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1. Service Overview

A. The Contractor agrees to provide to the California Department of Health Care Services (hereafter referred to as DHCS, the Department, or the State) the Medi-Cal behavioral health services described herein.

B. The Contractor will provide or arrange for the provision of the following specialty mental health services (SMHS), Drug Medi-Cal Organized Delivery System (DMC-ODS) services, and/or Drug Medi-Cal (DMC) services as defined in this intergovernmental agreement (the "Contract") to Medi-Cal members residing in Contractor's County who meet the applicable access criteria.

C. This Contract covers the provision of:

[ ] SMHS. If this box is checked, Contractor will provide and/or arrange for the provision of SMHS as a Prepaid Inpatient Health Plan (PIHP) as defined in 42 Code of Federal Regulations (hereafter C.F.R.) part 438.2. All requirements in the Contract that are identified as SMHS requirements shall apply to Contractor if this box is checked.

[ ] DMC-ODS services. If this box is checked, Contractor will provide and/or arrange for the provision of DMC-ODS services operating as a PIHP as defined in 42 C.F.R. part 438.2. All requirements in the Contract that are identified as DMC-ODS requirements shall apply to Contractor if this box is checked.

[ ] DMC-ODS Partnership Health Plan of California (PHC) Model. If this box is checked, Contractor will subcontract with PHC for the provision of certain DMC-ODS services. All requirements in the Contract that are identified as DMC-ODS PHC Model requirements, as well as all requirements identified as DMC-ODS requirements (except as otherwise specified), will apply to Contractor if this box is checked.

[X] DMC services. If this box is checked, Contractor will provide and/or arrange for the provision of DMC State Plan services under a fee-for-service structure. All requirements in the Contract that are identified as DMC requirements shall apply to Contractor if this box is checked.

D. The services identified above are referred to as "Covered Services" in the remainder of this Contract.

E. {Integrated contracts only}

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1) If the Contractor chooses to provide both SMHS and DMC-ODS services within this Contract, Contractor will provide and arrange for the provision of both SMHS and DMC-ODS services operating as a single PIHP with a non-risk contract as defined in 42 C.F.R. part 438.2. All requirements in the Contract that are identified as applying to integrated contracts (DMC-ODS) shall apply to Contractor.

2) If the Contractor chooses to provide both SMHS and DMC services within this Contract, Contractor will provide and arrange for the provision of SMHS operating as a PIHP as defined in 42 C.F.R. part 438.2 and will provide or arrange for the provision of DMC services under a fee-for-service structure, outside the PIHP managed care structure. All requirements in the Contract that are identified as applying to integrated contracts (DMC) shall apply to Contractor.

2. Service Location

The services shall be performed at the Contractor's contracting and participating facilities, and at other facilities as set forth in the Contract, including out-of-network facilities as applicable.

3. Service Hours

A. {SMHS and DMC-ODS only} Services shall be provided on a 24-hour, seven (7) days a week basis, as set forth in the Contract.

B. {DMC only} Services must 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 Contract will be:

Department of Health Care Services	**County of Name**
Program Director: Linda Dornseif Telephone: 916-224-8155 Email: linda.dornseif@dhcs.ca.gov	Contact Name Telephone: XXX-XXX-XXXX Email: countycontact@county.com

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B. Direct all inquiries to:

Department of Health Care Services	**County of Name**
Medi-Cal Behavioral Health Division/Program Policy Section Attention: Ivan Bhardwaj 1501 Capitol Avenue, MS 2702 Sacramento, CA, 95814 Telephone: 916-842-8598 Email: ivan.bhardwaj@dhsc.ca.gov	County Division Name Contact Name Address: XXXX Street City, State Telephone: XXX-XXX-XXXX Fax: XXX-XXX-XXXX Email: countycontact@county.com

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 Contract.

5. General Authority

A. {SMHS} This Contract is entered into in accordance with Welfare and Institutions Code (hereafter W&I Code) sections 14680 -14727, and 14184.100 et seq. W&I Code section 14712 requires DHCS to implement managed mental health care for Medi-Cal members through contracts with mental health plans. The Department and Contractor agree that this Contract meets that requirement for the County.

B. {DMC-ODS} The Contractor has elected to opt into the DMC-ODS to provide or arrange covered DMC-ODS services described under this Contract to Medi-Cal members who reside within the Contractor's County borders. This Contract is an intergovernmental agreement between the State and Contractor by authority of chapter 3 (§ 11758.10 et seq.) of Part 1, Division 10.5 of the Health & Safety (H&S) Code and with approval of Contractor's County Board of Supervisors (or designee) for the purpose of providing alcohol and drug services. This Contract is entered into in accordance with Health and Safety Code section 11848.5, W&I Code sections 14021.51–14021.53, 14124.20– 14124.25, and 14184.100 et seq., and Behavioral Health Information Notice (BHIN) 23-001 (including any successor BHIN).

C. {DMC} This Contract is entered into pursuant to W&I Code section 14124.20, and Health and Safety Code section 11772, for the purpose of providing DMC services in the Contractor's service area pursuant to W&I Code sections §14021.51 – 14021.53, 14124.20 – 14124.25, 14184.100

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et seq, Health and Safety Code section 11848.5, and Title 22 of the California Code of Regulations sections 51341.1, 51490.1, and 51516.1.

D. {SMHS and DMC-ODS} Federal PIHP Requirements.

1) The Contractor shall comply with federal requirements for nonrisk PIHPs as set forth in 42 C.F.R. part 438, except insofar as those requirements have been deemed inapplicable to county behavioral health programs under the Department's federally approved 1915(b) waiver. See pages 18–19 of the Department's June 23, 2023, amendment to the 1915(b) waiver, or the equivalent pages under any successor amendment.

2) The Centers for Medicare and Medicaid Services (CMS) shall review and approve the parts of this Contract that govern Contractor's delivery of services as a PIHP, in accordance with 42 C.F.R. part 438.3(a).

E. All Exhibits, Attachments, and Sections in this Contract apply to the delivery of all covered services identified in Exhibit A, Scope of Work, Section 1, except as otherwise indicated in this Contract.

F. Where a requirement in this Contract applies to more than one service type or delivery system, but is followed by a legal citation that only applies to one service type or delivery system (i.e. SMHS, DMC-ODS, or DMC), the legal citation does not limit application of the corresponding contracting requirements to one service type or delivery system.

G. No provision of this Contract is intended to obviate or waive any requirements of applicable law or regulation. In the event a provision of this Contract is open to varying interpretations, the Contract provision shall be interpreted in a manner that is consistent with applicable law and regulation. In the event of a conflict between the terms of this Contract and a State or federal statute or regulation, or a BHIN, the Contractor shall adhere to the applicable statute, regulation, or BHIN.

H. The State and the Contractor identified in the State Standard (STD) Form 213 are the only parties to this Contract. This Contract is not intended, nor shall it be construed, to confer rights on any third party.

I. It is understood and agreed that nothing contained in this Contract shall be construed to impair the single state agency authority of DHCS for the Medi-Cal program.

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6. Electronic and IT Accessibility Requirements Under the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990

The Contractor agrees to ensure that deliverables developed and produced, pursuant to this Contract shall comply with the accessibility requirements of sections 7405 and 11135 of the California Government Code, section 508 of the Rehabilitation Act of 1973 as amended (29 U.S.C. § 794d), and regulations implementing that Act as set forth in Part 1194 of Title 36 of the C.F.R., and the portions of the Americans with Disabilities Act of 1990 related to electronic and IT accessibility requirements and implementing regulations. In 1998, Congress amended the Rehabilitation Act of 1973 to require Federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. California Government Code sections 7405 and 11135 codify section 508 of the Rehabilitation Act requiring accessibility of electronic and information technology.

7. Services to be Performed; Contract Performance

A. See the Attachments to Exhibit A for a detailed description of the services to be performed.

B. Contractor must maintain the necessary organization and level of staffing to implement and operate this Contract. Contractor must ensure the following:

1) Contractor has an accountable Board of Supervisors or county Behavioral Health Director;

2) Compliance with this Contract is a high priority and that Contractor is committed to supplying any necessary resources to assure full performance of the Contract;

3) [Reserved]

4) Adequate staffing in medical and other health services, fiscal and administrative capacity sufficient to effectively conduct Contractor's business; and

5) Written procedures are developed and maintained for conducting Contractor's business, including the provision of health care services, in compliance with federal and State Medicaid law.

8. Loss of Federal Authority

Should any part of the scope of work under this Contract relate to a state program receiving Federal Financial Participation (FFP) that is no longer authorized by law (e.g., which has been vacated by a court of law, or for

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which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of such program authority. DHCS will adjust payments that are specific to any state program or activity receiving FFP that is no longer authorized by law. If Contractor works on a state program or activity receiving FFP that is no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If DHCS has paid Contractor in advance to work on a no-longer-authorized state program or activity receiving FFP and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work shall be returned to DHCS. However, if Contractor worked on a state program or activity receiving FFP prior to the date legal authority ended for that state program or activity, and DHCS paid Contractor for that work, Contractor may keep the payment for that work even if the payment was made after the date the state program or activity receiving FFP lost legal authority. DHCS will attempt to provide Contractor with timely notice of the loss of program authority, however, failure by DHCS to provide notice of the loss of program authority shall not constitute a basis for Contractor to retain payments made for work performed following the date of the loss of program authority.

9. Executive Order N-6-22 – Russia Sanctions

On March 4, 2022, Governor Gavin Newsom issued Executive Order N-6-22 (the EO) regarding Economic Sanctions against Russia and Russian entities and individuals. “Economic Sanctions” refers to sanctions imposed by the U.S. government in response to Russia’s actions in Ukraine, as well as any sanctions imposed under state law. The EO directs state agencies to terminate contracts with, and to refrain from entering any new contracts with, individuals or entities that are determined to be a target of Economic Sanctions. Accordingly, should the State determine Contractor is a target of Economic Sanctions or is conducting prohibited transactions with sanctioned individuals or entities, that shall be grounds for termination of this agreement. The State shall provide Contractor advance written notice of such termination, allowing Contractor at least 30 calendar days to provide a written response. Termination shall be at the sole discretion of the State.

10. Americans with Disabilities Act

Contractor agrees to ensure that deliverables developed and produced, pursuant to this Agreement must comply with the accessibility requirements of Sections 7405 and 11135 of the California Government Code, Section 508 of the

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Rehabilitation Act of 1973 as amended (29 U.S.C. § 794d), regulations implementing the Rehabilitation Act of 1973 as set forth in Part 1194 of Title 36 of the Code of Federal Regulations, and the Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 et seq.). In 1998, Congress amended the Rehabilitation Act of 1973 to require Federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. California Government Code Sections 7405 and 11135 codifies Section 508 of the Rehabilitation Act of 1973 requiring accessibility of EIT.

Exhibit A – Attachment 1
[RESERVED]

Exhibit A – Attachment 2A
[RESERVED]

Exhibit A – Attachment 2B
[RESERVED]

Exhibit A – Attachment 2C
[RESERVED]

Exhibit A – Attachment 2D
[RESERVED]

Exhibit A - Attachment 2E
{DMC only}: SCOPE OF SERVICES

1. Standard Requirements

A. Initial Assessment and Services Provided During the Assessment Process

1) The Contractor shall arrange for an LPHA, registered or certified counselor, clinical trainee, medical assistant, or other qualified provider to conduct DMC initial assessments via face-to-face, by telehealth or by telephone (synchronous audio-only) and may be done in the community or the home. If the initial assessment of the members is completed by a registered or certified counselor, clinical trainee, medical assistant, or other qualified provider, then the LPHA shall evaluate that initial assessment with the individual who completed the assessment and the LPHA shall make and document the initial diagnosis. The consultation between the LPHA and the individual qualified to conduct the assessment can be conducted in person, by video conference or by telephone.

i. Covered and clinically appropriate DMC services are reimbursable for up to 30 days following the first visit with an LPHA, registered/certified counselor, or Peer Support Specialist, whether or not a Diagnostic and Statistical Manual (DSM) diagnosis for Substance-Related and Addictive Disorders is established, or up to 60 days for members under age 21, or if a provider documents that the member is experiencing homelessness and therefore requires additional time to complete the assessment.

ii. All SUD treatment services provided to a DMC member during the initial assessment process must be clinically appropriate to address that member's presenting condition.

2) Consistent with W&I Code § 14184.402(f), clinically appropriate and covered SUD prevention, screening, assessment, and treatment services are covered and reimbursable Medi-Cal services even when: 1) services are provided prior to determination of a diagnosis or prior to determination of whether DMC criteria are met, as described above; 2) the prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan; or 3) the member has a co-occurring mental health condition.

i. The Contractor shall not disallow reimbursement for DMC services provided during the assessment process if the

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{DMC only}: SCOPE OF SERVICES

assessment later determines that the member does not meet criteria for DMC.

ii. The Contractor shall not disallow reimbursement for DMC provided to a member who meets DMC criteria and has a co-occurring mental health condition.

B. Services Provided After the Assessment Process

1) To qualify for DMC services after the initial assessment process, members 21 years of age and older must meet one of the following criteria:

i. Have at least 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 (the diagnosis shall be made and documented by an LPHA), or

ii. Have had at least one diagnosis from the DSM for Substance Related and Addictive Disorders, with the exception of Tobacco Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

2) For members under the age of 21, covered services provided under DMC shall include all medically necessary SUD services as required pursuant to 42 U.S.C. § 1396d(r). Federal EPSDT statutes and regulations require States to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct or ameliorate health conditions.

C. Placement into the Appropriate Level of Care

1) In accordance with W&I Code § 14184.402(e), BHIN 23-068, and BHIN 24-045, the Contractor and DMC providers shall utilize the criteria adopted by the American Society of Addiction Medicine (ASAM) to determine the appropriate level of SUD treatment service for DMC members.

i. A full assessment utilizing the ASAM criteria is not required for a DMC member to begin receiving covered and reimbursable SUD treatment services; an abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services.

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2) The Contractor shall ensure that DMC providers are utilizing the ASAM criteria to determine the appropriate level of care.

D. Services Provided via Telehealth or Telephone

1) All DMC services, including initial assessments and medical necessity determinations, delivered via telehealth or telephone shall be provided in accordance with the telehealth requirements set forth in BHIN 23-018, and any subsequently issued BHINs that supersede BHIN 23-018.

E. Documentation Standards

1) The Contractor shall implement and comply with documentation standards as set forth in guidance issued by the Department, including in BHIN 23-068 and any subsequent guidance.

2) In the event of a conflict between the terms of this Contract relating to documentation and a state or federal statute or regulation, or a BHIN issued by DHCS, the Contractor shall adhere to the applicable statute, regulation, or BHIN.

2. Covered Services

A. The Contractor shall establish assessment, placement determination and referral procedures for, and shall provide or arrange for the provision of, covered services in the Contractor's service area that are medically necessary (as defined in Exhibit E, Attachment 1) and clinically appropriate to address the member's presenting condition, including services for members under the age of 21 consistent with EPSDT requirements. Covered services shall be provided in accordance with this Contract, the applicable statutes and regulations, BHIN 21-071, and any other relevant information notices issued by the Department.

B. Covered services include:

1) Outpatient Treatment Services

Outpatient Treatment Services (also known as Outpatient Drug Free or ODF) are provided to members as medically necessary. Outpatient Treatment Services include the following components:

i. Assessment

ii. Individual Counseling

iii. Group Counseling

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{DMC only}: SCOPE OF SERVICES

iv. Patient Education

v. Medication Services

vi. Medication Assisted Treatment (MAT) for Opioid Use Disorders (OUD)

vii. SUD Crisis Intervention Services

2) Narcotic Treatment Program Services

Narcotic Treatment Program (NTP) Services is an outpatient program that provides FDA-approved drugs to treat SUDs when ordered by a physician as medically necessary. NTPs are required to offer and prescribe medications including methadone, buprenorphine, naloxone and disulfiram. NTPs shall offer adequate counseling services to each member as clinically necessary. Narcotic Treatment Program include the following components:

i. Assessment

ii. Individual Counseling

iii. Group Counseling

iv. Patient Education

v. Medical Psychotherapy

vi. Medication Services

vii. MAT for OUD

viii. SUD Crisis Intervention Services

3) Intensive Outpatient Treatment Services

Intensive Outpatient Treatment services are provided to members when medically necessary in a structured programming environment. Intensive Outpatient Treatment includes the following components:

i. Assessment

ii. Individual Counseling

iii. Group Counseling

iv. Patient Education

v. Medication Services

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vi. MAT for OUD

vii. SUD Crisis Intervention Services

4) Perinatal Residential Substance Use Disorder Treatment

Perinatal Residential Substance Use Disorder Treatment is a non-institutional, non-medical, residential program which provides rehabilitation services to pregnant and postpartum women with a substance use disorder diagnosis. Each member shall live on the premises and shall be supported in their efforts to restore and apply interpersonal and independent living skills and access community support systems. Perinatal Residential Substance Use Disorder Treatment programs shall provide a range of activities and services for pregnant and postpartum members. Supervision shall be available day and night, seven days a week. Medically necessary rehabilitative services are provided in accordance with individualized member needs. The cost of room and board is not reimbursable under the Medi-Cal program. Facilities shall store and safeguard all residents' medications, and facility staff members may assist with resident's self-administration of medication. Perinatal Residential Substance Use Disorder Treatment include the following components:

i. Assessment

ii. Individual Counseling

iii. Group Counseling

iv. MAT for OUD

v. Patient Education

vi. SUD Crisis Intervention Services

5) Medication Assisted Treatment

Medication Assisted Treatment (also known as medication assisted treatment (MAT)) for Opioid Use Disorders (OUD) includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. § 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. § 262) to treat opioid use disorders as authorized by the Social Security Act Section 1905(a)(29). MAT providers shall offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services and maintain a DHCS

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approved MAT policy pursuant to BHIN 23-054, and any subsequent guidance issued by the Department. The provider shall also comply with all other requirements in BHIN 23-054.

MAT for OUD include the following components:

i. Assessment for MAT for OUD.

ii. Individual Counseling for MAT for OUD.

iii. Group Counseling for MAT for OUD.

iv. Patient Education for MAT for OUD.

v. Medical Psychotherapy for MAT for OUD.

vi. Medication Services for MAT for OUD.

vii. SUD Crisis Intervention Services for MAT for OUD.

viii. Prescribing and monitoring of MAT for OUD.

6) Peer Support Services. If the Contractor has opted to provide Peer Support Services and has been approved by DHCS, the Contractor shall comply with the peer support services provisions in Exhibit A, Attachment 2F.

7) Other services approved by a State Plan amendment or waiver authorizing federal financial participation.

C. Medi-Cal SUD treatment services for Members under age 21.

1) Under the EPSDT mandate and in accordance with BHIN 22-003, the Contractor shall provide all SUD treatment services that are coverable under 42 U.S.C. § 1396d(a)) whether or not it is covered under the Medicaid State Plan, including but not limited to covered DMC and Drug Medi-Cal – Organized Delivery Services (DMC-ODS) (referred to as Expanded SUD Treatment Services in the State Plan). The array of SUD treatment services covered in the State Plan are described in the “Substance Use Disorder Treatment Services” and the “Expanded Substance Use Disorder Treatment Services” sections of Supplement 3 to Attachment 3.1-A in the California State Plan.

2) The Contractor shall provide screening and early intervention services to members under the age of 21 at risk of developing an SUD regardless of whether they meet diagnosis criteria for a behavioral health disorder. Any member under the age of 21 who is

screened and determined to be at risk of developing an SUD may receive any service component covered under the outpatient level of care as early intervention services. A diagnosis from the Diagnostic and Statistical Manual or International Classification of Diseases, Tenth Edition (ICD-10) for Substance-Related and Addictive Disorders is not required for early intervention services. Early intervention services are provided under the outpatient treatment modality and must be made available by counties based on individual clinical need, even if the member under age 21 is not participating in the full array of outpatient treatment services.

D. Community-Based Mobile Crisis Intervention Services (also referred to as "Mobile Crisis Services")

1) Upon receiving approval from DHCS, the Contractor shall provide or arrange for the provision of, qualifying mobile crisis services in accordance with the following: BHIN 23-025, and any subsequently issued BHINs that supersede BHIN 23-025, and Contractor's DHCS-approved implementation plan.

2) Mobile Crisis Services are designed to provide relief to members experiencing a behavioral health crisis:

i. Through de-escalation and stabilization techniques.

ii. By reducing the immediate risk of danger and subsequent harm to the member.

iii. By preventing unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement.

E. The Contractor, to the extent applicable, shall comply with *Sobky v. Smoley* (E.D. Cal. 1994) 855 F. Supp. 1123 (E.D. Cal 1994) (Document 2A).

3. Availability of Services

In addition to the access standards discussed in Exhibit A, Attachment 8 (as applicable to DMC), Contractor shall comply with the following:

A. Tribal Communities and Organizations. The Contractor shall regularly assess (e.g. review population information available through the Census Bureau, compare to information obtained in CalOMS Treatment to determine whether population is being reached, survey Tribal representatives for insight into potential barriers) the substance use service needs of the American Indian/Alaskan Native (AI/AN) population

within the Contractor's geographic area and shall engage in regular and meaningful consultation and collaboration with elected officials of the tribe, or their designee for the purpose of identifying issues/barriers to service delivery and improvement of the quality, effectiveness, and accessibility of services available to AI/AN communities within the County.

B. County of Responsibility

1) Covered services, whether provided directly by the Contractor or through contracted providers with DMC-certified and enrolled programs, shall be provided to members without regard to the members' county of residence.

2) The Contractor is financially responsible for all covered services provided to members that reside in the Contractor's county.

3) The Contractor shall accept claims from any DMC enrolled provider, regardless of the location of the provider, for any covered services provided to members residing in the Contractor's county. The Contractor shall reimburse the provider through a contract or other agreement with that provider.

4) The Contractor shall require all contracted providers to inform the Contractor when a member that resides in the Contractor's county is referred to, and served by, an out-of-county provider.

4. Federal NPI Requirements

The Contractor shall require all contracted providers, and any subpart of a contracted provider that would be a covered health care provider if it were a separate legal entity, to comply with 45 C.F.R. § 162.410(a)(1). For purposes of this paragraph, a covered health care provider shall have the same definition as a covered entity set forth in 45 C.F.R. § 160.103. DHCS shall make payments for covered services only if the Contractor is in compliance with federal regulations.

5. No Unlawful Use or Unlawful Use Messages Regarding Drugs

The 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- and alcohol-related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (Health & Safety Code §§ 11999-11999.3). By signing this Contract, the Contractor agrees that it will enforce**,** and will require its subcontractors and contract providers to enforce, these requirements.

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6. Counselor Certification

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 registered or certified as defined in Chapter 8 of Division 4 of Title 9 of C.C.R. (Document 3H).

7. Practice Guidelines

A. The Contractor will follow the guidelines in Document 1G, "Perinatal Practice Guidelines," in developing and implementing perinatal treatment and recovery programs funded under this Exhibit, until new Perinatal Practice Guidelines are established and adopted. No formal amendment of this Contract is required for new guidelines to be incorporated into this Contract.

B. The Contractor will follow the guidelines in Document 1V, "Adolescent Substance Use Disorder Best Practice Guidelines," in developing and implementing youth treatment programs funded under this Exhibit. No formal amendment of this Contract is required for new guidelines to be incorporated into this Contract.

8. Requirements for Provider Contracts and Subcontracts

The Contractor shall include the following provisions in all of its contracts with contracted providers and/or subcontractors, as applicable, in addition to any other requirements specified under this Contract or applicable law:

A. The following provisions in Exhibit A, Attachment 2E:

1) Section 5 (No Unlawful Use or Unlawful Use Messages Regarding Drugs)

2) Section 6 (Counselor Certification)

3) Section 7 (Practice Guidelines)

B. Exhibit A, Attachment 4, Section 6 (HIPAA and Additional Data Standards)

C. The following provisions in Exhibit E:

1) Section 5.C (Nondiscrimination)

2) Sections 7.B and 7.C (under State and Federal Law Governing this Contract)

3) The federal and state laws enumerated in Sections 7.D and 7.E, to the extent they are applicable.

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D. Provider contracts shall, in addition, require that contracted providers comply with the applicable regulations and guidelines, including:

1) To ensure equal access to quality care by diverse populations, adopting the Federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards (Document 3V).

2) 21 C.F.R., Part 1300, et seq

3) 42 C.F.R, .Part 8 (Medications for the Treatment of Opioid Use Disorder)

4) 22 C.C.R. §§ 51341.1, 51490.1, and 51516.1 (Document 2C)

5) Minimum Quality Treatment Standards (Document 2F(a))

6) 9, C.C.R., §§ 10000, et seq.

7) 22, C.C.R. §§ 51000, et seq.

8) Instructions on record retention, including maintaining records for each service rendered, to whom it was rendered, and the date of service, pursuant to W&I Code § 14124.1.

In the event of conflicts, the provisions of Title 22 shall control if they are more stringent.

9. Additional DMC Requirements Defined Elsewhere in Exhibit A

In addition to the requirements set forth in this Attachment 2E, the Contractor shall comply with the following requirements set forth elsewhere in Exhibit A with respect to its DMC activities:

A. Avoidance of Conflicts of Interest by Contractor

1) {Integrated Contracts Only} In Exhibit A, Attachment 1 (Organization and Administration): Section 6.E (Avoidance of Conflicts of Interest by Contractor), as well as the California Political Reform Act, Public Contract Code § 10365.5, and Government Code § 1090.

2) {Standalone DMC Contracts Only}

i. DHCS intends to avoid any real or apparent conflict of interest on the part of the Contractor, the subcontractor, or employees, officers and directors of the Contractor or subcontractor. Thus, DHCS reserves the right to determine, at its sole discretion, whether any information, assertion or

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claim received from any source indicates the existence of a real or apparent conflict of interest; and, if a conflict is found to exist, to require the Contractor to submit additional information or a plan for resolving the conflict, subject to DHCS review and prior approval.

ii. Conflicts of interest include, but are not limited to:

a. An instance where the Contractor or subcontractor, or any employee, officer, or director of the Contractor or subcontractor has an interest, financial or otherwise, whereby the use or disclosure of information obtained while performing services under the Contract would allow for private or personal benefit or for any purpose that is contrary to the goals and objectives of the Contract.

b. An instance where the Contractor's or subcontractor's employees, officers, or directors use their positions for purposes that are, or give the appearance of being, motivated by a desire for private gain for themselves or others, such as those with whom they have family, business or other ties.

iii. If DHCS is or becomes aware of a known or suspected conflict of interest, DHCS will notify the Contractor of the known or suspected conflict and the Contractor will be given an opportunity to respond to or resolve the alleged conflict. A Contractor with a suspected conflict of interest will have five (5) working days from the date of notification to provide DHCS with complete information regarding the suspected conflict. If a conflict of interest is determined to exist by DHCS and cannot be resolved to the satisfaction of DHCS, the conflict will be grounds for terminating the Agreement. DHCS may, at its discretion upon receipt of a written request from the Contractor, authorize an extension of the timeline indicated herein.

B. In Exhibit A, Attachment 3 (Financial Requirements):

1) Section 2 (Payments for American Indian and Alaska Native Health Care Providers (IHCPs))

C. In Exhibit A, Attachment 4 (Management Information Systems):

1) Section 4 (MEDSLITE Access);

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2) Section 5 (ICD-10); and

3) Section 6 (HIPAA and Additional Data Standards).

D. Parity in Mental Health and SUD Benefits

1) {Integrated Contracts Only}: In Exhibit A, Attachment 6 (Utilization Management Program): Section 3 (Parity in Mental Health and SUD Benefits)

2) {Standalone DMC Contracts Only}

i. The Contractor shall not impose financial requirements or quantitative treatment limitations, as defined in 42 C.F.R. § 438.900, for any member receiving covered services. (42 C.F.R. § 438.910(b), 438.920(a); BHIN 22-070.)

ii. The Contractor shall not impose aggregate lifetime or annual dollar limits, as defined in 42 C.F.R. § 438.900, for any member receiving covered services. (42 C.F.R. § 438.905(a), (b).)

iii. The Contractor shall not impose non-quantitative treatment limitations for covered services, as defined in 42 C.F.R. Part 438, Subpart K, in any benefit classification (i.e., inpatient and outpatient) unless the Contractor's policies and procedures have been determined by the Department to comply with Title 42 of the Code of Federal Regulations, part 438, subpart K. (42 C.F.R. § 438.910(d).)

iv. The Contractor shall submit to the Department, upon request, any policies and procedures or other documentation necessary for the State to establish and demonstrate compliance with Title 42 of the Code of Federal Regulations, part 438, subpart K, regarding parity in mental health and SUD benefits. Contractor shall, at a minimum, submit such documentation at the time it enters into this Contract with DHCS and any time there has been a significant change in the Contractor's operations that would affect parity, including changes in a quantitative treatment limitation or non-quantitative treatment limitation on a covered SMHS or SUD benefit. Such documentation shall be subject to DHCS approval pursuant to subparagraph iii of this section.

E. Minor Consent

Exhibit A – Attachment 2E
{DMC only}: SCOPE OF SERVICES

1) {Integrated Contracts Only} In Exhibit A, Attachment 7 (Access and Availability of Services): Section 9 (Minor Consent)

2) {Standalone DMC Contracts Only} Minor Consent

   i. Minors who are 12 years of age or older do not need parent, legal guardian, or Authorized Representative consent to access medical care and counseling relating to the diagnosis and treatment of a drug- or alcohol-related problem, with the exception of replacement narcotic therapy, pursuant to Family Code section 6929.

   ii. A minor who is 16 years of age or older does not need parent, legal guardian, or Authorized Representative consent to receive medications for opioid use disorder from a licensed narcotic treatment program as replacement narcotic therapy pursuant to Family Code section 6929, only if, and to the extent that, it is permitted by federal law.

   iii. Contractor must ensure access to the minor consent services described above from any contracted provider if the member is otherwise eligible to receive such services and the provider is otherwise eligible and certified to provide them.

   iv. Contractor must ensure members are informed of the availability of these services, including informing the minor whether or not they may consent on their own behalf.

F. In Exhibit A, Attachment 8 (Provider Network, Contracted Providers, and Timely Access):

1) Section 2.A & B (under Assessment of Capacity);

2) Section 4.B (Timely Access);

3) Section 9 (DMC Provider Certification, Credentialing, and DATAR Enrollment); and

4) Section 11 (Termination of a Provider Contract).

G. In Exhibit A, Attachment 10 (Coordination and Continuity of Care):

1) Section 2 (Screening and Assessment Period)

2) Section 3 (Coordination with Managed Care Programs)

H. In Exhibit A, Attachment 11 (Information Requirements):

Exhibit A – Attachment 2E
{DMC only}: SCOPE OF SERVICES

1) Section 3 (Language and Format);

2) Section 4 (Handbook); and

3) Section 5 (Provider Directory).

I. The entirety of Exhibit A, Attachment 12 (Member Problem Resolution).

J. In Exhibit A, Attachment 13 (Program Integrity):

1) Section 1.C (under General Requirements);

2) Section 2 (Periodic Audits);

3) Section 6 (Suspension of Provider Payments);

4) Section 9 (Contractor Monitoring of Contracted Providers);

5) Section 10 (State Monitoring - Postservice Postpayment Utilization Reviews); and

6) Section 11 (Reporting Fraud and Program Complaints)

K. In Exhibit A, Attachment 14 (Reporting Requirements):

1) Section 4 (Network Adequacy and Timely Access);

2) Section 9 (Additional Reporting Requirements Regarding DMC Services); and

3) Section 10 (Failure to Meet Reporting Requirements).

10. DMC Reference Documents

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

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

B. Document 1G: Perinatal Practice Guidelines FY 2018-19

C. Document 1K: Drug and Alcohol Treatment Access Report (DATAR) User Manual

D. Document 1P: Alcohol and/or Other Drug Program Certification Standards (February 2020)

E. Document 1V: Adolescent Substance Use Disorder Best Practices Guide

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

Exhibit A – Attachment 2E
{DMC only}: SCOPE OF SERVICES

G. Document 2C: Title 22, California Code of Regulations

H. Document 2F(a): Minimum Quality Drug Treatment Standards for DMC

I. Document 2G: Drug Medi-Cal Billing Manual

J. Document 2K: Multiple Billing Override Certification (MC 6700)

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

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

M. Document 2P: County Certification - Cost Report Year-End Claim for Reimbursement

N. Document 2P(a): Drug Medi-Cal Provider Cost Report Excel Workbook

O. 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

P. 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

Q. Document 3J: CalOMS Treatment Data Collection Guide

R. Document 3S: CalOMS Treatment Data Compliance Standards

S. Document 3T: Non-Drug Medi-Cal and Drug Medi-Cal DHCS Local Assistance Funding Matrix

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

U. Document 4A: Drug Medi-Cal Claim Submission Certification – County Contracted Provider – DHCS Form MC 100186 with Instructions

V. Document 4B: Drug Medi-Cal Claim Submission Certification – County Operated Provider – DHCS Form MC 100187 with Instructions

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

X. Document 4E: Treatment Standards for Substance Use Diagnosis: A Guide for Services (Spring 2010)

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

Exhibit A – Attachment 2E
{DMC only}: SCOPE OF SERVICES

Z. Document 5A: Confidentiality Agreement

Exhibit A - Attachment 2F
[RESERVED]

Exhibit A – Attachment 3
FINANCIAL REQUIREMENTS

1. [Reserved]

2. Payments for American Indian and Alaska Native Health Care Providers (IHCPs)

A. Claims from IHCPs must be paid in accordance with the timeliness requirements in 42 C.F.R. sections 438.14(b)(2)(iii), 447.45, and 447.46 as applicable.

B. The Contractor shall pay IHCPs at rates consistent with the requirements of 42 C.F.R. section 438.14(b)(2) and (c) and the State Plan, and as set forth in Department guidance, including BHINs 22-020 (SMHS), 22-053 (DMC-ODS), and 23-027 (DMC), as applicable, and any subsequent information notices.

1) Department guidance specifies payment parameters for different types of IHCPs, including: Tribal 638 providers enrolled in Medi-Cal as Indian Health Services-Memorandum of Agreement (IHS/MOA) providers; Indian Health Service (IHS) facilities; Tribal federally qualified health centers (FQHCs); IHCPs that are enrolled as FQHCs, but not as Tribal FQHCs; and Urban Indian Organizations (UIOs).

2) These payment parameters apply to all covered services provided by IHCPs to the Contractor's members. The Contractor is not obligated to contract with IHCPs for services provided to non-AI/AN members, but if the Contractor chooses to contract with an IHCP for the care of non-AI/AN members, the payment provisions in this section apply to services for those non-AI/AN members.

C. [Reserved]

3. [Reserved]

4. [Reserved]

5. [Reserved]

6. [Reserved]

7. [Reserved]

Exhibit A – Attachment 4
MANAGEMENT INFORMATION SYSTEMS

1. {SMHS and DMC-ODS only} Health Information Systems

A. The Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data. (42 C.F.R. § 438.242(a); 9 C.C.R. § 1810.376). The system shall provide information on areas including, but not limited to, utilization, claims, grievances, and appeals. (42 C.F.R. § 438.242(a)). The Contractor shall comply with Section 6504(a) of the Affordable Care Act which requires that State claims processing and retrieval systems are able to collect data elements necessary to enable the mechanized claims processing and information retrieval systems in operation by the State to meet the requirements of § 1903(r)(1)(F) of the Social Security Act. (42 C.F.R. § 438.242(b)(1)).

B. The Contractor's health information system shall, at a minimum:

1) Collect data on member and provider characteristics as specified by the Department, and on services furnished to members as specified by the Department; (42 C.F.R. § 438.242(b)(2)).

2) Ensure that data received from providers is accurate and complete by:

i. Verifying the accuracy and timeliness of reported data, including data from network providers the Contractor is compensating; (42 C.F.R. § 438.242(b)(3)(i)).

ii. Screening the data for completeness, logic, and consistency; and (42 C.F.R. § 438.242(b)(3)(ii)).

iii. Collecting service information in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for quality improvement and care coordination efforts. (42 C.F.R. § 438.242(b)(3)(iii)).

3) Make all collected data available to the Department and, upon request, to CMS. (42 C.F.R. § 438.242(b)(4)).

C. The Contractor's health information system is not required to collect and analyze all elements in electronic formats. (9 C.C.R. § 1810.376(c)).

2. {SMHS and DMC-ODS only} Encounter Data

The Contractor shall submit encounter data to the Department in connection with submitting claims, or otherwise at a frequency and level specified by the Department and CMS. (42 C.F.R. § 438.242(c)(2)). The Contractor shall ensure collection and maintenance of sufficient member encounter data to identify the

Exhibit A – Attachment 4
MANAGEMENT INFORMATION SYSTEMS

provider who delivers service(s) to the member. (42 C.F.R. § 438.242(c)(1)). The Contractor shall submit all member encounter data that the Department is required to report to CMS under 42 C.F.R. § 438.818. (42 C.F.R. § 438.242(c)(3)). The Contractor shall submit encounter data to the state in standardized Accredited Standards Committee (ASC) X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats, and the ASC X12N 835 format as appropriate. (42 C.F.R. § 438.242(c)(4)).

3. {SMHS and DMC-ODS only} Interoperability Rule Patient Access Application Programming Interface

In compliance with the terms of BHIN 22-068 and any subsequently issued BHINs that supersede BHIN 22-068, Contractor shall implement and maintain a secure, standards-based Patient Access Application Programming Interface (API) and a publicly accessible, standards-based Provider Directory API, as discussed in Exhibit A, Attachment 11, Section 5, that can connect to mobile applications and be available through a public-facing digital endpoint on Contractor's website. (45 C.F.R. § 170.215; 42 C.F.R. §§ 431.60, 431.70, 438.10, and 438.242).

4. MEDSLITE Access

The Contractor shall perform the following:

A. Establish County Behavioral Health MEDSLITE Coordinators (MEDSLITE Coordinators) to work with DHCS. These MEDSLITE Coordinators are required to sign and submit an Oath of Confidentiality to DHCS. Only these designated MEDSLITE Coordinators may initiate requests to add, delete, or otherwise modify a MEDSLITE user account. These MEDSLITE Coordinators are responsible for maintaining an active list of the Contractor's users with MEDSLITE access and collecting a signed MEDSLITE Oath of Confidentiality from each user. The MEDSLITE Coordinators are responsible for ensuring users are informed they cannot share user accounts, that MEDSLITE is to be used for only authorized purposes, and that all activity is logged. The MEDSLITE Coordinators may be changed by written notice to DHCS. They should be employees at an appropriate level in the organization, with sufficient responsibility to carry out the duties of this position. The MEDSLITE Coordinators will provide, assign, delete, and track user login identification information for authorized staff members. They are responsible for ensuring processes are in place which result in prompt MEDSLITE account deletion requests when the Contractor's users leave employment or no longer require access due to change in job duties.

Exhibit A – Attachment 4
MANAGEMENT INFORMATION SYSTEMS

B. Ensure that information furnished or secured via MEDSLITE shall be used solely for the purposes described in this Contract. The information obtained from MEDSLITE shall be used exclusively to administer the Medi-Cal program. The Contractor further agrees that information obtained under this Contract will not be reproduced, published, sold, or released in original or any other form for any purpose other than identified in this Contract.

C. Ensure that any agents, including a subcontractor, (if prior approval is obtained from DHCS) to whom they provide DHCS data, agree in writing to the same requirements for privacy and security safeguards for confidential data that apply to the Contractor with respect to this Contract. The Contractor shall seek prior written approval from DHCS before providing DHCS data to a subcontractor.

D. Adhere to security and confidential provisions outlined in Exhibit F, the Privacy and Security Provisions for the protection of any information exchanged with DHCS.

E. During the term of this Contract, the Contractor agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident involving DHCS data following the process outlined within Exhibit F, Section 17.

F. In order to enforce this MEDSLITE Access provision, the Contractor agrees to assist DHCS in performing compliance assessments. These assessments may involve compliance review questionnaires, and/or review of the facilities, systems, books, and records of the Contractor, with reasonable notice from DHCS. Such reviews shall be scheduled at times that take into account operational and staffing demands. The Contractor agrees to promptly remedy all violations of any provision of this Contract and certify the same to DHCS in writing, or to enter into a written Corrective Action Plan with DHCS containing deadlines for achieving compliance with specific provisions of this Contract.

5. ICD-10

A. The Contractor shall use the criteria sets in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR), or current edition, as the clinical tool to make diagnostic determinations.

B. Once a DSM-5 diagnosis is determined for a mental health disorder and/or a substance-related and addictive disorder, the Contractor shall determine the corresponding diagnosis in the ICD-10-CM, or current edition.

Exhibit A – Attachment 4
MANAGEMENT INFORMATION SYSTEMS

C. The Contractor shall use the ICD-10-CM diagnosis code(s), or current edition, to submit a claim for covered services to receive reimbursement of FFP.

6. HIPAA and Additional Data Standards

A. If any of the work performed under this Contract is subject to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (HIPAA), Contractor shall perform the work in compliance with all applicable provisions of HIPAA.

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

2) 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.

B. Trading Partner Requirements

1) 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 C.F.R. § 162.915 (a)).

2) 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 C.F.R. § 162.915 (b)).

3) 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 C.F.R. § 162.915 (c)).

4) 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 C.F.R. § 162.915 (d)).

C. Concurrence for Test Modifications to HHS Transaction Standards

Exhibit A – Attachment 4
MANAGEMENT INFORMATION SYSTEMS

1) 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.

D. Adequate Testing

1) 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.

E. Deficiencies

1) 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.

F. Code Set Retention

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

G. Data Transmission Log

1) 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 Contract. 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 5
[RESERVED]

Exhibit A – Attachment 6
UTILIZATION MANAGEMENT AND PARITY

1. [Reserved]

2. [Reserved]

3. Parity in Mental Health and SUD Benefits

A. The Contractor shall not impose financial requirements or quantitative treatment limitations, as defined in 42 C.F.R. § 438.900, for any member receiving covered services. (42 C.F.R. § 438.910(b), 438.920(a); BHIN 22-070.)

B. The Contractor shall not impose aggregate lifetime or annual dollar limits, as defined in 42 C.F.R. § 438.900, for any member receiving covered services. (42 C.F.R. § 438.905(a), (b).)

C. The Contractor shall not impose non-quantitative treatment limitations for covered services, as defined in 42 C.F.R. Part 438, Subpart K, in any benefit classification (i.e., inpatient and outpatient) unless the Contractor's policies and procedures have been determined by the Department to comply with Title 42 of the Code of Federal Regulations, part 438, subpart K. (42 C.F.R. § 438.910(d).)

D. The Contractor shall submit to the Department, upon request, any policies and procedures or other documentation necessary for the State to establish and demonstrate compliance with Title 42 of the Code of Federal Regulations, part 438, subpart K, regarding parity in mental health and SUD benefits. Contractor shall, at a minimum, submit such documentation at the time it enters into this Contract with DHCS and any time there has been a significant change in the Contractor's operations that would affect parity, including changes in a quantitative treatment limitation or non-quantitative treatment limitation on a covered SMHS or SUD benefit. Such documentation shall be subject to DHCS approval pursuant to paragraph C of this section.

Exhibit A – Attachment 7
[RESERVED]

Exhibit A – Attachment 8
PROVIDER NETWORK, CONTRACTED PROVIDERS, AND TIMELY ACCESS

1. [Reserved]

2. Assessment of Capacity

A. The Contractor shall implement mechanisms to assess the capacity of service delivery for its members. This includes monitoring the number, type, and geographic distribution of mental health and SUD services within the Contractor's delivery system.

B. The Contractor shall implement mechanisms to assess the accessibility of services within its service delivery area. This shall include the assessment of responsiveness of the Contractor's 24-hour toll-free telephone number (as described in Exhibit A, Attachment 7, Section 8), timeliness of scheduling routine appointments, timeliness of services for urgent conditions, and access to after-hours care.

1) Subject to DHCS provider enrollment and certification requirements, the Contractor shall maintain continuous availability and accessibility of covered services and facilities, service sites, and personnel to provide the covered services. Such services shall not be limited due to budgetary constraints.

2) When a member makes a request for covered services, the Contractor shall require services to be initiated with reasonable promptness in accordance with the timely access standards defined below in Section 4. 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.

C. [Reserved]

3. [Reserved]

4. Timely Access

A. [Reserved]

B. {DMC only} Timely Access. The Contractor shall establish, comply with, and report on Timely Access Standards, Alternative Access Standards (AAS), and Telehealth Services in accordance with requirements set forth in BHIN 22-070, and any subsequently issued BHINs that supersede BHIN 22-070.

C. The applicable waiting time for a particular appointment may be extended at the member's request if the following conditions are met:

Exhibit A – Attachment 8
PROVIDER NETWORK, CONTRACTED PROVIDERS, AND TIMELY ACCESS

1) The member's medical record notes that waiting will not have a detrimental impact on the member's health, as determined by the referring or treating licensed health care provider, or by the health professional providing triage or screening services, who is acting within the scope of their practice consistent with professionally recognized standards of practice;

2) The provider's decision to extend the applicable waiting time is noted in the member's medical record and made available to DHCS upon request; and

3) Contractor ensures that the member receives notice of the provider's decision to extend the applicable waiting time with an explanation of the member's right to file a grievance disputing the extension. (W&I Code § 14197, subd. (d)(1)(A); Health & Safety Code § 1367.03, subd. (a)(5)(H); 28 C.C.R. § 1300.67.2.2(c)(5)(H); BHIN 22-073.)

D. Contractor must ensure that its contracted providers and subcontractors participate in all timely access survey(s) and network adequacy activities conducted by DHCS or its contractors. Contractor must include language to this effect in any new or amended network provider or subcontractor agreements executed after the effective date of this Contract.

5. [Reserved]

6. [Reserved]

7. [Reserved]

8. [Reserved]

9. {DMC and DMC-ODS only} DMC Provider Certification and Monitoring

A. DHCS shall certify eligible providers to participate in the DMC program.

B. This certification shall be performed prior to the date on which the Contractor begins to deliver services under this Contract at any site.

C. Perinatal Services. Contractor shall require that providers of perinatal DMC services are properly certified to provide these services and comply with the applicable requirements contained in:

1) [Reserved]

2) {DMC only} 22 C.C.R. section 51341.1 related to services for pregnant and postpartum women.

Exhibit A – Attachment 8
PROVIDER NETWORK, CONTRACTED PROVIDERS, AND TIMELY ACCESS

D. Contracted Providers

1) [Reserved]

2) {DMC only} The Contractor shall only use licensed, certified, registered, or waived providers, in good standing and acting within their scope of practice, for services that require a license, registration, certification, or waiver. This includes

i. Clinical social worker (CSW), marriage and family therapist (MFT), and professional clinical counselor (PCC) candidates who have submitted their applications for associate registration to the California Board of Behavioral Sciences (BBS) within 90 days of their degree award date and are completing supervised experience toward licensure to provide SMHS, DMC-ODS and DMC services to Medi-Cal members, in accordance with BHIN 24-023 and any subsequent departmental guidance.

a. CSW, MFT, and PCC candidates must act within their scopes of practice under California law. Contractor must obtain and maintain documentation to verify that the candidate's BBS application has been submitted and is pending and must subsequently verify that the registration is approved.

b. Services rendered by CSW, MFT, and PCC candidates completing supervised experience can be reimbursed while their BBS application is pending. In the event the BBS application is not approved by BBS, the services provided by the candidate are not Medi-Cal reimbursable.

E. The Contractor 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 Contractor shall ensure that a new DMC certification application is submitted to PED reflecting the change.

F. 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

Exhibit A – Attachment 8
PROVIDER NETWORK, CONTRACTED PROVIDERS, AND TIMELY ACCESS

PED 60 days prior to the desired effective date of the reduction of covered services or relocation.

G. [Reserved]

H. 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 members 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 may conduct unannounced certification and recertification on-site visits at clinics pursuant to W&I Code section 14043.7.

I. {DMC only} Credentialing and Re-credentialing. The Contractor shall establish and comply with provider credentialing, re-credentialing, and attestation provisions in accordance with the requirements set forth in BHIN 22-070.

10. [Reserved]

11. Termination of a Provider Contract

A. The Contractor shall notify the Department of the termination of any contract with a contracted provider, and the basis for termination, within two business days.

B. The Contractor shall submit the notification using a Secure Managed File Transfer system specified by DHCS.

C. [Reserved]

12. [Reserved]

13. [Reserved]

Exhibit A – Attachment 9
[RESERVED]

Exhibit A – Attachment 10
COORDINATION AND CONTINUITY OF CARE

1. [Reserved]

2. Screening and Assessment Period

A. Consistent with the No Wrong Door policies set forth in W&I Code § 14184.402, BHIN 22-011, BHIN 22-065, and any related Department guidance, the Contractor must cover the assessment and any SMHS and/or SUD services provided during the assessment period for any member seeking care.

B. As of the effective date identified by DHCS, the Contractor must use DHCS-approved standardized mental health screening tools set forth in DHCS guidance (including standardized screening tools specific for adults and standardized screening tools specific for children and youth) to ensure members seeking mental health services who are not currently receiving covered SMHS or NSMHS are referred to the appropriate delivery system for mental health services, either in the Contractor network or the Managed Care Plan network, in accordance with the No Wrong Door policies set forth in W&I Code § 14184.402(h).

3. Coordination with Managed Care Plans

A. The Contractor shall enter into a Memorandum of Understanding (MOU) with any Medi-Cal managed care plan serving the Contractor's members. The Contractor shall ensure the components of the MOU comply with guidance issued by DHCS regarding MOU requirements. The Contractor shall monitor the effectiveness of its MOU with Medi-Cal managed care plans.

B. [Reserved]

C. [Reserved]

D. {DMC only} Additional Requirements: The MOU shall comply with BHIN 24-016 and any subsequently issued BHINs that supersede BHIN 24-016.

4. {SMHS and DMC-ODS only} Transition of Care

A. The Contractor shall implement a transition of care policy that is in accordance with applicable state and federal regulations, MHSUD IN 18-059 (for SMHS), BHIN 23-001 (for DMC-ODS), and any BHINs issued by the Department for parity in mental health and substance use disorder benefits subsequent to the effective date of this Contract (42 C.F.R. § 438.62(b)(1)-(2).) At a minimum, the Contractor shall provide the transition of care policy to members and potential members in the member

Exhibit A – Attachment 10
COORDINATION AND CONTINUITY OF CARE

handbook and member notices. (See Exhibit A, Attachment 11 Section 1.E.)

Exhibit A – Attachment 11
INFORMATION REQUIREMENTS

1. [Reserved]

2. [Reserved]

3. Language and Format

A. Nondiscrimination Requirements, Language Assistance, and Information Access for Individuals with Limited English Proficiency and/or Disabilities (42 C.F.R. § 438.10; W&I Code § 14029.91; W&I Code § 14727; Government Code § 11135; 28 C.F.R. §§ 35.160-35.164; 28 C.F.R. § 36.303; 45 C.F.R. Part 92; 42 U.S.C. § 18116; 42 U.S.C. 12101*et seq*.)).

1) The Contractor shall comply with all applicable state and federal requirements regarding nondiscrimination, language assistance, information access, including but not limited to, the Dymally-Alatorre Bilingual Services Act, § 1557 of the Patient Protection and Affordable Care Act, the Americans with Disabilities Act, and § 504 of the Rehabilitation Act.

2) The Department shall use the following methodologies to identify the prevalent non–English languages spoken by members and potential members throughout the State, and in the Contractor's service area:

i. Threshold Standard Language: A population group of mandatory eligible members residing in the Contractor's service area who indicate their primary language as a language other than English, and that meet a numeric threshold of 3,000 or 5% of the eligible member population, whichever is lower; and

ii. A population group of mandatory eligible members residing in the Contractor's service area who indicate their primary language as a language 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.

3) Nondiscrimination Notice

i. The Nondiscrimination Notice must be sent in conjunction with each of the following significant notices sent to members:

a. Notices of Adverse Benefit Determination.

b. Grievance acknowledgement letter.

Exhibit A – Attachment 11
INFORMATION REQUIREMENTS

c. Appeal acknowledgement letter.

d. Grievance resolution letter.

e. Notice of Appeal Resolution.

ii. The Contractor shall post a Department-approved nondiscrimination notice that informs members, potential members, and the public about nondiscrimination, protected characteristics, and accessibility requirements, and conveys the Contractor's compliance with the requirements.

iii. The nondiscrimination notice shall be posted in at least a 12-point font and be included in any documents that are vital or critical to obtaining services and/or benefits, and all other informational notices targeted to members, potential members, and the public. Informational notices include not only documents intended for the public, such as outreach, education, and marketing materials, but also written notices requiring a response from an individual and written notices to an individual such as those pertaining to rights or benefits.

iv. The nondiscrimination notice shall also be posted in at least a 12-point font in conspicuous physical locations where the Contractor interacts with the public, and on the Contractor's website in a location that allows any visitor to the website to easily locate the information.

v. The nondiscrimination notice shall include all legally required elements under the applicable subsections of Government Code § 11135.

vi. The nondiscrimination notice shall include information on how to file a discrimination grievance with:

a. The Contractor and the Department's Office of Civil Rights 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

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discrimination based on race, color, national origin, sex, age, or disability.

vii. The Contractor is not prohibited from posting the nondiscrimination notice in additional publications and communications.

4) Language Assistance Taglines

i. The Language Assistance Taglines must be sent in conjunction with each of the following significant notices sent to members:

a. Notices of Adverse Benefit Determination.

b. Grievance acknowledgement letter.

c. Appeal acknowledgement letter.

d. Grievance resolution letter.

e. Notice of Appeal Resolution.

ii. The Contractor shall post Department-approved taglines in a conspicuously visible size (no less than 12-point font), in English and at least the top 18 non-English languages in the State (as determined by the Department), informing members, potential members, and the public of the availability of no-cost language assistance services, including assistance in non-English languages and the provision of free auxiliary aids and services for people with disabilities.

iii. Taglines shall be posted in any documents that are vital or critical to obtaining services and/or benefits, conspicuous physical locations where the Contractor interacts with the public, on the Contractor's website in a location that allows any visitor to the website to easily locate the information, and in all member information and other information notice, in accordance with federal and state requirements.

5) Language Assistance Services

i. Language assistance services shall be provided free of charge, be accurate and timely, and protect the privacy and independence of the limited English proficiency (LEP) individual. There are two primary types of language assistance services: oral and written. LEP individuals are not

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required to accept language assistance services, although a qualified interpreter may be used to assist in communicating with an LEP individual who has refused language assistance services.

ii. The Contractor shall comply with the following oral interpretation requirements:

iii. Contractors shall provide oral interpretation services from a qualified interpreter, on a 24-hour basis, at all key points of contact, at no cost to members. Key points of contact refer to common points of access to covered services, including but not limited to the Contractor's member problem resolution process, Contractor-owned or -operated or contract hospitals, and any other central access locations established by the Contractor. Key points of contact may include medical care settings and non-medical care settings.

iv. Font shall be provided in all languages and is not limited to threshold or concentration standard languages.

v. Interpretation can take place in-person, through a telephonic interpreter, or internet or video remote interpreting (VRI) services. However, the Contractor is prohibited from using remote audio or VRI services that do not comply with federal quality standards, or relying on unqualified bilingual/multilingual staff, interpreters, or translators. The Contractor should not solely rely on telephone language lines for interpreter services. Rather, telephonic interpreter services should supplement face-to-face interpreter services, which are a more effective means of communication.

vi. An interpreter is a person who renders a message spoken in one language into one or more languages. An interpreter shall be qualified and have knowledge in both languages of the relevant terms or concepts particular to the program or activity and the dialect spoken by the LEP individual. In order to be considered a qualified interpreter for an LEP individual, the interpreter must: 1) have demonstrated proficiency in speaking and understanding both English and the language spoken by the LEP individual; 2) be able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from the language spoken by the LEP individual and English, using any necessary specialized vocabulary, terminology, and phraseology; and 3) adhere to

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generally accepted interpreter ethics principles, including client confidentiality.

vii. If the Contractor provides a qualified interpreter for an individual with LEP through remote audio interpreting services, the Contractor shall provide real-time audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality audio without lags or irregular pauses in communication; a clear, audible transmission of voices; and adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the remote interpreting services.

viii. The Contractor is prohibited from requiring LEP individuals to provide their own interpreters, or from relying on bilingual/multilingual staff members who do not meet the qualifications of a qualified interpreter. Some bilingual/multilingual staff may be able to communicate effectively in a non-English language when communicating information directly in that language but may not be competent to interpret in and out of English. Bilingual/multilingual staff may be used to communicate directly with LEP individuals only when they have demonstrated to the Contractor that they meet all the qualifications of a qualified interpreter listed above.

ix. The Contractor is prohibited from relying on an adult or minor child accompanying an LEP individual to interpret or facilitate communication except when: 1) there is an emergency involving an imminent threat to the safety or welfare of the individual or the public and a qualified interpreter is not immediately available; or, 2) the LEP individual specifically requests that an accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under the circumstances. Prior to using a family member, friend or, in an emergency only, a minor child as an interpreter for an LEP individual, the Contractor shall first inform the individual that they have the right to free interpreter services and second, ensure that the use of such an interpreter will not compromise the effectiveness of services or violate the LEP individual’s confidentiality. The Contractor shall also ensure

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that the LEP individual's refusal of free interpreter services and their request to use family members, friends, or a minor child as an interpreter is documented.

x. The Contractor shall comply with the following written translation requirements:

xi. The Contractor shall use a qualified translator when translating written content in paper or electronic form. A qualified translator is a translator who: 1) adheres to generally accepted translator ethics principles, including client confidentiality; 2) has demonstrated proficiency in writing and understanding both written English and the written non-English language(s) in need of translation; and 3) is able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology, and phraseology.

xii. At a minimum, the Contractor shall provide written translations of member information in the threshold and concentration languages.

6) Effective Communication with Individuals with Disabilities

i. The Contractor shall comply with all applicable requirements of federal and state disability law and take appropriate steps to ensure effective communication with individuals with disabilities, as described in BHIN 24-007.

ii. The Contractor shall make member information available in large print (no less than 20-point font) alternative format.

iii. The Contractor shall not require an individual with a disability to provide their own interpreter. The Contractor is also prohibited from relying on an adult or minor child accompanying an individual with a disability to interpret or facilitate communication except as described in BHIN 24-007. Prior to using a family member, friend, or, in an emergency only, a minor child as an interpreter for an individual with a disability, the Contractor shall first inform the individual that they have the right to free interpreter services and second, ensure that the use of such an interpreter will not compromise the effectiveness of services or violate the individual's confidentiality. The Contractor shall

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ensure that the refusal of free interpreter services and the individual's request to use a family member, friend, or a minor child as an interpreter is documented.

iv. The Contractor shall make reasonable modifications to policies, practices, or procedures when such modifications are necessary to avoid discrimination based on disability.

4. Handbook

A. The Contractor shall mail members a physical copy of the handbook and provider directory, offer members a physical copy of the handbook and provider directory when the member first accesses services, or ensure that members receive a link to the online versions of these member materials after receiving the member's consent to receive the handbook and provider directory electronically. (9 C.C.R. § 1810.360(e); BHIN 24-034.)

B. The Contractor shall ensure that the handbook includes the current toll-free telephone number for the 24/7 access line described in Exhibit A, Attachment 7, Section 8. (42 C.F.R. § 438.10(g)(2)(xiv)).

C. The member handbook shall include information that enables the member to understand how to effectively use the managed care program. This information shall include, at a minimum:

1) Benefits provided by the Contractor. (42 C.F.R. § 438.10(g)(2)(i)).

2) How and where to access any benefits provided by the Contractor, including any cost sharing, and how transportation is provided. (42 C.F.R. § 438.10(g)(2)(ii)).

i. The amount, duration, and scope of benefits available under the Contract in sufficient detail to ensure that members understand the benefits to which they are entitled. (42 C.F.R. § 438.10(g)(2)(iii)).

ii. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the member's provider. (42 C.F.R. § 438.10(g)(2)(iv)).

iii. Any restrictions on the member's freedom of choice among network providers. (42 C.F.R. § 438.10(g)(2)(vi)).

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iv. The extent to which, and how, members may obtain benefits from out-of-network providers. (42 C.F.R. § 438.10(g)(2)(vii)).

v. Cost sharing, if any, consistent with the California State Plan § 4.18. (42 C.F.R. § 438.10(g)(2)(viii)).

vi. Member rights and responsibilities, including the elements specified in 42 C.F.R. 438.100 as specified in Section 7 of this Attachment. (42 C.F.R. § 438.10(g)(2)(ix)).

vii. The process of selecting and changing the member's provider. (42 C.F.R. § 438.10(g)(2)(x)).

viii. Grievance, appeal, and State Hearing procedures and timeframes, consistent with 42 C.F.R. sections 438.400 through 438.424, in a state-developed or state-approved description. Such information shall include:

a. The right to file grievances and appeals;

b. The Contractor shall include information on filing a Discrimination Grievance with the Contractor, the Department's 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 member believes they have been unlawfully discriminated against, they have the right to file a Discrimination Grievance with the Contractor, the Department's Office of Civil Rights, and the United States Department of Health and Human Services, Office for Civil Rights;

c. The requirements and timeframes for filing a grievance or appeal;

d. The availability of assistance in the filing process;

e. The right to request a State Hearing after the Contractor has made a determination on a member's appeal which is adverse to the member;

f. The fact that, when requested by the member, benefits that the Contractor seeks to reduce or terminate will continue if the member files an appeal or a request for State Hearing within the timeframes

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specified for filing, and that the member may, consistent with state policy, be required to pay the cost of services furnished while the appeal or State Hearing is pending if the final decision is adverse to the member. (42 C.F.R. § 438.10(g)(2)(xi)).

ix. How to exercise an advance directive, as set forth in 42 C.F.R. section 438.3(j). (42 C.F.R. § 438.10(g)(2)(xii)).

x. How to access auxiliary aids and services, including additional information in in alternative formats or languages. (42 C.F.R. § 438.10(g)(2)(xiii)).

xi. The Contractor's toll-free telephone number for member services, medical management, and any other unit providing services directly to members. (42 C.F.R. § 438.10(g)(2)(xiv)).

xii. Information on how to report suspected fraud or abuse. (42 C.F.R. § 438.10(g)(2)(xv)).

xiii. Additional information that is available upon request, includes the following:

a. Information on the structure and operation of the Contractor.

b. Physician incentive plans as set forth in 42 C.F.R. section 438.3(i). (42 C.F.R. § 438.10(f)(3)).

D. The Contractor shall give each member notice of any significant change, as defined by the Department, to information in the handbook at least 30 days before the intended effective date of the change. (42 C.F.R. § 438.10(g)(4)).

E. Consistent with 42 C.F.R. section 438.10(g)(3) and BHIN 24-034 (and any subsequently issued BHINs that supersede BHIN 24-034), the handbook will be considered provided if the Contractor delivers the handbook as required below:

1) Direct Delivery

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

ii. Offers a printed copy of the information to the member during in-person interactions; or

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iii. Provides the information by email after obtaining the member's agreement to receive the information by email.

AND

2) Website

i. Posts the information on the Contractor's website in a manner that is readily accessible;

ii. Advises the member in paper or electronic form that the information is available on the internet and includes the applicable internet addresses;

iii. Provides that members with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost; and

iv. Inform members the information is available in paper form without charge upon request and provide the member handbook upon request within five (5) business days.

5. Provider Directory

A. The Contractor must follow the Department's provider directory policy, as described in MHSUDS IN 18-020 or BHIN 22-070, as applicable, and any subsequently issued BHINs that supersede these guidance documents.

1) [Reserved]

B. The Contractor shall make provider directories available in electronic and paper form upon request, and maintain a publicly accessible standards-based Provider Directory API as described in 42 C.F.R. § 431.70 and BHIN 22-068 and any subsequently issued BHINs that supersede BHIN 22-068 or BHIN 22-070, as applicable, and meet the same technical standards of the Patient Access API and ensure that the provider directories include the following information for all providers who receive Medicaid funding to order, refer, or render covered services under this Contract including all network providers, and each licensed, waivered, or registered mental health or SUD provider employed by the Contractor, each provider organization, including a hospital or pharmacy, or individual practitioner contracting with the Contractor, and each licensed, waivered, or registered mental health or SUD provider employed by a provider organization to deliver Medi-Cal services (BHINs 22-068 and 22-070; 42 C.F.R. section 438.10(h)(1)):

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1) Information on the services and benefits available, including specialty (as applicable).

2) The names, medical group/foundation, independent physician/provider associations, and any group affiliations, street addresses, telephone numbers, specialty, email address(es), as appropriate, and website URLs of current contracted providers by category.

3) The provider's cultural and linguistic capabilities, including languages (including ASL) offered by the provider or a skilled medical interpreter at the provider's office.

4) Whether providers' offices/facilities have accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

5) A means to identify which providers are accepting new members.

6) Type of practitioner as appropriate.

7) National Provider Identifier number.

8) California License number and type of license.

9) Whether the provider has completed cultural competence training.

10) Hours and days when each service location is open, including the availability of evening and/or weekend hours.

C. Information included in a paper provider directory shall be updated at least monthly and electronic provider directories and Provider Directory API shall be updated no later than 30 calendar days after the Contractor receives updated provider information. The Contractor shall ensure processes are in place to allow providers to promptly verify or submit changes to the information required to be in the directory. (42 C.F.R. § 438.10(h)(3); 42 CFR § 431.70; BHIN 22-068.)

D. Provider directories shall be made available on the Contractor's website in a machine-readable file and format as specified by HHS. (42 C.F.R. § 438.10(h)(4)).

1) {DMC-ODS PHC Model only} The provider directory must also be made available on the Contractor's website in a machine-readable file and format as specified by HHS;

E. {DMC only} The provider directory shall include a statement that affirms a DMC county member's right to obtain covered services from any enrolled

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and DMC-certified provider, even if that provider is not listed in the provider directory.

6. **[Reserved]**

7. **[Reserved]**

8. **[Reserved]**

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MEMBER PROBLEM RESOLUTION

1. General Provisions

A. The Contractor shall have a grievance and appeal system in place for members. (42 C.F.R. §§ 438.228(a), 438.402(a); 9 C.C.R. § 1850.205; BHIN 22-070.) The grievance and appeal system shall be implemented to handle appeals of adverse benefit determinations and grievances and shall include processes to collect and track information about them. The Contractor's member problem resolution processes shall include:

1) A grievance process;

2) An appeal process; and,

3) An expedited appeal process. (42 C.F.R. § 438.228(a); 9 C.C.R. § 1850.205(b); BHIN 22-070.)

B. For the grievance, appeal, and expedited appeal processes, the Contractor shall comply with the following requirements:

1) The Contractor shall ensure that each member has adequate information about the Contractor's problem resolution processes by taking at least the following actions:

i. Including information describing the grievance, appeal, and expedited appeal processes in the Contractor's member handbook and providing the member handbook to members as described in Exhibit A, Attachment 11, Section 4 of this Contract. (9 C.C.R. § 1850.205(c)(1)(A); 42 C.F.R. § 438.10(g).)

ii. At all contracted provider sites, other than out-of-network providers:

a. Posting notices explaining grievance, appeal, and expedited appeal process procedures in locations at all Contractor provider sites. Notices shall be sufficient to ensure that the information is readily available to both members and provider staff. The posted notice shall also explain the availability of State Hearings after the exhaustion of an appeal or expedited appeal process, including information that a State Hearing may be requested whether or not the member has received a notice of adverse benefit determination. (9 C.C.R. §§ 1850.205(c)(1)(B) and 1850.210; BHIN 22-070.)

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b. Make available forms that may be used to file grievances, appeals, and expedited appeals and self-addressed envelopes that members can access, without having to make a verbal or written request to anyone. (9 C.C.R. § 1850.205(c)(1)(C); BHIN 22-070.)

iii. Give members any reasonable assistance in completing the forms and other procedural steps related to a grievance or appeal. This includes, but is not limited to, providing interpreter services, auxiliary aids and services upon request, and toll-free numbers with TTY/TDD and interpreter capability. (42 C.F.R. § 438.406(a); 42 C.F.R. § 438.228(a); BHIN 22-070.)

2) The Contractor shall allow members to file grievances and request appeals. (42 C.F.R. § 438.402(c)(1); BHIN 22-070.) The Contractor shall have only one level of appeal for members. (42 C.F.R. § 438.402(b); 42 C.F.R. § 438.228(a); BHIN 22-070.)

3) A member may request a State Hearing after receiving notice under 438.408 that the adverse benefit determination is upheld. (42 C.F.R. § 438.402(c)(1); 42 C.F.R. § 438.408(f).)

4) The Contractor shall adhere to the notice and timing requirements in §438.408. If the Contractor fails to adhere to these notice and timing requirements, the member is deemed to have exhausted the Contractor's appeals process and may initiate a State Hearing. (42 C.F.R. §§ 438.402(c)(1)(i)(A), 438.408(c)(3); BHIN 22-070.)

5) The Contractor shall acknowledge receipt of each grievance, appeal, and request for expedited appeal of adverse benefit determinations to the member, in writing, within five calendar days. (42 C.F.R. § 438.406(b)(1); 42 C.F.R. § 438.228(a); 9 C.C.R. § 1850.205(d)(4); BHIN 22-070.) Provided, however, that grievances received over the telephone or in-person by the Contractor or a contracted provider that are resolved to the member's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written acknowledgment.

6) The Contractor shall allow a provider, or authorized representative, acting on behalf of the member and with the member's written consent to request an appeal or expedited appeal, file a grievance, or request a State Hearing, with the exception that providers cannot

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request continuation of benefits. (42 C.F.R. § 438.402(c)(1)(i)-(ii); 9 C.C.R. § 1850.205(c)(2); BHIN 22-070.)

7) [Reserved]

8) At the member's request, the Contractor shall identify staff or another individual, such as a legal guardian, to be responsible for assisting a member with these processes, including providing assistance in writing the grievance, appeal, or expedited appeal. If the individual identified by the Contractor is the person providing SMHS or SUD services to the member requesting assistance, the Contractor shall identify another individual to assist that member. (9 C.C.R. § 1850.205(c)(4).) Assistance includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability. (42 C.F.R. § 438.406(a); BHIN 22-070.)

9) The Contractor shall not subject a member to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal. (9 C.C.R. § 1850.205(c)(5); 42 C.F.R. § 438.100(c); BHIN 22-070.)

10) The Contractor's procedures for the member problem resolution processes shall maintain the confidentiality of each member's information, including compliance with HIPAA and other applicable federal and state laws. (9 C.C.R. § 1850.205(c)(6).)

11) The Contractor shall include a procedure to transmit issues identified as a result of the grievance, appeal or expedited appeal processes to the Contractor's Quality Improvement Committee, the Contractor's administration or another appropriate body within the Contractor's operations. The Contractor shall consider these issues in the Contractor's Quality Improvement Program, as required by 9 C.C.R. § 1810.440(a)(5). (9 C.C.R. § 1850.205(c)(7); BHIN 22-070.)

12) The Contractor shall ensure that decision makers on grievances and appeals of adverse benefit determinations were not involved in any previous level of review or decision-making and were not subordinates of any individual who was involved in a previous level of review or decision-making. (42 C.F.R. § 438.406(b)(2)(i); 42 C.F.R. § 438.228(a); BHIN 22-070.)

13) The Contractor shall ensure that individuals making decisions on grievances and appeals have the appropriate clinical expertise, as determined by the Department, in treating the member's condition

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or disease, if the decision involves an appeal based on a denial of medical necessity, a grievance regarding denial of a request for an expedited appeal, or if the grievance or appeal involves clinical issues.(42 C.F.R. § 438.406(b)(2)(ii)(A)-(C); 42 C.F.R. § 438.228(a); BHIN 22-070.)

14) The Contractor shall provide the member a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor must inform the member of the limited time available for this sufficiently in advance of the resolution timeframe for appeals specified in § 438.408(b) and (c) in the case of expedited resolution. (42 C.F.R. § 438.406(b)(4); BHIN 22-070.)

15) The Contractor shall ensure that decision makers on grievances and appeals of adverse benefit determinations take into account all comments, documents, records, and other information submitted by the member or member's representative, without regard to whether such information was submitted or considered in the initial adverse benefit determination. (42 C.F.R. § 438.406(b)(2)(iii); 42 C.F.R. § 438.228(a); BHIN 22-070.)

16) The Contractor shall provide the member and their representative the member'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. (42 C.F.R. § 438.406(b)(5); BHIN 22-070.)

17) The Contractor shall provide the member and their representative the member's case file free of charge and sufficiently in advance of the resolution timeframe for standard and expedited appeal resolutions. (42 C.F.R. § 438.406(b)(5); BHIN 22-070.)

18) The Contractor shall treat oral inquiries seeking to appeal an adverse benefit determination as appeals (to establish the earliest possible filing date for the appeal) and must confirm these oral inquiries in writing, unless the member or the provider requests expedited resolution. (42 C.F.R. § 438.406(b)(3); BHIN 22-070.)

19) The Contractor's member problem resolution process shall not replace or conflict with the duties of county patient's rights advocates. (W&I Code § 5520.)

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2. Handling of Grievances and Appeals

The Contractor shall adhere to the following record keeping, monitoring, and review requirements:

A. Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal. (42 C.F.R. § 438.416(a); 9 C.C.R. § 1850.205(d)(1); BHIN 22-070.) Each record shall include, but not be limited to: a general description of the reason for the appeal or grievance the date received, the date of each review or review meeting, resolution information for each level of the appeal or grievance, if applicable, and the date of resolution at each level, if applicable, and the name of the covered person whom the appeal or grievance was filed. (42 C.F.R. § 438.416(b)(1)-(6); BHIN 22-070.)

B. Record in the grievance and appeal log or another central location determined by the Contractor, the final dispositions of grievances, appeals, and expedited appeals, including the date the decision is sent to the member. If there has not been final disposition of the grievance, appeal, or expedited appeal, the reason(s) shall be included in the log. (9 C.C.R. § 1850.205(d)(2).)

C. Provide a staff person or other individual with responsibility to provide information requested by the member or the member’s representative regarding the status of the member's grievance, appeal, or expedited appeal. (9 C.C.R. 9, § 1850.205(d)(3).)

D. Identify in its grievance, appeal, and expedited appeal documentation, the roles and responsibilities of the Contractor, the provider, and the member. (9 C.C.R. 9, § 1850.205(d)(5).)

E. Provide notice, in writing, to any provider identified by the member or involved in the grievance, appeal, or expedited appeal of the final disposition of the member's grievance, appeal, or expedited appeal. (9 C.C.R. § 1850.205(d)(6).)

F. Maintain records in the grievance and appeal log accurately and in a manner accessible to the Department and available upon request to CMS. (42 C.F.R. § 438.416(c).)

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3. Grievance Process

The Contractor's grievance process shall, at a minimum:

A. Allow members to file a grievance either orally, or in writing at any time with the Contractor. (42 C.F.R. § 438.402(c)(2)(i) and (c)(3)(i); BHIN 22-070.)

B. The Contractor shall provide to the member written acknowledgement of receipt of the grievance. The acknowledgment letter shall include the date of receipt, as well as the name, telephone number, and address of the Plan representative who the member may contact about the grievance. The written acknowledgement to the member must be postmarked within five calendar days of receipt of the grievance. Grievances received over the telephone or in-person by the Contractor or a contracted provider that are resolved to the member's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written notification of resolution using the Written Notification of Grievance Resolution form.

C. Resolve each grievance as expeditiously as the member's health condition requires not to exceed 30 calendar days from the day the Contractor receives the grievance. (42 C.F.R. § 438.408(a)-(b)(1).)

D. [Reserved]

E. Provide written notification to the member or the appropriate representative of the resolution of a grievance and documentation of the notification or efforts to notify the member, if they could not be contacted. (9 C.C.R. § 1850.206(c); BHIN 22-070.)

F. Notify the member of the resolution of a grievance in a format and language that meets applicable notification standards. (42 C.F.R. § 438.408(d)(1); 42 C.F.R. § 438.10; BHIN 22-070.)

4. Discrimination Grievances

A. For Discrimination Grievances:

1) 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. (W&I Code § 14727(a)(4); 45 C.F.R. § 84.7; 28 C.F.R. § 35.107; see 42 U.S.C. § 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B; BHIN

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22-070.) The Discrimination Grievance Coordinator shall be available to:

i. Answer questions and provide appropriate assistance to the Contractor staff and members regarding the Contractor's state and federal nondiscrimination legal obligations.

ii. Advise the Contractor about nondiscrimination best practices and accommodating persons with disabilities.

iii. Investigate and process any Americans with Disabilities Act, § 504 of the Rehabilitation Act, § 1557 of the Affordable Care Act, and/or California Government Code § 11135 grievances received by the Contractor.

2) The Contractor shall adopt procedures to ensure the prompt and equitable resolution of discrimination-related complaints. (W&I Code § 14727(a)(4); 45 C.F.R. § 84.7; 28 C.F.R. § 35.107; see 42 U.S.C. § 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B; BHIN 22-070.) The Contractor shall not require a member to file a Discrimination Grievance with the Contractor before filing the complaint directly with the DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights.

3) Within ten calendar days of mailing a Discrimination Grievance resolution letter to a member, the Contractor must submit, in a secure format, the following information regarding the complaint to the DHCS Office of Civil Rights' designated Discrimination Grievance email box (DHCS.DiscriminationGrievances@dhcs.ca.gov). (California Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B; BHIN 22-070):

i. The original complaint.

ii. The provider's or other accused party's response to the complaint.

iii. Contact information for the personnel primarily responsible for investigating and responding to the complaint on behalf of the Contractor.

iv. Contact information for the member filing the complaint, and for the provider or other accused party that is the subject of the complaint.

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v. All correspondence with the member regarding the complaint, including, but not limited to, the Discrimination Grievance acknowledgment letter and resolution letter(s) sent to the member.

vi. 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.

5. Appeals Process

A. The Contractor's appeal process shall, at a minimum:

1) Allow a member, or a provider or authorized representative acting on the member's behalf, to file an appeal orally or in writing. (42 C.F.R. § 438.402(c)(3)(ii); BHIN 22-070.) The member may file an appeal within 60 calendar days from the date on the adverse benefit determination notice (42 C.F.R. § 438.402(c)(2)(ii); BHIN 22-070.);

2) The Contractor shall ensure that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals. The date the Contractor receives the oral appeal shall be considered the filing date for the purpose of applying the appeal timeframes (42 C.F.R. § 438.406(b)(3).);

3) Resolve each appeal and provide notice, as expeditiously as the member's health condition requires, within 30 calendar days from the day the Contractor receives the appeal. (42 C.F.R. § 438.408(a) and (b)(2); BHIN 22-070.);

4) [Reserved]

5) Allow the member, their representative, or the legal representative of a deceased member's estate, to be included as parties to the appeal. (42 C.F.R. § 438.406(b)(6); BHIN 22-070.)

B. The Contractor shall notify the member, and/or their representative, of the resolution of the appeal in writing in a format and language that, at a minimum, meets applicable notification standards. (42 C.F.R. §§ 438.408(d)(2)(i), 438.408(e), 438.10; MHSUD IN 18-010E; BHIN 22-070.) The notice shall contain the following:

1) The results of the appeal resolution process (42 C.F.R. § 438.408(e)(1).);

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2) The date that the appeal decision was made (42 C.F.R. § 438.408(e)(1).);

3) If the appeal is not resolved wholly in favor of the member, the notice shall also contain:

i. Information regarding the member's right to a State Hearing and the procedure for requesting a State Hearing, if the member has not already requested a State Hearing on the issue involved in the appeal; (42 C.F.R. § 438.408(e)(2)(i).) and

ii. Information on the member's right to continue to receive benefits while the State Hearing is pending and how to request the continuation of benefits; (42 C.F.R. § 438.408(e)(2)(ii).)

6. Expedited Appeal Process

A. "Expedited Appeal" is an appeal used when the Contractor (for a request from the member) or the provider indicates (in making the request on the member's behalf or supporting the member's request) that taking the time for a standard resolution could seriously jeopardize the member's life, physical or mental health, or ability to attain, maintain, or regain maximum function. (42 C.F.R. § 438.410; BHIN 22-070.)

B. The Contractor's expedited appeal process shall, at a minimum:

1) Be used when the Contractor determines or the member and/or the member's provider certifies that taking the time for a standard appeal resolution could seriously jeopardize the member's life, physical or mental health or ability to attain, maintain, or regain maximum function. (42 C.F.R. § 438.410(a).)

2) Allow the member to file the request for an expedited appeal orally without requiring the member to submit a subsequent written, signed appeal. (42 C.F.R. § 438.402(c)(3)(ii).)

3) Ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's expedited appeal. (42 C.F.R. § 438.410(b).)

4) [Reserved]

5) Resolve an expedited appeal as expeditiously as the member's health condition requires and no later than 72 hours after the day

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Contractor receives the appeal. (42 C.F.R. § 438.408(b)(3); BHIN 22-070.)

6) Provide a member with a written notice of the expedited appeal disposition and make reasonable efforts to provide oral notice to the member and/or their representative. The written notice shall meet the requirements of 9 C.C.R. section 1850.207(h) and Exhibit A Attachment 12 Section 5.B. (42 C.F.R. § 438.408(d)(2); 9 C.C.R. § 1850.207(h); BHIN 22-070.)

7) If the Contractor denies a request for an expedited appeal resolution, the Contractor shall:

i. Transfer the expedited appeal request to the timeframe for standard resolution of no longer than 30 calendar days from the day the Contractor receives the appeal, as set forth above. (42 C.F.R. § 438.410(c)(1); BHIN 22-070.)

ii. Make reasonable efforts to give the member and their representative prompt oral notice of the denial of the request for an expedited appeal. Provide written notice of the decision and reason for the decision within two calendar days of the date of the denial, and inform the member of the right to file a grievance if they disagree with the decision. (42 C.F.R. § 438.410(c)(2); 42 C.F.R. § 438.408(c)(2).) The written notice of the denial of the request for an expedited appeal is not a Notice of Adverse Benefit Determination. (9 C.C.R. § 1810.230.5.)

7. Contractor Obligations Related to State Hearing

"State Hearing" means the hearing provided by the State to members pursuant to 22 C.C.R. §§ 50951 and 50953, and9 C.C.R. § 1810.216.6:

A. If a member requests a State Hearing, the Department shall grant the request. (42 C.F.R. § 431.220(a)(5).) The right to a State Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the member and provider by the Contractor in its notice of decision or Notice of Adverse Benefit Determination. (42 C.F.R. § 431.206(b); 42 C.F.R. § 431.228(b).) Members and providers shall also be informed of the following:

1) In general, a member may request a State Hearing only after receiving notice that the Contractor is upholding the adverse benefit determination. (42 C.F.R. § 438.408(f)(1).)

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2) If the Contractor fails to adhere to notice and timing requirements under 42 C.F.R. section 438.408, the member is deemed to have exhausted the Contractor's appeals process, and the member may initiate a State Hearing. (42 C.F.R § 438.408(f)(1)(i); 42 C.F.R. § 438.402(c)(1)(i)(A); BHIN 22-070.)

3) The member, or a provider or authorized representative with the member's written consent, may request a State Hearing. (42 C.F.R. § 438.402(c)(1)(ii).)

B. The Contractor shall represent the Contractor's position in hearings, as defined in 42 C.F.R. section 438.408(f)(3) dealing with members' appeals of denials, modifications, deferrals or terminations of covered services, as applicable.

C. The Contractor shall carry out the final decisions of the hearing process with respect to issues within the scope of the Contractor's responsibilities under this Contract.

D. Nothing in this section is intended to prevent the Contractor from pursuing any options available for appealing a hearing decision.

8. Expedited Hearing

"Expedited Hearing" means a hearing provided by the State, used when the Contractor determines, or the member or the member's provider certifies that following the 90-day timeframe for a State Hearing as established in 42 C.F.R. section 431.244(f)(1) would seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. (42 C.F.R. § 431.244(f)(1); 42 C.F.R. § 438.410(a); 9 C.C.R. § 1810.216.4.)

9. Continuation of Services During Appeal; Effectuation of Decision from Appeal or State Hearing

A. Notwithstanding Title 9 C.C.R. section 1850.215, Contractor must automatically continue providing the disputed services to the member while the appeal and State Hearing are pending if all of the following conditions are met:

1) The member filed their appeal within the required timeframes set forth in 42 C.F.R. section 438.420;

2) The appeal involves the termination, suspension, or reduction of previously authorized Covered Services;

3) The disputed services were ordered by the member's provider; and

4) The period covered by the original authorization has not expired.

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B. Services provided to a member while an appeal or State Hearing is pending must continue until one of the following occur: (42 C.F.R. §§ 438.420(c)(1)-(3), 438.408(d)(2)):

1) The member withdraws their request for an appeal or a State Hearing;

2) The member fails to request a State Hearing and continuation of disputed services within ten calendar days of when the NOABD was sent; or

3) The final State Hearing decision is adverse to the member.

C. Contractor must pay for disputed services if the member received the disputed services while the appeal or State Hearing was pending. (42 C.F.R. § 438.420(d)). Contractor must ensure the member is not billed for services provided while the appeal or State Hearing is pending even if the State Hearing finds the disputed services were not medically necessary.

D. The Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires, but no later than 72 hours from the date the Contractor receives notice reversing the determination if the services were not furnished while the appeal or State Hearing was pending and if the Contractor or State Hearing officer reverses a decision to deny, limit, or delay services. (42 C.F.R. § 438.424(a).)

10. Provision of Notice of Adverse Benefit Determination

A. The Contractor shall notify the requesting provider within 24 hours, and give the member written notice as specified below, 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. (42 C.F.R. § 438.210(c); 42 C.F.R. § 438.404; BHIN 22-070.) The Contractor shall provide a member with a Notice of Adverse Benefit Determination (NOABD) under the circumstances defined in 42 C.F.R. § 438.400 under Adverse Benefit Determination.

B. The Contractor shall give members timely and adequate notice of an adverse benefit determination in writing and shall meet the language and format requirements of 42 Code of Federal Regulations part 438.10. (42 C.F.R. § 438.404(a); 42 C.F.R. § 438.10; BHIN 22-070.) The NOABD shall contain the items specified in 42 Code of Federal Regulations part 438.404 (b) and Cal. Code Regs., tit. 9, § 1850.212, and shall comply with the parameters specified below, regardless of whether the NOABD pertains to covered services.

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1) When the denial or modification involves a request from a provider for continued Contractor payment authorization of a service or when the Contractor reduces or terminates a previously approved Contractor payment authorization, notice shall be provided in accordance with 22 C.C.R. § 51014.1. (9 C.C.R. § 1850.210(a)(1).)

2) A NOABD is not required when a denial is a non-binding verbal description to a provider of the services that may be approved by the Contractor. (9 C.C.R. § 1850.210(a)(2).)

3) Except as provided below, a NOABD is not required when the denial or modification is a denial or modification of a request for the Contractor payment authorization for a service that has already been provided to the member. (9 C.C.R. § 1850.210(a)(4).)

4) A NOABD is required when the Contractor denies or modifies a payment authorization request from a provider for a service that has already been provided to the member when the denial or modification is a result of post-service, prepayment determination by the Contractor that the service was not medically necessary or otherwise was not a service covered by the Contractor. (9 C.C.R. § 1850.210(b).)

5) The Contractor shall deny the Contractor payment authorization request and provide the member with a NOABD when the Contractor does not have sufficient information to approve or modify, or deny on the merits, a Contractor payment authorization request from a provider within the timeframes required by 9 C.C.R. Sections 1820.220 or 1830.215. (9 C.C.R. § 1850.210(c).)

6) [Reserved]

7) The Contractor shall provide a member with a NOABD when the Contractor or its providers determine that the criteria for access to services have not been met and that the member is not entitled to any SMHS or SUD services from the Contractor. The NOABD shall, at the election of the Contractor, be hand-delivered to the member on the date of the Adverse Benefit Determination or mailed to the member in accordance with 9 C.C.R. section 1850.210(f)(1), and shall specify the information contained in 9 C.C.R. section 1850.212(b). (9 C.C.R. § 1850.210(g).)

8) For the purpose of this Attachment, each reference to a Medi-Cal managed care plan in 22 C.C.R. section 51014.1, shall mean the Contractor. (9 C.C.R. § 1850.210(h).)

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9) For the purposes of this Attachment, “medical service”, as used in 22 C.C.R. section 51014.1, shall mean covered services that are subject to prior authorization by a Contractor pursuant to 9 C.C.R. sections 1820.100 and 1830.100. (9 C.C.R. § 1850.210(i).)

C. The Contractor shall retain copies of all Notices of Adverse Benefit Determination issued to members under this Section in a centralized file accessible to the Department. The Department shall engage in random reviews of the Contractor and its contracted providers and subcontractors to ensure that they are notifying members in a timely manner (9 C.C.R. § 1850.210(j).)

D. The Contractor shall allow the State to engage in reviews of the Contractor’s records pertaining to Notices of Adverse Benefit Determination so the Department may ensure that the Contractor is notifying members in a timely manner.

11. Contents and Timing of NOABD

A. The Contractor shall include the following information in the NOABD, regardless of whether the NOABD pertains to SMHS or SUD services:

1) The adverse benefit determination the Contractor has made or intends to make; (42 C.F.R. § 438.404(b)(1).)

2) The reason for the adverse benefit determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member’s adverse benefit determination. Such information includes criteria to access SMHS and/or SUD services, and any processes, strategies, or evidentiary standards used in setting coverage limits; (42 C.F.R. § 438.404(b)(2).)

3) Citations to the regulations or Contractor payment authorization procedures supporting the adverse benefit determination; (9 C.C.R. § 1850.212(a)(3).)

4) The member’s right to file, and procedures for exercising, an appeal or expedited appeal with the Contractor, including information about exhausting the Contractor’s one level of appeal and the right to request a State Hearing after receiving notice that the adverse benefit determination is upheld; (42 C.F.R. § 438.404(b)(3)-(b)(4).)

5) The circumstances under which an appeal process can be expedited and how to request it; (42 C.F.R. § 438.404(b)(5).)

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6) The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and that the member shall not be held liable for the cost of the benefits if the hearing decision upholds the Contractor's adverse benefit determination.

7) Information about the member's right to request a State Hearing or an expedited State Hearing, including:

   i. The method by which a hearing may be obtained; (9 C.C.R. § 1850.212(a)(5)(A).)

   ii. A statement that the member may be either self-represented, or represented by an authorized third party such as legal counsel, a relative, friend, or any other person; (9 C.C.R. § 1850.212(a)(5)(B).)

   iii. An explanation of the circumstances under which a covered service will be continued if a State Hearing is requested; (9 C.C.R. § 1850.212(a)(5)(C).) and

   iv. The time limits for requesting a State Hearing or an expedited State Hearing. (9 C.C.R. § 1850.212(a)(5)(D).)

B. The Contractor shall mail the NOABD within the following timeframes, regardless of whether the NOABD pertains to SMHS or SUD services:

1) For termination, suspension, or reduction of previously authorized Medi-Cal covered services, at least 10 days before the date of action. (42 C.F.R. § 438.404(c)(1); 42 C.F.R. § 431.211.) The Contractor shall mail the NOABD in as few as 5 days prior to the date of action if the Contractor has facts indicating that action should be taken because of probable fraud by the member, and the facts have been verified, if possible, through secondary sources. (42 C.F.R. § 438.404(c)(1); 42 C.F.R. §.431.214.)

2) For denial of payment, at the time of any action affecting the claim. (42 C.F.R. § 438.404(c)(2).)

3) For standard service authorizations that deny or limit services, as expeditiously as the member's condition requires not to exceed the time limits below. (42 C.F.R. § 438.404(c)(3); 42 C.F.R. § 438.210(d)(1)(i).)

   i. Until December 31, 2025, the decision shall be made within 14 calendar days following Contractor's receipt of the request for service. (42 C.F.R § 438.210(d)(1)(i)(A).)

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ii. Effective January 1, 2026, the decision shall be made within 7 calendar days following the Contractor's receipt of the request for service. (42 C.F.R § 438.210(d)(1)(i)(B).)

4) [Reserved]

5) [Reserved]

6) [Reserved]

7) The Contractor shall give notice on the date that the timeframes expire, when service authorization decisions are not reached within the applicable timeframes for either standard or expedited service authorizations. (42 C.F.R. § 438.404(c)(5).)

8) If a provider indicates, or the Contractor determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or their ability to attain, maintain, or regain maximum function, the Contractor must make an expedited service authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. (42 C.F.R. § 438.404(c)(6); 42 C.F.R. 438.210(d)(2)(i).)

9) [Reserved]

10) The Contractor shall deposit the NOABD with the United States Postal Service in time for pick-up on the date that the applicable timeframe expires. (9 C.C.R. § 1850.210(f).)

C. The Adverse Benefit Determination shall be effective on the date of the NOABD and the Contractor shall mail the NOABD by the date of adverse benefit determination when any of the following occur:

1) The death of a member; (42 C.F.R. § 431.213(a).)

2) Receipt of a signed written member statement requesting service termination or giving information requiring termination or reduction of services, provided the member understands that this will be the result of supplying that information; (42 C.F.R. § 431.213(b)(1)-(b)(2).)

3) The member's admission to an institution where they are ineligible for further services; (42 C.F.R. § 431.213(c).)

4) The member's whereabouts are unknown, and mail directed to them has no forwarding address; (42 C.F.R. § 431.213(d).)

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5) Notice that the member has been accepted for Medicaid services by another local jurisdiction; (42 C.F.R. § 431.213(e).)

6) A change in the member's physician's prescription for the level of medical care; (42 C.F.R. § 431.213(f).) or

7) The notice involves an adverse determination with regard to preadmission screening requirements of § 1919(e)(7) of the Act. (42 C.F.R. § 431.213(g).)

8) The transfer or discharge from a facility will occur in an expedited fashion. (42 C.F.R. § 431.213(h).)

12. {SMHS, DMC-ODS, and Integrated DMC/SMHS Contracts} Annual Grievance and Appeal Report

The Contractor is required to submit to the Department a report that summarizes member grievances, appeals and expedited appeals, for members receiving either SMHS or SUD services, in accordance with BHIN 22-036, filed from July 1 of the previous year through June 30 of that year by September 1 of each year. The report shall include the total number of grievances, appeals and expedited appeals by type, by subject areas established by the Department, and by disposition. (42 C.F.R. § 438.66(e).)

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1. General Requirements

A. [Reserved]

B. [Reserved]

C. {DMC only} The Contractor is responsible for ensuring program integrity of its DMC services and its contracted providers through a system of oversight.

1) Contractor shall comply with the monitoring and reporting obligations under this Contract, as well as state and federal law and regulations, including, but not limited to:

i. 42 CFR §§ 431.800 et seq., 433.51, 438.10, 438.320, 438.416, 438.206, 440.230, 440.260, 455 et seq., 456 et seq., 456.23;

ii. 22 C.C.R. §§ 51490, 51490.1, 51159;

iii. W&I Code §§ 14124.1, 14124.2.

2) Contractor shall certify the DMC claims submitted to DHCS represent claims eligible for FFP and attest that the submitted claims have been subject to review and verification process for accuracy and legitimacy (42 CFR §§ 430.30, 433.32, and 433.51). The Contractor shall not knowingly submit claims for services rendered to any member after the member's date of death, or from unenrolled or disenrolled providers.

2. Periodic Audits

Contractor shall be subject to an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, the Contractor. The audit shall occur no less frequently than once every three years. Contractor shall comply with BHIN 23-044 and subsequently issued BHINs that supersede BHIN 23-044. The Department or its contractor shall conduct the audit. (42 C.F.R. § 438.602(e)).

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3. [Reserved]

4. [Reserved]

5. [Reserved]

6. Suspension of Provider Payments

A. If a 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 pursuant to W&I Code sections 14043.36(a). DHCS may also issue a payment suspension to a provider pursuant to W&I Code § 14107.11 and 42 C.F.R. section 455.23.

1) [Reserved]

B. Information about a provider's administrative sanction status is confidential until such time as the action is either completed or resolved.

1) With respect to DMC providers, Contractor shall execute the Confidentiality Agreement, attached as Document 5A. The Confidentiality Agreement permits DHCS to communicate with Contractor concerning contracted DMC providers that are subject to administrative sanctions.

7. [Reserved]

8. [Reserved]

9. Contractor Monitoring of Contracted Providers

A. Contractor shall conduct ongoing monitoring of contracted providers (except out-of-network providers, if applicable) for compliance with the terms of this contract.

1) {<u>Standalone DMC and DMC-ODS Contracts only</u>}

i. The Contractor shall conduct, at least annually (i.e., every 12-months), a programmatic and utilization review of DMC providers to assure covered services are being appropriately rendered. The annual review shall include an on-site visit of the DMC provider. Reports of the annual review shall be provided to DHCS' County/Provider Operations and Monitoring Branch at:

DHCS
Medi-Cal Behavioral Health Division

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1501 Capitol Avenue, MS# 2621
Sacramento, CA 95814
Or by using a Secure Managed File Transfer system specified by DHCS.

ii. The review reports shall be provided to DHCS within 14 calendar days of completion by the Contractor.

2) [Reserved]

B. [Reserved]

C. {DMC only} The Contractor shall, on a monthly basis, monitor the status of all contracted providers to ensure they maintain active enrollment in the DMC program and to check for triggering recertification events. The Contractor shall notify DHCS PED by e-mail at DHCSDMCRecert@dhcs.ca.gov within five business days of learning any of the following, whether during the monthly monitoring or following notice from the contracted provider:

1) A contracted provider'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;

2) A contracted provider surrenders its certification or closes its facility; or

3) A contracted provider has a triggering recertification event, including but not limited to change in ownership, change in scope of services, remodeling of facility, or change in location.

10. {DMC and DMC-ODS only} State Monitoring - Postservice Postpayment and Postservice Prepayment Utilization Reviews

A. DHCS shall conduct Postservice Postpayment and Postservice Prepayment Utilization Reviews of the contracted DMC-Certified Providers to determine whether the services were provided in accordance with. as applicable, Exhibit A, Attachment 2C, Section 22 (DMC-ODS: "Requirements for Services"), or Attachment 2E, Section 8 (DMC: "Requirements for Provider Contracts and Subcontracts"). DHCS shall issue the PSPP report to the Contractor with a copy to the provider. The Contractor shall be responsible for their contracted providers and Contractor-operated programs to ensure any deficiencies are remediated pursuant to subsection B, below.

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B. The Department shall recover payments made if Postservice Postpayment Utilization Review uncovers evidence that the claim(s) should not have been paid, services have been improperly utilized, or requirements cited above in subsection A were not met.

1) 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 using a Secure Managed File Transfer system specified by DHCS within 60 days of the date of the PSPP report.

2) [Reserved]

3) {Standalone DMC and DMC-ODS Contracts only}

i. The CAP shall:

a. Be documented on the DHCS CAP template

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

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

d. Correcting the deficiency

e. Ensuring on-going compliance

f. Provide a specific description of how the provider will ensure on-going compliance.

g. Specify the target date of implementation of the corrective action.

ii. DHCS shall provide written approval of the CAP to the Contractor with a copy to the subcontractor. If DHCS does not approve the CAP, DHCS will provide guidance on the deficient areas and request an updated CAP. The subcontractor shall revise the CAP and submit it to the Contractor for review and approval. The Contractor shall submit a revised Contractor-approved CAP to DHCS within 30 days of the DHCS notification.

iii. If the subcontractor does not submit an initial or revised CAP to the Contractor, or does not implement the approved CAP provisions within the designated timeline, then DHCS may withhold funds from the Contractor until the subcontractor is

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in compliance. DHCS shall inform the Contractor when funds will be withheld.

iv. The Contractor shall monitor and attest compliance and/or completion by subcontractors with CAP requirements 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 subcontractor. Submission of DHCS Form 8049, as identified in this section, by the Contractor shall be accomplished within the timeline specified in the approved CAP, as noted by DHCS.

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

1) Requests for first-level appeals:

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

a. Behavioral Health Compliance Section Chief Medical Review Branch, Audits and Investigations Division DHCS PO Box 997413, MS 2621 Sacramento, CA 95899-7413

ii. 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.

iii. The letter shall identify the specific claim(s) involved and describe the disputed (in) action regarding the claim.

a. 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.

b. The Department shall acknowledge Contractor letter within 15 calendar days of receipt.

c. The Department shall inform the Contractor of the Department’s decision and the basis for the decision within 15 calendar days after the Department’s acknowledgement notification. The Department shall have the option of extending the decision response

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time if additional information is required from the Contractor. The Contractor will be notified if the Department extends the response time limit.

D. A Contractor 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 Department has failed to acknowledge the grievance or complaint within 15 calendar days of its receipt, or

ii. The Contractor is dissatisfied with the action taken by the Department where the conclusion is based on the Department's evaluation of the merits.

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

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

Office of Administrative Hearings and Appeals (OAHA)
3831 N. Freeway Blvd., Suite 200
Sacramento, CA 95834

4) In referring an appeal to the OAHA, the Contractor shall submit all of the following:

i. A copy of the original written appeal sent to the Department.

ii. A copy of the Department's Audit Report to which the appeal applies. If received by the Contractor, a copy of the Department's specific finding(s), and conclusion(s) regarding the appeal with which the Contractor is dissatisfied.

E. 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.

F. The Department shall monitor the contracted provider's compliance with Contractor utilization review requirements. The federal government may also review the existence and effectiveness of DHCS' utilization review system.

Exhibit A – Attachment 13
PROGRAM INTEGRITY

G. Contractor shall, at a minimum, implement and maintain compliance with the requirements described in Exhibit A, Attachment 2C, Section 22 for the purposes of reviewing the utilization, quality, and appropriateness of covered services and ensuring that all applicable Medi-Cal requirements are met.

H. Contractor shall ensure that contracted provider sites keep a record of the members/patients being treated at that location.

11. {DMC and DMC-ODS only} Reporting Complaints

A. All complaints received by the Contractor regarding a DMC-Certified provider shall be forwarded to DHCS using a Secure Managed File Transfer system specified by DHCS within two business days of completion.

B. {DMC-ODS only} Complaints for Residential Adult Alcoholism or Drug Misuse Recovery or Treatment Facilities, and counselor complaints may be made by using the Complaint Form, which is available and may be submitted online: http://www.dhcs.ca.gov/individuals/Pages/Sud-Complaints.aspx.

C. {DMC only} Report suspected Medi-Cal Fraud to DHCS's Program Integrity Unit at bhpiu@dhcs.ca.gov

D. {DMC only} Complaints for licensed, adult alcoholism or drug misuse recovery or treatment facilities, or Alcohol and/or Other Drug (AOD) Certified Treatment Facilities shall be addressed to:

Department of Health Care Services
Licensing and Certification Division
P.O Box 997413., MS# 2601
Sacramento, CA 95899-7413
Email: SUDcomplaints@dhcs.ca.gov
Public Number: (916) 322-2911
Toll Free Number: (877) 685-8333

The Complaint Form is available and can be submitted online at: http://www.dhcs.ca.gov/individuals/Pages/Sud-Complaints.aspx.

The Contractor shall be responsible for investigating complaints and providing the results of all investigations to DHCS using a Secure Managed File Transfer system specified by DHCS.

Exhibit A – Attachment 14
REPORTING REQUIREMENTS

1. [Reserved]

2. [Reserved]

3. [Reserved]

4. Network Adequacy and Timely Access

The Contractor shall submit, in a manner and format determined by the Department, documentation to demonstrate compliance with the Department's requirements for availability and accessibility of services, including the adequacy of the provider network, as described in Exhibit A, Attachment 8. (42 C.F.R. § 438.604(a)(5).)

5. [Reserved]

6. [Reserved]

7. [Reserved]

8. Parity in Mental Health and Substance Use Disorder Services

The Contractor shall submit to the Department, upon request, any policies and procedures or other documentation necessary for the State to establish and demonstrate compliance with 42 C.F.R. part 438, subpart K, regarding parity in mental health and substance use disorder benefits.

9. {DMC and DMC-ODS only} Additional Reporting Requirements Regarding SUD Services

A. California Outcomes Measurement System (CalOMS) for Treatment (CalOMS-Tx)

1) Contractor shall comply with the CalOMS-Tx data collection system requirements for submission of CalOMS-Tx data or contract with a software vendor that complies with this requirement. If applicable, 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.

2) 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

Exhibit A – Attachment 14
REPORTING REQUIREMENTS

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.

3) 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.

4) Contractor shall comply with data collection and reporting requirements established by the DHCS CalOMS-Tx Data Collection Guide (Document 3J), all former Department of Alcohol and Drug Programs Bulletins, and all applicable DHCS Information Notices relevant to CalOMS-Tx data collection and reporting requirements, including BHIN 24-030.

5) 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.

6) 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.

7) Contractor shall participate in CalOMS-Tx informational meetings, trainings, and conference calls.

8) Contractor shall implement and maintain a system for collecting and electronically submitting CalOMS-Tx data.

9) Contractor shall meet the requirements as identified in Exhibit F, Business Associate Addendum and Exhibit F, Attachment I – Social Security Administration Agreement.

B. CalOMS-Tx General Information.

1) 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

Exhibit A – Attachment 14
REPORTING REQUIREMENTS

granted, at DHCS' sole discretion, for the Contractor to resolve the problem before non-DMC payments are withheld.

2) If DHCS experiences system or service failure, an extension equal to the number of business days of the system or service failure shall be granted for the Contractor's late data submission.

3) 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 DMC funds.

4) 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.

C. Drug and Alcohol Treatment Access Report (DATAR).

1) The Contractor shall be responsible for ensuring that all contracted providers submit a monthly DATAR report in an electronic copy format as provided by DHCS.

2) The Contractor shall ensure that perinatal treatment providers who reach or exceed 90 percent of their dedicated capacity report this information to DHCSPerinatal@dhcs.ca.gov within seven days of reaching capacity.

3) The Contractor shall ensure that all DATAR reports are submitted to DHCS by contracted providers the 10th of the month following the report activity month.

4) The Contractor shall ensure that all contracted providers are enrolled in DHCS' web-based DATAR program for submission of data, accessible on the DHCS website when executing the subcontract.

5) 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 by writing a secure, encrypted email to SUDDATARSupport@dhcs.ca.gov.

6) If DHCS experiences system or service failure, an extension equal to the number of business days of the system or service failure shall be granted for the Contractor's late data submission.

7) [Reserved]

Exhibit A – Attachment 14
REPORTING REQUIREMENTS

D. [Reserved]

10. Failure to Meet Reporting Requirements

A. Contractor agrees that DHCS has the right to withhold payments until Contractor has submitted any required data and reports to DHCS, as identified in Exhibit A or as identified in Document 1F(a), Reporting Requirement Matrix for Counties. (W&I Code § 14197.7(o)(1); BHIN 22-045.)

B. Upon identifying a failure to meet required reporting requirements, 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 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.

C. 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 30 days in advance of when funds will be withheld. (BHIN 22-045.)

D. The Contractor may appeal the imposition of a temporary withhold pursuant to W&I Code section 14197.7, subdivisions (k) and (m) and BHIN 22-045 or any subsequent Departmental guidance. (W&I Code § 14197.7(o)(2).)

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

1. Medical Assistance Payment Provisions

A. The Department will reimburse the Contractor for Covered Services provided pursuant to the requirements in Exhibit A to this contract, based upon a fee schedule developed by the Department and specified in the approved Medicaid State plan and waivers.

B. Contractor shall submit claims in accordance with Department guidance, including the applicable program billing manual and any superseding guidance, including with respect to verifying Medi-Cal eligibility and Other Health Coverage (OHC). Providers that submit claims to Contractor or DHCS for covered services shall submit claims in accordance with Department guidance, including the applicable program billing manual and any superseding guidance, including with respect to verifying Medi-Cal eligibility and Other Health Coverage (OHC).

2. Budget Contingency Clause

This provision is a supplement to provision number nine (Federal Contract Funds) in Exhibit D which is attached hereto as part of this Contract.

A. Federal Budget

If federal funding for Federal Financial Participation (FFP) reimbursement in relation to this contract is eliminated or substantially reduced by Congress, the Department and the Contractor each shall have the option either to cancel this contract or to propose a contract amendment to address changes to the program required as a result of the elimination or reduction of federal funding.

B. Delayed Federal Funding

The Contractor and the Department agree to consult with each other on interim measures for program operation that may be required to maintain adequate services to members in the event that there is likely to be a delay in the availability of federal funding.

3. Contractor Claims and Federal Financial Participation

A. Nothing in this contract shall limit the Contractor's ability to submit claims for appropriate FFP reimbursement for any covered services, utilization review and quality assurance (UR/QA), Medi-Cal Administrative Activities and/or administrative costs. The Contractor shall ensure compliance with all requirements necessary for Medi-Cal reimbursement for these services and activities, including the requirements in Welfare and Institutions (W&I) Code, section 14184.403.

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

B. Claims for FFP reimbursement shall be submitted by the Contractor to the Department for adjudication throughout the fiscal year.

4. Audits and Recovery of Overpayments

A. In the case of federal audit exceptions, the Department will follow federal audit appeal processes unless the Department, in consultation with the County Behavioral Health Director's Association of California, determines that those appeals are not cost beneficial. The Department will involve the Contractor in developing the response to any draft federal audit reports that directly impact the county.

B. Whenever there is a final state or federal audit exception, the Department may use any recovery methods available under the law, not limited to W&I Code, Sections 14124.24, 14176, 14177, 14707, 14718, and Government Code section 12419.5, to offset the amount of any federal disallowance, audit exception, or overpayment against subsequent claims from the Contractor.

1) Offsets may be done at any time, after the department has invoiced or otherwise notified the Contractor about the audit exception, disallowance, or overpayment. The Department shall determine the amount that may be withheld from each payment to the Contractor.

2) The maximum withheld amount shall be 25 percent of each payment as long as the Department is able to comply with the federal requirements for repayment of FFP pursuant to 42 United States Code (U.S.C.) §1396b(d)(2)). The Department may increase the maximum amount when necessary for compliance with federal laws and regulations.

C. Pursuant to title 42 of the Code of Federal Regulations (C.F.R.) section 438.602, data submitted to the Department are subject to audit in the manner and form prescribed by the Department. Contractor and its subcontractors shall be subject to audits and/or reviews, including client record reviews, by the Department. Any audit of Contractor's data shall occur within three years of the date of receipt by the Department with signed certification by the Contractor's Behavioral Health Director or an individual who has delegated authority to sign for and reports directly to the Contractor's Behavioral Health Director. A signature is required before the data will be considered final. For purposes of this section, the data shall be considered audited once the Department has informed the Contractor in writing of its intent to make adjustments or once the Department has informed the Contractor in writing of its intent to close the audit.

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

D. If the adjustments result in the Department owing payments to the Contractor, the Department shall submit a claim to the federal government for the related FFP within 30 days contingent upon sufficient budget authority.

5. Claims Adjudication Process

A. Pursuant to W&I Code section 14184.403, claims for Medicaid reimbursement shall comply with eligibility and service requirements under applicable federal and state law.

B. The Contractor shall certify that any funds transferred to the Department by the Contractor qualify for FFP pursuant to 42 C.F.R. section 433.51, any other applicable federal Medicaid laws, and the CalAIM Special Terms and Conditions, and are not derived from impermissible sources such as recycled Medicaid payments, Federal money excluded from use as State match, impermissible taxes, and non-bona fide provider-related donations. Impermissible sources do not include revenue relating to patient care or other revenue received from federal health care programs to the extent that the program revenue is not obligated to the State as the source of funding.

The Contractor shall certify each claim submitted to the Department in accordance with 42 C.F.R. sections 438.604, 438.606, 438.608, and 455.18, as applicable, and any additional claiming parameters specified in Department guidance. The Contractor's Behavioral Health Director or an individual with authority delegated by the Behavioral Health Director shall sign the certification, declaring under penalty of perjury that, to the best of their knowledge and belief, the claim in all respects is true, correct, and in accordance with the law and meets the requirements of 42 C.F.R. sections 438.604 and 438.606. The Contractor shall have mechanisms that support the Behavioral Health Director's certification, including the certification that the services for which claims were submitted were provided to the member. If the Department requires additional information from the Contractor that will be used to establish Department payments to the Contractor, the Contractor shall certify that the additional information provided is in accordance with 42 C.F.R., section 438.604.

C. Claims not meeting federal and/or state requirements shall be returned to Contractor as not approved for payment, along with a reason for denial. Claims meeting all Health Insurance Portability and Accountability Act (HIPAA) transaction requirements and any other applicable federal or state privacy laws or regulations and certified by the Contractor in accordance with 42 C.F.R., Section 438.604, 438.606, and 455.18 shall be processed for adjudication.

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

D. If the Department or the Contractor determines that changes must be made relating to either the Department's or the Contractor's claims submission and adjudication systems due to federal or state law changes or business requirements, both the Department and the Contractor agree to provide notice to the other party as soon as practicable prior to implementation. This notice shall include information and comments regarding the anticipated requirements and impacts of the projected changes. The Department and the Contractor agree to meet and discuss the design, development, and costs of the anticipated changes prior to implementation.

6. Payment Data Certification

The Contractor shall certify the data it provides to the Department to be used in determining payment to the Contractor, in accordance with 42 C.F.R. sections 438.604 and 438.606.

7. System Changes

In the event changes in federal or state law or regulations, including court decisions and interpretations, necessitate a change in either the fiscal or program obligations or operations of the Contractor or the Department, or a change in obligation for payment of covered services, the Contract may be amended as needed to address the changes in accordance with Exhibit E.

8. Administrative Reimbursement

A. Contractor may submit claims for administrative expenditures under the following subsections, as applicable. For any given administrative expenditure, Contractor may submit a claim under only one of the following subsections.

B. {SMHS only} Mental Health Medi-Cal Administrative Activities

1) The Contractor may submit claims for reimbursement of Mental Health Medi-Cal Administrative Activities (MHMAA) pursuant to W&I Code section 14132.47 and the MHMAA Implementation Plan. The Contractor shall not submit claims for MHMAA unless it has submitted a claiming plan to the Department which was approved by the Department and is effective during the quarter in which the costs being claimed were incurred. In addition, the Contractor shall not submit claims for reimbursements of MHMAA that are not consistent with the Contractor's approved Medi-Cal Administrative Activities claiming plan. The Contractor shall not use the relative value methodology to report its MHMAA costs on the final annual MHMAA claim.

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

2) Claims for reimbursement of MHMAA may be submitted to the Department on a quarterly basis. The Contractor shall submit a final annual claim for costs incurred in a state fiscal year to the Department by December 31st following the close of that fiscal year. The Department shall reconcile all quarterly payments with the final annual claim. If the total quarterly payments are greater than the total payments due to the Contractor based upon the final annual claim, the Department shall recoup the difference from the Contractor and return the overpayment to the Federal government pursuant to 42 C.F.R. 433.316. If the total quarterly payments are less than the total payments due to the Contractor based upon the final annual claim, the Department shall make an adjusting payment to the Contractor. The Contractor may e-mail DHCS at MHMAA@dhcs.ca.gov to request the MHMAA invoice template.

C. {DMC and DMC-ODS only} County-Based Medi-Cal Administrative Activities

Certain administrative activities may qualify for reimbursement as County-Based Medi-Cal Administrative Activities (CMAA) pursuant to W & I Code section 14132.47 and applicable Department guidance.

D. Administrative Costs and Utilization Review /Quality Assurance

1) Administrative costs that are not claimed under subsection B or C above shall be claimed separately in a manner consistent with federal Medicaid requirements and the approved Medical Assistance Program Cost Allocation Plan and shall be limited to:

i. 10 percent of the total approved and paid claims to the Contractor for Medicaid Children's Health Insurance Program (MCHIP) services; and

ii. 15 percent of the total approved and paid claims to the Contractor for other medical assistance.

The cost of performing UR/QA activities shall be reimbursed separately and shall not be included in administrative costs.

2) The Contractor may submit claims for reimbursement of Administrative Costs and UR/QA costs to the Department on a quarterly basis. The Contractor shall submit a final annual claim for administrative costs and UR/QA costs incurred in a state fiscal year to the Department by December 31st following the close of that fiscal year. The Department shall reconcile all quarterly payments for administrative costs and UR/QA costs with the final annual

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

claims. If the total quarterly payments are greater than the total payments due to the Contractor based upon the final annual claims, the Department shall recoup the difference from the Contractor and return the overpayment to the Federal government pursuant to 42 C.F.R. Part 433, Subpart F. If the total quarterly payments are less than the total payments due to the Contractor based upon the final annual claims, the Department shall make an adjusting payment to the Contractor.

3) The Contractor shall use the appropriate claiming forms for this Contract:

   i. {Integrated Contracts (DMC-ODS and DMC counties)} MC 1982 B-1 for administrative costs and the MC 1982 C-1 for UR/QA costs. The Contractor may claim administrative and UR/QA costs for SMHS and SUD services on a single form.

   ii. {Standalone SMHS Contracts} MC 1982 B for administrative costs and MC 1982 C for UR/QA costs.

   iii. {Standalone DMC and DMC-ODS Contracts (incl. PHC Model)} MC 5312 for administrative costs and DHCS 5311 for UR/QA costs.

4) {DMC only} If, while completing the UR/QA requirements under this Contract, any of the Contractor's skilled professional medical personnel and directly supporting staff meet the criteria set forth in 42 C.F.R. 432.50(d)(1), then the Contractor shall submit a written request that specifically demonstrates how the skilled professional medical personnel and directly supporting staff meet all of the applicable criteria set forth in 42 C.F.R. 432.50(d)(1) and outline the duties they will perform to assist DHCS, or DHCS' skilled professional medical personnel, in activities that are directly related to the administration of the DMC Program. DHCS shall respond to the Contractor's written request within 20 days with either a written agreement pursuant to 42 C.F.R. 432.50(d)(2) approving the request, or a written explanation as to why DHCS does not agree that the Contractor's skilled professional medical personnel and directly supporting staff meet the criteria set forth in 42 C.F.R. 432.50(d)(1).

9. [Reserved]

10. [Reserved]

Exhibit E
ADDITIONAL PROVISIONS

1. Contract Amendment Process

A. If, during the term of this Contract, a party wishes to amend the Contract, that party may notify the other party so that the parties can engage in informal discussions and consultations preceding the formal amendment process, as set forth below.

B. All amendments proposed by one party shall be provided in writing to the other party.

1) Any such proposal shall set forth a detailed explanation of the reason and basis for the proposed amendment, a complete statement of costs and benefits of the proposed amendment and the text of the desired amendment.

2) Timing of proposed amendments,

i. {Integrated Contracts (DMC and DMC-ODS)} Any proposed amendments requested by the Contractor must be submitted to DHCS by October 1 of each calendar year in order for the amendment to be effective for the following calendar year, beginning on January 1.

ii. {Standalone Contracts (SMHS, DMC, and DMC-ODS)} Any proposed amendments requested by the Contractor must be submitted to DHCS by May 1 of each state fiscal year in order for the amendment to be effective for the following state fiscal year, beginning on July 1.

3) These proposed amendments shall be duly approved by the County Board of Supervisors or its authorized designee and signed by a duly authorized representative.

C. The other party shall acknowledge receipt of the proposal in writing within 10 calendar days and shall have 60 calendar days (or such different period as the parties mutually may set) after receipt of such proposal to review and consider the proposal, to consult and negotiate with the proposing party, and to accept or reject the proposal. Acceptance or rejection may be made orally within the 60-day period and shall be confirmed in writing within five days thereafter. The party proposing an amendment shall have the right to withdraw the proposal at any time prior to acceptance or rejection by the other party.

D. If the parties agree on an amendment to the Contract, the agreed upon changes shall be made through the State's official agreement amendment process.

Exhibit E
ADDITIONAL PROVISIONS

1) No amendment will be considered binding on either party until it is formally approved by both parties and the Department of General Services (DGS), if DGS approval is required. If DGS approval is not required, the amendment will be binding on both parties on the date executed by both parties.

2. Contract Renewal; Contract Cancellation/Termination

A. Contract Renewal

This Contract may be renewed if the Contractor continues to meet the requirements under this Contract and applicable law. Failure to meet these requirements shall be cause for nonrenewal of the Contract. (42 C.F.R. § 438.708; W&I Code § 14714(b)(1).) The Department may base the decision to renew on timely completion of a mutually agreed-upon plan of correction of any deficiencies, submissions of required information in a timely manner, and/or other conditions of the Contract. (W&I Code § 14714(b)(1).)

B. Contract Termination or Nonrenewal by Contractor

1) The Contractor may, at its discretion, terminate or not renew this Contract with respect to SMHS, DMC, and/or DMC-ODS services (as applicable).

2) If, with respect to SMHS, DMC, and/or DMC-ODS services (as applicable), the Contractor terminates or does not renew its Contract, or is unable to meet the standards set by the Department, the Contractor shall deliver written notice of the termination, nonrenewal or failure to meet standards to the Department at least 180 calendar days prior to the effective date of termination or Contract expiration. (9 C.C.R. § 1810.323(a).)

C. Contract Termination or Nonrenewal by the Department

1) The Department may terminate this Contract in accordance with the timelines specified in Welfare and Institutions Code sections 14197.7, 14714 (hereafter W&I) and Cal. Code Regs., tit. 9, section 1810.323. Specifically:

i. The Department will immediately terminate this Contract if the Department finds that there is an immediate threat to the health and safety of Medi-Cal members. (W.&I. Code §§ 14714(d); 14197.7.)

ii. Upon at least 60 calendar days' written notice, DHCS shall terminate this Contract if the United States Secretary of Health and Human Services has determined the Contractor

Exhibit E
ADDITIONAL PROVISIONS

does not meet the federal requirements for participation in the Medicaid program. (W&I Code § 14197.7(i))

iii. Upon at least 90 calendar days' written notice, DHCS may cancel or terminate this Contract if DHCS finds that Contractor fails to comply with Contract requirements, state or federal law or regulations, or the state plan or approved waivers, or for other good cause. (W.&I. Code § 14197.7(a).) Good cause includes, but is not limited to:

a. A finding of deficiency that results in improper denial or delay in the delivery of health care services, potential endangerment to patient care, disruption in the Contractor's provider network, failure to approve continuity of care, that claims accrued or to accrue have not or will not be recompensed, or a delay in required Contractor reporting to the department. (W&I Code § 14197.7(a))

b. A failure of the Contractor, or its subcontractors or contracted providers, to comply with W&I Code sections 14124.24 or 14184.100 et seq., or BHIN 24-001.

iv. Upon at least 180 calendar days' written notice, DHCS may terminate this Contract for any reason.

2) Contract termination or cancellation shall be effective as of the date indicated in DHCS' notification to the Contractor, unless Contractor appeals the termination, or termination is immediate pursuant to Exhibit E, Section 2.C.1.i. The notice shall identify any final performance, invoicing, or payment requirements.

3) Contractor may appeal Contract termination pursuant to W&I Code section 14197.7(c)(1) or for termination of Contracts for SMHS, section 14714(d).

D. Termination of Contractor's Obligations Following Contract Non-Renewal or Termination

1) The provisions of subsection D apply regardless of whether the Contract is terminated or not renewed, and regardless of whether the termination or non-renewal is initiated by Contractor or by the Department.

i. {All Integrated Contracts (DMC and DMC-ODS)} Prior to January 1, 2027, in lieu of pursuing the termination

procedures in this section, the Department may permit Contractor to transition from an integrated Medi-Cal behavioral health contract to separate contracts for SMHS and/or DMC/DMC-ODS services (as applicable), only if the Department concludes that Contractor meets all applicable requirements for those contracts.

2) All obligations to provide covered services under this Contract shall automatically terminate on the effective date of any termination of this Contract. The Contractor shall be responsible for providing covered services to members until the termination or expiration of the Contract and shall remain liable for the processing and payment of invoices and statements for covered services provided to members prior to such expiration or termination.

3) If this Contract is terminated or not renewed , the Department shall ensure that SMHS and/or DMC services are provided to Medi-Cal members, in accordance with Welf. & Inst. Code sections 14712 (SMHS) and/or 14124.21 (DMC). The Department shall divert county funds pursuant to W& I Code sections 14712(d), 14714(b), and 14124.21(c), as applicable, and Government Code section 30027.10, as necessary to provide SMHS and/or DMC services (as applicable) in the Contractor's services area.

   i. {DMC-ODS Only} Subsection 3 above does not apply if the Contractor opts to provide DMC services following the termination of its DMC-ODS Contract.

4) Transfer of Records; Continuity of Care

   i. In the event this Contract is nullified, terminated, or not renewed, the Contractor shall deliver its entire fiscal and program records pertaining to the performance of this Contract to DHCS, which will retain the records for the required retention period.

   ii. Prior to the termination of this Contract and upon request by the Department, Contractor shall assist the State in the orderly transfer of members' health care. In doing this, the Contractor shall make available to the Department copies of medical records, patient files, and any other pertinent information, including information maintained by any subcontractor or contracted provider, necessary for efficient member case management, as determined by the Department.

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ADDITIONAL PROVISIONS

iii. The preceding sections i and ii shall not apply with respect to the Contractor's behavioral health program operations if:

a. The Contractor will continue providing covered services or arrange for provision of covered services under a new agreement with the Department with substantially similar requirements, as determined by the Department;

b. {DMC-ODS only} Or, the Contractor immediately begins providing DMC services to members in accordance with the State Plan upon termination of this Contract; provided, however, that subsections i and ii above shall apply if the Contractor or the Department, in accordance with W&I Code section 14124.21, decide that the Contractor shall not provide DMC services.

5) The Department shall notify members of their Medi-Cal behavioral health benefits and options available upon termination or expiration of this Contract.

3. Contract Disputes

Should a dispute arise between the Contractor and the Department relating to performance under this Contract, the Contractor shall follow the Dispute Resolution Processes for compliance reviews and sanctions outlined in W&I Code section 14197.7, BHIN 23-006, BHIN 23-044, and any subsequent guidance issued by the Department, except for disputes governed by a different dispute resolution process under applicable law.

4. Fulfillment of Obligation

A. All Attachments and Sections within Exhibit E apply to the delivery of all covered services under this contract. The presence of a citation that applies to only one delivery system does not limit application of the corresponding requirements to only that delivery system, except as expressly otherwise indicated in this Exhibit.

B. No covenant, condition, duty, obligation, or undertaking continued or made a part of this Contract shall be waived except by written agreement of the parties hereto, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply. Until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party shall have the

Exhibit E
ADDITIONAL PROVISIONS

right to invoke any remedy available under this Contract, or under law, notwithstanding such forbearance or indulgence.

C. Waiver of any default shall not be deemed to be a waiver of any subsequent default. Waiver of breach of any provision of this Contract shall not be deemed to be a waiver of any other or subsequent breach and shall not be construed to be a modification of the terms of this Contract.

5. Additional Provisions

A. Inspection Rights/Record Keeping Requirements

1) Exhibit D(F), Provision 7 (Audit and Record Retention), which is attached hereto as part of this Contract, supplements the following requirements.

2) The following obligations apply for 10 years from the term end date of this Contract, or in the event the Contractor has been notified that an audit or investigation of this Contract has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later. The Contractor, and subcontractors and contracted providers, shall:

i. Allow the Department, CMS, the Office of the Inspector General, the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized designees, to evaluate Contractor's, and subcontractors', performance under this Contract, including the quality, appropriateness, and timeliness of services provided, and to inspect, evaluate, and audit any and all records, documents, and the premises, equipment and facilities maintained by the Contractor and its subcontractors pertaining to such services at any time. (See 42 C.F.R. §§ 438.3(h) and 438.230(c)(3)(i-iii)).

ii. Retain all records and documents originated or prepared pursuant to the Contractor's or subcontractor's performance under this Contract, including member grievance and appeal records identified in Exhibit A, Attachment 12, Section 2 and the data, information and documentation specified in (or that demonstrates compliance with) 42 C.F.R. §§ 438.604, 438.606, 438.608, and 438.610, as applicable. (42 C.F.R. § 438.3(u); see also § 438.3(h)).

3) "Records and documents" include but are not limited to all physical and electronic records and documents originated or prepared

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pursuant to the Contractor's or subcontractor's performance under this Contract including working papers, reports, financial records and documents of account, member records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for members.

B. Notices

Unless otherwise specified in this Contract, all notices to be given under this Contract shall be in writing and shall be deemed to have been given when mailed, to the Department or the Contractor at the following addresses, unless the Contract explicitly requires notice to another individual or organizational unit:

Department of Health Care Services Medi-Cal Behavioral Health Division 1501 Capitol Avenue, MS 2702 Sacramento, CA 95814	County of Name Address

C. Nondiscrimination

1) Consistent with the requirements of applicable federal law, such as 42 C.F.R. § 438.3(d)(3) and (4), and state law, the Contractor shall not engage in any unlawful discriminatory practices in the admission of members, assignments of accommodations, treatment, evaluation, employment of personnel, or in any other respect on any ground protected under federal or state law, including sex, race, color, gender, gender identity, religion, marital status, national origin, ethnic group identification, ancestry, age, sexual orientation, medical condition, genetic information, or mental or physical handicap or disability. (42 U.S.C. § 18116; 42 C.F.R. § 438.3(d)(3-4); 45 C.F.R. § 92.2; Government Code § 11135(a); W&I Code § 14727(a)(3)).

2) The Contractor shall comply with the provisions of Section 504 of the Rehabilitation Act of 1973, as amended (codified at 29 U.S.C. § 794), prohibiting exclusion, denial of benefits, and discrimination against qualified individuals with a disability in any federally assisted programs or activities, and shall comply with the implementing regulations in 45 C.F.R. Parts 84 and 85, as applicable.

3) The Contractor shall include the nondiscrimination and compliance provisions of this Contract in all subcontracts and provider contracts to perform work under this Contract.

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4) Noncompliance with the nondiscrimination requirements in this subsection C shall constitute grounds for state to withhold payments under this Contract or terminate all, or any type, of funding provided hereunder.

D. Relationship of the Parties

The Department and the Contractor are, and shall at all times be deemed to be, independent agencies. Each party to this Contract shall be wholly responsible for the manner in which it performs the obligations and services required of it by the terms of this Contract. Nothing herein contained shall be construed as creating the relationship of employer and employee, or principal and agent, between the parties or any of their agents or employees. Each party assumes exclusively the responsibility for the acts of its employees or agents as they relate to the services to be provided during the course and scope of their employment. The Department and its agents and employees shall not be entitled to any rights or privileges of the Contractor's employees and shall not be considered in any manner to be Contractor employees. The Contractor and its agents and employees shall not be entitled to any rights or privileges of state employees and shall not be considered in any manner to be state employees.

E. [Reserved]

F. Freeze Exemptions

1) If Contractor adopts a hiring freeze during the term of this Contract, such hiring freeze shall not be applied to the positions funded, in whole or in part, by this Contract.

2) Contractor shall not implement any personnel policy, which may adversely affect the performance of this Contract, or the positions funded, in whole or in part, by this Contract.

3) If Contractor adopts a travel freeze or travel limitation policy during the term of this Contract, such policy shall not restrict travel funded, in whole or in part, by this Contract.

4) If Contractor adopts a purchasing freeze or purchase limitation policy during the term of this Contract, such policy shall not restrict or limit purchases funded, in whole or in part, by this Contract.

G. Force Majeure

Neither party shall be responsible for delays or failures in performance resulting from acts beyond the control of either party. Such acts shall include but not be limited to acts of God, fire, flood, earthquake, other

natural disaster, nuclear accident, strike, lockout, riot, freight-embargo, related-utility, or governmental statutes or regulations super-imposed after the fact. If a delay or failure in performance by the Contractor arises out of a default of its subcontractor or contracted provider, and if such default arises out of causes beyond the control of both the Contractor and subcontractor or contracted provider, and without the fault or negligence of either of them, the Department shall not sanction the Contractor because of such delay or failure. In the event of such acts, the Contractor shall take reasonable steps to perform under this Contract.

H. Participation in the County Behavioral Health Director's Association of California

1) The Contractor's County Administrator or designee 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.

2) The Contractor's County Administrator or designee shall attend any special meetings called by the Director of DHCS.

6. Duties of the State

In discharging its obligations under this Contract, and in addition to the obligations set forth in other parts of this Contract, the Department shall perform the following duties:

A. Payment for Services

The Department shall make the appropriate payments set forth in Exhibit B and take all appropriate steps to secure and pay FFP to the Contractor, once the Department receives FFP, for claims submitted by the Contractor.

B. Reviews

1) The Department shall conduct compliance reviews including but not limited to reviews of access and quality of care in the Contractor's county, at least once every three years. (9 C.C.R. § 1810.380, subdivision (a); W&I Code § 14197.7; 42 C.F.R. § 438.66; BHIN 23-044.)

2) {SMHS and DMC-ODS only} The Department shall also arrange for an annual external quality review of the Contractor. (42 C.F.R. § 438.350; and 9 C.C.R. section 1810.380, subd. (a)(7).)

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C. Monitoring for Compliance; Corrective Action; Sanctions

1) Monitoring criteria shall include, but not be limited to:

i. Whether the quality of work or services being performed conforms to Exhibit A.

ii. Whether the Contractor has established and is monitoring appropriate quality standards.

iii. Whether the Contractor is abiding by all the terms and requirements of this Contract.

2) During the review, the Department shall review the status of the Quality Improvement Plan, as described in Exhibit A, Attachment 5 and the Contractor's monitoring activities.

i. This review shall include the Contractor's service delivery system, member protections, access to services, authorization for services, compliance with regulatory and contractual requirements of the waiver, and a member records review.

ii. This review shall provide DHCS with information as to whether the Contractor is complying with its responsibility to monitor service delivery capacity.

3) When monitoring activities identify areas of non-compliance, the Department shall issue a report to the Contractor detailing findings of the review and recommendations. (9 C.C.R. § 1810.380, subd. (a); W&I Code § 14197.7; 42 C.F.R. § 438.66; BHIN 23-044; BHIN 23-006).

i. If the Department determines that the Contractor has failed to comply with any applicable requirements, the Department may:

a. Engage the Contractor to determine if there are challenges that can be addressed with facilitation and technical assistance; and/or

b. Request a corrective action plan (CAP) from the Contractor to address those deficiencies within 60 days or such other timeframe as may be specified by the Department. The Contractor shall submit a CAP to the Department within the timeframe required by the Department.

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ii. The Contractor's CAP shall:

a. Be documented on the DHCS CAP template.

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

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

d. Correcting the deficiency; and

e. Ensuring on-going compliance.

f. Provide a specific description of how the provider will ensure on-going compliance.

g. Specify the target date of implementation of the corrective action.

iii. The Department shall provide written acknowledgement of the CAP to the Contractor. If the Contractor does not address all of the deficiencies in the CAP submitted by the Contractor, the Department shall provide guidance on the deficient areas in the CAP acknowledgement letter and request an updated CAP from the Contractor.

iv. If the Contractor fails to submit a CAP or if the Contractor does not implement the approved CAP provisions within the designated timeline, then the Department may withhold funds or issue monetary sanctions until the Contractor is in compliance, terminate this Contract for cause, remove the Contractor from the DMC-ODS Waiver (if applicable), or take any other actions it deems necessary to resolve the Contractor's deficiencies. The Department shall inform the Contractor 30 calendar days in advance of when funds will be withheld.

4) The Department may impose administrative and monetary sanctions, including the temporary withhold of federal financial participation and realignment payments, on the Contractor for any of the following in accordance with W&I Code section 14197.7; BHINs 22-045, 23-006, and 24-044; and other guidance issued by the Department pursuant to W&I Code section 14197.7, subdivision (r):

i. violations of the terms of this Contract, applicable federal and state law and regulations, the Medi-Cal state plan, or approved waivers;

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ii. failure to comply with the requirements of a CAP; or

iii. for other good cause.

5) The Contractor shall prepare and submit a report to the Department that provides information for the areas set forth in 42 C.F.R. section 438.66(b) and (c) as outlined in Exhibit A, Attachment 14, Section 7, in the manner specified by the Department.

D. {SMHS only} Certification of Organizational Provider Sites Owned or Operated by the Contractor

1) The Department shall certify the organizational provider sites that are owned, leased or operated by the Contractor, in accordance with 9 C.C.R. section 1810.435, and the requirements specified in Exhibit A, Attachment 8, Section 8. This certification shall be performed prior to the date on which the Contractor begins to deliver services under this Contract at these sites and once every three years after that date, unless the Department determines an earlier date is necessary. The on-site review required by 9 C.C.R. section 1810.435, subdivision (e), shall be conducted of any site owned, leased, or operated by the Contractor and used to deliver covered services to members, except that on-site review is not required for public school or satellite sites.

2) The Department may allow the Contractor to begin delivering covered services to members at a site subject to on-site review by the Department prior to the date of the on-site review, provided the site is operational and has all required fire clearances. The earliest date the Contractor may begin delivering covered services at a site subject to on site review by the Department is the date the Contractor requested certification of the site in accordance with procedures established by the Department, the date the site was operational, or the date a required fire clearance was obtained, whichever date is latest.

3) The Department may allow the Contractor to continue delivering covered services to members at a site subject to on-site review by the Department as part of the recertification process prior to the date of the on-site review, provided the site is operational and has all required fire clearances.

4) Nothing in this section precludes the Department from establishing procedures for issuance of separate provider identification numbers for each of the organizational provider sites operated by the

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Contractor to facilitate the claiming of FFP by the Contractor and the Department's tracking of that information.

E. Excluded Providers

1) The Department shall review the ownership and control disclosures submitted by the Contractor, and any subcontractors as required in 42 C.F.R. section 438.608(c).

2) Consistent with the requirements in 42 C.F.R. section 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.

3) If the Department finds a party that is excluded, it shall promptly notify the Contractor and take action consistent with 42 C.F.R. section 438.610(d).

F. Performance Measurement

The Department shall measure the Contractor's performance based on Medi-Cal approved claims and other data submitted by the Contractor to the Department using standard measures established by the Department in consultation with stakeholders.

G. Website Transparency

The Department shall post on its website the documents and reports described in 42 C.F.R. sections 438.10(c)(3) and 438.602(g).

H. Member Support System (42 C.F.R. § 438.71(a) & (b)(1)(ii).)

The Department shall develop and implement a member support system, which must perform outreach to members and/or authorized representatives and be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.

7. State and Federal Law Governing this Contract

A. The Contractor/Subrecipient Designation: the Contractor is considered a contractor subject to 2 C.F.R part 200 (45 C.F.R. part 75).

B. The Contractor agrees to comply with all applicable federal and state law, including but not limited to the statutes and regulations incorporated by reference below, any applicable federal and state laws that pertain to member rights, and applicable sections of the State Plan, applicable

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federal waivers, and applicable Behavioral Health Information Notices (BHINs) in its provision of covered services.

1) The Contractor agrees to comply with any changes to these statutes and regulations, State Plan, federal waivers, and BHINs that occur during the Contract period. The Contractor shall also comply with any newly applicable statutes, regulations, State Plan Amendments, federal waivers, and BHINs that become effective during the Contract period. These obligations shall apply without the need for a Contract amendment(s). If the parties amend the affected provisions to conform to the changes in law, the amendment shall be retroactive to the effective date of such changes in law.

2) To the extent there is a conflict between the terms of this Contract and any federal or state statute or regulation, the State Plan, federal waivers, or BHIN, the Contractor shall comply with the federal or state statute or regulation, the State Plan, federal waiver, or BHIN and the conflicting Contract provision shall no longer be in effect.

3) The parties agree that the terms of this Contract are severable and in the event that changes in law render provisions of the Contract void, the unaffected provisions and obligations of this Contract will remain in full force and effect.

C. The Contractor agrees to comply with all existing policy letters issued by the Department. All policy letters issued by the Department subsequent to the effective date of this Contract shall provide clarification of the Contractor's obligations pursuant to this Contract, and may include instructions to the Contractor regarding implementation of mandated obligations pursuant to state or federal statutes or regulations, or pursuant to judicial interpretation.

D. Federal Laws Governing this Contract. This section reminds Contractor of the need to comply with federal laws to the extent they are applicable, including but not limited to:

1) Title 42 United States Code;

2) Title 42 of the Code of Federal Regulations, including:

i. 42 C.F.R. Part 438, Medicaid Managed Care, limited to those provisions that apply to Prepaid Inpatient Health Plans (PIHPs), except for the provisions that are inapplicable to this Contract pursuant to the current CalAIM 1915(b) Waiver Approved Application (see Section A, Part I.A).

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ii. 42 C.F.R. § 455.

iii. 42 C.F.R. §§ 8.1 through 8.6, regarding MAT.

iv. 42 C.F.R. Part 2.

3) [Reserved];

4) 21 C.F.R. §§ 1301.01 through 1301.93, Department of Justice, Controlled Substances;

5) Title VI of the Civil Rights Act of 1964;

6) Title VII 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.

7) Title IX of the Education Amendments of 1972;

8) Age Discrimination Act of 1975;

9) Age Discrimination in Employment Act (29 CFR Part 1625).

10) Rehabilitation Act of 1973;

11) Americans with Disabilities Act;

12) Section 1557 of the Patient Protection and Affordable Care Act, including the implementing regulations at 45 C.F.R. Part 92;

13) Deficit Reduction Act of 2005;

14) Balanced Budget Act of 1997;

15) 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.

16) 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.

17) 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.

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

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

20) 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.

21) The Copeland Anti-Kickback Act, which requires that all contracts and subcontracts in excess of $2000 for construction or repair awarded by the Contractor and its subcontractors shall include a provision for compliance with the Copeland Anti-Kickback Act.

22) The Davis-Bacon Act, as amended, which provides that, when required by Federal Medicaid program legislation, all construction contracts awarded by the Contractor and its subcontractors of more than $2,000 shall include a provision for compliance with the Davis-Bacon Act as supplemented by Department of Labor regulations.

23) The Contract Work Hours and Safety Standards Act, as applicable, which requires that all subcontracts awarded by the Contractor in excess of $2,000 for construction and in excess of $2,500 for other subcontracts that involve the employment of mechanics or laborers shall include a provision for compliance with the Contract Work Hours and Safety Standards Act.

E. Pursuant to W&I Code section 14704, a regulation or order concerning Medi-Cal SMHS adopted by the State Department of Mental Health pursuant to W&I Code, division 5 (commencing with Section 5000), as in effect preceding the effective date of section 14704, shall remain in effect and shall be fully enforceable, unless and until the readoption, amendment, or repeal of the regulation or order by the Department, or until it expires by its own terms. Such a regulation or order may also be superseded by information notice.

F. State Laws Governing this Contract. This section reminds Contractor of the need to comply with state laws to the extent they are applicable, including but not limited to:

1) W&I Code, division 5

2) W&I Code section 14000 et seq., including:

i. Sections 14021, 14021.5, 14021.6

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ii. Sections 14043 et seq.

iii. Sections 14059.5, 14184.402, and 14184.403

iv. Section 14100.2

v. Sections 14680-14685.1

vi. Sections 14700-14727

3) Chapter 7, Part 3, Division 9, W&I Code, division 9, part 3, chapter 7

4) Health and Safety Code, division 10.5, part 2, commencing with section 11760.

5) Government Code section 16367.8.

6) Title 2, Division 3, Article 9.5 of the Gov. Code, commencing with Section 11135.

7) Cal. Code Regs., tit. 9, including:

i. Division 4, chapter 6, commencing with section 10800.

ii. Division 4, chapter 8, commencing with § 13000 (Certification of Alcohol and Other Drug Counselors).

iii. Sections 1810.100 et. seq. – Medi-Cal Specialty Mental Health Services, except for those regulations that are superseded by BHINs.

iv. Sections 9000-14240

8) Cal. Code Regs., tit. 22, including:

i. Sections 50951 and 50953

ii. Sections 51014.1 and 51014

iii. Sections 51341.1, 51490.1 and 51516.1 (with the exception of the provisions superseded by W&I Code, division 9, part 3, chapter 7, article 5.51, as set forth in this contract and/or BHINs related to medical necessity, documentation requirements, and payment reform)

9) State Administrative Manual (SAM), Chapter 7200 (General Outline of Procedures).

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10) Fair Employment and Housing Act (Gov. Code section 12900 et seq.) and the applicable regulations promulgated thereunder (Cal. Code Regs., tit. 2, Div. 4 § 7285.0 et seq.).

G. No state funds, Federal funds, or mental health or substance use disorder realignment funds (e.g., Behavioral Health Subaccount of the Local Revenue Fund 2011, Mental Health Subaccount of the Local Revenue Fund) shall be used by the Contractor, or its subcontractors or contracted providers, for sectarian worship, instruction, and/or proselytization. No state funds shall be used by the Contractor, or its subcontractors or contracted providers, to provide direct, immediate, or substantial support to any religious activity.

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GENERAL DEFINITIONS

Exhibit E defines the terms used in this Contract. The following definitions shall apply, but, in the event of a conflict: Exhibit E shall take precedence over state regulations; and the Medi-Cal state plan and Department guidance shall take precedence over both Exhibit E and state regulations. 42 C.F.R. Part 438, Cal. Code Regs., tit. 9, sections 1810.100-1850.535 and 9000 *et seq.,* Cal. Code Regs., tit. 22, sections 51341, 51490.1 & 51516.1; and H&S Code section 11750 *et seq.*

1. "Advance Directives" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of the health care when the individual is incapacitated.
2. "Abuse" means provider practices that are inconsistent with sound, fiscal, business, or medical practices, and result in an unnecessary cost to the Medi-Cal 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 member practices that result in unnecessary cost to the Medi-Cal program. (See 42 C.F.R. §§ 438.2, 455.2)
3. "Adolescents" means members under age 21.
4. "Adult" means members 21 years of age or over.
5. "Alcohol or other Drug (AOD) Counselor" means: 1) either certified or registered by an organization that is recognized by the Department of Health Care Services and accredited with the National Commission for Certifying Agencies (NCCA); and 2) meets all California State education, training, and work experience requirements set forth in the Counselor Certification Regulations, 9 C.C.R., division 4, chapter 8.
6. "American Indian/Alaska Native (AI/AN)" means any person defined in Title 25 United States Code sections 1603(13), 1603(28), or section 1679(a), or who has been determined eligible as an Indian under 42 C.F.R. section 136.12.
7. "Ancillary Service" means to include individualized connection, referral, and linkages to community-based services and supports.
8. "Appeal" means a review by the Contractor of an adverse benefit determination or a denial to expedite an authorization decision.
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.

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10. “ASAM Criteria” means the comprehensive set of guidelines developed by the American Society of Addiction Medicine for placement, continued stay, transfer, or discharge of patients with addiction and co-occurring conditions.

11. “Calendar Week” means the seven-day period from Sunday through Saturday.

12. “Complaint” means requesting to have a problem solved or have a decision changed because the individual is not satisfied. Depending on the circumstances, a complaint may also qualify as a grievance or an appeal.

13. "Contractor" means the Contractor named in this Intergovernmental Agreement.

14. "Contracted Provider” means:

    A. For SMHS and DMC-ODS programs (if applicable to Contractor): All network providers (including providers owned or operated by Contractor), and any out-of-network providers with whom Contractor contracts for the delivery of covered services to members.

    B. For DMC programs (if applicable to Contractor): A DMC-certified provider (including a provider owned or operated by Contractor) that has entered into an agreement with the Contractor to be a provider of covered services.

15. “Corrective Action Plan (CAP)” means the written plan of action which the Contractor or its contracted provider develops and submits to DHCS to address or correct a deficiency or process that is non-compliant with applicable standards.

16. “County of Responsibility” means the county that is financially responsible for the behavioral health needs and services of a given member.

17. "Covered Services" refer to:

    A. SMHS, as enumerated in Exhibit A, Attachment 2A and further defined in Exhibit E, Attachment 2; and either

    B. DMC-ODS services, as enumerated in Exhibit A, Attachment 2C and further defined in Exhibit E, Attachment 3, as applicable to this Contract; or

    C. DMC services, as enumerated in Exhibit A, Attachment 2E and further defined in Exhibit E, Attachment 3, as applicable to this Contract.

18. “Days” means calendar days, unless otherwise specified.

19. “Dedicated Capacity” means the historically calculated service capacity, by modality, adjusted for the projected expansion or reduction in services, which the

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Contractor agrees to make available to provide SUD services to persons eligible for Contractor services.

20. "Department" means the California Department of Health Care Services (DHCS).

21. “Direct Provider Contract” means a contract established between DHCS and a DMC enrolled provider entered into pursuant to this Contract for the provision of DMC services.

22. “Director” means the Director of DHCS.

23. “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.

24. “DMC-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 22 C.C.R. section 51341.1.

25. “DMC 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.

26. “DMC 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 DMC certification termination notice.

27. “DMC Temporary Suspension” means the provider is temporarily suspended from participating in the DMC program pursuant to W&I Code section 14043.36, subdivision (a). The provider cannot bill for DMC services from the effective date of the temporary suspension.

28. “Drug Medi-Cal Organized Delivery System (DMC-ODS)” is a Medi-Cal SUD delivery system to provide SUD treatment services to members in counties that choose to opt into and implement the program.

29. “Drug Medi-Cal (DMC) Program” means the state system wherein members receive covered services from DMC-certified substance use disorder treatment providers.

30. “Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)” means the federal mandate under Section 1905(r) of the Act, which requires the Contractor to ensure that all members under age 21 receive all applicable mental health or

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SUD services needed to correct or ameliorate health conditions that are coverable under Section 1905(a) of the Act. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a health condition. Services that sustain, support, improve, or make more tolerable a health condition are considered to ameliorate the condition and are thus covered as EPSDT services.

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

32. "Emergency" 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:

    A. Placing the health of the individual (or, for a pregnant member, the health of the member or their unborn child) in serious jeopardy;

    B. Serious impairment to bodily functions;

    C. Serious dysfunction of any bodily organ or part; or

    D. Death.

33. "Excluded Services" means services that are not covered under this Contract.

34. "Expanded Substance Use Disorder Treatment Services" means services listed in Supplement 3 to Attachment 3.1-A of the California Medi-Cal State Plan.

35. "Face-to-Face" means a service occurring in person.

36. "Federal Financial Participation (FFP)" means the share of federal Medicaid funds for reimbursement of covered services.

37. "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to self or some other person. It includes an act that constitutes fraud under applicable State and Federal law. (42 C.F.R. §§ 438.2, 455.2)

38. "Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination or an appeal of a denial to expedite an authorization decision. 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 member's rights regardless of whether remedial action is requested. (42 C.F.R. § 438.400)

39. "Grievance and Appeal System" means the processes the Contractor implements to handle appeals of an adverse benefit determination and grievances, as well as

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the processes to collect and track information about them, as described in Exhibit A, Attachment 12.

40. "Hospitalization" means a supervised recovery period in a facility that provides hospital inpatient care.

41. "Habilitative services and devices" help a person keep, learn, or improve skills and functioning for daily living. (45 C.F.R. § 156.115(a)(5)(i))

42. "Homelessness" means the member meets the definition established in section 11434a of the federal McKinney-Vento Homeless Assistance Act. Specifically, this includes (A) individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 103(a)(1) of the Act); and (B) includes: (i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals; (ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 103(a)(2)(C)); (iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and (iv) migratory children (as such term is defined in section 1309 of the Elementary and Secondary Education Act of 1965) who qualify as homeless for the purposes of this subtitle because the children are living in circumstances described in clauses (i) through (iii).

43. Indian Health Care Provider (IHCP) means a health care program operated by the IHS ("IHS facility"), an Indian Tribe, a Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in section 4 of the Indian Health Care Improvement Act. (25 U.S.C. § 1603; 42 C.F.R. § 438.14(a)).

44. "Indian Health Service (IHS) facilities" means facilities and/or health care programs administered and staffed by the federal Indian Health Service.

45. "Involvement in child welfare" means the member has an open child welfare services case, or the member is determined by a child welfare services agency to be at imminent risk of entering foster care but able to safely remain in their home or kinship placement with the provision of services under a prevention plan, or the member is a child whose adoption or guardianship occurred through the child welfare system. A child has an open child welfare services case if: a) the child is in foster care or in out of home care, including both court-ordered and by voluntary agreement; or b) the child has a family maintenance case (pre-placement or post-reunification), including both court-ordered and by voluntary

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agreement. A child can have involvement in child welfare whether the child remains in the home or is placed out of the home.

46. "Juvenile justice involvement" means the member (1) has ever been detained or committed to a juvenile justice facility, or (2) is currently under supervision by the juvenile delinquency court and/or a juvenile probation agency. Members who have ever been in custody and held involuntarily through operation of law enforcement authorities in a juvenile justice facility, including youth correctional institutions, juvenile detention facilities, juvenile justice centers, and other settings such as boot camps, ranches, and forestry/conservation camps, are included in the "juvenile justice involvement" definition. Members on probation, who have been released home or detained/placed in foster care pending or post-adjudication, under probation or court supervision, participating in juvenile drug court or other diversion programs, and who are otherwise under supervision by the juvenile delinquency court and/or a juvenile probation agency also meet the "juvenile justice involvement" criteria.

47. "Licensed Practitioners of the Healing Arts (LPHA)" includes any of the following: licensed physicians, licensed psychologists (including waivered psychologists), licensed clinical social workers (including waivered or registered clinical social workers), licensed professional clinical counselors (including waivered or registered professional clinical counselors), licensed marriage and family therapists (including waivered or registered marriage and family therapists), registered nurses (including certified nurse specialists and nurse practitioners), licensed vocational nurses, licensed psychiatric technicians, and licensed occupational therapists.

48. "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 Social Security Act.

49. "Medically necessary" or "medical necessity" has the same meaning as set forth in W&I Code sections 14059.5 and 14184.402 and any related guidance issued by the Department.

    A. For members 21 years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

    B. For members under 21 years of age, a service is "medically necessary" or a "medical necessity" if the service meets the EPSDT standard set forth in Section 1396d(r)(5) of Title 42 of the United States Code, including if the service is necessary to correct or ameliorate mental health conditions and SUDs, as described above under the definition of ESPDT.

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50. "Member" means a Medi-Cal recipient who is eligible to receive services from the Contractor.

51. "Modality" means those necessary overall general service activities to provide substance use disorder services as described in Health and Safety Code, division 10.5.

52. A "Network Provider" means a provider or group of providers, including a provider owned or operated by Contractor, that has a network provider agreement with Contractor or a subcontractor, and receives Medicaid funding directly or indirectly to order, refer or render covered SMHS and/or DMC-ODS services under this Contract (as applicable to Contractor). A network provider is not a subcontractor by virtue of the network provider agreement. (42 C.F.R. § 438.2) (The term "network provider" is not applicable to DMC programs.)

53. "Out-of-network provider" means, for purposes of SMHS and DMC-ODS programs, a provider or group of providers that does not have a network provider agreement with Contractor or with a subcontractor. A provider may be "out of network" for one behavioral health managed care program, but in the network of another behavioral health managed care program. (The term "out-of-network provider" is not applicable to DMC programs.)

54. "Out-of-plan provider" has the same meaning as out-of-network provider.

55. "Overpayment" means any payment made by Contractor to a subcontractor or contracted provider to which the subcontractor or contracted provider is not entitled under Title XIX of the Act, or any payment to Contractor by the Department to which Contractor is not entitled under Title XIX of the Act. (42 C.F.R. § 438.2)

56. "Payment Suspension" means a DMC-certified provider has been issued a notice pursuant to W&I Code section 14107.11 and is not authorized to receive payments after the payment suspension date for DMC services, regardless of when the service was provided.

57. "Peer Support Specialist" means an individual with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification who meets ongoing education requirements and provides services under the direction of a Behavioral Health Professional. (State Plan, Supplement 3 to Attachment 3.1-A, page 2j [TN 22-0026].)

58. "Performance" means providing the dedicated capacity for covered services, and more generally, abiding by the terms of Exhibit A and all applicable state and federal statutes, regulations, and standards in expending funds for the provision of covered services under this Contract.

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59. "Physician Incentive Plans" mean any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee.

60. "Physician services" means services provided by an individual licensed under state law to practice medicine.

61. "PIHP" means Prepaid Inpatient Health Plan. A Prepaid Inpatient Health Plan is an entity that:

    A. Provides medical services to members under contract with the Department, and on the basis of prepaid capitation payments, or other payment arrangement that does not use state plan rates;

    B. Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its members; and

    C. Does not have a comprehensive risk contract. (42 C.F.R. § 438.2)

62. "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.

63. "Postservice Postpayment (PSPP) Utilization Review" means the review for DMC/DMC-ODS program compliance 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 this Contract.

64. "Postservice Prepayment Utilization Review" means the review for DMC/DMC-ODS program compliance and or integrity conducted by DHCS. DHCS will provide technical assistance for areas identified that did not comply with the applicable statutes, regulations, or standards (Cal. Code Regs., tit. 22, § 51159(b)).

65. "Prior authorization" means a formal process requiring a provider to obtain advance approval for the amount, duration, and scope of covered services.

66. "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.

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67. “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.

68. “Prescription drugs” means simple substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are:

    A. Prescribed by a physician or other licensed practitioner of the healing arts within the scope of professional practice as defined and limited by Federal and State law;

    B. Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and

    C. Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

69. “Provider” means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so, including providers employed, owned, or operated by the Contractor. (42 C.F.R. 438.2)

70. “Utilization Review/Quality Assessment (UR/QA)” 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:

    A. Such services are or were reasonable and medically necessary and whether such services and items are allowable; and

    B. The quality of such services meets professionally recognized standards of health care.

71. “Rehabilitation Services” includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of their practice under state law, for maximum reduction of physical or mental disability and restoration of a member to their best possible functional level.

72. “Relapse” means a single instance of a member's substance use or a member's return to a pattern of substance use.

73. “Relapse Trigger” means an event, circumstance, place or person that puts a member at risk of relapse.

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74. “Revenue" means Contractor’s income from sources other than the state allocation.

75. “Safeguarding medications” means facilities will store all resident medication and facility staff members may assist with resident’s self-administration of medication.

76. “Satellite site” means a site owned, leased or operated by an organizational provider at which SMHS are delivered to members fewer than 20 hours per week, or, if located at a multiagency site at which SMHS are delivered by no more than two employees or contractors of the provider.

77. “Service Area" means the geographical area under the Contractor’s jurisdiction.

78. “Service Authorization Request” means a member’s request for the provision of a service.

79. “Service Element” is the specific type of service performed within the more general service modalities.

80. “Short-Term Resident” means any member receiving residential SUD services; regardless of the length of stay. The member is considered a “short-term resident” of the residential facility in which they are receiving the services.

81. “Significant Change" means a change in the scope of covered services under this Contract, an increase or decrease in the amount or types of services that are available, an increase or decrease in the number of network providers, or any other change that would impact the benefits available through this Contract.

82. “State Hearing” means a hearing provided by the State to members pursuant to Cal. Code Regs., tit. 22, § 50951 and 50953 and Cal. Code Regs., tit. 9, § 1810.216.6. State Hearings shall comply with all applicable 42 CFR requirements.

83. “Subcontractor” means an individual or entity that has a contract with Contractor that relates directly or indirectly to the performance of the Contractor’s obligations under this Contract. (42 C.F.R. § 438.2.) A contracted provider is not a subcontractor by virtue of its provider agreement to deliver covered services. Notwithstanding the foregoing, for purposes of Exhibit D(F) the term “subcontractor” shall include contracted providers.

84. “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.

85. “Substance Use Disorder Medical Director” has the same meaning as in 22 C.C.R. section 51000.24.4.

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86. “Support Groups” means linkages to self-help and support, spiritual and faith-based support.

87. “Support Plan” means a list of individuals and/or organizations that can provide support and assistance to a member to maintain sobriety.

88. “Telehealth” means contact with a member via synchronous audio and video by an LPHA, Peer Support Specialist, or registered or certified counselor and may be done in the community or the home.

89. “Telephone” means contact with a member via synchronous, real-time audio-only telecommunications systems.

90. “Therapy” means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal, strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a member in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a member or group of members and may include family therapy directed at improving the member's functioning and at which the member is present. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].)

91. “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 members or five percent of the member population, whichever is lower, in an identified geographic area.

92. “Transportation Services” means provision of or arrangement for transportation to and from medically necessary treatment.

93. “Treatment Planning” means a service activity to develop or update a member’s course of treatment, documentation of the recommended course of treatment, and monitoring a member’s progress. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].)

94. “Tribal 638 Providers” –means Federally recognized Tribes or Tribal organizations that contract or compact with IHS to plan, conduct and administer one or more individual programs, functions, services or activities under Public Law 93-638.

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A. A Tribal 638 provider enrolled in Medi-Cal as an Indian Health Services-Memorandum of Agreement (IHS-MOA) provider must appear on the “List of American Indian Health Program Providers” set forth in APL 17-020, Attachment 1 in order to qualify for reimbursement as a Tribal 638 Provider under BHIN 22-020.

B. A Tribal 638 provider enrolled in Medi-Cal as a Tribal Federally Qualified Health Center (FQHC) provider is governed by and must enroll in Medi-Cal consistent with the Tribal FQHC criteria established in the California State Plan, the Tribal FQHC section of the Medi-Cal provider manual, and APL 21-008. Tribal 638 providers enrolled in Medi-Cal as a Tribal FQHC must appear on the “List of Tribal Federally Qualified Health Center Providers," which is set forth on Attachment 2 to APL 21-008.

95. “Urban Indian Organizations (UIO)” – A Nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 1653(a) of Title 25 of the Code of Federal Regulations.

96. “Urgent care” means a condition perceived by a member 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.

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1. "Assessment" means a service activity designed to collect information and evaluate the current status of a member's mental, emotional, or behavioral health to determine whether Rehabilitative Mental Health Services are medically necessary and to recommend or update a course of treatment for that member. Assessments shall be conducted and documented in accordance with applicable State and Federal statutes, regulations, and standards. (State Plan, Supplement 3 to Attachment 3.1-A, page 1 [TN 22-0023].)

2. "Adult Residential Treatment Services" are recovery focused rehabilitative services provided in a non-institutional, residential setting for members who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days. Adult residential treatment services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone. Services will not be claimable unless the member has been admitted to the program and there is face-to-face contact between the member and a treatment staff person of the facility on the day of the service. This service includes one or more of the following components: assessment, treatment planning, therapy, and psychosocial rehabilitation. (State Plan, Supplement 3 to Attachment 3.1-A, page 2f [TN 22-0023].)

3. "Community-Based Mobile Crisis Intervention Services (also referred to as "Mobile Crisis Services")" are services that provide rapid response, individual assessment and community-based stabilization to Medi-Cal members who are experiencing a behavioral health crisis. Mobile Crisis Services are designed to provide relief to members experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement. Mobile Crisis Services include warm handoffs to appropriate settings and providers when the member requires additional stabilization and/or treatment services; coordination with and referrals to appropriate health, social and other services and supports, as needed, and short-term follow-up support to help ensure the crisis is resolved and the member is connected to ongoing care. Mobile Crisis Services are directed toward the member in crisis but may include contact with a family member(s) or other significant support collateral(s) if the purpose of the collateral's participation is to assist the member in addressing their behavioral health crisis and restoring the member to the highest possible functional level. Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the member is experiencing the behavioral health crisis. Locations may include, but are not limited to, the member's home,

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school, or workplace, on the street, or where a member socializes. Mobile Crisis Services claimed under this option cannot be provided in hospitals or other facility settings. Mobile crisis services shall be available to members experiencing behavioral health crises 24 hours a day, 7 days a week, and 365 days a year.

4. "Crisis Intervention" is an unplanned, expedited service to or on behalf of, a member to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a member to cope with a crisis, while assisting the member in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting. It may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. This service includes one or more of the following service components: assessment, therapy, and referral and linkages. Crisis Intervention services may either be face-to-face or by telephone or telehealth and may be provided in a clinic setting or anywhere in the community. (State Plan, Supplement 3 to Attachment 3.1-A, page 2d [TN 22-0023].)

5. "Crisis Residential Treatment Services" are therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program (short term-3 months or less) as an alternative to hospitalization for members experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. This service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days. Crisis residential treatment services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone. Services will not be claimable unless the member has been admitted to the program and there is face-to-face contact between the member and a treatment staff person of the facility on the day of the service. This service includes one or more of the following: assessment, treatment planning, therapy, psychosocial rehabilitation, and crisis intervention. (State Plan, Supplement 3 to Attachment 3.1-A, page 2g [TN 22-0023].)

6. "Crisis Stabilization" is an unplanned, expedited service lasting less than 24 hours, to or on behalf of, a member to address an urgent condition that requiring immediate attention that cannot be adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services which, if the condition and symptoms are not treated, present an imminent threat to the member or others, or substantially increase the risk of the member becoming gravely disabled. Crisis stabilization must be provided on site at a licensed 24-hour health care facility, at a hospital based outpatient

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program (services in a hospital based outpatient program are provided in accordance with 42 CFR 440.20), or at a provider site certified by the Department of Health Care Services to perform crisis stabilization and some service components may be delivered through telehealth or telephone. Crisis stabilization is an all-inclusive program and no other Rehabilitative Mental Health Services are reimbursable during the same time period this service is reimbursed. Crisis stabilization may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member.

Medical backup services must be available either on site or by written contract or agreement with a general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies. Medications must be available on an as needed basis and the staffing pattern must reflect this availability. All members receiving crisis stabilization must receive an assessment of their physical and mental health. This may be accomplished using protocols approved by a physician. If outside services are needed, a referral that corresponds with the member 's needs will be made, to the extent resources are available. This service includes one or more of the following service components: assessment, therapy, crisis intervention, medication support services, referral and linkages. (State Plan, Supplement 3 to Attachment 3.1-A, page 2e [TN 22-0023].)

7. “Day Rehabilitation” is a structured program which provides services to a distinct group of individuals. Day rehabilitation is intended to improve or restore personal independence and functioning necessary to live in the community or prevent deterioration of personal independence consistent with the principles of learning and development. Services are available for at least three hours each day. Day rehabilitation is a program that lasts less than 24 hours each day. Day rehabilitation may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. This service includes one or more of the following service components: assessment, treatment planning, therapy, and psychosocial rehabilitation. (State Plan, Supplement 3 to Attachment 3.1-A, page 2c [TN 22-0023].)

8. “Day Treatment Intensive” is a structured, multi-disciplinary program of therapy that may be used as an alternative to hospitalization, or to avoid placement in a more restrictive setting, or to maintain the client in a community setting and which provides services to a distinct group of members who receive services for a at least three hours per day and lasts less than 24 hours each day. This service includes one or more of the following service components: assessment, treatment planning, therapy, and psychosocial rehabilitation. This service may include contact with significant support persons or other collaterals if the purpose

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of their participation is to focus on the treatment of the member. Day treatment intensive services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone. (State Plan, Supplement 3 to Attachment 3.1-A, page 2c [TN 22-0023].)

9. "Intensive Care Coordination (ICC)" is a targeted case management service that facilitates assessment of care planning for and coordination of services to members under age 21 who are eligible for the full scope of Medi-Cal services and who meet medical criteria to access SMHS. ICC service components include: assessing; service planning and implementation; monitoring and adapting; and transition. ICC services are provided through the principles of the Integrated Core Practice Model (ICPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a child, their family and involved child-serving systems. The CFT is comprised of – as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends, and clergy and all ancillary individuals who work together to develop and implement the client plan and are responsible for supporting the child and family in attaining their goals. ICC also provides an ICC coordinator who:

    A. Ensures that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/child driven and culturally and linguistically competent manner and that services and supports are guided by the needs of the child;

    B. Facilitates a collaborative relationship among the child, their family and systems involved in providing services to the child;

    C. Supports the parent/caregiver in meeting their child's needs;

    D. Helps establish the CFT and provides ongoing support; and

    E. Organizes and matches care across providers and child serving systems to allow the child to be served in their community.

10. "Intensive Home Based Services (IHBS)" are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child's functioning and are aimed at helping the child build skills necessary for successful functioning in the home and community and improving the child's family's ability to help the child successfully function in the home and community. IHBS services are provided in accordance with the Integrated Core Practice Model (ICPM) by the Child and Family Team (CFT) in coordination with the family's overall service plan which may include IHBS. Service activities may

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include, but are not limited to assessment, treatment plan, therapy, rehabilitation and include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. IHBS is provided to members under 21 who are eligible for the full scope of Medi-Cal services and who meet the access criteria for SMHS.

11. "Medication Support Services" include prescribing, administering, dispensing and monitoring drug interactions and contradictions of psychiatric medications or biologicals that are necessary to alleviate the symptoms behavioral health conditions. This service includes one or more of the following service components: evaluation of the need for medication; evaluation of clinical effectiveness and side effects; medication education including instruction in the use, risks and benefits of, and alternatives for medication; treatment planning. Medication support services may include prescription, dispensing, monitoring, or administration of medication related to substance use disorder services for members with co-occurring mental health conditions and substance use disorder. Medication support services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication support services may be provided face-to-face, by telephone or by telehealth, and may be provided anywhere in the community. Medication support services may be delivered as a standalone service or as a component of crisis stabilization.

12. "Mental Health Services" are individual, group, or family-based interventions that are designed to provide a reduction of the member's mental or emotional disability, and restoration, improvement and/or preservation of individual and community functioning, and continued ability to remain in the community consistent with the goals of recovery, resiliency, learning, development, independent living, and enhanced self-sufficiency and that are not provided as components of adult residential services, crisis residential services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Mental health services may include contact with significant support persons or other collateral if the purpose of their participation is to focus on the treatment of the member. This service includes one or more of the following service components: assessment, treatment planning, therapy, and psychosocial rehabilitation. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].)

13. "Peer Support Services" are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set

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recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower members through strength-based coaching, support linkages to community resources, and to educate members and their families about their conditions and the process of recovery. Peer support services may be provided with the member or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer support services can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member by supporting the achievement of the member's treatment goals.

A. Peer support services are based on an approved plan of care and may be delivered as a standalone service. Peer support services include one or more of the following service components:

B. Educational Skill Building Groups, which are groups provided in a supportive environment in which members and their families learn coping mechanisms and problem-solving skills in order to help the members achieve desired outcomes. These groups promote skill building for the members in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

C. Engagement, which means Peer Support Specialist led activities and coaching to encourage and support members to participate in behavioral health treatment. Engagement may include supporting members in their transitions and supporting members in developing their own recovery goals and processes.

D. Therapeutic Activity, which means structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the member's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the member; promotion of self-advocacy; resource navigation; and collaboration with the members and others providing care or support to the member, family members, or significant support persons. (State Plan, Supplement 3 to Attachment 3.1-A, page 2 [TN 22-0023].)

14. "Psychiatric Health Facility Services" are therapeutic and/or rehabilitative services provided in a psychiatric health facility licensed by DHCS. Psychiatric health facilities are licensed to provide acute inpatient psychiatric treatment to individuals with major mental disorders. Psychiatric health facility services may include contact with significant support persons or other collaterals if the purpose

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of their participation is to focus on the treatment of the member. Services are provided in a psychiatric health facility under a multidisciplinary model and some service components may be delivered through telehealth or telephone. Psychiatric health facilities may only admit and treat patients who have no physical illness or injury that would require treatment beyond what ordinarily could be treated on an outpatient basis. Services include the following components: assessment, treatment planning, therapy, psychosocial rehabilitation, and crisis intervention. These services are separate from those categorized as "Psychiatric Inpatient Hospital". (State Plan, Supplement 3 to Attachment 3.1-A, page 2g [TN 22-0023].)

15. "Psychiatric Inpatient Hospital Services" include both acute psychiatric inpatient hospital services and administrative day services. Acute psychiatric inpatient hospital services are provided to members for whom the level of care provided in a hospital is medically necessary to diagnose or treat a covered mental illness. Administrative day services are inpatient hospital services provided to members who were admitted to the hospital for an acute psychiatric inpatient hospital service and the member's stay at the hospital must be continued beyond the member's need for acute psychiatric inpatient hospital services due to lack of residential placement options at non-acute residential treatment facilities that meet the needs of the member.

    Psychiatric inpatient hospital services are provided by SD/MC hospitals and FFS/MC hospitals. SMHS programs claim reimbursement for the cost of psychiatric inpatient hospital services provided by SD/MC hospitals through the SD/MC claiming system. FFS/MC hospitals claim reimbursement for the cost of psychiatric inpatient hospital services through the Fiscal Intermediary. SMHS programs are responsible for authorization of psychiatric inpatient hospital services reimbursed through either billing system. For SD/MC hospitals and FFS/MC hospitals, the daily rate does not include professional services, which are billed separately from the SD/MC and FFS/MC inpatient hospital services via the SD/MC claiming system.

16. "Psychosocial Rehabilitation" means a recovery or resiliency focused service activity which addresses a mental health need. This service activity provides assistance in restoring, improving, and/or preserving a member's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the member. Psychosocial rehabilitation includes assisting members to develop coping skills by using a group process to provide peer interaction and feedback in developing problem-solving strategies. In addition, psychosocial rehabilitation includes therapeutic interventions that utilize self-expression such as art, recreation, dance or music as a modality to develop or enhance skills.

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These interventions assist the member in attaining or restoring skills which enhance community functioning including problem solving, organization of thoughts and materials, and verbalization of ideas and feelings. Psychosocial rehabilitation also includes support resources, and/or medication education. Psychosocial rehabilitation may be provided to a member or a group of members. (State Plan, Supplement 3 to Attachment 3.1-A, page 2a [TN 22-0023].)

17. "Referral and Linkages" are services and supports to connect a member with primary care, specialty medical care, SUD treatment providers, mental health providers, and community-based services and supports. This includes identifying appropriate resources, making appointments, and assisting a member with a warm handoff to obtain ongoing support. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].)

18. "Targeted case management" is a service that assists a member in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination and referral; monitoring service delivery to ensure member access to services and the service delivery system; monitoring of the member's progress, placement services, and plan development. TCM services may be face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community. Additionally, services may be provided by any person determined by the SMHS program to be qualified to provide the service, consistent with the scope of practice and state law.

19. "Therapeutic Behavioral Services (TBS)" are intensive, individualized, short-term outpatient treatment interventions for members up to age 21. Individuals receiving these services have serious emotional disturbances (SED), are experiencing a stressful transition or life crisis and need additional short-term, specific support services.

20. "Therapeutic Foster Care (TFC) Services" model allows for the provision of short-term, intensive, highly coordinated, trauma informed and individualized specialty mental health services activities (plan development, rehabilitation and collateral) to children up to age 21 who have complex emotional and behavioral needs and who are placed with trained, intensely supervised and supported TFC parents. The TFC parent serves as a key participant in the therapeutic treatment process of the child. The TFC parent will provide trauma informed interventions that are medically necessary for the child. TFC is intended for children youth who require intensive and frequent mental health support in a family environment. The TFC service model allows for the provision of certain specialty mental health services activities (plan development, rehabilitation and collateral) available under the EPSDT benefit as a home-based alternative to high level care in institutional

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settings such as group homes and an alternative to Short Term Residential Therapeutic Programs (STRTPs).

21. “Therapy” means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal, strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a member in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a member or group of members and may include family therapy directed at improving the member's functioning and at which the member is present. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].)

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1. "Assessment" means activities to evaluate or monitor the status of a member's behavioral health and determine the appropriate level of care and course of treatment for that member. Assessments shall be conducted in accordance with applicable State and Federal laws, and regulations, and standards. Assessment may be initial and periodic, and may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member. Assessment services may include one or more of the following components:

   A. Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder.

   B. Diagnosis of substance use disorders utilizing the current DSM and assessment of treatment needs for medically necessary treatment services. This may include a physical examination necessary for treatment and evaluation.

   C. Treatment planning, a service activity that consists of development and updates to documentation needed to plan and address the member's needs, planned interventions and to address and monitor a member's progress and restoration of member to their best possible functional level.

2. "Community-Based Mobile Crisis Intervention Services (also referred to as "Mobile Crisis Services")" are services that provide rapid response, individual assessment and community-based stabilization to Medi-Cal members who are experiencing a behavioral health crisis. Mobile Crisis Services are designed to provide relief to members experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement. Mobile Crisis Services include warm handoffs to appropriate settings and providers when the member requires additional stabilization and/or treatment services; coordination with and referrals to appropriate health, social and other services and supports, as needed, and short-term follow-up support to help ensure the crisis is resolved and the member is connected to ongoing care. Mobile Crisis Services are directed toward the member in crisis but may include contact with a family member(s) or other significant support collateral(s) if the purpose of the collateral's participation is to assist the member in addressing their behavioral health crisis and restoring the member to the highest possible functional level. Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the member is experiencing the behavioral health crisis. Locations may include, but are not limited to, the member's home, school, or workplace, on the street, or where a member socializes. Mobile Crisis Services claimed under this option cannot be provided in hospitals or other

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facility settings. Mobile crisis services shall be available to members experiencing behavioral health crises 24 hours a day, 7 days a week, and 365 days a year.

3. "Family Therapy" means a rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the member's recovery as well as the holistic recovery of the family system. Family members can provide social support to the member and help motivate their loved one to remain in treatment. There may be times when, based on clinical judgment, the member is not present during the delivery of this service, but the service is for the direct benefit of the member.

4. "Group Counseling" consists of contacts with multiple members at the same time. Group Counseling shall focus on the needs of the participants. Group counseling means contacts in which one or more therapists or counselors treat two or more members at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served. A member 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 member 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.

5. "Individual Counseling" consists of contacts with a member. Individual counseling can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member by supporting the achievement of the member's treatment goals. Individual counseling also includes preparing the beneficiary to live in the community, and providing linkages to treatment and services available in the community.

6. "Medical psychotherapy" means a counseling service to treat SUDs other than OUD conducted by the medical director of a Narcotic Treatment Program on a one-to-one basis with the member.

7. "Medication Services" means the prescription or administration of medication related to substance use disorder services, or the assessment of the side effects or results of the medication. Medication Services may include prescription or administration of medication related to mental health services for members with a co-occurring substance use disorder and mental health condition. Medication Services does not include MAT for Opioid Use Disorders (OUD) or MAT for Alcohol Use Disorders (AUD) and other Non-Opioid Substance Use Disorders. Medication Services includes prescribing, administering, and monitoring medications used in the treatment or management of SUD and/or withdrawal management not included in the definitions of MAT for OUD or MAT for AUD services.

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8. "Medications for Addiction Treatment (also known as medication assisted treatment (MAT)) for Alcohol Use Disorders (AUD) and Non-Opioid Substance Use Disorders" includes all FDA-approved drugs and services to treat AUD and other non-opioid SUDs involving FDA-approved medications to treat AUD and non-opioid SUDs.

9. "Medications for Addiction Treatment (also known as medication assisted treatment (MAT)) for Opioid Use Disorders (OUD)" includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders.

10. "Narcotic Treatment Program" or "NTP means an outpatient program that provides FDA-drugs approved to treat SUDs when ordered by a physician as medically necessary. NTPs are required to offer and prescribe medications including methadone, buprenorphine, naloxone and disulfiram. A member must receive at minimum fifty minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided as medically necessary.

11. "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.

12. "Observation" means the process of monitoring the member's course of withdrawal. The Contractor shall ensure observation be conducted at the frequency required by applicable state and federal laws, regulations, and standards. This may include but is not limited to observation of the member's health status.

13. "Patient Education" means education for the member on addiction, treatment, recovery and associated health risks.

14. "Peer Support Services" are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower members through strength-based coaching, support linkages to community resources, and to educate members and their families about their conditions and the process of recovery. Peer support services may be provided with the member or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer support services can include contact with

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family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member by supporting the achievement of the member's treatment goals.

A. Peer support services are based on an approved plan of care and may be delivered as a standalone service. Peer support services include one or more of the following service components:

B. Educational Skill Building Groups, which are groups provided in a supportive environment in which members and their families learn coping mechanisms and problem-solving skills in order to help the members achieve desired outcomes. These groups promote skill building for the members in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

C. Engagement, which means Peer Support Specialist led activities and coaching to encourage and support members to participate in behavioral health treatment. Engagement may include supporting members in their transitions and supporting members in developing their own recovery goals and processes.

D. Therapeutic Activity, which means structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the member's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the member; promotion of self-advocacy; resource navigation; and collaboration with the members and others providing care or support to the member, family members, or significant support persons. (State Plan, Supplement 3 to Attachment 3.1-A, page 6h [TN 24-0042].)

15. "Perinatal DMC Services" means covered services as well as parent/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 parent and fetus or infant; and coordination of ancillary services (Cal. Code Regs., tit. 22, § 51341.1(c)(4)).

16. "Recovery monitoring" means recovery coaching, monitoring designed for the maximum reduction of the member's SUD.

17. "Recovery Services" means a DMC-ODS service designed to support recovery and prevent relapse with the objective of restoring the member to their best

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possible functional level. Recovery Services emphasize the member's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to members.

18. "Substance Use Disorder Crisis Intervention Services" means contacts with a member in crisis. A crisis means an actual relapse or an unforeseen event or circumstance which presents to the member an imminent threat of relapse. SUD Crisis Intervention Services shall focus on alleviating the crisis problem, be limited to the stabilization of the member's immediate situation, and be provided in the least intensive level of care that is medically necessary to treat their condition.

19. "Unit of Service" means:

    A. For care coordination, intensive outpatient treatment, outpatient services, Naltrexone treatment services, and recovery services contact with a member 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 SUDs 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 9 C.C.R., chapter 4, commencing with § 10000.

    D. For clinician 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 member, per bed rate.

    F. For withdrawal management per member per visit/daily unit of service.