STC 138 (c), perinatal clients shall receive lengths of stay up to the length of the pregnancy and postpartum period (60 days after the pregnancy ends).

9. Adolescents, under the age of 21, shall receive continuous residential services for a maximum of 30 days. Adolescent beneficiaries may receive a 30-day extension if that extension is determined to be medically necessary. Adolescent beneficiaries are limited to one extension per year.

   i. Nothing in the DMC-ODS overrides any EPSDT requirements. Adolescent beneficiaries may receive a longer length of stay based on medical necessity.

I. Case Management

In addition to the general case management requirements outlined in Article III.R of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific case management requirements:

1. The Contractor shall ensure case management services are available for all eligible beneficiaries, based on the frequency documented in the individualized treatment plan. In some cases, case management services may be provided telephonically.

2. As documented on the treatment plan, case management provides advocacy and care coordination to physical and mental health, transportation, housing, vocational, educational, and transition services for reintegration into the community.

3. The Contractor shall be responsible for the oversight and monitoring of case management services.

4. A registered or certified counselor or LPHA shall provide case management activities and services.

5. Case management shall be consistent with and shall not violate confidentiality of alcohol and drug patients as set forth in 42 CFR Part 2, and California law.

J. Physician Consultation

In addition to the general physician consultation requirements outlined in Article III.S of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific physician consultation requirements:

1. Physician Consultation shall include DMC-ODS physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists for complex cases which may address medication selection, dosing, side effect management, adherence, drug-to-drug interactions or LOC considerations.

   i. Physician consultation services for DMC-ODS waiver services shall only be billed by and reimbursed to DMC-ODS providers.

K. Recovery Services

In addition to the general recovery services requirements outlined in Article III.T of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific recovery services requirements:

1. The Contractor shall ensure the network providers offer beneficiaries SUD recovery services, when a Medical Director or LPHA has determined that recovery services are medically necessary and after the DMC-ODS beneficiary is discharged from SUD treatment services.

   i. Recovery services shall be made available to DMC-ODS beneficiaries in accordance with their individualized treatment plan.

   ii. The Contractor shall ensure recovery services are not provided while the DMC-ODS beneficiary is receiving SUD treatment services.

2. The components of recovery services include:

   i. Outpatient individual or group counseling (relapse prevention).
   ii. Recovery monitoring/coaching (via telephone or the internet).

iii. Peer-to-peer assistance.
iv. Care coordination to services to education services, life skills, employment services, and job training.
v. Care coordination to childcare, child development and support services, and marriage/family counseling.
vi. Care coordination to housing assistance, transportation, case management, and individual service coordination.

3. Non-DMC-ODS recovery services will not be reimbursable.

L. Withdrawal Management

In addition to the general withdrawal management requirements outlined in Article III.U of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific withdrawal management requirements:

1. The Contractor shall ensure the network providers deliver Withdrawal Management services (ASAM Level 3.2-WM) to beneficiaries, when determined by a Medical Director or an LPHA to be medically necessary, and in accordance with an individualized treatment plan.

2. Withdrawal Management services shall be determined by the Medical Director, LPHAs, by contracted and licensed physicians, or by nurse practitioners, as medically necessary, and in accordance with the individualized beneficiary treatment plan.

3. The components of Withdrawal Management services include intake, observation, medication services, care coordination and discharge services.

4. For beneficiaries in Withdrawal Management, the Contractor shall ensure case management services are provided to coordinate care with ancillary service providers and facilitate transitions between LOCs.

M. Opioid (Narcotic) Treatment Program Services

In addition to the general opioid (narcotic) treatment program (OTP) services requirements outlined in Article III.V of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific opioid (narcotic) treatment program services requirements:

Exhibit A, Attachment I
Program Specifications

1. The Contractor shall ensure Opioid (Narcotic) Treatment Program (ASAM OTP Level 1) services are available in Narcotic Treatment Provider licensed facilities. Medically necessary services shall be provided in accordance with an individualized treatment plan determined by a licensed physician, and approved and authorized according to the State of California requirements.

2. The components of OTPs include intake, individual and group counseling, patient education, transportation services, medication services, collateral services, crisis intervention services, treatment planning, medical psychotherapy and discharge services.

3. The Contractor shall ensure beneficiaries receive, at a minimum, 50 minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month. Additional services may be provided based on medical necessity.

4. The Contractor shall ensure the beneficiaries are scheduled for their first face-to-face service and intake assessment on the same day they are admitted.

5. The Contractor shall ensure case management services are available to coordinate care with treatment and ancillary service providers and to facilitate transitions between levels of care.

6. Beneficiaries may be simultaneously participating in OTP services and other ASAM LOCs.

N. Additional Medication Assisted Treatment (MAT)

As stated in Article V.A of Exhibit A, Attachment I, the Contractor has elected to provide Additional MAT services as a Contractor specific service. Therefore, the Contractor shall comply with the following Contractor specific Additional MAT requirements:

1. The Contractor shall ensure the network providers make available Additional MAT (ASAM OTP Level 1) to beneficiaries.

2. The network providers may prescribe buprenorphine, topiramate, gabapentin, naltrexone (oral and injectable), acamprosate, disulfiram, and naloxone. Other approved medications in the treatment of SUDs may also be prescribed, as medically necessary.

Exhibit A, Attachment I
Program Specifications

3. Additional MAT (ASAM OTP Level 1) may include the assessment, treatment planning, ordering, prescribing, and monitoring of all medications for SUDs. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician, LPHA, or licensed prescriber working within their scope of practice.

4. The Contractor shall ensure case management to coordinate care with treatment and ancillary service providers and facilitate transitions between levels of care.

5. Beneficiaries may simultaneously participate in Additional MAT services and other ASAM LOCs.

Attachment B

Delegated Service Standards / Delegation Agreement

I. Recitals

Siskiyou County (County) allocates the following activities to Partnership HealthPlan of California (Plan), effective July 1, 2020.

II. Allocated Activities

On behalf of County, Plan agrees to perform the activities and responsibilities outlined in County's Intergovernmental Agreement with the California Department of Health Care Services for Drug Medi-Cal Organized Delivery System (DMC-ODS) services (Attachment A). Plan shall remain in compliance with all applicable state and federal laws and regulations, including, without limitation, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; Section 1557 of the Patient Protection and Affordable Care Act; the conflict of interest safeguards described in 42 CFR §438.58 and with the prohibitions described in section 1902 (a)(4)(C) of the Act applicable to contracting officers, employees, or independent Contractors.

Attachment B-1 –Describes the respective responsibilities of the parties' services, including required documentation and reporting requirements, attached hereto and made part of this Agreement. These Attachments are a working document that describes the responsibility for designated performance activities, required documentation, the reporting frequency, and County's oversight activities, respectively.

Attachment B-1 –Will be reviewed annually by both Parties, and will be updated as needed, of which will be agreed by all Parties, in writing.

The County process for monitoring and evaluating services provided by Plan include, but are not limited to, the following activities:

a. County monitoring of applicable reports on Plan's performance.
b. County's annual evaluation of delegated activities, including Plan's program performance and/or evaluations, and follow-up on opportunities for improvement, as applicable.
c. County participation in the review and development of policies, procedures, and quality of care strategies.

Attachment B-1

County Responsibilities Delegated to Partnership HealthPlan of California

This document specifies the services delegated by County to Plan

The purpose of the following is to specify the services delegated by County to Plan under this Agreement. All activities are to be performed in accordance with the terms and conditions set forth in County's Intergovernmental Agreement with the California Department of Health Care Services, included as Exhibit A herein. Plan agrees to be accountable for all responsibilities delegated by County and shall not further delegate (sub-delegate) any such responsibilities without prior written approval by County, unless outlined in this Agreement. Plan shall provide periodic performance and activity reports to County.

Unless otherwise specified, the following responsibilities will be associated with each delegated functions:

- The Plan shall carry out the functions identified.
- County shall, on an annual basis, review pertinent policies and procedures guiding the function(s); and, on a quarterly basis review reports on the functions provided.

A. GENERAL PROVISIONS

Standard Contract Requirements (42 CFR § 438.3)

Discrimination:

- Enrollment discrimination is prohibited; enrollment and services shall be provided regardless of health status; race, color, national origin, sex, sexual orientation, gender identity of disability.
- Enrollment and services shall be provided regardless of health status or need for health care services.
- All Federal and State civil rights laws shall be followed; the Plan shall not unlawfully discriminate, exclude people, or treat them differently, on any ground protected under Federal or State law, including 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 Plan will not use any policy or practice that has the effect of discriminating on the basis 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 Plan shall post a Department-approved nondiscrimination notice and language taglines in at least the top 16 non-English languages in the State, as determined by the Department, in a conspicuously visible font size, in conspicuous physical locations where the Plan interacts with the public, in a conspicuous location on the Plan's website that is accessible on the Plan's home page, and in significant communications and significant publications targeted to beneficiaries, enrollees, applicants, and members of the public, as required by 45 CFR § 92.8.
- The Plan shall provide information on how to file a Discrimination Grievance with:

a. The Plan and the Department if there is a concern of discrimination based on 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.
b. The United States Department of Health and Human Services Office of Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability.

- The Plan may cover, for beneficiaries, services that are in addition to those covered under the State Plan as follows including any services that the Plan voluntarily agrees to provide; any services necessary for the Plan's compliance with the parity requirements set forth in 42 CFR §438.900 et, al. but only to the extent such services are necessary for the Plan to comply with 42 CFR §438.910.

Compliance with applicable laws and conflict of interest safeguards:

- The Plan shall comply with all applicable Federal and state laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); The Age Discrimination Act of 1975; the Rehabilitation Act of 1973; The Americans with Disabilities Act of 1990 as amended; Section 1557 of the Patient Protection and Affordable Care Act.
- The Plan shall comply with the conflict of interest safeguards described in 42 CFR §438.58 and with the prohibitions described in section 1902(a)(4)(C) of the Act applicable to contracting officers, employees, or independent Contractors.

Provider Preventable Conditions:

- The Plan shall comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions. The Plan shall report all identified provider-preventable conditions to the Department.
- The Plan make no payments to a provide for a provider- preventable condition that meets the following criteria:
    a. Is identified in the state plan;
    b. Has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;
    c. Has a negative consequence for the beneficiary; or
    d. Is auditable.
- The Plan shall use and submit the report using the DHCS Drug Medi-Cal Organized Delivery System Provider Preventable Conditions (PPC) Reporting Form at the time of discovery of any provider preventable conditions that are covered under this provision to:

  Department of Health Care Services
  Medi-Cal Behavioral Health Division
  15-00 Capital Avenue, MS 2623
  Sacramento, CA 95814

Or by secure, encrypted email to: ODSSubmissions@dhcs.ca.gov

Inspection and Audit of Records; Access to Facilities:

- Allow for the inspection, audit and access to Plan, its sub-contractors or any network providers, facilities for County, State or federal officials, including access to premises, physical facilities and equipment where Medicaid related activities are conducted.
- The right to audit under this section exists for ten years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.

Subcontracts:
The Plan shall require that subcontractors not bill beneficiaries for covered services under a contractual, referral, or other arrangement with the Plan in excess of the amount that would be owed by the individual if the Plan had directly provided the services. (42 U.S.C. 139u-2(b)(6)(C))

- All subcontractors shall fulfill the requirements or activity delegated to them in accordance with 42 CFR §438.230.
- The Plan shall require that subcontractors not bill beneficiaries for the covered services under a contractual, referral, or other arrangement with the Plan in excess of the amount that would be owed by the individual if the Plan had directly provided the services. (42 U.S.C. 1396u-2(b)(6)(C))

Choice of Network Provider:

- Each beneficiary shall be allowed to choose his or her network provider to the extent possible and appropriate.

Audited Financial Reports and Recordkeeping:

- The Plan shall submit audited financial report specific to this Agreement shall be provided to the County and State on an annual basis. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted accounting standards.
- Plan, required subcontractors, and network providers will retain beneficiary and grievance and appeal records in compliance with 42 CFR §438.416 and the data, information and documentation specified in 42 CFR §§ 438.604, 438.606, 438.608 and 438.610 for a period of no less than ten years.

Information Requirements (42 CFR §438.10):

- The Plan shall provide all required information in this section to beneficiaries and potential beneficiaries in a manner and format that may be easily understood and is readily accessible by such beneficiaries and potential beneficiaries.
- The Plan shall operate a website that will be linked to that of the Department that provides content consistent 42 CFR §§ 438:10
- For consistency in the information provided to beneficiaries, the Plan shall use:
    a. The Department-developed definitions for managed care terminology, including appeal, emergency medical condition, emergency services, excluded services, grievance, health insurance, hospitalization, medically necessary, network, non-participating provider, physician services, plan,

preauthorization, participating provider, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services, and urgent care.

b. The Department-approved beneficiary handbooks and beneficiary notices.

- The Plan shall provide the required information in this section to each beneficiary.
- The Plan shall not provide the beneficiary information required in this section electronically unless all of the following are met:
    a. The format is readily accessible.
    b. The information is placed in a location on the Department or the Plan website that is prominent and readily accessible.
    c. The information is provided in an electronic form, which can be electronically retained and printed.
    d. The information is consistent with the content and language requirements of this section.
    e. The beneficiary is informed that the information is available in paper form without charge upon request and provides it upon request within five business days.
- The Plan shall have in place mechanisms to help beneficiaries and potential beneficiaries understand the requirements and benefits of the plan.

Language and Format:

- The Department shall use the methodology below for identifying the prevalent non–English languages spoken by beneficiaries and potential beneficiaries throughout the state, and in the Plan's service area.
    a. A population group of mandatory Medi-Cal beneficiaries residing in the service area who indicate their primary language as other than English and that meet a numeric threshold of 3,000 or five percent of the beneficiary population, whichever is lower.
    b. A population group of mandatory Medi-Cal beneficiaries residing in the Plan's service area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes.
- The Plan shall make oral interpretation available in all languages and written translation available in each prevalent non–English language. All written materials for potential beneficiaries shall include language taglines in at least the top 16 non-English languages by individuals with limited English proficiency of the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information. Large print means printed in a font size no smaller than 18 point.
- The Plan shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, beneficiary handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non–English languages in its particular service area. Written materials shall also be made available in alternative formats upon request of the potential beneficiary or beneficiary at no cost. Auxiliary aids and services shall also be made available upon request of the potential beneficiary or beneficiary at no cost. Written materials shall include taglines in the prevalent non–English languages in the state, as well as large print, explaining the availability of written

translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the Contractor's member/customer service unit. Large print means printed in a font size no smaller than 18 point.

- Pursuant to WIC 14029.91(e)(1), the Plan shall make interpretation services available free of charge and in a timely manner to each beneficiary. This includes oral interpretation and the use of auxiliary aids (e.g. TTY/TDY and American Sign Language) and services, including qualified interpreters for individuals with disabilities (WIC 14029.91(e)(2)). Oral interpretation requirements apply to all non–English languages, not just those that the Department identifies as prevalent.
- Pursuant to WIC 14029.91(a)(1)(B), Oral interpretation services shall be provided by an interpreter that, at a minimum, meets all of the following qualifications:
    - a. Demonstrated proficiency in speaking and understanding both spoken English and the language spoken by the limited-English-proficient beneficiary.
    - b. The ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from the language spoken by the limited-English-proficient beneficiary and English, using any necessary specialized vocabulary, terminology, and phraseology.
    - c. Adherence to generally accepted interpreter ethics principles, including client confidentiality.
- Pursuant to WIC Section 14029.91(a)(1)(C), the Plan shall not require a beneficiary with limited English proficiency to provide his or her own interpreter or rely on a staff member who does not meet the qualifications described in WIC 14029.91(a)(1)(B).
- The Plan shall not rely on an adult or minor child accompanying the limited-English-proficient beneficiary to interpret or facilitate communication except under the circumstances described in WIC Section 14029.91 (a)(1)(D).
- The Plan shall notify its beneficiaries:
    - a. That oral interpretation is available for any language and written translation is available in prevalent languages to individuals whose primary language is not English. This may include, but is not limited to:
        - 1) Qualified interpreters;
        - 2) Information written in other languages.
    - b. That auxiliary aids and services are available upon request and at no cost for beneficiaries with disabilities. Free aids and services to people with disabilities to help them communicate better may include, but are not limited to:
        - 1) Qualified sign language interpreters;
        - 2) Written information in other formats (large print, audio, accessible electronic formats, other formats.)
        - 3) How to access services:
- Pursuant to 45 CFR §92.201, the Plan shall not require a beneficiary with limited English proficiency to accept language assistance services.
- The Plan shall provide, all written materials for potential beneficiaries and beneficiaries consistent with the following:
    - a. Use easily understood language and format.
    - b. Use a font size no smaller than 12 point.

- Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of beneficiaries or potential beneficiaries with disabilities or limited English proficiency.
    a. Include a large print tagline in at least the top 16 non-English languages and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 point.

Information for Potential Beneficiaries:

- The Plan shall provide the information specified in this section to each potential beneficiary, either in paper or in electronic format, at the time that the potential beneficiary is first required to enroll in the Plan's program.
- The information for potential beneficiaries shall include, at a minimum, all of the following:
    a. The basic features of managed care.
    b. Which populations are subject to mandatory enrollment and the length of the enrollment period.
    c. The service area covered by the Plan.
    d. Covered benefits including;
        1) Which benefits are provided by the Plan.
        2) Which, if any, benefits are provided directly by the Department.
        3) The provider directory and formulary information.
        4) Any cost sharing that will be imposed by the Plan consistent with those set forth in the State Plan.
        5) The requirements to provide adequate access to covered services, including the network adequacy standards established in 42 CFR §438.68.
        6) The Plan's entities responsible for coordination of beneficiary care.
        7) To the extent available, quality and performance indicators for the Plan, including beneficiary satisfaction.

Information for All Beneficiaries:

- The Plan shall make a good faith effort to give written notice of termination of a contracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each beneficiary who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

Beneficiary handbook:

- The Plan shall utilize and require its subcontracted and network providers to utilize, the State approved beneficiary handbook.
- The Plan shall provide each beneficiary a beneficiary handbook, within a reasonable time after receiving notice of the beneficiary's enrollment, which serves as the summary of benefits and coverage described in 42 CFR §147.200(a).
- The content of the beneficiary handbook shall include information that enables the beneficiary to understand how to effectively use the managed care program. This information shall include at a minimum:

a. Benefits provided by the Plan, including Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefits.
b. How and where to access any benefits, including EPSDT benefits, provided by the State, including any cost sharing, and how transportation is provided.

- The amount, duration, and scope of benefits available under the Agreement in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled.
- Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care for other benefits not furnished by the Plan or a subcontracted or network provider.
- The extent to which, and how, after-hours care is provided.
- Any restrictions on the beneficiary's freedom of choice among network providers.
- The extent to which, and how, beneficiaries may obtain benefits from out-of- network providers.
- Cost sharing, if any, imposed under the State Plan.
- Beneficiary rights and responsibilities including:
  a. The beneficiary's right to receive beneficiary and plan information; and
  b. The elements specified in 42 CFR §438.100, and outlined in Article II.D., 1 of Attachment A.
- Grievance, appeal, and fair hearing procedures and timeframes, consistent with Article II.G. of Attachment A of this Agreement, in a State-developed or State-approved description (WIC 14029.91(e)(4)). Such information shall include:
  a. The right to file grievances and appeals;
     1) The Plan shall include information on filing a Discrimination Grievance with the Plan, the DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights, and shall specifically include information stating that the Plan complies with all State and Federal civil rights laws. If a beneficiary believes they have been unlawfully discriminated against, they have the right to file a Discrimination Grievance with the Plan, the Department's Office of Civil Rights, and the United States Department of Health and Human Services, Office for Civil Rights.
  b. The requirements and timeframes for filing a grievance or appeal;
  c. The availability of assistance in the filing process;
  d. The right to request a state fair hearing after the Plan has made a determination on a beneficiary's appeal which is adverse to the beneficiary;
  e. The fact that, when requested by the beneficiary, benefits that the Plan seeks to reduce or terminate will continue if the beneficiary files an appeal or a request for state fair hearing within the timeframes specified for filing, and that the beneficiary may, consistent with State policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the beneficiary.
- How to access auxiliary aids and services, including additional information in alternative

formats or languages. The Plan shall specifically include specific information regarding:

- The provision of cost free aids and services to individuals with disabilities (qualified sign language interpreters, written information in other languages).
- The toll-free telephone number for member services, medical management, and any other unit providing services directly to beneficiaries; and
- Information on how to report suspected fraud or abuse.
- The beneficiary handbook will be considered to be provided if the Plan:
    - a. Mails a printed copy of the information to the beneficiary's mailing address.
    - b. Provides the information by email after obtaining the beneficiary's agreement to receive the information by email.
    - c. Posts the information on the Plan's website and advises the beneficiary in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that beneficiaries with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.
    - d. Provides the information by any other method that can reasonably be expected to result in the beneficiary receiving that information.
- The Plan shall give each beneficiary notice of any significant change in the information specified above, at least 30 days before the intended effective date of the change.

Provider Directory:

- The Plan shall make available in electronic form and, upon request, in paper form, the following information about network providers:
    - a. The provider's name as well as any group affiliation;
    - b. Street address(es);
    - c. Telephone number(s);
    - d. Website URL, as appropriate;
    - e. Specialty, as appropriate;
    - f. Whether the provider will accept new beneficiaries;
    - g. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the providers' office, and whether the provider has completed cultural competence training; and
    - h. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.
- The Plan shall include the following provider types covered under in Attachment A in the provider directory:
    - a. Physicians, including specialists
    - b. Hospitals
    - c. Pharmacies
    - d. Behavioral health providers
- Information included in a paper provider directory shall be updated at least monthly and electronic provider directories shall be updated no later than 30 calendar days after the Plan receives updated provider information.
- Provider directories shall be made available on the Plan's website in a machine- readable

file and format as specified by the Secretary of Health and Human Services.

Formulary:
- The Plan shall make available in electronic or paper form, the following information about its formulary:
    a. Which medications are covered (both generic and name brand); and
    b. What tier each medication resides.
- Formulary drug lists shall be made available on the Plan's website in a machine-readable file and format as specified by the Secretary.

Provider Discrimination Prohibited (42 CFR § 438.12):
- The Plan shall not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification.
- If the Plan declines to include individual or groups of providers in its provider network, it shall give the affected providers written notice of the reason for its decision.
- In all contracts with network providers, the Plan shall comply with the requirements specified in 42 CFR §438.214.
- This section may not be construed to:
    a. Require the Plan to subcontract with providers beyond the number necessary to meet the needs of its beneficiaries.
    b. Preclude the Plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.
    c. Preclude the Plan from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to beneficiaries.

Indians, Indian Health Care Providers (IHCPs) and Indian Managed Care Entities (IMCEs) (42 CFR § 438.14)
- The Plan shall demonstrate that there are sufficient IHCPs participating in the provider network to ensure timely access to services available under this Agreement from such providers for Indian beneficiaries who are eligible to receive services.
- The Plan shall require that IHCPs, whether participating or not, be paid for covered services provided to Indian beneficiaries who are eligible to receive services from such providers as follows:
    a. At a rate negotiated between the Plan and the IHCP, or
    b. In the absence of a negotiated rate, at a rate not less than the level and amount of payment that Plan would make for the services to a participating provider which is not an IHCP; and
    c. Make payment to all IHCPS in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR §447.45 and §447.46.
- The Plan shall permit Indian beneficiaries to obtain services covered under the contract between the State and the Plan from out-of- network IHCPs from whom the beneficiary is otherwise eligible to receive such services.
- Where timely access to covered services cannot be ensured due to few or no IHCPs, the

Plan will be considered to have demonstrated that there are sufficient IHCPs participating in the provider network to ensure timely access to service by permitting Indian beneficiaries to access out-of-state IHCPs.

- The Plan shall permit an out- of-network IHCP to refer an Indian beneficiary to a network provider.

Payment requirements:

- When an IHCP is enrolled in Medicaid as a :
  but not a participating provider of the Plan, it shall be paid an amount equal to the amount the Plan would pay a FQHC that is a network provider but is not an IHCP, including any supplemental payment from the Department to make up the difference between the amount the Plan pays and what the IHCP FQHC would have received under fee-for-service (FFS);
- When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of the Plan or not, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State Plan's FFS payment methodology.
- When the amount an IHCP receives from the Plan is less than the amount required above the Department shall make a supplemental payment to the IHCP to make up the difference between the amounts the Plan pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

B. RELATING TO STATE'S RESPONSIBILITIES

- The Plan shall have in place a transition of care policy consistent with the requirements of the Department's transition of care policy.
- Provide the transition of care policy to beneficiaries and potential beneficiaries in the beneficiary handbook and notices.
- State monitoring requirements (42 CFR §438.66).
- The Plan shall make available for the monitoring of performance:
  - a. Beneficiary grievance and appeal logs;
  - b. Provider complaint and appeal logs;
  - c. Findings from the State's External Quality Review process;
  - d. Results from any beneficiary or provider satisfaction survey conducted by the State or the Plan;
  - e. Performance on required quality measures;
  - f. Medical management committee reports and minutes;
  - g. The annual quality improvement plan for the Plan;
  - h. Customer service performance data submitted by the Plan, and
  - i. performance data submitted by the beneficiary support system.
- Network Adequacy Standards (42 CFR §438.68).
- The Plan shall adhere to, in all geographic areas within the Plan's service area, all applicable time and distance standards for network providers developed by the Department, including those set forth in WIC Section 14197 and any Information Notices issued pursuant to that section.

- Pursuant to WIC Section 14197(d)(1)(A), the Plan shall ensure that all beneficiaries seeking outpatient and intensive outpatient (non-OTP) services be provided with an appointment within 10 business days of a non-OTP service request.
- Pursuant to WIC Section 14197(d)(3) the Plan shall ensure that all beneficiaries seeking OTP services are provided with an appointment within three business days of an OTP service request.
- If the Plan cannot meet the time and distance standards set forth in this section, the Plan shall submit a request for alternative access standards to the Department.
- Pursuant to WIC Section 14197(e), DHCS may grant requests for alternative access standards if the Plan has exhausted all other reasonable options to obtain providers to meet the applicable standard or if DHCS determines that the Plan has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.
- The Plan shall include a description of the reasons justifying the alternative access standards.
    a. Requests for alternative access standards shall be approved or denied on a ZIP code and service type basis.
- Requests for alternative access standards may include seasonal considerations (e.g. winter road conditions) when appropriate. Furthermore, the Plan shall include an explanation about gaps in the Plan's geographic service area, including information about uninhabitable terrain within the county (e.g., desert, forestland), as appropriate. The use of clinically appropriate telecommunications technology may be considered in determining compliance with the applicable standards established in the DHCS Information Notice 18-011 and/or approving an alternative access request.
- DHCS will make a decision to approve or deny the request within 90 days of submission by the Plan. DHCS may stop the 90-day timeframe, on one or more occasions as necessary, in the event of an incomplete submission or to obtain additional information from the Plan (WIC 14197(e)(3)).
- If the Plan does not comply with the applicable standards at any time, DHCS may impose additional corrective actions, including fines, penalties, the withholding of payments, special requirements, probationary or corrective actions, or any other actions deemed necessary to ensure compliance.
- Fines and penalties imposed by the Department shall be in the amounts specified below:
    a. First violation: $500, plus $25 per day for each day that the Plan continues to be out of compliance.
    b. Second and subsequent violation: $500, plus $25 per day for each day that the Plan continues to be out of compliance.
    c. The Department shall monitor beneficiary access to each provider type on an ongoing basis and communicate the findings to CMS in the managed care program assessment report required under 42 CFR §438.66.

C. BENEFICIARY RIGHTS AND PROTECTIONS

Beneficiary Rights (42 CFR § 438.100):

- The Plan shall have written policies guaranteeing the beneficiary's rights specified in 42 CFR 438.100. The Plan shall comply with any applicable federal and State laws that pertain to beneficiary rights, and that ensure that its employees and network providers

observe and protect those rights. Specific rights:

a. Receive information regarding the Plan in accordance with 42 CFR §438.10;
b. Be treated with respect and with due consideration for his or her dignity and privacy;
c. Receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand;
d. Participate in decisions regarding his or her health care, including the right to refuse treatment;
e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.;
f. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR §164.524 and §164.526.

- The Plan shall ensure that its beneficiaries have the right to be furnished health care services in accordance with 42 CFR §§ 438.206 through 438.210.
- Free exercise of rights, the Plan shall ensure that each beneficiary is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Plan and its network providers treat the beneficiary.
- Compliance with other Federal and state laws.
- The Plan shall comply with any other applicable Federal and state laws, including, but not limited to:

a. Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80;
b. The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91;
c. The Rehabilitation Act of 1973;
d. Title IX of the Education Amendments of 1972 (regarding education programs and activities);
e. Titles II and III of the Americans with Disabilities Act;
f. Section 1557 of the Patient Protection and Affordable Care Act.

Provider-Beneficiary Communications (42 CFR § 438.102):

- The Plan shall not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a beneficiary who is his or her patient, for:

a. The beneficiary's health status, medical care, or treatment options, including any alternative treatment that may be self- administered;
b. Any information the beneficiary needs to decide among all relevant treatment options;
c. The risks, benefits, and consequences of treatment or non-treatment;
d. The beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express

preferences about future treatment decisions.

Liability for Payment (42 CFR § 438.106):

- The Plan shall ensure that beneficiaries are not held liable for any of the following:
  - a. The Plan's debts, in the event of the entity's insolvency;
  - b. Covered services provided to the beneficiary, for which:
    - 1) The state does not pay the Plan; or
    - 2) The Plan or the State does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.
  - c. Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the beneficiary would owe if the Plan covered the services directly.

Cost Sharing (42 CFR § 438.108):

- Any cost sharing imposed on beneficiaries shall be in accordance with §447.50 through §447.82 of 42 CFR.

D. PLAN'S STANDARDS AS A PIHP

1. Availability of Services (42 CFR §438.206):

- The Plan shall ensure that all services covered under the State Plan are available and accessible to beneficiaries in a timely manner.
- Covered services delivered by network providers shall meet the standards developed by the Department in accordance with 42 CFR §438.68.
- The Plan shall, consistent with the scope of its contracted services, meet the following requirements:
  - a. Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under this Agreement for all beneficiaries, including those with limited English proficiency or physical or mental disabilities;
  - b. Provide for a second opinion from a network provider, or arrange for the beneficiary to obtain one outside the network, at no cost to the beneficiary,
  - c. If the provider network is unable to provide necessary services, covered under this Agreement, to a particular beneficiary, the Plan shall adequately and timely cover these services out-of-network for the beneficiary, for as long as the Plan's provider network is unable to provide them.
  - d. Require out-of-network providers to coordinate with the Plan for payment and ensures the cost to the beneficiary is no greater than it would be if the services were furnished within the network.
  - e. Demonstrate that its network providers are credentialed as required by 42 CFR §438.214.
  - f. The Plan shall comply with the following timely access requirements:
    - 1) Meet and require its network providers to meet Department standards for timely access to care and services, taking into account the urgency of the need for services;

2) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid FFS, if the provider serves only Medicaid beneficiaries;
3) Make services included in this Agreement available 24 hours a day, 7 days a week, when medically necessary;
4) Establish mechanisms to ensure compliance by network providers;
5) Monitor network providers regularly to determine compliance; and
6) Take corrective action if there is a failure to comply by a network provider.

- Access and cultural considerations (WIC §14029.91):
  a. The Plan shall participate in the Department's efforts to promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

2. Accessibility considerations (45 CFR §§ 92.204 & 92.205).
   - The Plan shall ensure that their health programs or activities provided through electronic and information technology are accessible to individuals with disabilities, unless doing so would result in undue financial and administrative burdens or a fundamental alteration in the nature of the health programs or activities. When undue financial and administrative burdens or a fundamental alteration exist, the covered entity shall provide information in a format other than an electronic format that would not result in such undue financial and administrative burdens or a fundamental alteration but would ensure, to the maximum extent possible, that individuals with disabilities receive the benefits or services of the health program or activity that are provided through electronic and information technology.
   - The Plan shall ensure accessible equipment for Medicaid beneficiaries with physical or mental disabilities. The Plan and its network providers shall make reasonable modifications to policies, practices, or procedures when such modifications are necessary to avoid discrimination on the basis of disability, unless the Plan or its network providers can demonstrate that making the modifications would fundamentally alter the nature of the health program or activity. For the purposes of this section, the term ''reasonable modifications'' shall be interpreted in a manner consistent with the term as set forth in the ADA Title II regulation at 28 CFR 35.130(b)(7).

3. Assurances of Adequate Capacity and Services (42 CFR §438.207):
   - The Plan shall give assurances and provide supporting documentation that demonstrates the capacity to serve the expected enrollment in the service area in accordance with the ODS waiver standards for access and timeliness of care, including the standards at 42 CFR §438.68 and 42 CFR §438.206I(1):
   - The Plan shall submit documentation to the Department to demonstrate that it complies with the following requirements:
     a. Offers an appropriate range of specialty services that are adequate for the

anticipated number of beneficiaries.

- Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area.
- The Plan shall submit network adequacy documentation to the Division via email to: ODSSubmisions@dhcs.ca.gov
    - a. At the time it enters into this Agreement with the County;
    - b. On an annual basis, on or before April 1;
    - c. Within 10 business days of significant change in the Plan's operation that would affect the adequacy and capacity of services, including composition of the Plan's provider network;
    - d. As requested by the Department.
- The Plan's failure to submit network adequacy documentation in a timely manner shall subject the Plan to fines, sanctions and penalties as described in this Agreement Attachment A (Article II.C.5.ii.i and Article II.C.5.ii.j.)
- Upon receipt of the Plan's network adequacy documentation, the Department shall either certify the Plan's network adequacy documentation or inform the Plan that its documentation does not meet applicable time and distance standards, or Department approved alternate access standard.
- Upon receipt of the Department's determination that the Plan does not meet the applicable time and distance standards, or a DHCS approved alternate access standard, the Plan shall submit a Corrective Action Plan (CAP) for approval to DHCS that describes action steps that the Plan will immediately implement to ensure compliance with applicable network adequacy standards within the Department's approved timeframe.
- The Plan shall submit updated network adequacy documentation as requested by the Department.
- If the Department determines that the Plan does not comply with the applicable standards at any time, the Department may require a CAP, impose fines, or penalties, withhold payments, or any other actions deemed necessary by the Department to ensure compliance with network adequacy standards.
- Fines and penalties imposed by the Department for late submissions shall be in the amounts specified below:
    - First violation: $500, plus $25 per day for each day that the item to be submitted is late.
    - Second and subsequent violation: $500, plus $25 per day for each day that the item to be submitted is late.

4. Coordination and Continuity of Care (42 CFR §438.208):
    - The Plan shall comply with the care and coordination requirements detailed in Attachment A.
    - As all beneficiaries receiving DMC-ODS services shall have special health care needs, the Plan shall implement mechanisms for identifying, assessing, and producing a treatment plan for all beneficiaries that have been assessed to need a course of treatment, and as specified below.
    - The Plan shall implement procedures to deliver care to and coordinate services for all of

its beneficiaries. These procedures shall meet Department requirements and shall do the following:

a. Ensure that each beneficiary has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary. The beneficiary shall be provided information on how to contact their designated person or entity.

b. Coordinate the services the Plan furnishes to the beneficiary:

   1) Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.
   2) With the services the beneficiary receives from any other managed care organization.
   3) With the services the beneficiary receives in FFS Medicaid.
   4) With the services the beneficiary receives from community and social support providers.

c. Make a best effort to conduct an initial screening of each beneficiary's needs, within 90 calendar days of the effective date of enrollment for all new beneficiaries, including subsequent attempts if the initial attempt to contact the beneficiary is unsuccessful.

- The treatment or service plan shall be:

  a. Developed with beneficiary participation, and in consultation with any providers caring for the beneficiary;

  b. Developed by a person trained in person- centered planning using a person-centered process and plan as defined in 42 CFR §441.301I(1) and (2);

  c. Approved by the Plan in a timely manner, if this approval is required by the Plan;

  d. In accordance with any applicable Plan quality assurance and utilization review standards; and

  e. Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the beneficiary's circumstances or needs change significantly, or at the request of the beneficiary per 42 CFR §441.301(c)(3).

- For beneficiaries with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the Plan shall have a mechanism in place to allow beneficiaries to directly access a specialist as appropriate for the beneficiary's condition and identified needs.

5. Coverage and Authorization of Services (42 CFR §438.210):

   - The Plan shall furnish medically necessary services covered by this Agreement in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in 42 CFR§440.230, and for beneficiaries under the age of 21, as set forth in 42 CFR §440, subpart B.

- The Plan:
    a. Shall ensure that the medically necessary services provided are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished; and,
    b. Shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of diagnosis, type of illness, or condition of the beneficiary.
- The Plan may place appropriate limits on a service based on criteria applied under the State Plan, such as medical necessity.
- The Plan may place appropriate limits on a service for the purpose of utilization control, provided that:
    a. The services furnished can reasonably achieve their purpose; and
    b. The services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services and supports.
- Authorization of services:
    a. The Plan and its subcontractors shall have in place, and follow, written authorization policies and procedures.
    b. The Plan shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.
    c. The Plan shall consult with the requesting provider for medical services when appropriate.
    d. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by an individual who has appropriate expertise in addressing the beneficiary's medical and behavioral health.
    e. Notice of adverse benefit determination.
        1) The Plan shall notify the requesting provider, and give the beneficiary written notice of any decision by the Plan to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The beneficiary's notice shall meet the requirements of 42 CFR§438.404.
- Standard authorization decisions:
    a. For standard authorization decisions, the Plan shall provide notice as expeditiously as the beneficiary's condition requires, not to exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days when:
        1) The beneficiary, or the provider, requests extension; or
        2) The Plan justifies (to the Department upon request) a need for additional information and how the extension is in the beneficiary's interest.
- Expedited authorization decisions:
    a. For cases in which a provider indicates, or the Plan determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain

maximum function, the Plan shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than 72 hours after receipt of the request for service.

b. The Plan may extend the 72-hour time period by up to 14 calendar days if the beneficiary requests an extension, or if the Plan justifies (to the Department upon request) a need for additional information and how the extension is in the beneficiary's interest.

- Compensation for utilization management activities:
  a. Consistent with 42 CFR §438.3(i), and 42 CFR§422.208, compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

6. Provider Selection (42 CFR §438.214):
   The Plan shall implement written policies and procedures for selection and retention of network provider that, at a minimum meet the following requirements:
   - Credentialing and re- credentialing requirements:
     a. The Plan shall follow the State's established uniform credentialing and re-credentialing policy that addresses behavioral and substance use disorders, outlined in DHCS Information Notice 18-019.
     b. The Plan shall follow a documented process for credentialing and re-credentialing of network providers.
   - Nondiscrimination:
     a. The Plan's network provider selection policies and procedures, consistent with 42 CFR §438.12, shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
   - Excluded Providers:
     a. The Plan shall not employ or subcontract with providers excluded from participation in Federal health care programs under either Section 1128 or Section 1128A of the Act.
   - Additional Department requirements:
     b. The Plan shall comply with any additional requirements established by the Department.

7. Confidentiality (42 CFR §438.224):
   - For medical records and any other health and enrollment information that identifies a particular beneficiary, the Plan shall use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E and 42 CFR Part 2, to the extent that these requirements are applicable.

8. Grievance and Appeal Systems (42 CFR §438.228):
   - The Plan shall have in effect a grievance and appeal system that meets the requirements outlined in Article II.G of Attachment A of this Agreement.

- The Plan shall be responsible for issuing any Notice of Adverse Benefit Determination (NOABD) under 42 CFR Part 431, subpart E. The Department shall conduct random reviews of the Plan and its network providers to ensure that they are notifying beneficiaries in a timely manner.

9. Subcontractual Relationships and Delegation (42 CFR §438.230):
   - The requirements of this section apply to any contract or written arrangement that the Plan has with any subcontractor or network provider.
   - The Plan shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract.
   - All contracts or written arrangements between the Plan and any contracted provider shall specify the following:
     - a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.
     - b. The subcontractor or provider agrees to perform the delegated activities and reporting responsibilities specified in compliance with the Plan's contract obligations.
     - c. The contract or written arrangement shall either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the Department or the Plan determine that the contracted provider has not performed satisfactorily.
     - d. The subcontractor or provider agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions; and
     - e. The subcontractor or network provider agrees that:
       - 1) The Department, CMS, the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the contracted provider that pertain to any aspect of services and activities performed, or determination of amounts payable under this Agreement at any time.
       - 2) The subcontractor or network provider will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid beneficiaries.
       - 3) The Department, CMS, the HHS Inspector General, the Comptroller General, or their designees' right to audit the subcontractor or network provider will exist through 10 years from the final date of the contract period or from the date of completion of any audit whichever is later.
       - 4) If the Department, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the Department, CMS, or the HHS Inspector

General may inspect, evaluate, and audit the subcontractor or network provider at any time.

10. Practice Guidelines (42 CFR §438.236):
- The Plan shall adopt practice guidelines that meet the following requirements:
  a. Are based on valid and reliable clinical evidence or a consensus of providers in the particular field;
  b. Consider the needs of the Plan's beneficiaries;
  c. Are adopted in consultation with contracting health care professionals; and
  d. Are reviewed and updated periodically as appropriate.
- The Plan shall disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.
- The Plan shall ensure that all decisions for utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply, are consistent with the guidelines.

11. Health Information Systems (42 CFR §438.242):
- The Plan shall maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this part. The systems shall provide information on areas including, but not limited to, utilization, claims, and grievances and appeals.
- The Plan shall comply with Section 6504(a) of the Affordable Care Act.
- The Plan shall collect data on beneficiary and provider characteristics as specified by the Department, and on all services furnished to beneficiaries through an encounter data system or other methods as may be specified by the Department.
- The Plan shall ensure that data received from providers is accurate and complete by:
  a. Verifying the accuracy and timeliness of reported data, including data from network providers the Plan is compensating.
  b. Screening the data for completeness, logic, and consistency.
  c. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for Department Medicaid quality improvement and care coordination efforts.
- The Plan shall make all collected data available to the Department and, upon request, to CMS.
- The Plan shall collect and maintain sufficient beneficiary encounter data to identify the provider who delivers any item(s) or service(s) to beneficiaries.
- The Plan shall submit beneficiary encounter data to the Department, annually and upon request, as specified by CMS and the Department, based on program administration, oversight, and program integrity needs.
- The Plan shall submit all beneficiary encounter data that the Department is required to report to CMS under 42 CFR §438.818.
- The Plan shall submit encounter data to the Department in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate.

E. QUALITY MEASUREMENT AND IMPOVEMENT; EXTERNAL QUALITY REVIEW

1. Quality Assessment and Performance Improvement Program (PIP) (42 CFR §438.330):
   - The Plan shall establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its beneficiaries.
   - The Plan's comprehensive quality assessment and performance improvement program shall include at least the following elements:
     a. Performance improvement projects.
     b. Collection and submission of performance measurement.
     c. Mechanisms to detect both underutilization and overutilization of services.
     d. Mechanisms to assess the quality and appropriateness of care furnished to beneficiaries with special health care needs, as defined by the Department in the quality strategy under 42 CFR §438.340.
   - The Department shall identify standard performance measures, including those measure that may be specified by CMS, relating to the performance of the Plan.
   - Annually, the Plan shall:
     a. Measure and report on its performance, using the standard measures required by the Department;
     b. Submit to the State data, specified by the Department, which enables the Department to calculate Plan's performance using the standard measures identified by the Department; or
     c. Perform a combination of the activities described above.
   - Performance improvement projects:
     a. The Plan shall conduct performance improvement projects, including any performance improvement projects required by CMS that focus on both clinical and nonclinical areas.
     b. Each performance improvement project shall be designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction, and shall include the following elements:
        1) Measurement of performance using required quality indicators;
        2) Implementation of interventions to achieve improvement in the access to and quality of care;
        3) Evaluation of the effectiveness of the interventions based on the performance measure;
        4) Planning and initiation of activities for increasing or sustaining improvement.
   - The Plan shall report the status and results of each project conducted to the Department as requested, but not less than once per year.

2. Department Review of Plan's Accreditation Status (42 CFR § 438.332):
   - The Plan shall inform County and Department if it has been accredited by a private independent accrediting entity. The Plan is not required to obtain accreditation by a private independent accrediting entity.
   - If the Plan has received accreditation by a private independent accrediting entity, then the Plan shall authorize the private independent accrediting entity to provide the County and Department a copy of the most recent accreditation review, including:

a. Accreditation status, survey type and level (as applicable);
b. Accreditation results, including recommended actions or improvements, corrective action, plans, and summaries of findings; and
c. Expiration date of the accreditation

F. GRIEVANCE AND APPEAL SYSTEM:

1. General Requirements (42 CFR §438.402):

- The Plan shall have a grievance and appeal system in place for beneficiaries.

The Plan shall have only one level of appeal for beneficiaries.

Filing requirements:

1. Authority to file:
    a. A beneficiary may file a grievance and request an appeal with the Plan. A beneficiary may request a state fair hearing after receiving notice under 42 CFR §438.408 that the adverse benefit determination is upheld.
        - In the case that the Plan fails to adhere to the notice and timing requirements in 42 CFR §438.408, the beneficiary is deemed to have exhausted the Plan's appeals process. The beneficiary may initiate a state fair hearing.
        - The Department may offer and arrange for an external medical review if the following conditions are met.
            1) The review shall be at the beneficiary's option and shall not be required before, or used as a deterrent to, proceeding to the State fair hearing.
            2) The review shall be independent of both the Department and the Plan.
            3) The review shall be offered without any cost to the beneficiary.
            4) The review shall not extend any of the timeframes specified in 42 CFR §438.408 and shall not disrupt the continuation of benefits in 42 CFR §438.420.
                i. With the written consent of the beneficiary, a provider or an authorized representative may request an appeal or file a grievance, or request a state fair hearing, on behalf of a beneficiary, with the exception that providers cannot request continuation of benefits as specified in 42 CFR §438.420(b)(5).

2. Timing:
    a. Grievance:
        - The beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, may file a grievance with the Plan at any time.
    b. Appeal:

- The Plan shall allow the beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, to file a request for an appeal to the Plan within 60 calendar days from the date on the adverse benefit determination notice.

3. Procedures:
   a. Grievance:
      - The beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as State law permits, may file a grievance either orally or in writing and, as determined by the Department, either with the Department or with the Plan.

   b. Appeal:
      - The beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as State law permits, may request an appeal either orally or in writing. Further, unless an expedited resolution is requested, an oral appeal shall be followed by a written, signed appeal.

2. Timely and Adequate Notice of Adverse Benefit Determination (42 CFR §438.404):

- Notice:
  The Plan shall give beneficiaries timely and adequate notice of an adverse benefit determination in writing consistent with the requirements below and in 42 CFR §438.10.
- Content of notice:
  a. The notice shall explain the following:
     1) The adverse benefit determination the Plan has made or intends to make.
     2) The reasons for the adverse benefit determination, including the right of the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
     3) The beneficiary's right to request an appeal of the Plan's adverse benefit determination, including information on exhausting the Plan's one level of appeal described at 42 CFR §438.402(b) and the right to request a State fair hearing consistent with 42 CFR§438.402(c).
     4) The procedures for exercising these appeal rights.
     5) The circumstances under which an appeal process can be expedited and how to request it.
     6) The beneficiary's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the beneficiary may be required to pay the costs of these services.

- Timing of notice:
    - a. The Plan shall mail the notice within the following timeframes:
        - 1) At least 10 days before the date of the action, when the action is a termination, suspension, or reduction of previously authorized Medicaid-covered services.
        - 2) For denial of payment, at the time of any action affecting the claim.
        - 3) For standard authorization decisions that deny or limit services, as expeditiously as the beneficiary's condition requires within state-established timeframes that shall not exceed 14 calendar days following receipt of the request for services.
    - b. The Plan shall be allowed to extend the 14-calendar day notice of adverse benefit determination timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the beneficiary or the provider requests an extension.
        - 1) The Plan shall be allowed to extend the 14 calendar day NOABD timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the Plan justifies a need (to the Department, upon request) for additional information and shows how the extension is in the beneficiary's best interest.
        - 2) Consistent with 42 CFR §438.210(d)(1)(ii), the Plan shall:
            - i. Give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he or she disagrees with that decision; and
            - ii. Issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.
- For service authorization decisions not reached within the timeframes specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire;
- For expedited service authorization decisions, within the timeframes specified in §438.210(d)(2);
    - a. The Plan shall be allowed to mail the notice of adverse benefit determination as few as five days prior to the date of action if the Plan has facts indicating that action should be taken because of probable fraud by the beneficiary, and the facts have been verified, if possible, through secondary sources.
    - b. The Plan shall mail the notice of adverse benefit determination by the date of the action when any of the following occur:
        - 1) The recipient has died.
        - 2) The beneficiary submits a signed written statement requesting service termination.
        - 3) The beneficiary submits a signed written statement including information that requires service termination or reduction and indicates that he understands that service

termination or reduction will result.

4) The beneficiary has been admitted to an institution where he or she is ineligible under the plan for further services.
5) The beneficiary's address is determined unknown based on returned mail with no forwarding address.
6) The beneficiary is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
7) A change in the level of medical care is prescribed by the beneficiary's physician.
8) The notice involves an adverse determination with regard to pre-admission screening requirements of section 1919(e)(7) of the Act.
9) The transfer or discharge from a facility will occur in an expedited fashion.

3. Discrimination Grievances (45 CFR § 92.7; WIC §14029.91(e)(4)):

- For Discrimination Grievances, the Plan shall designate a Discrimination Grievance Coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law.
- The Plan shall adopt Discrimination Grievance procedures that ensure the prompt and equitable resolution of discrimination-related complaints. The Plan shall not require a beneficiary to file a Discrimination Grievance with the Plan before filing the grievance directly with DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights.
- Within ten calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary, the Plan shall submit the following information regarding the Discrimination Grievance to the DHCS Office of Civil Rights:
  a. The original complaint.
  b. The provider’s or other accused party’s response to the complaint.
  c. Contact information for the Plan’s personnel responsible for investigating and responding to the complaint.
  d. Contact information for the beneficiary filing the complaint.
  e. Contact information for the provider or the other accused party that is the subject of the complaint.
  f. All correspondence with the beneficiary regarding the complaint, including but not limited to, Discrimination Grievance acknowledgement and resolution letter(s) sent to the beneficiary.
  g. The results of the Plan’s investigation, copies if any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

4. Handling of Grievances and Appeals (42 CFR §438.406):

- In handling grievances and appeals, the Plan shall give beneficiaries any reasonable

assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

- The Plan's process for handling beneficiary grievances and appeals of adverse benefit determinations shall:
    a. Acknowledge receipt of each grievance and appeal within five calendar days.
    b. Ensure that the individuals who make decisions on grievances and appeals are individuals:
        1) Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.
        2) Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the Department, in treating the beneficiary's condition or disease;
            - An appeal of a denial that is based on lack of medical necessity.
            - A grievance regarding denial of expedited resolution of an appeal.
            - A grievance or appeal that involves clinical issues.
        3) Who take into account all comments, documents, records, and other information submitted by the beneficiary or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.
    c. Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and shall be confirmed in writing, unless the beneficiary or the provider requests expedited resolution.
    d. Provide the beneficiary a reasonable opportunity, in-person and in writing, to present evidence and testimony and make legal and factual arguments. The Plan shall inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution.
    e. Provide the beneficiary and his or her representative the beneficiary's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the appeal of the adverse benefit determination. This information shall be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b} and (c).

f. Include, as parties to the appeal:

i. The beneficiary and his or her representative; or

ii. The legal representative of a deceased beneficiary's estate.

5. Resolution and Notification: Grievances and Appeals (42 CFR §438.408**):**

- The Plan shall resolve each grievance and appeal, and provide notice, as expeditiously as the beneficiary's health condition requires, within the following timeframes:

a. Standard resolution of grievances: 90 calendar days from the day, the Plan receives the grievance.

b. Standard resolution of appeals: 30 calendar days from the day, the Plan receives the appeal. This timeframe may be extended in the manner described below.

c. Expedited resolution of appeals: 72 hours after the Plan receives the appeal. This timeframe may be extended under in the manner described below.

- Extension of timeframes:

a. The Plan may extend the timeframes standard and expedited resolution of appeals by up to 14 calendar days if:

1) The beneficiary requests the extension; or

2) The Plan shows (to the satisfaction of the Department, upon its request) that there is need for additional information and how the delay is in the beneficiary's interest.

- If the Plan extends the timeframes not at the request of the beneficiary, it shall complete all of the following:

a. Make reasonable efforts to give the beneficiary prompt oral notice of the delay;

b. Within two calendar days, give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he or she disagrees with that decision;

c. Resolve the appeal as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

- If the Plan fails to adhere to the notice and timing requirements in this section, the beneficiary is deemed to have exhausted the Plan's appeals process. The beneficiary may initiate a state fair hearing.
- Format of notice:

a. Grievance:

1) The Plan shall notify the beneficiary of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR §438.1.

b. Appeals:

1) For all appeals, the Plan shall provide written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR §438.10.

2) For notice of an expedited resolution, the Plan shall also make reasonable efforts to provide oral notice.

c. The written notice of the resolution shall include the following:

1) The results of the resolution process and the date it was completed;

2) For appeals not resolved wholly in favor of the beneficiaries:

i. The right to request a state fair hearing;

ii. How to make the request for a state fair hearing;

iii. The right to request and receive benefits, while the hearing is pending, and how to make the request.

6) That the beneficiary may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the Plan's adverse benefit determination.

- Requirements for state fair hearings:

a. A beneficiary may request a state fair hearing only after receiving notice that the Plan is upholding the adverse benefit determination.

b. If the Plan fails to adhere to the notice and timing requirements in 42 CFR §438.408, then the beneficiary is deemed to have exhausted the Plan's appeals process. The beneficiary may initiate a state fair hearing.

c. The Department shall offer and arrange for an external medical review when the following conditions are met:

1) The review shall be at the beneficiary's request and shall not be required before, or used as a deterrent to, proceeding to the state fair hearing;

2) The review shall be independent of both the Department and the Plan;

3) The review shall be offered without any cost to the beneficiary;

4) The review shall not extend any of the timeframes specified in 42 CFR §438.408 and shall not disrupt the continuation of benefits in 42 CFR §438.420.

d. State fair hearing:

1) The beneficiary shall request a state fair hearing no later than 120 calendar days from the date of the Plan's notice of resolution.

2) The parties to the state fair hearing include the Plan,

as well as the beneficiary and his or her representative or the representative of a deceased beneficiary's estate.

6. Expedited Resolution of Appeals (42 CFR §438.410):
   - The Plan shall establish and maintain an expedited review process for appeals when the Plan determines (for a request from the beneficiary) or the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
     a. The Plan shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's appeal.
     b. If the Plan denies a request for expedited resolution of an appeal, it shall;
        1) Transfer the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2);
        2) Follow the requirements in 42 CFR §438.408(c)(2).

7. Information About the Grievance and Appeal System to Providers and Subcontractors(42CFR §438.414)
   - The Plan shall provide the information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.

8. Recordkeeping Requirements (42 CFR §438.416):
   - The Plan shall maintain records of grievances and appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the Department quality strategy.
   - The record of each grievance or appeal shall contain, at a minimum, all of the following information:
     a. A general description of the reason for the appeal or grievance;
     b. The date received;
     c. The date of each review or, if applicable, review meeting;
     d. Resolution at each level of the appeal or grievance, if applicable;
     e. Date of resolution at each level, if applicable;
     f. Name of the covered person for whom the appeal or grievance was filed.
   - The record shall be accurately maintained in a manner accessible to the County and the Department and available upon request to CMS.

9. Continuation of Benefits While the Plan's Appeal and the State Fair Hearing Are Pending (42 CFR §438.420):
   - Timely files mean files for continuation of benefits on or before the later of the following:
     a. Within ten calendar days of Plan sending the notice of adverse benefit determination;
     b. The intended effective date of the Plan's proposed adverse benefit

determination;

- The Plan shall continue the beneficiary's benefits if all of the following occur:
    - a. The beneficiary files the request for an appeal timely in accordance with 42 CFR §438.402(c)(1)(ii) and (c)(2)(ii);
    - b. The appeal involves the termination, suspension, or reduction of previously authorized services;
    - c. An authorized provider ordered the services;
    - d. The period covered by the original authorization has not expired;
    - e. The beneficiary timely files for continuation of benefits.
- At the beneficiary's request, the Plan shall continue or reinstate the beneficiary's benefits while the appeal or state fair hearing is pending, the benefits shall be continued until one of following occurs:
    - a. The beneficiary withdraws the appeal or request for State fair hearing;
    - b. The beneficiary fails to request a state fair hearing and continuation of benefits within 10 calendar days after the Plan sends the notice of an adverse resolution to the beneficiary's appeal under 42 CFR §438.408(d)(2);
    - c. A state fair hearing officer issues a hearing decision adverse to the beneficiary.
- If the final resolution of the appeal or state fair hearing is adverse to the beneficiary, that is, upholds the Plan's adverse benefit determination, the Plan may, consistent with the Department's usual policy on recoveries under 42 CFR §431.230(b), recover the cost of services furnished to the beneficiary while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

10. Effectuation of Reversed Appeal Resolutions (42 CFR §438.424):
    - The Plan shall authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires (but no later than 72 hours from the date it receives notice reversing the determination), if the services were not furnished while the appeal was pending and if the Plan or state fair hearing officer reverses a decision to deny, limit, or delay services.
    - The Plan shall pay for disputed services received by the beneficiary while the appeal was pending, unless state policy and regulations provide for the state to cover the cost of such services, when the Plan or State fair hearing officer reverses a decision to deny authorization of the services.

G. ADDITIONAL PROGRAM INTEGRITY SAFEGUARDS

1. Basic Rule (42 CFR §438.600):
- As a condition for receiving payment under a Medicaid managed care program, the Plan shall comply with the requirements in 42 CFR §438.604, §438.606, §438.608 and §438.610, as applicable and as outlined below.

2. State Responsibilities (42 CFR §438.602):
- Monitoring Contractor compliance. Consistent with 42 CFR §438.66, the Department

shall monitor the Plan's compliance, as applicable, with 42 CFR §§438.604, 438.606, 438.608, 438.610, 438.230, 438.808, 438.900 et seq.

- Screening, enrollment, and revalidation of providers.
- The Department shall screen and enroll, and revalidate every five years, all of the Plan's network providers, in accordance with the requirements of 42 CFR, Part 455, Subparts B and E. This provision does not require the network provider to render services to FFS beneficiaries.

3. Ownership and control information:

- The Department shall review the ownership and control disclosures submitted by the Plan, and any subcontractors as required in 42 CFR §438.608(c).

4. Federal database checks:

- Consistent with the requirements in 42 CFR §455.436, the Department shall confirm the identity and determine the exclusion status of the Plan, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the Plan through routine checks of Federal databases. This includes the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases as the state or Secretary may prescribe. These databases shall be consulted upon contracting and no less frequently than monthly thereafter. If the Department finds a party that is excluded, it shall promptly notify the Plan and take action consistent with 42 CFR §438.610(c).

5. Periodic audits:

- The Department shall periodically, but no less frequently than once ever three years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, the Plan.

6. Whistleblowers:

- The Department shall receive and investigate information from whistleblowers relating t the integrity of the Plan, subcontractors, or network providers receiving Federal funds under 42 CFR, Part 438.

7. Transparency:

- The Department shall post on its website, as required in 42 CFR § 438.10©(3), the following documents and reports:
    - This Agreement;
    - The data at 42 CFR §438.604 (a)(5);
    - The name and title of individuals included in CFR §438.604 (a)(6);
    - The result of any audits performed pursuant Article II, Section H, Paragraph (v) of this Agreement.

8. Contracting integrity:

- The Department shall have in place conflict of interest safeguards described in 42 CFR

§438.58 and shall comply with the requirement described in section 1902(a)(4)(C) of the Act applicable to contracting officers, employees, or independent contractors.

9. Entities located outside of the U.S:

- The Department shall ensure that the Plan is not located outside of the United States and that no claims paid by the Plan to a network provider, out of network provider, subcontractor, or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates.

10. Data, Information, and Documentation that shall be submitted (42 CFR §438.604):

- The Plan shall submit to the Department the following data:
    a. Encounter data in the form and manner described in 42 CFR §438.818;
    b. Documentation described in 42 CFR §438.207(b) on which the Department bases its certification that the Plan has complied with the Department's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR §438.206;
    c. Information on ownership and control described in 42 CFR §455.104 from the Plan's subcontractors as governed by 42 CFR §438.230;
    d. The annual report of overpayment recoveries as required in 42 CFR §438.608(d)(3).

- In addition to the data, documentation, or information above, the Plan shall submit any other data, documentation, or information relating to the performance of the Plan's program integrity safeguard obligations required by the Department or the Secretary.

11. Source, Content, and Timing of Certification (42 CFR §438.606):

- The data, documentation, or information specified in 42 CFR §438.604 shall be certified by either the Plan's Chief Executive Officer; Chief Financial Officer; or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.
- The certification shall attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR §438.604 is accurate, complete, and truthful.
- The Plan shall submit the certification concurrently with the submission of the data, documentation, or information required in 42 CFR §438.604(a) and (b).

12. Program Integrity Requirements (42 CFR §438.608):

- The Plan, and its subcontractors to the extent that the subcontractors are delegated responsibility by the Plan for coverage of services and payment of claims under this Agreement, shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse.

    A. The arrangements or procedures shall include the following:

a. A compliance program that includes, at a minimum, all of the following elements:
   1) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements;
   2) The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Agreement and who reports directly to the Chief Executive Officer and the Board of Commissioners;
   3) The establishment of a Regulatory Compliance Committee on the Board of Commissioners and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under this Plan;
   4) A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and state standards and requirements under this Plan;
   5) Effective lines of communication between the compliance officer and the organization's employees;
   6) Enforcement of standards through well-publicized disciplinary System:
      - Guidelines: Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self- evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies), to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement.

B. Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the Department.

C. Provision for prompt notification to the Department when it receives information about changes in a beneficiary's circumstances that may affect the beneficiary's eligibility including all of the following:
   a. Changes in the beneficiary's residence;
   b. The death of a beneficiary.

D. Provision for notification to the Department when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program. Including the termination of the provider agreement with the Plan.

E. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were

received by beneficiaries and the application of such verification processes on a regular basis.

F. If the Plan makes or receives annual payments under this Agreement of at least $5,000,000, provision for written policies for all employees of the entity, and of any subcontractor or agent, that provide detailed information about the False Claims Act and other Federal and state laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

G. Provision for the prompt referral of any potential fraud, waste, or abuse that the Plan identifies to the Department Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.

H. Provision for the Plan's suspension of payments to a network provider for which the Department determines there is a credible allegation of fraud in accordance with 42 CFR §455.23.

- The Plan shall ensure that all network providers are enrolled with the Department as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 CFR part 455, subparts B and E. This provision does not require the network provider to render services to FFS beneficiaries.
- The Plan and all its subcontractors shall provide reports to the Department within 60 calendar days when it has identified payments in excess of amounts specified in this Agreement.
- Treatment of recoveries made by the Plan of overpayments to providers:
  - a. The Plan shall specify in accordance with this Agreement:
    - 1) The retention policies for the treatment of recoveries of all overpayments from the Plan to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.
    - 2) The process, timeframes, and documentation required for reporting the recovery of all overpayments.
    - 3) The process, timeframes, and documentation required for payment of recoveries of overpayments to the state in situations where the Plan is not permitted to retain some or all of the recoveries of overpayments.
    - 4) This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.
- The Plan shall have a mechanism for a network provider to report to the Plan when it has received an overpayment, to return the overpayment to the Plan within 60 calendar days after the date on which the overpayment was identified, and to notify the Plan in writing of the reason for the overpayment.
  - a. The Plan shall report annually to the Department on their recoveries of overpayments.

13. Prohibited Affiliations (42 CFR §438.610):

a. The Plan and its subcontractors shall not knowingly have a relationship of the type described in paragraph (c) of this subsection with the following:

1) An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
2) An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in paragraph (a)(1) of this section.

b. The Plan and its subcontractors shall not have a relationship with an individual or entity that is excluded from participation in any Federal Health Care Program under section 1128 or 1128A of the Act.

c. The relationships described in paragraph (a) of this section, are as follows:
1) A director, officer, or partner of the Plan.
2) A subcontractor of the Plan, as governed by 42 CFR §438.230.
3) A person with beneficial ownership of 5 percent or more of the Plan's equity.
4) A network provider or person with an employment, consulting or other arrangement with the Plan for the provision of items and services that are significant and material to the Plan's obligations under this Agreement.

d. If the Department finds that the Plan is not in compliance, the Department:
1) Shall notify the Secretary of the noncompliance; and
2) May continue an existing agreement with the County or Plan unless the Secretary directs otherwise; or
3) May not renew or otherwise extend the duration of an existing agreement with the Plan unless the Secretary provides to the State and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.
4) Nothing in this section shall be construed to limit or otherwise affect any remedies available to the U.S. under sections 1128, 1128A or 1128B of the Act.

e. The Plan shall provide the County and the Department with written disclosure of any prohibited affiliation under this section by the Plan or any of its subcontractors.

14. Disclosures on Information and Ownerships Control (42 CFR §455.104):

- The Plan and its network providers shall provide the following disclosures through the DMC certification process described in Attachment A, Article III.J:
  a. The name and address of any person (individual or corporation) with an ownership or control interest in the Plan. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
  b. Date of birth and Social Security Number (in the case of an individual).
  c. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest.

d. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

e. The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

f. The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

- Disclosures are due at any of the following times:

  a. Upon the Plan submitting the proposal in accordance with the Department's procurement process;

  b. Upon the Plan executing this Agreement with the Department;

  c. Upon renewal or extension of this Agreement; and within 35 days after any change in ownership of the Plan.

- The Plan shall provide all disclosures to the County and the Department.
- Federal financial participation (FFP) shall be withheld from the County and Plan for Plan's failure to disclose ownership or control information as required by this section.
- For the purposes of this section "person with an ownership or control interest" means a person or corporation that:

  a. Has an ownership interest totaling 5 percent or more in a disclosing entity;

  b. Has an indirect ownership interest equal to 5 percent or more in a disclosing entity;

  c. Has a combination of direct and indirect ownership interests equal to 5 percent or more in a disclosing entity;

  d. Owns an interest of 5 percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least 5 percent of the value of the property or assets of the disclosing entity;

  e. Is an officer or director of a disclosing entity that is organized as a corporation; or

  f. Is a partner in a disclosing entity that is organized as a partnership.

15. Parity in Mental Health and Substance Use Disorder Benefits (42 CFR §438.900 et seq.): General Parity Requirement:

- To ensure compliance with the parity requirements set forth in 42 CFR §438.900 et seq., the Plan shall not impose, or allow any of its subcontractors to impose, any financial requirements, Quantitative Treatment Limitations, or Non-Quantitative Treatment Limitations in any classification of benefit (inpatient, outpatient, emergency care, or prescription drugs) other than those limitations permitted and outlined in this Agreement.

- The Plan shall not apply any financial requirement or treatment limitation to substance use disorder services in any classification of benefit that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification of benefit furnished to beneficiaries (whether or not the benefits are furnished by the Plan), (42 CFR 438.910(b)(1)).
- The Plan shall provide substance use disorder services to beneficiaries in every classification in which medical/surgical benefits are provided, (42 CFR 438.910(b)(2)).

Quantitative Limitations:

- The Plan shall not apply any cumulative financial requirement for substance use disorder services in a classification that accumulates separately from any established for medical/surgical services in the same classification, (42 CFR § 438.910(b)(1)).

Non-Quantitative Limitations:

- The Plan shall not impose a non-quantitative treatment limitation for substance use disorder benefits in any classification unless, under the policies and procedures of the Plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. (42 CFR § 438.910(d))
- The Plan shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for substance use disorder services that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits. (42 CFR § 438.910(d)(3)).

H. PROGRAM SPECIFICATIONS

Provision of Services:

1. Provider Specifications:

- The Plan, its network providers, and the providers' staff shall ensure that:
  - a. Professional staff shall be licensed, registered, certified or recognized under California scope of practice statutes;
  - b. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws:
    - 1) Licensed Practitioners of the Healing Arts (LPHA) include:
      - i. Physician;
      - ii. Nurse Practitioners;
      - iii. Physician Assistants;
      - iv. Registered Nurses;
      - v. Registered Pharmacists;
      - vi. Licensed Clinical Psychologists;

vii. Licensed Clinical Social Worker;
viii. Licensed Professional Clinical Counselor;
ix. Licensed Marriage and Family Therapists; and
x. Licensed Eligible Practitioners working under the supervision of Licensed Clinicians.

c. Non-professional staff shall receive appropriate onsite orientation and training prior to performing assigned duties. A professional and/or administrative staff shall supervise non-professional staff.
d. Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring.
e. Physicians shall receive a minimum of five hours of continuing medical education related to addiction medicine each year.
f. Professional staff (LPHAs) shall receive a minimum of five (5) hours of continuing education related to addiction medicine each year.
g. Registered and certified SUD counselors shall adhere to all requirements in CCR Title 9, §13000 et seq.

2. Services for Adolescents and Youth:

- Assessment and services for adolescents will follow the American Society of Addiction Medicine (ASAM) adolescent treatment criteria.

I. ORGANIZED DELIVERY SYSTEM (ODS) TIMELY COVERAGE

1. Non-Discrimination - Member Discrimination Prohibition:

- Plan shall accept individuals eligible for enrollment in the order in which they apply without restriction in accordance with this Agreement and shall take affirmative action to ensure that beneficiaries are provided covered services, and will not discriminate against individuals eligible to enroll under the United States and the State of California. The Plan shall not unlawfully discriminate against any person pursuant to:
    a. Title VI of the Civil Rights Act of 1964;
    b. Title IX of the Education Amendments of 1972 (regarding education and programs and activities);
    c. The Age Discrimination Act of 1975;
    d. The Rehabilitation Act of 1973;
    e. The Americans with Disabilities Act.
- DMC-ODS services shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in this opt-in County. Determination of who may receive the DMC- ODS benefits shall be performed in accordance with DMC- ODS Special Terms and Conditions (STC) 132{d), Article II.E.4 of this Agreement, and as follows:
    a. The Plan or its subcontracted provider shall verify the Medicaid eligibility determination of an individual. When the subcontracted provider conducts the initial eligibility verification, that verification shall be reviewed and approved by the Plan prior to payment for services. If the individual is eligible to receive services from tribal health programs operating under the

Indian Self- Determination Education Assistance Act (ISDEAA), then the determination shall be conducted as set forth in the Tribal Delivery System - Attachment BB to the STCs.

b. All beneficiaries shall meet the following medical necessity criteria:

1) The individual shall have received a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders or non-substance use related disorders.

2) The individual shall meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.

- For beneficiaries in treatment prior to implementation of the DMC-ODS, the provider must conduct an ASAM assessment by the due date of the next updated treatment plan or continuing services justification, whichever occurs first. If the assessment determines a different level of care, the provider shall refer the beneficiary to the appropriate level of care.
- Adolescents are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under the age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Nothing in the DMC-ODS overrides any EPSDT requirements.
- In addition to Article III.B.2.ii, the initial medical necessity determination, for an individual to receive a DMC-ODS benefit, shall be performed by a Medical Director or an LPHA. If a beneficiary's assessment and intake information are completed by a counselor through a face-to-face review or telehealth, the Medical Director or LPHA shall evaluate each beneficiary's assessment and intake information with the counselor to establish whether that beneficiary meets medical necessity criteria. The ASAM Criteria shall be applied to determine placement into the level of assessed services.
- For an individual to receive ongoing DMC-ODS services, the Medical Director or LPHA shall reevaluate that individual's medical necessity qualification at least every six months through the reauthorization process and document their determination that those services are still clinically appropriate for that individual.
- For an individual to receive ongoing Opioid Treatment Program/Narcotic Treatment Program (OTP/NTP) services, the Medical Director or LPHA shall reevaluate that individual's medical necessity qualification within two years from admission and annually thereafter through the reauthorization process and determine that those services are still clinically appropriate for that individual.

J. COVERED SERVICES

- In addition, to the coverage and authorization of services requirements set forth in Article II.E.4 of Attachment A of this Agreement, the Plan shall:

a. Identify, define, and specify the amount, duration, and scope of each medically necessary service that the Plan is required to offer;

b. Require that the medically necessary services identified be furnished in an amount, duration, and scope that is no less than the amount, duration, and

scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in 42 CFR §440.230;

c. Specify the extent to which the Plan is responsible for covering medically necessary services related to the following:
   1) The prevention, diagnosis, and treatment of health impairments;
   2) The ability to achieve age-appropriate growth and development;
   3) The ability to attain, maintain, or regain functional capacity.

- The Plan shall deliver the DMC-ODS Covered Services within a continuum of care as defined in the ASAM criteria.
- Mandatory DMC-ODS Covered Services include:

a. Withdrawal Management (minimum one level);
b. Intensive Outpatient;
c. Outpatient;
d. Opioid (Narcotic) Treatment Programs;
e. Recovery Services;
f. Case Management;
g. Physician Consultation;
h. Perinatal Residential Treatment Services (excluding room and board):
   1) Room and board shall not be a covered expenditure under the DMC-ODS. Room and board may be paid with funding sources unrelated to the DMC-ODS;
   2) Non-perinatal Residential Treatment Services (excluding room and board);
   3) Room and board shall not be a covered expenditure under the DMC-ODS. Room and board may be paid with funding sources unrelated to DMC- ODS.

- The Plan is responsible for ensuring that its beneficiaries are able to receive all medically necessary DMC-ODS services. If the Plan's provider network is unable to provide necessary services to a particular beneficiary, the Plan shall adequately and timely cover these services out-of-network for as long as the Plan's network is unable to provide them.
- According to STC 147(c), the Plan shall ensure that a beneficiary that resides in a county that does not participate in DMC-ODS does not experience a disruption of OTP/NTP services. The Plan shall require all OTP/NTP subcontractors to provide any medically necessary NTP services covered by the California Medi-Cal State Plan to beneficiaries that reside in a county that does not participate in DMC-ODS. The Plan shall require all OTP/NTP subcontractors that provide services to an out-of-county beneficiary to submit the claims for those services to the county in which the beneficiary resides (according to MEDS).
- The Plan, to the extent applicable, shall comply with "Sobky v. Smoley" (Document 2A), 855 F. Supp. 1123 (E.D. Cal 1994), incorporated by this reference.
- Plan shall comply with federal and state mandates to provide SUD treatment services deemed medically necessary for Medi-Cal eligible pregnant and postpartum women.
- In accordance with the EPSDT mandate under 1905(r) of the Social Security Act, the Plan shall ensure that all beneficiaries under age 21 receive all applicable medically necessary services needed to correct and ameliorate health conditions that are coverable under Section 1905(a) of the Social Security Act.

Financing:

- Payment for Services:
  a. The County shall pay Plan the Per Utilizer Per Month (PUPM) rate identified in Attachment A (Intergovernmental Agreement), Exhibit B (Fiscal Provisions) for each beneficiary who receives at least one service in a month.
  b. The County shall submit a claim to the Department's Short-Doyle Medi-Cal claiming system for each DMC-ODS service the subcontractor provides to a Medi-Cal beneficiary.
  c. The County shall certify the public total allowable expenditures incurred to provide all DMC-ODS services for Medi-Cal beneficiaries.
  d. DHCS shall reimburse the County the federal and state share of the Contractor's certified public expenditures using the sharing rations identified in Attachment A's Exhibit B to this Agreement and the Plan shall attest to the accuracy, completeness, and truthfulness of claims and payment data, under penalty of perjury.
  e. Pursuant to Title 42 CFR 433.138 and 22 CCR 51005(a), if a beneficiary has Other Health Coverage (OHC), then the County shall bill that OHC prior to billing DMC to receive either payment from the OHC, or a notice of denial from the OHC indicating that:
     1) The recipient's OHC coverage has been exhausted, or
     2) The specific service is not a benefit of the OHC.
  f. If the County submits a claim to an OHC and receives partial payment of the claim, the County may submit the claim to DMC and is eligible to receive payment up to the maximum DMC rate for the service, less the amount of the payment made by the OHC.
  g. DHCS, pursuant to the process set forth in WIC 14021.51 shall set the OTP/NTP reimbursement rate. The Plan shall require the subcontractor to reimburse all OTP/NTP providers at this rate.
  h. Pursuant to WIC 14124.24(h), OTP/NTP providers shall submit cost reports to DHCS.

K. AVAILABILITY OF SERVICES

In addition to the availability of services requirements set forth in Article II.E.1 of this Agreement, the Plan shall:

a. Consider the numbers and types (in terms of training, experience and specialization) of providers required to ensure the availability and accessibility of medically necessary services;
b. Maintain and monitor a network of appropriate providers that is supported by written agreements for subcontractors and that is sufficient to provide its beneficiaries with adequate access to all services covered under this Agreement.
c. In establishing and monitoring the network, document the following:
   1) The anticipated number of Medi-Cal eligible beneficiaries;

2) The expected utilization of services, taking into account the characteristics and SUD treatment needs of beneficiaries;
3) The expected number and types of providers in terms of training and experience needed to meet expected utilization;
4) The numbers of network providers who are not accepting new beneficiaries;
5) The geographic location of providers and their accessibility to beneficiaries, considering distance, travel time, means of transportation ordinarily used by Medi-Cal beneficiaries, and physical access for disabled beneficiaries.

L. ACCESS TO SERVICES

- Subject to DHCS provider enrollment certification requirements, the Plan shall maintain continuous availability and accessibility of covered services and facilities, service sites, and personnel to provide the covered services through use of DMC certified providers. Such services shall not be limited due to budgetary constraints.
- When a beneficiary makes a request for covered services, the Plan shall require services to be initiated with reasonable promptness. Plan shall have a documented system for monitoring and evaluating the quality, appropriateness and accessibility of care, including a system for addressing problems that develop regarding waiting times and appointments.
- In addition, to the coverage and authorization of services requirements set forth in Attachment A Article II.E.4 of this Agreement, the Plan shall:
  a. Authorize DMC-ODS services in accordance with the medical necessity criteria specified in Title 22, Section 51303 and the coverage provisions of the approved State Medi-Cal Plan;
  b. If services are denied, inform the beneficiary in accordance with Attachment A Article II.G.2 of this Agreement;
  c. Provide prior authorization for residential services within 24 hours of the prior authorization request being submitted by the provider:
     1) Prior authorization is prohibited for non- residential DMC-ODS services.
     2) The Plan's prior authorization process shall comply with the parity requirements set forth in 42 CFR §438.910(d).
  d. Review the DSM and ASAM Criteria documentation to ensure that the beneficiary meets the requirements for the service;
  e. Have written policies and procedures for processing requests for initial and continuing authorization of services;
  f. Have a mechanism in place to ensure that there is consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate;
  g. Track the number, percentage of denied and timeliness of requests for authorization for all DMC-ODS services that are submitted, processed, approved and denied;
  h. Pursuant to 42 CFR §438.3(I), allow each beneficiary to choose his or her health professional to the extent possible and appropriate;

i. Require that treatment programs are accessible to people with disabilities in accordance with Title 45, Code of Federal Regulations (hereinafter referred to as CFR). Part 84 and the Americans with Disabilities Act;
j. Have a 24/7 toll free number for prospective beneficiaries to call to access DMC-ODS services and make oral interpretation services available for beneficiaries, as needed;
k. Must guarantee that it will not avoid costs for services covered in this Agreement by referring enrollees to publicly supported health care resources.

- Covered services, whether provided directly by the Plan or through subcontractor with DMC certified and enrolled programs, shall be provided to beneficiaries in the following manner:
  a. DMC-ODS services in the ODS Plan;
  b. Access to State Plan services shall remain at the current, pre-implementation level or expand upon implementation.

M. COORDINATION OF CARE

- In addition to meeting the coordination and continuity of care requirements set forth in Attachment A, Article II.E.3, the Plan shall develop a care coordination plan that provides for seamless transitions of care for beneficiaries with the DMC-ODS system of care. Plan is responsible for developing a structured approach to care coordination to ensure that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient) without disruptions to services.
- In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, the Plan shall ensure that beneficiaries have access to recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.
- The Plan shall include in its contracts with all network providers the following elements which should be implemented at the point of care to ensure clinical integration:
  a. Comprehensive substance use, physical, and mental health screening;
  b. Beneficiary engagement and participation in an integrated care program as needed;
  c. Shared development of care plans by the beneficiary, caregivers, and all providers;
  d. Collaborative treatment planning with managed care;
  e. Delineation of case management responsibilities;
  f. A process for resolving disputes between the County and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved.
  g. Availability of clinical consultation, including consultation on medications.
  h. Care coordination and effective communication among providers including procedures for exchanges of medical information.
  i. Navigation support for patients and caregivers.

j. Facilitation and tracking of referral between systems including bidirectional referral protocol.

N. AUTHORIZATION OF SERVICES – RESIDENTIAL PROGRAMS

- The Plan shall implement residential treatment program standards that comply with the authorization of services requirements set forth in Attachment A, Article II.E.4 and shall:
  a. Establish, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services for residential programs;
  b. Ensure that residential services are provided in DHCS or Department of Social Services (DSS) licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria;
  c. Ensure that residential services may be provided in facilities with no bed capacity limit;
  d. Ensure that the length of residential services comply with the following time restrictions:
     1) Adults, ages 21 and over, may receive up to two continuous short-term residential regimens per 365-day period. A short-term residential regimen is defined as one residential stay in a DHCS licensed facility for a maximum of 90-days per 365-day period;
     2) An adult beneficiary may receive one 30-day extension, if that extension is medically necessary, per 365-day period;
     3) Adolescents, under the age of 21, may receive up to 30 days non-continuous regimen per 365-day period; Adolescent beneficiaries receiving residential treatment shall be stabilized as soon as possible and moved down to a less intensive level of treatment. Adolescent beneficiaries may receive a 30-day extension if that extension is determined to be medically necessary. Adolescent beneficiaries are limited to one extension per 365-day period. Nothing in the DMC-ODS overrides any EPSDT requirements. EPSDT beneficiaries may receive a longer length of stay based on medical necessity. If determined to be medically necessary, perinatal beneficiaries may receive a longer length of stay than those described above.
  e. Ensure that at least one ASAM level of Residential Treatment Services is available to beneficiaries in the first year of implementation.
  f. Demonstrate ASAM levels of Residential Treatment Services (Levels 3.1-3.5) within three years of CMS approval of the county implementation plan and state-county Agreement and describe coordination for ASAM Levels 3.7 and 4.0.
  g. Enumerate the mechanisms that the Plan has in effect that ensure the consistent application of review criteria for authorization decisions, and

require consultation with the requesting provider when appropriate.

h. Require written notice to the beneficiary of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested be made by a health care professional who has appropriate clinical expertise in treating the beneficiary's condition or disease.

- Pursuant to 42 CFR §431.201, the Plan shall define service authorization request in a manner that at least includes a beneficiary's request for the provision of a service.

O. PROVIDER SELECTION AND CERTIFICATION

- In addition to complying with the provider selection requirements set forth in Attachment A, Article II.E.5 and the provider discrimination prohibitions in Article II.B.3, the Plan:
  a. Shall have written policies and procedures for selection and retention of providers that are in compliance with the terms and conditions of this Agreement and applicable federal laws and regulations;
  b. Shall apply those policies and procedures equally to all providers regardless of public, private, for-profit or non-profit status, and without regard to whether a provider treats persons who require high-risk or specialized services;
  c. Shall not discriminate against persons who require high-risk or specialized services;
  d. Shall subcontract with providers in another state where out-of-state care or treatment is rendered on an emergency basis or is otherwise in the best interests of the person under the circumstances;
  e. Shall select only providers that have a license and/or certification issued by the State that is in good standing;
  f. Shall select only providers that, prior to the furnishing of services under this Agreement, have enrolled with, or revalidated their current enrollment with, DHCS as a DMC provider under applicable federal and state regulations;
  g. Shall select only providers that have been screened in accordance with 42 CFR §455.450(c) ("high" categorical risk) prior to furnishing services under this Agreement, have signed a Medicaid provider agreement with DHCS as required by 42 CFR § 431.107, and have complied with the ownership and control disclosure requirements of 42 CFR §455.104;
  h. DHCS shall deny enrollment and DMC certification to any provider (as defined in Welfare & Institutions Code section 14043.1), or a person with ownership or control interest in the provider (as defined in 42 CFR §455.101), that, at the time of application, is under investigation for fraud or abuse pursuant to Part 455 of Title 42 of the Code of Federal Regulations, unless DHCS determines that there is good cause not to deny enrollment upon the same bases enumerated in 42 CFR §455.23(e). If a provider is under investigation for fraud or abuse, that provider shall be subject to temporary suspension pursuant to Welfare & Institutions Code section 14043.36. Upon receipt of a credible allegation of fraud, a provider

shall be subject to a payment suspension pursuant to Welfare & Institutions Code section 14107.11 and DHCS may thereafter collect any overpayment identified through an audit or examination. During the time a provider is subject to a temporary suspension pursuant to Welfare & Institutions Code section 14043.36, the provider, or a person with ownership or control interest in the provider (as defined in 42 CFR §455.101), may not receive reimbursement for services provided to a DMC-ODS beneficiary. A provider shall be subject to suspension pursuant to Welfare and Institutions Code section 14043.61, if claims for payment are submitted for services provided to a Medi-Cal beneficiary by an individual or entity that is ineligible to participate in the Medi- Cal program. A provider will be subject to termination of provisional provider status pursuant to Welfare and Institutions Code section 14043.27, if the provider has a debt due and owing to any government entity that relates to any federal or State health care program, and has not been excused by legal process from fulfilling the obligation. Only providers newly enrolling or revalidating their current enrollment on or after January 1, 2015 would be required to undergo fingerprint-based background checks required under 42 CFR §455.434.

Disclosures that shall be provided:

- A disclosure from any provider or disclosing entity is due at any of the following times:
    a. Upon the provider or disclosing entity submitting the provider application.
    b. Upon the provider or disclosing entity executing the provider agreement;
        1) Upon request of the Medicaid agency during the re-validation of enrollment process under 42 CFR §455.414.
        2) Within 35 days after any change in ownership of the disclosing entity.
    c. All disclosures shall be provided to the Medicaid agency.
    d. Consequences for failure to provide required disclosures:
        1) Federal Financial Participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.
- The Plan shall only select providers that have a Medical Director who, prior to the delivery of services under this Agreement, has enrolled with DHCS under applicable state regulations, has been screened in accordance with 42 CFR §455.450(a) as a "limited" categorical risk within a year prior to serving as a Medical Director under this Agreement, and has signed a Medicaid provider agreement with DHCS as required by 42 CFR §431.107.
- The Plan may contract individually with LPHAs to provide DMC-ODS services in the network.
- The Plan shall have a protest procedure for providers that are not awarded a subcontract. The Plan's protest procedure shall ensure that:
    a. Providers that submit a bid to be a subcontracted provider, but are not

selected, shall exhaust the Plan's protest procedure if a provider wishes to appeal to DHCS.

b. If the Plan does not render a decision within 30 calendar days after the protest was filed with the Plan, then the protest shall be deemed denied and the provider may appeal the failure to DHCS.

P. DMC CERTIFICATION AND ENROLLMENT

- DHCS shall certify eligible providers to participate in the DMC program.
- The DHCS shall certify any network providers. This certification shall be performed prior to the date on which the Plan begins to deliver services under this Agreement at these sites.
- Plan shall require that providers of perinatal DMC services are properly certified to provide these services and comply with the applicable requirements contained in Attachment A, Article III.PP.
- Plan shall require all the network providers of services to be licensed, registered, DMC certified and/or approved in accordance with applicable laws and regulations.
- Plan's subcontracts shall require that providers comply with the following regulations and guidelines:
  a. Title 21, CFR Part 1300. et seq. Title 42. CFR. Part 8;
  b. Title 22. Section 51490.1(a);
  c. Attachment A, Exhibit A, Attachment I, Article III.PP – Requirements for Services;
  d. Title 9, Division 4. Chapter 4 Subchapter 1. Sections 10000 et. seq. Title 22, Division 3. Chapter 3. Sections 51000. et seq.
- In the event of conflicts, the provisions of Title 22 shall control if they are more stringent.
- The Plan shall notify Provider Enrollment Division (PED) of an addition or change of information in a provider’s pending DMC certification application within 35 days of receiving notification from the provider. The Plan shall ensure that a new DMC certification application is submitted to PED reflecting the change.
- The Plan shall be responsible for ensuring that any reduction of covered services or relocations by providers are not implemented until the approval is issued by DHCS. Within 35 days of receiving notification of a provider's intent to reduce covered services or relocate, the Plan shall submit, or require the provider to submit, a DMC certification application to PED. The DMC certification application shall be submitted to PED 60 days prior to the desired effective date of the reduction of covered services or relocation.
- The Plan shall notify DHCS PED by e-mail at DHCSDMCRecert@dhcs.ca.gov within two business days of learning that a subcontractor’s license, registration, certification, or approval to operate a SUD program or provide a covered service is revoked, suspended, modified, or not renewed by entities other than DHCS.
  a. A provider's certification to participate in the DMC program shall automatically terminate in the event that the provider, or its owners, officers or directors are convicted of Medi-Cal fraud, abuse, or malfeasance. For purposes of this section, a conviction shall include a plea of guilty or nolo contendere.

Q. CONTINUED CERTIFICATION

- All DMC certified providers shall be subject to continuing certification requirements at least once every five years. DHCS may allow the Plan to continue delivering covered services to beneficiaries at a site subject to on-site review by DHCS as part of the recertification process prior to the date of the on-site review, provided the site is operational, the certification remains valid, and has all required fire clearance.
- DHCS shall conduct unannounced certification and recertification on-site visits at clinics pursuant to W&I Code. Section 14043.7.

R. LABORATORY TESTING REQUIREMENTS

1. 42 CFT Part 493 sets forth the conditions that all laboratories shall meet to be certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Except as specified in paragraph (2) of this section, a laboratory will be cited as out of compliance with section 353 of the Public Health Service Act unless it:
    a. Has a current, unrevoked or unsuspended certificate of waiver, registration certificate, certificate of compliance, certificate for PPM procedures, or certificate of accreditation issued by HHS applicable to the category of examinations or procedures performed by the laboratory, or
    b. Is CLIA-exempt.

2. These rules do not apply to components or functions of:
    a. Any facility or component of a facility that only performs testing for forensic purposes;
    b. Research laboratories that test human specimens but do not report patient specific results for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of individual patients, or
    c. Laboratories certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), in which drug testing is performed which meets SAMHSA guidelines and regulations. However, all other testing conducted by a SAMHSA-certified laboratory is subject to this rule.

3. Laboratories under the jurisdiction of an agency of the Federal Government are subject to the rules of 42 CFT 493, except that the Secretary may modify the application of such requirements as appropriate.

S. RECOVERY FROM OTHER SOURCES OR PROVIDERS

- The Plan shall recover the value of covered services rendered to beneficiaries whenever the beneficiaries are covered for the same services, either fully or partially, under any other state or federal medical care program or under other contractual or legal entitlement including, but not limited to, a private group or indemnification program, but excluding instances of the tort liability of a third party or casualty liability insurance.
- The monies recovered are retained by the County. However, County's claims for FFP for

services provided to beneficiaries under this Agreement shall be reduced by the amount recovered.

- The Plan shall maintain accurate records of monies recovered from other sources.
- Nothing in this section supersedes the Plan's obligation to follow Federal requirements for claiming FFP for services provided to beneficiaries with other coverage under this Agreement.

T. EARLY INTERVENTION (ASAM LEVEL 0.5)

- Plan shall identify beneficiaries at risk of developing a substance use disorder or those with an existing substance use disorder and offer those beneficiaries:
  a. screening for adults and youth;
  b. brief treatment as medically necessary, and
  c. when medically indicated a referral to treatment with a formal linkage.

U. OUTPATIENT SERVICES (ASAM LEVEL 1.0)

- Outpatient services consist of up to nine hours per week of medically necessary services for adults and less than six hours per week of services for adolescents. Group size is limited to no less than two (2) and no more than twelve (12) beneficiaries.
- Outpatient services includes:
  a. Assessment
  b. Treatment planning
  c. Individual and group counseling
  d. Family therapy
  e. Patient education
  f. Medication services
  g. Collateral services
  h. Crisis intervention services, and
  i. Discharge planning and coordination
- Services may be provided in-person, by telephone, or by telehealth, and in any appropriate setting in the community.

V. INTENSIVE OUTPATIENT SERVICES (ASAM LEVEL 2.1)

- Intensive outpatient services involves structured programming provided to beneficiaries as medically necessary for a minimum of nine hours and a maximum of 19 hours per week for adult perinatal and non-perinatal beneficiaries. Adolescents are provided a minimum of six and a maximum of 19 hours per week. Group size is limited to no less than two (2) and no more than twelve (12) beneficiaries.
- Network providers may provide more than 19 hours per week to adults when determined by a Medical Director or an LPHA to be medical necessary, and in accordance with the individualized treatment plan.
- Network providers may extend a beneficiary's length of treatment when determined by a Medical Director or an LPHA to be medically necessary, and in accordance with the individualized treatment plan.

- Intensive outpatient services shall include assessment, treatment planning, individual and/or group counseling, patient education, family therapy, medication services, collateral services, crisis intervention services, treatment planning, and discharge planning and coordination.
- Services may be provided in-person, by telephone, or by telehealth, and in any appropriate setting in the community.

W. RESIDENTIAL TREATMENT SERVICES

- Residential services are provided in DHCS or DSS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.
- Residential services can be provided in facilities with no bed capacity limit.
- The length of residential services range from 1 to 90 days with a 90-day maximum for adults and 30-day maximum for adolescents per 365-day period; unless medical necessity authorizes a one-time extension of up to 30 days per 365-day period:
    a. Only two non-continuous 90-day regimens may be authorized in a one-year period (365 days). The average length of stay for residential services is 30 days.
    b. Perinatal beneficiaries shall receive a length of stay for the duration of their pregnancy, plus 60- days postpartum.
    c. EPSDT adolescent beneficiaries shall receive a longer length of stay, if found to be medically necessary.

X. CASE MANAGEMENT

- Case management services are defined as a service that assists a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.
- The Plan shall ensure that case management services focus on coordination of SUD care, integration around primary care especially for beneficiaries with a chronic substance use disorder, and interaction with the criminal justice system, if needed.
- The Plan shall be responsible for determining which entity monitors the case management activities.
- Case management services may be provided by a LPHA or a certified counselor.
- The Plan shall coordinate a system of case management services with physical and/or mental health in order to ensure appropriate level of care.
- Case management services may be provided face-to- face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.

Y. PHYSICIAN CONSULTATION SERVICES

- Physician Consultation Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are designed to assist DMC physicians by allowing them to seek expert advice when developing treatment plans for specific DMC-ODS beneficiaries.

Physician consultation services may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

- Plan may contract with one or more physicians or pharmacists in order to provide consultation services.
- The Plan shall only allow DMC providers to bill for physician consultation services.

Z. RECOVERY SERVICES

- Recovery Services includes:
  - a. Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care;
  - b. Recovery Monitoring: Recovery coaching, monitoring via telephone and internet;
  - c. Substance Abuse Assistance: Peer-to-peer services and relapse prevention;
  - d. Education and Job Skills: Linkages to life skills, employment services, job training, and education services;
  - e. Family Support: Linkages to childcare, parent education, child development support services, family/marriage education;
  - f. Support Groups: Linkages to self-help and support, spiritual and faith-based support;
  - g. Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.
- Recovery services shall be utilized when the beneficiary is triggered, when the beneficiary has relapsed, or simply as a preventative measure to prevent relapse. As part of the assessment and treatment needs of Dimension 6. Recovery Environment of the ASAM Criteria and during the transfer/transition planning process, the contractor shall provide beneficiaries with recovery services.
- Additionally, the Plan shall:
  - a. Provide recovery services to beneficiaries as medically necessary;
  - b. Provide beneficiaries with access to recovery services after completing their course of treatment;
  - c. Deliver recovery services either face-to- face, by telephone, or by telehealth, and in any appropriate setting in the community with the beneficiary.

AA. WITHDRAWAL MANAGEMENT

- The Plan shall ensure network providers deliver a minimum one of the five levels of withdrawal management (WM) services according to the ASAM Criteria, when determined by a Medical Director or LPHA as medically necessary, and in accordance with the beneficiary's individualized treatment plan.
- The Plan shall ensure that all beneficiaries that are receiving both residential services and WM services are monitored during the detoxification process.
- The Plan shall provide medically necessary habilitative and rehabilitative services in accordance with an individualized treatment plan prescribed by a licensed physician or

licensed prescriber.

BB. OPIOD (NARCOTIC) TREATMENT PROGRAM SERVICES (OTP/NTP)

- Pursuant to W&I Code. Section 14124.22, an OTR/NTP provider who is also enrolled as a Medi-Cal provider may provide medically necessary treatment of concurrent health conditions to Medi-Cal beneficiaries who are not enrolled in managed care plans as long as those services are within the scope of the provider's practice. OTP/NTP providers shall refer all Medi-Cal beneficiaries that are enrolled in managed care plans to their respective managed care plan to receive medically necessary medical treatment of their concurrent health conditions.
- The diagnosis and treatment of concurrent health conditions of Medi-Cal beneficiaries that are not enrolled in managed care plans by a Narcotic Treatment Program provider may be provided within the Medi-Cal coverage limits. When the services are not part of the SUD treatment reimbursed pursuant to W&I Code, Section 14021.51, the services rendered shall be reimbursed in accordance with the Medi-Cal program. Services reimbursable under this section shall include all of the following:
    - a. Medical treatment visits;
    - b. Diagnostic blood, urine, and X-rays;
    - c. Psychological and psychiatric tests and services;
    - d. Quantitative blood and urine toxicology assays; and
    - e. Medical supplies.
- An OTP/NTP provider who is enrolled as a Medi-Cal fee-for-service provider shall not seek reimbursement from a beneficiary for SUD treatment services, if the OTP/NTP provider bills the services for treatment of concurrent health conditions to the Medi-Cal fee-for-service program.
- The Plan shall subcontract with licensed NTPs to offer services to beneficiaries who meet medical necessity criteria requirements.
- Services shall be provided in accordance with a plan determined by a licensed prescriber.
- Offer and prescribe medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone, and disulfiram.
- Services provided as part of an OTP/NTP shall include assessment, treatment planning, individual and group counseling, patient education, medication services, collateral services, crisis intervention services, treatment planning; medical psychotherapy, and discharge services.
- Beneficiaries shall receive between 50 and 200 minutes of counseling per calendar month with a therapist or counselor, and when medically necessary, additional counseling services may be provided.

CC. CULTURAL COMPETENCE PLAN

- The Plan shall develop a cultural competency plan and subsequent plan updates.
- Plan shall promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

DD. IMPLEMENTATION PLAN

- The Plan shall comply with the provisions of the Plan's Implementation Plan (IP) as approved by DHCS.
- The Plan shall not provide DMC-ODS services without:
    - a. An approved Implementation Plan approved by DHCS and CMS; and
    - b. A CMS approved Intergovernmental Agreement executed by DHCS and the County's Board of Supervisors.
- The Plan shall obtain written approval by DHCS prior to making any changes to the Implementation Plan.

EE. ADDITIONAL PROVISIONS

1. Additional intergovernmental Agreement Restrictions:
    - This Agreement is subject to any additional restrictions, limitations, conditions, or statutes enacted or amended by the federal or state governments, which may affect the provisions, terms, or funding of this Agreement in any manner.

2. Voluntary Termination of DMC-ODS Services:
    - The Plan may terminate this Agreement at any time, for any reason, by giving 60 days written notice to County and DHCS. The County shall be paid for DMC-ODS services provided to beneficiaries up to the date of termination. Upon termination, the County shall immediately begin providing DMC services to beneficiaries in accordance with the State Plan.

3. Nullification of DMC-ODS Services:
    - The parties agree that failure of the Plan, or its subcontractors, to comply with W&I Section 14124.24, the Special Terms and Conditions, and this Agreement, shall be deemed a breach that results in the termination of this Agreement for cause.
    - In the event of a breach, the DMC-ODS services shall terminate. The County shall immediately begin providing DMC services to the beneficiaries in accordance with the State Plan.

4. Hatch Act:
    - Plan agrees to comply with the provisions of the Hatch Act (Title 5 USC, Sections 1501-1508) which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.

5. No Unlawful Use or Unlawful Messages Regarding Drugs:
    - Plan agrees to that information produced through these funds, and which pertains to drug and alcohol related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug or alcohol related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (HSC

Section 11999-11999.3). By signing this Agreement, Plan agrees that it shall enforce, and shall require its subcontractors to enforce, these requirements.

6. Noncompliance with Reporting Requirements:
   - Plan agrees that County and DHCS have the right to withhold payments until Plan has submitted any required data and reports, as identified in Attachment A, Exhibit A, Attachment 1 or as identified in Document 1F(a), Reporting Requirement Matrix for Counties.

7. Limitation on Use of Funds for Promotion of Legalization of Controlled Substances:
   - None of the funds made available through this Agreement may be used for any activity that promotes the legalization of any drug or other substance included in Schedule I of Section 202 of the Controlled Substances Act (21 USC 812).

8. Health Insurance Portability and Accountability Act (HIPAA) of 1996:
   - If any of the work performed under this Agreement is subject to HIPAA, Plan shall perform the work in compliance with all applicable provisions of HIPAA. As identified in Attachment A, Exhibit F, DHCS, the County and the Plan shall cooperate to assure mutual agreement as to those transactions among them, to which this Provision applies. Refer to Attachment A, Exhibit F for additional information.

9. Trading Partner Requirements:
   a. No changes:
      Plan hereby agrees that for personal health information, it shall not change any definition, data condition or use of a data element or segment as proscribed in the HHS Transaction Standard Regulation (45 CFR Part 162.915).
   b. No additions:
      Plan hereby agrees that for personal health information, it shall not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation (45 CFR Part 162.915(b)).
   c. No Unauthorized Uses:
      Plan hereby agrees that for personal health information, it shall not use any code or data elements that either are marked "not used" in the HHS Transaction's implementation specification or are not in the HHS Transaction Standard's implementation specifications (45 CFR Part 162.915(c))
   d. No Changes to Meaning or Intent:
      Plan hereby agrees that for personal health information, it shall not change the meaning or intent of any of the HHS Transaction Standard's implementation specification (45 CFR Part 162.915(d).

10. Concurrence for Test Modifications to HHS Transaction Standards:
    - Plan agrees and understands that there exists the possibility that DHCS or others may request an extension from the uses of the standard in the HHS Transaction

Standards. If this occurs, Plan agrees that it shall participate in such test modifications.

a. Adequate Testing:
Plan is responsible to adequately test all business rules appropriate to their types and specialties. If the Plan is acting as a clearinghouse for enrolled providers, Plan has obligations to adequately test all business rules appropriate to each and even provider type and specialty for which they provide clearinghouse services.

b. Deficiencies:
The Plan agrees to cure transactions errors or deficiencies identified by DHCS, and transactions errors or deficiencies identified by an enrolled provider if the Plan is acting as a clearinghouse for that provider. If the Plan is a clearinghouse, the Plan agrees to properly communicate deficiencies and other pertinent information regarding electronic transactions to enrolled providers for which they provide clearinghouse services.

c. Code Set Retention:
Both Parties understand and agree to keep open code sets being processed or used in this Agreement for at least the current billing period or any appeal period, whichever is longer.

d. Data Transmission Log:
Plan shall establish and maintain a Data Transmission Log, which shall record any and all data transmissions taking place during the term of this Agreement. All parties shall take necessary and reasonable steps to ensure that such Data Transmission Logs constitute a current, accurate, complete, and unaltered record of any and all Data Transmissions among the Parties, and shall be retained by each Party for no less than twenty-four (24) months following the date of the Data Transmission. The Data Transmission Log may be maintained on computer media or other suitable means provided that, if necessary to do so, the information contained in the Data Transmission Log may be retrieved in a timely manner and presented in readable form.

11. Counselor Certification:

- Any counselor or registrant providing intake, assessment or need for services, treatment or recovery planning, individual or group counseling to participants, patients, or residents in a DHCS licensed or certified program is required to be certified as defined in CCR Title 9, Division 4, Chapter 8. (Document 3H).

12. Cultural and Linguistic Proficiency:

- To ensure equal access to quality care by diverse populations, each service

provider receiving funds from this Agreement shall adopt the Federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards (Attachment A, Document 3V) and comply with 42 CFR 438.206(c)(2).

13. Trafficking Victims Protection Act of 2000:
    - Plan and its network providers that provide services covered by this Agreement shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 (22 USC 7104(g)) as amended by section 1702. For full text of the award term, go to: http://uscode.house.gov/vie w.xhtml?req=granuleid:USC- prelim-title22- section7104d&num=0&editio n=prelim

14. Youth Treatment Guidelines:
    - Plan shall follow the guidelines in Attachment A, Document 1V, incorporated by this reference, "Youth Treatment Guidelines" in developing and implementing adolescent treatment programs funded under this Agreement, until such time new Youth Treatment Guidelines are established and adopted. No formal amendment of this Agreement is required for new guidelines to be incorporated into this Agreement.

15. Nondiscrimination in Employment and Services:
    - By signing this Agreement, Plan certifies that under the laws of the United States and the State of California, incorporated into this Agreement by reference and made a part hereof as it set forth in full, Plan shall not unlawfully discriminate against any person.

16. Federal Law Requirements:
    - Title VI of the Civil Rights Act of 1964, Section 2000d, as amended, prohibiting discrimination based on race, color or national origin in federally funded programs;
    - Title IX of the Education Amendments of 1972 (regarding education programs and activities), if applicable;
    - Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing;
    - Age Discrimination Act of 1975 (45 CFR Part 90) as amended (42 USC Sections 6101-6107), which prohibits discrimination on the basis of age;
    - Age Discrimination in Employment Act (29 CFR Part 1625);
    - Title I of the Americans with Disabilities Act (28 CFR Part 1630) prohibiting discrimination against the disabled in employment;
    - Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities;
    - Title III of the Americans with Disabilities Act (29 CFR Part 36) regarding access;
    - Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities;

- Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under Federal contracts and construction contracts greater than $10,000 funded by Federal financial assistance;
- Executive Order 13166 (67 FR 41455) to improve access to Federal services for those with limited English proficiency;
- The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse;
- The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616) as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism.

17. State Law Requirements:
    - Fair Employment and Housing Act (Government Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (California Administrative Code Title 2, Section 7285.0 et seq.);
    - Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135;
    - Title 9, Division 4, Chapter 8, commencing with Section 10800;
    - No State or Federal funds shall be used by the Plan or its subcontractors, for sectarian worship, instruction, and/or proselytization. No State funds shall be used by the Plan, or its subcontractors, to provide direct, immediate, or substantial support to any religious activity;
    - Noncompliance with the requirements of nondiscrimination in services shall constitute grounds for State to withhold payments under this Agreement or terminate all, or any type, of funding provided hereunder.

18. Investigations and Confidentiality of Administrative Actions:
    - Plan acknowledges that if a DMC provider is under investigation by DHCS or any other state, local or federal law enforcement agency for fraud or abuse, DHCS may temporarily suspend the provider from the DMC program, pursuant to W&I Code Sections 14043.36(a). Information about a provider's administrative section status is confidential until such time as the action is either completed or resolved. DHCS may also issue a Payment Suspension to a provider pursuant to W&I Code, Section 14107.11 and Code of Federal Regulations, Title 42, Section 455.23. The Plan is to withhold payments from a DMC provider during the time a Payment Suspension is in effect.
    - Plan shall execute the Confidentiality Agreement attached in Attachment A Document 5A. The Confidentiality Agreement permits DHCS to communicate with Plan concerning network providers that are subject to administrative sanctions.

19. Subcontract Provisions:
    - Plan shall include all of the Foregoing provisions in all of its subcontracts.

FF. BENEFICIARY PROBLEM RESOLUTION PROCESS

1. Plan shall establish and comply with a beneficiary problem resolution process.

2. Plan shall inform network and providers at the time they enter into a subcontract about:
    a. The beneficiary's right to a state fair hearing, how to obtain a hearing and the representation rules at the hearing;
    b. The beneficiary's right to file grievances and appeals and the requirements and timeframes for filing;
    c. The beneficiary's right to give written consent to allow a provider, acting on behalf of the beneficiary, to file an appeal. A provider may file a grievance or request a state fair hearing on behalf of a beneficiary, if the state permits the provider to act as the beneficiary's authorized representative in doing so;
    d. The beneficiary may file a grievance, either orally or in writing, and as determined by DHCS, either with DHCS or with the Plan;
    e. The availability of assistance with filing grievances and appeals;
    f. The toll-free number to file oral grievances and appeals;
    g. The beneficiary's right to request continuation of benefits during an appeal or state fair hearing filing although the beneficiary may be liable for the cost of any continued benefits if the action is upheld;
    h. Any state determined provider's appeal rights to challenge the failure of the Plan to cover a service.

3. The Plan shall represent the Plan's position in fair hearings, as defined in 42 CFR §438.408 dealing with beneficiaries' appeals of denials, modifications, deferrals or terminations of covered services. The Plan shall carry out the final decisions of the fair hearing process with respect to issues within the scope of the Plan's responsibilities under this Agreement. Nothing in this section is intended to prevent the Plan from pursuing any options available for appealing a fair hearing decision:
    a. Pursuant to 42 CFR §438.228, the Plan shall develop problem resolution processes that enable beneficiary to request and receive review of a problem or concern he or she has about any issue related to the Plan's performance of its duties, including the delivery of SUD treatment services.

4. The Plan's beneficiary problem resolution processes shall include:
    a. A grievance process;
    b. An appeal process; an
    c. An expedited appeal process.

GG. SUBCONTRACTS

1. In addition to complying with the sub contractual relationship requirements set forth in Article II.E.8 of this Agreement, the Plan shall ensure that all subcontracts require that the Plan oversee and is held accountable for any functions and responsibilities that the Plan delegates to any subcontractor.

2. Each subcontract shall:

a. Fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract;

b. Ensure that the Plan evaluates the prospective subcontractor's ability to perform the activities to be delegated;

c. Require a written agreement between the Plan and the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor, and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate;

d. Ensure that the Plan subcontractor's performance on an ongoing basis and subject it to an annual onsite review, consistent with statutes, regulations, and Attachment A, Article III., PP;

e. Ensure that the Plan identifies deficiencies or areas for improvement, the subcontractor shall take corrective actions and the Plan shall ensure that the subcontractor implements these corrective actions.

3. The Plan shall include the following provider requirements in all subcontracts with providers:

a. Culturally Competent Services:
Providers are responsible to provide culturally competent services. Providers shall ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations. Translation services shall be available for beneficiaries, as needed.

b. Medication Assisted Treatment:
Providers will have procedures for linkage/integration for beneficiaries requiring medication assisted treatment. Provider staff will regularly communicate with physicians of beneficiaries who are prescribed these medications unless the beneficiary refuses to consent to sign a 42 CFR part 2 compliant release of information for this purpose.

c. Evidence Based Practices (EBPs):
Providers will implement at least two of the following EBPs based on the timeline established in the county implementation plan. The two EBPs are per provider per service modality. Plan and Counties will ensure the providers have implemented EBPs. The State will monitor the implementation and regular training of EBPs to staff during reviews. The required EBPs include:

1) Motivational Interviewing:
A beneficiary-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on beneficiaries' past successes;

2) Cognitive-Behavioral Therapy:
Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned;

3) Relapse Prevention:
A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment;

4) Trauma-Informed Treatment:
Services shall take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control;

5) Psycho-Education:
Psycho-educational groups are designed to educate beneficiaries about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries' lives, to instill self-awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

HH. PROGRAM INTEGRITY REQUIREMENTS

1. Services Verification:
To assist DHCS in meetings its obligation under 42 CFR §455.1{a)(2), the Plan shall establish a mechanism to verify whether services were actually furnished to beneficiaries.

2. DMC Claims and Reports:
   a. Plan or network providers that bill DHCS, or the Plan for DMC-ODS services shall submit claims in accordance with Department of Health Care Service's DMC Provider Billing Manual.
   b. Plan and network providers that provide DMC services shall be responsible for verifying the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for DMC services to that beneficiary for that month. Medi-Cal eligibility verification should be performed prior to rendering service, in accordance with and as described in the DHCS DMC Provider Billing Manual. Options for verifying the eligibility of a Medi-Cal beneficiary are described in the Department of Health Care Services DMC Provider Billing Manual.

3. Claims for DMC Reimbursement:
Claims for DMC reimbursement shall include DMC-ODS services covered under the

Special Terms and Conditions of this Agreement, and any State Plan services covered under Title 22, Section 51341.1(c-d) and administrative charges that are allowed under W&I Code, Sections 14132.44 and 14132.47.

a. Plan shall submit to DHCS the "Certified Expenditure" form reflecting either:

1) The approved amount of the 837P claim file, after the claims have been adjudicated; or

2) The claimed amount identified on the 837P claim file, which could account for both approved and denied claims:

i. Plan shall submit to DHDHCS the Drug Medi-Cal Certification Form DHCS 100224A (Document 4D) for each 837P transaction approved for reimbursement of the Federal Medicaid funds;

ii. DMC service claims shall be submitted electronically in a Health Insurance Portability and Accountability Act (HIPAA) compliant format (837P);

iii. All adjudicated claim information shall be retrieved by the Plan via an 835 HIPAA compliant format (Health Care Claim Payment/Advice).

4. The following forms shall be prepared as needed and retained by the provider for review by state staff:

a. Good Cause Certification (6065A), Document 2L(a);

b. Good Cause Certification (6065B), Document 2L(b);

c. In the absence of good cause documented on the Good Cause Certification (6065A or 6065B) form, claims that are not submitted within 30-days of the end of the month of service shall be denied. The existence of good cause shall be determined by DHCS in accordance with Title 22, Sections 51008 and 51008.5.

II. QUALITY MANAGEMENT (QM) PROGRAM

1. The Plan's QM Program shall improve Plan's established treatment outcomes through structural and operational processes and activities that are consistent with current standards of practice.

2. The Plan shall have a written description of the QM Program, which clearly defines the QM Program's structure and elements, assigns responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement.

3. Annually, Plan shall:

a. Measure and report to County and DHCS its performance using standard measures required by DHCS including those that incorporate the requirements set forth in Article II.F.1 of this Agreement;

b. Submit to County and DHCS data specified by DHCS that enables DHCS to measure the Plan's performance, or
c. Perform a combination of the activities described above.
d. Evaluate and update the QM Program annually as necessary as set forth in Attachment A, Article II.F.1 of this Agreement.

4. During the Triennial Reviews. DHCS and County shall review the status of the Quality Improvement Plan and the Plan's monitoring activities.
   a. This review shall include the service delivery system, beneficiary protections, access to services, authorization for services, compliance with regulatory and contractual requirements of the waiver, and a beneficiary records review;
   b. This triennial review shall provide County and DHCS with information as to whether the Plan is complying with their responsibility to monitor their service delivery capacity;
   c. The Plan and counties shall receive a final report summarizing the findings of the triennial review, and if out of compliance, the Plan shall submit a plan of correction (POC) within 60 days of receipt of the final report. DHCS and County shall follow-up with the POC to ensure compliance.

5. The QM Program shall conduct performance- monitoring activities throughout the Plan's operations. These activities shall include, but not be limited to, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, and resolution of beneficiary grievances.

6. The Plan shall ensure continuity and coordination of care with physical health care providers. The Plan shall coordinate with other human services agencies used by its beneficiaries.

7. The Plan shall have mechanisms to detect both underutilization of services and overutilization of services, as required by Attachment A, Article II.F.1 of this Agreement.

8. The Plan shall implement mechanisms to assess beneficiary/family satisfaction. The Plan shall assess beneficiary/family satisfaction by:
   a. Surveying beneficiary/family satisfaction with the Plan's services at least annually;
   b. Evaluating beneficiary grievances, appeals and fair hearings at least annually;
   c. Evaluating requests to change persons providing services at least annually; and
   d. The Plan shall inform providers of the results of beneficiary/family satisfaction activities.

9. The Plan shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a

person licensed to prescribe or dispense prescription drugs. Monitoring shall occur at least annually.

10. The Plan shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The Plan shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the Plan at least annually.

11. The Plan shall have a QM Work Plan covering the current agreement cycle with documented annual evaluations and documented revisions as needed. The Plan's QM Work Plan shall evaluate the impact and effectiveness of its quality assessment and performance improvement program. The QM Work Plan shall include:
    a. Evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Attachment A, Article II.G.8 and Article of this Agreement;
    b. Evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service;
    c. A description of completed and in-process QM activities, including performance improvement projects. The description shall include:
        1) Monitoring efforts for previously identified issues, including tracking issues over time;
        2) Objectives, scope, and planned QM activities for each year,
        3) Targeted areas of improvement or change in service delivery or program design.
    d. A description of mechanisms the Plan has implemented to assess the accessibility of services within its service delivery area. This shall include goals for responsiveness for the Plan's 24-hour toll-free telephone number, timeliness for scheduling of routine appointments, timeliness of services for urgent conditions, and access to after-hours care.

12. Evidence of compliance with the requirements for cultural competence and linguistic competence specified in Attachment A, Article II.B.2 of this Agreement and Attachment A, Article II.E.1 of this Agreement.

JJ. STATE MONITORING – POSTSERVICE POSTPAYMENT AND POSTSERVE PREPAYMENT – UTILIZATION REVIEWS

1. DHCS shall conduct Post service Post payment and Post service Prepayment (PSPP) Utilization Reviews of the contracted DMC providers to determine whether the DMC services were provided in accordance with Attachment A, Article III., PP. DHCS shall issue the PSPP report to the Plan with a copy to County and network provider. The Plan shall be responsible for their subcontracted providers and their Plan run programs to ensure any deficiencies are remediated pursuant to Attachment A, Article III.DD. The Plan shall attest the deficiencies have been remediated and are complete, pursuant to

Attachment A, Article III.EE.5 of this Agreement.

2. The Department shall recover payments made if subsequent investigation uncovers evidence that the claim(s) should not have been paid, DMC-ODS services have been improperly utilized, and requirements of Attachment A, Article III., PP were not met.
   a. All deficiencies identified by PSPP reports, whether or not a recovery of funds results, shall be corrected and the entity that provided the services shall submit a Plan approved corrective action plan (CAP) to the Department within 60 days of the date of the PSPP report.
      1) The corrective action plan shall:
         - Be documented on the DHCS CAP template;
         - Provide a specific description of how the deficiency shall be corrected;
         - Identify the title of the individual responsible for (1) correcting the deficiency and (2) ensuring on-going compliance;
         - Provide a specific description of how the provider will ensure on-going compliance;
         - Specify the target date of implementation of the corrective action.
      2) DHCS shall provide written approval of the CAP to the Plan with a copy to the provider. If DHCS does not approve the CAP, DHCS shall provide guidance on the deficient areas and request an updated CAP from the Plan with a copy to the provider. Plan shall submit an updated CAP to the DHCS analyst that conducted the review within 30 days of notification.
      3) If a CAP is not submitted, or the provider does not implement the approved CAP provisions within the designated timeline, then DHCS may withhold funds from the Plan until the entity that provided the services is in compliance with Attachment A, Exhibit A. Attachment I. DHCS shall inform the Plan when funds shall be withheld.

3. The Plan and/or subcontractor may appeal DMC dispositions concerning demands for recovery of payment and/or programmatic deficiencies of specific claims. Such Appeals shall be handled as follows:
   a. Requests for first-level appeals:
      1) The Plan shall initiate action by submitting a letter to:
         Division Chief MCBHD
         1500 Capital Avenue, MS-2623
         Sacramento, CA 95814
      2) The Plan shall submit the letter on the official stationery of the Plan and it shall be signed by an authorized representative of the Plan;
      3) The letter shall identify the specific claim(s) involved and describe the disputed inaction regarding the claim.
   b. The letter shall be submitted to the address listed above within 90 calendar

days of receipt from the date the Plan received written notification of the decision to disallow claims.

c. The MCBHD shall acknowledge Plan letter within 15 calendar days of receipt.

d. MCBHD shall inform the Plan of MCBHD's decision and the basis for the decision within 15 calendar days after the MCBHD's acknowledgement notification. The MCBHD shall have the option of extending the decision response time if additional information is required from the provider and/or county. The Plan will be notified if the MCBHD extends the response time limit.

e The Plan may initiate a second level appeal to the Office of Administrative Hearings and Appeals (OAHA):

1) The second level process may be pursued only after complying with first-level procedures and only when:
   i. The MCBHD has failed to acknowledge the grievance or complaint within 15 calendar days of its receipt, or
   ii. The Plan is dissatisfied with the action taken by the MCBHD where the conclusion is based on the MCBHD's evaluation of the merits;
   iii. The second-level appeal shall be submitted to the Office of Administrative Hearings and Appeals within 30 calendar days from the date MCBHD failed to acknowledge the first-level appeal or from the date of the MCBHD 's first-level appeal decision letter;

2) All second-level appeals made in accordance with this section shall be directed to:

   Office of Administrative Hearings and Appeals
   1029 J Street, Suite 200, MS 0016
   Sacramento, CA 95814

3) In referring an appeal to the OAHA, the Plan shall submit all of the following:
   i. A copy of the original written appeal sent to the MCBHD;
   ii. If received by the Plan, a copy of the MCBHD's specific finding(s), and conclusion(s) regarding the appeal with which the Plan is dissatisfied.

4. The appeal process listed here shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of DHCS pursuant to Attachment A, Exhibit B of this Agreement.

5.. State shall monitor the subcontractor's compliance with PSPP utilization review requirements, as specified in Attachment A, Article III.EE. The Plan is required to monitor the subcontractor's compliance pursuant to Attachment A, Article III., AA of this

Agreement. The federal government may also review the existence and effectiveness of DHCS's utilization review system.

6. Plan shall, at a minimum, implement and maintain compliance with the system of review described in Attachment A, Article III, PP for the purposes of reviewing the utilization, quality, and appropriateness of covered services and ensuring that all applicable Medi-Cal requirements are met.

7. Plan shall assure that subcontractor sites shall keep a record of the beneficiaries/patients being treated at that location. Plan shall retain beneficiary records for a minimum of 10 years, in accordance with 42 CFR §438.3(h), from the finalized cost settlement process with the Department. When an audit by the Federal Government or DHCS has been started before the expiration of the 10-year period, the beneficiary records shall be maintained until completion of the audit and the final resolution of all issues.

KK. CONTRACTOR MONITORING

1. Plan shall conduct, at least annually, a utilization review of network providers to assure covered services are being appropriately rendered. The annual review shall include an on-site visit of the service provider. Reports of the annual review shall be provided to DHCS's and Integrity Branch at:

   Department of Health Care Services
   Medi-Cal Behavioral Health Division
   1500 Capital Avenue, MS 2623
   Sacramento, CA 95899-7413

   or by secure, encrypted email to: SUDCountyReports@dhcs.c a.gov.

   - The Plan's reports shall be provided to DHCS within 2 weeks of completion. Technical assistance is available to counties from MCBHD.

2. If significant deficiencies or significant evidence of noncompliance with the terms of the DMC-ODS waiver, or this Agreement are found in Plan, DHCS shall engage the County and Plan to determine if there are challenges that can be addressed with facilitation and technical assistance. If the Plan remains noncompliant, the Plan shall submit a corrective action plan (CAP) to DHCS. The CAP shall detail how and when the Plan shall remedy the issue(s). DHCS may remove the Plan from participating in the Waiver if the CAP is not promptly implemented.

3. If the Plan is removed from participating in the Waiver, the County shall provide DMC services in accordance with the California Medi-Cal State Plan.

4. Plan shall ensure that DATAR submissions, detailed in Attachment A, Article III., FF, are complied with by all treatment providers and network treatment providers. Plan shall attest that each network provider is enrolled in DATAR at the time of execution of the subcontract.

5. The Plan shall monitor and attest compliance and/or completion by Providers with CAP

requirements (detailed in Attachment A, Article III.DD) of this Exhibit as required by any PSPP review. The Plan shall attest to County and DHCS, using the form developed by DHCS that the requirements in the CAP have been completed by the Plan and/or the provider. Submission of DHCS Form 8049 by Plan shall be accomplished within the timeline specified in the approved CAP, as noticed by DHCS.

6. Plan shall attest that DMC claims submitted to DHCS have been subject to review and verification process for accuracy and legitimacy, (45 CFR §430.30, §433.32, §433.51). Plan shall not knowingly submit claims for services rendered to any beneficiary after the beneficiary's date of death, or from uncertified or decertified providers.

LL. REPORTING REQUIREMENTS

1. Plan agrees that DHCS has the right to withhold payments until Plan has submitted any required data and reports to DHCS, as identified in Attachment A, Exhibit A. Attachment I or as identified in Attachment A, Document 1F(a). Reporting Requirement Matrix for Counties.

2. Plan shall submit documentation to DHCS in a format specified by DHCS that complies with the following requirements:
    a. Offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service area.
    b. Maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of beneficiaries in the area.
    c. Demonstrates the Plan’s compliance with the parity requirements set forth in 42 CFR §438.900 et seq.

3. The Plan shall submit the documentation described in paragraph (2) of this section as specified by DHCS, but no less frequently than the following:
    a. At the time it enters into this Agreement.
    b. At any time there has been a significant change (as in the Plan's operations) that would affect adequate capacity and services, and parity including:
        1) Changes in Plan services, benefits, geographic service area or payments, or
        2) Enrollment of a new population in the Plan.
    c. Changes in quantitative limitation or non-quantitative limitation on a substance use disorder benefit;
        1) After DHCS reviews the documentation submitted by the Plan, DHCS shall complied with the State's requirements for availability of services, as set forth in §438.206.certify to CMS that the Plan has complied with the State's requirements for availability of services, as set forth in §438.206, and parity requirements, as set forth in 42 CFR 438.900 et. seq.

2) CMS' right to inspect documentation. DHCS shall make available to CMS, upon request, all documentation collected by DHCS from the Plan.

4. California Outcomes Measurement System (CalOMS) for Treatment (CalOMS-Tx)

- The CalOMS-Tx business rules and requirements are:
  a. Plan shall arrange for compliance with the CalOMS-Tx data collection system requirements for submission of CalOMS- Tx data. A Business Associate Agreement (BM) shall be established between the Plan and any relevant software vendor. The BM shall state that DHCS is allowed to return the processed CalOMS-Tx data to the entity that supplied the data to DHCS.
  b. Plan conduct information technology (IT) systems testing and pass state certification testing before commencing submission of CalOMS-Tx data. If the Plan subcontracts with vendor for IT services, Plan is responsible for ensuring that the subcontracted IT system is tested and certified by the DHCS prior to submitting CalOMS-Tx data. If Plan changes or modifies the CalOMS-Tx IT system, then Plan shall re-test and pass state re- certification prior to submitting data from new or modified system.
  c. Electronic submission of CalOMS-Tx data shall be submitted by Plan within 45-days from the end of the last day of the report month.
  d. Plan shall comply with data collection and reporting requirements established by the DHCS CalOMS-Tx Data Collection Guide (Document 3J), and all former Department of Alcohol and Drug Programs Bulletins and DHCS Information Notices relevant to CalOMS-Tx data collection and reporting requirements.
  e. Plan shall submit CalOMS-Tx admission, discharge, annual update, resubmissions of records containing errors or in need of correction, and "provider no activity" report records in an electronic format approved by DHCS.
  f. Plan shall comply with the CalOMS-Tx Data Compliance Standards established by DHCS identified in (Document 3S) for reporting data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method.
  g. Plan shall participate in CalOMS-Tx informational meetings, trainings, and conference calls.
  h. Plan shall implement and maintain a system for collecting and electronically submitting CalOMS-Tx data.
  i. Plan shall meet the requirements as identified in Attachment A, Exhibit F, Privacy and Information Security Provisions.

- CalOMS-Tx General Information
  a. If the Plan experiences system or service failure or other extraordinary circumstances that affect its ability to timely submit

CalOMS-Tx data, and/or meet other CalOMS-Tx compliance requirements, Plan shall report the problem in writing by secure, encrypted e-mail to DHCS at itservicedesk@DHCS.ca.gov before the established data submission deadlines. The written notice shall include a remediation plan that is subject to review and approval by DHCS. A grace period of up to 60-days may be granted, at DHCS's sole discretion, for the Plan to resolve the problem before non-DMC payments are withheld.

b. If DHCS experiences system or service failure, no penalties shall be assessed to the Plan for late data submission.

c. Plan shall comply with the treatment data quality standards established by DHCS. Failure to meet these standards on an ongoing basis may result in withholding non-DMC funds.

d. If the Plan submits data after the established deadlines, due to a delay or problem, the Plan shall still be responsible for collecting and reporting data from time of delay or problem.

5. Drug and Alcohol Treatment Access Report (DATAR)

- The DATAR business rules and requirements:

a. The Plan shall be responsible for ensuring that the network providers submit a monthly DATAR report in an electronic copy format as provided by DHCS.

b. In those instances, where the Plan maintains, either directly or indirectly, a central intake unit or equivalent which provides intake services including a waiting list, the Plan shall identify and begin submitting monthly DATAR reports for the central intake unit by a date to be specified by DHCS.

c. The Plan shall ensure that all DATAR reports are submitted by either Plan-operated treatment services and by each subcontracted treatment provider to DHCS by the 10th of the month following the report activity month.

d. The Plan shall ensure that all applicable providers are enrolled in DHCS's web-based DATAR program for submission of data, accessible on the DHCS website when executing the subcontract.

e. If the Plan or its subcontractor experiences system or service failure or other extraordinary circumstances that affect its ability to timely submit a monthly DATAR report, and/or to meet data compliance requirements, the Plan shall report the problem in writing before the established data submission deadlines. The written notice shall include a corrective action plan that is subject to review and approval by DHCS. A grace period of up to 60- days may be granted, at DHCS's sole discretion, for the Plan to resolve the problem before non- DMC payments are withheld (See Attachment A, Exhibit B, Part II, Section 2).

f. If DHCS experiences system or service failure, no penalties shall be assessed to Plan for late data submission.

g. The Plan shall be considered compliant if a minimum of 95% of required DATAR reports from the Plan's network providers are received by the due date.

6. Failure to Meet Reporting Requirements

- Failure to meet required reporting requirements shall result in:
  a. DHCS or County shall issue a Notice of Deficiency (Deficiencies) to Plan regarding specified providers with a deadline to submit the required data and a request for a Corrective Action Plan (CAP) to ensure timely reporting in the future. DHCS shall approve or reject the CAP or request revisions to the CAP, which shall be resubmitted to DHCS within 30-days.
  b. If the Plan has not ensured compliance with the data submission or CAP request within the designated timeline, then DHCS may withhold funds until all data is submitted. DHCS shall inform the Plan when funds shall be withheld.

MM. TRAINING

- Training to DMC Subcontractors:
  a. The Plan shall ensure that all network providers receive training on the DMC-ODS requirements, at least annually. The Plan shall report compliance with this section to County and DHCS annually as part of the DHCS County Monitoring process.
  b. The Plan shall require network providers to be trained in the ASAM Criteria prior to providing services.
     1) The Plan shall ensure that, at minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled, "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care". A third module entitled, "Introduction to The ASAM Criteria" is recommended for all county and provider staff participating in the Waiver. With assistance from the state, counties will facilitate ASAM provider trainings.
     2) The Plan shall ensure that all residential service providers meet the established ASAM criteria for each level of residential care they provide and receive an ASAM Designation prior to providing DMC-ODS services.

NN. PROGRAM COMPLAINTS

- The Plan shall be responsible for investigating complaints and providing the results of all investigations to DHCS by secure, encrypted e-mail to SUDCountyReports@dhcs.ca.gov within two business days of completion.
- Complaints for Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities, and counselor complaints may be made by using the

complaint form. The Complaint Form is available, and may be submitted, online: http://www.dhcs.ca.gov/individuals/Pages/Sud-Complaints.aspx

- Suspected Medi-Cal fraud, waste, or abuse must be reported to:
  DHCS Medi-Cal Fraud: (800) 822-6222 or Fraud@dhcs.ca.gov

OO. RECORD RETENTION

- Plan shall include instructions on record retention and include in any subcontract with providers the mandate to keep and maintain records for each service rendered, to whom it was rendered, and the date of service, pursuant to WIC 14214.1 and 42 CFR §438.3(h) and 438.3(u).

PP. SUBCONTRACT TERMINATION

- The Plan shall notify County and the Department of the termination of any subcontract with a certified provider, and the basis for termination of the subcontract, within two business days. The Plan shall submit the notification by secure, encrypted email to: SUDCountyReports@dhcs.ca.gov

QQ. CORRECTIVE ACTION PLAN

1. If the Plan fails to ensure any of the foregoing oversight through an adequate system of monitoring, utilization review, and fiscal and programmatic controls. DHCS may request a corrective action plan (CAP) from the Plan to address these deficiencies and a timeline for implementation. Failure to submit a CAP or adhere to the provisions in the CAP can result in a withhold of funds allocated to Plan for the provision of services, and/or termination of this Agreement for cause.

2. Failure to comply with Monitoring requirements shall result in:
   a. DHCS shall issue a report to County and Plan after conducting monitoring, utilization, or fiscal auditing reviews of the Plan. When the DHCS report identifies non-compliant services or processes, it shall require a CAP. The Plan shall submit a CAP to County and DHCS within the timeframes required by DHCS.
      1) The CAP shall:
         - Be documented in the DHCS CAP template.
         - Provide a specific description of how the deficiency shall be corrected.
         - Identify the title of the individual(s) responsible for: (1) Correcting the deficiency; (2) Ensuring on-going compliance.
         - Provide a specific description of how the provider will ensure on-going compliance.
         - Specify the target date of implementation of the corrective action.

2) DHCS shall provide written approval of the CAP to the Plan. If DHCS does not approve the CAP submitted by the Plan. DHCS shall provide guidance on the deficient areas and request an updated CAP from the Plan with a new deadline for submission.

3) If a CAP is not submitted, or, the Plan does not implement the approved CAP provisions within the designated timeline, then DHCS may withhold funds until the Plan is in compliance. DHCS shall inform the Plan when funds shall be withheld.

RR. QUALITY IMPROVEMENT (QI) PROGRAM

1. Plan shall establish an ongoing quality assessment and performance improvement program consistent with Attachment A, Article II.F.1 of this Agreement.

2. CMS, in consultation with DHCS and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by DHCS in this Agreement.

3. Performance improvement projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and beneficiary satisfaction.

4. The monitoring of accessibility of services outlined in the Quality Improvement (QI) Plan will at a minimum include:

   a. Timeliness of first initial contact to face-to-face appointment.
   b. Frequency of follow-up appointments in accordance with individualized treatment plans.
   c. Timeliness of services of the first dose of OTP/NTP services.
   d. Access to after-hours care.
   e. Responsiveness of the beneficiary access line.
   f. Strategies to reduce avoidable hospitalizations.
   g. Coordination of physical and mental health services with waiver services at the provider level.
   h. Assessment of the beneficiaries' experiences.
   i. Telephone access line and services in the prevalent non-English languages.

5. The Plan's QI program shall monitor the Plan's service delivery system with the aim of improving the processes of providing care and better meeting the needs of its beneficiaries. The QI Program shall ultimately be accountable to the Plan's CEO.

6. The Plan shall establish a QI Committee to review the quality of SUD treatment services provided to beneficiaries. The QI Committee shall recommend policy decisions, review

and evaluate the results of QI activities, including performance improvement projects; institute needed QI actions, ensure follow-up of QI processes, and document QI Committee meeting minutes regarding decisions and actions taken. The QI committee shall recommend policy decisions, review and evaluate the results of QI activities, institute needed QI actions, ensure follow-up of QI process and document QI committee minutes regarding decisions and actions taken.

7. The Plan's QI Committee shall review the following data at a minimum on a quarterly basis since external quality review (EQR) site reviews will begin after Plan implementation. The External Quality Review Organization (EQRO) shall measure defined data elements to assess the quality of service provided y the Plan. These data elements shall be incorporated into the EQRO protocol:
    a. Number of days to first DMC-ODS service at appropriate level of care after referral.
    b. Existence of a 24/7 telephone access line with prevalent non- English language(s).
    c. Access to DMC-ODS services with translation services in the prevalent non-English language(s).

8. Operation of the QI program shall include substantial involvement by a licensed SUD staff person.

9. QI Program shall include active participation by the Plan's practitioners and providers, as well as beneficiaries and family members, in the planning, design and execution of the QI Program.

10. The Plan shall maintain a minimum of two active Performance Improvement Projects (PIPs) that meet the criteria in 42 CFR §438.330(b)(1) and (d). Performance improvement projects shall focus on a clinical area, as well as one non-clinical area.

11. PIPs shall:
    a. Measure performance using required quality indicators.
    b. Implement system interventions to achieve improvement in quality.
    c. Evaluate the effectiveness of interventions.
    d. Plan and initiate activities for increasing or sustaining improvement.

12. The Plan shall report the status and results of each PIP to DHCS, as requested.

13. Each PIP shall be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care annually.

SS. UTILIZATION MANAGEMENT PROGRAM

- The Plan shall have a Utilization Management (UM) Program assuring that beneficiaries have appropriate access to SUD services, medical necessity has been

established, the beneficiary is at the appropriate ASAM level of care, and that the interventions are appropriate for the diagnosis and level of care. The Plan shall have a documented system for collecting, maintaining and evaluating accessibility to care and waiting list information, including tracking the number of days to first DMC•ODS service at an appropriate level of care following initial request or referral for all DMC-ODS services.

TT. FORMATION AND PURPOSE

Control Requirements:
Performance under the terms of Attachment A, Exhibit I, is subject to all applicable federal and state laws, regulations and standards. The Plan shall:

a. Require its subcontractors to establish written policies and procedures consistent with the requirements listed below.
b. Monitor for compliance with the written procedures.
c. Be held accountable for audit exceptions taken by DHCS against Plan and its subcontractors for any failure to comply with these requirements:
    1) HSC, Division 10.5, commencing with Section 11760
    2) Title 9, Division 4, commencing with Section 13000;
    3) Government Code Section 16367.8
    4) Title 42, CFR Sections 8.1 through 8.6
    5) Title 21, CFR, Sections 1301.01 through 1301.93, Department of Justice, Controlled Substances; and Chapter 7200 (General Outline of Procedures)
d. Plan shall be familiar with the above laws, regulations and guidelines and shall assure that its subcontractors are also familiar with such requirements.
e. The provisions of Attachment A, Exhibit A, Attachment I are not intended to abrogate any provisions of law or regulation, or any standards existing or enacted during the term of this Agreement.

UU. PERFORMANCE PROVISIONS

Monitoring:

- Plan's performance under this Exhibit A, Attachment I, shall be monitored by County and DHCS annually during the term of this Agreement. Monitoring criteria shall include, but not be limited to:
    a. Whether the quantity of work or services being performed conforms to Attachment A.
    b. Whether the Plan has established and is monitoring appropriate quality standards.
    c. Whether the Plan is abiding by all the terms and requirements of this Agreement.
- Plan shall conduct annual onsite monitoring reviews of services and subcontracted services for programmatic and fiscal requirements. Plan shall submit copies of their monitoring and audit reports to County and to DHCS within two weeks of issuance. Reports should be sent by secure, encrypted e-mail to:

SUDCountyReports@dhcs.ca.gov . Alternatively, mail to:

Department of Health Care Services
Medi-Cal Behavioral Division
1500 Capital Avenue MS 2623
Sacramento, CA 95814

- Failure to comply with the above provisions shall constitute grounds for DHCS to suspend or recover payments, subject to the Plan's right of appeal, or may result in termination of this Agreement or both.

Performance Requirements:

1. Plan shall provide services based on funding set forth in Attachment A, Exhibit B, Attachment I, and under the terms of this Agreement.

2. Plan shall provide services to all eligible persons in accordance with federal and State statutes and regulations. Plan shall assure that in planning for the provision of services, the following barriers to services are considered and addressed:
    a. Lack of educational materials or other resources for the provision of services;
    b. Geographic isolation and transportation needs of persons seeking services or remoteness of services;
    c. Institutional, cultural, and/or ethnicity barriers;
    d. Language differences;
    e. Lack of service advocates;
    f. Failure to survey or otherwise identify the barriers to service accessibility; and,
    g. Needs of persons with a disability.

3. Plan shall comply with any additional requirements of the documents that have been incorporated by reference, including, but not limited to, those in the Exhibit A - Statement of Work.

4. Amounts awarded pursuant to Attachment A, Exhibit B, Attachment I, shall be used exclusively for providing DMC-ODS services consistent with the purpose of the funding.

5. DHCS shall issue a report to County and Plan after conducting monitoring or, utilization, reviews of Plan or Plan network providers. When the DHCS report identifies non-compliant services or processes, it shall require a CAP. The Plan, or in coordination with its subcontracted provider, shall submit a CAP to County and DHCS within 60-calendar days from the date of the report. The CAP shall be electronically submitted, directly to the DHCS analyst who conducted the review.

6. The CAP shall follow the requirements in Attachment A, Article III.KK.2.

VV. REQUIREMENTS FOR SERVICES

1. Confidentiality:

All substance use disorder treatment services shall be provided in a confidential setting in compliance with 42 CFR, Part 2 requirements.

2. Perinatal Services:
   - Perinatal services shall address treatment and recovery issues specific to pregnant and postpartum women, such as relationships, sexual and physical abuse, and development of parenting skills.
   - Perinatal services shall include:
     a. Mother/child habilitative and rehabilitative services (i.e., development of parenting skills, training in child development, which may include the provision of cooperative child care pursuant to Health and Safety Code Section 1596.792);
     b. Service access (i.e., provision of or arrangement for transportation to and from medically necessary treatment);
     c. Education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant; and
     d. Coordination of ancillary services (i.e., assistance in accessing and completing dental services, social services, community services, educational/ vocational training and other services, which are medically necessary to prevent risk to fetus or infant).
     e. Medical documentation that substantiates the beneficiary's pregnancy and the last day of pregnancy shall be maintained in the beneficiary record.
     f. Plan shall comply with the perinatal program requirements as outlined in the Perinatal Practice Guidelines. The Perinatal Practice Guidelines are attached to Attachment A, Document 1G, incorporated by reference. The Plan shall comply with the current version of these guidelines until new Perinatal Practice Guidelines are established and adopted. The incorporation of any new Perinatal Practice Guidelines into this Agreement shall not require a formal amendment.

3. Narcotic Treatment Services
   - OTP/NTP services and regulatory requirements shall be provided in accordance with CCR Title 9, Chapter 4.

4. Naltrexone Treatment Services
   - For each beneficiary, all of the following shall apply:
     a. The provider shall confirm and document that the beneficiary meets all of the following conditions:
        1) Has a documented history of opiate addiction.
        2) Is at least 18 years of age.
        3) Has been opiate free for a period of time to be determined by a physician based on the physician's clinical judgment. The provider shall administer a body specimen test to confirm the opiate free status of the beneficiary.

4) Is not pregnant and is discharged from the treatment if she becomes pregnant.

- The physician shall certify the beneficiary's fitness for treatment based upon the beneficiary's physical examination, medical history, and laboratory results; and
- The physician shall advise the beneficiary of the overdose risk should the beneficiary return to opiate use while taking Naltrexone and the ineffectiveness of opiate pain relievers while on Naltrexone.

5. Substance Use Disorder Medical Director:

- The SUD Medical Director's responsibilities shall, at a minimum, include all of the following:
  - Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
  - Ensure that physicians do not delegate their duties to non-physician personnel.
  - Develop and implement medical policies and standards for the provider.
  - Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
  - Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
  - Ensure that provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries, determine the medical necessity of treatment for beneficiaries.
  - Ensure that provider's physicians are adequately trained to perform other physician duties.
- The SUD Medical Director may delegate his/her responsibilities to a physician consistent with the provider's medical policies and standards; however. the substance use disorder medical director shall remain responsible for ensuring all delegated duties are properly performed.

6. Provider Personnel

- Personnel files shall be maintained on all employees and volunteers and interns and shall contain the following:
  a. Application for employment and/or resume;
  b. Signed employment confirmation statement/duty statement;
  c. Job description;
  d. Performance evaluations;
  e. Health records/status as required by the provider. AOD Certification or CCR Title 9;
  f. Other personnel actions (e.g. commendations, discipline, status change. employment incidents and/or injuries);
  g. Training documentation relative to substance use disorders and treatment;
  h. Current registration, certification, intern status. or licensure;
  i. Proof of continuing education required by licensing or certifying agency and program; and
  j. Provider's Code of Conduct.

- Job descriptions shall be developed, revised as needed, and approved by the provider's governing body. The job descriptions shall include:
  - a. Position title and classification;
  - b. Duties and responsibilities;
  - c. Lines of supervision; and
  - d. Education, training, work experience, and other qualifications for the position.
- Written provider code of conduct for employees and volunteers and interns shall be established which addresses at least the following:
  - a. Use of drugs and/or alcohol;
  - b. Prohibition of social/business relationship with beneficiary's or their family members for personal gain;
  - c. Prohibition of sexual contact with;
  - d. Conflict of interest;
  - e. Providing services beyond scope;
  - f. Discrimination against beneficiary's or staff;
  - g. Verbally, physically, or sexually harassing, threatening, or abusing beneficiary's family members or other staff;
  - h. Protection beneficiary confidentiality;
  - i. Cooperate with complaint investigations;

- If a provider utilizes the services of volunteers and or interns. procedures shall be implemented which address:
  - a. Recruitment;
  - b. Screening; Selection;
  - c. Training and orientation;
  - d. Duties and assignments;
  - e. Scope of practice;
  - f. Supervision;
  - g. Evaluation; and
  - h. Protection of beneficiary confidentiality.

- Written roles and responsibilities and a code of conduct for the medical director shall be clearly documented, signed and dated by a provider representative and the physician.

7. Beneficiary Admission:

- Each provider shall include in its policies, procedures, and practice, written admission and readmission criteria for determining beneficiary’s eligibility and the medical necessity for treatment. These criteria shall include, at minimum:
  - a. DSM diagnosis;
  - b. Use of alcohol/drugs of abuse;
  - c. Physical health status; and
  - d. Documentation of social and psychological problems.

- If a potential beneficiary does not meet the admission criteria, the beneficiary shall be

referred to an appropriate service provider.

- If a beneficiary is admitted to treatment, the beneficiary shall sign a consent to treatment form.
- The medical director or LPHA shall document the basis for the diagnosis in the beneficiary record.
- All referrals made by the provider staff shall be documented in the beneficiary record.
- Copies of the following documents shall be provided to the beneficiary upon admission:
    - a. Beneficiary rights,
    - b. share of cost if applicable,
    - c. notification of DMC funding accepted as payment in full, and
    - d. consent to treatment.

8. Assessment:

- The provider shall assure a counselor or LPHA completes a personal, medical, and substance use history for each beneficiary upon admission to treatment.
    - a. Assessment for all beneficiaries shall include at a minimum:
        - 1) Drug/Alcohol use history;
        - 2) Medical history;
        - 3) Family history;
        - 4) Psychiatric/psychological history;
        - 5) Social/recreational history;
        - 6) Financial status/history;
        - 7) Educational history;
        - 8) Employment history;
        - 9) Criminal history;
        - 10) Previous SUD treatment history.

- The medical director or LPHA shall review each beneficiary's personal, medical and substance use history if completed by a counselor within 30 calendar days of each beneficiary's admission to treatment date.

9. Beneficiary Record:

- In addition to the requirements of 22 CCR § 51476(a). the provider shall:
    - a. Establish, maintain, and update as necessary, an individual beneficiary record for each beneficiary admitted to treatment and receiving services.
    - b. Each beneficiary's individual beneficiary record shall include documentation of personal information.
    - c. Documentation of personal information shall include all of the following:
        - 1) Information specifying the beneficiary's identifier (i.e. name. number).
        - 2) Date of beneficiary's birth, the beneficiary's sex, race and/or ethnic background, beneficiary's address and telephone number, beneficiary's next of kin or emergency contact.
- Documentation of treatment episode information shall include documentation of all

activities, services, sessions and assessments, including but not limited to all of the following:

a. Intake and admission data, including, if applicable, a physical examination.
b. Treatment plans.
c. Progress notes.
d. Continuing services justifications.
e. Laboratory test orders and results.
f. Referrals.
g. Discharge plan.
h. Discharge summary.
i. Contractor authorizations for Residential Services.
j. Any other information relating to the treatment services rendered to the beneficiary.

10. Diagnostic Requirements:

- The Medical Director or LPHA shall evaluate each beneficiary's assessment and intake information if completed by a counselor through a face-to-face review or telehealth with the counselor to establish a beneficiary meets medical necessity criteria in Attachment A, Article III.B.2.ii.
    a. The medical director or LPHA shall document separately from the treatment plan the basis for the diagnosis in the beneficiary's record within 30 calendar days of each beneficiary's admission to treatment date.
        i. The basis for the diagnosis shall be a narrative summary based on DSM-5 criteria, demonstrating the Medical Director or LPHA evaluated each beneficiary's assessment and intake information, including their personal, medical and substance use history.
        ii. The Medical Director or LPHA shall type or legibly print their name and sign and date the diagnosis documentation.

11. Physical Examination Requirements:

- If a beneficiary had a physical examination within the twelve-month period prior to the beneficiary's admission to treatment date, the physician or registered nurse practitioner or physician's assistant (physician extenders) shall review documentation of the beneficiary's most recent physical examination within 30 calendar days of the beneficiary's admission to treatment date.
    a. If a provider is unable to obtain documentation of a beneficiary's most recent physical examination, the provider shall describe the efforts made to obtain this documentation in the beneficiary's individual patient record.
    b. As an alternative to complying with paragraph (i) above or in addition to complying with paragraph (i) above, the physician or physician extender may perform a physical examination of the beneficiary within 30 calendar days of the beneficiary's admission to treatment date.
    c. If the physician or a physician extender has not reviewed the documentation of the beneficiary's physical examination as provided for in

paragraph (i), or the provider does not perform a physical examination of the beneficiary as provided for in paragraph (ii), then the LPHA or counselor shall include in the beneficiary's initial and updated treatment plans the goal of obtaining a physical examination. until this goal has been met and the physician has reviewed the physical examination results. The physician shall type or legibly print their name, sign, and date documentation to support they have reviewed the physical examination results. The signature shall be adjacent to the typed or legibly printed name.

12. Treatment Plan:

- For each beneficiary admitted to treatment services, the LPHA or counselor shall prepare an individualized written initial treatment plan, based upon the information obtained in the intake and assessment process.
  a. The LPHA or counselor shall attempt to engage the beneficiary to meaningfully participate in the preparation of the initial treatment plan and updated treatment plans.
     1) The initial treatment plan and updated treatment plans shall include all of the following:
        i. A statement of problems identified through the ASAM, other assessment tool(s) or intake documentation.
        ii. Goals to be reached which address each problem.
        iii. Action steps that will be taken by the provider and/or beneficiary to accomplish identified goals.
        iv. Target dates for the accomplishment of action steps and goals.
        v. A description of the services, including the type of counseling, to be provided and the frequency thereof.
        vi. The assignment of a primary therapist or counselor.
        vii. The beneficiary's diagnosis as prior documented by the Medical Director or LPHA.
        viii. If a beneficiary has not had a physical examination within the 12-month period prior to the beneficiary’s admission to treatment date, a goal that the beneficiary has a physical examination.
        ix. If documentation of a beneficiary's physical examination, which was performed during the prior 12 months, indicates a beneficiary has a significant medical illness, a goal that the beneficiary obtains appropriate treatment for the illness.
  b. The provider shall ensure that the initial treatment plan meets all of the following requirements:
     1) The LPHA or counselor shall complete, type or legibly print their name, and sign and date the initial treatment plan within 30 calendar days of the admission to treatment date. The signature shall be adjacent to the typed or legibly printed name.
     2) The beneficiary shall review, approve, type or legibly print their name, sign and date the initial treatment plan, indicating whether the beneficiary participated in preparation of the plan within 30 calendar days of the

admission to treatment date.

i. If the beneficiary refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment.

3) If a counselor completes the initial treatment plan, the Medical Director or LPHA shall review the initial treatment plan to determine whether services are medically necessary (as defined in Attachment A, Article IV) and appropriate for the beneficiary.

- If the Medical Director or LPHA determines the services in the initial treatment plan are medically necessary, the medical director or LPHA shall type or legibly print their name, and sign and date the treatment plan within 15 calendar days of signature by the counselor. The signature shall be adjacent to the typed or legibly printed name.

- The provider shall ensure that the treatment plan is reviewed and updated as described below:
  a. The LPHA or counselor shall complete, type or legibly print their name, sign and date the updated treatment plan no later than 90 calendar days after signing the initial treatment plan and no later than every 90 calendar days thereafter, or when there is a change in treatment modality or significant event, whichever comes first. The signature shall be adjacent to the typed or legibly printed name. The updated treatment plan shall be updated to reflect the current treatment needs of the beneficiary.
  b. The beneficiary shall review, approve, type or legibly print their name and, sign and date the updated treatment plan, indicating whether the beneficiary participated in preparation of the plan, within 30 calendar days of signature by the LPHA or counselor.
     1) If the beneficiary refuses to sign the updated treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment.
  c. If a counselor completes the updated treatment plan, the Medical Director or LPHA shall review each updated treatment plan to determine whether continuing services are medically necessary (as defined in Attachment A, Article IV) and appropriate for the beneficiary.
     1) If the Medical Director or LPHA determines the services in the updated treatment plan are medically necessary, they shall type or legibly print their name and sign and date the updated treatment plan within 15 calendar days of signature by the counselor. The signature shall be adjacent to the typed or legibly printed name.

13. Sign in Sheet:

- Establish and maintain a sign-in sheet for every group counseling session which shall include all of the following:
  a. The LPHA(s) and/or counselor(s) conducting the counseling session shall type or legibly print their name(s), sign, and date the sign-in sheet on the same day of the session. The signature(s) must be adjacent to the typed or legibly printed name(s). By signing the sign-in sheet, the LPHA(s) and/or

counselor(s) attest that the sign-in sheet is accurate and complete.

b. The date of the counseling session.

c. The topic of the counseling session.

d. The start and end time of the counseling session.

e. A typed or legibly printed list of the participants' names and the signature of each participant that attended the counseling session. The participants shall sign the sign-in sheet at the start of or during the counseling session.

14. Progress Notes:

- Progress notes shall be legible and completed as follows:
    - a. For outpatient services, Naltrexone treatment services, and recovery services, each individual and group session, the LPHA or counselor who conducted the counseling session or provided the service shall record a progress note for each beneficiary who participated in the counseling session or treatment service.
    - b. The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven calendar days of the counseling session. The signature shall be adjacent to the typed or legibly printed name.

- Progress notes are individual narrative summaries and shall include all of the following:
    - a. The topic of the session or purpose of the service.
    - b. A description of the beneficiary's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals.
    - c. Information on the beneficiary's attendance, including the date, start and end times of each individual and group counseling session or treatment service.
    - d. Identify if services were provided in- person, by telephone, or by telehealth.
    - e. If services were provided in the community, identify the location and how the provider ensured confidentiality.

- For intensive outpatient treatment and residential treatment services, the LPHA or counselor shall record at a minimum one progress note per calendar week for each beneficiary participating in structured activities including counseling sessions or other treatment services.
    - a. The LPHA or counselor shall type or legibly print their name and sign and date progress notes within the following calendar week.
    - b. Progress notes are individual narrative summaries and shall include all of the following:
        - 1) A description of the beneficiary's progress on the treatment plan, problems, goals, action steps, objectives, and/or referrals.
        - 2) A record of the beneficiary's attendance at each counseling session including the date, start and end times and topic of the counseling session.
        - 3) Identify if services were provided in- person, by telephone, or by

telehealth.

4) If services were provided in the community, identify the location and how the provider ensured confidentiality.

c. For each beneficiary provided case management services, the LPHA or counselor who provided the treatment service shall record a progress note.

1) The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven calendar days of the case management service.

2) Progress notes shall include all of the following:

i. Beneficiary's name.

ii. The purpose of the service.

iii. A description of how the service relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referrals.

iv. Date, start and end times of each service.

v. Identify if services were provided in- person, by telephone, or by telehealth

vi. If services were provided in the community, identify the location and how the provider ensured confidentiality.

d. For physician consultation services, additional medication assisted treatment, and withdrawal management, the Medical Director or LPHA working within their scope of practice who provided the treatment service shall record a progress note and keep in the beneficiary's file.

1) The Medical Director or LPHA shall type or legibly print their name and sign and date the progress note within seven calendar days of the service. The signature shall be adjacent to the typed or legibly printed name.

2) Progress notes shall include all of the following:

i. Beneficiary's name.

ii. The purpose of the service.

iii. Date, start and end times of each service.

iv. Identify if services were provided face-to-face, by telephone or by telehealth.

15. Continuing Services:

- Continuing services shall be justified as shown below:

a. For outpatient services, intensive outpatient services, Naltrexone treatment, and case management:

1) For each beneficiary. no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the LPHA or counselor shall review the beneficiary's progress and eligibility to continue to receive treatment services and recommend whether the beneficiary should or should not continue to receive treatment services at the same level of care.

b. For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the Medical Director or LPHA shall determine medical necessity for continued services for the beneficiary. The determination of medical necessity shall be documented by the Medical Director or LPHA in the beneficiary's individual patient record and shall include documentation that all of the following have been considered:
    1) The beneficiary's personal, medical and substance use history.
    2) Documentation of the beneficiary's most recent physical examination.
    3) The beneficiary's progress notes and treatment plan goals.
    4) The LPHA's or counselor's recommendation.
    5) The beneficiary's prognosis.
c. The medical director or LPHA shall type or legibly print their name, and sign and date the continuing services information when completed. The signature shall be adjacent to the typed or legible printed name.
d. If the Medical Director or LPHA determines that continuing treatment services for the beneficiary is not medically necessary, the provider shall discharge the beneficiary from the current level of care (LOC) and transfer to the appropriate services.
e. Residential services length of stay shall be in accordance with Attachment A, Article 111.H of this Agreement.

16. Discharge:

- Discharge of a beneficiary from treatment may occur on a voluntary or involuntary basis. For outpatient services, intensive outpatient services and residential services, in addition to the requirements of this subsection, an involuntary discharge is subject to the requirements set forth in Attachment A, Article 11.G.2 of this Agreement.

- An LPHA or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom the provider loses contact.
    a. The discharge plan shall include, but not be limited to, all of the following:
        1) A description of each of the beneficiary's relapse triggers.
        2) A plan to assist the beneficiary to avoid relapse when confronted with each trigger.
        3) A support plan.
    b. The discharge plan shall be prepared within 30 calendar days prior to the scheduled date of the last face-to-face treatment with the beneficiary.
        1) If a beneficiary is transferred to a higher or lower level of care based on ASAM criteria within the same DMC certified program, they are not required to be discharged unless there has been more than a 30 calendar day lapse in treatment services.

c. During the LPHA's or counselor's last face-to-face treatment with the beneficiary, the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. A copy of the discharge plan shall be provided to the beneficiary and documented in the beneficiary record.

- The LPHA or counselor shall complete a discharge summary for any beneficiary with whom the provider lost contact, in accordance with all of the following requirements:
  a. The LPHA or counselor shall complete the discharge summary within 30 calendar days of the date of the last face-to-face treatment contact with the beneficiary.
  b. The discharge summary shall include all of the following:
     1) The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment.
     2) The reason for discharge.
     3) A narrative summary of the treatment episode.
     4) The beneficiary's prognosis.

17. Reimbursement of Documentation:
- If the Plan allows for the inclusion of the time spent documenting when billing for a unit of service delivered, the Plan shall require its subcontracted providers to include the following information in their progress notes:
  - The date the progress note was completed.
  - The start and end time of the documentation of the progress note.
- Documentation activities shall be billed as a part of the covered service unit.

WW. COUNTY SPECIFIC REQUIREMENTS

- Additional Medication Assisted Treatment (MAT)
  As stated in Attachment A, Article V.A of Exhibit A, Attachment I, the Plan has elected to provide Additional MAT services as a Plan specific service. Therefore, the Plan shall comply with the following Plan specific MAT requirements:

  a. The Plan shall ensure Additional MAT (ASAM OTP Level 1) is available to DMC-ODS beneficiaries.
  b. The network providers may be able to prescribe buprenorphine, topiramate, gabapentin, naltrexone (oral and injectable), acamprosate, disulfiram, and naloxone. Other approved medications in the treatment of SUDs may also be prescribed, as medically necessary.
  c. Additional MAT (ASAM OTP Level 1) may include the assessment, treatment planning, ordering, prescribing, and monitoring of all medications for SUDs. Medically necessary services are provided in accordance with an individualized treatment plan determined by a licensed physician, LPHA, or licensed prescriber working within their scope of practice.
  d. The Plan shall ensure case management to coordinate care with treatment

and ancillary service providers and facilitate transitions between levels of care.

e. Beneficiaries may simultaneously participate in MAT services and other ASAM LOCs.

Attachment C

ADDITIONAL FISCAL PROVISIONS

Fiscal Provisions of Master Agreement between Partnership HealthPlan of California and each of the 8 Regional Model Counties

By the fifteenth of the month, Partnership HealthPlan of California (PHC) will provide COUNTY with a detailed invoice of the beneficiaries served the previous month. The invoice will include the following information:

- Number of beneficiaries served by modality of service and by aid code.
- Per Utilizer Per Month (PUPM) assessment
- Assessment for PHC administration and quality services
- Assessment for non-federally eligible costs (e.g. room and board for beneficiaries placed at residential facilities).

By: Siskiyou County will pay PHC the full amount detailed on the invoice.

PHC agrees to provide COUNTY with the documentation needed to comply with all of the financial provisions of Attachment A and for other reasonable financial reporting and auditing.

ATTACHMENT D
MEMORANDUM OF UNDERSTANDING BETWEEN
SISKIYOU COUNTY (COUNTY)
AND
PARTNERSHIP HEALTH PLAN OF CALIFORNIA (PHC)

This MEMORANDUM OF UNDERSTANDING (MOU) is made by and between Siskiyou County **(**hereinafter referred to as COUNTY) and PARTNERSHIP HEALTHPLAN OF CALIFORNIA (hereinafter referred to as PHC) in order to implement applicable provisions of Title 22, California Code of Regulations (Drug/Medi-Cal Program) and Drug-Medi/Cal Organized Delivery System (DMC-ODS) Standard Terms and Conditions (STCs).

The purpose of this Memorandum of Understanding is to describe the responsibilities of COUNTY and of PHC in the delivery of substance use services provided as part of the DMC-ODS to Medi-Cal beneficiaries who are served by all parties. It is the intention of all parties to provide good coordination of care among each agency's providers in order to ensure that Medi-Cal beneficiaries receive high quality, appropriate care. The parties jointly acknowledge that where responsibilities are delegated or assigned to another agency, such as from the County to Partnership HealthPlan, or from Partnership HealthPlan to Beacon Health Options, the ultimate responsibility lies with the County or Plan as laid out in this MOU.

RESPONSIBILITY	SISKIYOU COUNTY	PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC)
PROVIDER NETWORKS	COUNTY will ensure provision of a current list of contract providers to PHC upon finalization of this MOU, along with any additions or deletions as they occur.	PHC will maintain a current list of contract providers on its website, www.partnershiphp.org, which can be accessed by COUNTY.
LIAISONS	COUNTY will appoint a Liaison to coordinate activities with PHC and will notify COUNTY providers of the roles and responsibilities of the COUNTY Liaison(s). The COUNTY Liaison(s) will meet with PHC semi-annually or as needed in order to resolve operational, administrative and policy issues, and if necessary, to recommend changes to this MOU document. COUNTY Liaison(s) will be responsible to communicate issues and changes to the COUNTY Leadership.	PHC will appoint a Liaison to coordinate activities with COUNTY and will notify PHC providers of the roles and responsibilities of the PHC Liaison. PHC Liaison will meet with COUNTY semi-annually or as needed to resolve operational, administrative and policy issues and, if necessary, recommend changes to the MOU. PHC Liaison will communicate issues and changes to PHC leadership, DHCS and to its providers.
ADDITIONAL COMMUNICATION AND OVERSIGHT	COUNTY agrees to appoint representatives to meet with PHC, as necessary, regarding: • program oversight; • quality improvement; • problem and dispute resolution; • ongoing management of the MOU; and • clinical operations (screening, assessment, referrals, care management, care coordination, and exchange of medical information.)	PHC agrees to appoint representatives to meet with COUNTY, regarding: • program oversight; • quality improvement; • problem and dispute resolution; • ongoing management of the MOU; and • clinical operations (screening, assessment, referrals, care management, care coordination, and exchange of medical information.)

RESPONSIBILITY	SISKIYOU COUNTY	PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC)
	The Liaison serves as the primary contact between the County and PHC. Appointed representatives would be in leadership roles. PHC and County's leadership would work together to resolve higher level operational and clinical issues.	Appointed representatives at PHC would be in leadership roles. PHC and County's leadership would work together to resolve higher level operational and clinical issues.
MEMBER AND PROVIDER EDUCATION	COUNTY will collaborate with PHC on education efforts regarding access to PHC and COUNTY covered substance use services.	PHC will collaborate with COUNTY on education efforts regarding access to PHC and covered substance use services.
SCOPE OF SERVICE	COUNTY is responsible for the provision of 24 hours/day, 7 days/week, a toll-free phone number for prospective beneficiaries to call to access Drug/Medi-Cal Organized Delivery System (DMC-ODS) services. COUNTY is responsible to provide the required DMC-ODS substance use disorder services to Medi-Cal beneficiaries who are SISKIYOU County residents and meet Medical Necessity criteria outlined in Title 22, Sections 51303 and 54301 of California Code of Regulations (CCR) and the DMC-ODS STCs, and under the COUNTY columns in Attachment 1 of this MOU. The toll-free phone number to access these services is (800) 842-8979.	PHC will be responsible for providing beneficiaries with all covered health care services as specified in the PHC contract with DHCS and under the Medi-Cal column in Attachment 1 of this MOU. The toll-free, nationwide number to access non-mental health services is (800) 863-4155. When possible, and in the interest of providing comprehensive, well integrated healthcare services, PHC physicians will address the following conditions as they arise in the course of treating a medical illness and make appropriate referrals to COUNTY: • Comprehensive substance use, physical health and mental health screening, including ASAM Level 0.5 alcohol misuse screening and counseling (AMSC) services; • Medication Assisted Treatment, as clinically indicated and within the scope of practice of the PCP (Primary Care Physician), to be provided at the PCP site; for substance use services to be referred to an appropriate COUNTY provider.

RESPONSIBILITY	SISKIYOU COUNTY	PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC)
DIAGNOSTIC ASSESSMENT AND TRIAGE	COUNTY will ensure the triage of requests for substance use disorder services for Medi-Cal beneficiaries whose substance use condition would not otherwise be responsive to health care services or substance use screening and ASAM Level 0.5 alcohol misuse screening and counseling (AMSC) services provided by PHC. COUNTY will, for those beneficiaries who are referred to COUNTY or seek assessment from COUNTY, ensure the arrangement of a telephonic screening and referral or face-to-face assessment and diagnosis to determine if a beneficiary meets medical necessity criteria for DMC-ODS services as defined by the County for Title 22, CCR Sections 51303 and 54301, and the DMC-ODS STCs. COUNTY is not obligated to reimburse PHC providers for assessment of those conditions listed as the primary management responsibility of PHC.	Not Applicable.
REFERRALS	COUNTY will accept referrals from PHC staff, PHC providers and PHC beneficiaries for determination of medical necessity for DMC-ODS services. Referrals may be written, telephonic or electronically transmitted and should include a summary of member's medical history, mental health and substance use history, current medications, including Medication Assisted Treatment medications, and a current/suggested treatment plan and current treatment provider(s). In the event of an urgent need, verbal referrals shall be followed by written documentation within 3 days of the referral. COUNTY will refer each beneficiary contacting COUNTY and undergoing either a phone consultation or face-to-face assessment to their PCP or to PHC as follows: 1. For beneficiaries evidencing a need for health services other than substance use disorders (irrespective of whether the beneficiary also evidences the need for substance use disorders), COUNTY will provide the beneficiary with its recommendation that the beneficiary connect with the beneficiary's PCP or, if the beneficiary does not have a PCP, with PHC. COUNTY will endeavor to obtain any required consent from the beneficiary to allow COUNTY to forward a written referral to the PCP or PHC. Permitted referrals may be written, telephonic or electronically	PHC will receive referrals for primary health and assessment for mild to moderate mental health services from COUNTY staff, providers, and member's self-referral. Referrals should include a clear reason for referral, and if appropriate releases are signed, a summary of member's substance use history, current psychotropic medications, including current Medication Assisted Treatment medications, and a current /suggested treatment plan based on information from the most recent screening process, as available from COUNTY. PHC will accept referrals from COUNTY when the service needed is one provided by PHC and when it has been determined that the beneficiary does not meet medical necessity criteria for substance use disorder treatment services as specified in Title 22, CCR and the DMC-ODS STCs. PHC and COUNTY will work toward improving solutions for communication between providers about beneficiaries they have in common.

RESPONSIBILITY	SISKIYOU COUNTY	PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC)
REFERRALS	transmitted and should include a summary of relevant information and the reason referral is being made (eg., beneficiary describes general need associated with mild to moderate mental health services, beneficiary has engaged in activities putting him/her at risk of needle borne disease, etc.). Recommendations and referrals made hereunder shall be evidenced in the record COUNTY maintains in connection with any services provided to the beneficiary. 2. For each individual not evidencing a need for any health services, COUNTY will nevertheless provide a general recommendation that the individual connect with their PCP, or if they do not have a PCP, with PHC, to promote the individual's access to healthcare services. These recommendations shall be evidenced in COUNTY' record of its interaction with the individual. If all medical necessity criteria are met as determined by COUNTY, COUNTY will arrange for substance use disorder treatment services by a COUNTY provider. When the service needed is one provided by PHC and when it has been determined that the beneficiary does not meet medical necessity criteria for DMC-ODS services as specified in Title 22, CCR and the DMC-ODS STCs, COUNTY will endeavor to obtain any required consent from the beneficiary to allow COUNTY to forward a referral to the appropriate provider or to PHC and will then forward such referral. COUNTY will encourage all substance use clients to identify client's PCP whenever possible. Whenever possible, substance use providers will obtain written consent from the client to share information with their PCP in order that when healthcare issues not addressed by COUNTY are identified or suspected by substance use providers, the provider will refer the beneficiary to the PCP identified by the beneficiary, and advise the PCP of the referral outcome by faxing the referral form with outcome of referral review to the PCP so that it can be placed in the record. The COUNTY provider will document that the referral form has been faxed.	PHC will have a system, including bidirectional referral protocols, to make and track referrals to and from COUNTY. Referrals to COUNTY can be made directly to DMC-ODS providers or the COUNTY Access Line (707) 253-4063. Referrals to PHC for Health Services can be made by calling (800) 863-4144.

RESPONSIBILITY	SISKIYOU COUNTY	PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC)
	COUNTY will have a system, including bidirectional referral protocols, to make and track referrals to and from PHC. COUNTY and PHC will work toward improving solutions for communication between providers about beneficiaries they have in common. **(DMC-ODS STCs, Section 4(i))**	
NOTIFICATION OF REFERRALS FROM OTHER SOURCES	COUNTY will receive requests for substance use disorder treatment services for members directly from non-PHC providers (e.g., member, juvenile justice system, school system). COUNTY will provide information to PHC if requested and appropriate releases are in place.	PHC will direct sources (e.g., members, juvenile justice system, school system) to contact COUNTY directly when requesting substance use services for PHC members.
SERVICE AUTHORIZATION	COUNTY will authorize Residential substance use treatment services for Siskiyou County residents who are Medi-Cal beneficiaries that meet medical necessity criteria as specified in Title 22, CCR and the DMC-ODS STCs.	PHC will authorize medical or mental health assessment and/or treatment services by providers who are credentialed by and contracted with PHC for covered PHC health care services including mild to moderate mental health services. PHC will authorize medical care for ASAM Residential Levels 3.7 and 4 (Medically monitored inpatient services) and ASAM Withdrawal Management Levels 3.7-WM and 4-WM (Medically monitored inpatient withdrawal management). If hospitalization is arranged by a member's provider, then the member will need Prior Approval from PHC. In some cases, the admission may be one that is covered by fee for service Medi-Cal rather than PHC; in those instances, PHC will direct the provider to seek the treatment authorization from the State. Prior approval is not required when a member is admitted to a hospital for an emergency, though once the member's health has become stable, then the provider must request Prior Approval from PHC for post-stabilization care.
CARE COORDINATION	COUNTY will collaborate with PHC on identifying a point of contact from COUNTY who will initiate, provide and maintain ongoing care coordination as mutually agreed upon in PHC's and COUNTY' protocols.	PHC will collaborate with COUNTY on identifying a point of contact who will initiate, provide and maintain ongoing care coordination as mutually agreed upon in PHC's, and COUNTY' protocols.

RESPONSIBILITY	SISKIYOU COUNTY	PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC)
	Care coordination will include: 1. Coordination of care for treatment provided by the COUNTY; and 2. Transition of care for members transitioning to or from PHC to COUNTY services. 3. A process for ensuring effective communication among providers, including procedures for exchanges of medical information, in order to: 1) engage in collaborative treatment planning with PHC; 2) facilitate shared development of care plans by the beneficiary, caregivers and all providers; 3) review and update the care plan of members, as clinically indicated; 4) ensure pertinent information, such as prescribed medications that may impact substance use, mental health or physical health care, are communicated to relevant providers; and 5) follow-up to ensure the beneficiary is engaging and participating in integrated services, as needed, and accessing appropriate PHC and COUNTY services. Beneficiaries that meet medical necessity criteria for DMC-ODS Case Management services will have access to a Care Manager provided by COUNTY or through its contracted providers. Case management services can include care coordination (as described above), coordinating with the PHC case manager and/or PHC assigned point of contact, monitoring the beneficiary's progress in services, linkage to physical and mental health care, navigation support for patients and caregivers, collaborative care planning, and following-up with the beneficiary to ensure they are accessing appropriate PHC and DMC-ODS services.	Care coordination will include: 1. A process for reviewing and updating the care plan of members, as clinically indicated (i.e., following crisis intervention or hospitalization). The process must include triggers for updating care plans and coordinating with Beacon providers; and 2. Transition of care for members transitioning to or from PHC to COUNTY services. 3. A process for ensuring effective communication among providers, including procedures for exchanges of medical information, in order to: 1) engage in collaborative treatment planning with COUNTY; 2) facilitate shared development of care plans by the beneficiary, caregivers and all providers; 3) review and update the care plan of members, as clinically indicated; 4) ensure pertinent information, such as prescribed medications that may impact substance use, mental health or physical health care, are communicated to relevant providers; and 5) follow-up to ensure the beneficiary is engaging and participating in integrated services, as needed, and accessing appropriate PHC and COUNTY services.
CONSULTATION	COUNTY may provide clinical consultation at the discretion of the COUNTY provider, and training to PHC clinicians and/or PHC staff on various topics as requested and mutually agreed upon. Clinical consultation and training may be arranged in collaboration and consultation with PHC's Chief Medical Officer, or designee, and may include written, telephone conferencing, or in-person settings as arranged between the parties.	PHC and/or their providers may provide clinical consultation and training to COUNTY staff and/or its providers on various topics as requested and mutually agreed upon. Clinical consultation and training will be arranged in collaboration and consultation with the COUNTY Medical Director, or designee, and may include written, telephone conferencing, or in-person settings as arranged between the parties.

RESPONSIBILITY	SISKIYOU COUNTY	PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC)
	(DMC-ODS STCs, Section 4(i))	
TRANSPORTATION		**Non-Medical Transport:** PHC will arrange and pay for transportation services relating to County administered Medi-Cal services for PHC beneficiaries who meet the attestation requirements of PHC. **Non-Emergency Medical Transportation:** PHC will arrange and pay for all other non-emergency medical transportation services for PHC beneficiaries who meet the attestation requirements of the Plan. **Emergency Medical Transportation:** PHC maintains the responsibility to pay for emergency transportation services
CONFIDENTIALITY GUIDELINE FOR EXCHANGE OF MEDICAL INFORMATION	COUNTY providers will arrange for appropriate management of a member's care, including the exchange of medical records information, with a member's other healthcare providers, mental health providers or providers of specialty mental health services. COUNTY will encourage COUNTY providers to exchange clinical information and work cooperatively with PHC providers and to share information in a timely manner to assure continuity of health care. COUNTY providers will maintain the confidentiality of medical records in accordance with applicable state and federal laws and regulations. COUNTY will make every effort to obtain necessary 42 CFR, Part 2 compliant authorizations to exchange information. COUNTY can only exchange information with consent from the beneficiary. **(Welfare and Institutions Code Section 5328)** **(Code of Federal Regulations Title 42, Part 2)** **(Code of Federal Regulations Title 45, 160 and 164)** **(Code of Federal Regulations Title 42, Part 438.208(b)(4) and Part 438.224**	PHC providers will arrange for appropriate management of a member's care, including the exchange of medical records information, with a member's other healthcare providers, COUNTY providers, mental health providers or providers of specialty mental health services. PHC will encourage its providers to exchange clinical information and work cooperatively with COUNTY' providers to share information in a timely manner to assure continuity of health care. PHC providers will maintain the confidentiality of medical records in accordance with applicable state and federal laws and regulations. PHC will ensure compliance with the re-disclosure regulations included in 42 CFR, Part 2.

RESPONSIBILITY	SISKIYOU COUNTY	PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC)
	(DMC-ODS STCs, Section 4(i))	
APPEAL RESOLUTION PROCESS	COUNTY will ensure that beneficiaries and providers are given an opportunity for reconsideration and an appeal for denied, reduced, or terminated services. COUNTY will ensure that beneficiaries receiving DMC-ODS services will continue to receive those services while the dispute is being resolved. **(Code of Federal Regulations, Title 42, Part 438, Subpart F**	PHC will ensure that beneficiaries and providers are given an opportunity for reconsideration and an appeal for denied, reduced, or terminated services. PHC will ensure that medically necessary services and/or prescribed medications when medically safe continue to be provided to beneficiaries receiving such services while the dispute is being resolved.
GRIEVANCES AND COMPLAINTS	COUNTY has established a process for beneficiaries and providers to register grievances regarding any aspect of the substance use disorder treatment services they receive or fail to receive from COUNTY. COUNTY brochures and grievance forms are available at all services sites. COUNTY and PHC will coordinate resolution activities where both plans are involved. **(Code of Federal Regulations, Title 42, Part 438, Subpart F**	PHC have an established process for beneficiaries and providers to register complaints regarding any aspect of the health care they receive or fail to receive from PHC. PHC grievance packets are available at PHC or may be obtained by calling (707) 863-4120. PHC, and Napa MHP or COUNTY will coordinate resolution activities where both plans are involved.
DISPUTE RESOLUTION REFERRALS	Disagreement and disputes will be brought to a meeting of the COUNTY and PHC Liaisons or Agency Designee for resolution. COUNTY staff will make a good faith effort to agree to resolutions that are in the best interest of beneficiaries and are agreeable to all parties involved. Beneficiaries will continue to receive medically necessary services while the disagreement or dispute is being resolved in accordance with Title 42, Part 438, Subpart F.	Disagreement and disputes will be brought to a meeting of the PHC and COUNTY Liaisons and Medical Directors for resolution. PHC staff will make a good faith effort to agree to resolutions that are in the best interest of PHC beneficiaries and are agreeable to all parties involved. Beneficiaries will continue to receive medically necessary services while the disagreement or dispute is being resolved in accordance with Title 42, Part 438, Subpart F.
QUALITY ASSURANCE	COUNTY will work jointly with PHC Quality Management staff to develop monitors and measures of access, appropriateness of referrals, cross-system referrals, continuity and coordination of care, utilization of resources, satisfaction, adherence to protocols and guidelines, and outcomes of treatment, including measures to	PHC will work jointly with COUNTY Quality Management staff to develop monitors and measures of access, appropriateness of referrals, cross-system referrals, continuity and coordination of care, utilization of resources, satisfaction, adherence to protocols and guidelines, and outcomes of treatment,

RESPONSIBILITY	SISKIYOU COUNTY	PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC)
	track program compliance and success towards projected outcomes.	including measures to track program compliance and success towards projected outcomes.

Term: This MOU is in effect from the last date of signature below and shall remain in full force and effect until terminated by mutual agreement by all parties.

Counterparts: This MOU may be executed by electronic signature or in one or more counterparts, each of which shall be deemed an original, but all of which, together, shall constitute one agreement.

Siskiyou County

Michael N. Kobseff, Chair, Board of Supervisors — Date: 5/5/2020

ATTEST:
LAURA BYNUM
County Clerk & Ex-Officio
Clerk of the Board
By: ______________________
Deputy

Partnership HealthPlan of California (PHC)

Elizabeth Gibboney, Chief Executive Officer — Date: 5/21/2020

Robert Moore, MD, MPH, Chief Medical Officer — Date: 5/21/2020

Peggy Hoover, RN, Senior Director, Health Services — Date: 5/21/2020

ATTACHMENT 1

Partnership HealthPlan of California (PHC) – Siskiyou County (COUNTY) Responsibility Matrix for Drug/Medi-Cal Organized Delivery System (DMC-ODS) Services

Type of Service	ASAM Level of Care	Meets Criteria to Receive DMC-ODS Services*
SBIRT/Early Intervention	0.5	PHC (alcohol only)
Outpatient Services	1	COUNTY
Intensive Outpatient Services	2.1	COUNTY
Residential	3.1 and 3.5	COUNTY
Residential	3.7 and 4	PHC (medical care)
Withdrawal Management	3.2- WM	COUNTY
Withdrawal Management	3.7 and 4	PHC (medical care)
Methadone Maintenance	OTP-1	COUNTY
Recovery Services	N/A	COUNTY
Case Management	N/A	COUNTY
Physician Consultation	N/A	COUNTY

*DMC-ODS Program Criteria: Per the DMC-ODS STCs, in order to receive services through the DMC-ODS, the beneficiary must be enrolled in Medi-Cal, reside in Siskiyou County and meet the following medical necessity criteria:

i. Must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; or be assessed to be at risk for developing substance use disorder (for youth under 21).
ii. Must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.
iii. If applicable, must meet the ASAM adolescent treatment criteria.

DMC-ODS Determination of Medicaid eligibility and Medical Need Determination of who may receive the DMC-ODS benefit will be performed as follows:

i. Medicaid eligibility must be verified by the county or county contracted provider.
ii. The initial medical necessity determination for the DMC-ODS benefit must be performed through a face-to-face review or telehealth by a Medical Director, licensed physician, or Licensed Practitioner of the Healing Arts (LPHA). After establishing a diagnosis, the ASAM Criteria will be applied to determine placement into the level of assessed services.
iii. Medical necessity qualification for ongoing receipt of DMC-ODS is determined at least every six months through the reauthorization process for individuals determined by the Medical Director, licensed physician or LPHA to be clinically appropriate; except for NTP services which will require reauthorization annually.

EXHIBIT E

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("BAA"), effective as of July 1, 2020 ("Effective Date") is entered into by and between PARTNERSHIP HEALTHPLAN OF CALIFORNIA (the "Plan" or "Covered Entity") and SISKIYOU COUNTY ("Business Associate"). PARTNERSHIP HEALTHPLAN OF CALIFORNIA and Siskiyou County may be referred to individually as a "Party" or collectively as "Parties."

WHEREAS, the Parties have entered into a Master Services Agreement effective July 1, 2020 ("Agreement") which may require Business Associate's use or disclosure of protected health information ("PHI") in performance of the services described in the Agreement on behalf of the Plan.

WHEREAS, the Parties are committed to complying with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act and any regulations promulgated thereunder (collectively the "HIPAA Rules").

WHEREAS, this BAA, in conjunction with the HIPAA Rules, sets forth the terms and conditions pursuant to which PHI (in any format) that is created, received, maintained, or transmitted by, the Business Associate from or on behalf of the Plan, will be handled between the Business Associate, the Plan and with third parties during the term of the Agreement(s) and after its termination.

NOW THEREFORE, the Parties hereby agree as follows:

1. DEFINITIONS

1.1 The following terms used in this BAA shall have the same meaning as those terms in the HIPAA Rules: Availability, Breach, Confidentiality, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Integrity, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

2. SPECIFIC DEFINITIONS

2.1 "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this BAA, shall mean Siskiyou County.

2.2 "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this BAA, shall mean PARTNERSHIP HEALTHPLAN OF CALIFORNIA.

2.3 "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

2.4 "Services" shall mean, to the extent and only to the extent they involve the creation, use or disclosure of PHI, the services provided by Business Associate to the Plan under the Agreement, including those set forth in this BAA, as amended by written consent of the parties from time to time.

3. RESPONSIBILITIES OF BUSINESS ASSOCIATE

Business Associate agrees to:

3.1 Not use or disclose PHI other than as permitted or required by the BAA or as required by law;

3.2 Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI, to prevent use or disclosure of PHI other than as provided for by the BAA;

3.3 Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI that it creates, receives, maintains, or transmits on behalf of the Plan. Business Associate shall comply with the applicable standards at Subpart C of 45 CFR Part 164;

3.4 Promptly report to the Plan any use or disclosure of PHI not provided for by the BAA of which it becomes aware, including, but not limited to, Breaches or suspected Breaches of unsecured PHI under 45 CFR 164.410, and any Security Incident or suspected Security Incidents of which it becomes aware. Business Associate shall report the improper or unauthorized use or disclosure of PHI within 24 hours to the Plan. Business Associate shall take all reasonable steps to mitigate any harmful effects of such Breach or Security Incident. Business Associate shall indemnify the Customer against any losses, damages, expenses or other liabilities including reasonable attorney's fees incurred as a result of Business Associate's or its agent's or Subcontractor's unauthorized use or disclosure of PHI including, but not limited to, the costs of notifying individuals affected by a Breach;

3.5 In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information;

3.6 Make available PHI in a designated record set to the Plan as necessary to satisfy the Plan's obligations under 45 CFR 164.524;

3.7 Make any amendment(s) to PHI in a designated record set as directed or agreed to by the Plan pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy the Plan's obligations under 45 CFR 164.526;

3.8 Forward any requests from a Plan member for access to records maintained in accordance with the BAA as soon as they are received. The Plan will maintain responsibility for making determinations regarding access to records;

3.9 Direct any requests for an amendment from an individual as soon as they are received to the Plan. The Business Associate will incorporate any amendments from the Plan immediately upon direction from the covered entity;

3.10 Maintain and make available the information required to provide an accounting of disclosures to the Plan as necessary to satisfy the Plan's obligations under 45 CFR 164.528;

3.11 Forward any requests from a Plan member for an accounting of disclosures maintained in accordance with the BAA as soon as they are received. The Plan will maintain responsibility for making determinations regarding the provision of an accounting of disclosures;

3.12 To the extent the Business Associate is to carry out one or more of the Plan's obligations under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and

3.13 Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

4. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

4.1 Business Associate may only use or disclose PHI as necessary to perform the services set forth in the Agreement.

4.2 Business Associate must obtain approval from the Plan before providing any de-identified information in accordance with 45 CFR 164.514(a)-(c). Business Associate, if approved, will obtain instructions for the manner in which the de-identified information will be provided.

4.3 Business Associate may use or disclose PHI as required by law.

4.4 Business Associate agrees to make uses and disclosures and requests for PHI consistent with the Plan's minimum necessary policies and procedures.

4.5 Business Associate may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by the Plan except for the specific uses and disclosures set forth below.

4.6 Business Associate may use PHI for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, provided the disclosures are required by law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

5. PROVISIONS FOR COVERED ENTITY TO INFORM BUSINESS ASSOCIATE OF PRIVACY PRACTICES AND RESTRICTIONS

5.1 The Plan shall notify Business Associate of any limitations in the notice of privacy practices under 45 CFR 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of PHI.

5.2 The Plan shall notify Business Associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her PHI, to the extent that such changes may affect Business Associate's use or disclosure of PHI.

5.3 The Plan shall notify Business Associate of any restriction on the use or disclosure of PHI that the Plan has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of PHI.

6. PERMISSIBLE REQUESTS BY COVERED ENTITY

6.1 The Plan shall not request Business Associate to use or disclose PHI in any manner that would not be permissible under Subpart E of 45 CFR Part 164 if done by covered entity.

7. TERM AND TERMINATION

7.1 Term. The Term of this BAA shall be effective as of July 1, 2020 and shall terminate on the expiration date of the Agreement or on the date the Plan terminates for cause as authorized in Paragraph 7.2 below, whichever is sooner.

7.2 Termination for Cause. Business Associate authorizes termination of this BAA by the Plan, if the Plan determines, in its sole discretion, that Business Associate has violated a material term of this BAA and either:

7.2.1 The Plan provides Business Associate an opportunity to cure the Breach or end the violation within a time specified and Business Associate does not cure the Breach or end the violation within the time specified by the Plan; or

7.2.2 The Plan immediately terminates this BAA upon notice if the Plan determines, in its sole discretion, that a cure is not possible.

7.3 Obligations of Business Associate Upon Termination. Upon termination of this BAA for any reason, Business Associate, with respect to PHI received from the Plan, or created, maintained, or received by Business Associate on behalf of the Plan, shall:

7.3.1 Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;

7.3.2 Return to covered entity or, if agreed to by covered entity, destroy the remaining PHI that the Business Associate still maintains in any form;

7.3.3 Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as Business Associate retains the PHI;

7.3.4 Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out at section 4 of this BAA which applied prior to termination; and

7.3.5 Return to covered entity or, if agreed to by covered entity, destroy the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

7.4 Survival. The obligations of Business Associate under this Section shall survive the termination of this BAA.

8. MISCELLANEOUS

8.1 No Third Party Beneficiaries. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of Parties, any rights, remedies, obligations or liabilities whatsoever.

8.2 Regulatory References. A reference in this BAA to a section in the HIPAA Rules means the section as in effect or as amended.

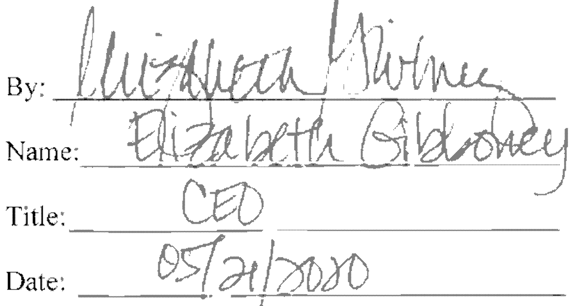
8.3 Amendment. The Parties agree to take such action as is necessary to amend this BAA from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

8.4 Interpretation. Any ambiguity in this BAA shall be interpreted to permit compliance with the HIPAA Rules.

8.5 Counterparts; Facsimile Signatures. This BAA may be executed in any number of counterparts, each of which will be deemed an original and all of which together will constitute one and the same document. This BAA may be executed and delivered by facsimile or in PDF format via email, and any such signatures will have the same legal effect as manual signatures. If a Party delivers its executed copy of this BAA by facsimile signature or email, such party will promptly execute and deliver to the other party a manually signed original if requested by the other party.

Acknowledged and agreed:

PARTNERSHIP HEALTHPLAN OF CALIFORNIA "PHC"



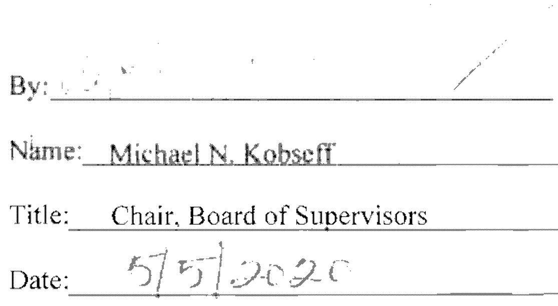
By: ______________________

Name: Elizabeth Gibboney

Title: CEO

Date: 05/21/2020

SISKIYOU COUNTY



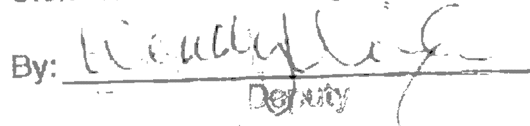
By: ______________________

Name: Michael N. Kobseff

Title: Chair, Board of Supervisors

Date: 5/5/2020

ATTEST:
LAURA BYNUM
County Clerk & Ex-Officio
Clerk of the Board



By: ______________________
Deputy

ATTACHMENT F

Optional Provision of Substance Use Services for Non-Medi-Cal Individuals

Siskyou COUNTY may request that PLAN arrange for the provision of non-residential SUD services to individuals that are not eligible for Medi-Cal, referred to herein as "Non Medi-Cal". COUNTY agrees to pay PHC $500 during each month in which the Plan administers these services for "Non Medi-Cal" clients. COUNTY and PLAN further agree to the following with regard Non Medi-Cal Individuals:

COUNTY prior approval needed

PHC will arrange for services only to those clients that are either:

(1) Referred by the County's designated liaison(s)
(2) Assessed and accepted for care by a provider that the County has verified, in writing, is authorized to provides these services for Non Medi-Cal individuals.
    a. Authorized providers will first screen these individuals for potential Medi-Cal eligibility
    b. For those clients not eligible for Medi-Cal, the provider will serve these clients after receiving authorization from the designated County liaison(s).

Invoicing

Provider(s) will submit invoices, in a format approved by PHC, to PHC for payment.

Note

Non Medi-Cal clients will not be eligible for the Plan-administered grievance or State Fair Hearings, care coordination, Beacon screening and referral or other PHC managed care responsibilities.