STATE OF CALIFORNIA

STANDARD AGREEMENT AMENDMENT

STD. 213A_DHCS (Rev. 03/18)

☒ Check here if additional pages are added: 232 Page(s)

Agreement Number	Amendment Number
16-93236	A02
Registration Number:	

1. This Agreement is entered into between the State Agency and Contractor named below:

State Agency's Name (Also known as DHCS, CDHS, DHS or the State)

Department of Health Care Services

Contractor's Name (Also referred to as Contractor)

County of Santa Clara

2. The term of this Agreement is: June 15, 2017 through June 30, 2019

3. The maximum amount of this Agreement after this amendment is: **$** 116,401,681 One Hundred Sixteen Million, Four Hundred One Thousand, Six Hundred Eighty-One Dollars

4. The parties mutually agree to this amendment as follows. All actions noted below are by this reference made a part of the Agreement and incorporated herein:

I. The effective date of this amendment is the date approved by DHCS.

II. **Purpose of amendment:** This amendment 1) modifies the terms and conditions; and 2) increases the budget in year 3 to compensate the Contractor for performing additional services.

III. Certain changes made in this amendment are shown as: Text additions are displayed in **bold and underline**. Text deletions are displayed as strike through text (i.e., ~~Strike~~).

IV. Paragraph 3 (maximum amount payable) on the face of the original STD 213 is increased by $4,590,607 and is amended to read: ~~$111,811,074 (One Hundred Eleven Million, Eight Hundred Eleven Thousand, Seventy-Four Dollars)~~ **$116,401,681 (One Hundred Sixteen Million, Four Hundred One Thousand, Six Hundred Eighty-One Dollars)**.

(Continued on next page)

All other terms and conditions shall remain the same.

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR		**CALIFORNIA Department of General Services Use Only**
Contractor's Name *(If other than an individual, state whether a corporation, partnership, etc.)* County of Santa Clara		
By *(Authorized Signature)* ✍	Date Signed *(Do not type)*	
Printed Name and Title of Person Signing S. Joseph Simitian, President, Board of Supervisors		
Address 70 West Hedding Street San Jose, CA 95126		
STATE OF CALIFORNIA		
Agency Name Department of Health Care Services		
By *(Authorized Signature)* ✍	Date Signed *(Do not type)*	
Printed Name and Title of Person Signing Carrie Talbot, Chief, Contract Management Unit		☒ Exempt per: **W&I Code 14087.4**
Address 1501 Capitol Avenue, Suite 71.2048, MS 1400, P.O. Box 997413, Sacramento, CA 95899-7413		

V. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit A A2 – Scope of Work (4 pages)

All references to Exhibit A A1 – Scope of Work in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit A A2 – Scope of Work. Exhibit A A1 – Scope of Work is hereby replaced in its entirety by the attached revised exhibit.

VI. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit A, Attachment I A2 – Program Specifications (~~143~~ **175** pages)

All references to Exhibit A, Attachment I A1– Program Specifications in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit A, Attachment I A2 – Program Specifications. Exhibit A, Attachment I A1– Program Specifications is hereby replaced in its entirety by the attached revised exhibit.

VII. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit B A2 – Budget Detail and Payment Provisions (13 **14** pages)

All references to Exhibit B A1 – Budget Detail and Payment Provisions in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit B A2 – Budget Detail and Payment Provisions. Exhibit B A1 – Budget Detail and Payment Provisions is hereby replaced in its entirety by the attached revised exhibit.

VIII. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit B, Attachment I A2 – Funding Amounts (1 page)

All references to Exhibit B, Attachment I A1 – Funding Amounts, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit B, Attachment I A2 – Funding Amounts. Exhibit B, Attachment I A1 – Funding Amounts is hereby replaced in its entirety by the attached revised exhibit.

IX. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit E A2 – Additional Provisions (4 pages)

All references to Exhibit E A1 – Additional Provisions, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit E A2 – Additional Provisions. Exhibit E A1 – Additional Provisions is hereby replaced in its entirety by the attached revised exhibit.

X. Paragraph 4 (incorporated exhibits) on the face of the original STD 213 is amended to add the following revised exhibit:

Exhibit F A2 – Privacy and Information Security Provisions (~~28~~ **32** pages)

All references to Exhibit F A1 – Privacy and Information Security Provisions in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit F A2 – Privacy and Information Security Provisions. Exhibit F A1 – Privacy and Information Security Provisions is hereby replaced in its entirety by the attached revised exhibit.

Exhibit A A2
Scope of Work

1. Service Overview

Contractor agrees to provide to the California Department of Health Care Services (DHCS) the services described herein.

The term “contract” or “agreement” shall also mean, “Intergovernmental Agreement.”

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

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

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

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

2. Service Location

The services shall be performed at applicable facilities in the County of Santa Clara.

3. Service Hours

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

4. Project Representatives

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

Exhibit A A2
Scope of Work

Department of Health Care Services	**County of Santa Clara**
Contract/Grant Manager: Robert Strom	Santa Clara County Department of Alcohol and Drug Services Bruce Copley, Director
Telephone: (916) 713-8553 Fax: (916) 322-1176 Email: Robert.Strom@dhcs.ca.gov	Telephone: (408) 792-5692 Fax: (408) 947-8703 Email: Bruce.Copley@hhs.sccgov.org

B. Direct all inquiries to:

Department of Health Care Services	**County of Santa Clara**
Department of Health Care Services SUD PPFD - PSGMB Attention: Matthew Shields Mail Station Code 2624 P.O. Box 997413 Sacramento, CA, 95899-7413 Telephone: (916) 713-8948 Fax: (916) 322-1176 Email: Matthew.Shields@dhcs.ca.gov	Santa Clara County Alcohol and Drug Services Attention: County AOD Program Administrator 976 Lenzen Avenue, 3rd Floor San Jose, CA 95126-2737 Telephone: (408) 792-5692 Fax: (408) 947-8703

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 Intergovernmental Agreement.

5. Americans with Disabilities Act

Contractor agrees to ensure that deliverables developed and produced, pursuant to this Agreement shall comply with the accessibility requirements of Section 508 of the Rehabilitation Act and the Americans with Disabilities Act of 1973 as amended (29 U.S.C. § 794 (d), and regulations implementing that act as set forth in Part 1194 of Title 36 of the Federal Code of 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 section 11135 codifies section 508 of the Act requiring accessibility of electronic and information technology.

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

Exhibit A A2
Scope of Work

7. Reference Documents

The following documents are hereby incorporated by reference into the DMC-ODS Waiver contract though they may not be physically attached to the contract but will be issued in a CD under separate cover:

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

Document 1G: Perinatal Practice Guidelines

http://www.dhcs.ca.gov/individuals/Documents/Perinatal_Practice_Guidelines_FY1819.pdf

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

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

http://www.dhcs.ca.gov/provgovpart/Pages/DATAR.aspx

Document 1P: Alcohol and/or Other Drug Program Certification Standards (May 1, 2017)

http://www.dhcs.ca.gov/Documents/DHCS_AOD_Certification_Standards.pdf

Document 1V: Youth Treatment Guidelines

http://www.dhcs.ca.gov/individuals/Documents/Youth_Treatment_Guidelines.pdf

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

Document 2G Drug Medi-Cal Billing Manual

http://www.dhcs.ca.gov/formsandpubs/Documents/DMC_Billing_Manual_2017-Final.pdf

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

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

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

Exhibit A A2
Scope of Work

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

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

~~http://www.calregs.com~~

https://govt.westlaw.com/calregs/Search/Index

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

~~http://www.calregs.com~~

https://govt.westlaw.com/calregs/Search/Index

Document 3J: CalOMS Treatment Data Collection Guide

http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf

Document 3S CalOMS Treatment Data Compliance Standards

http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Data_Cmpliance%20Standards%202014.pdf

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

~~https://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15~~

https://www.thinkculturalhealth.hhs.gov/clas

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

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

Document 5A : Confidentiality Agreement

Exhibit A, Attachment I A2
Program Specifications

I. Preamble

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

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

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

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

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

F. This Agreement requires the Contractor to ensure the availability and accessibility of adequate numbers of facilities, service locations, service sites, and professional, allied, and supportive personnel to provide medically necessary services, and ensure the authorization of services for urgent conditions. The DMC-ODS provides for automatic mandatory enrollment of all Medi-Cal beneficiaries in the single PIHP operating in the county in which the beneficiary resides. PIHPs in a very small county or in any one geographic area may have a limited number of providers for a particular service. If additional providers are not needed to meet general access requirements, the Contractor is not obligated to subcontract with additional providers to provide more choices for an individual beneficiary.

Exhibit A, Attachment I A2
Program Specifications

II. Federal Requirements

A. Waived and Inapplicable Federal Requirements

1. The Contractor is operating as a PIHP. Accordingly, the following provisions of 42 CFR §438 are not applicable to this Intergovernmental Agreement: 42 CFR §438.3(s)(t) – Standard Contract Requirements; 42 CFR §438.4 – Actuarial Soundness; 48 CFR §438.5 – Rate Development Standards; 438 CFR §438.6 – Special Contract Provisions Related to Payment; 42 CFR §438.7 – CMS Review and Approval of the Rate Certifications; 42 C.F.R. §438.8 - Medical loss ratio (MLR) standards; 42 C.F.R. §438.9 - Provisions that apply to non-emergency medical transportation PAHPs; 42 CFR 438.10(g)(2)(ii)(A) and (B) – Information Requirements; 42 CFR §438.50 – State Plan Requirements; 42 CFR §438.54(c) – Voluntary Managed Care Enrollment; 42 CFR §438.71(b)(1)(i&iii)(c)(d) – Beneficiary Support System; 42 CFR §438.74 – State Oversight of Minimum MLR Requirements; 42 CFR §438.104 - Marketing Activities; 42 CFR §438.110 - Member Advisory Committee; 42 CFR §438.114 – Emergency and Poststabilization Services; 42 CFR §438.116 – Solvency Standards; 42 CFR §438.206(b)(2) – Women's Health Services (No women's health services are provided through the DMC-ODS Waiver); 42 CFR §438.208(c)(1) – Identification of Individuals with Special Health Care Needs; 42 CFR §§438.700-730 – Sanctions; 42 CFR §438.802 – Basic Requirements; 42 CFR §438.808 – Exclusion of Entities; 42 CFR §438.810 – Expenditures for Enrollment Broker Services; 42 CFR §431.51(b)(2) and §441.202 (No family planning services, including abortion procedures, are provided through the DMC-ODS Waiver); and 42 CFR §§455.100-104 – Disclosure Requirements.
2. Under this DMC-ODS, free choice of providers is restricted. That is, beneficiaries enrolled in this program shall receive DMC-ODS services through the Contractor, operating as a PIHP. Based on this service delivery model, the Department has requested, and Centers for Medicare & Medicaid Services (CMS) has granted approval to waive the following 42 CFR §438 provisions for this Agreement: 42 CFR §438.10(f)(3) – Notice Requirements; 42 CFR §438.52 - Choice of MCOs, PIHPs, PAHPs, PCCMs, and

PCCM Entities; 42 CFR §438.56 – Disenrollment: Requirements and Limitations.

B. General Provisions

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

i. CMS shall review and approve this Agreement.

ii. Enrollment discrimination is prohibited.

a. The Contractor shall accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under this Agreement.

b. Enrollment is mandatory.

c. The Contractor shall not, based on health status or need for health care services, discriminate against individuals eligible to enroll.

d. The Contractor shall not discriminate against individuals eligible to enroll based on race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. (WIC 14029.91 (e)(3))

e. The Contractor will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

f. The Contractor shall provide information on how to file a discrimination complaint with the United States Department of Health and Human Services Office of Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex. (WIC 14029.91(e)(5))

iii. Services that may be covered by the Contractor.

a. The Contractor may cover, for beneficiaries, services that are in addition to those covered under the State Plan as follows:

i. Any services that the Contractor voluntarily agrees to provide.

ii. Any services necessary for compliance by the Contractor with the parity requirements set

forth in 42 CFR §438.900 et. al and only to the extent such services are necessary for the Contractor to comply with 42 CFR §438.910.

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

a. The Contractor shall comply with all applicable Federal and state laws and regulations including:
   i. Title VI of the Civil Rights Act of 1964.
   ii. Title IX of the Education Amendments of 1972 (regarding education programs and activities).
   iii. The Age Discrimination Act of 1975; the Rehabilitation Act of 1973.
   iv. The Americans with Disabilities Act of 1990 as amended.
   v. Section 1557 of the Patient Protection and Affordable Care Act.

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

c. Provider-preventable condition requirements:
   i. The Contractor shall comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions. The Contractor shall report all identified provider-preventable conditions to the Department.
   ii. The Contractor shall not make payments to a provider for provider-preventable conditions that meet the following criteria:
      1. Is identified in the state plan.
      2. Has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of

procedures supported by evidence-based guidelines.

3. Has a negative consequence for the beneficiary.
4. Is auditable.

iii. The Contractor shall use and submit the report using the DHCS Drug Medi-Cal Organized Delivery System Provider Preventable Conditions (PPC) Reporting Form at the time of discovery of any provider preventable conditions that are covered under this provision to:

Department of Health Care Services
SUD Program, Policy and Fiscal Division
Performance & Integrity Branch
PO Box 997413, MS-2627
Sacramento, CA 95899-7413

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

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

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

vi. Subcontracts.

a. All subcontracts shall fulfill the requirements or activity delegated under the subcontract in accordance with 42 CFR §438.230.
b. The Contractor shall require that subcontractors not bill beneficiaries for covered services under a contractual, referral, or other arrangement with the

Contractor in excess of the amount that would be owed by the individual if the Contractor had directly provided the services. (42 U.S.C. 1396u–2(b)(6)(C))

vii. Choice of network provider.

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

viii. Audited financial reports.

a. The Contractor shall submit audited financial reports specific to this Agreement on an annual basis. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

ix. Recordkeeping requirements.

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

2. Information Requirements (42 CFR §438.10).

i. Basic Rules

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

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

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

a. The Department developed definitions for managed care terminology, including appeal, emergency medical condition, emergency services, excluded services, grievance, health insurance, hospitalization, medically necessary, network, non-participating

provider, physician services, plan, preauthorization, participating provider, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services, and urgent care.

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

iii. The Contractor shall provide the required information in this section to each beneficiary.

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

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

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

vi. Language and format:

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

ii. A population group of mandatory Medi-Cal beneficiaries residing in the Contractor's service area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes.

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

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

ix. Pursuant to WIC 14029.91(e)(1), the Contractor shall make interpretation services available free of charge and in a timely manner to each beneficiary. This includes oral interpretation and the use of auxiliary aids (e.g. TTY/TDY and American Sign Language) and services, including qualified interpreters for individuals with disabilities (WIC

14029.91(e)(2)). Oral interpretation requirements apply to all non–English languages, not just those that the Department identifies as prevalent.

a. Pursuant to WIC 14029.91(a)(1)(B), Oral interpretation services shall be provided by an interpreter that, at a minimum, meets all of the following qualifications:
    i. Demonstrated proficiency in both English and the target language.
    ii. Knowledge in both English and the target language of health care terminology and concepts relevant to health care delivery systems.
    iii. Adheres to generally accepted interpreter ethics principle, including client confidentiality.

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

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

xii. The Contractor shall notify its beneficiaries:

a. That oral interpretation is available for any language and written translation is available in prevalent languages.
b. That auxiliary aids and services are available upon request and at no cost for beneficiaries with disabilities.
c. How to access services.

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

xiv. The Contractor shall provide, all written materials for potential beneficiaries and beneficiaries consistent with the following:

a. Use easily understood language and format.
b. Use a font size no smaller than 12 point.
c. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of beneficiaries or potential beneficiaries with disabilities or limited English proficiency.
d. Include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 point.

xv. Information for potential beneficiaries.

a. The Contractor shall provide the information specified in this section to each potential beneficiary, either in paper or in electronic format, at the time that the potential beneficiary is first required to enroll in the Contractor's program.
b. The information for potential beneficiaries shall include, at a minimum, all of the following:
    i. The basic features of managed care.
    ii. Which populations are subject to mandatory enrollment and the length of the enrollment period.
    iii. The service area covered by the Contractor.
    iv. Covered benefits including:
        1. Which benefits are provided by the Contractor.
        2. Which, if any, benefits are provided directly by the Department.
    v. For a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Department shall provide information about where and how to obtain the service.
    vi. The provider directory and formulary information.

vii. Any cost sharing that will be imposed by the Contractor consistent with those set forth in the State Plan.
viii. The requirements for each Contractor to provide adequate access to covered services, including the network adequacy standards established in 42 CFR §438.68.
ix. The Contractor's entities responsible for coordination of beneficiary care.
x. To the extent available, quality and performance indicators for the Contractor, including beneficiary satisfaction.

xvi. Information for all beneficiaries of the Contractor.

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

xvii. Beneficiary handbook.

a. The Contractor shall utilize, and require its subcontracted providers to utilize, the state developed model beneficiary handbook.
b. The Contractor shall provide each beneficiary a beneficiary handbook, within a reasonable time after receiving notice of the beneficiary's enrollment, which serves as the summary of benefits and coverage described in 45 CFR § 147.200(a).
c. The content of the beneficiary handbook shall include information that enables the beneficiary to understand how to effectively use the managed care program. This information shall include at a minimum:
    i. Benefits provided by the Contractor, including Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefits.
    ii. How and where to access any benefits, including EPSDT benefits, provided by the

state, including any cost sharing, and how transportation is provided.

1. In the case of a counseling or referral service that a subcontracted provider does not cover because of moral or religious objections, the Contractor shall inform the beneficiaries that the service is not covered.
2. The Contractor shall inform beneficiaries how they can access the services that are not covered by the subcontracted provider because of moral or religious objections.

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

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

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

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

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

viii. Cost sharing, if any, is imposed under the State Plan.

ix. Beneficiary rights and responsibilities, including:

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

x. Grievance, appeal, and fair hearing procedures and timeframes, consistent with Article II.G of this Agreement, in a state-developed or state-approved description (WIC 14029.91(e)(4)). Such information shall include:
    1. The right to file grievances and appeals.
    2. The requirements and timeframes for filing a grievance or appeal.
    3. The availability of assistance in the filing process.
    4. The right to request a state fair hearing after the Contractor has made a determination on a beneficiary's appeal, which is adverse to the beneficiary.
    5. The fact that, when requested by the beneficiary, benefits that the Contractor seeks to reduce or terminate will continue if the beneficiary files an appeal or a request for state fair hearing within the timeframes specified for filing, and that the beneficiary may, consistent with state policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the beneficiary.

xi. How to access auxiliary aids and services, including additional information in alternative formats or languages.

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

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

d. The beneficiary handbook will be considered to be provided if the Contractor:
    i. Mails a printed copy of the information to the beneficiary's mailing address.

ii. Provides the information by email after obtaining the beneficiary's agreement to receive the information by email.
iii. Posts the information on the Contractor's website and advises the beneficiary in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that beneficiaries with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.
iv. Provides the information by any other method that can reasonably be expected to result in the beneficiary receiving that information.

e. The Contractor shall give each beneficiary notice of any significant change in the information specified above, at least 30 days before the intended effective date of the change.

xviii. Provider Directory.

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

disabilities, including offices, exam room(s) and equipment.

b. The Contractor shall include the following provider types covered under this Agreement in the provider directory:
   i. Physicians, including specialists
   ii. Hospitals
   iii. Pharmacies
   iv. Behavioral health providers
c. Information included in a paper provider directory shall be updated at least monthly and electronic provider directories shall be updated no later than 30 calendar days after the Contractor receives updated provider information.
d. Provider directories shall be made available on the Contractor's website in a machine-readable file and format as specified by the Secretary of Health and Human Services.

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

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

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

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

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

iv. This section may not be construed to:

a. Require the Contractor to subcontract with providers beyond the number necessary to meet the needs of its beneficiaries.

b. Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.

c. Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to beneficiaries.

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

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

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

a. At a rate negotiated between the Contractor and the IHCP.

b. In the absence of a negotiated rate, at a rate not less than the level and amount of payment that Contractor would make for the services to a participating provider, which is not an IHCP.

c. Make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR 447.45 and 447.46.

iii. The Contractor shall permit Indian beneficiaries to obtain services covered under the contract between the State and

the Contractor from out-of-network IHCPs from whom the beneficiary is otherwise eligible to receive such services.

iv. In a state where timely access to covered services cannot be ensured due to few or no IHCPs, an MCO, PIHP, PAHP and PCCM entity will be considered to have demonstrated that there are sufficient IHCPs participating in the Contractor's provider network to ensure timely access to services if—

a. Indian beneficiaries are permitted by the Contractor to access out-of-state IHCPs.
b. The Contractor has a provider network, shall permit an out-of-network IHCP to refer an Indian beneficiary to a network provider.

v. Payment requirements.

a. When an IHCP is enrolled in Medicaid as a FQHC but not a participating provider of the Contractor, it shall be paid an amount equal to the amount the Contractor would pay a FQHC that is a network provider but is not an IHCP, including any supplemental payment from the Department to make up the difference between the amount the Contractor pays and what the IHCP FQHC would have received under FFS.
b. When an IHCP is not enrolled in Medicaid as a FQHC, regardless of whether it participates in the network of the Contractor or not, it has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of a published encounter rate, the amount it would receive if the services were provided under the State plan's FFS payment methodology.
c. When the amount an IHCP receives from the Contractor is less than the amount required by paragraph (v)(b) above, the Department shall make a supplemental payment to the IHCP to make up the difference between the amounts the Contractor entity pays and the amount the IHCP would have received under FFS or the applicable encounter rate.

C. State Responsibilities

1. **Conflict of Interest Safeguards (42 CFR §438.58).**
   - **i.** The Department shall have in effect safeguards against conflict of interest on the part of Department and local officers and employees and agents of the Department who have responsibilities relating to this Agreement. These safeguards shall be at least as effective as the safeguards specified in section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).
2. **Prohibition of Additional Payments (42 CFR §438.60).**
   - **i.** The Department shall ensure that no payment is made to a network provider other than by the Contractor for services covered under this Agreement, except when these payments are specifically required to be made by the Department in Title XIX of the Act, in 42 CFR chapter IV.
3. **Continued Services to Beneficiaries (42 CFR §438.62).**
   - **i.** The Department shall arrange for Medicaid services to be provided without delay to any Medicaid beneficiary of the Contractor if this Agreement is terminated.
   - **ii.** The Department shall have in effect a transition of care policy to ensure continued access to services during a transition from fee-for-service (FFS) to the Contractor or transition from one Contractor to another when a beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.
   - **iii.** The Contractor shall implement a transition of care policy consistent with the requirements of the Department's transition of care policy.
   - **iv.** The Department shall make its transition of care policy publicly available and provide instructions on how beneficiaries and potential beneficiaries access continued services upon transition. At a minimum, the Contractor shall provide the transition of care policy to beneficiaries and potential beneficiaries in the beneficiary handbook and notices.
4. **State Monitoring Requirements (42 CFR §438.66).**

i. The Department shall have in effect a monitoring system for the Contractor.

ii. The Department's monitoring system is outlined in Article III.DD of this Agreement.

iii. The Department shall use data collected from its monitoring activities to improve the performance of the Contractor. That data shall include, at minimum:

a. Beneficiary grievance and appeal logs
b. Provider complaint and appeal logs
c. Findings from the State's External Quality Review process
d. Results from any beneficiary or provider satisfaction survey conducted by the State or the Contractor
e. Performance on required quality measures
f. Medical management committee reports and minutes
g. The annual quality improvement plan for the Contractor
h. Customer service performance data submitted by the Contractor and performance data submitted by the beneficiary support system

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

i. Beginning on July 1, 2018, the Contractor shall comply with the Department's network adequacy standards.

ii. The Department's network adequacy standards are as follows:

a. Pursuant to WIC Section 14197(c)(4), the Contractor shall maintain a network of outpatient and intensive outpatient (non-OTP) providers that are located within the following applicable time and distance standards:

i. Up to 15 miles or 30 minutes from the beneficiary's place of residence for Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara counties.

ii. Up to 30 miles or 60 minutes from the beneficiary's place of residence for Marin, Placer, Riverside, San Joaquin, Santa Cruz,

Solano, Sonoma, Stanislaus, and Ventura counties.

iii. Up to 60 miles or 90 minutes from the beneficiary's place of residence for Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Imperial, Inyo, Kern, Kings, Lake, Lassen, Madera, Mariposa, Mendocino, Merced, Modoc, Monterey, Mono, Napa, Nevada, Plumas, San Benito, San Bernardino, San Luis Obispo, Santa Barbara, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, and Yuba counties.

b. Pursuant to WIC Section 14197(d)(3), the Contractor's shall ensure that all beneficiaries seeking non-OTP services be provided with an appointment within 10 business days of a non-OTP service request.

c. Pursuant to WIC Section 14197(c)(4), the Contractor shall maintain a network of OTP providers that are located within the following applicable time and distance standards:

i. Up to 15 miles or 30 minutes from the beneficiary's place of residence for Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara counties.

ii. Up to 30 miles or 60 minutes from the beneficiary's place of residence for Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura counties.

iii. Up to 45 miles or 75 minutes from the beneficiary's place of residence for Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba counties.

iv. Up to 60 miles or 90 minutes from the beneficiary's place of residence for Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa, Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne counties.

d. Pursuant to WIC Section 14197(d)(1)(A), the Contractor shall ensure that all beneficiaries seeking OTP services are provided with an appointment within three business days of an OTP service request.

e. If the Contractor cannot meet the time and distance standards set forth in this section, the Contractor shall submit a request for alternative access standards to the department.

f. Pursuant to WIC 14197(e), DHCS may grant requests for alternative access standards if the Contractor has exhausted all other reasonable options to obtain providers to meet the applicable standard or if DHCS determines that the Contractor has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.

i. The Contractor shall include a description of the reasons justifying the alternative access standards.

1. Requests for alternative access standards shall be approved or denied on a zip code and service type basis.
2. Requests for alternative access standards may include seasonal considerations (e.g. winter road conditions), when appropriate. Furthermore, the Contractor shall include an explanation about gaps in the county's geographic service area, including information about uninhabitable terrain within the county (e.g., desert, forestland), as appropriate. The use of clinically appropriate telecommunications technology may be

considered in determining compliance with the applicable standards established in the DHCS Information Notice 18-011 and/or for the purpose of approving an alternative access request.

g. DHCS will make a decision to approve or deny the request within 90 days of submission by the Contractor. DHCS may stop the 90-day timeframe, on one or more occasions as necessary, in the event of an incomplete submission or to obtain additional information from the Contractor. (WIC 14197(e)(3))
h. If the Contractor does not comply with the applicable standards at any time, DHCS may impose additional corrective actions, including fines, penalties, the withholding of payments, special requirements, probationary or corrective actions, or any other actions deemed necessary to ensure compliance.
i. Fines and penalties imposed by the Department shall be in the amounts specified below:
    i. First violation: $500, plus $25 per day for each day that the Contractor continues to be out of compliance.
    ii. Second and subsequent violation: $500, plus $25 per day for each day that the Contractor continues to be out of compliance.

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

D. Beneficiary Rights and Protections

1. Beneficiary Rights (42 CFR §438.100).

i. The Contractor shall have written policies guaranteeing the beneficiary's rights specified in this section.

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

iii. Specific rights.

a. The Contractor shall ensure that its beneficiaries have the right to:
    i. Receive information regarding the Contractor's PIHP and plan in accordance with 42 CFR §438.10.
    ii. Be treated with respect and with due consideration for his or her dignity and privacy.
    iii. Receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand. (The information requirements for services that are not covered under the Agreement because of moral or religious objections are set forth in 42 CFR §438.10(g)(2)(ii)(A) and (B).)
    iv. Participate in decisions regarding his or her health care, including the right to refuse treatment.
    v. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
    vi. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR § 164.524 and 164.526.
b. The Contractor shall ensure that its beneficiaries have the right to be furnished health care services in accordance with 42 CFR §§438.206 through 438.210.

iv. Free exercise of rights.

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

v. Compliance with other Federal and state laws.

a. The Contractor shall comply with any other applicable Federal and state laws, including, but not limited to:

i. Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80.

ii. The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91.

iii. The Rehabilitation Act of 1973.

iv. Title IX of the Education Amendments of 1972 (regarding education programs and activities).

v. Titles II and III of the Americans with Disabilities Act.

vi. Section 1557 of the Patient Protection and Affordable Care Act.

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

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

a. The beneficiary's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

b. Any information the beneficiary needs to decide among all relevant treatment options.

c. The risks, benefits, and consequences of treatment or non-treatment.

d. The beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatment.

e. To express preferences about future treatment decisions.

ii. Subject to the information requirements set forth below, if the Contractor would otherwise be required to provide, reimburse for, or provide coverage of, a counseling or referral service because of the requirement set forth above, the Contractor is not required to do so if it objects to the service on moral or religious grounds.

iii. Information requirements.

a. If the Contractor elects to not provide a counseling or referral service based on moral or religious grounds, then the Contractor shall furnish information about the services it does not cover as follows:
    i. To the Department:
        1. With its application for a Medicaid contract.
        2. Whenever the Contractor adopts the policy during the term of the contract.
    ii. Consistent with the provisions of 42 CFR §438.10, to beneficiaries, within 90 days after adopting the policy for any particular service.
    iii. The Contractor shall furnish the information to the beneficiary at least 30 days before the effective date of the policy for any particular service.

iv. The Contractor shall inform its beneficiaries how they can obtain information from the Department about how to access the service that it has excluded based on moral or religious grounds.

v. Information requirements: state responsibility.
    a. For each service excluded by the Contractor based on moral or religious grounds, the Department shall provide information on how and where to obtain the service, as specified in 42 CFR §438.10.

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

i. The Contractor shall ensure that its beneficiaries are not held liable for any of the following:
    a. The Contractor's debts, in the event of the entity's insolvency.
    b. Covered services provided to the beneficiary, for which:
        i. The state does not pay the Contractor.
        ii. The Contractor or the Department does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.

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

4. Cost Sharing (42 CFR §438.108).

i. Any cost sharing imposed on beneficiaries shall be in accordance with §§ 447.50 through 447.82 of Code of Federal Regulations Chapter 42.

E. Contractor Standards as a PIHP

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

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

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

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

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

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

d. Require out-of-network subcontractors and providers to coordinate with the Contractor for payment and ensures the cost to the beneficiary is no greater than

it would be if the services were furnished within the network.

e. Demonstrate that its network providers are credentialed as required by 42 CFR §438.214.

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

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

iv. Access and cultural considerations (WIC 14029.91).

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

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

a. The Contractor shall ensure that their health programs or activities provided through electronic and information technology are accessible to individuals with disabilities, unless doing so would result in undue financial and administrative burdens or a fundamental

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

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

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

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

ii. The Contractor shall submit documentation to the Department to demonstrate that it complies with the following requirements:

a. Offers an appropriate range of specialty services that are adequate for the anticipated number of beneficiaries for the service area.
b. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area.

iii. The Contractor shall submit network adequacy documentation to the SUD Program, Policy and Fiscal Division (PPFD) via email to ODSSubmissions@dhcs.ca.gov:

a. Upon entering into this Agreement with the Department.
b. On an annual basis, on or before April 1.
c. Within 10 business days of a significant change in the Contractor's operations that would affect the adequacy and capacity of services, including composition of the Contractor's provider network.
d. As requested by the Department.

iv. The Contractor's failure to submit network adequacy documentation in a timely manner shall subject the Contractor to fines, sanctions and penalties as described in Article II.C.5.g.

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

vi. Upon receipt of the Department's determination that the Contractor does not meet the applicable time and distance standards, or a DHCS approved alternate access standard, the Contractor shall submit a Corrective Action Plan (CAP) for approval to DHCS that describes action steps that the Contractor will immediately implement to ensure compliance

with applicable network adequacy standards within the Department's approved timeframe.

vii. The Contractor shall submit updated network adequacy documentation as requested by the Department.

viii. If the Department determines that the Contractor does not comply with the applicable standards at any time, the Department may require a CAP, impose fines, or penalties, withhold payments, or any other actions deemed necessary by the Department to ensure compliance with network adequacy standards (WIC 14712(e)).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

i. The Contractor shall furnish medically necessary services covered by this Agreement in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in 42 CFR §440.230, and for beneficiaries under the age of 21, as set forth in 42 CFR §440, subpart B.

ii. The Contractor:

a. Shall ensure that the medically necessary services provided are sufficient in amount, duration, or scope

to reasonably achieve the purpose for which the services are furnished.

b. Shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of diagnosis, type of illness, or condition of the beneficiary.

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

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

a. The services furnished can reasonably achieve their purpose.

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

v. Authorization of services.

a. The Contractor and its subcontractors shall have in place, and follow, written authorization policies and procedures.

b. The Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

c. The Contractor shall consult with the requesting provider for medical services when appropriate.

d. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by an individual who has appropriate expertise in addressing the beneficiary's medical and behavioral health.

e. Notice of adverse benefit determination.

i. The Contractor shall notify the requesting provider, and give the beneficiary written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is

less than requested. The beneficiary's notice shall meet the requirements of 42 CFR §438.404.

vi. Standard authorization decisions.

a. For standard authorization decisions, the Contractor shall provide notice as expeditiously as the beneficiary's condition requires, not to exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days when:

i. The beneficiary, or the provider, requests extension.

ii. The Contractor justifies (to the Department, upon request) a need for additional information and how the extension is in the beneficiary's interest.

vii. Expedited authorization decisions.

a. For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires, and no later than 72 hours after receipt of the request for service.

b. The Contractor may extend the 72-hour time period by up to 14 calendar days if the beneficiary requests an extension, or if the Contractor justifies (to the Department, upon request) a need for additional information and how the extension is in the beneficiary's interest.

viii. Compensation for utilization management activities.

a. Consistent with 42 CFR §438.3(i) and 42 CFR §422.208, compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for the

individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

5. **Provider Selection (42 CFR §438.214).**
   - **i.** The Contractor shall implement written policies and procedures for selection and retention of network providers and -the implemented policies and procedures, at a minimum, meet the following requirements:
     a. Credentialing and re-credentialing requirements.
        i. The Contractor shall follow the state's established uniform credentialing and re-credentialing policy that addresses behavioral and substance use disorders, outlined in DHCS Information Notice 18-019.
        ii. The Contractor shall follow a documented process for credentialing and re-credentialing of network providers.
     b. Nondiscrimination.
        i. The Contractor's network provider selection policies and procedures, consistent with 42 CFR §438.12, shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
     c. Excluded providers.
        i. The Contractor shall not employ or subcontract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.
     d. Additional Department requirements.
        i. The Contractor shall comply with any additional requirements established by the Department.
6. **Confidentiality (42 CFR §438.224).**
   - **i.** For medical records and any other health and enrollment information that identifies a particular beneficiary, the Contractor shall use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and

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

7. **Grievance and Appeal Systems (42 CFR §438.228).**
   - **i.** The Contractor shall have in effect, a grievance and appeal system that meets the requirements outlined in Article II.G of this Agreement.
   - **ii.** The Contractor shall be responsible for issuing any Notice of Adverse Benefit Determination (NOABD) under 42 CFR Part 431, subpart E. The Department shall conduct random reviews of the Contractor and its providers and subcontractors to ensure that they are notifying beneficiaries in a timely manner.
8. **Subcontractual Relationships and Delegation (42 CFR §438.230).**
   - **i.** The requirements of this section apply to any contract or written arrangement that the Contractor has with any subcontractor.
   - **ii.** Notwithstanding any relationship(s) that Contractor may have with any subcontractor, the Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Agreement.
   - **iii.** All contracts or written arrangements between the Contractor and any subcontractor shall specify the following:
     a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.
     b. The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the Contractor's contract obligations.
     c. The contract or written arrangement shall either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the Department or the Contractor determine that the subcontractor has not performed satisfactorily.
     d. The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including

applicable sub-regulatory guidance and contract provisions.

e. The subcontractor agrees that—
   i. The Department, CMS, the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's Contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under this Agreement at any time.
   ii. The subcontractor will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid beneficiaries.
   iii. The Department, CMS, the HHS Inspector General, the Comptroller General, or their designees' right to audit the subcontractor will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
   iv. If the Department, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the Department, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

9. Practice Guidelines (42 CFR §438.236).

i. The Contractor shall adopt practice guidelines that meet the following requirements:
   a. Are based on valid and reliable clinical evidence or a consensus of providers in the particular field.
   b. Consider the needs of the Contractor's beneficiaries.

c. Are adopted in consultation with contracting health care professionals.
d. Are reviewed and updated periodically as appropriate.

ii. The Contractor shall disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.

iii. The Contractor shall ensure that all decisions for utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

10. Health Information Systems (42 CFR §438.242).

i. The Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this part. The systems shall provide information on areas including, but not limited to, utilization, claims, and grievances and appeals.

ii. The Contractor shall comply with Section 6504(a) of the Affordable Care Act.

iii. The Contractor shall collect data on beneficiary and provider characteristics as specified by the Department, and on all services furnished to beneficiaries through an encounter data system or other methods as may be specified by the Department.

iv. The Contractor shall ensure that data received from providers is accurate and complete by—

a. Verifying the accuracy and timeliness of reported data, including data from network providers the Contractor is compensating.
b. Screening the data for completeness, logic, and consistency.
c. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for Department Medicaid quality improvement and care coordination efforts.

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

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

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

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

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

F. Quality Measurement and Improvement External Quality Review

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

i. The Contractor shall establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its beneficiaries.

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

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

a. Performance improvement projects.
b. Collection and submission of performance measurement.
c. Mechanisms to detect both underutilization and overutilization of services.

d. Mechanisms to assess the quality and appropriateness of care furnished to beneficiaries with special health care needs, as defined by the Department in the quality strategy under 42 CFR §438.340.

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

v. Annually, the Contractor shall:

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

vi. Performance improvement projects.

a. The Contractor shall conduct performance improvement projects, including any performance improvement projects required by CMS that focus on both clinical and nonclinical areas.
b. Each performance improvement project shall be designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction, and shall include the following elements:
    i. Measurement of performance using required quality indicators.
    ii. Implementation of interventions to achieve improvement in the access to and quality of care.
    iii. Evaluation of the effectiveness of the interventions based on the performance measures.

iv. Planning and initiation of activities for increasing or sustaining improvement.

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

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

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

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

a. Accreditation status, survey type, and level (as applicable).

b. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings.

c. Expiration date of the accreditation.

iii. The Department shall:

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

b. Update this information at least annually.

G. Grievance and Appeal System

1. General Requirements (42 CFR §438.402).

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

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

iii. Filing requirements:

a. Authority to file.

i. A beneficiary may file a grievance and request an appeal with the Contractor. A beneficiary may request a state fair hearing after receiving notice under 42 CFR §438.408 that the adverse benefit determination is upheld.
    1. In the case that the Contractor fails to adhere to the notice and timing requirements in 42 CFR §438.408, the beneficiary is deemed to have exhausted the Contractor's appeals process. The beneficiary may initiate a state fair hearing.
    2. The Department may offer and arrange for an external medical review if the following conditions are met.
        a. The review shall be at the beneficiary's option and shall not be required before, or used as a deterrent to, proceeding to the state fair hearing.
        b. The review shall be independent of both the Department and the Contractor.
        c. The review shall be offered without any cost to the beneficiary.
        d. The review shall not extend any of the timeframes specified in 42 CFR §438.408 and shall not disrupt the continuation of benefits in 42 CFR §438.420.

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

b. Timing:
   i. Grievance:
      1. The beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, may file a grievance with the Contractor at any time.
   ii. Appeal:
      1. The Contractor shall allow the beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, to file a request for an appeal to the Contractor within 60 calendar days from the date on the adverse benefit determination notice.
c. Procedures:
   i. Grievance:
      1. The beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, may file a grievance either orally or in writing and, as determined by the Department, either with the Department or with the Contractor.
   ii. Appeal:
      1. The beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, may request an appeal either orally or in writing. Further, unless an expedited resolution is requested, an oral appeal shall be followed by a written, signed appeal.

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

i. Notice.

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

ii. Content of notice.

a. The notice shall explain the following:

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

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

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

iv. The procedures for exercising these appeal rights.

v. The circumstances under which an appeal process can be expedited and how to request it.

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

iii. Timing of notice.

a. The Contractor shall mail the notice within the following timeframes:
    i. At least 10 days before the date of the adverse benefit determination, when the adverse benefit determination is a termination, suspension, or reduction of previously authorized Medicaid-covered services.
    ii. For denial of payment, at the time of any adverse benefit determination affecting the claim.
    iii. As expeditiously, as the beneficiary's condition requires within state-established timeframes that shall not exceed 14 calendar days following receipt of the request for service, for standard authorization decisions that deny or limit services.
        1. The Contractor shall be allowed to extend the 14 calendar day NOABD timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the beneficiary or the provider requests an extension.
        2. The Contractor shall be allowed to extend the 14 calendar day NOABD timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the Contractor justifies a need (to the Department, upon request) for additional information and shows how the extension is in the beneficiary's best interest. Consistent with 42 CFR §438.210(d)(1)(ii), the Contractor shall:
            a. Give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the

right to file a grievance if he or she disagrees with that decision.

b. Issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

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

v. For expedited service authorization decisions, within the timeframes specified in 42 CFR §438.210(d)(2).

b. The Contractor shall be allowed to mail the NOABD as few as five days prior to the date of action if the Contractor has facts indicating that action should be taken because of probable fraud by the beneficiary, and the facts have been verified, if possible, through secondary sources.

c. The Contractor shall mail the NOABD by the date of the action when any of the following occur:

i. The recipient has died.

ii. The beneficiary submits a signed written statement requesting service termination.

iii. The beneficiary submits a signed written statement including information that requires service termination or reduction and indicates that he understands that service termination or reduction will result.

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

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

vi. The beneficiary is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
vii. A change in the level of medical care is prescribed by the beneficiary's physician.
viii. The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act.
ix. The transfer or discharge from a facility will occur in an expedited fashion.

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

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

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

a. Acknowledge receipt of each grievance and appeal within five calendar days.
b. Ensure that the individuals who make decisions on grievances and appeals are individuals—
    i. Who, were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.
    ii. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the Department, in treating the beneficiary's condition or disease.
        1. An appeal of a denial that is based on lack of medical necessity.
        2. A grievance regarding denial of expedited resolution of an appeal.
        3. A grievance or appeal that involves clinical issues.

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

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

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

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

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

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

i. The Contractor shall resolve each grievance and appeal, and provide notice, as expeditiously as the beneficiary's health condition requires, within the following timeframes:

a. Standard resolution of grievances: 90 calendar days from the day the Contractor receives the grievance.
b. Standard resolution of appeals: 30 calendar days from the day the Contractor receives the appeal. This timeframe may be extended in the manner described below.
c. Expedited resolution of appeals: 72 hours after the Contractor receives the appeal. This timeframe may be extended under in the manner described below.

ii. Extension of timeframes.

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

iii. If the Contractor extends the timeframes not at the request of the beneficiary, it shall complete all of the following:

a. Make reasonable efforts to give the beneficiary prompt oral notice of the delay.
b. Within two calendar days, give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he or she disagrees with that decision.
c. Resolve the appeal as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

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

v. Format of notice:

a. Grievances.

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

b. Appeals.

i. For all appeals, the Contractor shall provide written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR §438.10.

ii. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice.

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

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

b. For appeals not resolved wholly in favor of the beneficiaries—

i. The right to request a state fair hearing.

ii. How to make the request a state fair hearing.

iii. The right to request and receive benefits, while the hearing is pending and how to make the request.

iv. That the beneficiary may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the Contractor's adverse benefit determination.

vii. Requirements for state fair hearings—

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

b. If the Contractor fails to adhere to the notice and timing requirements in 42 CFR §438.408, then the beneficiary is deemed to have exhausted the Contractor's appeals process. The beneficiary may initiate a state fair hearing.

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

5. Expedited Resolution of Appeals (42 CFR §438.410).

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

ii. The Contractor shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's appeal.

iii. If the Contractor denies a request for expedited resolution of an appeal, it shall:

a. Transfer the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2).
b. Follow the requirements in 42 CFR §438.408(c)(2).

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

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

7. Recordkeeping Requirements (42 CFR §438.416).

i. The Contractor shall maintain records of grievances and appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the Department quality strategy.

ii. The record of each grievance or appeal shall contain, at a minimum, all of the following information:

a. A general description of the reason for the appeal or grievance.
b. The date received.
c. The date of each review or, if applicable, review meeting.
d. Resolution at each level of the appeal or grievance, if applicable.
e. Date of resolution at each level, if applicable.
f. Name of the covered person for whom the appeal or grievance was filed.

iii. The record shall be accurately maintained in a manner accessible to the Department and available upon request to CMS.

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

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

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

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

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

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

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

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

9. Effectuation of Reversed Appeal Resolutions (42 CFR §438.424).

i. The Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's

health condition requires (but no later than 72 hours from the date it receives notice reversing the determination) if the services were not furnished while the appeal was pending and if the Contractor or state fair hearing officer reverses a decision to deny, limit, or delay services.

ii. The Contractor shall pay for disputed services received by the beneficiary while the appeal was pending, unless state policy and regulations provide for the state to cover the cost of such services, when the Contractor or state fair hearing officer reverses a decision to deny authorization of the services.

H. Additional Program Integrity Safeguards

1. Basic Rule (42 CFR §438.600).

i. As a condition for receiving payment under a Medicaid managed care program, the Contractor shall comply with the requirements in 42 CFR §§438.604, 438.606, 438.608 and 438.610, as applicable and as outlined below.

2. State Responsibilities (42 CFR §438.602).

i. Monitoring Contractor compliance.

a. Consistent with 42 CFR §438.66, the Department shall monitor the Contractor's compliance, as applicable, with 42 CFR §§438.604, 438.606, 438.608, 438.610, 438.230, 438.808, 438.900 et seq.

ii. Screening, enrollment, and revalidation of providers.

a. The Department shall screen and enroll, and revalidate every five years, all of the Contactor's network providers, in accordance with the requirements of 42 CFR, Part 455, Subparts B and E. This provision does not require the network provider to render services to FFS beneficiaries.

iii. Ownership and control information.

a. The Department shall review the ownership and control disclosures submitted by the Contractor, and any subcontractors as required in 42 CFR §438.608(c).

iv. Federal database checks.

a. Consistent with the requirements in 42 CFR §455.436, the Department shall confirm the identity

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

v. Periodic audits.

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

vi. Whistleblowers.

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

vii. Transparency.

a. The Department shall post on its website, as required in 42 CFR §438.10(c)(3), the following documents and reports:
    i. This Agreement.
    ii. The data at 42 CFR §438.604(a)(5).
    iii. The name and title of individuals included in 42 CFR §438.604(a)(6).

iv. The results of any audits performed pursuant Article II, Section H, Paragraph (v) of this Agreement.

viii. Contracting integrity.

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

ix. Entities located outside of the U.S.

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

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

i. The Contractor shall submit to the Department the following data:

a. Encounter data in the form and manner described in 42 CFR §438.818.

b. Documentation described in 42 CFR §438.207(b) on which the Department bases its certification that the Contractor has complied with the Department's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR §438.206.

c. Information on ownership and control described in 42 CFR §455.104 from the Contractor's subcontractors as governed by 42 CFR §438.230.

d. The annual report of overpayment recoveries as required in 42 CFR §438.608(d)(3).

ii. In addition to the data, documentation, or information above, the Contractor shall submit any other data, documentation, or information relating to the performance of the Contractor's

program integrity safeguard obligations required by the Department or the Secretary.

4. **Source, Content, and Timing of Certification (42 CFR §438.606).**
   - **i.** The data, documentation, or information specified in 42 CFR §438.604, shall be certified by either the Contractor's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.
   - **ii.** The certification shall attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR §438.604 is accurate, complete, and truthful.
   - **iii.** The Contractor shall submit the certification concurrently with the submission of the data, documentation, or information required in 42 CFR §438.604(a) and (b).
5. **Program Integrity Requirements (42 CFR §438.608).**
   - **i.** The Contractor, and its subcontractors to the extent that the subcontractors are delegated responsibility by the Contractor for coverage of services and payment of claims under this Agreement, shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse.
   - **ii.** The arrangements or procedures shall include the following:
     - a. A compliance program that includes, at a minimum, all of the following elements:
       - i. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements.
       - ii. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to

ensure compliance with the requirements of this Agreement and who reports directly to the Behavioral Health Director and the Board of Supervisors.

iii. The establishment of a Regulatory Compliance Committee on the Board of Supervisors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under this Contract.

iv. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and state standards and requirements under this Contract.

v. Effective lines of communication between the compliance officer and the organization's employees.

vi. Enforcement of standards through well-publicized disciplinary guidelines.

vii. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement.

b. Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the Department.

c. Provision for prompt notification to the Department when it receives information about changes in a

beneficiary's circumstances that may affect the beneficiary's eligibility including all of the following:

i. Changes in the beneficiary's residence.
ii. The death of a beneficiary.

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

iii. The Contractor shall ensure that all network providers are enrolled with the Department as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 CFR part 455, subparts B and

E. This provision does not require the network provider to render services to FFS beneficiaries.

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

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

a. The Contractor shall specify in accordance with this Exhibit A, Attachment I and Exhibit B of this Agreement:

i. The retention policies for the treatment of recoveries of all overpayments from the Contractor to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.

ii. The process, timeframes, and documentation required for reporting the recovery of all overpayments.

iii. The process, timeframes, and documentation required for payment of recoveries of overpayments to the state in situations where the Contractor is not permitted to retain some or all of the recoveries of overpayments.

iv. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

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

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

6. Prohibited Affiliations (42 CFR §438.610).

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

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

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

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

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

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

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

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

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

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

a. Shall notify the Secretary of the noncompliance.

b. May continue an existing agreement with the Contractor unless the Secretary directs otherwise.

c. May not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary provides to the state and to Congress a

written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.

d. Nothing in this section shall be construed to limit or otherwise affect any remedies available to the U.S. under sections 1128, 1128A or 1128B of the Act.

v. The Contractor shall provide the Department with written disclosure of any prohibited affiliation under this section by the Contractor or any of its subcontractors.

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

i. The Contractor and its subcontractors shall provide the following disclosures through the DMC certification process described in Article III.J:

a. The name and address of any person (individual or corporation) with an ownership or control interest in the Contractor. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

b. Date of birth and Social Security Number (in the case of an individual).

c. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a five percent or more interest.

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

with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

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

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

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

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

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

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

a. Has an ownership interest totaling five percent or more in a disclosing entity.
b. Has an indirect ownership interest equal to five percent or more in a disclosing entity.
c. Has a combination of direct and indirect ownership interests equal to five percent or more in a disclosing entity.
d. Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of the disclosing entity.

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

I. Conditions for Federal Financial Participation (FFP)

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

a. The amount the Department pays for the furnishing of medical services to eligible beneficiaries is a medical assistance cost.
b. The amount the Department pays for the Contractor's performance of other functions is an administrative cost.

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

1. General Parity Requirement

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

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

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

2. Quantitative Limitations

i. The Contractor shall not apply any cumulative financial requirement for substance use disorder services in a

classification that accumulates separately from any established for medical/surgical services in the same classification. (42 CFR 438.910(c)(3))

3. Non-Quantitative Limitations

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

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

III. Program Specifications

A. Provision of Services

1. Provider Specifications

i. The following requirements shall apply to the Contractor, the provider, and the provider staff:

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

i. Physician

ii. Nurse Practitioners

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

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

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

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

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

vi. Registered and certified SUD counselors shall adhere to all requirements in Title 9, Chapter 8.

2. Services for Adolescents and Youth

i. Assessment and services for adolescents will follow the ASAM adolescent treatment criteria.

B. Organized Delivery System (ODS) Timely Coverage

1. Non-Discrimination - Member Discrimination Prohibition

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

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

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

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

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

a. The individual shall have received a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders or be assessed to be at risk for developing substance use disorder (for youth under 21).
b. The individual shall meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.
c. For beneficiaries in treatment prior to implementation of the DMC-ODS, the provider must conduct an ASAM assessment by the due date of the next

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

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

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

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

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

C. Covered Services

Exhibit A, Attachment I A2
Program Specifications

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

a. Room and board shall not be a covered expenditure under the DMC-ODS. Room and board may be paid with funding sources unrelated to DMC-ODS.

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

5. Contractor shall comply with federal and state mandates to provide SUD treatment services deemed medically necessary for Medi-Cal eligible: (1) pregnant and postpartum women, and (2) adolescents under age 21 who are eligible under the EPSDT Program.

D. Financing

1. Payment for Services

i. For claiming Federal Financial Participation (FFP), the Contractor shall certify the total allowable expenditures incurred in providing the DMC-ODS services provided either through Contractor operated providers, contracted fee-for-service providers or contracted managed care plans.

ii. DHCS shall establish a Center for Medicare and Medicaid Services (CMS) approved Certified Public Expenditure (CPE) protocol before FFP associated with DMC-ODS services, is made available to DHCS. This DHCS approved CPE protocol (Attachment AA of the STCs) shall explain the process DHCS shall use to determine costs incurred by the counties under this demonstration.

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

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

a. The recipient's OHC coverage has been exhausted, or

b. The specific service is not a benefit of the OHC.

v. If the Contractor submits a claim to an OHC and receives partial payment of the claim, the Contractor may submit the claim to DMC and is eligible to receive payment up to the maximum DMC rate for the service, less the amount of the payment made by the OHC.

2. Rate Setting

i. The Contractor shall propose county-specific fee-for-service (FFS) provider rates for all modalities except the OTP/NTP modality. DHCS shall approve or deny those proposed rates to determine if the rates are sufficient to ensure access to available DMC-ODS services.

a. If DHCS denies the Contractor's proposed rates, the Contractor shall have an opportunity to adjust the rates and resubmit them to DHCS to determine if the adjusted rates are sufficient to ensure access to available DMC-ODS services. The Contractor shall receive DHCS approval of its rates prior to providing any covered DMC-ODS program services.

ii. The DHCS Rate Setting Work Group pursuant to the process set forth in WIC 14021.51 shall set the OTP/NTP reimbursement rate. The Contractor shall reimburse all OTP/NTP providers at this rate.

a. The Contractor shall ensure that all of its contracted OTP/NTP providers provide it with financial data on an annual basis. The Contractor shall collect and submit this data to the DHCS Rates Setting Work Group upon its request for the purpose of setting the OTP/NTP rates after the expiration of the DMC-ODS.

i. The DHCS Rates Setting Workgroup shall propose a recommended format for this annual financial data and DHCS shall approve a final format.

iii. Pursuant to WIC 14124.24(h), the Contractor shall not require OTP/NTP providers to submit cost reports to the Contractor for the purpose of cost settlement.

E. Availability of Services

1. In addition to the availability of services requirements set forth in Article II.E.1 of this Agreement, the Contractor shall:
   - **i.** Consider the number and types (in terms of training, experience, and specialization) of providers required to ensure the availability and accessibility of medically necessary services.
   - **ii.** Maintain and monitor a network of appropriate providers that is supported by written agreements for subcontractors, and that is sufficient to provide its beneficiaries with adequate access to all services covered under this Agreement.
   - **iii.** In establishing and monitoring the network, document the following:
     a. The anticipated number of Medi-Cal eligible beneficiaries.
     b. The expected utilization of services, taking into account the characteristics and SUD treatment needs of beneficiaries.
     c. The expected number and types of providers in terms of training and experience needed to meet expected utilization.
     d. The number of network providers who are not accepting new beneficiaries.
     e. The geographic location of providers and their accessibility to beneficiaries, considering distance, travel time, means of transportation ordinarily used by Medi-Cal beneficiaries, and physical access for disabled beneficiaries.

F. Access to Services

1. Subject to DHCS provider enrollment certification requirements, the Contractor shall maintain continuous availability and accessibility of covered services and facilities, service sites, and personnel to provide the covered services through use of DMC certified providers. Such services shall not be limited due to budgetary constraints.
2. When a beneficiary makes a request for covered services, the Contractor shall require services to be initiated with reasonable promptness. Contractor shall have a documented system for monitoring and evaluating the quality, appropriateness, and

accessibility of care, including a system for addressing problems that develop regarding waiting times and appointments.

3. In addition to the coverage and authorization of service requirements set forth in Article II.E.4 of this Agreement, the Contractor shall:

- **i.** Authorize DMC-ODS services in accordance with the medical necessity requirements specified in Title 22, Section 51303 and the coverage provisions of the approved State Medi-Cal Plan.
- **ii.** If services are denied, inform the beneficiary in accordance with Article II.G.2 of this Agreement.
- **iii.** Provide prior authorization for residential services within 24 hours of the prior authorization request being submitted by the provider.
  - a. Prior authorization is prohibited for non-residential DMC-ODS services.
  - b. The Contractor's prior authorization process shall comply with the parity requirements set forth in 42 CFR §438.910(d).
- **iv.** Review the DSM and ASAM Criteria documentation to ensure that the beneficiary meets the requirements for the service.
- **v.** Have written policies and procedures for processing requests for initial and continuing authorization of services.
- **vi.** Have a mechanism in place to ensure that there is consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate.
- **vii.** Track the number, percentage of denied, and timeliness of requests for authorization for all DMC-ODS services that are submitted, processed, approved, and denied.
- **viii.** Pursuant to 42 CFR 438.3(l), allow each beneficiary to choose his or her health professional to the extent possible and appropriate.
- **ix.** Require that treatment programs are accessible to people with disabilities in accordance with Title 45, Code of Federal Regulations (hereinafter referred to as CFR), Part 84 and the Americans with Disabilities Act.

x. Have a 24/7 toll free number for prospective beneficiaries to call to access DMC-ODS services and make oral interpretation services available for beneficiaries, as needed.

4. Covered services, whether provided directly by the Contractor or through subcontractor with DMC certified and enrolled programs, shall be provided to beneficiaries in the following manner:

i. DMC-ODS services approved through the Special Terms and Conditions shall be available to all beneficiaries that reside in the ODS County and enrolled in the ODS Plan.

ii. Access to State Plan services shall remain at the current, pre-implementation level or expand upon implementation.

G. Coordination of Care

1. In addition to meeting the coordination and continuity of care requirements set forth in Article II.E.3, the Contractor shall develop a care coordination plan that provides for seamless transitions of care for beneficiaries with the DMC-ODS system of care. Contractor is responsible for developing a structured approach to care coordination to ensure that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient) without disruptions to services.

2. In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, the Contractor shall ensure that beneficiaries have access to recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.

3. Contractor shall enter into a Memorandum Of Understanding (MOU) with any Medi-Cal managed care plan that enrolls beneficiaries served by the DMC-ODS. This requirement may be met through an amendment to the Specialty Mental Health Managed Care Plan MOU.

i. The following elements in the MOU should be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers:

a. Comprehensive substance use, physical, and mental health screening.

b. Beneficiary engagement and participation in an integrated care program as needed.
c. Shared development of care plans by the beneficiary, caregivers, and all providers.
d. Collaborative treatment planning with managed care.
e. Delineation of case management responsibilities.
f. A process for resolving disputes between the Contractor and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved.
g. Availability of clinical consultation, including consultation on medications.
h. Care coordination and effective communication among providers including procedures for exchanges of medical information.
i. Navigation support for patients and caregivers.
j. Facilitation and tracking of referrals between systems including bidirectional referral protocol.

H. Authorization of Services – Residential Programs

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

i. Establish, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services for residential programs.

ii. Ensure that residential services are provided in DHCS or Department of Social Services (DSS) licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.

iii. Ensure that residential services may be provided in facilities with no bed capacity limit.

iv. Ensure that the length of residential services comply with the following time restrictions:

a. Adults, ages 21 and over, may receive up to two non-continuous short-term residential regimens per 365-day period. A short-term residential regimen is

defined as one residential stay in a DHCS licensed facility for a maximum of 90 days per 365-day period.

i. An adult beneficiary may receive one 30-day extension, if that extension is medically necessary, per 365-day period.

b. Adolescents, under the age of 21, may receive up to two 30-day non-continuous regimens per 365-day period. Adolescent beneficiaries receiving residential treatment shall be stabilized as soon as possible and moved down to a less intensive level of treatment.

i. Adolescent beneficiaries may receive a 30-day extension if that extension is determined to be medically necessary. Adolescent beneficiaries are limited to one extension per 365-day period.

c. Nothing in the DMC-ODS overrides any EPSDT requirements. EPSDT beneficiaries may receive a longer length of stay based on medical necessity.

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

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

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

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

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

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

I. Provider Selection and Certification

1. In addition to complying with the provider selection requirements set forth in Article II.E.5 and the provider discrimination prohibitions in Article II.B.3, the Contractor:
   - **i.** Shall have written policies and procedures for selection and retention of providers that are in compliance with the terms and conditions of this Agreement and applicable federal laws and regulations.
   - **ii.** Shall apply those policies and procedures equally to all providers regardless of public, private, for-profit or non-profit status, and without regard to whether a provider treats persons who require high-risk or specialized services.
   - **iii.** Shall not discriminate against persons who require high-risk or specialized services.
   - **iv.** Shall subcontract with providers in another state where out-of-state care or treatment is rendered on an emergency basis or is otherwise in the best interests of the person under the circumstances.
   - **v.** Shall select only providers that have a license and/or certification issued by the state that is in good standing.
   - **vi.** Shall select only providers that, prior to the furnishing of services under this Agreement, have enrolled with, or revalidated their current enrollment with, DHCS as a DMC provider under applicable federal and state regulations.
   - **vii.** Shall select only providers that have been screened in accordance with 42 CFR 455.450(c) as a "high" categorical risk prior to furnishing services under this Agreement, have signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107, and have complied with the ownership and control disclosure requirements of 42 CFR 455.104. DHCS shall deny enrollment and DMC certification to any provider (as defined in Welfare & Institutions Code section 14043.1), or a person with ownership or control interest in the provider (as defined in 42 CFR 455.101), that, at the time of application, is under investigation for fraud or

abuse pursuant to Part 455 of Title 42 of the Code of Federal Regulations, unless DHCS determines that there is good cause not to deny enrollment upon the same bases enumerated in 42 CFR 455.23(e). If a provider is under investigation for fraud or abuse, that provider shall be subject to temporary suspension pursuant to Welfare & Institutions Code section 14043.36. Upon receipt of a credible allegation of fraud, a provider shall be subject to a payment suspension pursuant to Welfare & Institutions Code section 14107.11 and DHCS may thereafter collect any overpayment identified through an audit or examination. During the time a provider is subject to a temporary suspension pursuant to Welfare & Institutions Code section 14043.36, the provider, or a person with ownership or control interest in the provider (as defined in 42 CFR 455.101), may not receive reimbursement for services provided to a DMC-ODS beneficiary. A provider shall be subject to suspension pursuant to WIC 14043.61 if claims for payment are submitted for services provided to a Medi-Cal beneficiary by an individual or entity that is ineligible to participate in the Medi-Cal program. A provider will be subject to termination of provisional provider status pursuant to WIC 14043.27 if the provider has a debt due and owing to any government entity that relates to any federal or state health care program, and has not been excused by legal process from fulfilling the obligation. Only providers newly enrolling or revalidating their current enrollment on or after January 1, 2015 would be required to undergo fingerprint- based background checks required under 42 CFR 455.434.

2. **Disclosures that shall be provided.**
   - **i.** A disclosure from any provider or disclosing entity is due at any of the following times:
     - a. Upon the provider or disclosing entity submitting the provider application.
     - b. Upon the provider or disclosing entity executing the provider agreement.
     - c. Upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414.

d. Within 35 days after any change in ownership of the disclosing entity.

ii. All disclosures shall be provided to the Medicaid agency.

iii. Consequences for failure to provide required disclosures.

a. Federal Financial Participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.

3. The Contractor shall only select providers that have a Medical Director who, prior to the delivery of services under this Agreement, has enrolled with DHCS under applicable state regulations, has been screened in accordance with 42 CFR 455.450(a) as a “limited” categorical risk within a year prior to serving as a Medical Director under this Agreement, and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107.

4. The Contractor may contract individually with LPHAs to provide DMC-ODS services in the network.

5. The Contractor shall have a protest procedure for providers that are not awarded a subcontract. The Contractor’s protest procedure shall ensure that:

i. Providers that submit a bid to be a subcontracted provider, but are not selected, shall exhaust the Contractor’s protest procedure if a provider wishes to challenge the denial to DHCS.

ii. If the Contractor does not render a decision within 30 calendar days after the protest was filed with the Contractor, then the protest shall be deemed denied and the provider may appeal the failure to DHCS.

J. DMC Certification and Enrollment

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

2. The DHCS shall certify any Contractor-operated or non-governmental providers. This certification shall be performed prior to the date on which the Contractor begins to deliver services under this Agreement at these sites.

3. Contractor shall require that providers of perinatal DMC services are properly certified to provide these services and comply with

the applicable requirements contained in Article III.PP of this Exhibit A, Attachment I.

4. Contractor shall require all the subcontracted providers of services to be licensed, registered, DMC certified and/or approved in accordance with applicable laws and regulations. Contractor's subcontracts shall require that providers comply with the following regulations and guidelines:
   - **i.** Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8
   - **ii.** Title 22, Sections 51490.1(a)
   - **iii.** Exhibit A, Attachment I, Article III.PP – Requirements for Services
   - **iv.** Title 9, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq
   - **v.** Title 22, Division 3, Chapter 3, sections 51000 et. seq

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

6. The Contractor shall notify Provider Enrollment Division (PED) of an addition or change of information in a providers pending DMC certification application within 35 days of receiving notification from the provider. The Contractor shall ensure that a new DMC certification application is submitted to PED reflecting the change.

7. The Contractor shall be responsible for ensuring that any reduction of covered services or relocations by providers are not implemented until the approval is issued by DHCS. Within 35 days of receiving notification of a provider's intent to reduce covered services or relocate, the Contractor shall submit, or require the provider to submit, a DMC certification application to PED. The DMC certification application shall be submitted to PED 60 days prior to the desired effective date of the reduction of covered services or relocation.

8. The Contractor shall notify DHCS PED by e-mail at DHCSDMCRecert@dhcs.ca.gov within two business days of learning that a subcontractor's license, registration, certification, or approval to operate an SUD program or provide a covered service is revoked, suspended, modified, or not renewed by entities other than DHCS.
   - **i.** A provider's certification to participate in the DMC program shall automatically terminate in the event that the provider,

or its owners, officers or directors are convicted of Medi-Cal fraud, abuse, or malfeasance. For purposes of this section, a conviction shall include a plea of guilty or nolo contendere.

K. Continued Certification

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

L. Laboratory Testing Requirements

1. This part sets forth the conditions that all laboratories shall meet to be certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Except as specified in paragraph (2) of this section, a laboratory will be cited as out of compliance with section 353 of the Public Health Service Act unless it:
   - **i.** Has a current, unrevoked or unsuspended certificate of waiver, registration certificate, certificate of compliance, certificate for PPM procedures, or certificate of accreditation issued by HHS applicable to the category of examinations or procedures performed by the laboratory.
   - **ii.** Is CLIA-exempt.
2. These rules do not apply to components or functions of:
   - **i.** Any facility or component of a facility that only performs testing for forensic purposes.
   - **ii.** Research laboratories that test human specimens but do not report patient specific results for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of individual patients.
   - **iii.** Laboratories certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), in which drug testing is performed which meets SAMHSA guidelines and regulations. However, all other testing conducted by a SAMHSA-certified laboratory is subject to this rule.

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

M. Recovery from Other Sources or Providers

1. The Contractor shall recover the value of covered services rendered to beneficiaries whenever the beneficiaries are covered for the same services, either fully or partially, under any other state or federal medical care program or under other contractual or legal entitlement including, but not limited to, a private group or indemnification program, but excluding instances of the tort liability of a third party or casualty liability insurance.
2. The monies recovered are retained by the Contractor. However, Contractor's claims for FFP for services provided to beneficiaries under this Agreement shall be reduced by the amount recovered.
3. The Contractor shall maintain accurate records of monies recovered from other sources.
4. Nothing in this section supersedes the Contractor's obligation to follow federal requirements for claiming FFP for services provided to beneficiaries with other coverage under this Agreement.

N. Early Intervention (ASAM Level 0.5)

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

O. Outpatient Services (ASAM Level 1.0)

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

P. Intensive Outpatient Services (ASAM Level 2.1)

1. Intensive outpatient services involves structured programming provided to beneficiaries as medically necessary for a minimum of nine hours and a maximum of 19 hours per week for adult perinatal and non-perinatal beneficiaries. Adolescents are provided a minimum of six and a maximum of 19 hours per week. Group size is limited to no less than two (2) and no more than twelve (12) beneficiaries.
2. Intensive outpatient services shall include: assessment, treatment planning, individual and group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, and discharge planning and coordination.
3. Services may be provided in-person, by telephone, or by telehealth, and in any appropriate setting in the community.

Q. Residential Treatment Services

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

R. Case Management

1. Case management services are defined as a service that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

2. The Contractor shall ensure that case management services focus on coordination of SUD care, integration around primary care especially for beneficiaries with a chronic substance use disorder, and interaction with the criminal justice system, if needed.
3. The Contractor shall be responsible for determining which entity monitors the case management activities.
4. Case management services may be provided by an LPHA or a registered or certified counselor.
5. The Contractor shall coordinate a system of case management services with physical and/or mental health in order to ensure appropriate level of care.
6. Case management services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.

S. Physician Consultation Services

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

T. Recovery Services

1. Recovery Services shall include:
   - **i.** Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care.
   - **ii.** Recovery Monitoring: Recovery coaching, monitoring via telephone and internet.
   - **iii.** Substance Abuse Assistance: Peer-to-peer services and relapse prevention.

iv. Education and Job Skills: Linkages to life skills, employment services, job training, and education services.
v. Family Support: Linkages to childcare, parent education, child development support services, and family/marriage education.
vi. Support Groups: Linkages to self-help and support, spiritual and faith-based support.
vii. Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

2. Recovery services shall be utilized when the beneficiary is triggered, when the beneficiary has relapsed, or simply as a preventative measure to prevent relapse. As part of the assessment and treatment needs of Dimension 6, Recovery Environment of the ASAM Criteria and during the transfer/transition planning process, the Contractor shall provide beneficiaries with recovery services.
3. Additionally, the Contractor shall:
   i. Provide recovery services to beneficiaries as medically necessary.
   ii. Provide beneficiaries with access to recovery services after completing their course of treatment.
   iii. Provide recovery services either face-to-face, by telephone, or by telehealth, and in any appropriate setting in the community with the beneficiary.

U. Withdrawal Management

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

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

1. Pursuant to WIC 14124.22, an OTP/NTP provider who is also enrolled as a Medi-Cal provider may provide medically necessary treatment of concurrent health conditions to Medi-Cal beneficiaries who are not enrolled in managed care plans as long as those services are within the scope of the provider's practice. OTP/NTP providers shall refer all Medi-Cal beneficiaries that are enrolled in managed care plans to their respective managed care plan to receive medically necessary medical treatment of their concurrent health conditions.
2. The diagnosis and treatment of concurrent health conditions of Medi-Cal beneficiaries that are not enrolled in managed care plans by an OTP/NTP provider may be provided within the Medi-Cal coverage limits. When the services are not part of the SUD treatment reimbursed pursuant to WIC 14021.51, the services rendered shall be reimbursed in accordance with the Medi-Cal program. Services reimbursable under this section shall include all of the following:
   - **i.** Medical treatment visits
   - **ii.** Diagnostic blood, urine, and X-rays
   - **iii.** Psychological and psychiatric tests and services
   - **iv.** Quantitative blood and urine toxicology assays
   - **v.** Medical supplies
3. An OTP/NTP provider who is enrolled as a Medi-Cal fee-for-service provider shall not seek reimbursement from a beneficiary for SUD treatment services, if the OTP/NTP provider bills the services for treatment of concurrent health conditions to the Medi-Cal fee-for-service program.
4. The Contractor shall subcontract with licensed NTPs to offer services to beneficiaries who meet medical necessity criteria requirements.
5. Services shall be provided in accordance with an individualized beneficiary plan determined by a licensed prescriber.
6. Offer and prescribe medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone, and disulfiram.
7. Services provided as part of an OTP/NTP shall include: assessment, treatment planning, individual and group counseling,

patient education, medication services, collateral services, crisis intervention services, treatment planning, medical psychotherapy, and discharge services.

i. Beneficiaries shall receive between 50 and 200 minutes of counseling per calendar month with a therapist or counselor, and, when medically necessary, additional counseling services may be provided.

8. Courtesy Dosing

i. An OTP/NTP provider may provide replacement narcotic therapy to visiting beneficiaries approved to receive services on a temporary basis (less than 30 days) in accordance with Title 9, Section 10295. Prior to providing replacement narcotic therapy to a visiting beneficiary, an OTP/NTP provider must comply with Title 9, Section 10210(d).

ii. The Contractor shall accept, and reimburse, a claim from any subcontracted OTP/NTP provider (Referring OTP/NTP) that pays another OTP/NTP for providing courtesy dosing (Dosing OTP/NTP) to a beneficiary. The Contractor shall use the reimbursement rate established in the OTP/NTP provider's subcontract.

W. Cultural Competence Plan

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

X. Implementation Plan

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

Y. Additional Provisions

1. **Additional Intergovernmental Agreement Restrictions**

i. This Agreement is subject to any additional restrictions, limitations, conditions, or statutes enacted or amended by the federal or state governments, which may affect the provisions, terms, or funding of this Agreement in any manner.

2. **Voluntary Termination of DMC-ODS Services**
   i. The Contractor may terminate this Agreement at any time, for any reason, by giving 60 days written notice to DHCS. The Contractor shall be paid for DMC-ODS services provided to beneficiaries up to the date of termination. Upon termination, the Contractor shall immediately begin providing DMC services to beneficiaries in accordance with the State Plan.
3. **Nullification of DMC-ODS Services**
   i. The parties agree that failure of the Contractor, or its subcontractors, to comply with W&I section 14124.24, the Special Terms and Conditions, and this Agreement, shall be deemed a breach that results in the termination of this Agreement for cause.
   ii. In the event of a breach, DMC-ODS services shall terminate. The Contractor shall immediately begin providing DMC services to the beneficiaries in accordance with the State Plan.
4. **Hatch Act**
   i. Contractor agrees to comply with the provisions of the Hatch Act (Title 5 USC, Sections 1501-1508), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.
5. **No Unlawful Use or Unlawful Use Messages Regarding Drugs**
   i. Contractor agrees that information produced through these funds, and which pertains to drug and alcohol related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug or alcohol related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (HSC Section 11999-11999.3). By signing this Agreement,

Contractor agrees that it shall enforce, and shall require its subcontractors to enforce, these requirements.

6. **Noncompliance with Reporting Requirements**
   i. Contractor agrees that DHCS has the right to withhold payments until Contractor has submitted any required data and reports to DHCS, as identified in this Exhibit A, Attachment I or as identified in Document 1F(a), Reporting Requirement Matrix for Counties.
7. **Limitation on Use of Funds for Promotion of Legalization of Controlled Substances**
   i. None of the funds made available through this Agreement may be used for any activity that promotes the legalization of any drug or other substance included in Schedule I of Section 202 of the Controlled Substances Act (21 USC 812).
8. **Health Insurance Portability and Accountability Act (HIPAA) of 1996**
   i. If any of the work performed under this Agreement is subject to the HIPAA, Contractor shall perform the work in compliance with all applicable provisions of HIPAA. As identified in Exhibit F, DHCS and the Contractor shall cooperate to ensure mutual agreement as to those transactions between them, to which this Provision applies. Refer to Exhibit F for additional information.
   ii. **Trading Partner Requirements**
      a. No Changes. Contractor hereby agrees that for the personal health information (Information), it shall not change any definition, data condition or use of a data element or segment as proscribed in the federal HHS Transaction Standard Regulation. (45 CFR Part 162.915 (a))
      b. No Additions. Contractor hereby agrees that for the Information, it shall not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation. (45 CFR Part 162.915 (b))
      c. No Unauthorized Uses. Contractor hereby agrees that for the Information, it shall not use any code or data elements that either are marked “not used” in the

HHS Transaction's Implementation specification or are not in the HHS Transaction Standard's implementation specifications. (45 CFR Part 162.915 (c))

d. No Changes to Meaning or Intent. Contractor hereby agrees that for the Information, it shall not change the meaning or intent of any of the HHS Transaction Standard's implementation specification. (45 CFR Part 162.915 (d))

iii. Concurrence for Test Modifications to HHS Transaction Standards

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

iv. Adequate Testing

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

v. Deficiencies

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

vi. Code Set Retention

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

vii. Data Transmission Log

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

9. Counselor Certification

i. Any counselor or registrant providing intake, assessment of need for services, treatment or recovery planning, individual or group counseling to participants, patients, or residents in a DHCS licensed or certified program is required to be certified as defined in Title 9, Division 4, Chapter 8. (Document 3H)

10. Cultural and Linguistic Proficiency

i. To ensure equal access to quality care by diverse populations, each service provider receiving funds from this Agreement shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards (Document 3V) and comply with 42 CFR 438.206(c)(2).

11. Trafficking Victims Protection Act of 2000

i. Contractor and its subcontractors that provide services covered by this Agreement shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 (22 U.S.C.

7104(g)) as amended by section 1702. For full text of the award term, go to: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title22-section7104d&num=0&edition=prelim

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

i. The Contractor's County AOD Program Administrator shall participate and represent the county in meetings of the County Behavioral Health Director's Association of California for the purposes of representing the counties in their relationship with DHCS with respect to policies, standards, and administration for SUD services.

ii. The Contractor's County AOD Program Administrator shall attend any special meetings called by the Director of DHCS.

13. Youth Treatment Guidelines

i. Contractor shall follow the guidelines in Document 1V, incorporated by this reference, "Youth Treatment Guidelines," in developing and implementing adolescent treatment programs funded under this Exhibit, until such time new Youth Treatment Guidelines are established and adopted. No formal amendment of this Agreement is required for new guidelines to be incorporated into this Agreement.

14. Nondiscrimination in Employment and Services

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

15. Federal Law Requirements:

i. Title VI of the Civil Rights Act of 1964, Section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in federally funded programs.

ii. Title IX of the education amendments of 1972 (regarding education and programs and activities), if applicable.

iii. Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color,

religion, sex, handicap, familial status or national origin in the sale or rental of housing.

iv. Age Discrimination Act of 1975 (45 CFR Part 90), as amended (42 USC Sections 6101 – 6107), which prohibits discrimination on the basis of age.

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

vi. Title I of the Americans with Disabilities Act (29 CFR Part 1630) prohibiting discrimination against the disabled in employment.

vii. Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities.

viii. Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.

ix. Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.

x. Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than $10,000 funded by federal financial assistance.

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

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

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

16. State Law Requirements:

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

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

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

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

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

17. Investigations and Confidentiality of Administrative Actions

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

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

18. Subcontract Provisions

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

Z. Beneficiary Problem Resolution Process

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

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

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

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

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

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

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

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

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

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

3. The Contractor shall represent the Contractor's position in fair hearings, as defined in 42 CFR 438.408 dealing with beneficiaries' appeals of denials, modifications, deferrals or terminations of covered services. The Contractor shall carry out the final decisions of the fair hearing process with respect to issues within the scope of the Contractor's responsibilities under this Agreement. Nothing in this section is intended to prevent the Contractor from pursuing any options available for appealing a fair hearing decision.

i. Pursuant to 42 CFR 438.228, the Contractor shall develop problem resolution processes that enable beneficiary to request and receive review of a problem or concern he or she has about any issue related to the Contractor's performance of its duties, including the delivery of SUD treatment services.

4. The Contractor's beneficiary problem resolution processes shall include:

i. A grievance process

ii. An appeal process

iii. An expedited appeal process

AA. Subcontracts

1. In addition to complying with the subcontractual relationship requirements set forth in Article II.E.8 of this Agreement, the Contractor shall ensure that all subcontracts require that the Contractor oversee and is held accountable for any functions and responsibilities that the Contractor delegates to any subcontractor.

2. Each subcontract shall:

i. Fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract.

ii. Ensure that the Contractor evaluates the prospective subcontractor's ability to perform the activities to be delegated.

iii. Require a written agreement between the Contractor and the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor, and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

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

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

3. The Contractor shall include the following provider requirements in all subcontracts with providers:

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

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

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

a. Motivational Interviewing: A beneficiary-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on beneficiaries' past successes.
b. Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
c. Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.
d. Trauma-Informed Treatment: Services shall take into account an understanding of trauma, and place priority on trauma survivors’ safety, choice and control.
e. Psycho-Education: Psycho-educational groups are designed to educate beneficiaries about substance abuse, and related behaviors and consequences.

Psycho-educational groups provide information designed to have a direct application to beneficiaries' lives, to instill self- awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

BB. Program Integrity Requirements

1. Service Verification. To assist DHCS in meeting its obligation under 42 CFR 455.1(a)(2), the Contractor shall establish a mechanism to verify whether services were actually furnished to beneficiaries.
2. **DMC Claims and Reports**
   - **i.** Contractor or providers that bill DHCS or the Contractor for DMC-ODS services shall submit claims in accordance with Department of Health Care Service's DMC Provider Billing Manual.
   - **ii.** Contractor and subcontractors that provide DMC services shall be responsible for verifying the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for DMC services to that beneficiary for that month. Medi-Cal eligibility verification should be performed prior to rendering service, in accordance with and as described in the DHCS DMC Provider Billing Manual. Options for verifying the eligibility of a Medi-Cal beneficiary are described in the Department of Health Care Services DMC Provider Billing Manual.
   - **iii.** Claims for DMC reimbursement shall include DMC-ODS services covered under the Special Terms and Conditions of this Agreement, and any State Plan services covered under Title 22, Section 51341.1(c-d) and administrative charges that are allowed under WIC, Sections 14132.44 and 14132.47.
     a. Contractor shall submit to DHCS the "Certified Expenditure" form reflecting either: 1) the approved amount of the 837P claim file, after the claims have been adjudicated, or 2) the claimed amount identified

on the 837P claim file, which could account for both approved and denied claims. Contractor shall submit to DHCS the Drug Medi-Cal Certification Form DHCS 100224A (Document 4D) for each 837P transaction approved for reimbursement of the federal Medicaid funds.

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

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

a. Good Cause Certification (6065A), Document 2L(a)
b. Good Cause Certification (6065B), Document 2L(b)
c. In the absence of good cause documented on the Good Cause Certification (6065A or 6065B) form, claims that are not submitted within 30 days of the end of the month of service shall be denied. The existence of good cause shall be determined by DHCS in accordance with Title 22, Sections 51008 and 51008.5.

3. Certified Public Expenditure - County Administration

i. Separate from direct service claims as identified above, the Contractor may submit an invoice for administrative costs for administering the DMC-ODS program on a quarterly basis. The form requesting reimbursement shall be submitted to DHCS.

a. Mail Form MC 5312 to:
Department of Health Care Services
Fiscal Management & Accountability Section
1500 Capitol Avenue, MS 2629
P.O. Box 997413, Sacramento, CA 95899-7413

Alternatively, scan signed Form MC 5312 and email to:
sudfmab@dhcs.ca.gov

4. **Certified Public Expenditure – Quality Assurance and Utilization Review (QA/UR)**
   i. Separate from direct service claims as identified above, the Contractor may submit an invoice for QA/UR for administering the DMC-ODS quality management program on a quarterly basis. The form requesting reimbursement shall be submitted to DHCS.
      a. **Mail Form DHCS 5311 to:**
         Department of Health Care Services
         Fiscal Policy Unit - Attention: QA/UR
         SUD Program, Policy and Fiscal Division, MS 2628
         P.O. Box 997413
         Sacramento, CA 95899-7413

CC. Quality Management (QM) Program

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

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

ii. This triennial review shall provide DHCS with information as to whether the counties are complying with their responsibility to monitor their service delivery capacity.

iii. The counties shall receive a final report summarizing the findings of the triennial review, and if out of compliance, the Contractor shall submit a corrective action plan (CAP) within 60 days of receipt of the final report. DHCS shall follow-up with the CAP to ensure compliance.

5. The QM Program shall conduct performance-monitoring activities throughout the Contractor's operations. These activities shall include, but not be limited to, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, and resolution of beneficiary grievances.

6. The Contractor shall ensure continuity and coordination of care with physical health care providers. The Contractor shall coordinate with other human services agencies used by its beneficiaries. The Contractor shall assess the effectiveness of any MOU with a physical health care plan.

7. The Contractor shall have mechanisms to detect both underutilization of services and overutilization of services, as required by Article II.F.1 of this Agreement.

8. The Contractor shall implement mechanisms to assess beneficiary/family satisfaction. The Contractor shall assess beneficiary/family satisfaction by:

a. Surveying beneficiary/family satisfaction with the Contractor's services at least annually.
b. Evaluating beneficiary grievances, appeals and fair hearings at least annually.
c. Evaluating requests to change persons providing services at least annually.
d. The Contractor shall inform providers of the results of beneficiary/family satisfaction activities.

9. The Contractor shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. Monitoring shall occur at least annually.

10. The Contractor shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The Contractor shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the Contractor at least annually.

11. The Contractor shall have a QM Work Plan covering the current Agreement cycle with documented annual evaluations and documented revisions as needed. The Contractor's QM Work Plan shall evaluate the impact and effectiveness of its quality assessment and performance improvement program. The QM Work Plan shall include:

- **i.** Evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Article II.F.1 and Article II.G.7 of this Agreement.
- **ii.** Evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service.
- **iii.** A description of completed and in-process QM activities, including performance improvement projects. The description shall include:
  - a. Monitoring efforts for previously identified issues, including tracking issues over time.
  - b. Objectives, scope, and planned QM activities for each year.
  - c. Targeted areas of improvement or change in service delivery or program design.
- **iv.** A description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area. This shall include goals for responsiveness for the Contractor's 24-hour toll-free

telephone number, timeliness for scheduling of routine appointments, timeliness of services for urgent conditions, and access to after-hours care.

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

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

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

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

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

a. The CAP shall:

i. Be documented on the DHCS CAP template.

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

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

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

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

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

b. DHCS shall provide written approval of the CAP to the Contractor with a copy to the provider. If DHCS does not approve the CAP, DHCS shall provide guidance on the deficient areas and request an updated CAP from the Contractor with a copy to the provider. Contractor shall submit an updated CAP to the DHCS Analyst that conducted the review, within 30 days of notification.

c. If a CAP is not submitted, or, the provider does not implement the approved CAP provisions within the designated timeline, then DHCS may withhold funds from the Contractor until the entity that provided the services is in compliance with this Exhibit A, Attachment I. DHCS shall inform the Contractor when funds shall be withheld.

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

i. Requests for first-level appeals:

a. The provider and/or Contractor shall initiate action by submitting a letter to:

Division Chief
DHCS SUD-PPFD
P.O. Box 997413, MS-2621
Sacramento, CA 95899-7413

i. The provider and/or Contractor shall submit the letter on the official stationery of the provider and/or Contractor and it shall be signed by an authorized representative of the provider and/or Contractor.

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

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

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

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

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

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

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

iv. In referring an appeal to the OAHA, the provider and/or Contractor shall submit all of the following:
a. A copy of the original written appeal sent to the SUD-PPFD.

b. A copy of the SUD-PPFD's report to which the appeal applies.

If received by the provider and/or Contractor, a copy of the SUD-PPFD's specific finding(s), and conclusion(s) regarding the appeal with which the provider and/or Contractor is dissatisfied.

5. The appeal process listed here shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of DHCS pursuant to Exhibit B of this Agreement.

6. State shall monitor the subcontractor's compliance with Contractor utilization review requirements, as specified in Article III.EE. Counties are also required to monitor the subcontractor's compliance pursuant to Article III.AA of this Agreement. The federal government may also review the existence and effectiveness of DHCS' utilization review system.

7. Contractor shall, at a minimum, implement and maintain compliance with the requirements described in Article III.PP for the purposes of reviewing the utilization, quality, and appropriateness of covered services and ensuring that all applicable Medi-Cal requirements are met.

8. Contractor shall ensure that subcontractor sites shall keep a record of the beneficiaries/patients being treated at that location. Contractor shall retain beneficiary records for a minimum of 10 years, in accordance with 438.3(h), from the finalized cost settlement process with the Department. When an audit by the Federal Government or DHCS has been started before the expiration of the 10-year period, the beneficiary records shall be maintained until completion of the audit and the final resolution of all issues.

EE. Contractor Monitoring

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

Department of Health Care Services

SUD – Program, Policy, and Fiscal Division
Performance & Integrity Branch
PO Box 997413, MS-2627
Sacramento, CA 95899-7413

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

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

Technical assistance is available to counties from SUD-PPFD.

2. If significant deficiencies or significant evidence of noncompliance with the terms of the DMC-ODS waiver, or this Agreement, are found in a county, DHCS shall engage the Contractor to determine if there are challenges that can be addressed with facilitation and technical assistance. If the Contractor remains noncompliant, the Contractor shall submit a CAP to DHCS. The CAP shall detail how and when the Contractor shall remedy the issue(s). DHCS may remove the Contractor from participating in the Waiver if the CAP is not promptly implemented.

3. If the Contractor is removed from participating in the Waiver, the county shall provide DMC services in accordance with the California Medi-Cal State Plan.

4. Contractor shall ensure that DATAR submissions, detailed in Article III.FF of this Exhibit, are complied with by all treatment providers and subcontracted treatment providers. Contractor shall attest that each subcontracted provider is enrolled in DATAR at the time of execution of the subcontract.

5. The Contractor shall monitor and attest compliance and/or completion by providers with CAP requirements (detailed in Article III.DD) of this Exhibit as required by any PSPP review. The Contractor shall attest to DHCS, using the form developed by DHCS that the requirements in the CAP have been completed by the Contractor and/or the provider. Submission of DHCS Form 8049 by Contractor shall be accomplished within the timeline specified in the approved CAP, as noticed by DHCS.

6. Contractor shall attest that DMC claims submitted to DHCS have been subject to review and verification process for accuracy and legitimacy. (45 CFR 430.30, 433.32, 433.51). Contractor shall not

knowingly submit claims for services rendered to any beneficiary after the beneficiary's date of death, or from uncertified or decertified providers.

FF. Reporting Requirements

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

iv. CMS' right to inspect documentation. DHCS shall make available to CMS, upon request, all documentation collected by DHCS from the Contractor.

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

i. The CalOMS-Tx business rules and requirements are:

a. Contractor shall contract with a software vendor that complies with the CalOMS-Tx data collection system requirements for submission of CalOMS-Tx data. A Business Associate Agreement (BAA) shall be established between the Contractor and the software vendor. The BAA shall state that DHCS is allowed to return the processed CalOMS-Tx data to the vendor that supplied the data to DHCS.

b. Contractor shall conduct information technology (IT) systems testing and pass state certification testing before commencing submission of CalOMS-Tx data. If the Contractor subcontracts with vendor for IT services, Contractor is responsible for ensuring that the subcontracted IT system is tested and certified by the DHCS prior to submitting CalOMS-Tx data. If Contractor changes or modifies the CalOMS-Tx IT system, then Contractor shall re-test and pass state re-certification prior to submitting data from new or modified system.

c. Electronic submission of CalOMS-Tx data shall be submitted by Contractor within 45 days from the end of the last day of the report month.

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

e. Contractor shall submit CalOMS-Tx admission, discharge, annual update, resubmissions of records containing errors or in need of correction, and

"provider no activity" report records in an electronic format approved by DHCS.

f. Contractor shall comply with the CalOMS-Tx Data Compliance Standards established by DHCS identified in (Document 3S) for reporting data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method.
g. Contractor shall participate in CalOMS-Tx informational meetings, trainings, and conference calls.
h. Contractor shall implement and maintain a system for collecting and electronically submitting CalOMS-Tx data.
i. Contractor shall meet the requirements as identified in Exhibit F, Privacy and Information Security Provisions.

5. CalOMS-Tx General Information

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

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

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

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

6. Drug and Alcohol Treatment Access Report (DATAR)

i. The DATAR business rules and requirements:

a. The Contractor shall be responsible for ensuring that the Contractor-operated treatment services and all treatment providers with whom Contractor subcontracts or otherwise pays for the services, submit a monthly DATAR report in an electronic copy format as provided by DHCS.

b. In those instances where the Contractor maintains, either directly or indirectly, a central intake unit or equivalent, which provides intake services including a waiting list, the Contractor shall identify and begin submitting monthly DATAR reports for the central intake unit by a date to be specified by DHCS.

c. The Contractor shall ensure that all DATAR reports are submitted by either Contractor-operated treatment services and by each subcontracted treatment provider to DHCS by the 10th of the month following the report activity month.

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

e. If the Contractor or its subcontractor experiences system or service failure or other extraordinary circumstances that affect its ability to timely submit a monthly DATAR report, and/or to meet data compliance requirements, the Contractor shall report the problem in writing before the established data submission deadlines. The written notice shall include a CAP that is subject to review and approval by DHCS. A grace period of up to 60 days may be granted, at DHCS' sole discretion, for the Contractor to resolve the problem before non-DMC payments are withheld (See Exhibit B, Part II, Section 2).

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

g. The Contractor shall be considered compliant if a minimum of 95% of required DATAR reports from the Contractor's treatment providers are received by the due date.

7. Year-End Cost Settlement Reports

i. Pursuant to WIC 14124.24(g)(1) the Contractor shall submit to DHCS, no later than November 1 of each year, the following year-end cost settlement data for the previous fiscal year:

a. County Certification form (MC 6229): Submit via regular mail or overnight services. DHCS needs original signatures, not a copy.

b. Drug Medi-Cal (DMC) data: Submit the data via the Substance Use Disorder Cost Report System (SUDCRS) and submit the individual provider Excel files via email, regular mail, or overnight services.

c. DMC Provider Certification forms: Submit via regular mail or overnight services. DHCS needs original signatures, not a copy.

8. Failure to Meet Reporting Requirements

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

a. DHCS shall issue a Notice of Deficiency (Deficiencies) to Contractor regarding specified providers with a deadline to submit the required data and a request for a CAP to ensure timely reporting in the future. DHCS shall approve or reject the CAP or request revisions to the CAP, which shall be resubmitted to DHCS within 30 days.

b. If the Contractor has not ensured compliance with the data submission or CAP request within the designated timeline, then DHCS may withhold funds until all data is submitted. DHCS shall inform the Contractor when funds shall be withheld.

GG. Training

1. SUD-PPFD shall provide mandatory annual training to the Contractor on the DMC-ODS.

2. Contractor may request additional Technical Assistance or training from SUD-PPFD on an ad hoc basis.
3. Training to DMC Subcontractors
   i. The Contractor shall ensure that all subcontractors receive training on the DMC-ODS requirements, at least annually. The Contractor shall report compliance with this section to DHCS annually as part of the DHCS County Monitoring process.
   ii. The Contractor shall require subcontractors to be trained in the ASAM Criteria prior to providing services.
      a. The Contractor shall ensure that, at minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care". A third module entitled, "Introduction to The ASAM Criteria" is recommended for all county and provider staff participating in the Waiver. With assistance from the state, counties will facilitate ASAM provider trainings.
      b. The Contractor shall ensure that all residential service providers meet the established ASAM criteria for each level of residential care they provide and receive an ASAM Designation prior to providing DMC-ODS services.

HH. Program Complaints

1. The Contractor shall be responsible for investigating complaints and providing the results of all investigations to DHCS by secure, encrypted e-mail to SUDCountyReports@dhcs.ca.gov within two business days of completion.
2. Complaints for Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities, and counselor complaints may be made by telephoning the appropriate licensing branch listed below:

   SUD Compliance Division:

   Public Number: (916) 322-2911
   Toll Free Number: (877) 685-8333

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

3. Suspected Medi-Cal fraud, waste, or abuse must be reported to:

DHCS Medi-Cal Fraud: (800) 822-6222 or Fraud@dhcs.ca.gov

II. Record Retention

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

JJ. Subcontract Termination

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

KK. Corrective Action Plan

1. If the Contractor fails to ensure any of the foregoing oversight through an adequate system of monitoring, utilization review, and fiscal and programmatic controls, DHCS may request a CAP from the Contractor to address these deficiencies and a timeline for implementation. Failure to submit a CAP or adhere to the provisions in the CAP can result in a withholding of funds allocated to Contractor for the provision of services, and/or termination of this Agreement for cause.

2. Failure to comply with Monitoring requirements shall result in:

i. DHCS shall issue a report to Contractor after conducting monitoring or utilization reviews of the Contractor. When the DHCS report identifies non-compliant services or processes, it shall require a CAP. The Contractor shall submit a CAP to DHCS within the timeframes required by DHCS.

a. The CAP shall:

i. Be documented on the DHCS CAP template.

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

iii. Identify the title of the individual(s) responsible for:
    1. Correcting the deficiency
    2. Ensuring on-going compliance

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

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

ii. DHCS shall provide written approval of the CAP to the Contractor. If DHCS does not approve the CAP submitted by the Contractor, DHCS shall provide guidance on the deficient areas and request an updated CAP from the Contractor with a new deadline for submission.

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

LL. Quality Improvement (QI) Program

1. Contractor shall establish an ongoing quality assessment and performance improvement program consistent with Article II.F.1 of this Agreement.

2. CMS, in consultation with DHCS and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by DHCS in this Agreement.

3. Performance improvement projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and beneficiary satisfaction.

4. The monitoring of accessibility of services outlined in the Quality Improvement (QI) Plan will at a minimum include:

i. Timeliness of first initial contact to face-to-face appointment.

ii. Frequency of follow-up appointments in accordance with individualized treatment plans.

iii. Timeliness of services of the first dose of OTP/NTP services.

iv. Access to after-hours care.

v. Responsiveness of the beneficiary access line.

- **vi.** Strategies to reduce avoidable hospitalizations.
- **vii.** Coordination of physical and mental health services with waiver services at the provider level.
- **viii.** Assessment of the beneficiaries' experiences.
- **ix.** Telephone access line and services in the prevalent non-English languages.

5. The Contractor's QI program shall monitor the Contractor's service delivery system with the aim of improving the processes of providing care and better meeting the needs of its beneficiaries. The QI Program shall be accountable to the Contractor's Director.

6. The Contractor shall establish a QI Committee to review the quality of SUD treatment services provided to beneficiaries. The QI Committee shall recommend policy decisions; review and evaluate the results of QI activities, including performance improvement projects; institute needed QI actions; ensure follow-up of QI processes; and document QI Committee meeting minutes regarding decisions and actions taken. The QI committee shall recommend policy decisions; review and evaluate the results of QI activities; institute needed QI actions, ensure follow-up of QI process and document QI committee minutes regarding decisions and actions taken.

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

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

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

9. The QI Program shall include active participation by the Contractor's practitioners and providers, as well as beneficiaries

and family members, in the planning, design and execution of the QI Program.

10. The Contractor shall maintain a minimum of two active Performance Improvement Projects (PIPs) that meet the criteria in 42 CFR 438.240(b)(1) and (d). Performance improvement projects shall focus on a clinical area, as well as one non-clinical area.

11. PIPs shall:

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

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

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

MM. Utilization Management (UM) Program

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

NN. Formation and Purpose

1. Authority

- **i.** The state and the Contractor enter into this Agreement, by authority of Chapter 3 of Part 1, Division 10.5 of the Health and Safety Code (HSC) and with approval of Contractor's County Board of Supervisors (or designee) for the purpose of providing alcohol and drug services, which shall be reimbursed pursuant to Exhibit B. The state and the

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

2. **Control Requirements**
   - **i.** Performance under the terms of this Exhibit A, Attachment I, is subject to all applicable federal and state laws, regulations, and standards. The Contractor shall:
     - a. Require its subcontractors to establish written policies and procedures consistent with the requirements listed in 2(c).
     - b. Monitor for compliance with the written procedures.
     - c. Be held accountable for audit exceptions taken by DHCS against the Contractor and its subcontractors for any failure to comply with these requirements:
       - i. HSC, Division 10.5, commencing with Section 11760
       - ii. Title 9, Division 4, Chapter 8, commencing with Section 13000
       - iii. Government Code Section 16367.8
       - iv. Title 42, CFR, Sections 8.1 through 8.6
       - v. Title 21, CFR, Sections 1301.01 through 1301.93, Department of Justice, Controlled Substances
       - vi. State Administrative Manual (SAM), Chapter 7200 (General Outline of Procedures)
3. Contractor shall be familiar with the above laws, regulations, and guidelines and shall ensure that its subcontractors are also familiar with such requirements.
4. The provisions of this Exhibit A, Attachment I are not intended to abrogate any provisions of law or regulation, or any standards existing or enacted during the term of this Agreement.

OO. Performance Provisions

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

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

SUDCountyReports@dhcs.ca.gov

Alternatively, mail to:

Department of Health Care Services
SUD – Program, Policy, and Fiscal Division
Performance & Integrity Branch
PO Box 997413, MS-2627
Sacramento, CA 95899-7413

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

2. Performance Requirements

i. Contractor shall provide services based on funding set forth in Exhibit B, Attachment I, and under the terms of this Agreement.

ii. Contractor shall provide services to all eligible persons in accordance with federal and state statutes and regulations.

iii. Contractor shall ensure that in planning for the provision of services, the following barriers to services are considered and addressed:

a. Lack of educational materials or other resources for the provision of services.
b. Geographic isolation and transportation needs of persons seeking services or remoteness of services.

c. Institutional, cultural, and/or ethnicity barriers.
d. Language differences.
e. Lack of service advocates.
f. Failure to survey or otherwise identify the barriers to service accessibility.
g. Needs of persons with a disability.

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

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

5. DHCS shall issue a report to Contractor after conducting monitoring or utilization reviews of county or county subcontracted providers. When the DHCS report identifies non-compliant services or processes, it shall require a CAP. The Contractor, or in coordination with its subcontracted provider, shall submit a CAP to the DHCS Analyst that conducted the review, within 60 calendar days from the date of the report. The CAP shall be electronically submitted, directly to the DHCS analyst who conducted the review.

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

PP. Requirements for Services

1. Confidentiality.

i. All SUD treatment services shall be provided in a confidential setting in compliance with 42 CFR, Part 2 requirements.

2. Perinatal Services.

i. Perinatal services shall address treatment and recovery issues specific to pregnant and postpartum women, such as relationships, sexual and physical abuse, and development of parenting skills.

ii. Perinatal services shall include:

a. Mother/child habilitative and rehabilitative services (i.e., development of parenting skills, training in child development, which may include the provision of cooperative child care pursuant to Health and Safety Code Section 1596.792).

b. Service access (i.e., provision of or arrangement for transportation to and from medically necessary treatment).
c. Education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant.
d. Coordination of ancillary services (i.e., assistance in accessing and completing dental services, social services, community services, educational/vocational training and other services which are medically necessary to prevent risk to fetus or infant).

iii. Medical documentation that substantiates the beneficiary's pregnancy and the last day of pregnancy shall be maintained in the beneficiary record.

iv. Contractor shall comply with the perinatal program requirements as outlined in the Perinatal Practice Guidelines. The Perinatal Practice Guidelines are attached to this Agreement as Document 1G, incorporated by reference. The Contractor shall comply with the current version of these guidelines until new Perinatal Practice Guidelines are established and adopted. The incorporation of any new Perinatal Practice Guidelines into this Agreement shall not require a formal amendment.

3. Narcotic Treatment Programs.

i. OTP/NTP services and regulatory requirements shall be provided in accordance with Title 9, Chapter 4.

4. OTP/NTP Courtesy Dosing Documentation Requirements

i. The Contractor shall require the referring OTP/NTP to maintain documentation of the referral, and treatment by a Dosing OTP/NTP, in the beneficiary medical record for each day of courtesy dosing. The Contractor shall also require the Referring OTP/NTP to maintain a record of the invoice and payment for the courtesy dosing for each claim submitted for reimbursement. The invoice shall include all information needed to complete a claim, including dates of service, type of service, and units of service.

ii. If applicable, the Contractor shall require an OTP/NTP provider include entries on a cost report to capture the revenue and expenses related to courtesy dosing for the purpose of cost settlement.

5. Naltrexone Treatment Services.

i. For each beneficiary, all of the following shall apply:
   a. The provider shall confirm and document that the beneficiary meets all of the following conditions:
ii. Has a documented history of opiate addiction.
iii. Is at least 18 years of age.
iv. Has been opiate free for a period of time to be determined by a physician based on the physician's clinical judgment. The provider shall administer a body specimen test to confirm the opiate free status of the beneficiary.
v. Is not pregnant and is discharged from the treatment if she becomes pregnant.
vi. The physician shall certify the beneficiary's fitness for treatment based upon the beneficiary's physical examination, medical history, and laboratory results.
vii. The physician shall advise the beneficiary of the overdose risk should the beneficiary return to opiate use while taking Naltrexone and the ineffectiveness of opiate pain relievers while on Naltrexone.

6. Substance Use Disorder Medical Director.

i. The SUD Medical Director's responsibilities shall, at a minimum, include all of the following:
   a. Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
   b. Ensure that physicians do not delegate their duties to non-physician personnel.
   c. Develop and implement written medical policies and standards for the provider.
   d. Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
   e. Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
   f. Ensure that provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries, and determine the medical necessity of treatment for beneficiaries.
   g. Ensure that provider's physicians are adequately trained to perform other physician duties, as outlined in this section.

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

7. Provider Personnel.

i. Personnel files shall be maintained on all employees and volunteers/interns and shall contain the following:
   a. Application for employment and/or resume
   b. Signed employment confirmation statement/duty statement
   c. Job description
   d. Performance evaluations
   e. Health records/status as required by the provider, AOD Certification or Title 9
   f. Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries)
   g. Training documentation relative to substance use disorders and treatment
   h. Current registration, certification, intern status, or licensure
   i. Proof of continuing education required by licensing or certifying agency and program
   j. Provider’s Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying/licensing body’s code of conduct as well

ii. Job descriptions shall be developed, revised as needed, and approved by the provider’s governing body. The job descriptions shall include:
   a. Position title and classification
   b. Duties and responsibilities
   c. Lines of supervision
   d. Education, training, work experience, and other qualifications for the position

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

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

iv. If a provider utilizes the services of volunteers and/or interns, written procedures shall be implemented which address:
a. Recruitment
b. Screening and Selection
c. Training and orientation
d. Duties and assignments
e. Scope of practice
f. Supervision
g. Evaluation
h. Protection of beneficiary confidentiality

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

8. Beneficiary Admission.

i. Each provider shall include in its policies, procedures, and practice, written admission and readmission criteria for determining beneficiary's eligibility and the medical necessity for treatment. These criteria shall include, at a minimum:
a. DSM diagnosis
b. Use of alcohol/drugs of abuse
c. Physical health status
d. Documentation of social and psychological problems.

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

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

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

v. All referrals made by the provider staff shall be

documented in the beneficiary record.

vi. Copies of the following documents shall be provided to the beneficiary upon admission:
   a. Beneficiary rights, share of cost if applicable, notification of DMC funding accepted as payment in full, and consent to treatment.

vii. Copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries:
   a. A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay.
   b. Complaint process and grievance procedures.
   c. Appeal process for involuntary discharge.
   d. Program rules and expectations.

viii. Where drug screening by urinalysis is deemed medically appropriate the program shall:
   a. Establish written procedures, which protect against the falsification and/or contamination of any urine sample.
   b. Document urinalysis results in the beneficiary's file.

9. Assessment.

i. The provider shall ensure a counselor or LPHA completes a personal, medical, and substance use history for each beneficiary upon admission to treatment.
   a. Assessment for all beneficiaries shall include at a minimum:
      i. Drug/Alcohol use history
      ii. Medical history
      iii. Family history
      iv. Psychiatric/psychological history
      v. Social/recreational history
      vi. Financial status/history
      vii. Educational history
      viii. Employment history
      ix. Criminal history
      x. Legal status
      xi. Previous SUD treatment history
   b. The Medical Director or LPHA shall review each beneficiary's personal, medical, and substance use history if completed by a counselor within 30 calendar days of each beneficiary's admission to treatment date.

10. Beneficiary Record.

i. In addition to the requirements of 22 CCR § 51476(a), the provider shall:
   a. Establish, maintain, and update as necessary, an individual beneficiary record for each beneficiary admitted to treatment and receiving services.
   b. Each beneficiary's individual beneficiary record shall include documentation of personal information.
   c. Documentation of personal information shall include all of the following:
      i. Information specifying the beneficiary's identifier (i.e., name, number).
      ii. Date of beneficiary's birth, the beneficiary's sex, race and/or ethnic background, beneficiary's address and telephone number, and beneficiary's next of kin or emergency contact.

ii. Documentation of treatment episode information shall include documentation of all activities, services, sessions, and assessments, including, but not limited to all of the following:
   a. Intake and admission data including, a physical examination, if applicable.
   b. Treatment plans.
   c. Progress notes.
   d. Continuing services justifications.
   e. Laboratory test orders and results.
   f. Referrals.
   g. Discharge plan.
   h. Discharge summary.
   i. Contractor authorizations for Residential Services.
   j. Any other information relating to the treatment services rendered to the beneficiary.

11. Diagnosis Requirements.

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

diagnosis in the beneficiary's record within 30 calendar days of each beneficiary's admission to treatment date.

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

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

12. Physical Examination Requirements.

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

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

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

iii. If the physician or a physician extender, has not reviewed the documentation of the beneficiary's physical examination as provided for in paragraph (i), or the provider does not perform a physical examination of the beneficiary as provided for in paragraph (ii), then the LPHA or counselor shall include in the beneficiary's initial and updated treatment plans the goal of obtaining a physical examination, until this goal has been met and the physician has reviewed the physical examination results. The physician shall type or

legibly print their name, sign, and date documentation to support they have reviewed the physical examination results. The signature shall be adjacent to the typed or legibly printed name.

13. Treatment Plan.

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

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

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

1. A statement of problems identified through the ASAM, other assessment tool(s) or intake documentation.
2. Goals to be reached which address each problem.
3. Action steps that will be taken by the provider and/or beneficiary to accomplish identified goals.
4. Target dates for the accomplishment of action steps and goals.
5. A description of the services, including the type of counseling, to be provided and the frequency thereof.
6. The assignment of a primary therapist or counselor.
7. The beneficiary's diagnosis as documented by the Medical Director or LPHA.
8. If a beneficiary has not had a physical examination within the 12-month period prior to the beneficiary's admission to treatment date, a goal that the beneficiary have a physical examination.
9. If documentation of a beneficiary's physical examination, which was

performed during the prior 12 months, indicates a beneficiary has a significant medical illness, a goal that the beneficiary obtain appropriate treatment for the illness.

b. The provider shall ensure that the initial treatment plan meets all of the following requirements:
    i. The LPHA or counselor shall complete, type or legibly print their name, and sign and date the initial treatment plan within 30 calendar days of the admission to treatment date. The signature shall be adjacent to the typed or legibly printed name.
    ii. The beneficiary shall review, approve, type, or legibly print their name, sign and date the initial treatment plan, indicating whether the beneficiary participated in preparation of the plan, within 30 calendar days of the admission to treatment date.
        1. If the beneficiary refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment.
    iii. If a counselor completes the initial treatment plan, the Medical Director or LPHA shall review the initial treatment plan to determine whether services are medically necessary (as defined in Article IV) and appropriate for the beneficiary.
        1. If the Medical Director or LPHA determines the services in the initial treatment plan are medically necessary, the Medical Director or LPHA shall type or legibly print their name, and sign and date the treatment plan within 15 calendar days of signature by the counselor. The signature shall be adjacent to the typed or legibly printed name.

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

a. The LPHA or counselor shall complete, type, or legibly print their name, sign and date the updated treatment plan no later than 90 calendar days after signing the initial treatment plan, and no later than every 90 calendar days thereafter, or when there is a change in treatment modality or significant event, whichever comes first. The signature shall be adjacent to the typed or legibly printed name. The updated treatment plan shall be updated to reflect the current treatment needs of the beneficiary.
b. The beneficiary shall review, approve, type, or legibly print their name and, sign and date the updated treatment plan, indicating whether the beneficiary participated in preparation of the plan, within 30 calendar days of signature by the LPHA or counselor.
    i. If the beneficiary refuses to sign the updated treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment.
c. If a counselor completes the updated treatment plan, the Medical Director or LPHA shall review each updated treatment plan to determine whether continuing services are medically necessary (as defined in Article IV) and appropriate for the beneficiary.
    i. If the Medical Director or LPHA determines the services in the updated treatment plan are medically necessary, they shall type or legibly print their name and, sign and date the updated treatment plan, within 15 calendar days of signature by the counselor. The signature shall be adjacent to the typed or legibly printed name.

14. Sign-in Sheet.

i. Establish and maintain a sign-in sheet for every group counseling session, which shall include all of the following:
    a. The LPHA(s) and/or counselor(s) conducting the counseling session shall type or legibly print their name(s), sign, and date the sign-in sheet on the same day of the session. The signature(s) must be adjacent to the typed or legibly printed name(s). By signing the

sign-in sheet, the LPHA(s) and/or counselor(s) attest that the sign-in sheet is accurate and complete.

b. The date of the counseling session.
c. The topic of the counseling session.
d. The start and end time of the counseling session.
e. A typed or legibly printed list of the participants' names and the signature of each participant that attended the counseling session. The participants shall sign the sign-in sheet at the start of or during the counseling session.

15. Progress Notes.

i. Progress notes shall be legible and completed as follows:
   a. For outpatient services, Naltrexone treatment services, and recovery services, each individual and group session, the LPHA or counselor who conducted the counseling session or provided the service shall record a progress note for each beneficiary who participated in the counseling session or treatment service.
      i. The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven calendar days of the counseling session. The signature shall be adjacent to the typed or legibly printed name.
      ii. Progress notes are individual narrative summaries and shall include all of the following:
         1. The topic of the session or purpose of the service.
         2. A description of the beneficiary's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals.
         3. Information on the beneficiary's attendance, including the date, start and end times of each individual and group counseling session or treatment service.
         4. Identify if services were provided in-person, by telephone, or by telehealth.

5. If services were provided in the community, identify the location and how the provider ensured confidentiality.

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

c. For each beneficiary provided case management services, the LPHA or counselor who provided the treatment service shall record a progress note.
   i. The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven calendar days of the case management service. The signature shall be adjacent to the typed or legibly printed name.
   ii. Progress notes shall include all of the following:
      1. Beneficiary’s name.
      2. The purpose of the service.

3. A description of how the service relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referrals.
4. Date, start and end times of each service.
5. Identify if services were provided in-person, by telephone, or by telehealth.
6. If services were provided in the community, identify the location and how the provider ensured confidentiality.

d. For physician consultation services, additional medication assisted treatment, and withdrawal management, the Medical Director or LPHA working within their scope of practice who provided the treatment service shall record a progress note and keep in the beneficiary's file.
   i. The Medical Director or LPHA shall type or legibly print their name, and sign and date the progress note within seven calendar days of the service. The signature shall be adjacent to the typed or legibly printed name.
   ii. Progress notes shall include all of the following:
      1. Beneficiary's name.
      2. The purpose of the service.
      3. Date, start and end times of each service.
      4. Identify if services were provided face-to-face, by telephone or by telehealth.

16. Continuing Services.

i. Continuing services shall be justified as shown below:
   a. For outpatient services, intensive outpatient services, Naltrexone treatment, and case management:
      i. For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the LPHA or counselor shall review the beneficiary's progress and eligibility to continue to receive treatment services, and recommend whether the beneficiary should or should not continue to receive treatment services at the same level of care.

ii. For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the Medical Director or LPHA shall determine medical necessity for continued services for the beneficiary. The determination of medical necessity shall be documented by the Medical Director or LPHA in the beneficiary's individual patient record and shall include documentation that all of the following have been considered:

1. The beneficiary's personal, medical and substance use history.
2. Documentation of the beneficiary's most recent physical examination.
3. The beneficiary's progress notes and treatment plan goals.
4. The LPHA's or counselor's recommendation pursuant to Paragraph (i) above.
5. The beneficiary's prognosis.
   i. The Medical Director or LPHA shall type or legibly print their name, and sign and date the continuing services information when completed. The signature shall be adjacent to the typed or legibly printed name.

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

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

17. Discharge.

i. Discharge of a beneficiary from treatment may occur on a voluntary or involuntary basis. For outpatient services, intensive outpatient services and residential services, in

addition to the requirements of this subsection, an involuntary discharge is subject to the requirements set forth in Article II.G.2. of this Agreement.

ii. An LPHA or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom the provider loses contact.
    a. The discharge plan shall include, but not be limited to, all of the following:
        i. A description of each of the beneficiary's relapse triggers.
        ii. A plan to assist the beneficiary to avoid relapse when confronted with each trigger.
        iii. A support plan.
    b. The discharge plan shall be prepared within 30 calendar days prior to the scheduled date of the last face-to-face treatment with the beneficiary.
        i. If a beneficiary is transferred to a higher or lower level of care based on ASAM criteria within the same DMC certified program, they are not required to be discharged unless there has been more than a 30-calendar day lapse in treatment services.
    c. During the LPHA's or counselor's last face-to-face treatment with the beneficiary, the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. The signatures shall be adjacent to the typed or legibly printed name. A copy of the discharge plan shall be provided to the beneficiary and documented in the beneficiary record.

iii. The LPHA or counselor shall complete a discharge summary, for any beneficiary with whom the provider lost contact, in accordance with all of the following requirements:
    a. The LPHA or counselor shall complete the discharge summary within 30 calendar days of the date of the last face-to-face treatment contact with the beneficiary.
    b. The discharge summary shall include all of the following:

i. The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment.
ii. The reason for discharge.
iii. A narrative summary of the treatment episode.
iv. The beneficiary's prognosis.

18. Reimbursement of Documentation.

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

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

IV. Definitions

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

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

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

3. ***"Administrative Costs"*** means the Contractor's actual direct costs, as recorded in the Contractor's financial records and supported by source documentation, to administer the program or an activity to provide service to the DMC program. Administrative costs do not include the cost of treatment or other direct services to the beneficiary. Administrative costs may include, but are not limited to, the cost of training, programmatic and financial audit

reviews, and activities related to billing. Administrative costs may include Contractor's overhead per the approved indirect cost rate proposal pursuant to OMB Omni-Circular and the State Controller's Office Handbook of Cost Plan Procedures.

4. ***"Adverse benefit determination"*** means, in the case of an MCO, PIHP, or PAHP, any of the following:

   (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

   (2) The reduction, suspension, or termination of a previously authorized service.

   (3) The denial, in whole or in part, of payment for a service.

   (4) The failure to provide services in a timely manner, as defined by the state

   (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

   (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.

   (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

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

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

7. ***"ASAM Criteria-Medical Necessity"*** pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. It should not be restricted to acute care and narrow

medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs (as in Dimension 2); or Dimension 3 psychiatric issues (such as imminent suicidality). Rather, "medical necessity" encompasses all six assessment dimensions so that a more holistic concept would be "Clinical Necessity," "necessity of care," or "clinical appropriateness."

8. ***"Authorization"*** is the approval process for DMC-ODS Services prior to the submission of a DMC claim.

9. ***"Available Capacity"*** means the total number of units of service (bed days, hours, slots, etc.) that a Contractor actually makes available in the current fiscal year.

10. ***"Beneficiary"*** means a person who: (a) has been determined eligible for Medi-Cal; (b) is not institutionalized; (c) has a substance-related disorder per the current "Diagnostic and Statistical Manual of Mental Disorders (DSM)" criteria; and (d) meets the admission criteria to receive DMC covered services.

11. ***"Beneficiary/Enrollee Encounter Data"*** means the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a state and a MCO, PIHP, or PAHP that is subject to the requirements of §§438.242 and 438.818.

12. ***"Beneficiary Handbook"*** is the state developed model enrollee handbook.

13. ***"Calendar Week"*** means the seven-day period from Sunday through Saturday.

14. ***"Case Management"*** means a service to assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

15. ***"Certified Provider"*** means a substance use disorder clinic location that has received certification to be reimbursed as a DMC clinic by the state to provide services as described in Title 22, California Code of Regulations, Section 51341.1.

16. ***"Collateral Services"*** means sessions with therapists or counselors and significant persons in the life of a beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals.

Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.

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

18. ***"Contractor"*** means the county identified in the Standard Agreement or DHCS authorized by the County Board of Supervisors to administer substance use disorder programs.

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

20. ***"County"*** means the county in which the Contractor physically provides covered substance use treatment services.

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

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

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

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

25. ***"Delivery System"*** DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program. DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a

county that opts into the Pilot program. Upon approval of an implementation plan, the state shall contract with the county to provide DMC-ODS services. The county shall, in turn, contract with DMC certified providers or provide county-operated services to provide all services outlined in the DMC-ODS. Counties may also contract with a managed care plan to provide services. Participating counties with the approval from the state may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design or comparability of services. Counties may act jointly in order to deliver these services.

26. ***"Discharge services"*** means the process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

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

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

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

30. ***"Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)"*** means the federally mandated Medicaid benefit that entitles full-scope Medi-Cal-covered beneficiaries less than 21 years of age to receive any Medicaid service necessary to correct or ameliorate a defect, mental illness, or other condition,

    such as a substance-related disorder, that is discovered during a health screening.

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

32. ***"Emergency medical condition"*** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

    (1) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

    (2) Serious impairment to bodily functions.

    (3) Serious dysfunction of any bodily organ or part.

33. ***"Emergency services"*** means covered inpatient and outpatient services that are as follows:

    (1) Furnished by a provider that is qualified to furnish these services under this Title.

    (2) Needed to evaluate or stabilize an emergency medical condition.

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

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

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

37. ***"Family Therapy"*** means including a beneficiary's family members and loved ones in the treatment process, and education about factors that are important to the beneficiary's recovery as well as their own recovery can be conveyed. Family members may provide social support to beneficiaries, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

38. ***"Fair Hearing"*** means the state hearing provided to beneficiaries

upon denial of appeal pursuant to 22 CCR 50951 and 50953 and 9 CCR 1810.216.6. Fair hearings shall comply with 42 CFR 431.220(a)(5), 438.408(f), 438.414, and 438.10(g)(1).

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

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

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

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

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

44. ***"Group Counseling"*** means contacts in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served. A beneficiary that is 17 years of age or younger shall not participate in-group counseling with any participants who are 18 years of age or older. However, a beneficiary who is 17 years of age or younger may participate in group counseling with

participants who are 18 years of age or older when the counseling is at a provider's certified school site.

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

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

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

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

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

50. ***"Key Points of Contact"*** means common points of access to substance use treatment services from the county, including but not limited to the county's beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the county.

51. ***"Long-Term Services and Supports (LTSS)"*** means services and supports provided to beneficiaries of all ages who have

functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

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

53. ***"Managed Care Organization (MCO)"*** means an entity that has, or is seeking to qualify for, comprehensive risk contract under this part, and that is-

    (1) A Federally qualified HMO that meets the advance directives requirements of subpart l of part 489 of this chapter; or

    (2) Any public Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:

        (i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.

        (ii) Meets the solvency standards of the §438.116.

54. ***"Managed Care Program"*** means a managed care delivery system operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act.

55. ***"Maximum Payable"*** means the encumbered amount reflected on the Standard Agreement of this Agreement and supported by Exhibit B, Attachment I.

56. ***"Medical Necessity" and "Medically Necessary Services"*** means those SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or

treatment of a disease, illness, or injury consistent with 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.

57. ***"Medical Necessity Criteria"*** means adult beneficiaries must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, and must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria. Adults shall meet the ASAM Adult Dimensional Admission Criteria. Youth under 21 may be assessed to be at risk for developing a substance use disorder, and if applicable, must meet the ASAM adolescent diagnostic admission criteria. Beneficiaries under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health.

58. ***"Medical psychotherapy"*** means a type of counseling service that has the same meaning as defined in 9 CCR § 10345.

59. ***"Medication Services"*** means the prescription or administration of medication related to substance use disorder treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services.

60. ***"Modality"*** means those necessary overall general service activities to provide substance use disorder services as described in Division 10.5 of the HSC.

61. ***"Opioid (Narcotic) Treatment Program"*** means an outpatient clinic licensed by the state to provide narcotic replacement therapy directed at stabilization and rehabilitation of persons who are opiate-addicted and have a substance use diagnosis.

62. ***"Naltrexone Treatment Services"*** means an outpatient treatment service directed at serving detoxified opiate addicts by using the drug Naltrexone, which blocks the euphoric effects of opiates and helps prevent relapse to opiate addiction.

63. ***"Network"*** means the group of entities that have contracted with the PIHP to provide services under this Agreement.

64. ***"Network Provider"*** means any provider, group of providers, or entity that has a network provider agreement with a MCO, PIHP, PAHP, or a subcontract, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP or PAHP. A network provider is not a subcontractor by virtue of the network provider agreement.

65. ***"Non-participating provider"*** means a provider that is not engaged in the continuum of services under this Agreement.

66. ***"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.

67. ***"Non-Quantitative Treatment Limitation (NQTL)"*** means a limit on the scope or duration of benefits that is not expressed numerically. Non-quantitative treatment limitations include:

    a. Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
    b. Formulary design for prescription drugs;
    c. Network tier design;
    d. Standards for provider admission to participate in a network, including reimbursement rates;
    e. Methods for determining usual, customary, and reasonable charges;
    f. Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
    g. Exclusions based on failure to complete a course of treatment;

h. Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services; and
i. Standards for providing access to out-of-network providers.

68. ***"Nonrisk Contract"*** means a contract between the state and a PIHP or PAHP under which the contractor-

(1) Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in § 447.362, and

(2) May be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits

69. ***"Notice of Adverse Benefit Determination (NOABD)"*** means a formal communication of any action and consistent with 42 CFR 438.404 and 438.10.

70. ***"Observation"*** means the process of monitoring the beneficiary's course of withdrawal. It is to be conducted as frequently as deemed appropriate for the beneficiary and the level of care the beneficiary is receiving. This may include but is not limited to observation of the beneficiary's health status.

71. ***"Outpatient Services"*** means (ASAM Level 1.0) outpatient service directed at stabilizing and rehabilitating persons up to nine hours of service per week for adults, and less than six hours per week for adolescents.

72. ***"Overpayment"*** means any payment made to a network provider by a MCO, PIHP, or PAHP to which the network provider is not entitled to under Title XIX of the Act or any payment to a MCO, PIHP, or PAHP by a state to which the MCO, PIHP, or PAHP is not entitled to under Title XIX of the Act.

73. ***"Patient Education"*** means providing research based education on addiction, treatment, recovery and associated health risks.

74. ***"Participating provider"*** means a provider that is engaged in the continuum of services under this Agreement.

75. ***"Payment Suspension"*** means the Drug Medi-Cal certified provider has been issued a notice pursuant to WIC 14107.11 and is not authorized to receive payments after the payment suspension date for DMC services, regardless of when the service was provided.

76. ***"Performance"*** means providing the dedicated capacity in accordance with Exhibit B, Attachment I, and abiding by the terms of this Exhibit A, including all applicable state and federal statutes, regulations, and standards, including Alcohol and/or Other Drug Certification Standards (Document 1P), if applicable, in expending funds for the provision of SUD services hereunder.

77. "***Perinatal DMC Services"*** means covered services as well as mother/child habilitative and rehabilitative services; services access (i.e., provision or arrangement of transportation to and from medically necessary treatment); education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant; and coordination of ancillary services (Title 22, Section 51341.1(c) 4).

78. ***"Physician"*** as it pertains to the supervision, collaboration, and oversight requirements in sections 1861(aa)(2)(B) and (aa)(3) of the Act, a doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the State in which the function is performed.

79. ***"Physician Consultation"*** services are to support DMC physicians with complex cases, which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

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

81. ***"Plan"*** means any written arrangement, by one or more entities, to provide health benefits or medical care or assume legal liability for injury or illness.

82. ***"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.

83. ***"Postservice Postpayment (PSPP) Utilization Review"*** means the review for program compliance and medical necessity, conducted by the state after service was rendered and paid. The Department may recover prior payments of Federal and state funds if such a review determines that the services did not comply with the applicable statutes, regulations, or terms as specified in Article III.PP of this Agreement.

84. ***"Potential Beneficiary/Enrollee"*** means a Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given MCO, PIHP, PAHP, PCCM or PCCM entity, but is not yet an enrollee of a specific MCO, PIHP, PAHP, PCCM, or PCCM entity.

85. ***"Preauthorization"*** means approval by the Plan that a covered service is medically necessary.

86. ***"Prepaid Ambulatory Health Plan (PAHP)"*** means an entity that:

(1) Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State Plan payment rates.

(2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and

(3) Does not have a comprehensive risk contract.

87. ***"Prepaid Inpatient Health Plan (PIHP)"*** means an entity that:

(1) Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State Plan payment rates.

(2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and

(3) Does not have a comprehensive risk contract.

88. ***"Prescription drugs"*** means simple substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are:

(1) Prescribed by a physician or other licensed practitioner of the

healing arts within the scope of this professional practice as defined and limited by Federal and State law

(2) Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and

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

89. ***"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.

90. ***"Primary Care Case Management Entity (PCCM entity)"*** means an organization that provides any of the following functions, in addition to primary care case management services, for the state:

(1) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line.

(2) Development of enrollee care plans.

(3) Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program.

(4) Provision of payments to FFS providers on behalf of the state.

(5) Provision of enrollee outreach and education activities.

(6) Operation of a customer service call center.

(7) Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement.

(8) Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.

(9) Coordination with behavioral health systems/providers.

(10) Coordination with long-term services and supports

systems/providers.

91. ***"Primary Care Case Manager (PCCM)"*** means a physician, a physician group practice or, at State option, any of the following:

    (1) A physician assistant

    (2) A nurse practitioner

    (3) A certified nurse-midwife

92. ***"Primary care physician (PCP)"*** means a Physician responsible for supervising, coordinating, and providing initial and Primary Care to patients and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist.

93. ***"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.

94. ***"Projected Units of Service"*** means the number of reimbursable DMC units of service, based on historical data and current capacity, the Contractor expects to provide on an annual basis.

95. ***"Provider"*** means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services.

96. ***"Provider-preventable condition"*** means a condition that meets the definition of a health care-acquired condition — a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary under section 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State Plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients — or an "other provider-preventable condition," which is defined as a condition occurring in any health care setting that meets the following criteria:

    (1) Is identified in the State Plan.

(2) Has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.

(3) Has a negative consequence for the beneficiary.

(4) Is auditable.

(5) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

97. ***"Quantitative Treatment Limitation (QTL)"*** means a limit on the scope or duration of a benefit that is expressed numerically.

98. ***"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.

99. ***"Recovery monitoring"*** means recovery coaching, monitoring via telephone and internet. Recovery monitoring is only available in Recovery services.

100. ***"Recovery Services"*** are available after the beneficiary has completed a course of treatment. Recovery services emphasize the patient's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to patients.

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

102. ***"Relapse"*** means a single instance of a beneficiary's substance use or a beneficiary's return to a pattern of substance use.

103. ***"Relapse Trigger"*** means an event, circumstance, place or person that puts a beneficiary at risk of relapse.

104. ***"Residential Treatment Services"*** means a non-institutional, 24-hour non-medical, short-term residential program of any size that provides rehabilitation services to beneficiaries. Each beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills, and access community support systems. Programs shall provide a range of activities and services. Residential treatment shall include 24-hour structure with available trained personnel, seven days a week, including a minimum of five hours of clinical service a week to prepare beneficiary for outpatient treatment.

105. ***"Revenue"*** means Contractor's income from sources other than the state allocation.

106. ***"Safeguarding medications"*** means facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.

107. ***"Service Area"*** means the geographical area under Contractor's jurisdiction.

108. ***"Service Authorization Request"*** means a beneficiary's request for the provision of a service.

109. ***"Short-Term Resident"*** means any beneficiary receiving residential services pursuant to DMC-ODS, regardless of the length of stay, is a "short-term resident" of the residential facility in which they are receiving the services.

110. ***"State"*** means the Department of Health Care Services or DHCS.

111. ***"Subcontract"*** means an agreement between the Contractor and its subcontractors. A subcontractor shall not delegate its obligation to provide covered services or otherwise subcontract for the provision of direct patient/beneficiary services.

112. ***"Subcontractor"*** means an individual or entity that is DMC certified and has entered into an agreement with the Contractor to be a provider of covered services. It may also mean a vendor who has entered into a procurement agreement with the Contractor to

provide any of the administrative functions related to fulfilling the Contractor's obligations under the terms of this Exhibit A, Attachment I.

113. ***"Substance Abuse Assistance"*** means peer-to-peer services and relapse prevention. Substance abuse assistance is only available in Recovery services.

114. ***"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.

115. ***"Substance Use Disorder Medical Director"*** has the same meaning as in 22 CCR § 51000.24.4.

116. ***"Support Groups"*** means linkages to self-help and support, spiritual and faith-based support.

117. ***"Support Plan"*** means a list of individuals and/or organizations that can provide support and assistance to a beneficiary to maintain sobriety.

118. ***"Telehealth Between Provider and Beneficiary"*** means office or outpatient visits via interactive audio and video telecommunication systems.

119. ***"Telehealth Between Providers"*** means communication between two providers for purposes of consultation, performed via interactive audio and video telecommunications systems.

120. ***"Temporary Suspension"*** means the provider is temporarily suspended from participating in the DMC program as authorized by WIC 14043.36(a). The provider cannot bill for DMC services from the effective date of the temporary suspension.

121. ***"Threshold Language"*** means a language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

122. ***"Transportation Services"*** means provision of or arrangement for transportation to and from medically necessary treatment.

123. ***"Unit of Service"*** means:

(A) For case management, intensive outpatient treatment, outpatient services, Naltrexone treatment services, and recovery services contact with a beneficiary in 15-minute increments on a calendar day.
(B) For additional medication assisted treatment, physician services that includes ordering, prescribing, administering, and monitoring of all medications for substance use disorders per visit or in 15-minute increments.
(C) For narcotic treatment program services, a calendar month of treatment services provided pursuant to this section and Chapter 4 commencing with 9 CCR § 10000.
(D) For physician consultation services, consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists in 15-minute increments.
(E) For residential services, providing 24-hour daily service, per beneficiary, per bed rate.
(F) For withdrawal management per beneficiary per visit/daily unit of service.

124. ***"Urgent care"*** means a condition perceived by a beneficiary as serious, but not life threatening. A condition that disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 24-72 hours.

125. ***"Utilization"*** means the total actual units of service used by beneficiaries and participants.

126. ***"Withdrawal Management"*** means detoxification services provided in either an ambulatory or non-ambulatory setting consistent with the ASAM level of care criteria to DMC ODS beneficiaries.

V. Contractor Specific Requirements

Beginning June 15, 2017 and ending June 30, 2019, in addition to the general requirements outlined in Exhibit A, Attachment I, the Contractor agrees to the following Contractor specific requirements:

A. Covered Services

In addition to the Mandatory Covered Services outlined in Article III.C of Exhibit A, Attachment I, the Contractor shall establish assessment and referral procedures and shall arrange, provide, or subcontract for medically necessary Contractor Specific Covered Services in the

Contractor's service area in compliance with 42 CFR 438.210(a)(1), 438.210(a)(2), and 438.210(a)(3).

1. The Contractor shall deliver the Contractor Specific Covered Services within a continuum of care as defined in the ASAM criteria.
2. Contractor Specific Covered Services include:
   i. Additional Medication Assisted Treatment (MAT)
   ii. Partial Hospitalization
   iii. Transitional Housing

B. Access to Services

In addition to the general access to services requirements outlined in Article III.F of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific access to services requirements:

1. Beneficiaries shall access the Contractor's treatment services through the Behavioral Health Services Gateway Call Center (Gateway Call Center or Gateway), or through referral made by one of the post-authorization sites.
2. Gateway Call Center:
   i. The Gateway Call Center shall be the entry point for beneficiaries seeking Substance Use Disorder Services (SUDS). Beneficiaries shall be able to call a toll-free line as the first step toward admission in the substance use treatment system. Beneficiaries shall be referred to the Gateway Call Center from the courts, probation, parole, doctors, social workers, Child Protective Services (CPS), friends, family, and word of mouth.
   ii. The Gateway Call Center shall provide beneficiaries with 24/7 access and/or referral for outpatient screening, triage, residential, and detoxification services. The 24/7 access is for the continuum of care within the Substance Use Treatment system.
   iii. The Gateway Call Center staff shall conduct a brief substance use and risk screening to determine an initial Level of Care (LOC) placement. A comprehensive ASAM assessment shall subsequently be conducted at the treatment site. All provider sites shall be assessment sites. Thus, a beneficiary may be admitted to the LOC to which they were referred to by Gateway, or be moved to a higher

or lower LOC.

iv. In-custody beneficiaries shall have access to two dedicated phone lines in the jails that connect directly to the Gateway Call Center at no cost to in-custody callers. In-custody callers shall receive the same standards of service as other callers to the Gateway Call Center.

3. Referrals:

i. Referrals for service are made in four different ways: 1) appointment-based referrals; 2) post-authorization referrals; 3) care coordination referrals determined by the Quality Improvement Coordinators (QICs); and 4) same day intake or walk-in referrals.

ii. Appointment-based referrals:

a. Treatment providers shall allow beneficiaries to schedule their admission into treatment.

b. Treatment providers shall attempt to reschedule “no shows” to the initial appointment.

iii. Post-authorization referrals:

a. A post-authorization site is located in agencies that require the ability to directly screen and refer beneficiaries to treatment providers. Post-authorization locations include specific courts, a centralized facility for serving criminal justice beneficiaries, and withdrawal management services providers.

b. Beneficiaries shall access post-authorization sites as walk-ins or referrals from the courts or other agencies, such as the Probation Department. The post-authorization site shall then directly refer the beneficiary to treatment.

c. The primary purpose of post-authorization sites is to provide better services for beneficiaries by not requiring them to repeat information to the Gateway Call Center, already collected at a post-authorization site.

iv. Care Coordination referrals:

a. Beneficiaries with special needs or that present with special circumstances, such as high use of treatment

services, shall be reviewed by the QICs and placed in an appropriate LOC. Beneficiaries with special needs shall be referred to the Quality Improvement Division by the Gateway Call Center and Mental Health Department. Beneficiaries identified as high users enter the system of care via Care Coordination service through the Quality Improvement and Data Standards (QIDS) Division.

v. Same-day referrals:
   a. When beneficiaries call the residential placement coordinator (after their Gateway Call Center screening), the residential placement coordinator shall offer the beneficiary a bed for intake that same day (if capacity permits) to reduce early terminations.
   b. Same-day access in outpatient shall include a scheduled rotation of “on-call” outpatient providers. Beneficiaries referred by the Gateway Call Center to an “on-call” outpatient treatment provider shall be offered an intake/assessment appointment on the same day.

vi. Youth and MAT System Referrals
   a. This basic referral process detailed above shall be in the Youth and MAT systems with some variations required by the specific needs of the target populations.
   b. Beneficiaries can enter the youth system directly through the QIC who manages the treatment referrals for youth and transitional aged youth (up to 26 years), or from a third party such as the Probation Department, Social Services Department, juvenile justice system, community based organizations, high schools, parents and family members.
   c. Referrals for youth outpatient services shall be distributed to the appropriate county or community provider, based on the transportation needs, geographic needs, and gang affiliation.
   d. Referrals to the youth system shall receive individualized assistance through the post-

authorization referral coordinator or will be channeled directly through the Gateway Call Center.

e. Beneficiaries shall be screened and referred to MAT through the Gateway Call Center. Adult beneficiaries shall be screened for eligibility appropriateness for MAT and referred to one of methadone clinics depending on the beneficiary's place of residence.

4. Location and staff conducting ASAM assessments

i. Intake is the first session at all treatment sites across the system of care.

ii. An in-depth LOC assessment shall be conducted with each beneficiary using the American Society of Addiction Medicine's (ASAM) Criteria at each treatment site.

iii. The ASAM 6-dimensional (DIM) assessment shall be conducted by licensed, licensed-waivered, or state certified AOD counselors working under the direction of the clinic's Licensed Practitioner of the Healing Arts (LPHAs).

iv. LPHA staff shall review and sign all placement decisions that meet the medical necessity criteria.

v. When a beneficiary needs a LOC not currently available in the System, such as partial hospitalization or medically monitored Intensive Inpatient Treatment, they shall be referred to the most appropriate level available or given community referrals to those services.

C. Timely Access

In addition to the general timely access requirements outlined in Article II.E of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific timely access requirements:

1. For new referrals, appointments shall be made five days a week during normal business hours.

2. Outpatient providers shall be open Monday through Friday from 8 AM to 6 PM. Evening outpatient services are provided. The Santa Clara County Behavioral Health Department (SCCBHD) shall review hours of operation and make changes that best meet the needs of the Medi-Cal beneficiaries.

3. The Contractor shall provide beneficiaries with entry to treatment seven days a week when medically necessary.

4. The Contractor shall ensure a maximum of fourteen days

between referral (including from the Gateway Call Center) and first appointment for a face-to-face visit, which is the standard for outpatient placements.

5. All outpatient treatment agencies shall provide at least four face-to-face treatment sessions within the first thirty days of admission. The average length of stay for outpatient services is 90 days. Additional sessions may be scheduled based on individual needs.
6. Detoxification services shall be available seven days a week.
7. Beneficiaries that need afterhours care shall be referred to an on call clinician for immediate clinical disposition and/or care coordination.
8. Beneficiaries with an urgent condition shall receive services or attention from Care Coordination staff within 24 hours.
9. Residential providers shall take weekend admissions and evening admissions for beneficiary convenience.

D. Coordination and Continuity of Care

In addition to the general coordination and continuity of care requirements outlined in Article III.G of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor coordination and continuity of care requirements:

1. The Quality Improvement Division shall manage transitions among different levels of care.
2. The QIDS shall also authorize extensions of stay in residential treatment. This function includes successful transitions of beneficiaries that have been designated as “high utilizers” and other beneficiaries that have been transitioned to lower LOC but need upgrades to more intensive services. The QIDS staff shall manage these designated beneficiaries to ensure appropriate assessment and placement in treatment. QIDS staff shall also provide additional case management services necessary to address the individual special needs of this population.
   i. Routine movement:
      a. Once a beneficiary is admitted, movement from within the continuum will be routine.
      b. Providers shall be responsible for moving beneficiaries between providers (direct referral), which typically occurs when beneficiaries are discharged from a higher LOC to a lower LOC.

c. Direct referrals shall also occur when a beneficiary requests a move to a different provider within the same LOC.

ii. Non-routine movement:

a. Consultation and authorization from QICs shall be required to move a beneficiary to a higher LOC (e.g., outpatient to residential). ASAM 6 DIM and LOC Criteria shall be utilized to determine whether the move should be authorized.

b. Extension of residential stays shall require consultation with and authorization by a QIC prior to the transfer. ASAM 6 DIM and LOC Criteria, along with relevant clinical information, shall be utilized to determine authorizations for extensions of lengths of stay.

3. Care Coordination shall be offered by the Quality Improvement Division staff in special instances where there are provider-beneficiary issues, beneficiary-specific needs, or other unique circumstances. In all these instances, transfers shall require prior consultation and authorization with QICs.

4. Beneficiaries can be assessed as often as necessary; however, an ASAM assessment is generally valid for 180 days. Beneficiaries who return to the system following a break in treatment (discharge) require a re-assessment before they are placed in a LOC.

5. When a beneficiary receives inpatient substance use disorder (SUD) services (ASAM level 3.7 and 4.0 services) in an acute care hospital, or another Fee for Service (FFS) facility, the Contractor shall manage the needed transition of care to any lower level of care provided by a DMC-ODS provider. If the Contractor has subcontracted with either a Chemical Dependency Recovery Hospital (CDRH) or Acute Freestanding Psychiatric hospital for inpatient SUD services using other county funds, the same transition of care coordination is required.

6. When a beneficiary requires inpatient substance use disorder (SUD) services (ASAM level 3.7 and 4.0 services) in an acute care hospital, or another Fee for Service (FFS) facility, the Contractor shall manage the needed transition of care up to the

medically necessary LOC. If the Contractor has subcontracted with either a Chemical Dependency Recovery Hospital (CDRH) or Acute Freestanding Psychiatric hospital for inpatient SUD services using other county funds, the same transition of care coordination is required.

7. Case managers:

i. The Quality Improvement Division shall be responsible for managing beneficiary flow between levels of care after admission for all beneficiaries, including routine and non-routine transitions. QICs shall oversee the beneficiary transfer process, authorize extensions of stay in treatment, trouble-shoot for solutions for specific beneficiary problems and other beneficiary-related issues that arise during treatment. The actual decision to move from one LOC to another shall be overseen by a QIC.

ii. Case managers shall not be involved in decisions related to transition between LOC. Case managers may be involved in transporting beneficiaries from level to level. The case management program focuses on providing linkages to community services, assisting beneficiaries with applications for benefits and housing, and assisting beneficiaries in accessing food stamps, medical and dental care, clothing, transportation and other ancillary services.

E. Memorandum of Understanding

In addition to the general Memorandum of Understanding (MOU) requirements outlined in Article III.G.3 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor memorandum of understanding requirements:

1. The Contractor shall enter into MOUs with the subcontracted health plan providers. The MOUs shall outline mechanisms for sharing information and coordination of service delivery.

2. The following elements shall be covered in the MOUs:

i. Comprehensive substance use, physical, and mental health screening.

ii. Beneficiary engagement and participation in an integrated care program as needed.

iii. Shared development of care plans by the beneficiary, caregivers and all providers.

iv. Collaborative treatment planning with managed care.
v. Care coordination and effective communication among providers.
vi. Navigation support for patients and caregivers.
vii. Facilitation and tracking of referrals between systems.

3. The following policies and procedures shall be incorporated into the MOUs:
i. Information sharing policies and procedures.
ii. Agreed upon roles and responsibilities for sharing personal health information (PHI) for the purposes of medical and behavioral health care coordination.
iii. Coordinating medical and behavioral health care for beneficiaries enrolled in Medi-Cal Managed Care Plans that are receiving Medi-Cal specialty mental health or Drug Medi-Cal services through the SCCBHD.

4. The MOUs with health plans shall contain language that covers:
i. Plan for a fair hearing for denial of service.
ii. Provisions for a protocol to resolve issues related to denial of coverage or payment for services rendered.

5. The grievance system in the MOUs shall include:
i. Procedures for beneficiaries, providers, and MCOs to file grievances and appeal grievances.
ii. Time frames for reasonable action.
iii. Fair hearing procedures.
iv. Protocols for filing grievances.

6. All MOUs with MCOs shall be approved by the Contractor's counsel.

F. Authorization of Services – Residential Programs

In addition to the general authorization of residential services requirements outlined in Article III.H of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific authorization of residential services requirements:

1. Residential capacity in the system of care shall be managed by the QIDS Division.

2. When beneficiaries call the Gateway Call Center, they shall be triaged to the most appropriate modality using the Gateway Call Center screening tool. The triage determination at the Gateway Call Center shall constitute an authorization for Residential

Treatment and the beneficiary shall be referred to the Residential Placement Coordination List managed by QIDS Division.

3. The Residential Placement Coordinator and support staff shall be responsible for matching beneficiaries on the list to appropriate residential beds in accordance with established timeliness standards.
4. Providers shall contact the QIDS Division after completing a standardized intake assessment and request a formal authorization. The intake assessment will be electronically transmitted to the QIDS Division for record keeping and utilization management.
5. Beneficiaries shall be offered same day admissions if beds are available. Beneficiaries can also make an appointment and choose to schedule their admission day in advance. Post-authorizations sites shall offer assessment and screening on-site (e.g., Re-Unification Court, Assembly Bill (AB) 109, Juvenile Justice Court, and Parolee Re-Entry Centers, etc.) and shall directly refer beneficiaries to a residential bed (offering them an appointment or same day intake appointment).
6. The QIDS Division shall coordinate the placement of beneficiaries in residential treatment when the initial assessment requires it. If the recommendation involves an “upgrade” to a more intensive LOC, then the provider shall obtain an authorization through the QIDS Division. In instances where transfers cannot be arranged on the same day, the first provider shall admit the beneficiary and provide them with the intensity of services necessary to prevent their condition from deteriorating until a transfer can be arranged. Upgrades from outpatient to residential shall be given a high priority by QICs. Transfers between levels of care shall be documented both on paper and in the electronic health record.
7. In the Adult system, residential treatment shall be initially authorized for 45 days, and stays beyond 45 days shall be authorized by the Quality Improvement Division. The same full 6 DIM ASAM assessment shall be used at intake, and shall be used on the 35th day to determine re-authorizations for stays anticipated beyond 45 days.
8. In the Youth system, the residential length of stay shall be 30 days. Extensions shall be granted by QIC consultation based on

an individual's current clinical needs and ASAM assessment in keeping with a chronic care management philosophy where beneficiaries are stabilized at higher levels of care and then moved to lower levels of care within the community.

G. Early Intervention (ASAM Level 0.5)

The Contractor shall provide early intervention services in the manner described in Article III.N of Exhibit A, Attachment I.

H. Outpatient Services (ASAM Level 1)

In addition to the general outpatient services requirements outlined in Article III.O of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific outpatient services requirements:

1. There are minor differences in the ASAM Level 1 services provided to youth and adults, and age-appropriate treatment shall be provided to each beneficiary.
2. Youth Outpatient Services
   i. Outpatient services shall be available for youth under age 21 with a substance use diagnosis or are at-risk for developing a SUD.
   ii. The frequency of individual services, documented in the treatment plan, shall be based on the ASAM assessment and individual needs. The duration of ASAM Level 1 outpatient services for youth shall be no more than 6 hours per week.
   iii. Group Counseling shall be recommended for beneficiaries and shall be included in the treatment plan, based on individual needs.
   iv. These services shall be delivered in person, by phone or a tele-health medium.
   v. There shall not be a minimum number of treatment sessions per month for a youth to remain in treatment. Therefore, if a youth is detained in Juvenile Hall his/her case will be kept open for up to one year in order to maintain continuity of care. Modifications of this treatment standard shall be clinically determined based on beneficiary progress, as documented in the clinical record.
   vi. Youth shall be referred to ancillary services, such as educational support, when indicated by their ASAM assessment.

3. Adult Outpatient Services
   i. ASAM Level 1 services for adults shall be provided in regularly scheduled sessions of fewer than nine contact hours a week.
   ii. Treatment shall address major lifestyle, attitudinal, and behavioral issues that could potentially undermine the goals of treatment or to impair the individual's ability to cope with major life tasks without the use of alcohol, and/or other drugs. Treatment shall include individual counseling, family therapy and case management.
   iii. These services shall be tailored to each beneficiary's level of clinical severity as determined by the ASAM 6 DIM treatment assessment and are focused on helping the beneficiary make changes in their drug use or addiction.
   iv. In the event, an adult is known to be incarcerated, his/her case will be kept open for up to one year in order to maintain continuity of care. (DMC services cannot be reimbursed while a beneficiary is incarcerated under the DMC-ODS system.)

I. Intensive Outpatient Services (ASAM Level 2.1)

In addition to the general intensive outpatient services requirements outlined in Article III.P of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific intensive outpatient services requirements:

1. ASAM Level 2.1 shall provide adult outpatient services for between 9 to 19 hours per week and between 6 and 19 hours per week for youth and young adults. Youth, transitional aged youth and adults who exhibit more severe symptomology and needs that do not respond to less than 6 hours per week of treatment in outpatient settings shall be offered Level 2.1 Intensive Outpatient Services (IOP). Services may be provided up to 6 days a week for youth (including weekend activities) for up to a maximum 19 hours per week.
2. The target population for ASAM Level 2.1 services include youth and adults who exhibit impaired functioning at home, school (for youth), work, or in the community but do not require treatment in a residential setting.
3. ASAM Level 2.1 treatment shall include counseling and education

about addiction-related and co-occurring disorders.

4. ASAM Level 2.1 treatment shall be offered during regular business hours and after-school/work hours for school-aged and employed beneficiaries. Beneficiaries may be stepped down to ASAM Level 1 or up to Residential Treatment as needed. Perinatal Services:
   i. The primary counselor shall coordinate the treatment episode for beneficiaries and will provide targeted case-management for services such as housing, psychiatric or primary medical care.
   ii. Perinatal beneficiaries shall receive appropriate intensity of care within the outpatient spectrum, based on an assessment and discussion with the beneficiaries.
   iii. Beneficiaries may be referred to other more intensive treatment levels such as Women's Residential and Detoxification services, based on beneficiary need and ASAM assessment.

J. Residential Treatment Services

In addition to the general residential treatment services requirements outlined in Article III.Q of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific residential treatment services requirements:

1. Three levels of ASAM residential services shall be available to adults: ASAM Levels 3.3 and 3.5 in the second-year. Level 3.1 shall be available to adults in the first-year of this Intergovernmental Agreement.
2. The youth residential system shall provide ASAM Level 3.1 for residential treatment. The Youth System will offer Residential Level 3.5 as part of the ODS implementation in the second-year of this Intergovernmental Agreement.
3. Both gender-specific and mixed-gender residential services shall be offered.
4. Clinically Managed Low-Intensity Residential Services (ASAM Level 3.1)
   i. Residential Services ASAM Level 3.1 shall be available for youth 18 years and younger. ASAM Level 3.1 shall be available to adults in the first-year of this Intergovernmental Agreement.

ii. The goal of the residential therapeutic milieu is to promote the development of: (a) a youth's interpersonal and independent living skills at a pace that matches the youth's cognitive abilities, and (b) behavior patterns and habits designed to help youth successfully re-integrate back into the community. Residential treatment services involve a minimum of five hours of clinical services each week during the 30-day average length of stay.

iii. Following residential treatment, youth shall be stepped down to Wraparound services, Full Service Partnership (FSP) services, intensive outpatient, outpatient services, or other community services, based on individual needs to ensure the appropriate level of support for maintaining sobriety after discharge from treatment.

5. Clinically Managed Population-Specific High-Intensity Residential Services (ASAM Level 3.3)

i. Residential ASAM Level 3.3 shall be available for adults in the second-year, and is not a part of the adolescent continuum of care in the ASAM continuum.

ii. ASAM Level 3.3 residential services shall be available to beneficiaries with cognitive limitations, medical conditions, and/or are elderly and require treatment at a slower pace. Services are slower paced, more concrete, and more repetitive.

iii. Medical, psychiatric, psychological, laboratory, and toxicology services shall be available through consultation or referral.

6. Clinically Managed High-Intensity Residential Services (ASAM Level 3.5)

i. Residential ASAM Level 3.5 services shall be available for adults in the second-year. The Youth System will offer Residential Level 3.5 as part of the ODS implementation in the second-year of this Intergovernmental Agreement.

ii. ASAM level 3.5 shall focus on stabilization of signs and symptoms of high risk addiction, initiation or restoration of the recovery process and preparation for ongoing recovery in the broad continuum of care.

iii. This level of treatment shall rely on the treatment community

as a therapeutic agent.

iv. ASAM Level 3.5 services will be added to the continuum of care for youth in the second year of the ODS implementation. ASAM Level 3.5 provides 24-hour care by clinical staff for beneficiaries in a therapeutic milieu. Level 3.5 services will be used to provide services to youth and young adults, who face imminent danger with co-occurring issues, require stabilization of their symptoms, and require services to re-integrate into the community with adequate levels of support.

v. Perinatal residential treatment for women and their children under age 5, shall be provided at ASAM Level 3.5. This program shall comply with the Perinatal Services Network Guidelines. In addition to recovery, treatment shall focus on parenting and child development. Length of stay can extend up to 6 months when necessary.

7. Medically Monitored Intensive Inpatient Services – Adult/High Intensity Inpatient Services – Adolescent/Medically Managed Intensive Inpatient Services (Adult & Adolescent) (ASAM Level 3.7 and 4.0)

i. The Contractor shall establish an MOU with a local provider to provide ASAM 3.7 and 4.0 services. Beneficiaries shall receive services from these providers until they can be discharged to a lower LOC provided by the SCCBHD network.

K. Case Management

In addition to the general case management requirements outlined in Article III.R of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific case management requirements:

1. Programs at all ASAM Levels of Care for youth and adults shall offer case management services by on-site staff.

2. Services shall include, but will not be limited to, linking beneficiaries to other levels of care for substance use treatment, primary care, mental health, vocational, legal and housing resources, as well as case consultation services.

3. There is no designated length of stay for case management services. Individual needs shall be periodically assessed to determine the need for continued case management services.

4. Case management services shall be provided by licensed or credentialed staff persons.
5. Case management services for all beneficiaries shall be integrated with the treatment plan.
6. Case management services shall focus on addressing tangible needs such as shelter, employment, transportation, academic needs, and support beneficiaries' engagement and treatment progress.
7. The Youth System of Care shall utilize a clinical/rehabilitation approach to case management in which the therapist provides the therapy as well as the case management activities.
8. In the adult system, the primary treatment counselor/therapist may also provide case management services. When the case manager is not the primary treatment provider, he/she shall work closely with the primary counselor to support the treatment plan. Specific tasks such as transportation, assistance completing applications, or accompanying the beneficiary for appointments and other tasks shall be assigned to a community-worker or peer mentor. Adult system community-workers and peer mentors shall work under the direction of the credentialed or licensed counselor to provide a range of services, depending on the beneficiary's needs.

L. Physician Consultation

In addition to the general physician consultation requirements outlined in Article III.S of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific physician consultation requirements:

1. The DMC provider's physician/s will be able to consult for complex cases with addiction medicine specialists at the established physician consultation rate. Physician consultation may include: medication selection, dosing, side effect management, adherence, drug-drug interactions, or LOC considerations.
2. Services shall be delivered by phone, fax, email, and/or onsite-live-interactive videoconferencing.

M. Recovery Services

In addition to the general recovery services requirements outlined in Article III.T of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific recovery services requirements:

Exhibit A, Attachment I A2
Program Specifications

1. Beneficiaries shall be offered this service if they have relapsed.
2. Recovery services shall address the needs identified in ASAM 6 DIM, and services shall be provided face-to-face, by phone or via a tele-health medium.
3. Relapse education and warning sign identification shall occur throughout the duration of recovery services.
4. Youth shall be linked to recovery services that will address their psychosocial issues, help them develop self-management skills, and reinforce skills gained during treatment.
5. Recovery Services shall be available for adult beneficiaries with a SUD in remission but exhibit a high risk for relapse potential on ASAM DIMs 3 to 6.
6. Recovery Services shall be available for beneficiaries after completing the course of treatment if they are struggling with triggers, they relapse, or as a preventative measure. These services may be provided face-to-face or by telephone and may include, but are not limited to, Wellness Recovery Action Plan (WRAP) groups, Continuous Recovery Monitoring (CRM), drop-in support groups, and relapse prevention groups. WRAP is a wellness and recovery approach that is self-directed that involves peer-led groups. CRM was a pilot project that provided telephone check-ups after discharge for treatment to beneficiaries who had successfully completed treatment.
7. Recovery Services shall be available to beneficiaries upon the completion of treatment to prevent relapse.
8. Early Recovery Services for Youth
   i. Youth and young adults who are eligible for the early recovery services shall be either vulnerable to future substance use problems or at immediate risk for meeting the criteria for a SUD.
   ii. Referrals for service shall be made by the beneficiary, school staff (Multi-Service Team (MST) coordinator, discipline officer), parent or other third parties, such as, truancy court.
   iii. Primary Care Physicians shall screen young adults age 18 and older for substance use issues. Following the referral, the clinician shall meet with the youth or young adult to assess substance use related risk factors such as

possessing substances on the school campus or in the home environment, associating with known substance users, sudden poor academic performance and other problematic behaviors.

iv. Early recovery services for youth shall be delivered in clinic and/or school settings. Services in this level shall include individualized-brief intervention sessions. Content of these sessions shall include counseling interventions and psycho-education regarding the harmful effects of substances. Youth may be seen for up to ten sessions and then referred to mental health or SUD services as is medically necessary.

N. Withdrawal Management

In addition to the general withdrawal management requirements outlined in Article III.U of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific withdrawal management services requirements:

1. ASAM Level 3.2 shall be available to adult beneficiaries who meet the necessary ASAM criteria.
2. The components of withdrawal management services shall include intake and observation (Clinical Institute Withdrawal Assessment/CIWA).
3. At discharge from ASAM Level 3.2, beneficiaries shall be referred to either residential or outpatient services based on an assessment of individual needs.

O. Opioid (Narcotic) Treatment Program Services

In addition to the general opioid (narcotic) treatment program services requirements outlined in Article III.V of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific opioid (narcotic) treatment program services requirements:

1. The Contractor’s Narcotic Treatment Program is referred to as Medication Assisted Treatment (MAT), which provides treatment using approved medications for treating substance use.
2. Beneficiaries referred to the MAT program shall be screened for eligibility for MAT.
3. Both adults and youths shall receive MAT services if they meet the criteria for admission.
4. MAT services shall be provided in clinics licensed and accredited by Commission on Accreditation of Rehabilitating Facilities

(CARF) and staffed by board certified physicians specializing in Addiction Medicine, and licensed master's level clinicians or certified counselors.

5. MAT shall offer medications (e.g., methadone, naloxone, disulfiram, Suboxone and Vivitrol), counseling, case management, medical consultation, confidential human immunodeficiency virus (HIV) and tuberculosis (TB) testing and counseling to beneficiaries who meet the medical necessity criteria.

6. MAT prescriptions shall be provided through the patient's local or county pharmacies.

7. Methadone

i. Beneficiaries referred to methadone shall meet the admission and medical necessity criteria established by the California Code of Regulations (CCR) Title 9 and Federal regulations.

ii. Beneficiaries who meet admission criteria shall be admitted within 72 hours of the intake appointment.

iii. Admission to the methadone program involves two phases: Induction (including titration) and Stabilization.

iv. The induction phase (initial methadone dosing) is designed to attenuate withdrawal symptoms as quickly as is medically appropriate.

v. In the stabilization phase, the goal is to establish the dose of daily methadone that provides clinical efficacy, along with a margin of safety, for an appropriate duration of time.

vi. Methadone stabilization dosages shall be determined individually, within the limits stipulated by State and Federal regulations and MAT Policy and Procedures. If medically appropriate, higher initial dosage may be prescribed.

8. Suboxone

i. Admission to the Suboxone program shall require an evaluation by a program physician to establish medical necessity.

ii. Induction phase shall occur during the first week of treatment and involves onsite treatment and monitoring. Individuals are required to keep a follow up appointment for refilling their prescription. Individuals can be referred to counseling in

accordance with State and Federal regulations.

iii. Youth shall be referred to Suboxone services.

iv. Assessment using ASAM criteria shall be used to determine whether youths are eligible for Suboxone treatment and if the following criteria are met: diagnosis of opioid dependence or opioid use disorder, at least a one-year history of opioid dependence, and parental permission and involvement.

v. Opiate-addicted youth who are referred to MAT shall be evaluated by a MAT physician to determine if the youth meets the criteria for addiction medicine treatment.

P. Additional Medication Assisted Treatment

As stated in Article V.A of Exhibit A, Attachment I, the Contractor has elected to provide MAT services as a Contractor specific service. Therefore, the Contractor shall comply with the following Contractor specific MAT requirements:

1. Vivitrol treatment shall be available to outpatient beneficiaries at all MAT clinics.
2. Patients may refer themselves for Vivitrol treatment, but admission shall require an assessment by a licensed physician to determine whether the beneficiary is a good match for this medication.
3. Vivitrol shall be administered to volunteers from Substance Use Treatment System (SUTS) treatment programs with alcohol and/or opiate dependency upon consent to treatment.
4. The Vivitrol Treatment Program shall provide monthly assessments, reassessments, and medical services including evaluations, monthly injections follow up visits, and counseling.

Q. Partial Hospitalization

As stated in Article V.A of Exhibit A, Attachment I, the Contractor has elected to provide Partial Hospitalization services as a Contractor specific service. Therefore, the Contractor shall comply with the following Contractor Partial Hospitalization requirements:

1. Partial hospitalization (ASAM Level 2.5) shall be available to beneficiaries with unstable medical and psychiatric problems in the second year.
2. A minimum of 20 or more hours of service per week shall be provided in Level 2.5.

3. Beneficiaries shall have access to medical, psychological, psychiatric and toxicology services through consultation or referral. Psychiatric and other medical consultation will be available within 8 hours by phone and within 48 hours by person. Emergency services will be available 7 days a week and 24 hours a day, when the treatment program is not in session.
4. Beneficiaries may live in a residential facility, such as transitional housing with 24-hour supervision.

R. Transitional Housing

As stated in Article V.A of Exhibit A, Attachment I, the Contractor elects to provide Transitional Housing services as a Contractor specific service. Accordingly, the Contractor shall comply with the following Transitional Housing requirements: (Transitional Housing shall not be paid for under the DMC-ODS system.)

1. The Contractor shall make available Transitional Housing Units (THUs) to beneficiaries that are homeless, at risk for homelessness or living in unstable housing that may affect the beneficiaries' SUD recovery outcomes.
2. At-risk beneficiaries that have been placed in outpatient treatment shall be offered THUs for the duration of their outpatient treatment.
3. The average length of stay in a THU shall be between 90-180 days based on the treatment process.
4. THUs shall be provided by vendors that have contracts with the Contractor. THU vendors shall comply with the THU policies and procedures developed by the Contractor. The Contractor's THU policies and procedures shall govern the cleanliness and maintenance of the THUs.
5. The housing vendors shall work closely with the treatment providers.
6. Beneficiaries shall be required to pay up to 35 percent of their income for THUs services. Beneficiaries with food stamps are expected to use these benefits to partially cover their food costs.
7. The costs associated with THUs shall not be reimbursed through the DMC-ODS Waiver; therefore, the Contractor shall use other funding sources to pay for THU costs.

Exhibit B A2
Budget Detail and Payment Provisions

Part I - General Fiscal Provisions

Section 1 - General Fiscal Provisions

A. Fiscal Provisions

For services satisfactorily rendered, and upon receipt and approval of documentation as identified in Exhibit A, Attachment I, Article III, the Department of Health Care Services (DHCS) agrees to compensate the Contractor for actual expenditures incurred in accordance with the rates and/or allowable costs specified herein.

B. Use of State General Funds

Contractor may not use allocated Drug Medi-Cal (DMC) State General Funds to pay for any non-Drug Medi-Cal services.

C. Funding Authorization

Contractor shall bear the financial risk in providing any substance use disorder (SUD) services covered by this Agreement.

D. Availability of Funds

It is understood that, for the mutual benefit of both parties, this Intergovernmental Agreement may have been written before ascertaining the availability of congressional appropriation of funds in order to avoid program and fiscal delays that would occur if this Agreement were not executed until after that determination. In this event, DHCS may amend the amount of funding provided for in this Agreement based on the actual congressional appropriation.

E. Subcontractor Funding Limitations

Contractor shall reimburse its subcontractors that receive a combination of Drug Medi-Cal Organized Delivery System (DMC-ODS) funding and other federal or county realignment funding for the same service element and location based on the subcontractor's actual costs in accordance with Medicaid reimbursement requirements as specified in Title XIX or of the Social Security Act, DMC-ODS Special Terms and Conditions (STCs), and STCs' Attachments. Payments at interim rates shall be settled to lower of actual cost or customary charge at year-end.

F. Budget Contingency Clause

It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this Agreement does not appropriate sufficient funds for the program, this Agreement shall be of no further force and effect. In this event, DHCS

shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Agreement and Contractor shall not be obligated to perform any provisions of this Agreement.

If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, DHCS shall solely have the option to either cancel this Agreement with no liability occurring to DHCS, or offer an amended agreement to Contractor to reflect the reduced amount.

G. Expense Allowability/Fiscal Documentation

1. Invoices, received from a Contractor and accepted and/or submitted for payment by DHCS, shall not be deemed evidence of allowable agreement costs.

2. Contractor shall maintain for review and audit and supply to DHCS upon request, adequate documentation of all expenses claimed pursuant to this Agreement to permit a determination of expense allowability.

3. If the allowability or appropriateness of an expense cannot be determined by DHCS because invoice detail, fiscal records, or backup documentation is nonexistent or inadequate according to generally accepted accounting principles, and generally accepted governmental audit standards, all questionable costs may be disallowed and payment may be withheld by DHCS. Upon receipt of adequate documentation supporting a disallowed or questionable expense, reimbursement may resume for the amount substantiated and deemed allowable.

4. Costs and/or expenses deemed unallowable shall not be reimbursed or, if mistakenly reimbursed, those costs and/or expenses shall be subject to recovery by DHCS pursuant to Article III.DD of Exhibit A, Attachment I, the DMC-ODS STCs, and the STCs' Attachments.

Section 2 - General Fiscal Provisions - DMC-ODS

A. Return of Unexpended Funds

Contractor assumes the total cost of providing covered services on the basis of the payments delineated in this Exhibit B, Part II. Any State General Funds or Federal Medicaid funds paid to the Contractor, but not expended for DMC-ODS services shall be returned to DHCS.

B. Amendment or Cancellation Due to Insufficient Appropriation

This Agreement is valid and enforceable only if sufficient funds are made available to DHCS by the United States Government for the purpose of the DMC-ODS program. It is mutually agreed that if the Congress does not appropriate sufficient funds for this

program, DHCS solely has the option to void this Agreement or to amend the Agreement to reflect any reduction of funds.

C. Exemptions

Exemptions to the provisions of Item B above, of this Exhibit, may be granted by the California Department of Finance provided that the Director of DHCS certifies in writing that federal funds are available for the term of the Agreement.

D. Allowable costs

Allowable costs, as defined and in accordance with the DMC-ODS STCs and the STCs' Attachments, shall be determined in accordance with Title 42, Code of Federal Regulations (CFR), Chapter IV, Subchapter B, Parts 405 and 413, and Centers for Medicare and Medicaid Services (CMS), "Medicare Provider Reimbursement Manual (Publication Number 15)," which can be obtained from the Centers for Medicare & Medicaid Services, or www.cms.hhs.gov.

Exhibit B A2
Budget Detail and Payment Provisions

Part II - Reimbursements

Section 1 - General Reimbursement

A. Prompt Payment Clause

Payment will be made in accordance with, and within the time specified in, Government Code Chapter 4.5, commencing with Section 927.

B. Amounts Payable

1. The amount payable under this Agreement shall not exceed the amount identified on the State of California Standard Agreement form STD 213_DHCS.

2. Reimbursement shall be made for allowable expenses up to the amount annually encumbered commensurate with the state fiscal year in which services are performed and/or goods are received.

3. The funds identified for the fiscal years covered by under this Section, within this Exhibit, are subject to change depending on the availability and amount of funds appropriated by the Legislature and the Federal Government. The amount of funds available for expenditure by the Contractor shall be limited to the amount identified in the final allocations issued by DHCS for that fiscal year. Changes to allocated funds will require written amendment to the Agreement.

4. For each fiscal year, DHCS may settle costs for services to the Contractor and its subcontractors based on each fiscal year-end cost settlement report as the final amendment for the specific fiscal year cost settlement report to the approved Agreement.

Section 2 - DMC-ODS

A. To the extent that the Contractor provides the covered services in a satisfactory manner, in accordance with the terms and conditions of this Agreement, DHCS agrees to pay the Contractor Federal Medicaid funds according to Article III of Exhibit A, Attachment I. Subject to the availability of such funds, Contractor shall receive Federal Medicaid funds and/or State General Funds for allowable expenditures as established by the Federal Government and approved by DHCS, for the cost of services rendered to beneficiaries.

B. Any payment for covered services rendered pursuant to Exhibit A, Attachment I shall only be made pursuant to applicable provisions of Title XIX or Title XXI of the Social Security Act, the Welfare and Institutions (W&I) Code, the Health and Safety Code (HSC), the DMC-ODS STCs, and the STCs' Attachments.

Exhibit B A2
Budget Detail and Payment Provisions

C. It is understood and agreed that failure by the Contractor or its subcontractors to comply with applicable federal and state requirements in rendering covered services shall be sufficient cause for DHCS to deny payments, to recover payments, and/or terminate the Contractor or its subcontractor from DMC-ODS program participation. If DHCS or the Department of Health and Human Services (DHHS) disallows or denies payments for any claim, Contractor shall repay to DHCS the Federal Medicaid funds and/or State General Funds it received for all claims so disallowed or denied. The overpayment shall be recovered by any of the methods allowed in Division 9, Part 3, Chapter 7, Article 5.3 of the W&I Code and DMC-ODS STC 143(h)(vi).

D. Before a denial, recoupment, or disallowances are made, DHCS shall provide the Contractor with written notice of its proposed action. Such notice shall include the reason for the proposed action and shall allow the Contractor 60 days to submit additional information before the proposed action is taken. This requirement does not apply to the DMC-ODS Post Service Post Payment Utilization Reviews.

E. DHCS shall refund to the Contractor any recovered Federal DMC-ODS overpayment that is subsequently determined to have been erroneously collected, together with interest, in accordance with Division 9, Part 3, Chapter 7, Article 5.3 of the W&I Code.

F. Contractor shall be reimbursed by DHCS on the basis of its actual net reimbursable cost, not to exceed the unit of service maximum rate.

G. Claims submitted to the Contractor by a subcontracted provider that is not certified or whose certification has been suspended pursuant to the W&I Code section 14107.11 and 42 CFR 455.23, shall not be certified or processed for federal or state reimbursement by the Contractor. Payments for any DMC-ODS services shall be held by the Contractor until the payment suspension is resolved.

H. In the event an Agreement amendment is required pursuant to the preceding paragraph, Contractor shall submit to DHCS information as identified in Exhibit E, Section 1(D). To the extent the Contractor is notified of DHCS Budget Act allocation prior to the execution of the Agreement, DHCS and the Contractor may agree to amend the agreement after the issuance of the first revised allocation.

I. Reimbursement for covered services, other than Narcotic Treatment Program (NTP) services, shall be limited to the lower of:

   1. The provider's usual and customary charges to the general public for the same or similar services.

   2. The provider's actual allowable costs.

J. Reimbursement to NTP shall be limited to the lower of either the Uniform Statewide Daily Reimbursement (USDR) rate, pursuant to W&I Code Section 14021.51(h), or the

provider's usual and customary charge to the general public for the same or similar service. However, reimbursement paid by a county to an NTP provider for services provided to any person subject to Penal Code Sections 1210.1 or 3063.1 and for which the individual client is not liable to pay, does not constitute a usual or customary charge to the general public for the purpose of this section (W&I Code Section 14021.51(h)(2)(A)).

K. DHCS shall reimburse the Contractor the State General Funds and/or Federal Medicaid fund amount of the approved DMC-ODS claims and documents submitted in accordance with Article III of Exhibit A, Attachment I.

L. DHCS will adjust subsequent reimbursements to the Contractor to actual allowable costs. Actual allowable costs are defined in the Medicare Provider Reimbursement Manual (CMS-Pub.15), which can be obtained from the Centers for Medicare & Medicaid Services, Baltimore, Maryland, or www.cms.hhs.gov.

M. Contractors and subcontractors must accept, as payment in full, the amounts paid by DHCS in accordance with the DMC-ODS STCs and the STCs' Attachments. Contractors and subcontractors may not demand any additional payment from DHCS, client, or other third party payers.

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

Exhibit B A2
Budget Detail and Payment Provisions

Part III - Financial Audit Requirements

Section 1 - General Fiscal Audit Requirements

A. In addition to the requirements identified below, the Contractor and its subcontractors are required to meet the audit requirements as delineated in Exhibit C, General Terms and Conditions, and Exhibit D(F), Special Terms and Conditions, of this Agreement.

B. All expenditures of county realignment funds, state and federal funds furnished to the Contractor and its subcontractors pursuant to this Agreement are subject to audit by DHCS. Objectives of such audits may include, but not limited to, the following:

1. To determine whether units of service claimed/reported are properly documented by service records and accurately accumulated for claiming/reporting.

2. To validate data reported by the Contractor for prospective agreement negotiations.

3. To provide technical assistance in addressing current year activities and providing recommendation on internal controls, accounting procedures, financial records, and compliance with laws and regulations.

4. To determine the cost of services, net of related patient and participant fees, third-party payments, and other related revenues and funds.

5. To determine that expenditures are made in accordance with applicable state and federal laws and regulations and Agreement requirements.

6. To determine the facts in relation to analysis of data, complaints, or allegations, which may be indicative of fraud, abuse, willful misrepresentation, or failure to achieve the Agreement objectives of Exhibit C and D(F).

C. Unannounced visits may be made at the discretion of the DHCS to the Contractor and/or its subcontractors.

D. The refusal of the Contractor or its subcontractors to permit access to, and inspection of, electronic or print books and records, physical facilities, and/or refusal to permit interviews with employees, as described in this part, constitutes an express and immediate material breach of this Agreement and will be sufficient basis to terminate the Agreement for cause or default.

E. Reports of audits conducted by DHCS shall reflect all findings, recommendations, adjustments, and corrective action as a result of its finding in any areas.

Exhibit B A2
Budget Detail and Payment Provisions

Section 2 - DMC-ODS Financial Audits

A. In addition to the audit requirements set forth in Exhibit D(F), DHCS may also conduct financial audits of DMC-ODS programs, exclusive of NTP services, to accomplish any of, but not limited to, the following audit objectives:

   1. To review reported costs for validity, appropriate allocation methodology, and compliance with Medicaid laws and regulations.

   2. To ensure that only the cost of allowable DMC-ODS activities are included in reported costs.

   3. To determine the provider's usual and customary charge to the general public in accordance with CMS (The Medicare Provider Reimbursement Manual) (CMS-Pub.15), which can be obtained from the Centers for Medicare & Medicaid Services, Baltimore, Maryland, or www.cms.hhs.gov, for comparison to the DMC-ODS cost per unit.

   4. To review documentation of units of service and determine the final number of approved units of service.

   5. To determine the amount of clients' third-party revenue and Medi-Cal share of cost to offset allowable DMC-ODS reimbursement.

   6. To compute final settlement based on the lower of actual allowable cost or the usual and customary charge, in accordance with the DMC-ODS STCs and the STCs' Attachments.

B. In addition to the audit requirements set forth in Exhibit D(F), DHCS may conduct financial audits of NTP programs. For NTP services, the audits will address items A(3) through A(5) above, except that the comparison of the provider's usual and customary charge in A(3) will be to the DMC USDR rate in lieu of DMC-ODS cost per unit. In addition, these audits will include, but not be limited to:

   1. For those NTP providers required to submit a cost report pursuant to W&I Code Section 14124.24, a review of cost allocation methodology between NTP and other service modalities, and between DMC-ODS and other funding sources.

   2. A review of actual costs incurred for comparison to services claimed.

   3. A review of counseling claims to ensure that the appropriate group or individual counseling rate has been used and that counseling sessions have been billed appropriately.

4. A review of the number of clients in group sessions to ensure that sessions include no less than two and no more than twelve clients at the same time, with at least one Medi-Cal client in attendance.

5. Computation of final settlement based on the lower of USDR or the provider's usual and customary charge to the general public.

6. A review of supporting service, time, financial, and patient records to verify the validity of counseling claims.

C. Contractor shall be responsible for any disallowances taken by the Federal Government, DHCS, or the Bureau of State Audits as a result of any audit exception that is related to its responsibilities. Contractor shall not use funds administered by DHCS to repay one federal funding source with funds provided by another federal funding source, or to repay federal funds with state funds, or to repay state funds with federal funds.

D. Contractor agrees to promptly develop and implement any corrective action plans in a manner acceptable to DHCS in order to comply with recommendations contained in any audit report. Such corrective action plans shall include time-specific objectives to allow for measurement of progress and are subject to verification by DHCS within six months from the date of the plan.

E. Contractor, in coordination with DHCS, shall provide follow-up on all significant findings in the audit report, including findings relating to a subcontractor, and submit the results to DHCS.

   If differences cannot be resolved between DHCS and the Contractor regarding the terms of the final financial audit settlements for funds expended under Exhibit B, Contractor may request an appeal in accordance with the appeal process described in the Exhibit A, Attachment I and Division 9, Part 3, Chapter 7, Article 5.3 of the W&I Code. Contractor shall include a provision in its subcontracts regarding the process by which a subcontractor may file an audit appeal via the Contractor.

F. Providers of DMC-ODS services shall, upon request, make available to DHCS their fiscal and other records to assure that such providers have adequate recordkeeping capability and to assure that reimbursement for covered DMC-ODS services are made in accordance with Exhibit A, Attachment I, the DMC-ODS STCs, and the STCs' Attachments. These records include, but are not limited to, matters pertaining to:

   1. Provider ownership, organization, and operation

   2. Fiscal, medical, and other recordkeeping systems

   3. Federal income tax status

Exhibit B A2
Budget Detail and Payment Provisions

4. Asset acquisition, lease, sale, or other action

5. Franchise or management arrangements

6. Patient service charge schedules

7. Costs of operation

8. Cost allocation methodology

9. Amounts of income received by source and purpose

10. Flow of funds and working capital

G. Contractor shall retain records of utilization review activities, required in Exhibit A, Attachment I, Article III.EE herein, for a minimum of ten (10) years.

Exhibit B A2
Budget Detail and Payment Provisions

Part IV - Records

Section 1 - General Provisions

A. Maintenance of Records

Contractor shall maintain sufficient books, records, documents, and other evidence necessary for DHCS to audit Agreement performance and compliance. Contractor shall make these records available to DHCS, upon request, to evaluate the quality and quantity of services, accessibility and appropriateness of services, and to ensure fiscal accountability. Regardless of the location or ownership of such records, they shall be sufficient to determine if costs incurred by Contractor are reasonable, allowable and allocated appropriately. All records must be capable of verification by qualified auditors.

1. Contractor and subcontractors shall include in any contract with an audit firm a clause to permit access by DHCS to the working papers of the external independent auditor, and require that copies of the working papers shall be made for DHCS at its request.

2. Contractor and subcontractors shall keep adequate and sufficient financial records and statistical data to support the year-end documents filed with DHCS. All records must be capable of verification by qualified auditors.

3. Accounting records and supporting documents shall be retained for ten years. When an audit by the Federal Government, DHCS, or the California State Auditor has been started, the records shall be retained until completion of the audit and final resolution of all issues that arise in the audit. Final settlement shall be made at the end of the audit and appeal process.

4. Financial records shall be kept so that they clearly reflect the source of funding for each type of service for which reimbursement is claimed. These documents include, but are not limited to, all ledgers, books, vouchers, time sheets, payrolls, appointment schedules, client data cards, and schedules for allocating costs. All records must be capable of verification by qualified auditors.

5. Contractor's subcontracts shall require that all subcontractors comply with the requirements of Exhibit A, Attachment I, Article II and Article III.

6. Should a subcontractor discontinue its contractual agreement with the Contractor, or cease to conduct business in its entirety, Contractor shall be responsible for retaining the subcontractor's fiscal and program records for the required retention period. DHCS Administrative Manual (SAM) contains statutory requirements governing the retention, storage, and disposal of records pertaining to state funds. Contractor shall follow SAM requirements located at http://sam.dgs.ca.gov/TOC/1600.aspx.

Exhibit B A2
Budget Detail and Payment Provisions

The Contractor shall retain all records required by W&I Code section 14124.1, 42 CFR 433.32, Exhibit A, Attachment I, the DMC-ODS STCs and STCs' Attachments for reimbursement of services and financial audit purposes.

7. In the expenditure of funds hereunder, Contractor shall comply with the requirements of SAM and the laws and procedures applicable to the obligation and expenditure of federal and state funds.

B. Dispute Resolution Process

1. In the event of a dispute under Exhibit A, Attachment I, Article III other than an audit dispute, Contractor shall provide written notice of the particulars of the dispute to DHCS before exercising any other available remedy. Written notice shall include the Agreement number. The Director (or designee) of DHCS and the County Drug or Alcohol Program Administrator (or designee) shall meet to discuss the means by which they can effect an equitable resolution to the dispute. Contractor shall receive a written response from DHCS within 60 days of the notice of dispute. The written response shall reflect the issues discussed at the meeting and state how the dispute will be resolved.

2. As stated in Part III, Section 2, of this Exhibit, in the event of a dispute over financial audit findings between DHCS and the Contractor, Contractor may appeal the audit in accordance with Exhibit A, Attachment I and Division 9, Part 3, Chapter 7, Article 5.3 of the W&I Code. Contractor shall include a provision in its subcontracts regarding the process by which a subcontractor may file an audit appeal via the Contractor.

3. Contractors that conduct financial audits of subcontractors, other than a subcontractor whose funding consists entirely of non-Department funds, shall develop a process to resolve disputed financial findings and notify subcontractors of their appeal rights pursuant to that process. This section shall not apply to those grievances or compliances arising from the financial findings of an audit or examination made by or on behalf of DHCS pursuant to Part III of this Exhibit.

4. To ensure that necessary corrective actions are taken, financial audit findings are either uncontested or upheld after appeal may be used by DHCS during prospective agreement negotiations.

Exhibit B A2
Budget Detail and Payment Provisions

Part V - DMC-ODS Reimbursement Rates

A. **"Uniform Statewide Daily Reimbursement Rate (USDR)"** means the rate for NTP services based on a unit of service that is a daily treatment service, developed in accordance with Section 14021.6 of the W&I Code Section, Section 11758.42 of the HSC and Title 9, CCR, commencing with Section 10000 (Document 3G). The following table shows USDR rates.

Service	Unit of Service (UOS)	SFY 2017-18 Rate		SFY 2018-19 Rate	
		Non-Perinatal	Perinatal	Non-Perinatal	Perinatal
NTP - Methadone Dosing	Daily	$13.11	$14.11	**$13.54**	**$14.58**
NTP - Individual Counseling (*)	One 10-minute increment	$15.37	$16.39	**$15.88**	**$16.39**
NTP - Group Counseling (*)	One 10-minute increment	$3.43	$4.28	**$3.43**	**$4.28**
NTP - Buprenorphine[1]	Daily	$20.18	$28.02	**$16.91**	**$20.15**
NTP - Buprenorphine-Naloxone Combo Product	**Daily**	**—**	**—**	**$20.10**	**$23.34**
NTP - Disulfiram[2]	Daily	$10.47	$10.84	**$7.36**	**$7.59**
NTP - Naloxone[3] (2-pack Nasal Spray)	Dispensed as needed	$150.00	$150.00	**$144.60**	**$144.60**

(*) The NTP Contractors may be reimbursed for up to 200 minutes (20 ten-minute increments) of individual and/or group counseling per calendar month. If a medical necessity determination is made that requires additional NTP counseling beyond 200 minutes per calendar month, NTP Contractors may bill and be reimbursed for additional counseling (in 10 minute increments). Medical justification for the additional counseling must be clearly documented in the patient record. Reimbursement for covered NTP services shall be limited to the lower of the NTP's usual and customary charge to the general public for the same or similar services or the USDR rate.

1 - Buprenorphine: Average daily dose of 16 milligrams, sublingual tablets.

2 - Disulfiram: Average daily dose between 250 and 500 milligrams.

3 - Naloxone: One dose equal to 4 milligrams per 0.1 milliliter.

Exhibit B A2
Budget Detail and Payment Provisions

B. **"Unit of Service"** means a contact on a calendar day for outpatient drug free, intensive outpatient treatment, partial hospitalization, and residential treatment services. Units of service are identified in the following table:

Services Provided by Modality (funded by DMC-ODS)	Billing/Unit of Service (minutes, day, hour)	Interim Rates		
		FY 16-17	FY 17-18	FY 18-19
Encounter Rates				
Outpatient	15 minute increments	$61.69	$61.69	**$61.69**
Intensive Outpatient	15 minute increments	$23.79	$23.79	**$23.79**
Recovery Services	15 minute increments	$64.41	$64.41	**$64.41**
Case Management	15 minute increments	$37.77	$37.77	**$37.77**
Physician Consultation	15 minute increments	$234.62	$60.76	**$60.76**
Daily Rates				
Level 1-WM	Per Day	N/A	N/A	**N/A**
Level 2-WM	Per Day	N/A	N/A	**N/A**
Level 3.2-WM	Per Day	$171.16	$171.16	**$171.16**
Level 3.1- Residential	Per Day	$158.88	$158.88	**$158.88**
Level 3.3 - Residential	Per Day	$158.88	$158.88	**TBD**
Level 3.5 - Residential	Per Day	$158.88	$158.88	**TBD**
Optional				
Additional Medication Assisted Treatment	15 minute increments	$122.37	$60.76	**$60.76**
Partial Hospitalization	Per Day	$26.16	$152.25	**$152.25**

Exhibit B, Attachment I A2
Funding Amounts

Fiscal Year 2016-17	Funding Amount
	Original
State General Funds (7/1/16 to 6/30/17)	
Drug Medi-Cal SGF**	56,538
Non Perinatal ODS Waiver SGF**	599,615
Perinatal ODS Waiver SGF**	0
Administration Expenses**	0
TOTAL	**656,153**
SAPT Block Grant - FFY 2017 Award (10/1/16 to 6/30/18)	
Discretionary	8,135,598
Prevention Set-Aside	2,398,308
Friday Night Live/Club Live	30,000
Perintal	532,405
Adolescent/Youth	462,745
Total	**11,559,056**
Drug Medi-Cal Federal Share (7/1/16 to 6/30/17)	
ODS Non-Perinatal Federal Share	25,115,742
ODS Perinatal Federal Share	1,674,383
Administration Expenses (603)	0
TOTAL	**26,790,125**
GRAND TOTAL	**39,005,334**

Fiscal Year 2017-18	Funding Amount	
	Original	A01
State General Funds (10/1/17 to 6/30/18)		
Drug Medi-Cal SGF** (08)	0	0
Non Perinatal ODS Waiver SGF** (08)	~~7,624,113~~	6,251,773
Perinatal ODS Waiver SGF** (09)	~~0~~	609,929
QA/UR & Administration Expenses** (603)	~~0~~	762,411
TOTAL	**7,624,113**	**7,624,113**
SAPT Block Grant - FFY 2018 Award (10/1/17 to 6/30/19)		
Discretionary	~~8,135,598~~	0
Prevention Set-Aside	~~2,398,308~~	0
Friday Night Live/Club Live	~~30,000~~	0
Perintal	~~532,405~~	0
Adolescent/Youth	~~462,745~~	0
Total	**~~11,559,056~~**	**0**
Drug Medi-Cal Federal Share (7/1/17 to 6/30/18)		
ODS Non-Perinatal Federal Share (01)	~~25,115,742~~	22,457,938
ODS Perinatal Federal Share (03)	~~1,674,383~~	2,302,300
QA/UR & Administration Expenses (603)	~~0~~	4,018,519
TOTAL	**~~26,790,125~~**	**28,778,757**
GRAND TOTAL	**~~45,973,294~~**	**36,402,870**

Fiscal Year 2018-19	Funding Amount		
	Original	A01	A02
State General Funds (10/1/18 to 6/30/19)			
Drug Medi-Cal SGF** (08)	~~0~~	0	0
Non Perinatal ODS Waiver SGF** (08)	~~7,624,113~~	~~7,014,184~~	**6,318,327**
Perinatal ODS Waiver SGF** (09)	~~0~~	~~609,929~~	**549,419**
QA/UR & Administration Expenses** (603)	0	~~0~~	**1,030,161**
TOTAL	**7,624,113**	**~~7,624,113~~**	**7,897,907**
SAPT Block Grant - FFY 2019 Award (10/1/18 to 6/30/20)			
Discretionary	~~8,135,598~~	0	0
Prevention Set-Aside	~~2,398,308~~	0	0
Friday Night Live/Club Live	~~30,000~~	0	0
Perintal	~~532,405~~	0	0
Adolescent/Youth	~~462,745~~	0	0
Total	**~~11,559,056~~**	**0**	**0**
Drug Medi-Cal Federal Share (7/1/18 to 6/30/19)			
ODS Non-Perinatal Federal Share (01)	~~25,115,742~~	26,476,457	26,476,457
ODS Perinatal Federal Share (03)	~~1,674,383~~	2,302,300	2,302,300
QA/UR & Administration Expenses (603)	0	~~0~~	**4,316,813**
TOTAL	**~~26,790,125~~**	**~~28,778,757~~**	**33,095,570**
GRAND TOTAL	**~~45,973,294~~**	**~~36,402,870~~**	**40,993,477**

Original THREE-YEAR TOTAL	**~~130,951,922~~**
A01 THREE-YEAR TOTAL	**~~111,811,074~~**
A02 THREE-YEAR TOTAL	**116,401,681**

** State General Fund amounts are based on biannual DMC estimates approved by the Department of Finance. DHCS will revise the amounts through the contract amendment process for each new allocation.

Exhibit E A2
Additional Provisions

1. Amendment Process

A. Both the Contractor and the State may agree to amend or renegotiate the Intergovernmental Agreement.

B. Should either party, during the term of this Intergovernmental Agreement, desire a change or amendment to the terms of this Intergovernmental Agreement, such changes or amendments shall be proposed in writing to the other party, who will respond in writing as to whether the proposed changes/amendments are accepted or rejected. If accepted and after negotiations are concluded, the agreed upon changes shall be made through the State's official agreement amendment process. No amendment will be considered binding on either party until it is formally approved by the both parties and the Department of General Services (DGS), if DGS approval is required.

C. Intergovernmental Agreement amendments will be required to change encumbered amounts for each year of a multi-year contract period, of which the first amendment will be based on the Governor’s Budget Act allocation of that specific fiscal year. The signed Intergovernmental Agreement from the Contractor will be due to the Department of Health Care Services (DHCS) within 90 days from the issuance to the County. If the signed Intergovernmental Agreement from the Contractor is not received within 90 days from the issuance to the County, DHCS may withhold all non-DMC payments under Exhibit B of this Intergovernmental Agreement until the required amendment is received by the State.

D. Intergovernmental Agreement amendments may be requested by the Contractor until May 1 of each of the contract's fiscal years. An amendment proposed by either the Contractor or the State shall be forwarded in writing to the other party.

1) The proposed amendment submitted by Contractor shall include the proposed changes, and a statement of the reason and basis for the proposed change.

2) Amendments shall be duly approved by the County Board of Supervisors or its authorized designee, and signed by a duly authorized representative.

E. Contractor acknowledges that any newly allocated funds that are in excess of the initial amount for each fiscal year may be forfeited if DHCS does not receive a fully executable Intergovernmental Agreement amendment on or before June 30th.

F. State may settle costs for substance use disorder services based on the year-end cost settlement report as the final amendment to the approved Intergovernmental Agreement.

Exhibit E A2
Additional Provisions

2. Cancellation / Termination

A. This Intergovernmental Agreement may be cancelled by DHCS without cause upon 30 calendar days advance written notice to the Contractor.

B. DHCS reserves the right to cancel or terminate this Intergovernmental Agreement immediately for cause. The Contractor may submit a written request to terminate this Intergovernmental Agreement only if DHCS substantially fails to perform its responsibilities as provided herein.

C. The term "for cause" shall mean that the Contractor fails to meet the terms, conditions, and/or responsibilities of this Intergovernmental Agreement.

D. Intergovernmental Agreement termination or cancellation shall be effective as of the date indicated in DHCS' notification to the Contractor. The notice shall stipulate any final performance, invoicing or payment requirements.

E. Upon receipt of a notice of termination or cancellation, the Contractor shall take immediate steps to stop performance and to cancel or reduce subsequent agreement costs.

F. In the event of early termination or cancellation, the Contractor shall be entitled to payment for all allowable costs authorized under this Intergovernmental Agreement and incurred up to the date of termination or cancellation, including authorized non-cancelable obligations, provided such expenses do not exceed the stated maximum amounts payable.

G. In the event of changes in law that affect provisions of this Intergovernmental Agreement, the parties agree to amend the affected provisions to conform to the changes in law retroactive to the effective date of such changes in law. The parties further agree that the terms of this Intergovernmental Agreement are severable and in the event that changes in law render provisions of the Intergovernmental Agreement void, the unaffected provisions and obligations of this Intergovernmental Agreement will remain in full force and effect.

H. The following additional provisions regarding termination apply only to Exhibit A, Attachment I, of this Intergovernmental Agreement:

1) In the event the federal Department of Health and Human Services (hereinafter referred to as DHHS), or State determines Contractor does not meet the requirements for participation in the DMC-ODS Waiver Program, State will terminate payments for services provided pursuant to Exhibit A, Attachment I, of this Intergovernmental Agreement for cause.

2) All obligations to provide covered services under this Intergovernmental Agreement will automatically terminate on the effective date of any termination of this Intergovernmental Agreement. Contractor will be responsible for providing or arranging for covered services to beneficiaries

until the effective date of termination or expiration of the Intergovernmental Agreement.

Contractor will remain liable for processing and paying invoices and statements for covered services and utilization review requirements prior to the expiration or termination until all obligations have been met.

3) In the event Exhibit A, Attachment I, of this Intergovernmental Agreement is nullified, Contractor shall refer DMC clients to providers who are certified to provide State Plan services.

I. In the event this Intergovernmental Agreement is terminated, Contractor shall deliver its entire fiscal and program records pertaining to the performance of this Intergovernmental Agreement to the State, which will retain the records for the required retention period.

3. Avoidance of Conflicts of Interest by Contractor

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

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

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

2) An instance where the Contractor's or any 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.

C. If DHCS is or becomes aware of a known or suspected conflict of interest, the Contractor will be given an opportunity to submit additional information or to resolve the conflict. A Contractor with a suspected conflict of interest will have five (5) working days from the date of notification of the conflict by DHCS to provide 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.

D. Contractor acknowledges that state laws on conflict of interest, found in the Political Reform Act, Public Contract Code Section 10365.5, and Government Code Section 1090, apply to this Intergovernmental Agreement.

4. Freeze Exemptions

A. Contractor agrees that any hiring freeze adopted during the term of this Intergovernmental Agreement shall not be applied to the positions funded, in whole or part, by this Intergovernmental Agreement.

B. Contractor agrees not to implement any personnel policy, which may adversely affect performance or the positions funded, in whole or part, by this Intergovernmental Agreement.

C. Contractor agrees that any travel freeze or travel limitation policy adopted during the term of this Intergovernmental Agreement shall not restrict travel funded, in whole or part, by this Intergovernmental Agreement.

D. Contractor agrees that any purchasing freeze or purchase limitation policy adopted during the term of this Intergovernmental Agreement shall not restrict or limit purchases funded, in whole or part, by this Intergovernmental Agreement.

5. Force Majeure

Neither party shall be responsible for delays or failures in performance resulting from acts beyond the control of the offending 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, and if such default of its Subcontractor, arises out of causes beyond the control of both the Contractor and Subcontractor, and without the fault or negligence of either of them, the Contractor shall not be liable for damages of such delay or failure, unless the supplies or services to be furnished by the Subcontractor were obtainable from other sources in sufficient time to permit the Contractor to meet the required performance schedule.

6. Identification of Contractor versus Subrecipient

DHCS has classified this Agreement as a procurement contract. Therefore, the Contractor is considered a contractor, and not a subrecipient, for the purposes of U.S. Office of Management and Budget Uniform Guidance pursuant to 2 CFR 200.330

Exhibit F A2
Privacy and Information Security Provisions

This Exhibit F is intended to protect the privacy and security of specified Department information that the Contractor may access, receive, or transmit under this Agreement. The Department information covered under this Exhibit F consists of: (1) Protected Health Information (PHI) as defined under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA") and (2) Personal Information (PI) as defined under the California Information Practices Act (CIPA), at California Civil Code Section 1798.3.

Exhibit F consists of the following parts:

1. Exhibit F-1, HIPAA Business Associate Addendum, which provides for the privacy and security of PHI.

2. Exhibit F-2 provides for the privacy and security of PI under Civil Code Section 1798.3(a) and 1798.29.

3. Exhibit F-3, Miscellaneous Provision, sets forth additional terms and conditions that extend to the provisions of Exhibit F in its entirety.

Exhibit F A2
Privacy and Information Security Provisions

F-1
HIPAA Business Associate Addendum

1. Recitals.

A. A business associate relationship under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), 42 U.S.C. Section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 ("the HIPAA regulations") and the Final Omnibus Rule of 2013 between Department and Contractor arises only to the extent that Contractor creates, receives, maintains, transmits, uses or discloses PHI or ePHI on the Department's behalf, or provides services, arranges, performs, or assists in the performance of functions or activities on behalf of the Department that are included in the definition of "business associate" in 45 CFR. 160.103 where the provision of the service involves the disclosure of PHI or ePHI from the Department, including but not limited to, utilization review, quality assurance, or benefit management. To the extent Contractor performs these services, functions, and activities on behalf of Department, Contractor is the Business Associate of the Department, acting on the Department's behalf. The Department and Contractor are each a party to this Agreement and are collectively referred to as the "parties." A business associate is also directly liable and subject to civil penalties for failing to safeguard electronic protected health information in accordance with the HIPAA Security Rule. A "business associate" also is a subcontractor that creates, receives, maintains, or transmits protected health information on behalf of another business associate. Business Associate shall incorporate, when applicable, the relevant provisions of this Addendum into each subcontract or sub-award to such agents, subcontractors and vendors, including the requirement that any security incidents or breaches of unsecured PHI or PI be reported to Business Associate.

Exhibit F A2
Privacy and Information Security Provisions

B. The Department wishes to disclose to Contractor certain information pursuant to the terms of this Agreement, some of which may constitute Protected Health Information ("PHI"), including protected health information in electronic media ("ePHI"), under Federal law, to be used or disclosed in the course of providing services and activities as set forth in Section 1.A. of Exhibit F-1 of this Agreement. This information is hereafter referred to as "Department PHI".

C. The purpose of this Exhibit F-1 is to protect the privacy and security of the PHI and ePHI that may be created, received, maintained, transmitted, used or disclosed pursuant to this Agreement, and to comply with certain standards and requirements of HIPAA, the HITECH Act, and the HIPAA regulations and the Final Omnibus Rule of 2013, including, but not limited to, the requirement that the Department must enter into a contract containing specific requirements with the Contractor prior to the disclosure of PHI to Contractor, as set forth in 45 CFR Parts 160 and 164 and the HITECH Act and the Final Omnibus Rule of 2013. To the extent that data is both PHI or ePHI and Personally Identifying Information, both Exhibit F-2 and this Exhibit F-1 shall apply.

D. The terms used in this Exhibit F-1, but not otherwise defined, shall have the same meanings as those terms have in the HIPAA regulations. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

2. Definitions.

A. Breach shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations and the Final Omnibus Rule of 2013.

B. Business Associate shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations and the Final Omnibus Rule of 2013.

C. Department PHI shall mean Protected Health Information or Electronic Protected Health Information, as defined below, accessed by Contractor in a database maintained by the Department, received by Contractor from the Department or acquired or created by Contractor in connection with performing the functions, activities and services on behalf of the Department as specified in Section 1.A. of Exhibit F-1 of this Agreement. The terms PHI as used in this document shall mean Department PHI.

Exhibit F A2
Privacy and Information Security Provisions

D. Electronic Health Records shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 U.S.C. Section 17921 and implementing regulations.

E. Electronic Protected Health Information (ePHI) means individually identifiable health information transmitted by electronic media or maintained in electronic media, including but not limited to electronic media as set forth under 45 CFR section 160.103.

F. Individually Identifiable Health Information means health information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer, or health care clearinghouse, and relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual, as set forth under 45 CFR Section 160.103.

G. Privacy Rule shall mean the HIPAA Regulations that are found at 45 CFR Parts 160 and 164, subparts A and E.

H. Protected Health Information (PHI) means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or is transmitted or maintained in any other form or medium, as set forth under 45 CFR Section 160.103 and as defined under HIPAA.

I. Required by law means a mandate contained in law that compels an entity to make a use or disclosure of PHI that is enforceable in a court of law. This includes, but is not limited to, court orders and court-ordered warrants, subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information, and a civil or an authorized investigative demand. It also includes Medicare conditions of participation with respect to health care providers participating in the program, and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

J. Secretary means the Secretary of the U.S. Department of Health and Human Services ("HHS") or the Secretary's designee.

K. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of Department PHI, or confidential data utilized by Contractor to perform the services, functions and activities on behalf of Department as set forth in Section 1.A. of Exhibit F-1 of this Agreement; or interference with system operations in an information system that processes, maintains or stores Department PHI.

L. Security Rule shall mean the HIPAA regulations that are found at 45 CFR Parts 160 and 164.

M. Unsecured PHI shall have the meaning given to such term under the HITECH Act, 42 U.S.C. Section 17932(h), any guidance issued by the Secretary pursuant to such Act and the HIPAA regulations.

3. Terms of Agreement.

A. **Permitted Uses and Disclosures of Department PHI by Contractor.**

Except as otherwise indicated in this Exhibit F-1, Contractor may use or disclose Department PHI only to perform functions, activities, or services specified in Section 1.A of Exhibit F-1 of this Agreement, for, or on behalf of the Department, provided that such use or disclosure would not violate the HIPAA regulations or the limitations set forth in 42 CFR Part 2, or any other applicable law, if done by the Department. Any such use or disclosure, if not for purposes of treatment activities of a health care provider as defined by the Privacy Rule, must, to the extent practicable, be limited to the limited data set, as defined in 45 CFR Section 164.514(e)(2), or, if needed, to the minimum necessary to accomplish the intended purpose of such use or disclosure, in compliance with the HITECH Act and any guidance issued pursuant to such Act, and the HIPAA regulations.

B. **Specific Use and Disclosure Provisions**. Except as otherwise indicated in this Exhibit F-1, Contractor may:

1) **Use and Disclose for Management and Administration**. Use and disclose Department PHI for the proper management and administration of the Contractor's business, provided that such disclosures are required by law, or the Contractor obtains

reasonable assurances from the person to whom the information is disclosed, in accordance with section D(7) of this Exhibit F-1, that it will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Contractor of any instances of which it is aware that the confidentiality of the information has been breached.

2) **Provision of Data Aggregation Services**. Use Department PHI to provide data aggregation services to the Department to the extent requested by the Department and agreed to by Contractor. Data aggregation means the combining of PHI created or received by the Contractor, as the Business Associate, on behalf of the Department with PHI received by the Business Associate in its capacity as the Business Associate of another covered entity, to permit data analyses that relate to the health care operations of the Department

C. **Prohibited Uses and Disclosures.**

1) Contractor shall not disclose Department PHI about an individual to a health plan for payment or health care operations purposes if the Department PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full and the individual requests such restriction, in accordance with 42 U.S.C. Section 17935(a) and 45 CFR Section 164.522(a).

2) Contractor shall not directly or indirectly receive remuneration in exchange for Department PHI.

D. **Responsibilities of Contractor.**

Contractor agrees:

1) **Nondisclosure**. Not to use or disclose Department PHI other than as permitted or required by this Agreement or as required by law, including but not limited to 42 CFR Part 2.

2) **Compliance with the HIPAA Security Rule**. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Department PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of the

Department, in compliance with 45 CFR Sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of Department PHI other than as provided for by this Agreement. Contractor shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR Section 164, subpart C, in compliance with 45 CFR Section 164.316. Contractor shall develop and maintain a written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities, and which incorporates the requirements of section 3, Security, below. Contractor will provide the Department with its current and updated policies upon request.

3) **Security**. Contractor shall take any and all steps necessary to ensure the continuous security of all computerized data systems containing PHI and/or PI, and to protect paper documents containing PHI and/or PI. These steps shall include, at a minimum:

   a. Complying with all of the data system security precautions listed in Attachment A, Data Security Requirements.

   b. Achieving and maintaining compliance with the HIPAA Security Rule (45 CFR Parts 160 and 164), as necessary in conducting operations on behalf of DHCS under this Agreement.

   c. Providing a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III - Security of Federal Automated Information Systems, which sets forth guidelines for automated information systems in Federal agencies.

4) **Security Officer**. Contractor shall designate a Security Officer to oversee its data security program who shall be responsible for carrying out the requirements of this section and for communicating on security matters with the Department.

5) **Mitigation of Harmful Effects**. To mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of Department PHI by Contractor or its subcontractors in violation of the requirements of this Exhibit F.

Exhibit F A2
Privacy and Information Security Provisions

6) **Reporting Unauthorized Use or Disclosure.** To report to Department any use or disclosure of Department PHI not provided for by this Exhibit F of which it becomes aware.

7) **Contractor's Agents and Subcontractors**.

a. To enter into written agreements with any agents, including subcontractors and vendors to whom Contractor provides Department PHI, that impose the same restrictions and conditions on such agents, subcontractors and vendors that apply to Contractor with respect to such Department PHI under this Exhibit F, and that require compliance with all applicable provisions of HIPAA, the HITECH Act the HIPAA regulations, and the Final Omnibus Rule of 2013 including the requirement that any agents, subcontractors or vendors implement reasonable and appropriate administrative, physical, and technical safeguards to protect such PHI. As required by HIPAA, the HITECH Act, the HIPAA regulations and the Final Omnibus Rule of 2013, including 45 CFR Sections 164.308 and 164.314, Contractor shall incorporate, when applicable, the relevant provisions of this Exhibit F-1 into each subcontract or sub-award to such agents, subcontractors and vendors, including the requirement that any security incidents or breaches of unsecured PHI be reported to Contractor.

b. In accordance with 45 CFR Section 164.504(e)(1)(ii), upon Contractor's knowledge of a material breach or violation by its subcontractor of the agreement between Contractor and the subcontractor, Contractor shall:

i) Provide an opportunity for the subcontractor to cure the breach or end the violation and terminate the agreement if the subcontractor does not cure the breach or end the violation within the time specified by the Department; or

ii) Immediately terminate the agreement if the subcontractor has breached a material term of the agreement and cure is not possible.

8) **Availability of Information to the Department and Individuals to Provide Access and Information:**

a. To provide access as the Department may require, and in the time and manner designated by the Department (upon reasonable notice and during Contractor's normal business hours) to Department PHI in a Designated Record Set, to the Department (or, as directed by the Department), to an Individual, in accordance with 45 CFR Section 164.524. Designated Record Set means the group of records maintained for the Department health plan under this Agreement that includes medical, dental and billing records about individuals; enrollment, payment, claims adjudication, and case or medical management systems maintained for the Department health plan for which Contractor is providing services under this Agreement; or those records used to make decisions about individuals on behalf of the Department. Contractor shall use the forms and processes developed by the Department for this purpose and shall respond to requests for access to records transmitted by the Department within fifteen (15) calendar days of receipt of the request by producing the records or verifying that there are none.

b. If Contractor maintains an Electronic Health Record with PHI, and an individual requests a copy of such information in an electronic format, Contractor shall provide such information in an electronic format to enable the Department to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. Section 17935(e) and the HIPAA regulations.

9) **Confidentiality of Alcohol and Drug Abuse Patient Records.** Contractor agrees to comply with all confidentiality requirements set forth in Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2. Contractor is aware that criminal penalties may be imposed for a violation of these confidentiality requirements.

10) **Amendment of Department PHI**. To make any amendment(s) to Department PHI that were requested by a patient and that the Department directs or agrees should be made to assure compliance with 45 CFR Section 164.526, in the time and manner designated by the Department, with the Contractor being given a minimum of twenty days within which to make the amendment.

Exhibit F A2
Privacy and Information Security Provisions

11) **Internal Practices**. To make Contractor's internal practices, books, and records relating to the use and disclosure of Department PHI available to the Department or to the Secretary, for purposes of determining the Department's compliance with the HIPAA regulations. If any information needed for this purpose is in the exclusive possession of any other entity or person and the other entity or person fails or refuses to furnish the information to Contractor, Contractor shall provide written notification to the Department and shall set forth the efforts it made to obtain the information.

12) **Documentation of Disclosures**. To document and make available to the Department or (at the direction of the Department) to an individual such disclosures of Department PHI, and information related to such disclosures, necessary to respond to a proper request by the subject Individual for an accounting of disclosures of such PHI, in accordance with the HITECH Act and its implementing regulations, including but not limited to 45 CFR Section 164.528 and 42 U.S.C. Section 17935(c). If Contractor maintains electronic health records for the Department as of January 1, 2009 and later, Contractor must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations. The electronic accounting of disclosures shall be for disclosures during the three years prior to the request for an accounting.

13) **Breaches and Security Incidents*.*** During the term of this Agreement, Contractor agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

a. **Initial Notice to the Department.** (1) To notify the Department **immediately by telephone call or email or fax** upon the discovery of a breach of unsecured PHI in electronic media or in any other media if the PHI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person. (2) To notify the Department **within 24 hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement or this Exhibit F-1 or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Contractor as of the first day on

which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Contractor.

Notice shall be provided to the Information Protection Unit, Office of HIPAA Compliance. If the incident occurs after business hours or on a weekend or holiday and involves electronic PHI, notice shall be provided by calling the Information Protection Unit (916) 445-4646, (866) 866-0602 or by emailing privacyofficer@dhcs.ca.gov. Notice shall be made using the DHCS "Privacy Incident Report" form, including all information known at the time. Contractor shall use the most current version of this form, which is posted on the DHCS Information Security Officer website (www.dhcs.ca.gov, then select "Privacy" in the left column and then "Business Partner" near the middle of the page) or use this link: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of Department PHI, Contractor shall take:

i) Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment.

ii) Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

b. **Investigation and Investigation Report**. To immediately investigate such suspected security incident, security incident, breach, or unauthorized access, use or disclosure of PHI. Within 72 hours of the discovery, Contractor shall submit an updated "Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the Information Protection Unit.

c. **Complete Report**. To provide a complete report of the investigation to the Department Program Contract Manager and the Information Protection Unit within ten working days of the discovery of the breach or unauthorized use or disclosure. The report shall be submitted on the "Privacy Incident Report" form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred under applicable provisions of HIPAA, the HITECH Act, and the HIPAA regulations. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure. If the Department requests information in addition to that listed on the "Privacy Incident Report" form, Contractor shall make reasonable efforts to provide the Department with such information. If, because of the circumstances of the incident, Contractor needs more than ten working days from the discovery to submit a complete report, the Department may grant a reasonable extension of time, in which case Contractor shall submit periodic updates until the complete report is submitted. If necessary, a Supplemental Report may be used to submit revised or additional information after the completed report is submitted, by submitting the revised or additional information on an updated "Privacy Incident Report" form. The Department will review and approve the determination of whether a breach occurred and whether individual notifications and a corrective action plan are required.

d. **Responsibility for Reporting of Breaches.** If the cause of a breach of Department PHI is attributable to Contractor or its agents, subcontractors or vendors, Contractor is responsible for all required reporting of the breach as specified in 42 U.S.C. section 17932 and its implementing regulations, including notification to media outlets and to the Secretary (after obtaining prior written approval of DHCS). If a breach of unsecured Department PHI involves more than 500 residents of the State of California or under its jurisdiction, Contractor shall first notify DHCS, then the Secretary of the breach immediately upon discovery of the breach. If a breach involves more than 500 California residents, Contractor shall also provide, after obtaining written prior approval of DHCS, notice to the Attorney General for the State of California, Privacy Enforcement Section. If Contractor has reason to

believe that duplicate reporting of the same breach or incident may occur because its subcontractors, agents, or vendors may report the breach or incident to the Department in addition to Contractor, Contractor shall notify the Department, and the Department and Contractor may take appropriate action to prevent duplicate reporting.

e. **Responsibility for Notification of Affected Individuals.** If the cause of a breach of Department PHI is attributable to Contractor or its agents, subcontractors or vendors and notification of the affected individuals is required under state or Federal law, Contractor shall bear all costs of such notifications as well as any costs associated with the breach. In addition, the Department reserves the right to require Contractor to notify such affected individuals, which notifications shall comply with the requirements set forth in 42U.S.C. section 17932 and its implementing regulations, including, but not limited to, the requirement that the notifications be made without unreasonable delay and in no event later than 60 calendar days after discovery of the breach. The Department Privacy Officer shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made. The Department will provide its review and approval expeditiously and without unreasonable delay.

f. **Department Contact Information**. To direct communications to the above referenced Department staff, the Contractor shall initiate contact as indicated herein. The Department reserves the right to make changes to the contact information below by giving written notice to the Contractor. Said changes shall not require an amendment to this Addendum or the Agreement to which it is incorporated.

Exhibit F A2
Privacy and Information Security Provisions

Department Program Contract Manager	**DHCS Privacy Officer**	**DHCS Information Security Officer**
See the Exhibit A, Scope of Work for Program Contract Manager information	Information Protection Unit c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 (916) 445-4646; (866) 866-0602 Email: privacyofficer@dhcs.ca.gov Fax: (916) 440-7680	Information Security Officer DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: iso@dhcs.ca.gov Telephone: ITSD Service Desk (916) 440-7000; (800) 579-0874 Fax: (916) 440-5537

14) **Termination of Agreement.** In accordance with Section 13404(b) of the HITECH Act and to the extent required by the HIPAA regulations, if Contractor knows of a material breach or violation by the Department of this Exhibit F-1, it shall take the following steps:

a. Provide an opportunity for the Department to cure the breach or end the violation and terminate the Agreement if the Department does not cure the breach or end the violation within the time specified by Contractor or

b. Immediately terminate the Agreement if the Department has breached a material term of the Exhibit F-1 and cure is not possible.

15) **Sanctions and/or Penalties**. Contractor understands that a failure to comply with the provisions of HIPAA, the HITECH Act and the HIPAA regulations that are applicable to Contractors may result in the imposition of sanctions and/or penalties on Contractor under HIPAA, the HITECH Act and the HIPAA regulations.

E. Obligations of the Department.

The Department agrees to:

Exhibit F A2
Privacy and Information Security Provisions

1) **Permission by Individuals for Use and Disclosure of PHI**. Provide the Contractor with any changes in, or revocation of, permission by an Individual to use or disclose Department PHI, if such changes affect the Contractor's permitted or required uses and disclosures.

2) **Notification of Restrictions**. Notify the Contractor of any restriction to the use or disclosure of Department PHI that the Department has agreed to in accordance with 45 CFR Section 164.522, to the extent that such restriction may affect the Contractor's use or disclosure of PHI.

3) **Requests Conflicting with HIPAA Rules**. Not request the Contractor to use or disclose Department PHI in any manner that would not be permissible under the HIPAA regulations if done by the Department.

4) **Notice of Privacy Practices**. Provide Contractor with the web link to the Notice of Privacy Practices that DHCS produces in accordance with 45 CFR Section 164.520, as well as any changes to such notice. Visit the DHCS website to view the most current Notice of Privacy Practices at: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx or the DHCS website at www.dhcs.ca.gov (select "Privacy in the right column and "Notice of Privacy Practices" on the right side of the page).

F. Audits, Inspection and Enforcement.

If Contractor is the subject of an audit, compliance review, or complaint investigation by the Secretary or the Office for Civil Rights, U.S. Department of Health and Human Services, that is related to the performance of its obligations pursuant to this HIPAA Business Associate Exhibit F-1,Contractor shall immediately notify the Department. Upon request from the Department, Contractor shall provide the Department with a copy of any Department PHI that Contractor, as the Business Associate, provides to the Secretary or the Office of Civil Rights concurrently with providing such PHI to the Secretary. Contractor is responsible for any civil penalties assessed due to an audit or investigation of Contractor, in accordance with 42 U.S.C. Section 17934(c).

Exhibit F A2
Privacy and Information Security Provisions

G. Termination.

1) **Term.** The Term of this Exhibit F-1 shall extend beyond the termination of the Agreement and shall terminate when all Department PHI is destroyed or returned to the Department, in accordance with 45 CFR Section 164.504(e)(2)(ii)(J).

2) **Termination for Cause**. In accordance with 45 CFR Section 164.504(e)(1)(iii), upon the Department's knowledge of a material breach or violation of this Exhibit F-1 by Contractor, the Department shall:

   a. Provide an opportunity for Contractor to cure the breach or end the violation and terminate this Agreement if Contractor does not cure the breach or end the violation within the time specified by the Department or

   b. Immediately terminate this Agreement if Contractor has breached a material term of this Exhibit F-1 and cure is not possible.

Exhibit F A2
Privacy and Information Security Provisions

F-2
Privacy and Security of Personal Information and Personally Identifiable Information Not Subject to HIPAA

1. Recitals.

A. In addition to the Privacy and Security Rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) the Department is subject to various other legal and contractual requirements with respect to the personal information (PI) and personally identifiable information (PII) it maintains. These include:

1) The California Information Practices Act of 1977 (California Civil Code §§1798 et seq.).

2) Title 42 CFR, Chapter I, Subchapter A, Part 2.

B. The purpose of this Exhibit F-2 is to set forth Contractor's privacy and security obligations with respect to PI and PII that Contractor may create, receive, maintain, use, or disclose for, or on behalf of Department, pursuant to this Agreement. Specifically this Exhibit applies to PI and PII which is not Protected Health Information (PHI) as defined by HIPAA and therefore is not addressed in Exhibit F-1 of this Agreement, the HIPAA Business Associate Addendum; however, to the extent that data is both PHI or ePHI and PII, both Exhibit F-1 and this Exhibit F-2 shall apply.

C. The terms used in this Exhibit F-2, but not otherwise defined, shall have the same meanings as those terms have in the above referenced statute and Agreement. Any reference to statutory, regulatory, or contractual language shall be to such language as in effect or as amended.

2. Definitions.

A. Breach shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and the Final Omnibus Rule.

B. Business Associate shall have the meaning given to such term under HIPAA, the HITECH Act, the HIPAA regulations, and the final Omnibus Rule.

C. Electronic Health Record shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 U.S.C Section 17921 and implementing regulations.

D. Electronic Protected Health Information (ePHI) means individually identifiable health information transmitted by electronic media or

maintained in electronic media, including but not limited to electronic media as set forth under 45 CFR section 160.103.

E. Individually Identifiable Health Information means health information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual, as set forth under 45 CFR section 160.103.

F. Privacy Rule shall mean the HIPAA Regulation that is found at 45 CFR Parts 160 and 164.

G. Personal Information (PI) shall have the meaning given to such term in California Civil Code section 1798.29.

H. Protected Health Information (PHI) means individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or is transmitted or maintained in any other form or medium, as set forth under 45 CFR section 160.103.

I. Required by law means a mandate contained in law that compels an entity to make a use or disclosure of PHI that is enforceable in a court of law. This includes, but is not limited to, court orders and court-ordered warrants, subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information, and a civil or an authorized investigative demand. It also includes Medicare conditions of participation with respect to health care providers participating in the program, and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

J. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI or PI, or confidential data that is essential to the ongoing operation of the Business Associate's organization and intended for internal use; or interference with system operations in an information system.

K. Security Rule shall mean the HIPAA regulation that is found at 45 CFR Parts 160 and 164.

Exhibit F A2
Privacy and Information Security Provisions

3. Terms of Agreement.

A. **Permitted Uses and Disclosures of Department PI and PII by Contractor**

Except as otherwise indicated in this Exhibit F-2, Contractor may use or disclose Department PI only to perform functions, activities or services for or on behalf of the Department pursuant to the terms of this Agreement provided that such use or disclosure would not violate the California Information Practices Act (CIPA) if done by the Department.

B. **Responsibilities of Contractor**

Contractor agrees:

1) **Nondisclosure.** Not to use or disclose Department PI or PII other than as permitted or required by this Agreement or as required by applicable state and Federal law.

2) **Safeguards***.* To implement appropriate and reasonable administrative, technical, and physical safeguards to protect the security, confidentiality and integrity of Department PI and PII, to protect against anticipated threats or hazards to the security or integrity of Department PI and PII, and to prevent use or disclosure of Department PI or PII other than as provided for by this Agreement. Contractor shall develop and maintain a written information privacy and security program that include administrative, technical and physical safeguards appropriate to the size and complexity of Contractor's operations and the nature and scope of its activities, which incorporate the requirements of section 3, Security, below. Contractor will provide DHCS with its current policies upon request.

3) **Security.** Contractor shall take any and all steps necessary to ensure the continuous security of all computerized data systems containing PHI and/or PI, and to protect paper documents containing PHI and/or PI. These steps shall include, at a minimum:

a. Complying with all of the data system security precautions listed in Attachment A, Business Associate Data Security Requirements;

b. Providing a level and scope of security that is at least comparable to the level and scope of security established by

the Office of Management and Budget in OMB Circular No. A-130, Appendix III- Security of Federal Automated Information Systems, which sets forth guidelines for automated information systems in Federal agencies.

4) **Mitigation of Harmful Effects.** To mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of Department PI or PII by Contractor or its subcontractors in violation of this Exhibit F-2.

5) **Contractor's Agents and Subcontractors.** To impose the same restrictions and conditions set forth in this Exhibit F-2 on any subcontractors or other agents with whom Contractor subcontracts any activities under this Agreement that involve the disclosure of Department PI or PII to the subcontractor.

6) **Availability of Information to DHCS.** To make Department PI and PII available to the Department for purposes of oversight, inspection, amendment, and response to requests for records, injunctions, judgments, and orders for production of Department PI and PII. If Contractor receives Department PII, upon request by DHCS, Contractor shall provide DHCS with a list of all employees, contractors and agents who have access to Department PII, including employees, contractors and agents of its subcontractors and agents.

7) **Cooperation with DHCS.** With respect to Department PI, to cooperate with and assist the Department to the extent necessary to ensure the Department's compliance with the applicable terms of the CIPA including, but not limited to, accounting of disclosures of Department PI, correction of errors in Department PI, production of Department PI, disclosure of a security breach involving Department PI and notice of such breach to the affected individual(s).

8) **Confidentiality of Alcohol and Drug Abuse Patient Records.** Contractor agrees to comply with all confidentiality requirements set forth in Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2. Contractor is aware that criminal penalties may be imposed for a violation of these confidentiality requirements.

9) **Breaches and Security Incidents.** During the term of this Agreement, Contractor agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

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a. Initial Notice to the Department. (1) To notify the Department **immediately by telephone call or email or fax** upon the discovery of a breach of unsecured Department PI or PII in electronic media or in any other media if the PI or PII was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon discovery of a suspected security incident involving Department PII. (2) To notify the Department **within 24 hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of Department PI or PII in violation of this Agreement or this Exhibit F-1 or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Contractor as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Contractor.

b. Notice shall be provided to the Information Protection Unit, Office of HIPAA Compliance. If the incident occurs after business hours or on a weekend or holiday and involves electronic Department PI or PII, notice shall be provided by calling the Department Information Security Officer. Notice shall be made using the DHCS "Privacy Incident Report" form, including all information known at the time. Contractor shall use the most current version of this form, which is posted on the DHCS Information Security Officer website (www.dhcs.ca.gov, then select "Privacy" in the left column and then "Business Partner" near the middle of the page) or use this link: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx .

c. Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of Department PI or PII, Contractor shall take:

i. Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment; and

ii. Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

d. **Investigation and Investigation Report**. To immediately investigate such suspected security incident, security incident, breach, or unauthorized access, use or disclosure of PHI. Within 72 hours of the discovery, Contractor shall submit an updated "Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the Department Information Security Officer.

e. **Complete Report**. To provide a complete report of the investigation to the Department Program Contract Manager and the Information Protection Unit within ten working days of the discovery of the breach or unauthorized use or disclosure. The report shall be submitted on the "Privacy Incident Report" form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure. If the Department requests information in addition to that listed on the "Privacy Incident Report" form, Contractor shall make reasonable efforts to provide the Department with such information. If, because of the circumstances of the incident, Contractor needs more than ten working days from the discovery to submit a complete report, the Department may grant a reasonable extension of time, in which case Contractor shall submit periodic updates until the complete report is submitted. If necessary, a Supplemental Report may be used to submit revised or additional information after the completed report is submitted, by submitting the revised or additional information on an updated "Privacy Incident Report" form. The Department will review and approve the determination of whether a breach occurred and whether individual notifications and a corrective action plan are required.

f. **Responsibility for Reporting of Breaches.** If the cause of a breach of Department PI or PII is attributable to Contractor or its agents, subcontractors or vendors, Contractor is

responsible for all required reporting of the breach as specified in CIPA, section 1798.29. Contractor shall bear all costs of required notifications to individuals as well as any costs associated with the breach. The Privacy Officer shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made. The Department will provide its review and approval expeditiously and without unreasonable delay.

g. If Contractor has reason to believe that duplicate reporting of the same breach or incident may occur because its subcontractors, agents or vendors may report the breach or incident to the Department in addition to Contractor, Contractor shall notify the Department, and the Department and Contractor may take appropriate action to prevent duplicate reporting.

h. **Department Contact Information**. To direct communications to the above referenced Department staff, the Contractor shall initiate contact as indicated herein. The Department reserves the right to make changes to the contact information below by giving written notice to the Contractor. Said changes shall not require an amendment to this Addendum or the Agreement to which it is incorporated.

Department Program Contract Manager	**DHCS Privacy Officer**	**DHCS Information Security Officer**
See the Exhibit A, Scope of Work for Program Contract Manager information	Information Protection Unit c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 (916) 445-4646 Email: privacyofficer@dhcs.ca.gov Telephone:(916) 445-4646 Fax: (916) 440-7680	Information Security Officer DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: iso@dhcs.ca.gov Telephone: ITSD Service Desk (916) 440-7000 or (800) 579-0874 Fax: (916) 440-5537

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10) Designation of Individual Responsible for Security.

Contractor shall designate an individual, (e.g., Security Officer), to oversee its data security program who shall be responsible for carrying out the requirements of this Exhibit F-2 and for communicating on security matters with the Department.

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Privacy and Information Security Provisions

F-3
Miscellaneous Terms and Conditions
Applicable to Exhibit F

1) **Confidentiality of Alcohol and Drug Abuse Patient Records.** Contractor agrees to comply with all confidentiality requirements set forth in Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2. Contractor is aware that criminal penalties may be imposed for a violation of these confidentiality requirements.

2) **Disclaimer**. The Department makes no warranty or representation that compliance by Contractor with this Exhibit F, HIPAA or the HIPAA regulations will be adequate or satisfactory for Contractor's own purposes or that any information in Contractor's possession or control, or transmitted or received by Contractor, is or will be secure from unauthorized use or disclosure. Contractor is solely responsible for all decisions made by Contractor regarding the safeguarding of the Department PHI, PI and PII.

3) **Amendment**. The parties acknowledge that federal and state laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Exhibit F may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, and the HIPAA regulations, and other applicable state and Federal laws. Upon either party's request, the other party agrees to promptly enter into negotiations concerning an amendment to this Exhibit F embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, and the HIPAA regulations, and other applicable state and Federal laws. The Department may terminate this Agreement upon thirty (30) days written notice in the event:

   A) Contractor does not promptly enter into negotiations to amend this Exhibit F when requested by the Department pursuant to this section; or

   B) Contractor does not enter into an amendment providing assurances regarding the safeguarding of Department PHI that the Department deems is necessary to satisfy the standards and requirements of HIPAA and the HIPAA regulations.

4) **Judicial or Administrative Proceedings**. Contractor will notify the Department if it is named as a defendant in a criminal proceeding for a violation of HIPAA or other security or privacy law. The Department may terminate this Agreement if Contractor is found guilty of a criminal violation of HIPAA. The Department may terminate this Agreement if a finding or stipulation that the Contractor has violated any standard or requirement of

HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Contractor is a party or has been joined. DHCS will consider the nature and seriousness of the violation in deciding whether or not to terminate the Agreement.

5) **Assistance in Litigation or Administrative Proceedings**. Contractor shall make itself and any subcontractors, employees, or agents assisting Contractor in the performance of its obligations under this Agreement, available to the Department at no cost to the Department to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Department, its directors, officers or employees based upon claimed violation of HIPAA, or the HIPAA regulations, which involves inactions or actions by the Contractor, except where Contractor or its subcontractor, employee or agent is a named adverse party.

6) **No Third-Party Beneficiaries.** Nothing expressed or implied in the terms and conditions of this Exhibit F is intended to confer, nor shall anything herein confer, upon any person other than the Department or Contractor and their respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.

7) **Interpretation.** The terms and conditions in this Exhibit F shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, and the HIPAA regulations. The parties agree that any ambiguity in the terms and conditions of this Exhibit F shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act and the HIPAA regulations, and, if applicable, any other relevant state and Federal laws.

8) **Conflict.** In case of a conflict between any applicable privacy or security rules, laws, regulations or standards the most stringent shall apply. The most stringent means that safeguard which provides the highest level of protection to PHI, PI and PII from unauthorized disclosure. Further, Contractor must comply within a reasonable period of time with changes to these standards that occur after the effective date of this Agreement.

9) **Regulatory References.** A reference in the terms and conditions of this Exhibit F to a section in the HIPAA regulations means the section as in effect or as amended.

10) **Survival.** The respective rights and obligations of Contractor under Section 3, Item D of Exhibit F-1, and Section 3, Item B of Exhibit F-2, Responsibilities of Contractor, shall survive the termination or expiration of this Agreement.

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11) **No Waiver of Obligations.** No change, waiver, or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

12) **Audits, Inspection and Enforcement.** From time to time, and subject to all applicable Federal and state privacy and security laws and regulations, the Department may conduct a reasonable inspection of the facilities, systems, books and records of Contractor to monitor compliance with this Exhibit F. Contractor shall promptly remedy any violation of any provision of this Exhibit F. The fact that the Department inspects, or fails to inspect, or has the right to inspect, Contractor's facilities, systems and procedures does not relieve Contractor of its responsibility to comply with this Exhibit F. The Department's failure to detect a non-compliant practice, or a failure to report a detected non-compliant practice to Contractor does not constitute acceptance of such practice or a waiver of the Department's enforcement rights under this Agreement, including this Exhibit F.

13) **Due Diligence.** Contractor shall exercise due diligence and shall take reasonable steps to ensure that it remains in compliance with this Exhibit F and is in compliance with applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, and other applicable state and Federal law, and that its agents, subcontractors and vendors are in compliance with their obligations as required by this Exhibit F.

14) **Term.** The Term of this Exhibit F-1 shall extend beyond the termination of the Agreement and shall terminate when all Department PHI is destroyed or returned to the Department, in accordance with 45 CFR Section 164.504(e)(2)(ii)(I), and when all Department PI and PII is destroyed in accordance with Attachment A.

15) **Effect of Termination.** Upon termination or expiration of this Agreement for any reason, Contractor shall return or destroy all Department PHI, PI and PII that Contractor still maintains in any form, and shall retain no copies of such PHI, PI or PII. If return or destruction is not feasible, Contractor shall notify the Department of the conditions that make the return or destruction infeasible, and the Department and Contractor shall determine the terms and conditions under which Contractor may retain the PHI, PI or PII. Contractor shall continue to extend the protections of this Exhibit F to such Department PHI, PI and PII, and shall limit further use of such data to those purposes that make the return or destruction of such data infeasible. This provision shall apply to Department PHI, PI and PII that is in the possession of subcontractors or agents of Contractor.

Exhibit F A2
Privacy and Information Security Provisions

Attachment I
Business Associate Data Security Requirements

I. Personnel Controls.

A. ***Employee Training.*** All workforce members who assist in the performance of functions or activities on behalf of DHCS, or access or disclose DHCS PHI or PI must complete information privacy and security training, at least annually, at Business Associate's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member's name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following contract termination.

B. ***Employee Discipline.*** Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.

C. ***Confidentiality Statement.*** All persons that will be working with DHCS PHI or PI must sign a confidentiality statement that includes, at a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The statement must be signed by the workforce member prior to access to DHCS PHI or PI. The statement must be renewed annually. The Contractor shall retain each person's written confidentiality statement for DHCS inspection for a period of six (6) years following contract termination.

D. ***Background Check.*** Before a member of the workforce may access DHCS PHI or PI, a thorough background check of that worker must be conducted, with evaluation of the results to assure that there is no indication that the worker may present a risk to the security or integrity of confidential data or a risk for theft or misuse of confidential data. The Contractor shall retain each workforce member's background check documentation for a period of three (3) years following contract termination.

II. Technical Security Controls.

A. ***Workstation/Laptop encryption.*** All workstations and laptops that process and/or store DHCS PHI or PI must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as Advanced

Encryption Standard (AES). The encryption solution must be full disk unless approved by the DHCS Information Security Office.

B. ***Server Security.*** Servers containing unencrypted DHCS PHI or PI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.

C. ***Minimum Necessary.*** Only the minimum necessary amount of DHCS PHI or PI required to perform necessary business functions may be copied, downloaded, or exported.

D. ***Removable media devices.*** All electronic files that contain DHCS PHI or PI data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, smartphones, backup tapes etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.

E. ***Antivirus software.*** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.

F. ***Patch Management.*** All workstations, laptops and other systems that process and/or store DHCS PHI or PI must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within 30 days of vendor release.

G. ***User IDs and Password Controls.*** All users must be issued a unique user name for accessing DHCS PHI or PI. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password, at maximum within 24 hours. Passwords are not to be shared. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed every 90 days, preferably every 60 days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:

- Upper case letters (A-Z)
- Lower case letters (a-z)

- Arabic numerals (0-9)
- Non-alphanumeric characters (punctuation symbols)

H. ***Data Destruction.*** When no longer needed, all DHCS PHI or PI must be cleared, purged, or destroyed consistent with NIST Special Publication 800-88, Guidelines for Media Sanitization such that the PHI or PI cannot be retrieved.

I. ***System Timeout.*** The system providing access to DHCS PHI or PI must provide an automatic timeout, requiring re-authentication of the user session after no more than 20 minutes of inactivity.

J. ***Warning Banners.*** All systems providing access to DHCS PHI or PI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.

K. ***System Logging*****.** The system must maintain an automated audit trail which can identify the user or system process which initiates a request for DHCS PHI or PI, or which alters DHCS PHI or PI. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If DHCS PHI or PI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least 3 years after occurrence.

L. ***Access Controls.*** The system providing access to DHCS PHI or PI must use role based access controls for all user authentications, enforcing the principle of least privilege.

M. ***Transmission encryption.*** All data transmissions of DHCS PHI or PI outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing PHI can be encrypted. This requirement pertains to any type of PHI or PI in motion such as website access, file transfer, and E-Mail.

N. ***Intrusion Detection***. All systems involved in accessing, holding, transporting, and protecting DHCS PHI or PI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

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III. Audit Controls.

A. ***System Security Review.*** All systems processing and/or storing DHCS PHI or PI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.

B. ***Log Reviews.*** All systems processing and/or storing DHCS PHI or PI must have a routine procedure in place to review system logs for unauthorized access.

C. ***Change Control.*** All systems processing and/or storing DHCS PHI or PI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

IV. Business Continuity / Disaster Recovery Controls

A. ***Emergency Mode Operation Plan.*** Contractor must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic DHCS PHI or PI in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this Agreement for more than 24 hours.

B. ***Data Backup Plan.*** Contractor must have established documented procedures to backup DHCS PHI to maintain retrievable exact copies of DHCS PHI or PI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore DHCS PHI or PI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of DHCS data.

V. Paper Document Controls.

A. ***Supervision of Data.*** DHCS PHI or PI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. DHCS PHI or PI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

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B. ***Escorting Visitors.*** Visitors to areas where DHCS PHI or PI is contained shall be escorted and DHCS PHI or PI shall be kept out of sight while visitors are in the area.

C. ***Confidential Destruction.*** DHCS PHI or PI must be disposed of through confidential means, such as cross cut shredding and pulverizing.

D. ***Removal of Data.*** DHCS PHI or PI must not be removed from the premises of the Contractor except with express written permission of DHCS.

E. ***Faxing.*** Faxes containing DHCS PHI or PI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending the fax.

F. ***Mailing.*** Mailings of DHCS PHI or PI shall be sealed and secured from damage or inappropriate viewing of PHI or PI to the extent possible. Mailings which include 500 or more individually identifiable records of DHCS PHI or PI in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of DHCS to use another method is obtained.