

**Exhibit A, Attachment I
Program Specifications**

1. Provision of Services

This Exhibit A, Attachment I, ~~Part V~~ of the Contract is entered into by and between the State and the Contractor for the purpose of identifying and providing for covered DMC services for substance use disorder treatment in the Contractor's service area pursuant to Sections 11848.5(a) and (b) of the Health and Safety Code (hereinafter referred to as HSC), Sections 14124.20, 14021.51 – 14021.53, and 14124.20 – 14124.25 of the W&I, and Title 22 of the California Code of Regulations (hereinafter referred to as Title 22), Sections 51341.1, 51490.1, and 51516.1, and **Part 438 of the Code of Federal Regulations (hereinafter referred to as 42 CFR 438), including but not limited to sections 42 CFR 438.1, 42 CFR 438.6, 42 CFR 438.8, 42 CFR 438.50, and 42 CFR 438.62.**

- a. It is further agreed this Contract is controlled by applicable provisions of: (a) the W&I, Chapter 7, Sections 14000, et seq., in particular, but not limited to, Sections 14100.2, 14021, 14021.5, 14021.6, 14043, et seq., (b) Title 22, including but not limited to Sections 51490.1, 51341.1 and 51516.1; and (c) Division 4 of Title 9 of the California Code of Regulations (hereinafter referred to as Title 9).
- b. It is understood and agreed that nothing contained in this contract shall be construed to impair the single state agency authority of DHCS.
- c. The objective of this contract is to make substance use disorder 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 for reimbursable covered services rendered by certified DMC providers.
- d. Awards under the Medical Assistance Program (CFDA 93.778) are no longer excluded from coverage under the HHS implementation of the A-102 Common Rule, 45 CFR part 92 (*Federal Register*, September 8, 2003, 68 FR 52843-52844). This change is effective for any grant award under this program made after issuance of the initial awards for the second quarter of Federal Fiscal Year 2004. This program also is subject to the requirements of 45 CFR part 95 and the cost principles under Office of Management and Budget Circular A-87 (as provided in *Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government*, HHS Publication ASMB C-10, available on the Internet at http://www.dol.gov/oasam/boc/ASMB_C-10.pdf <http://rates.psc.gov/fms/dea/asmb%20c-10.pdf>).

A. Eligibility

Medi-Cal eligibility will be determined by the county department responsible for enrolling beneficiaries.

DMC-ODS eligibility will be determined based on the beneficiary having current Medi-Cal eligibility, the beneficiary meeting medical necessity based on the current DSM, and level of service will be determined by ASAM criteria.

The counties will have an enrollment process consistent with 42 CFR 438.52 and 42 CFR 438.56.

B. Covered Services

Pursuant to 42 CFR 438.210(a)(1) and (2), and 42 CFR 438.210(a)(3)(i), (ii), and (iii) each contract must:

- a. Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or

PAHP is required to offer. The State must ensure that the services offered under the contract are 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.

- b. Require that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
- c. Require that the entity may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition;
 - (a) The entity may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose.
- d. Contractor shall establish assessment and referral procedures and shall arrange, provide, or subcontract for 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). Covered services include:
 - (a) Outpatient drug-free treatment;
 - (b) Withdrawal management
 - (c) Narcotic replacement therapy;
 - (d) Naltrexone treatment;
 - (e) Additional Medication Assisted Treatment (MAT)
 - (f) Case Management
 - (g) Physician Consultation
 - (h) Intensive Outpatient Treatment and,
 - (i) Perinatal Residential Substance Abuse Services (excluding room and board).
 - i. Room and board will be reimbursable through the SAPT BG funding allocated to each county.
 - (j) Nonperinatal Residential Substance Abuse Services (excluding room and board).
 - i. Room and board will be reimbursable through the SAPT BG funding allocated to each county.
- e. Narcotic treatment program services per W&IC 14124.22:
 - (a) In addition to narcotic treatment program services, a narcotic treatment program provider who is also enrolled as a Medi-Cal provider may provide medically necessary treatment of concurrent health conditions within the scope of the provider's practice, to Medi-Cal beneficiaries who are not enrolled in managed care plans. Medi-Cal beneficiaries enrolled in managed care plans shall be referred to those plans for receipt of medically necessary medical treatment of concurrent health conditions.

- (b) Diagnosis and treatment of concurrent health conditions of Medi-Cal beneficiaries not enrolled in managed care plans by a narcotic treatment program provider may be provided within the Medi-Cal coverage limits. When the services are not part of the substance use disorder treatment reimbursed pursuant to Section 14021.51, services shall be reimbursed in accordance with the Medi-Cal program. Services reimbursable under this section shall include, but not limited to, all of the following:
- ii. Medical treatment visits
 - iii. Diagnostic blood, urine, and X-rays
 - iv. Psychological and psychiatric tests and services
 - v. Quantitative blood and urine toxicology assays
 - vi. Medical supplies
- (c) A narcotic treatment provider, who is enrolled as a Medi-Cal fee-for-service provider, shall not seek reimbursement from a beneficiary for substance abuse treatment services, if services for treatment of concurrent health conditions are billed to the Medi-Cal fee-for-service program.
- f. In the event of a conflict between the definition of services contained in this Section of the Contract, and the definition of services in Title 22, Sections 51341.1, 51490.1, and 51516.1, the provisions of Title 22 shall govern.
- g. 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.
- h. Contractor shall comply with federal and state mandates to provide alcohol and other drug treatment services deemed medically necessary for Medi-Cal eligible: (1) pregnant and postpartum women, and (2) youth under age 21 who are eligible under the EPSDT Program
- (a) If Drug Medi-Cal services are provided to Minor Consent beneficiaries, Contractor shall comply with California Family Code Section 6929, and California Code of Regulations, Title 22, Sections 50147.1, 50030, 50063.5, 50157(f)(3), 50167(a)(6)(D), and 50195(d).
- i. The Department shall make the appropriate payments set forth in Exhibit B and take all available steps to secure and pay FFP and Behavioral Health Subaccount (BHS) to the Contractor, once the Department receives FFP and SGF, for claims submitted by the Contractor. The Department shall notify Contractor and allow Contractor an opportunity to comment to the Department when questions are posed by CMS, or when there is a federal deferral, withholding, or disallowance with respect to claims made by the Contractor.
- j. Contractor shall amend its subcontracts for covered services in order to provide sufficient funds to match allowable federal Medicaid reimbursements for any increase in provider DMC services to beneficiaries.
- k. In the event that the Contractor fails to provide covered services in accordance with the provisions of this Contract, at the discretion of the State, Contractor may be required to forfeit its county realignment funds pursuant to Government Code Section 30027.10 (a) through (d) from the Behavioral Health Subaccount that is set aside for Drug Medi-Cal services and surrender its

authority to function as the administrator of covered services in its service area.

C. Financing

a. Rate Setting

- (a) Rates will be set in the State and County contract.
- (b) Counties will propose county-specific rates in their proposed implementation plans and the State will approve the rates.
- (c) If during the rate setting process, the State denies the proposed rates, the county will be provided the opportunity to adjust the rates and resubmit to the State.
- (d) The State will retain all approval of the rates in order to assess that the rates are sufficient to ensure access to available DMC-ODS waiver services.
- (e) For NTP services:
 - i. Counties will accept the State rate for NTP; or
 - ii. Counties will propose a rate setting methodology for NTP services founded on evidence-based and/or outcomes-based models. These rates will be subject to the same approval process described above.

2. Availability and Accessibility of Service

A. Availability of Services

a. Pursuant to 42 C.F.R. § 438.206(a) and (b), the Contractor shall ensure the availability and accessibility of adequate numbers and types of providers of medically necessary services. At a minimum, the Contractor shall meet the following requirements:

- (a) Maintain and monitor a network of appropriate providers that is supported by written agreements for subcontractors and that is sufficient to provide adequate access to all services covered under this contract. In establishing and monitoring the network, the Contractor must consider the following:
 - i. The anticipated number of Medi-Cal eligible clients.
 - ii. The expected utilization of services, taking into account the characteristics and SUD treatment needs of beneficiaries.
 - iii. The expected number and types of providers in terms of training and experience needed to meet expected utilization.
 - iv. The numbers of network providers who are not accepting new beneficiaries.
 - v. 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.
 - vi. To the extent required by 42 CFR 438.206(b)(4), if the Contractor is unable to provide necessary medical services covered under the contract to a particular beneficiary, the Contractor must adequately and timely cover these services out of network for the beneficiary, for as long as the Contractor is unable to provide them.
 - vii. Pursuant to 42 C.F.R. § 438.206(b)(5) and consistent with Cal. Code Regs., tit. 9, § ~~1830.229~~, the Contractor shall require that out-of-network providers coordinate

authorization and payment with the Contractor. As is consistent with 42 CFR 438.106 Cal. Code Regs., tit. 9, §1810.365, the Contractor must ensure that the cost to the beneficiary for services provided out of network pursuant to an authorization is no greater than it would be if the services were furnished within the Contractor's network.

- viii. The Contractor shall demonstrate that its providers are credentialed as required by 42 C.F.R. § 438.214.

B. Access to Services

- a. Subject to DHCS provider enrollment certification requirements, 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.

- (a) When a request for covered services is made by a beneficiary, Contractor shall require services to be initiated with reasonable promptness. Contractor shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop regarding waiting times and appointments.
- (b) The contractor shall authorize residential services in accordance with the medical necessity criteria specified in Title 22, Section 51303 and the coverage provisions of the approved state Medi-Cal Plan. Room and board are not reimbursable DMC service. If services are denied, the provider shall inform the beneficiary in accordance with Title 22, Section 51341.1 (p).
- (c) Contractor shall 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.
- (d) **Second Opinion.** The contract must require that the entity provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the enrollee to obtain one outside the network, at no cost to the enrollee. (42 CFR 438.206(b)(3))
- (e) All counties shall have a toll free number for prospective beneficiaries to call to access DMC-ODS services. Oral interpretation services must be made available for beneficiaries, as needed.
- (f) Covered services, whether provided directly by the Contractor or through subcontractors with DMC certified and enrolled programs, shall be provided to beneficiaries without regard to the beneficiaries' county of residence.
- (g) The failure of the Contractor or its Subcontractors to comply with Section B of this Part will be deemed a breach of this Contract sufficient to terminate this Contract for cause. In the event the Contract is terminated, the provision of this Exhibit, Attachment I, Part I, Section B, shall apply.

- b. Timely Access

In accordance with 42 C.F.R. § 438.206(c)(1), the Contractor shall comply with the requirements set forth in Cal. Code Regs., tit. 9, §1810.405, including the following:

- (a) Meet and require its providers to meet Department standards for timely access to care and services, taking into account the urgency of need for services.
- (b) Require subcontracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. If the provider only serves Medi-Cal beneficiaries, the Contractor shall require that hours of operation are comparable to the hours the provider makes available for Medi-Cal services that are not covered by the Contractor, or another Mental Health Plan.
- (c) Make services available to beneficiaries 24 hours a day, 7 days a week, when medically necessary.
- (d) Establish mechanisms to ensure that network providers comply with the timely access requirements;
- (e) Monitor network providers regularly to determine compliance with timely access requirements;
- (f) Take corrective action if there is a failure to comply with timely access requirements.

C. Adequate Capacity and Standards

Pursuant to 42 CFR 438.207, the Contractor shall assure adequate network capacity within the standards prescribed.

- a. Documentation of adequate capacity and services. Pursuant to 42 C.F.R. § 438.207(b), the Contractor must, when requested by the Department, submit documentation to the Department, in a format specified by the Department, and after receiving reasonable advance notice of its obligation, to demonstrate that the Contractor:
- b. Offers an appropriate range of substance use disorder treatment services that is adequate for the anticipated number of beneficiaries for the service area.
- c. 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.
- d. Consistent with 42 C.F.R. § 438.207(c)(2), whenever there is a change in the Contractor's operation that would cause a decrease of 25 percent or more in services or providers available to beneficiaries, the Contractor shall report this to the Department, including details regarding the change and plans to maintain adequate services and providers available to beneficiaries.

D. Coordination and Continuity of Care

Pursuant to 42 CFR 438.208, the Contractor shall assure coordination and continuity of care within the standards prescribed.

- a. Coordinate the services that the Contractor either furnishes or arranges to be furnished to the beneficiary with services that the beneficiary receives from any other Medi-Cal managed care plan or subcontractor in accordance with 42 CFR 438.208(3)(b)(2) ~~Cal. Code Regs., tit. 9 §1810.425.~~
- b. Ensure that, in the course of coordinating care, each beneficiary's privacy is protected in accordance with all federal and state privacy laws, including but not limited to 45 C.F.R. § 160 and § 164, to the extent that such provisions are applicable.
- c. Enter into a Memorandum of Understanding (MOU) with any Medi-Cal managed care plan serving

the Contractor's beneficiaries in accordance with 42 CFR 438.208 ~~Cal. Code Regs., tit. 9, § 4840.370~~. The Contractor shall notify the Department in writing if the Contractor is unable to enter into an MOU or if an MOU is terminated, providing a description of the Contractor's good faith efforts to enter into or maintain the MOU. The contractor shall monitor the effectiveness of its MOU with Physical Health Care Plans.

- d. Pursuant to 42 CFR 438.208(b)(1), (2), and (3), the contract must require that the entity implement procedures to:
- (a) ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.
 - (b) coordinate the services the MCO, PIHP, or PAHP furnishes to the enrollee with the services the enrollee receives from any other MCO, PIHP, or PAHP.
 - (c) share with other MCOs, PIHPs, and PAHPs serving the enrollee the results of its identification and assessment of any enrollee with special health care needs (as defined by the state) so that those activities need not be duplicated.
 - (d) to ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164. 45 CFR Part 164 specifically describes the requirements regarding the privacy of individually identifiable health information. Health plans must comply with these requirements if they meet the definition of health plan found at 160.103: group health plan; health insurance issuer; HMO; Medicaid programs; SCHIP program, any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care. CMS recommends that Medicaid Managed care contracts include a provision that states that the MCO/PIHP/PAHP, as applicable, is in compliance with the requirements in 45 CFR Parts 160 and 164.
 - (e) At State discretion, exceptions may exist for MCOs that serve dually eligible enrollees
- e. Enrollees with special health care needs
- (a) Identification. The State must implement mechanisms to identify persons with special health care needs to MCOs, PIHPs and PAHPs, as those persons are defined by the State. These identification mechanisms—
 - (b) Must be specified in the State's quality improvement strategy in §438.202; and
 - (c) May use State staff, the State's enrollment broker, or the State's MCOs, PIHPs and PAHPs. (42 CFR 438.208(c)(1))
 - (d) Assessment. The contract must require that the entity implement mechanisms to assess each Medicaid enrollee identified as having special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate health care professionals.
 - (e) Treatment plans. If the State requires the entity to produce a treatment plan for enrollees determined to need a course of treatment or regular care monitoring, the treatment plan must be—
 - i. Developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee;
 - ii. Approved by the entity in a timely manner, if this approval is required; and
 - iii. In accord with any applicable State quality assurance and utilization review standards.

- (f) **Direct Access to Specialists.** For enrollees determined to need a course of treatment or regular care monitoring, the entity must have a mechanism in place to allow enrollees to directly access a specialist as appropriate for the enrollee's condition and identified needs. (42 CFR 438.208(c)(4))

E. Authorization of Services

- A. Pursuant to 42 C.F.R. § 438.210(b), the Contractor shall implement mechanisms to assure authorization decision standards are met. The Contractor shall:
 - 1) Have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services.
 - 2) Have mechanisms in effect to ensure consistent application of review criteria for authorization decisions, and shall consult with the requesting provider when appropriate.
 - 3) Have 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.
 - 4) Have decisions made within the timeframes outlined for service authorizations in 42 C.F.R. § 438.210(d), and notices of action related to such decisions provided within the timeframes set forth in 42 C.F.R. § 438.404(c).
 - 5) Provide that compensation to individuals or entities that conduct utilization management activities must not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.
- B. The Contractor shall act on an authorization request for treatment for urgent conditions within one hour of the request per Cal. Code Regs., tit. 9, § 1810.405(c).
- C. Pursuant to 42 C.F.R. § 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.

F. Provision of Notice of Action

- 1) Consistent with 42 C.F.R. § 438.400(b) and ~~Cal. Code Regs., tit. 9, § 1810.200~~ "Action," in the case of a contractor, means:
 - a) A denial, modification, reduction or termination of a provider's request for contractor payment authorization of a substance use disorder treatment service covered by the contractor.
 - b) A determination by the contractor or its providers that the medical necessity criteria in STC 1.c.ii ~~Cal. Code Regs., tit. 9, §§ 1830.205(b)(1), (b)(2), (b)(3)(C), or 1830.210(a)~~ have not been met and the beneficiary is not entitled to any substance use disorder treatment services from the contractor.
 - c) A failure by the contractor to provide a substance use disorder treatment service covered by the contractor within the timeframe for delivery of the service established by the contractor; or

d) A failure by the contractor to act within the timeframes for resolution of grievances, appeals, or the expedited appeals.

2) Pursuant to 42 C.F.R. § 438.404(a), the Notice of Action (NOA) shall be in writing and shall meet the language and format requirements of 42 C.F.R. § 438.10(c) and (d) to ensure ease of understanding. The Notice of Action shall contain the items specified in 42 C.F.R. § 438.404 (b) ~~and Cal. Code Regs., tit. 9, § 1850.210.~~

Each contract must require the entity to notify the requesting provider, and give the enrollee written notice 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. For MCOs and PIHPs, the notice must meet the requirements of §438.404, except that the notice to the provider need not be in writing. (42 CFR 438.210(c))

3) The Contractor shall provide a beneficiary with an NOA when the Contractor denies or modifies a Contractor payment authorization request from a provider for a substance use disorder treatment service to the beneficiary.

4) When the denial or modification involves a request from a provider for continued Contractor payment authorization of a substance use disorder treatment service or when the Contractor reduces or terminates a previously approved Contractor payment authorization, notice shall be provided in accordance with Cal. Code. Regs., tit. 22, § 51014.1.

5) A NOA is not required when a denial is a non-binding verbal description to a provider of the substance use disorder treatment services that may be approved by the Contractor.

6) A NOA is not required when the Contractor modifies the duration of any approved substance use disorder treatment services as long as the Contractor provides an opportunity for the provider to request Contractor payment authorization of additional substance use disorder treatment services before the end of the approved duration of services.

7) Except as provided in subsection 6 below, a NOA is not required when the denial or modification is a denial or modification of a request for Contractor payment authorization for a substance use disorder treatment service that has already been provided to the beneficiary.

8) A NOA is required when the Contractor denies or modifies a payment authorization request from a provider for a substance use disorder treatment service that has already been provided to the beneficiary when the denial or modification is a result of post-service, prepayment determination by the Contractor that the service was not medically necessary or otherwise was not a service covered by the Contractor.

9) The Contractor shall deny the Contractor payment authorization request and provide the beneficiary with a NOA when the Contractor does not have sufficient information to approve or modify, or deny on the merits, a Contractor payment authorization request from a provider within the timeframes required by 42 CFR 438.404(c)(5) ~~Cal. Code Regs., tit. 9, §§ 1820.220 or 1830.215.~~

Standard Service Authorization denial –The MCO, PIHP or PAHP gives notice as expeditiously as the enrollee's health condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if the enrollee, or the provider, requests extension; or the MCO, PIHP, or PAHP justifies a need for additional information and how the extension is in the enrollee's interest (upon State request).

If the MCO, PIHP, or PAHP extends the timeframe, the contractor must give the enrollee written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a grievance if he or she disagrees with that decision; and issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires. (42 CFR 438.210(c); 42 CFR 438.210(d)(1); 42 CFR 438.404(c)(3) and 42 CFR 438.404(c)(4))

Expedited Service Authorization denial –For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP or PAHP gives notice must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 3 working days after receipt of the request for service.

Extension -The MCO, PIHP, or PAHP may extend the 3 working days time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies a need for additional information and how the extension is in the enrollee's interest (upon State request). (42 CFR 438.210(d)(2); 42 CFR 438.404(c)(6))

Untimely Service Authorization Decisions- MCO or PIHP gives notice on the date that the timeframes expire when service authorization decisions not reached within the timeframes for either standard or expedited service authorizations. Untimely service authorizations constitute a denial and are thus adverse actions. (42 CFR 438.404(c)(5))

10) The Contractor shall provide the beneficiary with a NOA if the Contractor fails to notify the affected parties of a grievance decision within 60 calendar days, of an appeal decision within 45 days, or of an expedited appeal decision within three working days. If the timeframe for a grievance, appeal or expedited appeal decision is extended pursuant to 42 C.F.R. § 438.408, 42 C.F.R. § 438.410(a), or 42 CFR 438.406(b)(2) Cal. Code Regs., tit. 9, §§ 1850.206, 1850.207 or 1850.208 and the Contractor failed to notify the affected parties of its decision within the extension period, the Contractor shall provide the beneficiary with a NOA.

11) The Contractor shall provide a beneficiary with a NOA if the Contractor fails to provide a substance use disorder treatment service covered by the Contractor within the timeframe for delivery of the service established by the Contractor.

12) The Contractor shall comply with the requirements of 42 C.F.R. § 438.404(b), and Cal. Code Regs., tit. 9, § 1850.210, regarding the content of NOAs and with the following timeframes for mailing of NOAs:

a) The written NOA issued pursuant to (1) or (6) above shall be deposited with the United States Postal Service in time for pick-up no later than the third working day after the action. A Notice of Action issued pursuant to (2) above shall be provided in accordance with the applicable timelines set forth in Cal. Code Regs., tit. 22, § 51014.1.

b) The written NOA issued pursuant to (7) or (8) above shall be deposited with the United States Postal Service in time for pick-up on the date that the applicable timeframe expires.

c) The written NOA issued pursuant to subsection (9) above shall be deposited with the United States Postal Service in time for pick up on the date that the timeframe for delivery of the service established by the Contractor expires.

13) When a NOA would not be required as described in (3)-(5) above, the Contractor shall provide a beneficiary with a NOA when the Contractor or its providers determine that the medical necessity criteria in STC 1.c.ii ~~Cal. Code Regs., tit. 9, §§1830.205(b)(1), (b)(2), (b)(3)(C), or 1830.210(a)~~ have not been met and that the beneficiary is not entitled to any substance use disorder treatment services from the Contractor. A NOA is not required when a provider, including the Contractor acting as a provider, determines that a beneficiary does not qualify for a specific service covered by the Contractor, including but not limited to: crisis intervention, crisis stabilization, crisis residential treatment services, psychiatric inpatient hospital services, or any substance use disorder treatment service to treat a beneficiary's urgent condition, provided that the determination does not apply to any other substance use disorder treatment service covered by the Contractor. The NOA shall, at the election of the Contractor, be hand-delivered to the beneficiary on the date of the action or mailed to the beneficiary in accordance with 42 CFR 438.404 ~~Cal. Code Regs., tit. 9, § 1850.210(f)(1)~~, and shall specify the information contained therein ~~Cal. Code Regs., tit. 9, § 1850.212(b)~~.

14) For the purpose of this Section, each reference to a Medi-Cal managed care plan in Cal. Code Regs., tit. 22, § 51014.1, shall mean the Contractor.

15) For the purposes of this Section, "medical service", as used in Cal. Code Regs., tit. 22, § 51014.1, shall mean substance use disorder treatment services that are subject to prior authorization by a Contractor pursuant to 42 CFR 438.210 ~~Cal. Code Regs., tit. 9, §§ 1820.100 and 1830.100~~.

16) The Contractor shall retain copies of all Notices of Action issued to beneficiaries under this Section in a centralized file accessible to the Department.

G. Contents of a NOA

1) The NOA issued pursuant to Section I of this contract and 42 C.F.R. § 438.404(b) ~~and Cal. Code Regs., tit. 9, §§1850.210(a)-(e) and 1850.212~~, shall contain the following information:

- a) The action taken by the Contractor;
- b) The reason for the action taken;
- c) Citations to the regulations or Contractor payment authorization procedures supporting the action;
- d) The beneficiary's right to file an appeal or expedited appeal with the Contractor;
- e) The circumstances under which an expedited resolution is available, and how to request it; and,
- f) Information about the beneficiary's right to request a fair hearing or an expedited fair hearing, including:
 - i. The method by which a hearing may be obtained;
 - ii. A statement that the beneficiary may be either self- represented, or represented by an authorized third party such as legal counsel, a relative, friend or any other person;
 - iii. An explanation of the circumstances under which a substance use disorder treatment service will be continued if a fair hearing is requested; and,

- iv. The time limits for requesting a fair hearing or an expedited fair hearing.
- 2) A NOA issued pursuant to 42 CFR 438.404 ~~Cal. Code Regs., tit. 9, §§ 1850.210(g) and 1850.212(b)~~, relating to denials for lack of medical necessity, shall specify the following:
 - a) The reason that the medical necessity criteria were not met, including a citation to the applicable regulation;
 - b) The beneficiary's options for obtaining care from sources other than the Contractor, if applicable;
 - c) The beneficiary's right to request a second opinion on the determination;
 - d) The beneficiary's right to file an appeal or expedited appeal with the Contractor; and,
 - e) The beneficiary's right to request a fair hearing or an expedited fair hearing, including:
 - i. The method by which a hearing may be obtained;
 - ii. The time period in which the request for a fair hearing or expedited fair hearing must be filed; and,
 - iii. That the beneficiary may be either self-represented, or represented by an authorized third party such as legal counsel, a relative, friend or any other person;
- K. Consistent with 42 C.F.R. § 438.404(c), the Contractor shall give notice at least 10 days before the effective date of action when the action is a termination, suspension, or reduction of previously authorized Medi-Cal-covered services, except:
 - 1) The period of advanced notice is shortened to 5 days if probable beneficiary fraud has been verified;
 - 2) The action shall be effective on the date of the Notice under the following circumstances:
 - a) The death of a beneficiary;
 - b) Receipt of a signed written beneficiary statement requesting service termination or giving information requiring termination or reduction of services (provided the beneficiary understands that this will be the result of supplying that information);
 - c) The beneficiary's admission to an institution where he or she is ineligible for further services;
 - d) The beneficiary's whereabouts are unknown and mail directed to him or her has no forwarding address;
 - e) Notice that the beneficiary has been accepted for Medicaid services by another local jurisdiction;
 - f) A change in the beneficiary's physician's prescription for the level of medical care; or
 - g) Endangerment of the safety or health of individuals in the facility; improvement in the

resident's health sufficient to allow a more immediate transfer or discharge; urgent medical needs that require a resident's immediate transfer or discharge; or notice that a resident has not resided in the nursing facility for 30 days (but only in adverse actions based on NF transfers).

3) If payment is denied, the Contractor shall give notice to the beneficiary on the date of the action.

L. Pursuant to 42 CFR 438.416 Cal. Code Regs., tit. 9, § 1810.375(a), the Contractor is required to submit to the Department a report that summarizes beneficiary grievances, appeals and expedited appeals filed from July 1 of the previous year through June 30 of that year by October 1 of each year. The report shall include the total number of grievances, appeals and expedited appeals by type, by subject areas established by the Department, and by disposition.

Notice of Action - State delegation. [State Option] The State Medicaid agency is required to send notices of action in the State Fair Hearing Regulations (42 CFR 431 Subpart E). If the State delegates its additional fair hearing notice responsibilities (under 42 CFR 431 subpart E) to the MCO, PIHP, or PAHP, any delegated notice responsibilities must be in the contract so that the contractor can include the additional content requirements under the fair hearing regulations in this notice. (42 CFR 438.228(b))

3. Provider Selection and Certification

1. Pursuant to 42 C.F.R. § 438.12(a)(2), in all contracts with providers the Contractor must comply with the requirements in 42 C.F.R. § 438.214.
2. The Contractor shall demonstrate that its providers are credentialed as required by 42 C.F.R. § 438.214.
3. Consistent with 42 C.F.R. § 438.214, the contractor shall have written policies and procedures for selection, retention, credentialing and recredentialing of providers; the provider selection policies and procedures must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
4. Pursuant to 42 C.F.R. § 438.12(a)(1), the Contractor may not discriminate in the selection, 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.
5. Declining providers. If an MCO, PIHP, or PAHP declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. 42 CFR 438.12 (a) of this section may not be construed to:
 - a. Require the MCO, PIHP, or PAHP to contract with providers beyond the number necessary to meet the needs of its enrollee.
 - b. Preclude the MCO, PIHP, or PAHP from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or
 - c. Preclude the MCO, PIHP or PAHP from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to enrollee. (42 CFR 438.12(a)(1), 42 CFR 438.12(b)(1))

A. DMC Certification and Enrollment

1. The State will certify eligible providers to participate in the DMC program.
2. The Department shall certify any county operated or non-governmental providers. This

certification shall be performed prior to the date on which the Contractor begins to deliver services under this contract at these sites.

3. Contractor shall require that providers of perinatal DMC services are properly certified to provide these services and comply with the requirements contained in Title 22, Section 51341.1, Services for Pregnant and Postpartum Women.
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:
 - (a) Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8;
 - (b) Drug Medi-Cal Certification Standards for Substance Abuse Clinics (Document 2E);
 - (c) Title 22, CCR, Sections 51341.1, 51490.1, and 51516.1, (Document 2C);
 - (d) Standards for Drug Treatment Programs (October 21, 1981) (Document 2F);
 - (e) Title 9, CCR, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq. ; and
 - (f) Title 22, CCR, sections 51000 et. seq.

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

5. The Contractor shall report to the state within 35 days of any addition or change in the information previously submitted in the application package for certification. The Contractor shall report the addition or change by submitting a complete application package for enrollment.
6. Contractor shall notify the State in writing prior to reducing the provision of covered services. In addition, any proposal to change the location where covered services are provided, or to reduce their availability, shall be submitted in an application to the State sixty (60) days prior to the proposed effective date. Contractor shall not implement proposed changes prior to receiving written approval from the State. Contractor shall not implement the proposed changes if the State denies the Contractor's proposal.
7. If, at any time, a Subcontractor's license, registration, certification, or approval to operate a substance use treatment program or provide a covered service is revoked, suspended, modified, or not renewed, the Contractor must notify DHCS within two business days.
 - (a) A provider's certification to participate in the DMC program shall automatically terminate in the event that the provider or its owners, officers or directors are convicted of Medi-Cal fraud, abuse or malfeasance. For purposes of this section, a conviction shall include a plea of guilty or nolo contendere.

B. Continued Certification

1. All DMC certified providers shall be subject to continuing certification requirements at least once every five years.
2. The Department may allow the Contractor to continue delivering covered services to

beneficiaries at a site subject to on-site review by the Department as part of the recertification process prior to the date of the on-site review, provided the site is operational, the certification remains valid, and has all required fire clearances.

3. State will conduct recertification on-site visits at clinics for circumstances identified in the "Drug Medi-Cal Certification Standards for Substance Abuse Clinics" (Document 2E). Document 2E contains the appeal process in the event the State disapproves a provider's request for certification or recertification and shall be included in the Contractor's subcontracts.

4. Recovery from Other Sources or Providers

- A. 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.
- B. The monies recovered are retained by the Contractor. However, Contractor's claims for FFP for services provided to beneficiaries under this contract shall be reduced by the amount recovered.
- C. The Contractor shall maintain accurate records of monies recovered from other sources.
- D. 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 contract.

Beneficiary Liability for Payment. Pursuant to Cal. Code Regs., tit. 9, § 1810.365, the Contractor or an affiliate, vendor, contractor, or sub-subcontractor of the Contractor shall not submit a claim to, or demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any substance use disorder or related administrative services provided under this contract, except to collect other health insurance coverage, share of cost, and co-payments. Consistent with 42 C.F.R. § 438.106, the Contractor or an affiliate, vendor, contractor, or sub-subcontractor of the Contractor shall not hold beneficiaries liable for debts in the event that the Contractor becomes insolvent, for costs of covered services for which the State does not pay the Contractor, for costs of covered services for which the State or the Contractor does not pay the Contractor's providers, for costs of covered services provided under a contract, referral or other arrangement rather than from the Contractor, or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a beneficiary with an emergency condition.

Protect Against Liability – subcontractors and referrals – subcontractors and referral providers may not bill enrollees any amount greater than would be owed if the entity provided the services directly (i.e., no balance billing by providers) (42 CFR 438.106(c); 42 CFR 438.6(l); 42 CFR 438.230; 42 CFR 438.204(a))

~~The MCO, and PIHP must meet the solvency standards established by the State for private health maintenance organizations, or be licensed or certified by the State as a risk-bearing entity except when the entity meets any one of the following conditions:~~

- ~~• The entity does not provide both inpatient hospital services and physician services~~
- ~~• Is a public entity~~
- ~~• Is (or is controlled by) one or more federally qualified health centers and meets the solvency~~

~~standards established by the State for those centers~~

~~• Has its solvency guaranteed by the State
(42 CFR 438.116(b)(1); and 42 CFR 438.116(b)(2))~~

~~Each non-federally qualified MCO, PIHP, and PAHP must provide assurances that Medicaid enrollees will not be liable for the entity's debt if the entity becomes insolvent. (42 CFR 438.116(a))~~

5. Subrogation

6. Beneficiary Brochure and Provider List

The Contractor shall be responsible for the production and update of its booklet section(s) and provider list in accordance with 42 C.F.R. § 438.10 and Cal. Code Regs., tit. 9, §1810.360. The Contractor shall establish criteria to update its booklet and provider list.

Pursuant to 42 C.F.R. § 438.10, the Contractor shall:

- 1) Notify all beneficiaries of their right to change providers;
- 2) Notify all beneficiaries of their right to request and obtain the following information:
 - a) Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the beneficiary's service area, including identification of providers that are not accepting new patients.
 - b) Any restrictions on the beneficiary's freedom of choice among network providers.
 - c) Beneficiary rights and protections, as specified in 42 CFR § 438.100.
 - d) The amount, duration, and scope of benefits available under this Contract in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled.
 - e) Procedures for obtaining benefits, including authorization requirements.
 - f) The extent to which, and how, beneficiaries may obtain benefits from out-of-network providers.
 - g) The extent to which, and how, after-hours and emergency coverage are provided, including:
 - i. What constitutes an emergency medical condition, emergency services, and post-stabilization services, with reference to the definitions in 42 C.F.R. § 438.114(a).
 - ii. The fact that prior authorization is not required for emergency services.
 - iii. The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.
 - iv. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the contract.
 - v. The fact that, subject to the provisions of 42 C.F.R. § 438.10(f)(6), the beneficiary has a right to use any hospital or other setting for emergency care.

- vi. The post-stabilization care services rules set forth in 42 C.F.R. § 422.113(c).
 - vii. Policy on referrals for specialty care and for other benefits not furnished by the enrollee's primary care provider.(42 CFR 438.10(f)(6)(x))
 - h) Cost sharing, if any.
 - i) How and where to access any benefits that are available under the State Plan but are not covered under this Contract, including any cost sharing, and how any necessary transportation is provided. Pursuant to 42 C.F.R. § 438.102(a)(2), for a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service. Pursuant to 42 C.F.R. § 438.102(b)(1), the Contractor must provide information about the services it does not cover on moral or religious grounds.
- B. The Contractor shall ensure that the general program literature it uses to assist beneficiaries in accessing services including, but not limited to, the booklet required by 42 C.F.R. § 438.10 ~~Cal. Code Regs., tit. 9, § 1810.360~~, materials explaining the beneficiary problem resolution and fair hearing processes ~~required by Cal. Code Regs., tit. 9, § 1850.205(c)(4)~~, and substance use disorder education materials used by the Contractor, are available in the threshold languages of the County in compliance with 42 C.F.R. § 438.10(c)(3).
- C. Pursuant to 42 C.F.R. § 438.10(c)(4) and (5) ~~and Cal. Code Regs., tit. 9, § 1810.410~~, the Contractor must make oral interpretation and sign language services available free of charge to each beneficiary. This applies to all non-English languages and not just those identified as prevalent. The Contractor must notify beneficiaries that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services.
- Language requirements. Each entity must make its written information available in the prevalent non-English languages in its particular service area. The State must establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees and provide the information to the entities. Each entity must make oral interpretation services available free of charge to each potential enrollee and enrollee. This applies to all non-English languages not just those that the State identifies as prevalent. The beneficiary is not to be charged for interpretation services. Either the State or the entity, at the State's discretion, will be responsible to pay for these services. Each entity must notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services. (42 CFR 438.10(c)(1), (2), (3), (4), and (5))
- Format and alternative format requirements. Written material must use easily understood language and format. Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats. (42 CFR 438.10(d)(1)(i) and 42 CFR 438.10(d) (1)(ii) and (2))
- D. Pursuant to 42 C.F.R. § 438.10(g) ~~and Cal. Code Regs., tit. 9, § 1850.205(c)(4)~~, the booklet shall include grievance, appeal and fair hearing procedures and timeframes, as provided in 42 C.F.R. §§ 438.400 through 438.424, using a Department-developed or Department-approved description that must include the following:
 - 1) For State Fair Hearing

- a) The right to hearing;
- b) The method for obtaining a hearing; and
- c) The rules that govern representation at the hearing.
- 2) The right to file grievances and appeals.
- 3) The requirements and timeframes for filing a grievance or appeal
- 4) The availability of assistance in the filing process.
- 5) The toll-free numbers that the beneficiary can use to file a grievance or an appeal by phone.
- 6) The fact that, when requested by the beneficiary:
 - a) Benefits will continue if the beneficiary files an appeal or a request for State Fair Hearing within the timeframes specified for filing.
- 7) The appeal rights that the Department has chosen to make available to providers consistent with in Cal. Code Regs., tit. 9, § 1850.315, to challenge the Contractor's failure to cover a service.
- 8) Advance Directives, as set forth in 42 C.F.R. § 438.6(i)(22).
- 9) Additional information that is available upon request, includes the following:
 - a) Information on the structure and operation of the Contractor.
 - b) Physician incentive plans as set forth in 42 C.F.R. § 438.6(h).
- E. The Contractor shall provide beneficiaries with a copy of the booklet and provider list when the beneficiary first accesses services and thereafter upon request in accordance with 42 C.F.R. § 438.10 Cal. Code Regs., tit. 9, § 1810.360.
- I. The Contractor shall ensure that the booklet above includes the current toll-free telephone number(s) that provides information in threshold languages and is available twenty-four hours a day, seven days a week.
- J. The Contractor shall ensure that provider directories:
 - 1) Include information on the category or categories of services available from each provider;
 - 2) Contain the names, locations, and telephone numbers of current contracted providers by category;
 - 3) Identify options for services in languages other than English and services that are designed to address cultural differences and;
 - 4) Provide a means by which a beneficiary can identify which providers are not accepting new beneficiaries.
- K. As required by 42 C.F.R. § 438.10(f)(4), when there is a change that the State defines as significant in the scope of substance use disorder treatment services covered by the Contractor, the update, in the form of a booklet insert, shall be provided to beneficiaries at least 30 days prior to the change.

L. Consistent with 42 C.F.R. § 438.10(f)(5), the Contractor must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each beneficiary who was seen on a regular basis by the terminated provider.

7. Requirements for Day Treatment Intensive and Day Rehabilitation

8. Documentation Standards

9. Cultural Competence Plan

The Contractor shall comply with the provisions of the Contractor's Cultural Competence Plan submitted in accordance with 42 CFR 438.206(c)(2) ~~Cal. Code Regs., tit. 9, § 1810.440~~, and approved by the Department. The Contractor shall update the Cultural Competence Plan and submit these updates to the Department for review and approval annually.

10. Implementation Plan

The Contractor shall comply with the provisions of the Contractor's Implementation Plan pursuant to ~~STC 4.c. Cal. Code Regs., tit. 9, § 1810.310~~ as approved by the Department, including the administration of beneficiary problem resolution processes as required by 42 C.F.R. § 438.10 ~~Cal. Code Regs., tit. 9, § 1850.205 through § 1850.208~~. The Contractor shall obtain written approval by the Department prior to making any changes to the Implementation Plan as approved by the Department. The Contractor may implement the changes after thirty (30) calendar days if the Department does not respond in writing within thirty calendar (30) days as provided in Cal. Code Regs., tit. 9, § 1810.310.

11. Additional Provisions

A. Additional Contract Restrictions

This Contract is subject to any additional restrictions, limitations, or conditions enacted by the Congress, or any statute enacted by the Congress, which may affect the provisions, terms, or funding of this Contract in any manner.

B. Nullification of Drug Medi-Cal (DMC) Treatment Program substance use disorder services (if applicable)

The parties agree that if the Contractor fails to comply with the provisions of Welfare and Institutions Code (W&I) Section 14124.24, all areas related to the DMC Treatment Program substance use disorder services shall be null and void.

Contractor agrees that the State has the right to withhold payments until Contractor has submitted any required data and reports to the State, as identified in this Exhibit A, Attachment I or as identified in Document 1F(a), Reporting Requirement Matrix for Counties.

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

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

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

C. Hatch Act

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.

D. No Unlawful Use or Unlawful Use Messages Regarding Drugs

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 Contract, Contractor agrees that it will enforce, and will require its Subcontractors to enforce, these requirements.

E. Noncompliance with Reporting Requirements

Contractor agrees that the State has the right to withhold payments until Contractor has submitted any required data and reports to the State, as identified in Exhibit A, Attachment I, Part III – Reporting Requirements, or as identified in Document 1F(a), Reporting Requirements Matrix for Counties.

F. Limitation on Use of Funds for Promotion of Legalization of Controlled Substances

None of the funds made available through this Contract 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).

H. Health Insurance Portability and Accountability Act (HIPAA) of 1996

If any of the work performed under this Contract is subject to the HIPAA, then Contractor shall perform the work in compliance with all applicable provisions of HIPAA. As identified in Exhibit G, the State and County shall cooperate to assure mutual agreement as to those transactions between them, to which this Provision applies. Refer to Exhibit G for additional information.

1. Trading Partner Requirements

- (a) No Changes. Contractor hereby agrees that for the personal health information (Information), it will 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 will 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 will 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 will not change the meaning or intent of any of the HHS Transaction Standard's implementation specification. (45 CFR Part 162.915 (d))

2. Concurrence for Test Modifications to HHS Transaction Standards

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

3. Adequate Testing

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.

4. Deficiencies

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

5. Code Set Retention

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

6. Data Transmission Log

Both Parties shall establish and maintain a Data Transmission Log, which shall record any and all Data Transmission taking place between the Parties during the term of this Contract. Each Party will 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 twenty-four (24) months following the date of the Data Transmission. The Data Transmission Log may be maintained on computer media or other suitable means provided that, if it is necessary to do so, the information contained in the Data Transmission Log may be retrieved in a timely manner and presented in readable form.

I. Nondiscrimination and Institutional Safeguards for Religious Providers

Contractor shall establish such processes and procedures as necessary to comply with the provisions of Title 42, USC, Section 300x-65 and Title 42, CFR, Part 54, (Reference Document 1B).

J. Counselor Certification

Any counselor 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, CCR, Division 4, Chapter 8. (Document 3H)

K. Cultural and Linguistic Proficiency

To ensure equal access to quality care by diverse populations, each service provider receiving funds from this contract 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).

L. Intravenous Drug Use (IVDU) Treatment

Contractor shall ensure that individuals in need of IVDU treatment shall be encouraged to undergo alcohol and other drug (AOD) treatment (42 USC 300x-23(b) of PHS Act).

M. Tuberculosis Treatment

Contractor shall ensure the following related to Tuberculosis (TB):

1. Routinely make available TB services to each individual receiving treatment for alcohol and other drug use and/or abuse;
2. Reduce barriers to patients' accepting TB treatment; and,
3. Develop strategies to improve follow-up monitoring, particularly after patients leave treatment, by disseminating information through educational bulletins and technical assistance.

N. Trafficking Victims Protection Act of 2000

Contractor and its Subcontractors that provide services covered by this Contract shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 as amended (22 U.S.C. 7104). For full text of the award term, go to: <http://www.samhsa.gov/grants/trafficking.aspx>
<http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=2&SID=30cef173ce45f9ae560f5ba6faf646b4&ty=HTML&h=L&n=pt2.1.175&r=PART>

O. Tribal Communities and Organizations

Contractor shall regularly assess (e.g. review population information available through Census, compare to information obtained in CalOMS Treatment to determine whether population is being reached, survey Tribal representatives for insight in potential barriers) the substance use service needs of the American Indian/Alaskan Native (AI/AN) population within the County geographic area and shall engage in regular and meaningful consultation and collaboration with elected officials of the tribe, Rancheria, or their designee for the purpose of identifying issues/barriers to service delivery and improvement of the quality, effectiveness and accessibility of services available to AI/NA communities within the County.

P. Participation of California Behavioral Health Directors Association and County Alcohol and Drug Program Administrators Association of California.

Pursuant to HSC Section 11801(g), the AOD administrator shall participate and represent the county in meetings of the California Behavioral Health Directors Association and County Alcohol and Drug Program Administrators Association of California for the purposes of representing the counties in

their relationship with the state with respect to policies, standards, and administration for alcohol and other drug abuse services.

Pursuant to HSC Section 11811.5(c), the county alcohol and drug program administrator shall attend any special meetings called by the Director of DHCS.

Q. Youth Treatment Guidelines

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

R. Restrictions on Grantee Lobbying – Appropriations Act Section 503

No part of any appropriation contained in this Act shall be used, other than for formal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support defeat legislation pending before the Congress, except in presentation to the Congress itself or any State legislature, except in presentation to the Congress or any State legislative body itself.

No part of any appropriation contained in this Act shall be used to pay the salary or expenses of any contract recipient, or agent during for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

S. Nondiscrimination in Employment and Services

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

T. Federal Law Requirements:

1. 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.
2. 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.
3. Age Discrimination Act of 1975 (45 CFR Part 90), as amended (42 USC Sections 6101 – 6107), which prohibits discrimination on the basis of age.
4. Age Discrimination in Employment Act (29 CFR Part 1625)
5. Title I of the Americans with Disabilities Act (29 CFR Part 1630) prohibiting discrimination against the disabled in employment
6. Title II of the Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities
7. Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access

8. Section 504 of the Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of handicap
 9. 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
 10. Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency
 11. The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse
 12. 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.
 13. Sanctions – Contractor shall be subject to sanctions in response to cases of non-compliance as delineated in 42 CFR 438.700 through 438.710 and 42 CFR 438.722 through 438.730.
 14. Investigations and Confidentiality of Administrative Actions
 - a. Contractor acknowledges that if a DMC provider is under investigation by the State or any other state, local or federal law enforcement agency for fraud or abuse, the State may temporarily suspend the provider from the DMC program, pursuant to W&I Section 14043.36(a). Information about a provider's administrative sanction status is confidential until such time as the action is either completed or resolved. The DHCS may also issue a Payment Suspension to a provider pursuant to W&I Section 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.
 - b. 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.
- U. State Law Requirements:
1. 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.).
 2. Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135.
 3. Title 9, Division 4, Chapter 8 of the CCR, commencing with Section 10800
 4. No state or federal funds shall be used by the Contractor or its Subcontractors for sectarian worship, instruction, 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.
 5. Noncompliance with the requirements of nondiscrimination in services shall constitute grounds for state to withhold payments under this Contract or terminate all, or any type, of

funding provided hereunder.

V. This Contract is subject to any additional restrictions, limitations, or conditions enacted by the federal or state governments after affect the provisions, terms, or funding of this Contract in any manner.

X. Conditions for Federal Financial Participation

Contractor shall meet all conditions for Federal Financial Participation, consistent with 42 CFR 438.802, 42 CFR 438.804, 42 CFR 438.806, 42 CFR 438.808, 42 CFR 438.810, 42 CFR 438.812.

12. Beneficiary Problem Resolution Processes

A. General Provisions

The Contractor shall represent the Contractor's position in fair hearings, as defined in Cal. Code Regs., tit. 9, § 1810.216.6, 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 contract. Nothing in this section is intended to prevent the Contractor from pursuing any options available for appealing a fair hearing decision.

- 1) Pursuant to 42 C.F.R. § 438.228 and Cal. Code Regs., tit. 9, § 1850.205, 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 substance use disorder treatment services.
- 2) The Contractor's beneficiary problem resolution processes shall include:
 - a) A grievance process;
 - b) An appeal process; and,
 - c) An expedited appeal process.
- 3) For the grievance, appeal, and expedited appeal processes, described in 42 C.F.R. 438 Subpart F and Cal. Code Regs., tit. 9, §§ 1850.206, 1850.207 and 1850.208 respectively, the Contractor shall comply with all of the following requirements:
 - a) Assure that each beneficiary has adequate information about the Contractor's problem resolution processes by taking at least the following actions:
 - i. Including information describing the grievance, appeal, and expedited appeal processes in the Contractor's beneficiary booklet and providing the beneficiary booklet to beneficiaries as described in Section 7 of this contract.
 - ii. Posting notices explaining grievance, appeal, and expedited appeal process procedures in locations at all Contractor provider sites. Notices shall be sufficient to ensure that the information is readily available to both beneficiaries and provider staff. The posted notice shall also explain the availability of fair hearings after the exhaustion of an appeal or expedited appeal process, including information that a fair hearing after may be requested whether or not the beneficiary has received a notice of action pursuant to 42 CFR 438.404 Cal. Code Regs., tit. 9, § 1850.210. For the purposes of this Section, a Contractor provider site means any office or facility owned or operated by the Contractor or a provider contracting with the Contractor at which beneficiaries may obtain substance use disorder

treatment services.

- iii. Pursuant to 42 C.F.R. § 438.10 ~~Cal. Code Regs., tit. 9, § 1850.205(c)(1)(C)~~, making available forms that may be used to file grievances, appeals, and expedited appeals and self-addressed envelopes that beneficiaries can access at all Contractor provider sites without having to make a verbal or written request to anyone.
- iv. Pursuant to 42 C.F.R. § 438.406(a)(1), giving beneficiaries any reasonable assistance in completing the forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability.
- b) Pursuant to 42 C.F.R. § 438.406(a)(2), the Contractor shall acknowledge receipt of each grievance appeal, and request for expedited appeal to the beneficiary in writing.
- c) Consistent with 42 C.F.R. § 438.402(b)(1)(ii), a beneficiary may authorize another person to act on the beneficiary's behalf. The beneficiary may select a provider as his or her representative in the appeal or expedited appeal process, if the provider consents.
- d) A beneficiary's legal representative may use the grievance, appeal, or expedited appeal processes on the beneficiary's behalf.
- e) At the beneficiary's request, the Contractor shall identify staff or another individual, such as a legal guardian, to be responsible for assisting a beneficiary with these processes, including providing assistance in writing the grievance, appeal, or expedited appeal. If the individual identified by the Contractor is the person providing substance use disorder treatment services to the beneficiary requesting assistance, the Contractor shall identify another individual to assist that beneficiary.
- f) A beneficiary shall not be subject to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal.
- g) Procedures for these beneficiary problem resolution processes shall maintain the confidentiality of each beneficiary's information.
- h) A procedure shall be included by which issues identified as a result of the grievance, appeal or expedited appeal processes are transmitted to the Contractor's Quality Improvement Committee, the Contractor's administration or another appropriate body within the Contractor's operations. These issues shall be considered in the Contractor's Quality Improvement Program, as required by 42 CFR 438.240 ~~Cal. Code Regs., tit. 9, § 1810.440(a)(5)~~.
- i) Individuals involved in any previous review or decision-making on the issue(s) presented in a problem resolution process shall not participate in making the decision on the grievance, appeal, or expedited appeal pursuant to 42 C.F.R. § 438.406(a)(3)(i).
- j) The individual making the decision on the grievance, appeal, or expedited appeal shall have the appropriate clinical expertise, as determined by the Contractor, required to treat the beneficiary's condition, if the grievance concerns the denial of a request for an expedited appeal or if the grievance, appeal, or expedited appeal addresses any clinical issue, including a lack of medical necessity pursuant to Title per 42, C.F.R. § 438.406(a)(3)(ii).
- 4) Pursuant to record keeping and review requirements in 42 C.F.R. § 438.416, and to facilitate monitoring consistent with 42 CFR 438.240 ~~Cal. Code Regs., tit. 9, §§1810.440(a)(5), 1850.205, 1850.206, 1850.207, and 1850.208~~, the Contractor shall:

- a) Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance or appeal. The log entry shall include, but not be limited to, the name of the beneficiary, the date of receipt of the grievance, appeal, or expedited appeal, and the nature of the problem;
 - b) Record in the grievance and appeal log or another central location determined by the Contractor, the final dispositions of grievances, appeals, and expedited appeals, including the date the decision is sent to the beneficiary. If there has not been final disposition of the grievance, appeal, or expedited appeal, the reason(s) shall be included in the log;
 - c) Provide a staff person or other individual with responsibility to provide information requested by the beneficiary or the beneficiary's representative regarding the status of the beneficiary's grievance, appeal, or expedited appeal;
 - d) Acknowledge the receipt of each grievance, appeal, and expedited appeal to the beneficiary in writing;
 - e) Identify in its grievance, appeal, and expedited appeal documentation, the roles and responsibilities of the Contractor, the provider, and the beneficiary;
 - f) Notify the beneficiary, in writing, of the final disposition of the problem resolution process including the reasons for the disposition; and
 - g) Notify, in writing, any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal.
- 5) No provision of a Contractor's beneficiary problem resolution processes shall be construed to replace or conflict with the duties of county patients' rights advocates as described in Welfare and Institutions Code Section 5520.

B. Grievance Process

Consistent with 42 C.F.R. §§ 438.400, 438.402, 438.406 and Cal. Code Regs., tit. 9, § 1850.206, the grievance process shall, at a minimum:

The contract must define a grievance as an expression of dissatisfaction about any matter other than an "action". (42 CFR 438.400)

- 1) Allow beneficiaries to present their grievance orally, or in writing;
- 2) Provide for a decision on the grievance and notify the affected parties within 60 calendar days of receipt of the grievance. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or if the Contractor determines that there is a need for additional information and that the delay is in the beneficiary's interest. If the Contractor extends the timeframe, the Contractor shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in 42 CFR 438.210 Cal. Code Regs., tit. 9, § 4840.230.5; and
- 3) Provide for notification of the beneficiary or the appropriate representative in writing of the grievance decision and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted.

C. Appeal Process

- 1) Consistent 42 C.F.R. § 438.408 and ~~Cal. Code Regs., tit. 9, §§ 1850.205 and 1850.207~~, the appeal process shall, at a minimum:
 - a) Allow a beneficiary to file an appeal orally or in writing pursuant to 42 C.F.R. § 438.402(b)(3)(ii);
 - b) Pursuant to 42 C.F.R. § 438.402(b)(3)(ii), require a beneficiary who makes an oral appeal, that is not an expedited appeal, to subsequently submit the appeal in writing. The date the Contractor receives the oral appeal shall be considered the filing date for the purpose of applying the appeal timeframes;
 - c) Pursuant to 42 C.F.R. § 438.408(b) and (c), provide for a decision on the appeal and notify the affected parties within 45 calendar days of receipt of the appeal. This timeframe may be extended by up to 14 calendar days, if the beneficiary requests an extension or the Contractor determines that there is a need for additional information and that the delay is in the beneficiary's interest. If the Contractor extends the timeframes, the Contractor shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in 42 CFR 438.210 ~~Cal. Code Regs., tit. 9, §1810.230.5~~;
 - d) Consistent with 42 C.F.R. § 438.408(f), inform the beneficiary of his or her right to request a fair hearing after the appeal process of the Contractor has been exhausted;
 - e) Allow the beneficiary to have a reasonable opportunity to present evidence and arguments of fact or law, in person and/or in writing, in accordance with the beneficiary's election;
 - f) Allow the beneficiary and/or his or her representative to examine the beneficiary's case file, including medical records, and any other documents or records considered before and during the appeal process, provided that there is no disclosure of the protected health information of any individual other than the beneficiary; and
 - g) Allow the beneficiary and/or his or her representative, or the legal representative of a deceased beneficiary's estate, to be included as parties to the appeal.
- 2) Pursuant to 42 C.F.R. § 438.408(e), the Contractor shall notify the beneficiary, and/or his or her representative, of the resolution of the appeal in writing. The notice shall contain:
 - a) The results of the appeal resolution process;
 - b) The date that the appeal decision was made;
 - c) If the appeal is not resolved wholly in favor of the beneficiary, the notice shall also contain:
 - i. Information regarding the beneficiary's right to a fair hearing and the procedure for filing for a fair hearing, if the beneficiary has not already requested a fair hearing on the issue involved in the appeal; and
 - ii. Information on the beneficiary's right to continue to receive benefits while the fair hearing is pending and how to request the continuation of benefits.
- 3) If the decision of the appeal resolution process reverses a decision to deny, limit or delay services, the Contractor shall promptly provide or arrange and pay for the services at issue in the appeal.

D. Expedited Appeal Process

"Expedited Appeal" means an appeal, as defined in 42 CFR 438.400 ~~Cal. Code Regs., tit. 9, §§ 1810.203.5 and 1810.216.2~~, to be used when the contractor determines or the beneficiary and/or the beneficiary's provider certifies that following the timeframe for an appeal as established in 42 C.F.R. § 438.408 ~~Cal. Code Regs., tit. 9, § 1850.207~~, would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function. In addition to meeting the requirements of 42 C.F.R. § 438.410(a), 42 CFR 438.406(b)(2), ~~and Cal. Code Regs., tit. 9, §§ 1850.205, 1850.207(a), (d), (e), (f), (g), and (i), and 1850.208~~, the expedited appeal process shall, at a minimum:

- 1) Be used when the Contractor determines or the beneficiary and/or the beneficiary's provider certifies that taking the time for a standard appeal resolution could seriously jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function.
- 2) Pursuant to 42 C.F.R. § 438.402(b)(3), allow the beneficiary to file the request for an expedited appeal orally without requiring that the request be followed by a written appeal.
- 3) Pursuant to 42 C.F.R. § 438.410(b), ensure that punitive action is not taken against a beneficiary or a provider because they request an expedited appeal or support a beneficiary's request for an expedited appeal.
- 4) Pursuant to 42 C.F.R. § 438.408(b)(3), resolve an expedited appeal and notify the affected parties in writing, no later than three working days after the Contractor receives the appeal. Pursuant to 42 C.F.R. § 438.408(c) this timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or the Contractor determines that there is need for additional information and that the delay is in the beneficiary's interest. If the Contractor extends the timeframes, the Contractor shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in 42 CFR 438.210 ~~Cal. Code Regs., tit. 9, § 1810.230.5~~.
- 5) Pursuant to 42 C.F.R. § 438.408(d)(2), provide a beneficiary with a written notice of the expedited appeal disposition and make reasonable efforts to provide oral notice to the beneficiary and/or his or her representative. ~~The written notice shall meet the requirements of Section 1850.207(h).~~
- 6) Pursuant to 42 C.F.R. § 438.410(c), if the Contractor denies a request for expedited appeal resolution:
 - a) Transfer the expedited appeal request to the timeframe for appeal resolution as required by 42 CFR 438.410 ~~Cal. Code Regs., tit. 9, § 1850.207(e)~~.
 - b) Make reasonable efforts to give the beneficiary and his or her representative prompt oral notice of the denial of the request for an expedited appeal and provide written notice within two calendar days of the date of the denial. The written notice of the denial of the request for an expedited appeal is not a Notice of Action as defined in 42 CFR 438.210 ~~Cal. Code Regs., tit. 9, § 1810.230.5~~.

E. Beneficiary Problem Resolution Processes Established by Providers

Nothing in the 42 C.F.R. §§ 438.10, 438.400, 438.402, 438.406, and 438.408 ~~Cal. Code Regs., tit. 9, §§ 1850.205, 1850.206, 1850.207, 1850.208 and 1850.209~~ precludes a provider other than the Contractor from establishing beneficiary problem resolution processes for beneficiaries receiving services from that provider. When such processes exist, beneficiaries shall not be required by the Contractor to use or exhaust the provider's processes prior to using the Contractor's beneficiary

problem resolution process, unless the following conditions have been met:

- 1) The Contractor delegates the responsibility for the beneficiary problem resolution process to the provider in writing, specifically outlining the provider's responsibility under the delegation;
- 2) The provider's beneficiary problem resolution process fully complies with this Section of the contract, the relevant provisions of 42 C.F.R. Subpart F, 438.400 ~~Cal. Code Regs., tit. 9, § 1850.205 and § 1850.209~~, and depending on processes delegated, 42 C.F.R. § 438.406, 42 C.F.R. § 438.408, and/or 42 C.F.R. § 438.410 ~~Cal. Code Regs., tit. 9, §§ 1850.206, 1850.207, and/or 1850.208~~; and
- 3) No beneficiary is prevented from accessing the grievance, appeal or expedited appeal processes solely on the grounds that the grievance, appeal or expedited appeal was incorrectly filed with either the Contractor or the provider.

F. Fair Hearing

"Fair Hearing" means the State hearing provided to beneficiaries pursuant to Title 22, CCR, Sections 50951 and 50953 ~~and Cal. Code Regs., tit. 9, § 1810.216.6.~~

Fair hearings must comply with 42 C.F.R. §§ 431.220(a)(5), 438.408(f), 438.414, and 438.10(g)(1).

- 1) If a beneficiary requests a State Fair Hearing, the Department (not the Contractor) shall grant the request. The right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the beneficiary and provider by Contractor in its notice of decision or notice of action. Beneficiaries and providers shall also be informed of the following:
 - a) A beneficiary may request a State Fair Hearing.
 - b) The provider may request a State Fair Hearing only if the Department permits the provider to act as the beneficiary's authorized representative.
 - c) The Department must permit the beneficiary to request a State Fair Hearing within a reasonable time period specified by the Department, not in excess of 90 days, from whichever of the following dates applies:
 - i. From the date indicated on the Contractor's notice of action, if the Department does not require exhaustion of the Contractor- level appeal procedures and the beneficiary appeals directly to the Department for a fair hearing.
 - ii. From the date indicated on the Contractor's notice of resolution, if the Department requires exhaustion of Contractor-level appeals.
- 2) The Department must reach its decisions within the specified timeframes:
 - a) Standard resolution: within 90 days of the date the beneficiary filed the appeal with the Contractor, if the beneficiary filed initially with the Contractor (excluding the days the beneficiary took to subsequently file for a State Fair Hearing), or the date the beneficiary filed for direct access to a State Fair Hearing.
 - b) Expedited resolution (if the appeal was heard first through the Contractor appeal process): within 3 working days from agency receipt of a hearing request for a denial of a service that:
 - i. Meets the criteria for an expedited appeal process but was not resolved using the Contractor's expedited appeal timeframes, or

- ii. Was resolved wholly or partially adversely to the beneficiary using the Contractor's expedited appeal timeframes.
- 3) Pursuant to 42 C.F.R. § 438.408(f)(2), 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.

G. Expedited Fair Hearing

"Expedited Fair Hearing" means a fair hearing, as described in 42 C.F.R. § 438.410(a), and ~~Cal. Code Regs., tit. 9, §§ 1810.216.4 and 1810.216.6~~, to be used when the Contractor determines, or the beneficiary and/or the beneficiary's provider certifies, that the following the timeframe for a fair hearing as established in 42 C.F.R. § 431.244(f)(1) would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

H. Continuation of Services Pending Fair Hearing Decision

- 1) A beneficiary receiving substance use disorder treatment services shall have a right to file for continuation of substance use disorder treatment services pending the outcome of a fair hearing pursuant to 42 CFR 438.420, and Cal. Code Regs., tit. 22., § 51014.2, and ~~Cal. Code Regs., tit. 9, § 1850.215~~.
- 2) The Contractor shall continue to provide substance use disorder treatment services pending the outcome of a fair hearing in accordance with Cal. Code Regs., tit. 22, § 51014.2. If the Contractor allows providers to deliver substance use disorder treatment services for a set number of visits or a set duration of time without prior authorization, the Contractor shall continue to provide substance use disorder treatment services pending the outcome of a fair hearing when the Contractor denies a payment authorization request from a provider requesting continuation of services beyond the number or duration permitted without prior authorization and the beneficiary files a timely request for fair hearing.
- 3) Before requesting a state fair hearing, the beneficiary must exhaust the Contractor's problem resolution processes as described in 42 CFR 438.400 ~~Cal. Code Regs., tit. 9, § 1850.205~~.

13. Subcontracts

Each contract must ensure that the entity oversees and is held accountable for any functions and responsibilities that it delegates to any subcontractor consistent with 42 CFR 438.6(l); 42 CFR 438.230(a); 42 CFR 438.230(b)(1), (2), (3), including:

- 1. All subcontracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract.
- 2. Each contract must ensure that the entity evaluates the prospective subcontractor's ability to perform the activities to be delegated.
- 3. The contract must require a written agreement between the entity 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.
- 4. Each contract must ensure that the entity monitor the subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by the State, consistent with industry standards or State MCO laws and regulations.
- 5. Each contract must ensure that the entity identifies deficiencies or areas for improvement, the entity and the subcontractor must take corrective action.

F. Subcontractor Documentation

Contractor shall require its Subcontractors that are not licensed or certified by the State to submit organizational documents to the State within thirty (30) days of its execution of an initial subcontract, within ninety (90) days of the renewal or continuation of an existing subcontract or when there has been a change in Subcontractor name or ownership. Organizational documents shall include the Subcontractor's Articles of Incorporation or Partnership Agreements (as applicable), and business licenses, fictitious name permits, and such other information and documentation as may be requested by the State.

14. Delegation

15. Program Integrity Requirements

- A. Compliance with state and federal law and regulations, including, but not limited to, 42 CFR 433.32, 42 CFR 433.51, 42 CFR 431.800 et. seq., 42 CFR 440.230, 42 CFR 440.260, 42 CFR 455 et. seq., 42 CFR 456 et. seq., 42 CFR 456.23, 22 CCR 51490, 22 CCR 51490.1, 22 CCR 51341.1, 22 CCR 51159, WIC 14124.1, and WIC 14124.2; **42 CFR 438.600, 42 CFR 438.602, 42 CFR 438.608.**
- B. The Contractor shall comply with the provisions of 42 C.F.R. §§ 438.604, 438.606 and 438.608, regarding the certification of accurate data submitted by the Contractor to the State and which require the Contractor to have administrative or management arrangements or procedures designed to guard against fraud and abuse.
- C. The Contractor shall comply with the provisions of 42 C.F.R. § 438.610, which relate to prohibited affiliations with individuals or affiliates of individuals 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 the guidelines implementing Executive Order No. 12549.
- D. Pursuant to 42 C.F.R. § 438.214(d), the Contractor shall not employ or contract with providers or other individuals and entities excluded from participation in federal health care programs (as defined in section 1128B(f) of the Social Security Act) under either Section 1128, 1128A, or 1156 of the Social Security Act. FFP is not available for amounts expended for providers excluded by Medicare, Medicaid, or the State Children's Health Insurance Program, except for emergency services.
- E. The Contractor shall periodically check the Office of the Inspector General's List of Excluded Individuals/Entities and the Medi-Cal Suspended and Ineligible Provider List (S & I List) to prevent employment of, or payments to, any individuals or entities on those lists, and per DMH Letter Number 10-05, this must be satisfied prior to Medi-Cal certification of any individual or organizational provider. If the provider is listed on either the Office of the Inspector General's List of Excluded Individuals/Entities or the Medi-Cal S & I List, the Contractor shall not certify or pay any provider with Medi-Cal funds, and any such inappropriate payments or overpayments may be subject to recovery and/or be the basis for other sanctions by the appropriate authority.
- F. Report. Pursuant to 42 C.F.R. § 455.1(a)(1), the Contractor must report fraud and abuse information to the Department.

- 1) If the Contractor identifies an issue or receives notification of a complaint concerning an incident of possible potential fraud or abuse, the Contractor shall conduct an internal investigation to determine the validity of the issue/complaint, regarding potential fraud and/or abuse, and develop and implement corrective action, if needed. The majority of potential fraud or abuse issues are expected to be resolved at the Contractor level.
 - 2) If the Contractor's internal investigation concludes that fraud or abuse has occurred or is suspected, the issue is egregious, or beyond the scope of the Contractor's ability to pursue, the Contractor shall report the issue to the Department for review and disposition.
 - 3) The Department is to be notified if the Contractor discontinues a provider contract or disciplines a provider due to a fraud or abuse issue.
- G. Service Verification. To assist the Department in meeting its obligation under 42C.F.R. § 455.1(a)(2), the Contractor shall have a way to verify whether services were actually furnished to beneficiaries.

Drug Medi-Cal Claims and Reports

Contractors or providers that bill the State or the County for services identified in Section 51516.1 of Title 22 shall submit claims in accordance with the Department of Health Care Services DMC Provider Billing Manual.

Claims for DMC reimbursement shall include only those services covered under Title 22, Section 51341.1(c-d) and administrative charges that are allowed under W&IC, Sections 14132.44 and 14132.47.

Contractor shall certify all data consistent with 42 CFR 438.600(a), (b), and (c); 42 CFR 438.604(b); and 42 CFR 438.606.

1. Contractor shall certify the public expenditure was made prior to submitting a claim for reimbursement. Contractor shall submit the "Certified Public Expenditure" form at the time of submitting the electronic Drug Medi-Cal claim, 42 CFR Section 433.51. Contractor shall submit to the State the Drug Medi-Cal Certification Form DHCS Form DHCS 100224A (Document 4D) for each claim file submitted for reimbursement of the federal Medicaid funds.
2. DMC service claims shall be submitted electronically in a Health Insurance Portability and Accountability Act (HIPAA) compliant format (837P). All adjudicated claim information must be retrieved by the Contractor via an 835 HIPAA compliant format (Health Care Claim Payment/Advice).
3. The following forms shall be prepared as needed and retained by the provider for review by State staff:
 - (a) Multiple Billing Override Certification (MC 6700), Document 2K
 - (b) Good Cause Certification (MC 6065A), Document 2L(a)
 - (c) Good Cause Certification (MC 6065B), Document 2L(b)

In the absence of good cause documented on the Good Cause Certification (MC 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 the State in accordance with Title 22, CCR, Sections 51008 and 51008.5.

4. Certified Public Expenditure County Administration

Separate from direct service claims as identified in #2 above, county may submit an invoice for administrative costs for administering the DMC program on a quarterly basis. The form requesting reimbursement shall be submitted to DHCS.

5. If while completing the Utilization Review and Quality Assurance requirements of this Exhibit A, Attachment I, Part V, Section 4 any of the Contractor's skilled professional medical and personnel and directly supporting staff meet the criteria set forth in 42 C.F.R. 432.50(d)(1), then the Contractor shall submit a written request that specifically demonstrates how the skilled professional medical personnel and directly supporting staff meet all of the applicable criteria set forth in 42 C.F.R. 432.50(5)(1) and outlines the duties they will perform to assist the Department, or the Department's skilled professional medical personnel, in activities that are directly related to the administration of the Drug Medi-Cal Program. The Department shall respond to the Contractor's written request within 20 days with either a written agreement pursuant to 42 C.F.R. 432.50(d)(2) approving the request or a written explanation as to why the Department does not agree that the Contractor's skilled professional medical personnel and directly supporting staff do not meet the criteria set forth in 42 C.F.R. 432.50(d)(1).

16. Disclosures

17. Additional Requirements

Sharing of Information with Beneficiaries

1. **Sharing of Information with Beneficiaries.** The Contractor shall not prohibit nor otherwise restrict, a licensed, waived, or registered professional, as defined in Cal. Code Regs., tit. 9, §§ 1810.223 and 1810.254, who is acting within the lawful scope of practice (pursuant to 42 C.F.R. § 438.102(a)(1)), from advising or advocating on behalf of a beneficiary for whom the provider is providing substance use disorder treatment services for any of the following:
2. Pursuant to 42 C.F.R. § 438.102(a)(2), for a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service. Pursuant to 42 C.F.R. § 438.102(b)(1), the Contractor must provide information about the services it does not cover on moral or religious grounds.
3. (c) **Information requirements: State responsibility.** For each service excluded by an MCO, PIHP, or PAHP under paragraph (a)(2) of this section, the State must provide information on how and where to obtain the service, as specified in §438.10, paragraphs (e)(2)(ii)(E) and (f)(6)(xii).
4. (d) **Sanction.** An MCO that violates the prohibition of paragraph (a)(1) of this section is subject to intermediate sanctions under subpart I of this part.
5. **Notice of provider termination.** The MCO, PIHP, and when appropriate, the PAHP or PCCM must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the terminated provider. (42 CFR 438.10(f)(5))

Limitation on Services for Moral or Religious Grounds.

Beneficiary Liability for Payment

Health Information System

Pursuant to 42 C.F.R. § 438.242 and consistent with Cal. Code Regs., tit. 9, § 1810.376, the Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas including, but not limited to, utilization, grievances, and appeals.

- 1) The Contractor's health information system shall, at a minimum:
 - a) Collect data on beneficiary and provider characteristics as specified by the Department, and on services furnished to beneficiaries as specified by the Department;
 - b) Ensure that data received from providers is accurate and complete by:
 - i. Verifying the accuracy and timeliness of reported data;
 - ii. Screening the data for completeness, logic, and consistency; and
 - iii. Collecting service information in standardized formats to the extent feasible and appropriate.
 - c) Make all collected data available to the Department and, upon request, to CMS.
- 2) Consistent with Cal. Code Regs., tit. 9, § 1810.376(c), the Contractor's health information system is not required to collect and analyze all elements in electronic formats.

Cost Sharing

- c. Cost Sharing. Pursuant to 42 C.F.R. § 438.108, any cost sharing imposed on Medicaid beneficiaries shall be in accordance with 42 C.F.R. §§ 447.50 through 447.60.

18. Quality Management (QM) Program

A. The Contractor's Quality Management (QM) Program shall improve Contractor's established outcomes through structural and operational processes and activities that are consistent with current standards of practice.

B. 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. The QM Program shall be evaluated annually and updated as necessary per Cal. Code Regs., tit. 9, § 1810.440(a)(6) and 42 C.F.R. § 438.240(e). (Triennial Review STC 5.c.)

C. 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.

D. 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.

E. The Contractor shall have mechanisms to detect both underutilization of services and overutilization of services, as required by 42 C.F.R. § 438.240(b)(3).

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

- 1) Surveying beneficiary/family satisfaction with the Contractor's services at least annually;
- 2) Evaluating beneficiary grievances, appeals and fair hearings at least annually; and
- 3) Evaluating requests to change persons providing services at least annually.
- 4) The Contractor shall inform providers of the results of beneficiary/family satisfaction activities.

G. 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.

H. The Contractor shall implement mechanisms to address meaningful clinical issues affecting beneficiaries system-wide.

I. 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.

J. The Contractor shall have a QM Work Plan covering the current contract cycle with documented annual evaluations and documented revisions as needed. The QM Work Plan shall include:

- 1) 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 42 CFR 438.240 Cal. Code Regs., tit. 9, § 1810.440(a)(5) and 42 C.F.R. § 438.416;
- 2) Evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service;
- 3) 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; and,

- c) Targeted areas of improvement or change in service delivery or program design.
- 4) 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; and
- 5) Evidence of compliance with the requirements for cultural competence and linguistic competence specified in 42 CFR 438.10 and 42 CFR 438.206 ~~Cal. Code Regs., tit. 9, § 1810.410.~~

State Monitoring

J. DHCS Monitoring Reviews and Financial Audits of Contractor

The Department shall monitor the Contractor's operations for compliance with the provisions of this contract and applicable federal and state law and regulations, including 42 CFR 438.66, 42 CFR 438.200, 42 CFR 438.202, and 42 CFR 438.204. Such monitoring activities shall include, but not be limited to, inspection and auditing of Contractor services, management systems and procedures, and books and records, as the Department deems appropriate, at any time during the Contractor's or facility's normal business hours. When monitoring activities identify areas of non-compliance, the Department shall issue reports to the Contractor detailing findings, recommendations, and corrective action.

Risk contracts must provide that the State agency and the Department may inspect and audit any financial records of the entity or its subcontractors. The Contract must state that there shall be no restrictions on the right of the State or Federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services and reasonableness of their costs. (42 CFR 438.6(g))

K. Post Service Post Payment Utilization Reviews

- a. The Department shall conduct Post Service Post Payment Utilization Reviews of claims for DMC services. The DHCS shall issue the PSPP report to the Contractor with a copy to subcontracted DMC provider. The Contractor shall be responsible to ensure any deficiencies are remediated pursuant to Sections 1 and 2 herein. The Contractor shall certify the deficiencies have been remediated and are complete, pursuant to Section 4(A), Paragraph (C), herein.
- b. State shall conduct Post Service Post Payment (PSPP) utilization reviews in accordance with Title 22 Section 51341.1. Any claimed DMC service may be reviewed for compliance with all applicable standards, regulations and program coverage after services are rendered and the claim paid.
- c. State shall take appropriate steps in accordance with Title 22, CCR, Section 51341.1 to recover payments made if subsequent investigation uncovers evidence that the claim(s) should not have been paid or that DMC services have been improperly utilized, and/or shall take the corrective action as appropriate. If programmatic or fiscal deficiencies are identified, the Provider shall be required to submit a Corrective Action Plan to DHCS via the Contractor for approval.
 - i. Pursuant to CCR, Title 22, Section 51341.1(o), all deficiencies identified by the Post Service Post Payment (PSPP) review, whether or not a recovery of

funds results, must be corrected and a Corrective Action Plan (CAP) must be submitted to the DMC PISP Unit within 60 days of the date of the report.

1. The plan shall:
 - a. Address each demand for recovery of payment and/or programmatic deficiency;
 - b. Provide a specific description of how the deficiency shall be corrected; and
 - c. Specify the date of implementation of the corrective action.
 2. DHCS will provide written approval of the CAP to the Contractor with a copy to the Provider. If DHCS does not approve the CAP submitted by the Provider via the Contractor, DHCS will provide guidance on the deficient areas and request an updated CAP from the Contractor with a copy to the Provider with a new deadline for submission.
 3. If the Provider, via the Contractor, does not submit a CAP, or, does not implement the approved CAP provisions within the designated timeline, then DHCS may withhold funds until the Contractor brings the Provider into compliance. The State shall inform the Contractor when funds will be withheld.
- d. 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 pursuant to Title 22, CCR, Section 51341.1(q). This section shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of the State pursuant to Exhibit B, Part II, Section 3, of this Contract.
 - e. State shall monitor the Subcontractor's compliance with PISP utilization review requirements in accordance with Title 22. Counties are also required to monitor of the subcontractor's compliance pursuant to Section 4, Paragraph A.2, of this contract. The federal government may also review the existence and effectiveness of the State's utilization review system.
 - f. Contractor shall implement and maintain compliance with the system of review described in Title 22, Section 51341.1, for the purposes of reviewing the utilization, quality, and appropriateness of covered services and ensuring that all applicable Medi-Cal requirements are met.
 - g. Contractor shall assure that subcontractor sites must keep a record of the clients/patients being treated at that location. Contractor shall retain client records for a minimum of three (3) years from the date of the last face-to-face contact. When an audit by the Federal Government or the State has been started before the expiration of the three-year period, the client records shall be maintained until completion of the audit and the final resolution of all issues as a result of the audit.

Contractor Monitoring

1) Contractor shall conduct, at least annually, a programmatic and fiscal audit of DMC providers to assure covered services are being appropriately rendered. The annual audit must include an on-site visit of the service provider. Reports of the annual audit shall be provided to the Department's DMC PSPP unit at:

Substance Use Disorder - Prevention, Treatment and Recovery Services Division, PSPP Unit
Department of Health Care Services
PO Box 997413, MS-2621
Sacramento, CA 95899-7413;

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

Audit reports shall be provided within 2 weeks of completion by the Contractor.

Technical assistance is available to counties from DHCS SUD PTRS.

- 2) Contractor shall ensure that DATAR submissions, detailed in Part III, Paragraph G of this contract are complied with by all treatment providers and subcontracted treatment providers. Contractor shall certify that each subcontracted provider is enrolled in DATAR at the time of execution of the subcontract.
- 3) Contractor must monitor and certify compliance and/or completion by Providers with CAP requirements (detailed in Section 4, Paragraph (A)(2)(c)) as required by any PSPP review. Contractor shall certify 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 form by Contractor must be accomplished within the timeline specified in the approved CAP, as noticed by DHCS.
- 4) Contractor shall certify that DMC claims submitted to the state have been subject to review and verification process for accuracy and legitimacy. (45 CFR 430.30, 433.32, 433.51). Contractors shall not submit claims for services rendered to any beneficiary after the beneficiary's date of death, or from uncertified or decertified providers.

Reporting Requirements

A. California Outcomes Measurement System (CalOMS) for Prevention (CalOMS-Pv)

The CalOMS-Pv Business Rules and Requirements are:

1. By utilization of the CalOMS Prevention User Manual, Contractor shall comply with requirements which address the collection of information required in the SAPT Block Grant.
2. Prevention services/activity data is to be reported by CalOMS-Pv by all funded primary prevention providers. Services are to be reported by the date of occurrence on a monthly basis. No more than one week's data shall be aggregated into one reported service.
3. All CalOMS-Pv service/activity data shall be reviewed by each county and released to the State no later than 30 days following the close of each quarter. The reporting quarters are: July through September; October through December; January through March; and April through June.
4. Reporting progress on prevention goals and objectives via the Evaluation Module within CalOMS-Pv shall be done on an annual basis. This information is due no later than September 30th of each fiscal year.

5. If the Contractor cannot submit CalOMS-Pv data by the established due dates, the Contractor shall submit a written request for an extension. The DHCS will make a decision and issue a written response on the request for an extension prior to the established due date.
6. Contractor shall participate in CalOMS-Pv informational meetings, trainings, and conference calls.

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

The CalOMS-Tx business rules and requirements are:

1. Contractor contracts 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) must be established between the Contractor and the software vendor. The BAA must state that DHCS is allowed to return the processed CalOMS-Tx data to the vendor that supplied the data to DHCS.
2. Contractor shall conduct information technology (IT) systems testing and pass State certification testing before commencing submission of CalOMS-Tx data. If the Contractor subcontracts with vendor for IT services, Contractor is responsible for ensuring that the subcontracted IT system is tested and certified by the DHCS prior to submitting CalOMS-Tx data. If Contractor changes or modifies the CalOMS-Tx IT system, then Contractor shall re-test and pass state re-certification prior to submitting data from new or modified system.
3. Electronic submission of CalOMS-Tx data is due 45 days from the end of the last day of the report month.
4. Contractor shall comply with data collection and reporting requirements established by the DHCS CalOMS-Tx Data Collection Guide (Document 3J) and all former Department of Alcohol and Drug Programs Bulletins and DHCS Information Notices relevant to CalOMS-Tx data collection.
5. Contractor shall submit CalOMS-Tx admission, discharge, annual update, resubmissions of records containing errors or in need of correction, and "provider no activity" report records in an electronic format approved by DHCS.
6. Contractor shall comply with the CalOMS-Tx Data Compliance Standards established by DHCS identified in Document 3S for reporting data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method.
7. Contractor shall participate in CalOMS-Tx informational meetings, trainings, and conference calls.
8. Contractor shall implement and maintain a system for collecting and electronically submitting CalOMS-Tx data.
9. Contractor shall meet the requirements as identified in Exhibit G, Privacy and Information Security Provisions and Exhibit G, Attachment I – SSA Agreement 2014.

G. CalOMS-Tx and CalOMS-Pv General Information

1. If the Contractor experiences system or service failure or other extraordinary circumstances that affect its ability to timely submit CalOMS-Tx and/or CalOMS-Pv data, and/or meet other CalOMS-Tx and/or CalOMS-Pv compliance requirements, Contractor shall report the problem in writing before the established data submission deadlines. The written notice shall include a remediation plan that is subject to review and approval by the State. A grace period of up to sixty (60) days may be granted, at the State's sole discretion, for the Contractor to resolve the problem before non-DMC payments are withheld.
2. If the State experiences system or service failure, no penalties will be assessed to the Contractor for late data submission.
3. Contractor shall comply with the treatment and prevention data quality standards established by the State. Failure to meet these standards on an ongoing basis may result in withholding non-DMC funds.
4. If the Contractor submits data after the established deadlines, due to a delay or problem, Contractor is still responsible for collecting and reporting data from time of delay or problem.

H. Drug and Treatment Access Report (DATAR)

The DATAR business rules and requirements are:

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

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 the State.
2. The Contractor shall ensure that all DATAR reports are submitted by either Contractor-operated treatment services and by each subcontracted treatment provider to the State by the 10th of the month following the report activity month.
3. The Contractor shall ensure that all applicable providers are enrolled in the State's web-based DATARWeb program for submission of data, accessible on the DHCS website when executing the subcontract.
4. 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 corrective action plan that is subject to review and approval by the State. A grace period of up to sixty (60) days may be granted, at the State's sole discretion, for the Contractor to resolve the problem before non-DMC payments are withheld (See Exhibit B, Part II, Section 2).
5. If the State experiences system or service failure, no penalties will be assessed to Contractor for late data submission.
6. 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.

I. Charitable Choice

Contractor shall submit annually the total number of referrals necessitated by religious objection to other alternative substance abuse providers. This information must be submitted to DHCS in a format prescribed by DHCS and at time required by DHCS (reference ADP Bulletin 04-5).

Training

- h. DHCS Substance Use Disorder Prevention, Treatment, and Recover Services (SUD PTRS) shall provide mandatory annual training to the Contractor on the requirements of Title 22 and the Drug Medi-Cal program requirements.
 - i. Contractor may request additional Technical Assistance or training from SUD PTRS on an ad hoc basis.
- A. Training to DMC Subcontractors
- 1) Contractor shall provide training on the requirements of Title 22 regulations and DMC requirements at least annually to all subcontracted providers. Attendance of any subcontracted provider at the annual trainings offered by DHCS (specified in Section 4, paragraph (A)(3) of this contract) shall suffice to meet the requirements of this provision. Contractor shall report compliance with this section to DHCS annually as part of the DHCS County monitoring process.

Monthly Monitoring

- A. Contractor shall check the status of all providers monthly to ensure that they are continuing active participation in the DMC program. Any subcontracted provider who surrenders their certification or closes their facility must be reported by the Contractor to the Department within two (2) business days of notification or discovery.
- B. During the monthly status check, the Contractor shall monitor for a triggering recertification event (change in ownership, change in scope of services, remodeling of facility, or change in location) and report any triggering events to the state within two (2) business days of notification or discovery.

Program Complaints

- 1) All complaints received by Contractor regarding a DMC certified facility shall be forwarded to the SUD Compliance Division, Complaints Unit within two (2) business days of receipt as follows.

Complaints are to be submitted to:
Department of Health Care Services
Substance Use Disorder Services – Compliance Division
P.O. Box 997413, MS# 2601
Sacramento, CA 95899-7413

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

Complaints can also be sent by FAX to:

Fax form to: (916) 445-5084

Complaints for Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities may also be made by telephoning the appropriate licensing branch listed below:

SUD Compliance Division:

Public Number: (916) 322-2911

Toll Free Number: (877) 685-8333

Counties shall be responsible for investigating complaints and providing the results of all investigations to the Department's SUD Complaint Compliance Division within two (2) business days of completion;

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 W&I Section 14214.1 and 42 CFR 433.32; and 22 CCR section 51341.1.

B. Subcontract Termination

1) The Contractor must notify DHCS of the termination of any contract with a certified subcontracted provider, and the basis for termination of the contract, within two (2) business days.

C. 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, the Department 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 withhold of SAPT funds allocated to Contractor for the provision of services, and/or termination of this contract for cause

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

i. DHCS shall issue a report to Contractor after conducting monitoring, utilization, or fiscal auditing reviews of a county. 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 following timeframes of receipt of the DHCS report.

a. The CAP shall include a statement of the problem and the goal of the actions the Contractor or its subcontracted provider will take to correct the deficiency or non-compliance. The CAP shall:

(1) Address the specific actions to correct deficiency or non-compliance;

Identify who/which unit(s) will act; who/which unit(s) are accountable for acting; and

- (2) Provide a timeline to complete the actions.
 - ii. DHCS will provide written approval of the CAP to the Contractor and the subcontracted provider. If DHCS does not approve the CAP submitted by the Contractor, DHCS will provide guidance on the deficient areas and request an updated CAP from the Contractor with a new deadline for submission.
 - iii. If the Contractor does not submit a CAP, or, does not implement the approved CAP provisions within the designated timeline, then the State may withhold funds until the Contractor is in compliance. The State shall inform the Contractor when funds will be withheld.

Evaluation

Through an existing contract with DHCS, University of California, Los Angeles, (UCLA) Integrated Substance Abuse Programs will conduct an evaluation to measure and monitor the outcomes from the DMC ODS Waiver. The design of the DMC-ODS evaluation will focus on the four key areas of access, quality, cost, and integration and coordination of care. California will utilize the SUD data system currently in place known as the California Outcomes Measurement System (CalOMS). CalOMS captures data from all SUD treatment providers which receive any form of government funding. The CalOMS data set, along with additional waiver specific data, will enable the State to evaluate the effectiveness of the DMC-ODS. The state will submit the complete design of the evaluation within 60 days of the approval of the amendment.

19. Quality Improvement (QI) Program

Contractor shall establish a quality assessment and performance improvement program consistent with 42 CFR 438.240.

- A. 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.
- B. The Contractor shall establish a QI Committee to review the quality of substance use disorder 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.
- C. The QI Program shall be accountable to the Contractor's Director as described in Cal. Code Regs., tit. 9, § 1810.440(a)(1).
- D. Operation of the QI program shall include substantial involvement by a licensed substance use disorders staff person, as described in Cal. Code. Regs., tit. 9, § 1810.440(a)(4).
- E. 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, as described in Cal. Code. Regs., tit. 9, § 1810.440(a)(2)(A-C).

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

G. QI activities shall include:

- 1) Collecting and analyzing data to measure against the goals, or prioritized areas of improvement that have been identified;
- 2) Identifying opportunities for improvement and deciding which opportunities to pursue;
- 3) Identifying relevant committees internal or external to the Contractor to ensure appropriate exchange of information with the QI Committee;
- 4) Obtaining input from providers, beneficiaries and family members in identifying barriers to delivery of clinical care and administrative services;
- 5) Designing and implementing interventions for improving performance;
- 6) Measuring effectiveness of the interventions;
- 7) Incorporating successful interventions into the Contractor's operations as appropriate; and
- 8) Reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Cal. Code Regs., tit. 9, § 1810.440(a)(5).

20. Utilization Management (UM) Program

Counties will have a Utilization Management (UM) Program assuring that beneficiaries have appropriate access to substance use disorder services; medical necessity has been established and the beneficiary is at the appropriate ASAM level of care and that the interventions are appropriate for the diagnosis and level of care.

Compensation for utilization management activities. Each contract must provide that, consistent with §438.6(h), and §422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee. (42 CFR 438.210(e))

21. Practice Guidelines

The Contractor shall comply with 42 C.F.R. § 438.236(b) and Cal. Code Regs., tit. 9, § 4840.326 which requires the adoption of practice guidelines.

A. Such guideline shall meet the following requirements:

- 1) They are based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field;

- 2) They consider the needs of the beneficiaries;
 - 3) They are adopted in consultation with contracting health care professionals; and
 - 4) They are reviewed and updated periodically as appropriate.
- B. Contractor shall disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.
- C. Contractor shall take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other areas to which the guidelines apply shall be consistent with the guidelines.

22. Non-Drug Medi-Cal/SAPT

A. Restrictions on Salaries

Contractor agrees that no part of any federal funds provided under this Contract shall be used by the Contractor or its Subcontractors to pay the salary and wages of an individual at a rate in excess of Level I of the Executive Schedule. Salary and wages schedules may be found at <http://www.opm.gov/oca>. SAPT Block Grant funds used to pay a salary in excess of the rate of basic pay for Level I of the Executive Schedule shall be subject to disallowance. The amount disallowed shall be determined by subtracting the individual's actual salary from the Level I rate of basic pay and multiplying the result by the percentage of the individual's salary that was paid with SAPT Block Grant funds (Reference: Terms and Conditions of the SAPT Block Grant award.)

B. Primary Prevention

1. The SAPT Block Grant regulation defines "Primary Prevention Programs" as those programs directed at "individuals who have not been determined to require treatment for substance abuse" (45 CFR 96.121). Primary Prevention includes strategies, programs and initiatives which reduce both direct and indirect adverse personal, social, health, and economic consequences resulting from problematic AOD availability, manufacture, distribution, promotion, sales, and use. The desired result of primary prevention is to promote safe and healthy behaviors and environments for individuals, families and communities. The Contractor shall expend not less than its allocated amount of the Substance Abuse Prevention and Treatment (SAPT) Block Grant on primary prevention as described in the SAPT Block Grant requirements (45 CFR 96.125). Inappropriate use of these funds for non-primary prevention services will require repayment of SAPT Block Grant funds.
2. This contract and any subcontract shall meet data reporting requirements for capacity, process and outcome as required by federal grant requirements. In addition to the Center for Substance Abuse Prevention (CSAP's) six strategies of Information Dissemination, Education, Alternative, Problem Identification and Referral, Community-Based Process, and Environmental, the data for the Institute of Medicine prevention categories of Universal, Selective and Indicated must be reported.
3. Use of the Strategic Prevention Framework (SPF) is mandatory for all counties and SPF-required data must be submitted via CalOMS Prevention as evidence of engagement and use of the practices. Adherence to the SPF by subcontractors is at the discretion of the subcontracting county.

4. No later than January 31 of each year, contractor shall submit a Prevention Mid-Year Budget to DHCS indicating how the SAPT Block Grant 20% Primary Prevention Set-Aside shall be spent. Examples of a Prevention Mid-Year Budget and supporting documentation can be viewed at <https://caprev.kithost.net/caprevent2013/pLandKB.aspx> (select Library, Fiscal - Prevention Mid-Year Budget Example for FY XX-XX).
- C. Perinatal Services Network Guidelines 2014
- Contractor shall comply with the requirements for perinatal programs funded under Exhibit A, Attachment I, contained in Document 1G, incorporated by this reference, "Perinatal Services Network Guidelines 2014" until such time new Perinatal Services Network Guidelines are established and adopted. No formal amendment of this contract is required for new guidelines to apply.
- D. Funds identified in this contract shall be used exclusively for county alcohol and drug abuse services to the extent activities meet the requirements for receipt of federal block grant funds for prevention and treatment of substance abuse described I subchapter XVII of Chapter 6A of Title 42 of the United State Code. (Health and Safety Code section 18100 et. seq.)

Section 2 – Formation and Purpose

A. Authority

State and the Contractor enter into this Exhibit A, Attachment I, Part IV, 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 will be reimbursed pursuant to Exhibit A, Attachment I. State and the Contractor identified in the Standard Agreement are the only parties to this Contract. This Contract is not intended, nor shall it be construed, to confer rights on any third party.

B. Control Requirements

1. Performance under the terms of this Exhibit A, Attachment I, Part IV, is subject to all applicable federal and state laws, regulations, and standards. In accepting the State drug and alcohol combined program allocation pursuant to HSC Sections 11814(a) and (b), Contractor shall: (i) establish, and shall require its Subcontractors to establish, written procedures consistent with the following requirements; (ii) monitor for compliance with the written procedures; and (iii) be held accountable for audit exceptions taken by the State against the Contractor and its Subcontractors for any failure to comply with these requirements:
 - (a) HSC, Division 10.5, commencing with Section 11760;
 - (b) Title 9, California Code of Regulations (CCR) (herein referred to as Title 9), Division 4, commencing with Section 9000;
 - (c) Government Code Section 16367.8;
 - (d) Government Code, Article 7, Federally Mandated Audits of Block Grant Funds Allocated to Local Agencies, Chapter 1, Part 1, Division 2, Title 5, commencing at Section 53130;
 - (e) Title 42 United State Code (USC), Sections 300x-21 through 300x-31, 300x-34,

300x-53, 300x-57, and 330x-65 and 66;

- (f) The Single Audit Act Amendments of 1996 (Title 31, USC Sections 7501-7507) and the Office of Management and Budget (OMB) Circular A-133 revised June 27, 2003;
- (g) Title 45, Code of Federal Regulations (CFR), Sections 96.30 through 96.33 and Sections 96.120 through 96.137;
- (h) Title 42, CFR, Sections 8.1 through 8.34;
- (i) Title 21, CFR, Sections 1301.01 through 1301.93, Department of Justice, Controlled Substances; and,
- (j) State Administrative Manual (SAM), Chapter 7200 (General Outline of Procedures).

Contractor shall be familiar with the above laws, regulations, and guidance and shall assure that its Subcontractors are also familiar with such requirements.

- 2. The provisions of this Exhibit A, Attachment I, Part IV, are not intended to abrogate any provisions of law or regulation, or any standards existing or enacted during the term of this Contract.
- 3. Contractor shall adhere to the applicable provisions of Title 45, CFR, Part 96, Subparts C and L, as applicable, in the expenditure of the SAPTBG funds. Document 1A, 45 CFR 96, Subparts C and L, is incorporated by reference.
- 4. Documents 1C and 1D(b), incorporated by this reference, contain additional requirements that shall be adhered to by those Contractors that receive the types of funds specified by each document. These exhibits and documents are:
 - (a) Document 1C, Driving-Under-the-Influence Program Requirements;
 - (b) Document 1D(b), SAPT Female Offender Treatment Project (FOTP).
- 5. In accordance with the Fiscal Year 2011-12 State Budget Act and accompanying law (Chapter 40, Statutes of 2011 and Chapter 13, Statutes of 2011, First Extraordinary Session), contractors that provide Women and Children's Residential Treatment Services shall comply with the program requirements (Section 2.5, Required Supplemental/Recovery Support Services) of the Substance Abuse and Mental Health Services Administration's Grant Program for Residential Treatment for Pregnant and Postpartum Women, RFA found at <http://www.samhsa.gov/Grants/2008/ti-08-009.doc> <http://www.samhsa.gov/grants/grant-announcements/ti-14-005>.

Section 3 - Performance Provisions

A. Monitoring

- 1. Contractor's performance under this Exhibit A, Attachment I, Part IV, shall be monitored by the State during the term of this Contract. Monitoring criteria shall include, but not be limited to:
 - (a) Whether the quantity of work or services being performed conforms to Exhibit B;

- (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 Contract;
 - (d) Whether the Contractor is abiding by the terms of the Perinatal Services Network Guidelines (Document 1G); and
 - (e) 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.
2. Failure to comply with the above provisions shall constitute grounds for the State to suspend or recover payments, subject to the Contractor's right of appeal, or may result in termination of the Contract or both.

B. Performance Requirements

- 1. Contractor shall provide services based on funding set forth in Exhibit B, Attachment I, and under the terms of this Contract.
- 2. Contractor shall provide services to all eligible persons in accordance with federal and state statutes and regulations. Contractor shall assure that in planning for the provision of services, the following barriers to services are considered and addressed:
 - (a) Lack of educational materials or other resources for the provision of services;
 - (b) Geographic isolation and transportation needs of persons seeking services or remoteness of services;
 - (c) Institutional, cultural, and/or ethnicity barriers;
 - (d) Language differences;
 - (e) Lack of service advocates;
 - (f) Failure to survey or otherwise identify the barriers to service accessibility; and,
 - (g) Needs of persons with a disability.
- 3. Contractor shall comply with any additional requirements of the documents that have been incorporated herein by reference, including, but not limited to, those on the "List of Exhibit A, Attachment I Documents incorporate by Reference for Fiscal Year 2014-15" which is attached to Exhibit A, Attachment I.
- 4. Amounts awarded pursuant to Exhibit A, Attachment I shall be used exclusively for providing alcohol and/or drug program services consistent with the purpose of the funding.
 - 1. DHCS shall issue a report to Contractor after conducting monitoring, utilization, or auditing 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 DHCS within the designated

timeframe specified by DHCS.

2. The CAP shall include a statement of the problem and the goal of the actions the Contractor and or its sub-contracted provider will take to correct the deficiency or non-compliance. The CAP shall:
 - (a) Address the specific actions to correct deficiency or non-compliance
 - (b) Identify who/which unit(s) will act; who/which unit(s) are accountable for acting; and
 - (c) Provide a timeline to complete the actions.

B. Year-End Cost Settlement Reports

Pursuant to W&I Section 14124.24 Contractor shall submit to the State, on November 1 of each year, the following year-end cost settlement documents by paper or electronic submission for the previous fiscal year:

1. Document 2P, County Certification Year-End Claim for Reimbursement
2. Document 2P(a) and 2P(b), Drug Medi-Cal Cost Report Forms for Intensive Outpatient Treatment for Non-Perinatal or Perinatal (if applicable)
3. Document 2P(c) and 2P(d), Drug Medi-Cal Cost Report Forms for Outpatient Drug Free Individual Counseling for Non-Perinatal or Perinatal (if applicable)
4. Document 2P(e) and 2P(f), Drug Medi-Cal Cost Report Forms for Outpatient Drug Free Group Counseling for Non-Perinatal or Perinatal (if applicable)
5. Document 2P(g), Drug Medi-Cal Cost Report Forms for Residential for Perinatal (if applicable)
6. Document 2P(h) and 2P(i), Drug Medi-Cal Expenditure Forms for Narcotic Treatment Programs for Non-Perinatal or Perinatal (if applicable)

Electronic program as prescribed by the State that contains the detailed cost report data

**Exhibit A, Attachment I
Program Specifications**

Part II – Definitions

23. Definitions

Section 1 - General Definitions.

The words and terms of this Contract are intended to have their usual meanings unless a particular or more limited meaning is associated with their usage pursuant to Division 10.5 of HSC, Section 11750 et seq., and Title 9, CCR, Section 9000 et seq.

- A. **"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.
- B. **"Contractor"** means the county identified in the Standard Agreement or the department authorized by the County Board of Supervisors to administer substance use disorder programs.
- C. **"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.
- D. **"County"** means the county in which the Contractor physically provides covered substance use treatment services.
- E. **"County Realignment Funds"** means Behavioral Health Subaccount funds received by the county as per California Code Section 30025.
- F. **"Days"** means calendar days, unless otherwise specified.
- G. **"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 non-Drug Medi-Cal substance use disorder services to persons eligible for Contractor services.
- H. **"Final Allocation"** means the amount of funds identified in the last allocation letter issued by the State for the current fiscal year.
- I. **"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.
- J. **"Interim Settlement"** means temporary settlement of actual allowable costs or expenditures reflected in the Contractor's year-end cost settlement report.
- K. **"Maximum Payable"** means the encumbered amount reflected on the Standard Agreement of this Contract and supported by Exhibit B, Attachment I.
- L. **"Modality"** means those necessary overall general service activities to provide substance use disorder services as described in Division 10.5 of the HSC.

- M.** “**Non-Drug Medi-Cal Amount**” means the contracted amount of SAPT Block Grant funds for services agreed to by the State and the Contractor.
- N.** “**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), in expending funds for the provision of alcohol and drug services hereunder.
- O.** “**Preliminary Settlement**” means the settlement of only SAPT funding for counties that do include DMC funding.
- P.** “**Revenue**” means Contractor’s income from sources other than the State allocation.
- Q.** “**Service Area**” means the geographical area under Contractor’s jurisdiction.
- R.** “**Service Element**” is the specific type of service performed within the more general service modalities. A list of the service modalities and service elements and service elements codes is incorporated into this Contract as Document 1H(a) “Service Code Descriptions”.
- S.** “**State**” means the Department of Health Care Services or DHCS.
- T.** “**Unit of Service**” means the type of unit used to quantify the service modalities/elements. The units of services are listed below:

Support Services	staff hours
Primary Prevention Services	N/A
Secondary Prevention Services	staff hours
Nonresidential Services (Outpatient and Aftercare)	staff hours
Intensive Outpatient Services	visit days
Residential Treatment Services	bed days
Narcotic Treatment Program	
Inpatient Detoxification	bed days
Outpatient Detoxification	slot days
Narcotic Replacement Therapy	slot days
Methadone	
Ancillary Services	staff hours
Driving Under-the-Influence	persons served

- U.** “**Utilization**” means the total actual units of service used by clients and participants.

Section 2 – Definitions Specific to Drug Medi-Cal

The words and terms of this Contract are intended to have their usual meaning unless a specific or more limited meaning is associated with their usage pursuant to the HSC, Title 9, and/or Title 22. Definitions of covered treatment modalities and services are found in Title 22 (Document 2C) and are incorporated by this reference.

- A.** “**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 Circular A-87 and the State Controller's Office Handbook of Cost Plan Procedures.

- B. **"Authorization"** is the approval process for DMC Services prior to the submission of a DMC claim.
- C. **"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. "Beneficiary" is equivalent to the term "Enrollee" in 42 CFR 438.10(a).
- D. **"Certified Provider"** means a substance use disorder clinic and/or satellite 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.
- E. **"Covered Services"** means those DMC services authorized by Title XIX or Title XXI of the Social Security Act; Title 22 Section 51341.1; W&I Section 14124.24; and California's Medicaid State Plan.
- F. **"Delivery System"** DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into the Waiver. 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 waiver. Upon approval of an implementation plan, the State will contract with the county to provide DMC-ODS services. The county will subcontract 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.
- G. **"Drug Medi-Cal Program"** means the state system wherein beneficiaries receive covered services from DMC-certified substance use disorder treatment providers.
- H. **"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 Termination of Certification termination notice.
- I. **"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.
- J. **"EPSDT (Supplemental Service)"** means the supplemental individual outpatient drug-free (ODF) counseling services provided to beneficiaries eligible for the EPSDT program. Supplemental individual ODF counseling consists of any necessary individual substance use disorder counseling not otherwise included in the ODF counseling modality under the DMC program.
- K. **"Provider Certification"** means the provider must be certified in order to participate in the Medi-Cal program.
- L. **"Federal Financial Participation (FFP)"** means the share of federal Medicaid funds for reimbursement of DMC services.
- M. **"Medical Necessity"** means those substance use treatment services that are reasonable and

necessary to protect life, prevent significant illness or disability, or alleviate severe pain through the diagnosis and treatment of a disease, illness, or injury or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1, and 42 CFR 438.210(a)(4).

- N.** "**Minor Consent DMC Services**" are those covered services that, pursuant to Family Code Section 6929, may be provided to persons 12-20 years old without parental consent.
- O.** "**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.
- P.** "**Payment Suspension**" means the Drug Medi-Cal certified provider has been issued a notice pursuant to W&I 14107.11 and is not authorized to receive payments after the payment suspension date for DMC services, regardless of when the service was provided.
- Q.** "**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).
- R.** "**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 shall end on the last day of the calendar month in which the 60th day occurs.
- S.** "**Post Service Post Payment (PSPP) Utilization Review**" means the review for program compliance and medical necessity conducted by the State after service was rendered and paid. State may recover prior payments of Federal and State funds if such review determines that the services did not comply with the applicable statutes, regulations, or standards (Cal. Code Regs. Title 22, Section 51341.1).
- T.** "**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.
- U.** "**Provider of DMC Services**" means any person or entity that provides direct substance use treatment services and has been certified by State as meeting the standards for participation in the DMC program set forth in the "DMC Certification Standards for Substance Abuse Clinics", Document 2E and "Standards for Drug Treatment Programs (October 21, 1981)", Document 2F.
- V.** "**Re-certification**" means the process by which the certified clinic and/or satellite program is required to submit an application and specified documentation, as determined by DHCS, to remain eligible to participate in and be reimbursed in through the DMC program. Re-certification shall occur no less than every five years from date of previous DMC certification or re-certification.
- W.** "**Satellite Site**" has the same meaning as defined in the DMC Certification Standards for Substance Abuse Clinics.
- X.** "**Statewide Maximum Allowances (SMA)**" means the maximum amount authorized to be paid by DMC for each covered unit of service for outpatient drug free, intensive outpatient treatment, perinatal residential, non-perinatal residential, Medication Assisted Treatment (MAT), and Naltrexone treatment services. While the rates are approved by the State, they are subject to change through the regulation process. The SMA for FY 2014-15 is listed in the "Unit of Service" table in Exhibit B, Part V.

- Y.** “**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/client services.
- Z.** “**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.
- AA.** “**Temporary Suspension**” means the provider is temporarily suspended from participating in the DMC program as authorized by W&I Section 14043.36(a). The provider cannot bill for DMC services from the effective date of the temporary suspension.

Section 23 42 CFR 438.2 Definitions

§438.2 Definitions. *Capitation payment* means a payment the State agency makes periodically to a contractor on behalf of each beneficiary enrolled under a contract for the provision of medical services under the State plan. The State agency makes the payment regardless of whether the particular beneficiary receives services during the period covered by the payment.

Comprehensive risk contract means a risk contract that covers comprehensive services, that is, inpatient hospital services and any of the following services, or any three or more of the following services:

- (1) Outpatient hospital services.
- (2) Rural health clinic services.
- (3) FQHC services.
- (4) Other laboratory and X-ray services.
- (5) Nursing facility (NF) services.
- (6) Early and periodic screening, diagnostic, and treatment (EPSDT) services.
- (7) Family planning services.
- (8) Physician services.
- (9) Home health services.

Federally qualified HMO means an HMO that CMS has determined is a qualified HMO under section 1310(d) of the PHS Act.

Health care professional means a physician or any of the following: a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist, therapist assistant, speech-language pathologist, audiologist, registered or practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

Health insuring organization (HIO) means a county operated entity, that in exchange for capitation payments, covers services for beneficiaries—

- (1) Through payments to, or arrangements with, providers;
- (2) Under a comprehensive risk contract with the State; and
- (3) Meets the following criteria—
 - (i) First became operational prior to January 1, 1986; or

- (ii) Is described in section 9517(e)(3) of the Omnibus Budget Reconciliation Act of 1985 (as amended by section 4734 of the Omnibus Budget Reconciliation Act of 1990).

Managed care organization (MCO) means an entity that has, or is seeking to qualify for, a comprehensive risk contract under this part, and that is—

- (1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or
- (2) Any public or private entity that meets the advance directives requirements and is determined 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 §438.116.

Nonrisk contract means a contract 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 of this chapter; 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.

Prepaid ambulatory health plan (PAHP) means an entity that—

- (1) Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid 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.

Prepaid inpatient health plan (PIHP) means an entity that—

- (1) Provides medical services to enrollees under contract with the State agency, and on the basis of prepaid 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.

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, or pediatrician, to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary care case management means a system under which a PCCM contracts with the State to furnish case management services (which include the location, coordination and monitoring of primary health care services) to Medicaid beneficiaries.

Primary care case manager (PCCM) means a physician, a physician group practice, an entity that employs or arranges with physicians to furnish primary care case management services or, at State option, any of the following:

- (1) A physician assistant.
- (2) A nurse practitioner.
- (3) A certified nurse-midwife.

Risk contract means a contract under which the contractor—

- (1) Assumes risk for the cost of the services covered under the contract; and
- (2) Incurs loss if the cost of furnishing the services exceeds the payments under the contract.

EXHIBIT A, ATTACHMENT I

**DOCUMENTS INCORPORATED BY REFERENCE
FOR FISCAL YEAR 2014-2015**

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

- Document 1B: Title 42, Code of Federal Regulations, Charitable Choice Regulations
http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr54_04.html
- Document 1F(a): Reporting Requirement Matrix – County Submission Requirements for the Department of Health Care Services
- Document 1H(a): Service Code Descriptions
- Document 1H(b): Program Code Listing
- Document 1H(c) : Funding Line Descriptions
- Document 1J(a): Non-Drug Medi-Cal Audit Appeals Process
- Document 1J(b): DMC Audit Appeals Process
- 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 (March 15, 2004)
http://www.dhcs.ca.gov/provgovpart/Pages/Facility_Certification.aspx
- Document 1T: CalOMS Prevention User Manual
- 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 2C: Title 22, California Code of Regulations
<http://ccr.oal.ca.gov>
- Document 2E: Drug Medi-Cal Certification Standards for Substance Abuse Clinics (Updated July 1, 2004)

<http://www.dhcs.ca.gov/provgovpart/Documents/DMC%20Documents%20for%20PED%20webpage/Drug%20Medi-Cal%20Certification%20Standards.pdf>
http://www.dhcs.ca.gov/services/adp/Documents/DMCA_Drug_Medi-Cal_Certification_Standards.pdf

Document 2F: Standards for Drug Treatment Programs (October 21, 1981)

<http://www.dhcs.ca.gov/provgovpart/Documents/DMC%20Documents%20for%20PED%20webpage/DMC%20Standards%20for%20Drug%20Treatment%20Programs.pdf>
http://www.dhcs.ca.gov/services/adp/Documents/DMCA_Standards_for_Drug_Treatment_Programs.pdf

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

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

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

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

Document 2P(a): Drug Medi-Cal Cost Report Forms – Intensive Outpatient Treatment – Non-Perinatal (form and instructions)

Document 2P(b): Drug Medi-Cal Cost Report Forms – Intensive Outpatient Treatment – Perinatal (form and instructions)

Document 2P(c): Drug Medi-Cal Cost Report Forms – Outpatient Drug Free Individual Counseling – Non-Perinatal (form and instructions)

Document 2P(d): Drug Medi-Cal Cost Report Forms – Outpatient Drug Free Individual Counseling – Perinatal (form and instructions)

Document 2P(e): Drug Medi-Cal Cost Report Forms – Outpatient Drug Free Group Counseling – Non-Perinatal (form and instructions)

Document 2P(f): Drug Medi-Cal Cost Report Forms – Outpatient Drug Free Group Counseling – Perinatal (form and instructions)

Document 2P(g): Drug Medi-Cal Cost Report Forms – Residential – Perinatal (form and instructions)

Document 2P(h): Drug Medi-Cal Cost Report Forms – Narcotic Treatment Program – County – Non-Perinatal (form and instructions)

Document 2P(i): Drug Medi-Cal Cost Report Forms – Narcotic Treatment Program – County – Perinatal (form and instructions)

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>

- 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>
- 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
- Document 3T Non-Drug Medi-Cal and Drug Medi-Cal Local Assistance Funding Matrix
- Document 3V Culturally and Linguistically Appropriate Services (CLAS) National Standards
<http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15>
- Document 4A : Drug Medi-Cal Claim Submission Certification – County Contracted Provider – DHCS Form MC 8186 with Instructions
- Document 4B : Drug Medi-Cal Claim Submission Certification – County Operated Provider – DHCS Form MC 8187 with Instructions
- Document 4D : Drug Medi-Cal Certification for Federal Reimbursement (DHCS 100224A)
- Document 4E : Treatment Standards for Substance Use Diagnosis: A Guide for Services (Spring 2010)
- Document 4F : Drug Medi-Cal (DMC) Services Quarterly Claim for Reimbursement of County Administrative Expenses (Form #MC 5312)
- Document 5A : Confidentiality Agreement