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1. Service Overview

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

The Contractor will provide or arrange for the provision of specialty mental health services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) services as defined in this intergovernmental agreement (the "Contract") to Medi-Cal members residing in County Name County who meet the applicable access criteria. Contractor will provide or arrange for the provision of SMHS and DMC-ODS services as a single Prepaid Inpatient Health Plan (PIHP) as defined in 42 Code of Federal Regulations (hereafter C.F.R.) part 438.2.

2. Service Location

The services shall be performed at the Contractor's contracting and participating facilities, and at other facilities as set forth in the Contract, including but not limited to out-of-network facilities.

3. Service Hours

The services shall be provided on a 24-hour, seven (7) days a week basis, as set forth in the Contract.

4. Project Representatives

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

Department of Health Care Services	**Contractor Name**
Name	Name
Telephone	Telephone
Email	Fax
	Email

B. Direct all inquiries to:

Department of Health Care Services	**Contractor Name**
Medi-Cal Behavioral Health	Attention
Division/Program Policy Section	Address
Attention	Telephone
1501 Capitol Avenue, MS 2702	Fax
Sacramento, CA, 95814	Email
Telephone	
Email	

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

5. General Authority

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

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

C. Pursuant to DHCS' Behavioral Health Administrative Integration initiative, the Contractor has elected to integrate the SMHS delivery system and the DMC-ODS into a single PIHP with a nonrisk contract, as defined in 42 C.F.R. part 438.2.

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

2) All Exhibits, Attachments, and Sections in this Contract apply to the delivery of both SMHS and DMC-ODS services, except as otherwise indicated in this Contract. The presence of a citation that applies to only one delivery system does not limit application of the corresponding contracting requirements to only that delivery system.

D. No provision of this Contract is intended to obviate or waive any requirements of applicable law or regulation. In the event a provision of this Contract is open to

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varying interpretations, the Contract provision shall be interpreted in a manner that is consistent with applicable law and regulation. In the event of a conflict between the terms of this Contract and a State or federal statute or regulation, or a BHIN, the Contractor shall adhere to the applicable statute, regulation, or BHIN.

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

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

G. The Centers for Medicare and Medicaid Services (hereafter CMS) shall review and approve this Contract, in accordance with 42 C.F.R. section 438.3(a).

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

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

7. Services to be Performed

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

8. Loss of Federal Authority

Should any part of the scope of work under this Contract relate to a state program receiving Federal Financial Participation (FFP) that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of such program authority. DHCS will adjust payments that are specific to any state program or activity receiving FFP

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

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1. Implementation Plan

A. The Contractor shall comply with the provisions of the Contractor's Implementation Plan for SMHS and for DMC-ODS as approved by the Department; provided, however, that the requirements of this Contract, applicable law, or Department guidance shall control to the extent there is any conflict between these authorities and the Contractor's Implementation Plan. The Contractor shall obtain written approval by the Department prior to making any changes to either Implementation Plan as approved by the Department.

B. If the Contractor has not previously implemented a Mental Health Plan or DMC-ODS program, or if Contractor will provide or arrange for the provision of covered benefits to new eligibility groups, then the Contractor shall develop an Implementation Plan that is consistent with the readiness review requirements set forth in 42 C.F.R. part 438.66(d)(4), and, as applicable, state requirements such as Cal. Code Regs. (hereafter C.C.R.), tit. 9, § 1810.310 (a). (See 42 C.F.R. § 438.66(d)(1) & (4).) The Department shall review and either approve, disapprove, or request additional information for each Implementation Plan.

2. Prohibited Affiliations

A. The Contractor shall not knowingly have any prohibited type of relationship, as described in subsection C, with individuals or entities listed below. The Contractor shall further require that its subcontractors and contracted providers abide by this requirement.

1) An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. (42 C.F.R. § 438.610(a)(1).)

2) An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 C.F.R. § 2.101, of a person described in this section. (42 C.F.R. § 438.610(a)(2).)

B. The Contractor, its contracted providers, and its subcontractors shall not have a prohibited type of relationship by employing or contracting with providers or other individuals and entities excluded from participation in federal health care programs (as defined 42 U.S.C. § 1320a-7b(f)) pursuant to 42 U.S.C. sections 1320a-7, 1320a-7a, 1320c-5, and 1395u(j)(2). (42 C.F.R. §§ 438.214(d)(1), 438.610(b).)

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C. The Contractor, its contracted providers, and its subcontractors shall not have the types of relationships prohibited by this section with an excluded, debarred, or suspended individual, provider, or entity.

1) A director, officer, agent, managing employee, or partner of the Contractor. (42 U.S.C. § 1320a-7(b)(8)(A)(ii); 42 C.F.R. § 438.610(c)(1).)

2) A subcontractor of the Contractor, as governed by 42 C.F.R. section 438.230. (42 C.F.R. § 438.610(c)(2).)

3) A person with beneficial ownership of 5 percent or more of the Contractor's equity. (42 C.F.R. § 438.610(c)(3).)

4) A network provider or person with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Contract. (42 C.F.R. § 438.610(c)(4).)

D. The Contractor, its contracted providers, and its subcontractors shall not employ or contract with, directly or indirectly, individuals or entities described in Subsections A and B for the furnishing of health care, utilization review, medical social work, administrative services, management, or provision of medical services (or the establishment of policies or provision of operational support for such services). (42 C.F.R. § 438.808(b)(3).)

E. The Contractor, its contracted providers, and its subcontractors shall not contract directly or indirectly with an individual convicted of crimes described in section 1128(b)(8)(B) of the Social Security Act. (42 C.F.R. § 438.808(b)(2))

F. The Contractor shall provide to the Department written disclosure of any prohibited affiliation identified by the Contractor, its contracted providers, or its subcontractors. (42 C.F.R. § 438.608(c)(1).)

3. Delegation

Unless specifically prohibited by this Contract or by federal or state law, the Contractor may delegate duties and obligations of Contractor under this Contract to subcontractors or contracted providers, if the Contractor determines that the subcontracting entities selected are able to perform the delegated duties in an adequate manner in compliance with the requirements of this Contract. The Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its Contract with the Department,

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notwithstanding any relationship(s) that the Contractor may have with any subcontractor or contracted provider. (42 C.F.R. § 438.230(b)(1).)

4. Subcontracts and Provider Contracts

A. This provision is a supplement to Section 5(Subcontract Requirements) in Exhibit D(F) which is attached hereto as part of this Contract.

1) Pursuant to Exhibit D(F), Section 5.c, the Department hereby, and until further notice, waives its right to prior review and approval of subcontracts or provider contracts, including existing subcontracts or provider contracts. The Department does not waive its right to review subcontracts or provider contracts for any other purpose outlined in this Contract.

B. No subcontract or provider contract terminates the legal responsibility of the Contractor to the Department to assure compliance with all terms and conditions of this Contract. (42 C.F.R. § 438.230(b).)

C. All subcontracts shall be in writing.

D. All provider contracts for inpatient and residential services shall require that contracted providers maintain necessary licensing, certification and mental health program approvals, as applicable.

E. Each subcontract and provider contract shall contain:

1) The delegated activities and obligations, including services provided, and related reporting responsibilities. (42 C.F.R. § 438.230(c)(1)(i).)

2) The subcontractor’s and contracted provider agreement to perform the delegated activities and reporting responsibilities in compliance with the Contractor’s obligations in this Contract. (42 C.F.R. § 438.230(c)(1)(ii).)

3) Subcontractor's and contracted provider’s agreement to submit reports as required by the Contractor and/or the Department.

4) The method and amount of compensation or other consideration to be received by the subcontractor or contracted provider from the Contractor.

5) The requirement that the subcontract or provider contract be governed by, and construed in accordance with, all laws and regulations and all contractual obligations of the Contractor under

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this Contract, including the federal and state requirements listed in Exhibit E, Section 6.

6) Requirement that the subcontractor or contracted provider comply with all applicable Medicaid laws, regulations, sub-regulatory guidance and contract provisions. (42 C.F.R. § 438.230(c)(2).)

7) Beginning and ending dates, as well as methods for amendment and, if applicable, extension of the subcontract or provider contract.

8) Provisions for full and partial revocation of the subcontract or provider contract, delegated activities or obligations, or application of other remedies permitted by state or federal law when the Department or the Contractor determine that the subcontractor or contracted provider has not performed satisfactorily. (42 C.F.R. § 438.230(c)(1)(iii).)

9) The nondiscrimination and compliance provisions of this Contract, including the nondiscrimination provisions at Exhibit E, Section 4.C, and any other provisions specifically identified in this Contract as applying to subcontractors or contracted providers.

10) A requirement that the subcontractor or contracted provider make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to Medi-Cal enrollees, Medi-Cal-related activities, services and activities furnished under the terms of the subcontract, or determinations of amounts payable, available at any time for inspection, examination or copying by the Department, CMS, U.S. Department of Health and Human Services (hereafter HHS) Inspector General, the United States Comptroller General, their designees, and other authorized federal and state agencies. (42 C.F.R. § 438.230(c)(3)(i)-(ii).) This audit right will exist for 10 years from the final date of the Contract period or from the date of completion of any audit, whichever is later. (42 C.F.R. § 438.230(c)(3)(iii).) The Department, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor or the contracted provider at any time if there is a reasonable possibility of fraud or similar risk. The Department's inspection shall occur at the subcontractor's or contracted provider's place of business, premises or physical facilities. (42 C.F.R. § 438.230(c)(3)(iv).)

11) A requirement that the subcontractor or contracted provider maintain books and records of its work pursuant to its subcontract or provider contract, in accordance with Exhibit E, Section 5.A. A

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requirement that the Contractor monitor the subcontractor's or contracted provider's compliance with the provisions of the subcontract or provider contract and this Contract and a requirement that the subcontractor or contracted provider provide a corrective action plan if deficiencies are identified.

12) Subcontractor's or contracted provider's agreement to hold harmless both the State and members in the event the Contractor cannot or does not pay for services performed by the subcontractor or contracted provider pursuant to the subcontract or provider contract.

13) Subcontractor's or contracted provider's agreement to comply with the Contractor's policies and procedures on advance directives and the Contractor's obligations for Physician Incentive Plans, if applicable based on the services provided under the subcontract or provider contract.

14) Subcontractor's or contracted provider's agreement that assignment or delegation of the subcontract or provider contract shall be void unless prior written approval is obtained from the Contractor.

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

5. Accreditation Status

A. The Contractor is not required to obtain accreditation by a private independent accrediting entity. The Contractor shall inform the Department whether it has been accredited by a private independent accrediting entity. (42 C.F.R. § 438.332(a).)

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

1) Its accreditation status, survey type, and level (as applicable);

2) Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and

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3) The expiration date of the accreditation. (42 C.F.R. § 438.332(b).)

6. Conflict of Interest

A. The Contractor shall comply with the conflict-of-interest safeguards described in:

1) 42 C.F.R. section 438.58 and the prohibitions described in section 1902(a)(4)(C) of the Social Security Act. (42 C.F.R. § 438.3(f)(2).); and

2) The California Political Reform Act, including Public Contract Code section 10365.5 and Government Code section 1090.

B. The Contractor's officers and employees shall not have a financial interest in this Contract, or a subcontract of this Contract made by them in their official capacity, or by any body or board of which they are members unless the interest is remote. (Gov. Code §§ 1090, 1091; 42 C.F.R. § 438.3(f)(2).)

C. No public officials at any level of local government shall make, participate in making, or attempt to use their official positions to influence a decision made within the scope of this Contract in which they know or have reason to know that they have a financial interest. (Gov. Code §§ 87100, 87103; 2 C.C.R. § 18704; 42 C.F.R. § 438.3(f)(2).)

1) If a public official determines not to act on a matter due to a conflict of interest within the scope of this Contract, the Contractor shall notify the Department by oral or written disclosure. (2 C.C.R. § 18707; 42 C.F.R. § 438.3(f)(2).)

2) Public officials, as defined in Government Code section 87200, shall follow the applicable requirements for disclosure of a conflict of interest or potential conflict of interest, once it is identified, and recuse themselves from discussing or otherwise acting upon the matter. (Gov. Code § 87105, 2 C.C.R. § 18707(a); 42 C.F.R. § 438.3(f)(2).)

D. The Contractor shall not utilize in the performance of this Contract any State officer or employee in the State civil service or other appointed State official unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular State employment. (Pub. Contract Code § 10410; 42 C.F.R. § 438.3(f)(2).)

1) The Contractor shall submit documentation to the Department of employees (current and former State employees) who may present a conflict of interest.

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E. Additional Requirements.

1) DHCS intends to avoid any real or apparent conflict of interest on the part of the Contractor, the subcontractor, or employees, officers and directors of the Contractor or subcontractor. Thus, DHCS reserves the right to determine, at its sole discretion, whether any information, assertion or claim received from any source indicates the existence of a real or apparent conflict of interest; and, if a conflict is found to exist, to require the Contractor to submit additional information or a plan for resolving the conflict, subject to DHCS review and prior approval.

2) Conflicts of interest include, but are not limited to:

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

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

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

7. Documentation Standards

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

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B. In the event of a conflict between the terms of this Contract relating to documentation and a state or federal statute or regulation, or a BHIN issued pursuant to W&I Code section 14184.402, subdivision (h)(3), the Contractor shall adhere to the applicable statute, regulation, or BHIN.

8. Laboratory Testing Requirements

A. 42 C.F.R. part 493 sets forth the conditions that all laboratories shall meet to be certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). A laboratory will be cited as out of compliance with section 353 of the Public Health Service Act unless it:

1) Has a current, unrevoked or unsuspended certificate of waiver, registration certificate, certificate of compliance, certificate for provider-performed microscopy procedures, or certificate of accreditation issued by HHS applicable to the category of examinations or procedures performed by the laboratory; or

2) Is CLIA-exempt.

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

1) Any facility or component of a facility that only performs testing for forensic purposes.

2) Research laboratories that test human specimens but do not report patient specific results for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of individual patients.

3) Laboratories certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), in which drug testing is performed which meets SAMHSA guidelines and regulations. However, all other testing conducted by a SAMHSA-certified laboratory is subject to this rule.

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

Exhibit A – Attachment 2A
SMHS: SCOPE OF SERVICES

1. Criteria for Members to Access Specialty Mental Health Services

The Contractor shall implement the criteria for access to SMHS (except for psychiatric inpatient hospital and psychiatric health facility services) established below. The Contractor shall ensure that these access criteria are accurately reflected in its manuals and other materials, including materials reflecting the responsibility of Medi-Cal managed care plans and the Fee for Service delivery system for covering non-specialty mental health services. (BHIN 21-073.)

A. Criteria for Adult Members to Access the SMHS Delivery System

For members 21 years of age or older, the Contractor shall provide covered SMHS for members who meet both of the following criteria, (1) and (2) below:

1) The member has one or both of the following:

   i. Significant impairment, where impairment is defined as distress, disability, or dysfunction in social, occupational, or other important activities; and/or

   ii. A reasonable probability of significant deterioration in an important area of life functioning,

AND

2) The member's condition as described in paragraph (1) is due to either of the following:

   i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems; or

   ii. A suspected mental disorder that has not yet been diagnosed.

(W&I Code § 14814.402, subd. (c).)

B. Criteria for Members under Age 21 to Access the SMHS Delivery System

For enrolled members under 21 years of age, Contractor shall provide all medically necessary SMHS required pursuant to section 1396d(r) of title 42 of the United States Code. Covered SMHS shall be provided to enrolled members who meet either of the following criteria:

1) The member has a condition placing them at high risk for a mental health disorder due to experience of trauma evidenced by any of the following: scoring in the high-risk range under a trauma screening tool

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SMHS: SCOPE OF SERVICES

approved by the Department, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness;

OR

2) The member meets both of the following requirements in A and B below:

A. The member has at least one of the following:

i. A significant impairment;

ii. A reasonable probability of significant deterioration in an important area of life functioning;

iii. A reasonable probability of not progressing developmentally as appropriate; or

iv. A need for SMHS, regardless of presence of impairment, that are not included within the mental health benefits that a Medi-Cal managed care plan is required to provide,

AND

B. The member's condition as described in subparagraph (A) is due to one of the following:

i. A diagnosed mental health disorder, according to the criteria of the current editions of the Diagnostic and Statistical Manual of Mental Disorders and the International Statistical Classification of Diseases and Related Health Problems;

ii. A suspected mental health disorder that has not yet been diagnosed; or

iii. Significant trauma placing the member at risk of a future mental health condition, based on the assessment of a licensed mental health professional.

(W&I Code § 14184.402, subd. (d).)

2. Provision of Services

A. For each member who meets the SMHS access criteria, as defined above, the Contractor shall provide or arrange, and pay for, the SMHS listed below that are medically necessary (as defined in Exhibit E, Attachment 1), and clinically appropriate to address that member's presenting condition, including services for a member who is under the age of 21

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SMHS: SCOPE OF SERVICES

consistent with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements. Contractor is obligated to cover all mental health services that are not covered under Medi-Cal Fee For Service (FFS) or by Managed Care Plans as non-specialty mental health services (NSMHS), as established in W&I Code section 14184.402(b), that are medically necessary EPSDT services for members under the age of 21 who meet SMHS access criteria. Covered services shall be provided in accordance with this Contract, the California Medicaid State Plan, the applicable statutes and regulations (including 9 C.C.R. §§ 1810.345, 1810.350 and 1810.405, and 42 C.F.R. § 438.210), and any relevant information notices issued by the Department. See Exhibit E, Attachment 2 (for detailed definitions of the SMHS listed below:

1) Mental Health Services;

2) Medication Support Services;

3) Day Treatment Intensive;

4) Day Rehabilitation;

5) Crisis Intervention;

6) Crisis Stabilization;

7) Adult Residential Treatment Services;

8) Crisis Residential Treatment Services;

9) Psychiatric Health Facility Services;

10) Intensive Care Coordination (for members under the age of 21);

11) Intensive Home Based Services (for members under the age of 21);

12) Therapeutic Behavioral Services (for members under the age of 21);

13) Therapeutic Foster Care (for members under the age of 21);

14) Psychiatric Inpatient Hospital Services;

15) Targeted Case Management;

16) Peer Support Services (if the Contractor has opted to provide Peer Support Services and has been approved by DHCS, the Contractor shall comply with the peer support services provisions in Attachment 2B); and

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SMHS: SCOPE OF SERVICES

17) For members under the age of 21, the Contractor shall provide all medically necessary SMHS required pursuant to section 1396d(r) of title 42 of the United States Code (W&I Code § 14184.402 (d)).

18) Community-Based Mobile Crisis Intervention Services (also referred to as "Mobile Crisis Services") (W&I Code § 14132.57, BHIN 23-025).

B. Medi-Cal Managed Care Plan members receive mental health disorder benefits in every classification - inpatient, outpatient, prescription drug and emergency – for which members receive medical/surgical benefits, in compliance with 42 C.F.R. section 438.910(b)(2). The Contractor is only required to provide inpatient and outpatient SMHS, as provided for in this Contract and as required pursuant to section 1396d(r) of title 42 of the United States Code. Prescription drug and emergency benefits are provided through other delivery systems.

3. Requirements for Emergency and Post-Stabilization Services

A. Emergency and post-stabilization services described in 42 C.F.R. section 438.114 provided in a hospital emergency department are not SMHS covered by Contractor. Emergency and post-stabilization services provided in a hospital emergency department for Medi-Cal members are covered by Medi-Cal Managed Care Plans or through fee-for-service. Medi-Cal Managed Care Plans cover and pay for medically necessary emergency and post stabilization services provided in a hospital emergency department including the following:

i. Emergency room professional services as described in 22 C.C.R. section 53855. This includes all professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services medically necessary to stabilize the member.

ii. Facility charges claimed by emergency departments (All Plan Letter (APL) 22-005, BHIN 22-011) for emergency room visits;

iii. Post-Stabilization services as defined in 42 C.F.R. section 438.114(a).

B. Contractor shall comply with BHIN 22-017, BHIN 22-011, and any subsequent Departmental guidance, pertaining to authorization requirements for inpatient psychiatric services and payment responsibilities for emergency services provided to individuals experiencing a psychiatric emergency medical condition, as defined in

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SMHS: SCOPE OF SERVICES

Health and Safety Code section 1317.1, in a hospital or psychiatric health facility.

C. Contractor shall not require prior authorization for a hospital or psychiatric health facility to treat a member who is experiencing a psychiatric emergency medical condition, whether the admission is voluntary or involuntary.

D. Contractor shall not restrict, limit, or direct the transfer of a Medi-Cal member who is experiencing a psychiatric emergency medical condition to a psychiatric inpatient facility before the member's condition is determined to be stable.

E. Contractor shall not require hospitals or Managed Care Plans to utilize Contractor's in-network or preferred psychiatric inpatient facilities until the member's condition is determined to be stable.

4. Requirements for Day Treatment Intensive and Day Rehabilitation

A. The Contractor shall require contracted providers to request prior authorization for day treatment intensive and day rehabilitation services, in accordance with BHIN 22-016 and any subsequent departmental notices.

B. The Contractor shall require that contracted providers of day treatment intensive and day rehabilitation meet the applicable requirements of 9 C.C.R. §§ 1840.318, 1840.328, 1840.330, 1840.350 and 1840.352.

C. The Contractor shall require that contracted providers of day treatment intensive and day rehabilitation programs include in the services provided one or more of the following service components: assessment, treatment planning, therapy, psychosocial rehabilitation. Both programs must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone.

D. Staffing Requirements. Staffing ratios shall be consistent with the requirements in 9 C.C.R. § 1840.350, for day treatment intensive, and 9 C.C.R. tit. 9 § 1840.352 for day rehabilitation. For day treatment intensive, staff shall include at least one staff person whose scope of practice includes psychotherapy.

1) Program staff may be required to spend time on day treatment intensive and day rehabilitation activities outside the hours of operation and therapeutic program (e.g., time for travel, documentation, and caregiver contacts).

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SMHS: SCOPE OF SERVICES

2) The Contractor shall require that at least one staff person be present and available to the group in the therapeutic milieu for all scheduled hours of operation.

3) The Contractor shall require day treatment intensive and day rehabilitation programs to maintain documentation that enables the Contractor and the Department to audit the program if it uses day treatment intensive or day rehabilitation staff who are also staff with other responsibilities (e.g., as staff of a group home, a school, or another mental health treatment program). The Contractor shall require that there is documentation of the scope of responsibilities for these staff and the specific times in which day treatment intensive or day rehabilitation activities are being performed exclusive of other activities.

E. The Contractor shall ensure that the contracted provider receives Medi-Cal reimbursement only if the member is present for at least 50 percent of scheduled hours of operation for that day. In cases where absences are frequent, it is the responsibility of the Contractor to ensure that the provider re-evaluates the member's need for the day rehabilitation or day treatment intensive program and takes appropriate action.

F. Documentation Standards. The Contractor shall ensure day treatment intensive and day rehabilitation documentation meets the documentation requirements in BHIN 23-068.

G. The Contractor shall ensure that day treatment intensive and day rehabilitation have at least one contact per month with a family member, caregiver or other significant support person identified by an adult member, or one contact per month with the legally responsible adult for a member who is a minor. This contact may be face-to-face, or by an alternative method (e.g., e-mail, telephone, etc.). Adult members may decline this service component. The contacts should focus on the role of the support person in supporting the member's community reintegration. The Contractor shall ensure that this contact occurs outside hours of operation and outside the therapeutic program for day treatment intensive and day rehabilitation.

H. Written Program Description. The Contractor shall ensure that all contracted Day treatment intensive programs and day rehabilitation programs have a written program description. The written program description must describe the specific activities of each service and reflects each of the required components of the services as described in this section. The Contractor shall review and approve or deny the written

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SMHS: SCOPE OF SERVICES

program description for compliance with this section. The Contractor shall not authorize a day treatment intensive or day rehabilitation provider to provide services until the Contractor approves the written program description.

I. Continuous Hours of Operation. The Contractor shall ensure that the provider applies the following when claiming for day treatment intensive and day rehabilitation services:

1) A half day shall be billed for each day in which the member receives face-to-face services in a program with services available four hours or less per day. Services must be available a minimum of three hours each day the program is open.

2) A full day shall be billed for each day in which the member receives face-to-face services in a program with services available more than four hours per day.

3) Although the member must receive face to face services on any full-day or half-day claimed, all service activities during that day are not required to be face-to-face with the member.

4) The requirement for continuous hours of operation does not preclude short breaks (for example, a school recess period) between activities. A lunch or dinner may also be appropriate depending on the program's schedule. The Contractor shall not include these breaks toward the total hours of operation of the day program for purposes of determining minimum hours of service.

5. Therapeutic Behavioral Services

Therapeutic Behavioral Services (TBS) are SMHS covered as EPSDT. (9 C.C.R. § 1810.215.) TBS are intensive, one-to-one services designed to help members and their parents/caregivers manage specific behaviors using short-term measurable goals based on the member's needs. TBS is described in the Department of Mental Health Information Notice 08-38.

Exhibit A – Attachment 2B
SMHS: PEER SUPPORT SERVICES

1. MEDI-CAL PEER SUPPORT SERVICES

A. The Contractor has taken the option to implement SMHS Medi-Cal Peer Support Services.

B. The Contractor shall provide, or arrange, and pay for Peer Support Services to Medi-Cal members. Contractor's provision of Peer Support Services shall conform to the requirements of Supplement 3 to Attachment 3.1-A and Supplement 3 to Attachment 3.1-B of the California State Plan and applicable DHCS BHINs.

C. Contractor's implementation of a Medi-Cal Peer Support Specialist Certification Program shall conform to the applicable requirements of Behavioral Health Information Notice (BHIN) 21-041 and to the requirements in any subsequent BHINs issued by the Department pursuant to W&I Code section 14045.21.

D. Voluntary Participation and Funding

1) The Contractor shall fund the nonfederal share of any applicable expenditures. (W&I Code § 14045.19(b)(2)) The Contractor's provision of Peer Support Services and the Contractor's participation in the Peer Support Specialist Certification Program shall not constitute a mandate of a new program or higher level of service that has an overall effect of increasing the costs mandated by the 2011 realignment legislation. (W&I Code § 14045.19(b)(3))

E. Provision of Peer Support Services

1) Peer Support Services may be provided face-to-face, by telephone or by telehealth with the member or significant support person(s) and may be provided anywhere in the community.

F. Peer Support Specialists

1) Contractor shall ensure that Peer Support Services are provided by certified Peer Support Specialists as established in BHIN 21-041.

G. Behavioral Health Professional and Peer Support Specialist Supervisors

1) The Contractor shall ensure that Peer Support Specialists provide services under the direction of a Behavioral Health Professional.

2) A Behavioral Health Professional must be licensed, waivered, or registered in accordance with applicable State of California licensure requirements and listed in the California Medicaid State Plan as a qualified provider of SMHS, DMC-ODS, or DMC.

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SMHS: PEER SUPPORT SERVICES

3) Peer Support Specialists may also be supervised by Peer Support Specialist Supervisors, as established in BHIN 21-041.

H. Practice Guidelines

1) Counties shall require Peer Support Specialists to adhere to the practice guidelines developed by the Substance Abuse and Mental Health Services Administration, *What are Peer Recovery Support Services* (Center for Substance Abuse Treatment, What are Peer Recovery Support Services? HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services), which may be accessed electronically through the following Internet World Wide Web connection: www.samhsa.gov/resource/ebp/what-are-peer-recovery-support-services.

I. Contractor shall oversee and enforce the certification standards and requirements set forth in W&I Code, division 9, part 3, chapter 7, article 1.4 (§ 14045.10 et seq.) and departmental guidance, including BHIN 21-041. Contractor shall ensure that the Medi-Cal Peer Support Specialist Certification Program:

1) Submits to the department a peer support specialist program plan in accordance with Enclosure 2 of BHIN 21-041 describing how the peer support specialist program will meet all of the federal and state requirements for the certification and oversight of peer support specialists.

2) Participates in periodic reviews conducted by the department to ensure adherence to all federal and state requirements.

3) Submits annual peer support specialist program reports to the department in accordance with Enclosure 5 of BHIN 21-041. Reports shall cover the fiscal year and shall be submitted by the following December 31st.

Exhibit A – Attachment 2C
DMC-ODS: SCOPE OF SERVICES

1. General Requirements

A. The Contractor has elected to opt into the DMC-ODS to provide or arrange for covered DMC-ODS services described under this Contract to eligible Medi-Cal individuals residing within the Contractor's county borders.

B. Coverage of Services (42 C.F.R. § 438.210).

1) The Contractor shall provide or arrange for the provision of DMC-ODS services that are medically necessary (as defined in Exhibit E, Attachment 1) and clinically appropriate to address each member's presenting condition, including services for members under the age of 21 consistent with Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements.

2) Covered services shall be provided in accordance with this Contract, BHIN 24-001, the applicable statutes and regulations, and any other relevant information notices issued by the Department.

C. Services That May Be Covered by the Contractor. The Contractor may cover, for members, services that are in addition to those covered under the State Plan as follows:

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

b. Any services necessary for compliance by the Contractor with the parity requirements set forth in 42 C.F.R. § 438.900 et. al and only to the extent such services are necessary for the Contractor to comply with 42 C.F.R. § 438.910. (42 C.F.R. § 438.3(e)(1)).

2. Provision of Services

A. Provider Specifications

1) Professional staff shall:

a. Be licensed, registered, enrolled, and/or approved in accordance with all applicable state and federal laws and regulations.

b. Abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Health Care Services.

2) Professional staff means any of the following:

a. Licensed Practitioners of the Healing Arts (LPHA), as defined in Exhibit E, Attachment 1.

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DMC-ODS: SCOPE OF SERVICES

b. An Alcohol or other drug (AOD) counselor, as defined in Exhibit E, Attachment 1.

c. Medical Director of a Narcotic Treatment Program who is a licensed physician in the State of California.

d. A Medi-Cal Peer Support Specialist with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and who meet all other applicable California state requirements, including ongoing education requirements.

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

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

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

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

7) Counselor Certification. Any counselor or registrant providing intake, assessment of need for services, treatment or recovery planning, individual or group counseling to participants, patients, or residents in a DHCS licensed or certified program is required to comply with the requirements in Chapter 8 of Division 4 of Title 9 of the C.C.R,. (Document 3H)

8) Adolescent Substance Use Disorder Best Practices Guide. Contractor shall follow the guidelines in Document 1V, incorporated by this reference, “Adolescent Substance Use Disorder Best Practices Guide,” in developing and implementing adolescent treatment programs funded under this Exhibit, until such time new guidelines are established and adopted. No formal amendment of this Contract is required for new guidelines to be incorporated into this Contract.

3. Organized Delivery System (ODS) Timely Coverage

A. To receive DMC-ODS services, a member shall be enrolled in Medi-Cal, and reside in Contractor’s county. Contractor shall provide or arrange for members to

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DMC-ODS: SCOPE OF SERVICES

receive DMC-ODS services consistent with the following assessment, access, and level of care determination criteria:

1) Initial Assessment and Services Provided During the Assessment Process:

   a. Providers shall complete initial assessments in accordance with each member's clinical needs and generally accepted standards of practice. The initial assessment shall be performed face-to-face or, by telehealth (synchronous audio and video), or by telephone (synchronous audio-only) by an LPHA or registered or certified counselor and may be done in the community or the home. If the assessment of the member is completed by a registered or certified counselor, then the LPHA shall evaluate that assessment with the counselor and the LPHA shall make the initial diagnosis. The consultation between the LPHA and the registered or certified counselor may be conducted in person, by video conferencing, or by telephone.

   b. A SUD diagnosis is not a prerequisite for access to covered DMC-ODS services. Covered and clinically appropriate DMC-ODS services are Medi-Cal reimbursable during the assessment process, whether or not a Diagnostic and Statistical Manual of Mental Disorder (DSM) diagnosis for Substance-Related and Addictive Disorders is immediately established. Specific level-of-care assessment and authorization policies remain in effect for Residential Treatment Services and Withdrawal Management Services.

   c. Covered and clinically appropriate DMC-ODS services (except for residential) shall be reimbursable for up to 30 days following the first visit with a Licensed Practitioner of the Healing Arts (LPHA), registered/certified counselor, or Medi-Cal Peer Support Specialist, whether or not a Diagnostic and Statistical Manual (DSM) diagnosis for Substance-Related and Addictive Disorders is established, or up to 60 days if the member is under age 21, or if a provider documents that the member is experiencing homelessness and therefore requires additional time to complete the assessment. If a member withdraws from treatment prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorders, and later returns, the 30-day time period starts over.

2) DMC-ODS Access for Members After Initial Assessment:

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DMC-ODS: SCOPE OF SERVICES

a. Members 21 years and older qualify for DMC-ODS services after the initial assessment process if they meet one of the following criteria:

i. Have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, or

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

b. Members under age 21 qualify to receive all medically necessary DMC-ODS services as required pursuant to 42 U.S.C. § 1396d(r). Federal EPSDT statutes and regulations require States to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct or ameliorate health conditions, regardless of whether those services are covered in the state's Medicaid State Plan. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

3) Additional Coverage Requirements and Clarifications consistent with W&I Code § 14184.402(f): Covered SUD prevention, screening, assessment, treatment, and recovery services are reimbursable Medi-Cal services when:

a. The services are provided prior to determination of a diagnosis or prior to determination of whether DMC-ODS access criteria are met, as described above. For services provided to members over the age of 21 during the assessment process as described above under the "Initial Assessment and Services Provided During the Assessment Process," the services must be clinically appropriate to be reimbursed. In addition, the Contractor shall not disallow reimbursement for clinically appropriate and covered DMC-ODS services provided during the assessment process if

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the assessment subsequently determines that the member does not meet the DMC-ODS access criteria for members after assessment. (See Exhibit A, Attachment. 2C, section 3, A., 1), c. above for duration limitations on reimbursement for the initial assessment.)

This does not eliminate the requirement that all DMC-ODS claims include a CMS approved International Classification of Diseases, Tenth Revision (ICD-10-CM) code. In cases where services are provided due to a suspected SUD that has not yet been diagnosed, options are available in the CMS approved ICD-10-CM diagnosis code list, for example, codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services." Refer to BHIN 22-013, and any subsequently issued BHINs that supersede BHIN 22-013 for additional information regarding code selection during the assessment period for outpatient behavioral health services.

b. The services were not included in an individual treatment plan. If the services are not included in a member's treatment plan, the Contractor shall implement the guidance in BHIN 23-068 related to documentation requirements that took effect as of January 1, 2024.

c. The member has a co-occurring mental health condition. Medically necessary covered DMC-ODS services delivered by contracted providers shall be covered and reimbursable Medi-Cal services whether or not the member has a co-occurring mental health condition. DMC-ODS counties shall not disallow reimbursement for covered DMC-ODS services provided to a member who has a co-occurring mental health condition if the member meets the DMC-ODS Access Criteria for Members After Assessment pursuant to BHIN 22-011 and any subsequently issued BHINs that supersede BHIN 22-011.

4) Level of Care Determination: The ASAM Criteria shall be used to determine placement into the appropriate level of care for all members, and is separate and distinct from determining medical necessity.

   a. Contracted providers shall use their clinical expertise to complete ASAM Level of Care assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice to ensure that members receive the right services, at the right time, and in the right place. However, contracted providers shall adhere to any licensure or certification requirements for those services, including any additional standards for member assessment.

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b. A full ASAM Criteria assessment is not required to deliver prevention and early intervention services for members under 21; a brief screening ASAM Criteria tool is sufficient for these services (see below regarding details about ASAM level of care 0.5).

c. A full ASAM Criteria assessment, or initial provisional referral tool for preliminary level of care recommendations, shall not be required to begin receiving DMC-ODS services.

d. Assessments shall be updated as clinically appropriate, such as when the member's condition changes.

e. A full ASAM assessment does not need to be repeated unless the member's condition changes.

f. These requirements for ASAM Level of Care assessments apply to NTP clients and settings.

5) Member placement and level of care determinations shall ensure that members are able to receive care in the least restrictive level of care that is clinically appropriate to treat their condition.

4. Covered Services

A. The Contractor shall provide all mandatory DMC-ODS services identified below, and may provide all optional DMC-ODS services identified under Attachments 2C & 2D, in accordance with the applicable requirements set forth in this Contract. The Contractor is responsible for providing services that relate to:

1) The prevention, diagnosis, and treatment of substance use disorders.

2) Members' ability to achieve age-appropriate growth and development.

3) Members' ability to attain, maintain, or regain functional capacity. (42 C.F.R. § 438.210(a)(5)).

B. The following are the mandatory and optional DMC-ODS Covered Services:

1) Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (for members under age 21) (mandatory).

2) Withdrawal Management Services (a minimum of one level is mandatory).

3) Intensive Outpatient Treatment Services (mandatory).

4) Outpatient Treatment Services (mandatory).

5) Narcotic Treatment Programs (mandatory).

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6) Recovery Services (mandatory).

7) Care Coordination (mandatory).

8) Clinician Consultation (mandatory).

9) Medications for Addiction Treatment (also known as Medication Assisted Treatment or MAT) (mandatory). This is defined as facilitating access to MAT off-site for members while they are receiving DMC-ODS treatment services if not provided on-site. Providing a member the contact information for a treatment program is insufficient.

10) Residential Treatment Services. At a minimum, ASAM Levels 3.1, 3.3, and 3.5 shall be made available within the timeframes outlined in Exhibit A, Attachment 2C, Section 12.G.5 (mandatory).

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

12) Partial Hospitalization (Optional).

13) Medi-Cal Peer Support Services (Optional).

14) Contingency Management Services (Optional).

15) Inpatient Services ASAM Levels 3.7 and 4.0 (Optional for Contractor to cover as DMC-ODS services; care coordination for ASAM Levels 3.7 and 4.0 delivered through Medi-Cal Fee for Service and Managed Care Plans is required).

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

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

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DMC-ODS: SCOPE OF SERVICES

5. Access to Services

A. Access to State Plan services shall remain at the level prior to the implementation of DMC-ODS or expand upon implementation. The Contractor shall not deny access to medically necessary services, including all FDA-approved medications for OUD if a member meets the medical necessity criteria for DMC-ODS services. Members shall not be put on a wait list to access any medically necessary services. Only Medi-Cal members for whom the county of responsibility is a DMC-ODS county are entitled to DMC-ODS services. This applies to American Indian and Alaska Native (AI/AN) Medi-Cal members as well as non-AI/AN Medi-Cal members. (BHIN 21-032 and any subsequently issued BHINs that supersede BHIN 21-032).

B. The Contractor shall ensure that a member that resides in a county that does not participate in DMC-ODS does not experience a disruption of Narcotic Treatment Program (NTP) services. The Contractor shall require all contracted NTP providers to provide any medically necessary DMC NTP services covered by the California State Plan to members that reside in a county that does not participate in DMC-ODS. The Contractor shall require all contracted NTP providers that provide services to an out-of-county member to submit the claims for those services to the county in which the member resides (according to MEDS).

C. If a member moves to a new county and initiates an inter-county transfer, the new county shall be immediately responsible for DMC-ODS treatment services and can claim reimbursement from DHCS through the Short Doyle Medi-Cal System, as of the date of the inter-county transfer initiation, including during the inter-county transfer process and before the inter-county transfer is completed or finalized. Contractor shall comply with all requirements under BHIN 21-032, All County Welfare Director Letter #18-02, and any applicable requirements set forth in all subsequent guidance issued by DHCS.

6. Authorization of Services – Residential Programs

A. The Contractor shall implement residential treatment program standards that comply with the authorization of services requirements set forth in this Contract, including in Exhibit A, Attachment 6, and shall:

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

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

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

4) Length of stay for adults, ages 21 and over, and adolescents, under the age of 21, shall be determined by an LPHA and authorized by DMC-ODS plans as medically necessary.

5) Ensure that the length of residential services comply with the following:

   i. The goal for a statewide average length of stay for residential services of 30 days is not a quantitative treatment limitation or hard "cap" on individual stays.

   ii. Lengths of stay in residential treatment settings shall be determined by individualized clinical need, including consideration of EPSDT requirements and the needs of perinatal members.

   iii. The Contractor shall ensure that members receiving residential treatment are transitioned to another level of care when clinically appropriate based on treatment progress.

   iv. The Contractor shall adhere to the length of stay monitoring requirements set forth by DHCS and length of stay performance measures established by DHCS and reported by the external quality review organization.

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

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

7. Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (ASAM Level 0.5)

A. Members under the age of 21 who are screened and determined to be at risk of developing an SUD may receive any service component covered under the outpatient level of care as early intervention services. An SUD diagnosis is not required for early intervention services. This does not eliminate the requirement that all Medi-Cal claims, including DMC-ODS claims, include a CMS approved ICD-10 diagnosis code. In cases where services are provided due to a suspected SUD that has not yet been diagnosed, options are available in the CMS approved ICD-10-CM diagnosis code list.

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B. Early intervention services shall be provided under the outpatient treatment modality and shall be available as needed based on individual clinical need, even if the member under age 21 is not participating in the full array of outpatient treatment services.

C. A full assessment utilizing the ASAM criteria is not required for a DMC member under the age of 21 to receive early intervention services; an abbreviated ASAM screening tool may be used. If the member under 21 meets diagnostic criteria for SUD, a full ASAM assessment shall be performed, and the member shall receive a referral to the appropriate level of care indicated by the assessment.

D. Early intervention services may be delivered in a wide variety of settings, and can be provided in person, by telehealth, or by telephone.

E. Nothing in this section shall limit or modify the scope of the EPSDT mandate.

8. Outpatient Treatment Services (ASAM Level 1.0)

A. Outpatient treatment services (also known as Outpatient Drug Free or ODF) are provided to members when medically necessary. Contracted providers shall offer up to nine hours a week for adults, and up to six hours a week for adolescents. Services received by the individual member may exceed the maximum based on individual medical necessity. Outpatient Treatment Services may be provided in person, by telehealth, or by telephone.

B. Outpatient services consist of up to nine hours per week of medically necessary services for adults and up to six hours per week of services for adolescents. Group size is limited to no less than two (2) and no more than twelve (12) members.

C. Outpatient Treatment Services include: assessment, care coordination, counseling (individual and group), family therapy, medication services, MAT for OUD, MAT for AUD and non-opioid SUDs, patient education, recovery services, SUD crisis intervention services.

D. Beginning on January 1, 2025, Outpatient Treatment Services shall only be provided in facilities certified by DHCS in accordance with Health and Safety Code section 11832 et seq. and BHIN 23-058 and any subsequently issued BHINs that supersede BHIN 23-058.

E. The Contractor shall either offer medications for addiction treatment (MAT, also known as medication-assisted treatment) directly, or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for members while they are receiving outpatient treatment services if not provided on-site. Providing a member the contact information for a treatment program is insufficient).

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F. Outpatient services are provided in DHCS certified programs that also have DMC certification.

9. Intensive Outpatient Treatment Services (ASAM Level 2.1)

A. Intensive Outpatient Treatment Services are provided to members when medically necessary in a structured programming environment. Contracted providers shall offer a minimum of nine hours with a maximum of 19 hours a week for adults, and a minimum of six hours with a maximum of 19 hours a week for adolescents. Services received by an individual member may exceed the maximum based on individual medical necessity. Intensive Outpatient Treatment Services may be provided in person, by telehealth, or by telephone.

B. Group size is limited to no less than two (2) and no more than twelve (12) members.

C. Intensive Outpatient Treatment Services includes: assessment, care coordination, counseling (individual and group), family therapy, medication services, MAT for OUD, MAT for AUD and non-opioid SUDs, patient education, recovery services, and SUD crisis intervention services.

D. Beginning on January 1, 2025, Intensive Outpatient Treatment Services shall only be provided by facilities certified by DHCS in accordance with Health and Safety Code section 11832 et seq. and BHIN 23-058 and any subsequently issued BHINs that supersede BHIN 23-058.

E. The Contractor shall offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for members while they are receiving intensive outpatient treatment services if not provided on-site. Providing a member the contact information for a treatment program is insufficient).

F. Intensive outpatient services are provided in DHCS certified programs that also have DMC certification.

10. Partial Hospitalization (ASAM Level 2.5)

A. (Optional) – If Contractor agrees to provide Partial Hospitalization Services, as identified in Exhibit A, Attachment 2D, Contractor shall comply with the following requirements:

1) Partial Hospitalization Services are clinically intensive programming designed to address the treatment needs of members with severe SUD requiring more intensive treatment services than can be provided at lower levels of care.

2) Partial Hospitalization Services may be provided in person, by

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synchronous telehealth, or by telephone. Level 2.5 Partial Hospitalization Programs typically have direct access to psychiatric, medical, and laboratory services, and are to meet the identified needs that warrant daily monitoring or management, but that can be appropriately addressed in a structured outpatient setting.

3) The Contractor shall ensure:

   i. Partial Hospitalization Services are delivered to members when medically necessary in a clinically intensive programming environment (offering 20 or more hours of clinically intensive programming per week).

   ii. Partial hospitalization (ASAM Level 2.5) shall be available to members with unstable medical and psychiatric problems. A minimum of 20 or more hours of service per week shall be provided in Level 2.5.

4) Partial Hospitalization Services include the following services components: assessment, care coordination, counseling (individual and group), family therapy, medication services, MAT for OUD, MAT for AUD and non-opioid SUDs, patient education, recovery services, SUD crisis intervention services.

5) The Contractor shall either offer MAT directly, or have effective referral mechanisms to the most clinically appropriate MAT services in place (defined as facilitating access to MAT off-site for members while they are receiving withdrawal management services if not provided on-site. Providing a member the contact information for a treatment program is insufficient).

11. Residential Treatment (ASAM Level 3.1-3.5); And Inpatient Services (ASAM 3.7-4.0)

A. Residential Treatment Services are delivered to members when medically necessary in a short-term residential program corresponding to at least one of the following levels:

1) Level 3.1 - Clinically Managed Low-Intensity Residential Services.

2) Level 3.3 - Clinically Managed Population-Specific High Intensity Residential Services.

3) Level 3.5 - Clinically Managed High Intensity Residential Services.

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B. Inpatient Treatment Services are delivered to members when medically necessary in a short-term inpatient program corresponding to at least one of the following levels:

    1) Level 3.7 - Medically Monitored Intensive Inpatient Services.

    2) Level 4.0 - Medically Managed Intensive Inpatient Services.

C. Residential services shall only be provided by residential facilities that have all of the following:

    1) A DHCS or DSS license;

    2) DMC certification; and

    3) DHCS designation or ASAM certification to provide at least one level of care (Level 3.1 - 3.5).

D. All Residential and Inpatient Treatment services shall be provided to a member while in a residential or inpatient treatment facility may be provided in person, by telehealth, or telephone. Telehealth and telephone services, when provided, shall supplement, not replace, the in-person services and the in-person treatment milieu; most services in a residential or inpatient facility shall be in-person.

E. A member receiving residential services or inpatient services pursuant to DMC-ODS, regardless of the length of stay, is a “short-term resident” of the residential or inpatient facility in which they are receiving the services. These services are intended to be individualized to treat the functional deficits identified in the ASAM Criteria. Each member shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems.

F. The Contractor shall either offer MAT directly, or have effective referral mechanisms in place to clinically appropriate MAT services (defined as facilitating access to MAT off-site for members while they are receiving residential treatment services if not provided on-site. Providing a member the contact information for a treatment program is insufficient).

G. Residential Treatment Services

    1) Residential Treatment Services for adults in ASAM Levels 3.1-3.5 are provided by DMC-certified providers who must be licensed and enrolled in accordance with all applicable state and federal laws and regulations. This includes:

        i. Residential facilities licensed by DHCS.

        ii. Residential facilities licensed by the Department of Social Services.

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iii. Chemical Dependency Recovery Hospitals (CDRHs) licensed by the Department of Public Health (DPH).

iv. Freestanding Acute Psychiatric Hospitals (FAPHs) licensed by DPH.

2) The Contractor shall ensure all providers delivering Residential Treatment services under DMC-ODS shall also be designated as capable of delivering care consistent with the ASAM Criteria. Residential treatment providers licensed by DHCS offering ASAM levels 3.1 - 3.5 shall also have a DHCS Level of Care (LOC) Designation and/or an ASAM LOC Certification that indicates that the program is capable of delivering care consistent with the ASAM Criteria.

3) To participate in the DMC-ODS program and offer ASAM Levels of Care 3.1 - 3.5, residential providers licensed by a state agency other than DHCS shall be DMC-certified. In addition, facilities licensed by a state agency other than DHCS shall have an ASAM LOC Certification for each level of care provided by the facility under the DMC-ODS program by January 1, 2024. The Contractor shall be responsible for ensuring and verifying that DMC-ODS providers delivering ASAM Levels of care 3.1 - 3.5 obtain an ASAM LOC Certification for each level of care provided effective January 1, 2024.

4) Residential Treatment services can be provided in facilities of any size. Contractor shall comply with the length of stay requirements set forth in Exhibit A, Attachment 2C, Section 6.A.

5) The Contractor shall implement coverage and ensure access for residential SUD treatment services as follows:

i. Upon implementation, the Contractor shall provide in-network access to ASAM 3.1, and the Contractor's network for that level of care shall comply with applicable network adequacy, and time or distance standards.

ii. Within two years of implementation, the Contractor shall provide in-network access to ASAM Level 3.5, and the Contractor's network for that level of care shall comply with applicable network adequacy, and time or distance standards.

iii. Within three years of implementation, the Contractor shall provide in-network access to ASAM Levels 3.3.

6) [Reserved]

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7) Residential Treatment Services include: assessment, care coordination, counseling (individual and group), family therapy, medication services, MAT for OUD, MAT for AUD and non-opioid SUDs, patient education, recovery services, and SUD crisis intervention services.

8) [Reserved]

9) Residential providers may apply to provide Incidental Medical Services pursuant to DHCS guidance.

H. Inpatient Services

1) The Contractor may voluntarily cover and receive reimbursement through the DMC-ODS program for inpatient ASAM Levels 3.7 and 4.0 delivered in general acute care hospitals, FAPHs, or CDRHs. Regardless of whether the Contractor covers ASAM Levels 3.7 or 4.0, the Contractor implementation plan shall describe referral mechanisms and care coordination for ASAM Levels 3.7 and 4.0. DHCS All-Plan Letter 18-001 clarifies coverage of voluntary inpatient detoxification through the Medi-Cal FFS program.

2) In order to participate in the DMC-ODS program and offer ASAM Levels of Care 3.7 and 4.0, inpatient providers licensed by a state agency other than DHCS must be DMC-certified.

3) Inpatient Treatment Services include the following services: assessment, care coordination, counseling (individual and group), family therapy, medication services, MAT for OUD, MAT for AUD and other non-opioid SUDs, patient education, recovery services, and SUD crisis intervention services.

12. Withdrawal Management

A. Withdrawal Management Services are provided to members experiencing withdrawal in the following outpatient, residential, or inpatient settings:

1) Level 1-WM: Ambulatory withdrawal management without extended on-site monitoring (Mild withdrawal with daily or less than daily outpatient supervision).

2) Level 2-WM: Ambulatory withdrawal management with extended on-site monitoring (Moderate withdrawal with daytime withdrawal management and support and supervision in a non-residential setting).

3) Level 3.2-WM: Clinically managed residential withdrawal management (24-hour support for moderate withdrawal symptoms that are not manageable in outpatient setting).

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4) Level 3.7-WM: Medically Managed Inpatient Withdrawal Management (24-hour care for severe withdrawal symptoms requiring 24-hour nursing care and physician visits).

5) Level 4-WM: Medically managed intensive inpatient withdrawal management (Severe, unstable withdrawal requiring 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability).

B. Withdrawal management services are urgent and provided on a short-term basis. When provided as part of withdrawal management services, service activities, such as the assessment, shall focus on the stabilization and management of psychological and physiological symptoms associated with withdrawal, engagement in care and effective transitions to a level of care where comprehensive treatment services are provided.

C. A full ASAM Criteria assessment shall not be required as a condition of admission to a facility providing Withdrawal Management. To facilitate an appropriate care transition, a full ASAM assessment, brief screening, or other tool to support referral to additional services is appropriate. If it has not already been completed in relation to the Withdrawal Management episode, the full ASAM Criteria assessment shall be completed within 30 days of the member's first visit with an LPHA or registered/certified counselor for non-Withdrawal Management services (or 60 days for members under 21, or members experiencing homelessness), as described above.

D. The Contractor shall provide, at a minimum, one of the five levels of withdrawal management (WM) services according to the ASAM Criteria, when determined by a Medical Director or LPHA as medically necessary.

E. The Contractor shall ensure that all members receiving withdrawal management services are provided in an outpatient, residential or inpatient setting. If member is receiving withdrawal management in a residential or inpatient setting, each member shall reside at the facility. All members receiving Withdrawal Management services, regardless in which type of setting, shall be monitored during the detoxification process.

1) The Contractor shall ensure observation be conducted at the frequency required by applicable state and federal laws, regulations, and standards. This may include but is not limited to observation of the member's health status.

F. Withdrawal Management Services include the following service components: assessment, care coordination, medication services, MAT for OUD, MAT for AUD and non-opioid SUDs, observation, and recovery services.

Exhibit A – Attachment 2C
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G. The Contractor shall either offer MAT directly or have effective referral mechanisms to the most clinically appropriate MAT services in place (defined as facilitating access to MAT off-site for members while they are receiving withdrawal management services if not provided on-site). Providing a member the contact information for a treatment program is insufficient.

13. Narcotic Treatment Program

A. Narcotic Treatment Program (NTP) is an outpatient program that provides Food and Drug Administration (FDA)-approved medications and biological products to treat SUDs when ordered by a physician as medically necessary. NTPs shall administer, dispense, or prescribe medications to members covered under the DMC-ODS formulary including methadone, buprenorphine (transmucosal and long-acting injectable), naltrexone (oral and long-acting injectable), naloxone and disulfiram.

1) If an NTP is unable to directly administer or dispense medically necessary medications covered under the DMC-ODS formulary, the NTP shall prescribe the medication for dispensing at a pharmacy or refer the member to a provider capable of dispensing the medication.

B. NTPs shall comply with all federal and state NTP licensing requirements.

1) If the NTP cannot comply with all federal and state NTP requirements, then the NTP must assist the member in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement.

C. The NTP shall offer the member a minimum of fifty minutes of counseling services per calendar month.

D. NTP services shall be provided in DHCS-licensed NTP facilities pursuant to Chapter 4 of Division 4 of Title 9 of the C.C.R., and 42 C.F.R. Part 8. Counseling services provided in the NTP modality can be provided in person, by telehealth, or by telephone. However, the medical evaluation for methadone treatment (which consists of a medical history, laboratory tests, and a physical exam) shall be is conducted in person.

E. NTP Services include the following service components: Assessment; care coordination; counseling; family therapy; medical psychotherapy; medication services; MAT for OUD; MAT for AUD and non-opioid SUDs; patient education; recovery services and SUD crisis intervention services.

Exhibit A – Attachment 2C
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F. Pursuant to W&I Code § 14124.22, an NTP provider who is also enrolled as a Medi-Cal provider may provide medically necessary treatment of concurrent health conditions to Medi-Cal members who are not enrolled in managed care plans as long as those services are within the scope of the provider's practice. NTP providers shall refer all Medi-Cal members that are enrolled in managed care plans to their respective managed care plan to receive medically necessary medical treatment of their concurrent health conditions.

G. The diagnosis and treatment of concurrent health conditions of Medi-Cal members that are not enrolled in managed care plans by an NTP provider may be provided within the Medi-Cal coverage limits. When the services are not part of the SUD treatment reimbursed pursuant to W&I Code § 14021.51, the services rendered shall be reimbursed in accordance with the Medi-Cal program. Services reimbursable under this section shall include all the following:

1) Medical treatment visits.
2) Diagnostic blood, urine, and X-rays.
3) Psychological and psychiatric tests and services.
4) Quantitative blood and urine toxicology assays.
5) Medical supplies.

H. An NTP provider who is enrolled as a Medi-Cal fee-for-service provider shall not seek reimbursement from a member for SUD treatment services, if the NTP provider bills the services for treatment of concurrent health conditions to the Medi-Cal fee-for-service program.

I. The Contractor shall contract with licensed NTPs to offer services to members as medically necessary.

J. Services shall be provided in accordance with an individualized member plan determined by a licensed prescriber.

14. Recovery Services

A. Members may receive Recovery Services based on self-assessment or provider assessment of relapse risk. Members do not need to be diagnosed as being in remission to access Recovery Services. Members may receive Recovery Services while receiving MAT services, including NTP services. Members may receive Recovery Services immediately after incarceration with a prior diagnosis of SUD.

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B. Recovery Services can be delivered and claimed as a standalone service, concurrently with the other levels of care of a covered DMC-ODS service, or as a service delivered as part of these levels of care.

C. Recovery services include: assessment, care coordination, counseling (individual and group), family therapy, recovery monitoring (which includes recovery coaching and monitoring designed for the maximum reduction of the member's SUD) and relapse prevention (which includes interventions designed to teach members with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the member's SUD).

D. Recovery Services may be provided in person, by telehealth, or by telephone.

15. Medi-Cal Peer Support Services (Optional)

A. If Contractor agrees to provide Medi-Cal Peer Support Services and has been approved to do so by DHCS, the Contractor shall comply with the Medi-Cal Peer Support Services provisions in Exhibit A, Attachment 2D, Section 5.

16. Contingency Management Services (Optional)

A. If Contractor agrees to provide Contingency Management Services and has been approved by DHCS, then the Contractor shall comply with the Contingency Management Services provisions in Exhibit A, Attachment 2D, Section 6.

17. Care Coordination

A. Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the member with linkages to services and supports designed to restore the member to their best possible functional level. Care Coordination can be provided in clinical or non-clinical settings and can be provided in person, by telehealth, or by telephone.

B. Care coordination shall be provided to a member in conjunction with all levels of treatment. Care coordination may also be delivered and claimed as a standalone service. Through executed memoranda of understanding, the Contractor shall implement care coordination services with other SUD, physical, and/or mental health services in order to ensure a member-centered and whole-person approach to wellness.

C. Care coordination services shall be provided by an AOD Counselor, Clinical Trainee, LPHA, or Medical Assistant.

D. Care coordination services shall include one or more of the following components:

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1) Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.

2) Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.

3) Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.

18. Clinical Consultation Services

E. Clinician Consultation Services consist of LPHAs, such as addiction medicine physicians, licensed clinicians, addiction psychiatrists, or clinical pharmacists, to support the provision of care.

F. Clinician Consultation is not a direct service provided to members. Clinician Consultation is designed to support DMC-ODS licensed clinicians with complex cases and may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. It includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific DMC-ODS members.

G. The Contractor may contract with one or more physicians, clinicians, or pharmacists specializing in addiction in order to provide consultation services. These consultations can occur in person, by telehealth, by telephone, or by asynchronous telecommunication systems.

H. The Contractor shall only allow DMC-certified providers to bill for clinician consultation services.

19. Medications for Addiction Treatment (also known as Medication Assisted Treatment or MAT)

A. MAT includes all FDA-approved drugs and biological products to treat Alcohol Use Disorder (AUD), Opioid Use Disorder (OUD), and any SUD. MAT may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered as part of a level of care listed in Exhibit A, Attachment 2C, Section 4.

B. When MAT is being provided as a standalone service, MAT includes the following components: assessment; care coordination; counseling (individual and

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group counseling); family therapy; medication services; patient education; prescribing and monitoring for MAT for OUD and AUD and non-opioid SUDs which is prescribing, administering, dispensing, ordering, monitoring, and/or managing the medications used for MAT for OUD, AUD and non-opioid SUDs; recovery services; SUD crisis intervention services; and withdrawal management services.

C. The Contractor shall require that all DMC-ODS network providers, at all levels of care, demonstrate that they either directly offer or have an effective referral mechanisms/process to MAT to members with SUD diagnoses that are treatable with Food and Drug administration (FDA)-approved medications and biological products. An effective referral mechanism/process is defined as facilitating access to MAT off-site for members while they are receiving treatment services if not provided on-site. Providing a member the contact information for a treatment program is insufficient. A facilitated referral to any Medi-Cal provider rendering MAT to the member is compliant whether or not they seek reimbursement through DMC-ODS. Members needing or utilizing MAT shall be served and cannot be denied treatment services or be required to be tapered off medications as a condition of entering or remaining in the program. The Contractor shall monitor the referral process or provision of MAT services.

D. The Contractor has the option to cover drug product costs for MAT when the medications are purchased and administered or dispensed outside of the pharmacy or NTP benefit (in other words, purchased by providers and administered or dispensed on site or in the community, and billed to the county DMC-ODS plan). If the Contractor makes this election, the Contractor may reimburse providers for the medications, including naloxone, trans-mucosal buprenorphine, and/or long-acting injectable medications (such as buprenorphine or naltrexone), administered in DMC facilities, and non-clinical or community settings. However, even if the Contractor does not choose to cover the drug product costs for MAT outside of the pharmacy or NTP benefit, the Contractor shall still be required to reimburse for MAT services even when provided by DMC-ODS providers in non-clinical settings and when provided as a standalone service.

E. All medications and biological products utilized to treat SUDs, including long-acting injectables, continue to be available through the Medi-Cal pharmacy benefit without prior authorization, and can be delivered to provider offices by pharmacies.

F. Members needing or utilizing MAT shall be served and cannot be denied treatment services or be required to decrease dosage or be tapered off medications as a condition of entering or remaining in the program. DMC-ODS providers offering MAT shall not deny access to medication or administratively

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discharge a member who declines counseling services. For patients with lack of connection to psychosocial services, more rigorous attempts at engagement in care may be indicated, such as using different evidence-based practices, different modalities (e.g., telehealth), different staff, and/or different services (e.g., Medi-Cal Peer Support Services). If the DMC-ODS provider is not capable of continuing to treat the member, the DMC-ODS provider shall assist the member in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement.

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

A. Upon receiving approval from DHCS, the Contractor shall provide or arrange for the provision of, qualifying mobile crisis services in accordance with BHIN 23-025, and any subsequently issued BHINs that supersede BHIN 23-025, DHCS-approved implementation plan, and the Mobile Crisis Services provisions in Exhibit A, Attachment 2D.

21. Training

B. The Contractor shall ensure their staff, including contracted staff providing or administering the DMC-ODS program are trained on the compliance requirements of applicable statutes, regulations, and BHINs.

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

D. Training for DMC-ODS network providers:

1) The Contractor shall ensure that all network providers receive annual training on the DMC-ODS requirements and shall maintain training records. The Contractor shall require network providers to be trained in the ASAM Criteria prior to providing services.

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

Exhibit A – Attachment 2C
DMC-ODS: SCOPE OF SERVICES

3) The Contractor shall ensure that all residential service providers meet the established ASAM criteria for each level of residential care they provide, receive either a DHCS Level of Care Designation or an ASAM Level of Care Certification for every Level of Care that they offer prior to providing DMC-ODS services, and adhere to all applicable requirements in BHIN 21-001 and its accompanying exhibits and any subsequently issued BHINs that supersede BHIN 21-001.

4) The Contractor shall ensure that all personnel who provide WM services or who monitor or supervise the provision of such service shall meet additional training requirements set forth in BHIN 21-001 and its accompanying exhibits and any subsequently issued BHINs that supersede BHIN 21-001.

22. Requirements for Services

A. Confidentiality.

1) All SUD treatment services shall be provided in a confidential setting in compliance with 42 C.F.R., Part 2 requirements.

B. Perinatal Services.

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

2) Perinatal services shall include:

a. Parent/child habilitative and rehabilitative services (i.e., development of parenting skills, training in child development, which may include the provision of cooperative childcare pursuant to Health & Safety Code § 1596.792).

b. Service access (i.e., provision of or arrangement for transportation to and from medically necessary treatment).

c. Education to reduce harmful effects of alcohol and drugs on the parent and fetus or the parent and infant.

d. Coordination of ancillary services (i.e., assistance in accessing and completing dental services, social services, community services, educational/vocational training and other services which are medically necessary to prevent risk to fetus or infant).

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3) Medical documentation that substantiates the member's pregnancy and the last day of pregnancy shall be maintained in the member record.

4) Contractor shall comply with the perinatal program requirements as outlined in the Perinatal Practice Guidelines. The Perinatal Practice Guidelines are attached to this Contract (Document 1G). The Contractor shall comply with the current version of these guidelines until new Perinatal Practice Guidelines are established and adopted. The incorporation of any new Perinatal Practice Guidelines into this Contract shall not require a formal amendment.

C. Substance Use Disorder Medical Director.

1) The SUD Medical Director's responsibilities shall, at a minimum, include all of the following:

a. Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.

b. Ensure that physicians do not delegate their duties to non-physician personnel.

c. Develop and implement written medical policies and standards for the provider.

d. Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.

e. Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.

f. Ensure that provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for members, and determine services are medically necessary.

g. Ensure that provider's physicians are adequately trained to perform other physician duties, as outlined in this section.

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

D. Network Provider Personnel.

Exhibit A – Attachment 2C
DMC-ODS: SCOPE OF SERVICES

1) Personnel files shall be maintained on all employees, contracted positions, volunteers, and interns, and shall contain the following:
    a. Application for employment and/or resume.
    b. Signed employment confirmation statement/duty statement.
    c. Job description.
    d. Performance evaluations.
    e. Health records/status as required by the provider, AOD Certification or Title 9 of the California Code of Regulations.
    f. Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries).
    g. Training documentation relative to substance use disorders and treatment.
    h. Current registration, certification, intern status, or licensure.
    i. Proof of continuing education required by licensing or certifying agency and program.
    j. Provider's Code of Conduct.
    k. Documentation of completion of personnel requirements set forth in BHIN 21-001 and any subsequently issued BHINs that supersede BHIN 21-001 for personnel providing detoxification checks.
2) Job descriptions shall be developed, revised as needed, and approved by the provider's governing body. The job descriptions shall include:
    a. Position title and classification.
    b. Duties and responsibilities.
    c. Lines of supervision.
    d. Education, training, work experience, and other qualifications for the position.
3) Written provider code of conduct for employees and volunteers/interns shall be established which addresses at least the following:
    a. Use of drugs and/or alcohol.

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b. Prohibition of social/business relationship with members or their family members for personal gain.

c. Prohibition of sexual contact with members.

d. Conflict of interest.

e. Providing services beyond scope.

f. Discrimination against members or staff.

g. Verbally, physically, or sexually harassing, threatening or abusing members, family members or other staff.

h. Protection of member confidentiality.

i. Cooperate with complaint investigations.

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

a. Recruitment.

b. Screening and Selection.

c. Training and orientation.

d. Duties and assignments.

e. Scope of practice.

f. Supervision.

g. Evaluation.

h. Protection of member confidentiality.

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

Exhibit A – Attachment 2C
DMC-ODS: SCOPE OF SERVICES

23. 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 (Heath & Safety Code § 11999-11999.3). By signing this Contract, Contractor agrees that it shall enforce, and shall require its subcontractors and contracted providers to enforce, these requirements.

24. 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 § 202 of the Controlled Substances Act (21 U.S.C. § 812).

25. DMC-ODS Reference Documents

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

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

B. Document 1G: Perinatal Practice Guidelines

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

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

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

F. Document 1V: Youth Treatment Guidelines

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

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

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

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

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

Exhibit A – Attachment 2C
DMC-ODS: SCOPE OF SERVICES

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

M. 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

N. 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

O. Document 3J: CalOMS Treatment Data Collection Guide

P. Document 3S: CalOMS Treatment Data Compliance Standards

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

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

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

T. Document 5A: Confidentiality Agreement

Exhibit A – Attachment 2D
DMC-ODS: CONTRACTOR-SPECIFIC REQUIREMENTS

In addition to the general requirements outlined in Exhibit A, Attachment I, the Contractor agrees to the following Contractor specific requirements:

1. Covered Services

A. The Contractor shall provide or arrange for the provision of the following medically necessary DMC-ODS Covered Services, as they are outlined in Exhibit A, Attachment 2C, Section 4, in the Contractor's service area, and in compliance with all State and federal statutes and regulations, the terms of this Contract, BHINs, and any other applicable authorities.

1) Alcohol and Drug Screening, Assessment, Brief Intervention, Referral to Treatment and Early Intervention Services (ASAM Level 0.5).

2) Outpatient Treatment Services (ASAM Level 1.0).

3) Intensive Outpatient Treatment Services (ASAM Level 2.1).

4) Partial Hospitalization (ASAM Level 2.5).

5) Residential Treatment Services (ASAM Levels 3.1 – 3.5).

   i. ASAM Levels 3.1, 3.3, and 3.5 shall be made available within the timeframes outlined in Attachment 2C, Section 12.G.5.

6) Withdrawal Management (ASAM 1.0, 2.0, 3.2, 3.7, 4.0-WM).

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

8) Recovery Services.

9) Medi-Cal Peer Support Services.

10) Care Coordination.

11) Clinician Consultation Services.

12) Medications for Addiction Treatment (also known as Medication Assisted Treatment or MAT).

13) Contingency Management Services

14) Mobile Crisis Services

2. Access to Services

In addition to the general access to services requirements outlined elsewhere in this Contract, the Contractor shall comply with the following DMC-ODS specific access to services requirements:

Exhibit A – Attachment 2D
DMC-ODS: CONTRACTOR-SPECIFIC REQUIREMENTS

A. MAL point of entry. The Contractor shall allow the member point of entry through the Member Access Line (MAL), as described in Exhibit A, Attachment 7, Section 8.

1) MAL Point of Entry. The Contractor shall screen members over the phone to determine whether there is sufficient information to make a referral to the appropriate level of care.

2) In the event the referral cannot be determined through the MAL, the Contractor's MAL shall refer and coordinate the member to a DMC-ODS network provider for a determination.

i. Members screened as having an urgent need (non-emergency) will be referred for an appointment with a qualified staff within 48 hours.

ii. The MAL shall be staffed by registered or certified alcohol or other drug counselors or LPHAs during normal business hours.

iii. The Contractor shall provide eligible, non-urgent members an appointment with the appropriate LOC provider within 10 business days from the initial referral.

B. Network provider point of entry. The Contractor shall allow members to appear in person at any DMC-ODS network provider.

1) DMC-ODS network providers shall ensure members receive in-person screening, assessment, and referral at appropriate network DMC-ODS provider sites.

2) DMC-ODS network providers shall accept referrals from:

i. The MAL

ii. County behavioral health site(s)

iii. DMC-ODS contracted providers

iv. Community Partners

3) The DMC-ODS network provider site(s) shall be staffed by AOD counselors or LPHAs.

4) The Contractor shall ensure the ASAM Criteria level of care determination is used to obtain relevant information to identify initial treatment needs to link members to the most appropriate LOC.

Exhibit A – Attachment 2D
DMC-ODS: CONTRACTOR-SPECIFIC REQUIREMENTS

i. The member may choose to receive DMC-ODS services at the initial DMC-ODS provider or choose to be referred to another appropriate DMC-ODS provider offering the initial LOC determined by the ASAM screening.

ii. In all cases, DMC-ODS provider staff shall consider geographic location, language needs and individual preference when making placement and referrals.

iii. Upon first contact, Contractor-operated and contracted DMC-ODS providers shall inform members of the benefits to which they are entitled.

iv. If the member appears in person, the DMC-ODS network provider shall allow members to receive same-day screenings, assessments, and referral, if available. In the event the member's ASAM screening determines the need for a LOC not offered by the DMC-ODS provider, the provider shall provide:

   a. The member a warm hand-off to an appropriate DMC-ODS provider.

   b. The completed ASAM tool to the appropriate DMC-ODS provider.

3. Coordination of Care

In addition to the general coordination and continuity of care requirements outlined in Exhibit A, Attachment 2C, Section 5, the Contractor shall comply with the following DMC-ODS specific coordination and continuity of care requirements:

A. Transitions to Other Levels of Care

1) Care coordinators shall ensure the transition of members to the appropriate LOC. This may include step-up or step-down in covered DMC-ODS services. Care coordinators shall provide warm hand-offs and transportation to the new LOC when medically necessary.

2) Care coordinators shall ensure transitions to other LOCs occur no later than 10 business days from the time of assessment or reassessment with no interruption of current treatment services.

3) The initial treating provider shall be responsible for arranging care coordination services and communicating with the next provider to ensure smooth transitions between LOCs.

Exhibit A – Attachment 2D
DMC-ODS: CONTRACTOR-SPECIFIC REQUIREMENTS

4) The Contractor shall manage a member's transition of care to a DMC-ODS provider when that member has received, and no longer requires, inpatient SUD services (ASAM level 3.7 and 4.0 services) in an acute care hospital, or another Fee for Service (FFS) facility, when the county-operated or DMC-ODS contracted provider is notified by the facility.

5) The Contractor shall manage a member's transition of care to a DMC-ODS provider when that member has received, and no longer requires, inpatient SUD services (ASAM level 3.7 and 4.0 services) in a contracted Chemical Dependency Recovery Hospital (CDRH) or Acute Freestanding Psychiatric hospital.

4. Inpatient Services

For Inpatient Services (ASAM Level 3.7 and ASAM 4.0) the Contractor shall coordinate care with managed care plans, who are responsible for managing and authorizing the inpatient benefit. In all instances, the Contractor shall ensure 42 C.F.R. Part 2 compliant releases are in place to coordinate care with inpatient facilities.

5. Medi-Cal Peer Support Services

A. The Contractor shall provide, or arrange, and pay for Peer Support Services to Medi-Cal members. Contractor's provision of Peer Support Services shall conform to the requirements of Supplement 3 to Attachment 3.1-A and Supplement 3 to Attachment 3.1-B of the California State Plan and applicable DHCS BHINs.

B. Contractor's implementation of a Medi-Cal Peer Support Specialist Certification Program shall conform to the applicable requirements of Behavioral Health Information Notice (BHIN) 21-041 and to the requirements in any subsequent BHINs issued by the Department pursuant to W&I Code section 14045.21.

C. Voluntary Participation and Funding

1) The Contractor shall fund the nonfederal share of any applicable expenditures. (W&I Code § 14045.19(b)(2)) The Contractor's provision of Peer Support Services and the Contractor's participation in the Peer Support Specialist Certification Program shall not constitute a mandate of a new program or higher level of service that has an overall effect of increasing the costs mandated by the 2011 realignment legislation. (W&I Code § 14045.19(b)(3))

D. Provision of Medi-Cal Peer Support Services

1) Medi-Cal Peer Support Services may be provided face-to-face, by telephone or by telehealth with the member or significant support person(s) and may be provided anywhere in the community.

Exhibit A – Attachment 2D
DMC-ODS: CONTRACTOR-SPECIFIC REQUIREMENTS

2) Medi-Cal Peer Support Services may be provided in conjunction with other services or levels of care described in Covered Services, including inpatient and residential services, but shall be billed separately. Based on clinical judgment, the member may not present during the delivery of Peer Support Services, but remains the focus of the service.

E. Medi-Cal Peer Support Specialists

1) Contractor shall ensure that Medi-Cal Peer Support Services are provided by certified Medi-Cal Peer Support Specialists as established in BHIN 21-041 and any subsequently issued BHINs that supersede BHIN 21-041.

F. Behavioral Health Professional and Medi-Cal Peer Support Specialist Supervisors

1) The Contractor shall ensure that Peer Support Specialists provide services under the direction of a Behavioral Health Professional.

G. A Behavioral Health Professional must be licensed, waivered, or registered in accordance with applicable State of California licensure requirements and listed in the California Medicaid State Plan as a qualified provider of DMC-ODS.

1) Peer Support Specialists may also be supervised by Peer Support Specialist Supervisors, as established in BHIN 21-041 and any subsequently issued BHINs that supersede BHIN 21-041.

H. Practice Guidelines

1) Counties shall require Peer Support Specialists to adhere to the practice guidelines developed by the Substance Abuse and Mental Health Services Administration, *What are Peer Recovery Support Services* (Center for Substance Abuse Treatment, *What are Peer Recovery Support Services?* HHS Publication No. (SMA) 09-4454. Rockville, MD: Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, www.samhsa.gov/resource/ebp/what-are-peer-recovery-support-services).

I. Contractor shall oversee and enforce the certification standards and requirements set forth in Article 1.4 of Chapter 7, Part 3, of Division 9 of the W&I Code and departmental guidance, including BHIN 21-041 and any subsequently issued BHINs that supersede BHIN 21-041. Contractor shall ensure that the Medi-Cal Peer Support Specialist Certification Program:

1) Submits to the department a Medi-Cal Peer Support Specialist Program plan in accordance with Enclosure 2 of BHIN 21-041 and any subsequently issued BHINs that supersede BHIN 21-041 describing how the peer support specialist program will meet all of the federal and state

Exhibit A – Attachment 2D
DMC-ODS: CONTRACTOR-SPECIFIC REQUIREMENTS

requirements for the certification and oversight of peer support specialists.

2) Participates in periodic reviews conducted by the department to ensure adherence to all federal and state requirements.

3) Submits annual peer support specialist program reports to the department in accordance with Enclosure 5 of BHIN 21-041 and any subsequently issued BHINs that supersede BHIN 21-041.Reports shall cover the fiscal year and shall be submitted by the following December 31st.

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

A. Mobile Crisis Services provide rapid response, individual assessment and community-based stabilization to Medi-Cal members who are experiencing a behavioral health crisis.

B. Mobile Crisis Services are designed to provide relief to members experiencing:

1) A behavioral health crisis, including through de-escalation and stabilization techniques.

2) Reduce the immediate risk of danger and subsequent harm.

3) Avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement.

C. Mobile Crisis Services shall include:

1) Warm handoffs to appropriate settings and providers when the member requires additional stabilization and/or treatment services.

2) Coordination with and referrals to appropriate health, social and other services and supports, as needed.

3) Short-term follow-up support to help ensure the crisis is resolved and the member is connected to ongoing care.

D. Mobile Crisis Services are directed toward the member in crisis but may include contact with a family member(s) or other significant support collateral(s) if the purpose of the collateral's participation is to assist the member in addressing their behavioral health crisis and restoring the member to the highest possible functional level.

E. Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the member is experiencing the behavioral health crisis. Locations may include, but are not limited to, the member's home, school, or workplace, on the street, or where a member socializes.

Exhibit A – Attachment 2D
DMC-ODS: CONTRACTOR-SPECIFIC REQUIREMENTS

F. Mobile Crisis Services claimed under this option cannot be provided in hospitals or other facility settings.

G. Mobile crisis services shall be available to members experiencing behavioral health crises 24 hours a day, 7 days a week, and 365 days a year.

7. Contingency Management Services

Upon receiving a written notification of readiness from the Department, the Contractor shall provide, or arrange for the provision of, Contingency Management Services in accordance with the requirements set forth in the Contingency Management BHIN 22-056 and any superseding BHINs issued pursuant to W&I Code § 14184.102(d).

Exhibit A – Attachment 2E
[RESERVED]

Exhibit A – Attachment 2F
[RESERVED]

Exhibit A – Attachment 3
FINANCIAL REQUIREMENTS

1. Provider Compensation

The Department shall ensure that no payment is made to a contracted provider other than by the Contractor for services covered under this Contract except when these payments are specifically required to be made by the Department in Title XIX of the Act or in 42 C.F.R. chapter IV. (42 C.F.R. § 438.60.)

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

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

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

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

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

C. To initiate payment, Contractor shall require IHCPs to submit claims in accordance with Contractor's claiming requirements. The rate on the AI submitted claim shall reflect the rate the IHCP should be paid for the service in accordance with the authorities cited in Exhibit A, Attachment 3, Section 2.B. However, if the rate claimed is incorrect for any reason, the amount due to the IHCP from Contractor shall be consistent with the authorities cited in Exhibit A, Attachment 3, Section 2.B.

3. Prohibited Payments

A. FFP is not available for any payment amount for services furnished by an excluded individual or entity, or at the direction of a physician during the period such physician is excluded when the person providing the service knew or had reason to know of the exclusion, or to an individual or entity

Exhibit A – Attachment 3
FINANCIAL REQUIREMENTS

when the Department failed to suspend payments during an investigation of a credible allegation of fraud. (42 U.S.C. § 1396b(i)(2).)

B. In accordance with 42 U.S.C. § 1396b (i), the Contractor is prohibited from paying for an item or service:

1) Furnished under this Contract by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to §1320a-7, 1320a-7a, 1320c-5, or 1395u(h)(2) of title 42.

2) Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or pursuant to section 1320a-7, 1320a-7a, 1320c-5, or 1395u(h)(2) of title 42 and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

3) Furnished by an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments.

4) With respect to any services or activities furnished for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

4. [Reserved]

5. Audit Requirements

The Contractor shall submit audited financial reports specific to this Contract on an annual basis. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards. (42 C.F.R. § 438.3(m).)

6. Recovery of Overpayments

A. The Contractor, and any subcontractor or any network provider of the Contractor, shall report to the Department within 60 calendar days when it has identified payments in excess of amounts specified for reimbursement of Medicaid services. (42 C.F.R. § 438.608(c)(3).)

B. The Contractor, or subcontractor, to the extent that the subcontractor is delegated responsibility for coverage of services and payment of claims

Exhibit A – Attachment 3
FINANCIAL REQUIREMENTS

under this Contract, shall implement and maintain arrangements or procedures that include provision for the suspension of payments to a network provider for which the State, or the Contractor, determines there is a credible allegation of fraud. (42 C.F.R. §§ 438.608(a)(8) and 455.23.)

C. The Contractor shall specify the retention policies for the treatment of recoveries of all overpayments from the Contractor to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse. The policy shall specify the process, timeframes, and documentation required for reporting the recovery of all overpayments. The Contractor shall require its network providers to return any overpayment to the Contractor within 60 calendar days after the date on which the overpayment was identified, including requiring the network provider to provide written notification of the reason for the overpayment to the Contractor. The Contractor shall also specify the process, timeframes, and documentation required for payment of recoveries of overpayments to the Department in situations where the Contractor is not permitted to retain some or all of the recoveries of overpayments. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations. Contractor shall comply with the reporting requirements, and other requirements, in BHIN 19-034. (42 C.F.R. § 438.608(d).) The Contractor shall annually report to the Department on their recoveries of overpayments. (42 C.F.R. §§ 438.604(a)(7) and 438.608(d).)

7. Physician Incentive Plans

A. The Contractor shall obtain approval from the Department prior to implementing a Physician Incentive Plan between the Contractor and a contracted provider (9 C.C.R. § 1810.438(h).).

1) Pursuant to 42 Code of Federal Regulations part 438.3(i), the Contractor shall comply with the requirements set forth in 42 C.F.R. sections 422.208 and 422.210.

2) Contractor shall not make payment, directly or indirectly, to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to a member. (42 C.F.R. § 422.208(c)(1).)

3) If a physician or physician group is put at substantial financial risk for services not provided by the physician/group, the Contractor shall ensure adequate stop-loss protection for the physician or physician group and conduct annual member surveys. (42 C.F.R. § 422.208(c)(2).)

Exhibit A – Attachment 3
FINANCIAL REQUIREMENTS

4) The Contractor shall provide information on its Physician Incentive Plan to any Medicaid member upon request (this includes the right to adequate and timely information on a Physician Incentive Plan). Such information shall include: whether the Contractor uses a physician incentive plan that affects the use of referral services, (2) the type of incentive arrangement, and (3) whether stop-loss protection is provided. (42 C.F.R. § 422.210(b).)

Exhibit A – Attachment 4
MANAGEMENT INFORMATION SYSTEMS

1. Health Information Systems

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

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

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

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

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

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

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

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

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

2. Encounter Data

The Contractor shall submit encounter data to the Department in connection with submitting claims, or otherwise at a frequency and level specified by the Department and CMS. (42 C.F.R. § 438.242(c)(2)). The Contractor shall ensure collection and maintenance of sufficient member encounter data to identify the provider who delivers service(s) to the member. (42 C.F.R. § 438.242(c)(1)). The

Exhibit A – Attachment 4
MANAGEMENT INFORMATION SYSTEMS

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

3. Interoperability Rule Patient Access Application Programming Interface

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

4. MEDSLITE Access

The Contractor shall perform the following:

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

B. Ensure that information furnished or secured via MEDSLITE shall be used solely for the purposes described in this Contract. The information obtained from MEDSLITE shall be used exclusively to administer the

Exhibit A – Attachment 4
MANAGEMENT INFORMATION SYSTEMS

Medi-Cal program. The Contractor further agrees that information obtained under this Contract will not be reproduced, published, sold, or released in original or any other form for any purpose other than identified in this Contract.

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

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

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

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

5. ICD-10

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

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

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

Exhibit A – Attachment 4
MANAGEMENT INFORMATION SYSTEMS

6. HIPAA and Additional Data Standards

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

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

2) As identified in Exhibit F, DHCS and the Contractor shall cooperate to ensure mutual agreement as to those transactions between them, to which this Provision applies. Refer to Exhibit F for additional information.

B. Trading Partner Requirements

1) No Changes. Contractor hereby agrees that for the personal health information (Information), it shall not change any definition, data condition or use of a data element or segment as proscribed in the federal HHS Transaction Standard Regulation (45 C.F.R. § 162.915 (a)).

2) No Additions. Contractor hereby agrees that for the Information, it shall not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation (45 C.F.R. § 162.915 (b)).

3) No Unauthorized Uses. Contractor hereby agrees that for the Information, it shall not use any code or data elements that either are marked “not used” in the HHS Transaction’s Implementation specification or are not in the HHS Transaction Standard’s implementation specifications (45 C.F.R. § 162.915 (c)).

4) No Changes to Meaning or Intent. Contractor hereby agrees that for the Information, it shall not change the meaning or intent of any of the HHS Transaction Standard’s implementation specification (45 C.F.R. § 162.915 (d)).

C. Concurrence for Test Modifications to HHS Transaction Standards

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

D. Adequate Testing

Exhibit A – Attachment 4
MANAGEMENT INFORMATION SYSTEMS

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

E. Deficiencies

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

F. Code Set Retention

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

G. Data Transmission Log

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

Exhibit A – Attachment 5
QUALITY IMPROVEMENT SYSTEM

1. Quality Assessment and Performance Improvement

A. The Contractor shall implement an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program for the services it furnishes to members, including quality management. (42 C.F.R. § 438.330(a)(1).) The Contractor's QAPI shall address both SMHS and DMC-ODS services, including strategies to ensure access to coordinated and culturally responsive care for members with co-occurring behavioral health needs.

B. The Contractor's QAPI Program shall improve the Contractor's established outcomes through structural and operational processes and activities that are consistent with current standards of practice.

C. The Contractor shall have a written description of the QAPI Program that clearly defines the QAPI 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 Contractor shall evaluate the impact and effectiveness of its QAPI Program annually and update the Program as necessary. (42 C.F.R. § 438.330(e)(2); 9 C.C.R. § 1810.440(a)(6).)

D. The QAPI Program shall include collection and submission of performance measurement data required by the Department, which may include performance measures specified by CMS. (42 C.F.R. § 438.330(a)(2).)

1) The Contractor shall measure and annually report to the Department its performance, using the standard measures identified by the Department. (42 C.F.R. § 438.330(b)(2), (c)(2).)

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

   a. Timeliness of first initial contact to face-to-face appointment or synchronous video or audio-only interaction, consistent with BHIN 23-018 or any subsequent Departmental guidance.

   b. Frequency of follow-up appointments.

   c. Timeliness of services of the first dose of NTP services.

   d. Access to after-hours care.

   e. Responsiveness of the member access line.

   f. Strategies to reduce avoidable hospitalizations.

Exhibit A – Attachment 5
QUALITY IMPROVEMENT SYSTEM

g. Coordination of physical, mental health, and SUD services at the provider level.

h. Assessment of the members' experiences.

i. Telephone access line and services in the prevalent non-English languages.

3) With respect to the data elements required for External Quality Review (EQR), as described under Exhibit A, Attachment 5, Section 4, below, the Contractor's QI Committee (as defined below) shall review those data at a minimum on a quarterly basis since EQR site reviews will begin after county implementation.

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

F. The Contractor shall have mechanisms to detect both underutilization of services and overutilization of services. (42 C.F.R. § 438.330(b)(3).)

G. The Contractor shall implement mechanisms to assess member/family satisfaction. The Contractor shall assess member/family satisfaction by:

1) Surveying member/family satisfaction with the Contractor's services at least annually;

2) Evaluating member grievances, appeals and State Hearings at least annually; and

3) Evaluating requests to change persons providing services at least annually.

H. The Contractor shall inform providers of the results of member/family satisfaction activities described in paragraph G.

I. 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.

J. The Contractor shall implement mechanisms to address meaningful clinical issues affecting members system-wide.

K. The Contractor shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The

Exhibit A – Attachment 5
QUALITY IMPROVEMENT SYSTEM

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.

L. The Contractor's QAPI Program shall include Performance Improvement Projects (PIPs) as specified in Exhibit A, Attachment 5, Section 5 below.

M. The Contractor shall ensure continuity and coordination of care with other managed care plans and medical providers. The Contractor shall coordinate with other human services agencies used by its members. The Contractor shall assess the effectiveness of any Memorandum of Understanding (MOU) with a managed care plan pursuant to Exhibit A, Attachment 10 Section 3 of this Contract.

2. Quality Improvement (QI) Work Plan

A. The Contractor shall have a Quality Improvement (QI) Work Plan covering the current Contract cycle with documented annual evaluations and documented revisions as needed. The QI Work Plan shall include:

1) Evidence of the monitoring activities including, but not limited to, maintaining, and reviewing member grievances, appeals, expedited appeals, State Hearings, expedited State Hearings, provider appeals, and clinical records reviews as required by 9 C.C.R. section 1810.440(a)(5) and 42 C.F.R. section 438.416(a) and under this Contract;

2) Evidence that QI activities, including PIPs, have contributed to meaningful improvement in clinical care and member service;

3) A description of completed and in-process QI activities, including PIPs. The description shall include:

a. Monitoring efforts for previously identified issues, including tracking issues over time;

b. Objectives, scope, and planned QI 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 (including the requirements defined under Exhibit A, Attachment 8, Section 2.B); and

Exhibit A – Attachment 5
QUALITY IMPROVEMENT SYSTEM

5) Evidence of compliance with the requirements for cultural competence and language and format, as specified in Exhibit A, Attachment 7 Section 2, and Exhibit A Attachment 11 Section 3.

3. Quality Improvement (QI) Committee and Program

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 members.

B. The Contractor shall establish a QI Committee to review the quality of specialty mental health and SUD treatment services provided to members. The QI Committee shall recommend policy decisions; review and evaluate the results of QI activities, including PIPs; 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. (9 C.C.R. § 1810.440(a)(1).)

D. Operation of the QI program shall include substantial involvement by a licensed mental health professional and a licensed SUD staff person. (9 C.C.R. § 1810.440(a)(4).)

E. The Contractor's practitioners and providers, members who have accessed specialty mental health and/or SUD treatment services through the Contractor, family members, legal representatives, or other persons similarly involved with members as described in 9 C.C.R. § 1810.440(a)(2)(A-C) shall be actively involved in the planning, design and execution of the QI Program.

F. 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, members and their family members in identifying barriers to delivery of clinical care and administrative services;

Exhibit A – Attachment 5
QUALITY IMPROVEMENT SYSTEM

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 the results of member grievances, appeals, expedited appeals, State Hearings, expedited State Hearings, provider appeals, and clinical records review as required by 9 C.C.R., § 1810.440(a)(5).

4. External Quality Review

A. The Contractor shall undergo annual, external independent reviews of the quality, timeliness, and access to the services covered under this Contract, which are conducted pursuant to Subpart E of Part 438 of the Code of Federal Regulations. (42 C.F.R. §§ 438.350(a) and 438.320)

B. Among other data elements, the EQR protocol shall include review of:

1) Number of days to first service at appropriate level of care after referral.

2) Existence of a 24/7 telephone access line with prevalent non-English language(s).

3) Access to services with translation services in the prevalent non-English language(s).

5. Performance Improvement Projects

A. The Contractor shall conduct a minimum of two PIPs per year, including any PIPs required by DHCS or CMS (42 C.F.R. § 438.330(a)). DHCS may require additional PIPs. One PIP shall focus on a clinical area and one on a non-clinical area. (42 C.F.R. § 438.330(b)(1) and (d)(1).) Each PIP shall:

1) Be designed to achieve significant improvement, sustained over time, in health outcomes and member satisfaction; (42 C.F.R. § 438.330(d).)

2) Include measurement of performance using objective quality indicators; (42 C.F.R. § 438.330(d)(2)(i).)

3) Include implementation of interventions to achieve improvement in the access to and quality of care; (42 C.F.R. § 438.330(d)(2)(ii).)

Exhibit A – Attachment 5
QUALITY IMPROVEMENT SYSTEM

4) Include an evaluation of the effectiveness of the interventions based on the performance measures collected as part of the PIP; (42 C.F.R. § 438.330(d)(2)(iii).) and,

5) Include planning and initiation of activities for increasing or sustaining improvement. (42 C.F.R. § 438.330(d)(2)(iv).)

B. The Contractor shall report the status and results of each PIP to the Department as requested, but not less than once per year. (42 C.F.R. § 438.330(d)(3).)

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

6. Practice Guidelines

A. The Contractor shall adopt practice guidelines. (42 C.F.R. § 438.236(b) and 9 C.C.R. § 1810.326)

B. Such guidelines shall meet the following requirements (42 C.F.R. § 438.236(b):

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 members;

3) They are adopted in consultation with network providers; and

4) They are reviewed and updated periodically as appropriate.

C. The Contractor shall disseminate the guidelines to all affected providers and, upon request, to members and potential members. (42 C.F.R. § 438.236(c).)

D. The Contractor shall take steps to assure that decisions for utilization management, member education, coverage of services, and any other areas to which the guidelines apply shall be consistent with the guidelines. (42 C.F.R. § 438.236(d))

Exhibit A – Attachment 6
UTILIZATION MANAGEMENT PROGRAM

1. Utilization Management

A. The Contractor shall operate a Utilization Management Program that is responsible for assuring that members have appropriate access to specialty mental health and SUD treatment services as required in this Contract.

B. The Utilization Management Program shall evaluate:

1) that services are medically necessary in accordance with the definition of “medical necessity” in Exhibit E, Attachment 1;

2) the appropriateness and efficiency of services provided to Medi-Cal members prospectively or retrospectively;

3) that the ASAM Criteria shall be used to determine placement into the appropriate level of care for SUD services only; and

4) that the interventions are appropriate for the diagnosis and level of care.

C. 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 member. (42 C.F.R. § 438.210(e).)

D. The Contractor may place appropriate limits on a service based on criteria applied under the State Plan, such as criteria for access to SMHS and/or SUD services and for the purpose of utilization control, provided that:

1) The services furnished are sufficient in amount, duration and scope to reasonably achieve the purpose for which the services are furnished. (42 C.F.R. § 438.210(a)(4)(ii)(A).)

2) The Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary covered service solely because of diagnosis, type of illness, or condition of the member. (42 C.F.R. Section 438.210(a)(3)(ii)) The Contractor may deny services based on W&I Code §§ 14184.402, subdivisions (a), (c), and (d); 14059.5; and departmental guidance and regulation. (42 C.F.R. § 438.210(a)(4)(i).)

3) The Contractor shall not avoid costs for services covered under this Contract by referring members to other publicly supported health care resources.

4) The services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the member’s ongoing need for such services and supports.

Exhibit A – Attachment 6
UTILIZATION MANAGEMENT PROGRAM

E. The Contractor shall have a documented system for collecting, maintaining and evaluating accessibility to care, including tracking:

1) The number of days to first SMHS or DMC-ODS service at an appropriate level of care following initial request or referral for all covered services;

2) Whether a member was delayed access to care due to an insufficient number of providers able to provide services and, how long such a member was delayed access to care; and

3) The number, percentage of denied, and timeliness of requests for authorization for all covered services that are submitted, processed, approved, and denied.

2. Service Authorization

A. Contractor shall implement mechanisms to assure authorization decision standards are met in accordance with this Contract, as well as BHINs 22-016 and 22-017, or any subsequent Departmental notices issued to address parity in mental health and SUD benefits subsequent to the effective date of this Contract, and any applicable state and federal regulations. (42 C.F.R. §§ 438.210, 438.910(d).) The Contractor shall:

1) Have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services. (42 C.F.R. § 438.210(b)(1).) The Contractor shall define service authorization request in a manner that at least includes a member's request for the provision of a service. (42 C.F.R. § 431.201.)

2) Have mechanisms in effect to ensure consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate. (42 C.F.R. § 438.210(b)(2)(i-ii).)

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 addressing the member's behavioral health needs. (42 C.F.R. § 438.210(b)(3).)

4) Notify the requesting provider and give the member written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 C.F.R. § 438.210(c)). The

Exhibit A – Attachment 6
UTILIZATION MANAGEMENT PROGRAM

member's notice shall meet the requirements in Exhibit A Attachment 12, Section 1, and any applicable state and federal law.

B. Additional Service Authorization Requirements: SMHS

1) Except as provided below, the Contractor shall comply with the authorization requirements and timeframes in BHINs 22-016 and 22-017 and any subsequent Departmental notices issued to address parity in mental health and SUD benefits, as well as any applicable state and federal regulations. (42 C.F.R. § 438.910(d).)

2) For outpatient SMHS that are subject to prior authorization, the following timelines apply, notwithstanding BHIN 22-016:

   a. The Contractor shall make a decision regarding a provider's request for prior authorization as expeditiously as the member's mental health condition requires, not to exceed five business days from Contractor's receipt of the information reasonably necessary and requested by the Contractor to make the determination, not to exceed 14 calendar days following Contractor's receipt of the request for service. This timeframe may not be extended.

   b. For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. This timeframe may not be extended. (42 C.F.R. § 438.210(d)(2))

3) Among other requirements, the Contractor shall not require prior authorization for an emergency admission for psychiatric inpatient hospital services, whether the admission is voluntary or involuntary. (BHIN 22-017; See 9 C.C.R. § 1820.200(d)).

C. Additional Service Authorization Requirements: DMC-ODS.

1) The Contractor shall provide prior authorization for residential and inpatient services within 24 hours of the prior authorization request being submitted by the provider. (BHIN 24-001.)

2) Prior authorization is prohibited for non-residential, non-inpatient DMC-ODS services. (BHIN 24-001.)

Exhibit A – Attachment 6
UTILIZATION MANAGEMENT PROGRAM

3. Parity in Mental Health and SUD Benefits

A. The Contractor shall not impose financial requirements or quantitative treatment limitations, as defined in 42 C.F.R. § 438.900, for any member receiving SMHS or DMC-ODS services. (42 C.F.R. § 438.910(b).)

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

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

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

Exhibit A – Attachment 7
ACCESS AND AVAILABILITY OF SERVICES

1. Member Eligibility & Enrollment

A. Medi-Cal members in Contractor's county are automatically enrolled with Contractor for purposes of SMHS and DMC-ODS services. (1915(b) waiver, § A, part I, para. C, p. 31.)

B. The Contractor shall be responsible for providing or arranging and paying for SMHS or SUD services for Medi-Cal eligible individuals in its county who require an assessment or meet criteria for access to SMHS or SUD services. (9 C.C.R. § 1810.228.)

1) The Contractor shall accept these individuals in the order in which they are referred (including self-referral) without restriction (unless authorized by CMS), up to the limits set under this Contract. (42 C.F.R. § 438.3(d)(1).)

2) The Contractor or its contracted provider shall verify the Medicaid eligibility determination of an individual. When the contracted provider conducts the initial eligibility verification, that verification shall be reviewed and approved by the Contractor prior to payment for services.

C. The Contractor shall not, on the basis of health status or need for health care services, discriminate against Medi-Cal eligible individuals in its county who require an assessment or meet criteria for access to SMHS or SUD treatment services. (42 C.F.R. § 438.3(d)(3).)

D. The Contractor shall not unlawfully discriminate against Medi-Cal eligible individuals in its county who require an assessment or meet criteria for access to SMHS or SUD treatment services on the basis of race, color, national origin, sex, sexual orientation, gender, gender identity, religion, marital status, ethnic group identification, ancestry, age, medical condition, genetic information, mental disability, or physical disability, and will not use any policy or practice that has the effect of discriminating on the basis of any of these protected traits. (42 U.S.C. § 18116; 42 C.F.R. § 438.3(d)(4); 45 C.F.R. § 92.2; Gov. Code § 11135(a); W&I Code § 14727(a)(3).)

2. Cultural Competence

A. The Contractor shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. (42 C.F.R. § 438.206(c)(2).)

Exhibit A – Attachment 7
ACCESS AND AVAILABILITY OF SERVICES

B. The Contractor shall comply with the provisions of the Contractor's Cultural Competence Plan, which shall be submitted to and approved by the Department in accordance with applicable Department guidance.

1) The Contractor shall develop a single Cultural Competence Plan that addresses both individuals with SMHS needs and individuals with SUD needs, and that describes strategies to ensure access to coordinated and culturally responsive care for members with co-occurring behavioral health needs.

2) The Contractor shall update the Cultural Competence Plan and submit these updates to the Department for review and approval annually. (9 C.C.R. § 1810.410, subds. (c)-(d).)

3) The Department shall act promptly to review the Contractor's Cultural Competence Plan submitted pursuant to 9 C.C.R. section 1810.410. The Department shall provide a Notice of Approval or a Notice of Disapproval, including the reasons for the disapproval, to the Contractor within 60 calendar days after receipt of the plan from the Contractor. If the Department fails to provide a Notice of Approval or Disapproval, the Contractor may implement the plan 60 calendar days from its submission to the Department.

C. The Contractor shall ensure that its contracted providers are responsible to provide culturally competent services.

1) Providers shall ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations.

2) To ensure equal access to quality care by diverse populations, each contracted provider receiving funds under this Contract shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards (Document 3V) and comply with 42 C.F.R. section 438.206(c)(2).

3. Out-of-Network Services

A. If the Contractor's provider network is unable to provide necessary services, within the time, distance, and timely access standards, covered under this Contract, to a particular member, the Contractor shall allow members to access the services and adequately and timely cover the services out-of-network, for as long as the Contractor's provider network is unable to provide them and in accordance with state and federal law, this

Exhibit A – Attachment 7
ACCESS AND AVAILABILITY OF SERVICES

Contract, and Department information notices, including BHIN 21-008, and any subsequent notices. (42 C.F.R. § 438.206(b)(4).)

1) Additional requirement for SMHS. The Contractor shall comply with the requirements of 9 CCR section 1830.220 regarding providing members access to out-of-network providers when a provider is available in Contractor's network.

2) Additional requirement for DMC-ODS residential services. The requirements in paragraph A apply with respect to each ASAM level of care that is covered by Contractor and medically necessary for a given member.

B. In cases where an out-of-network provider is not available within the time and distance standards, Contractor shall arrange for telehealth or transportation to an in-person visit. Contractor shall ensure that members have the right to an in-person visit if they do not want to accept a telehealth visit. Contractor shall ensure that services rendered by out-of-network providers, including those provided within a Department approved alternative access standard, comply with timely access standards.

C. The Contractor shall require that out-of-network providers coordinate authorization and payment with the Contractor. The Contractor must ensure that the cost to the member 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, consistent with9 C.C.R. section 1810.365. (42 C.F.R. § 438.206(b)(5).)

D. [Reserved]

E. Pursuant to Department guidance, the Contractor shall submit to the Department for approval policies and procedures regarding authorization of out-of-network services to establish compliance with parity requirements in 42 C.F.R. section 438.910(d)(3), including as described in Exhibit A, Attachment 6, Section 3.

4. SMHS: Foster Children Placed Out-of-County

The Contractor shall authorize, pay, provide or arrange for medically necessary specialty mental health services for foster children placed outside of their counties of origin in accordance with W&I Code sections 14717.1 and 14717.2 and pursuant to Department information notices. The Contractor shall follow Mental Health and Substance Use Disorder (MHSUDS) IN 17-032, 18-027, BHIN 19-041, and any subsequent Information Notices. These Information Notices

Exhibit A – Attachment 7
ACCESS AND AVAILABILITY OF SERVICES

include standardized templates that the Contractor may use or adapt to the Contractor's needs.

5. SMHS: Children in Adoption Assistance Program (AAP) and Kinship Guardian Assistance Payment (Kin-GAP)

A. The Contractor shall provide or arrange for the provision of medically necessary specialty mental health services to a child in the Adoption Assistance Program (AAP) residing within their adoptive parents' county of residence in the Contractor's county. These services are to be provided in the same way as the Contractor would provide services to any other child for whom the Contractor's county is listed as the county of responsibility on the Medi-Cal Eligibility Data System (MEDS). When treatment authorization requests are required, the Contractor shall be responsible for submitting treatment authorization requests to the mental health plan in the child's county of origin. (W&I Code § 16125.)

B. The Contractor shall provide or arrange for the provision of medically necessary specialty mental health services to a child in the Kinship-Guardian Assistance Program (Kin-GAP) residing within their legal guardian's county of residence in the Contractor's county. These services are to be provided in the same way that the Contractor would provide services to any other child for whom the Contractor county is listed as the county of responsibility on the MEDS. When treatment authorization requests are required, the Contractor shall be responsible for submitting treatment authorization requests to the mental health plan in the child's county of origin. (W&I Code § 11376.)

C. When the Contractor is the mental health plan in the county of origin for a child in AAP residing out-of-county with their adoptive parents (W&I Code § 16125) or a child in Kin-GAP residing out-of-county with their legal guardian (W&I Code § 11376) the Contractor shall be responsible for authorization and reauthorization of services for the child utilizing an expedited treatment authorization process that meets the authorization requirements set forth in MHSUDS Information Notice 22-016 and any applicable Departmental notices issued after the effective date of this Contract.

D. The Contractor shall comply with timelines specified in 9 C.C.R. § 1830.220(b)(4)(A)(1-3) and requirements set forth in MHSUDS Information Notice 22-016 and any applicable Departmental notices issued after the effective date of this Contract, when processing or submitting authorization requests for children in AAP, or Kin-GAP, living outside their county of origin.

Exhibit A – Attachment 7
ACCESS AND AVAILABILITY OF SERVICES

6. American Indian and Alaska Native (AI/AN) Members

A. Choice of provider. The Contractor shall permit AI/AN members to obtain covered services from certified IHCPs, including out-of-network IHCPs. (42 C.F.R. § 438.14(b)(4); BHINs 22-020 and 22-053.)

   1) The Contractor shall permit an out-of-network IHCP to refer an Indian member to a network provider. (42 C.F.R. § 438.14(b)(6).)

   2) The Contractor is not obligated to pay for services provided to non-AI/AN members by out-of-network IHCPs.

B. The Contractor shall demonstrate it has sufficient IHCPs participating in its provider network to ensure timely access to services available under the Contract from such providers for AI/AN members who are eligible to receive services. (42 C.F.R. § 438.14(b)(1).) The Contractor shall document good-faith efforts to contract with all IHCPs in the Contractor's county, in accordance with the Department's latest guidance on network adequacy certifications. (BHINs 22-020 and 22-053.)

7. Choice of Provider

The Contractor shall provide each member a choice of the person providing services to the extent possible and appropriate. (42 C.F.R. § 438.3(l); Cal. Code Regs., tit. 9, § 1830.225).

8. Integrated 24/7 Access Line

A. The Contractor shall maintain a 24/7 toll-free number that current or prospective members may call seeking access to SMHS and/or DMC-ODS services. The Contractor must maintain and publicize a single telephone number that supports access to both SMHS and DMC-ODS services.

B. The Contractor shall publish information about the access line on the Contractor's web page, on all information brochures, and prevention materials in all threshold languages.

C. The Contractor's access line shall provide oral and audio-logical (TTY/TDY) translations in the member's primary language.

D. The access line shall provide 24/7 referrals to services for urgent conditions and medical emergencies.

Exhibit A – Attachment 7
ACCESS AND AVAILABILITY OF SERVICES

9. Second Opinions

A. The Contractor shall provide second opinions from a network provider, or arrange for the member to obtain a second opinion outside the network, at no cost to the member. (42 C.F.R § 438.206(b)(3).)

B. At the request of a member, when the Contractor or its network provider has determined that the member is not entitled to SMHS due to not meeting the criteria for access to SMHS, the Contractor shall provide for a second opinion by a licensed mental health professional (other than a psychiatric technician or a licensed vocational nurse).

10. Minor Consent

A. Contractor must ensure access to the minor consent services specified in paragraph B without requiring prior authorization, from any in-network or out-of-network provider if the member is otherwise eligible to receive such services and the provider is otherwise eligible and certified to provide them.

   1) Contractor must ensure members are informed of the availability of these services without prior authorization.

   2) Minors who are 12 years of age or older and less than 18 years of age do not need parent, legal guardian, or Authorized Representative (AR) consent to access these services. Contractor, contracted providers, and other subcontractors are prohibited from disclosing any information relating to minor consent services without the express consent of the minor member.

B. Minor consent services include the following:

   1) A minor who is 12 years of age or older may consent to mental health treatment or counseling on an outpatient basis if the minor, in the opinion of the attending professional person, is mature enough to participate intelligently in the outpatient services, subject to the parameters in Family Code section 6924.

   2) A minor who is 12 years of age or older may consent to medical care and counseling relating to the diagnosis and treatment of an SUD, subject to the parameters in Family Code section 6929.

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

1. Provider Enrollment and Screening

A. The Contractor shall ensure that all network providers are enrolled with the state as Medi-Cal providers consistent with the provider disclosure, screening, and enrollment requirements of 42 C.F.R. part 455, subparts B and E. (42 C.F.R. § 438.608(b).) This provision does not require the network provider to render services to Medi-Cal Fee-for-Service members.

B. SMHS: The Contractor may execute network provider agreements, pending the outcome of screening, enrollment, and revalidation, of up to 120 days but must terminate a network provider immediately upon determination that the network provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the provider, and notify affected members. (42 C.F.R. § 438.602(b)(2).)

C. DMC-ODS: The Contractor shall contract only with providers that, prior to the furnishing of services under this Contract, have enrolled with, or revalidated their current enrollment with, DHCS as a DMC-certified provider under applicable federal and state regulations.

2. Assessment of Capacity

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

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

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

2) When a member makes a request for covered services, the Contractor shall require services to be initiated with reasonable promptness in accordance with the timely access standards defined below in Section 4. Contractor shall have a documented system for monitoring and evaluating the quality, appropriateness, and accessibility of care,

Exhibit A – Attachment 8
PROVIDER NETWORK

including a system for addressing problems that develop regarding waiting times and appointments.

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

1) Lack of educational materials or other resources for the provision of services.

2) Geographic isolation and transportation needs of persons seeking services or remoteness of services.

3) Institutional, cultural, and/or ethnicity barriers.

4) Language differences.

5) Lack of service advocates.

6) Failure to survey or otherwise identify the barriers to service accessibility.

7) Needs of persons with a disability.

3. Network Adequacy

A. The Contractor shall ensure that all services covered under this Contract are available and accessible to members in a timely manner and without utilizing waitlists. (42 C.F.R. § 438.206(a)).

B. The Contractor shall maintain and monitor a network of appropriate providers that is supported by written agreements and that is sufficient to provide adequate access to all services covered under this Contract for all members, including those with limited English proficiency or physical or mental disabilities. (42 C.F.R. § 438.206(b)(1).) In establishing and monitoring the network, the Contractor shall document the following:

1) The anticipated number of Medi-Cal eligible members.

2) The expected utilization of services, taking into account the characteristics of mental health and SUD treatment needs of members.

3) The expected number and types of providers in terms of training and experience needed to meet expected utilization.

4) The number of network providers who are not accepting new members.

Exhibit A – Attachment 8
PROVIDER NETWORK

5) The geographic location of providers and their accessibility to members, considering distance, travel time, means of transportation ordinarily used by Medi-Cal members, and physical access for disabled members.

C. The Contractor shall ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medi-Cal members with physical or mental disabilities. (42 C.F.R. § 438.206(b)(1) and (c)(3).)

D. The Contractor shall adhere to, in all geographic areas within the county, the network adequacy standards for adult and pediatric mental health and SUD providers developed by the Department to implement 42 C.F.R. sections 438.68, 438.206, and 438.207, including time and distance standards, timely access, capacity and composition standards, and other network capacity requirements, as specified in state law (including W&I Code § 14197) and the Department's current guidance regarding network adequacy certifications. (42 C.F.R. § 438.68(a), (b)(1)(iii) and (b)(3), 438.206(a); W&I Code § 14197.)

E. If Contractor cannot meet the time or distance standards in W&I Code section 14197, subdivisions (b) or (c), Contractor shall submit to the Department a request for Alternate Access Standards. (W&I Code § 14197, subd. (f)(3).) The Department will evaluate requests and grant appropriate exceptions as specified in the Department's current guidance regarding network adequacy certifications. (42 C.F.R. §§ 438.68(a) &(d), 438.206(a); W&I Code § 14197(f).)

4. Timely Access

A. In accordance with 42 C.F.R. section 438.206(c)(1), the Contractor shall:

1) Meet, and require network providers to meet, the standards for timely access to care and services, without utilizing waitlists and taking into account the urgency of need for services, pursuant to W&I Code section 14197, subdivision (d), and as specified in the Department's current guidance regarding timely access, BHIN 24-020, or any successor guidance.

2) Require network providers to have hours of operation during which services are provided to Medi-Cal members that are no less than the hours of operation during which the provider offers services to non-Medi-Cal members. If the provider only serves Medi-Cal members, the Contractor shall require that hours of operation are comparable to the hours the provider makes available for Medi-Cal

Exhibit A – Attachment 8
PROVIDER NETWORK

services that are not covered by the Contractor, or another county behavioral health program.

3) Make services available to members 24 hours a day, 7 days a week, when medically necessary.

4) Establish mechanisms to ensure that network providers comply with the timely access requirements;

5) Monitor network providers regularly to determine compliance with timely access requirements;

6) Take corrective action if a network provider fails to comply with timely access requirements.

B. [Reserved]

5. Documentation of Network Adequacy

A. The Contractor shall give assurances to the Department and provide supporting documentation that demonstrates Contractor has the capacity to serve the expected utilization in its service area in accordance with BHIN 24-020, and subsequent guidance issued by the Department. (42 C.F.R. § 438.207(a); W&I Code § 14197(f).)

B. The Contractor shall submit documentation to the Department, as specified in BHIN 24-020 and any subsequent guidance issued by the Department, to demonstrate that it complies with the following requirements:

1) Offers an appropriate range of specialty services that are adequate for the anticipated number of members for the service area.

2) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area. (42 C.F.R. § 438.207(b).)

C. The Contractor shall submit the documentation at the times specified in BHIN 24-020 and any subsequent guidance issued by the Department, but no less frequently than the following (42 C.F.R. § 438.207(c)):

1) At the time it enters into this Contract with the Department;

2) On an annual basis; and

3) Within 10 business days of a significant change in the Contractor's operations that would render the Contractor non-compliant with

Exhibit A – Attachment 8
PROVIDER NETWORK

standards for network adequacy and capacity including, but not limited to, the following types of changes:

a. Changes in services;

b. Changes in benefits;

c. Changes in geographic service area;

d. Changes in the composition of or payments to the Contractor's provider network; or

e. Enrollment of a new population in the Contractor's county.

D. The Contractor is required to notify DHCS by email of one of the above-listed changes at MHSDFinalRule@dhcs.ca.gov.The Contractor shall include details regarding the change and the Contractor's plans to ensure members continue to have access to adequate services and providers.

E. 274 Provider Network Data Reporting

1) The Contractor is required to submit provider network data to DHCS using the 274 standard on a monthly basis between the 1st and 10th of each month. (42 C.F.R. § 438.207(a))

2) The Contractor shall complete data submissions pursuant to DHCS BHIN 24-020 and 22-032 and any subsequent guidance issued by the Department.

6. [Reserved]

7. Provider Selection

A. The Contractor shall have and implement written policies and procedures for selection and retention of network providers to provide SMHS and/or SUD services that at a minimum meet the requirements of 42 C.F.R. part 438.214. These policies and procedures shall apply equally to all providers regardless of public, private, for-profit or non-profit status.

1) The Contractor shall select the qualified providers with whom they contract to establish its provider networks, except as otherwise provided in this Contract (e.g., IHCPs as described in Exhibit A, Attachment 7, Section 6).

B. The Contractor's policies and procedures for selection and retention of providers must not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. (42 C.F.R. §§ 438.12(a)(2), 438.214(c).)

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C. In all contracts with network providers, the Contractor must follow the Department's uniform credentialing and re-credentialing policy, including the policy that addresses behavioral and substance use disorders, outlined in DHCS Information Notice 18-019. The Contractor must follow a documented process for credentialing and re-credentialing of network providers. (42 C.F.R. §§ 438.12(a)(2), 438.214(b).)

D. The Contractor shall not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. (42 C.F.R. § 438.214(d).)

E. The Contractor may not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of their license or certification under applicable state law, solely on the basis of that license or certification. (42 C.F.R. § 438.12(a)(1).)

F. The Contractor shall give providers that apply to be network providers and with whom the Contractor decides not to contract written notice of the reason for a decision not to contract. (42 C.F.R. § 438.12(a)(1).)

G. This section, may not be construed to:

    1) Require the Contractor to contract with providers beyond the number necessary to meet the needs of its members;

    2) Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

    3) Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to members. (42 C.F.R. § 438.12(b).)

H. Upon request, the Contractor shall demonstrate to the Department that its providers are credentialed as required by this Contract. (42 C.F.R. § 438.206(b)(6).)

I. The Contractor shall only use licensed, registered, certified, or waivered providers, in good standing and acting within their scope of practice, for services that require a license, registration, certification, or waiver. ; This includes clinical social worker (CSW), marriage and family therapist (MFT), and professional clinical counselor (PCC) candidates who have submitted their applications for associate registration to the California Board of Behavioral Sciences (BBS) within 90 days of their degree award date and are

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completing supervised experience toward licensure to provide SMHS, DMC-ODS and DMC services to Medi-Cal members. (BHIN 24-023.)

1) CSW, MFT, and PCC candidates must act within their scopes of practice under California law. Medi-Cal behavioral health delivery systems must obtain and maintain documentation to verify that the candidate's BBS application has been submitted and is pending and must subsequently verify that the registration is approved.

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

J. Additional requirement applicable to network providers that furnish SMHS: The Contractor shall establish individual, group and organizational provider selection criteria as provided for in 9 C.C.R. section 1810.435(a).

K. Additional requirements applicable to providers that furnish DMC-ODS services:

1) The Contractor may contract only with DMC-certified providers to provide DMC-ODS services. DMC-certified providers that do not receive a contract with Contractor to provide DMC-ODS services cannot receive a direct contract with the State to provide DMC-ODS services to residents of DMC-ODS Counties.

2) The Contractor shall only select providers that have an SUD Medical Director who, prior to the delivery of services under this Contract, has enrolled with DHCS under applicable state regulations, has been screened in accordance with 42 C.F.R. section 455.450(a) as a "limited" categorical risk within a year prior to serving as a Medical Director under this Contract, and has signed a Medicaid provider agreement with DHCS as required by 42 C.F.R. section 431.107.

3) [Reserved]

4) Medication Assisted Treatment (MAT): DMC-ODS network providers, at all levels of care, shall demonstrate that they either directly offer or have an effective referral mechanism to the most clinically appropriate MAT services for members with SUD diagnoses that are treatable with medications or biological products (defined as facilitating access to MAT off-site for members if not provided on-site. Providing a member the contact information for a treatment program is insufficient). An appropriate facilitated referral to any Medi-Cal provider rendering MAT to the member is compliant whether or not that provider seeks reimbursement through

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DMC-ODS. The Contractor shall monitor the referral process or provision of MAT services.

5) Evidence Based Practices (EBPs): The Contractor shall ensure that providers implement at least two of the following EBPs based on the timeline established in the county implementation plan. The two EBPs are per provider, per service modality. The Contractor shall ensure the providers have implemented EBPs and are delivering the practices to fidelity. The State shall monitor the implementation of EBPs during reviews. The EBPs include:

    a. Motivational Interviewing: A member-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on members' past successes.

    b. Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.

    c. Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use disorder treatment.

    d. Trauma-Informed Treatment: Services shall take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.

    e. Psycho-Education: Psycho-educational groups are designed to educate members about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to members' lives, to instill self- awareness, suggest options for growth and change, identify community resources that can assist members in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

8. SMHS Provider Certification

A. The Contractor shall comply with 9 C.C.R. section 1810.435, in the selection of providers.

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B. [Reserved]

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

D. The Contractor shall certify, or use another SMHS program’s certification documents to certify, the organizational providers that contract with the Contractor to provide covered services in accordance with 9 C.C.R. section 1810.435, and the requirements specified prior to the date on which the provider begins to deliver services under the Contract, and once every three years after that date. The on-site review required by 9 C.C.R. section 1810.435, subdivision (d), as a part of the certification process, shall be performed at any site owned, leased, or operated by the provider and/or used to deliver covered services to members, except that on-site review is not required for public school or satellite sites.

E. The Contractor may allow an organizational provider to begin delivering covered services to members at a site subject to on-site review prior to the date of the on-site review, provided the site is operational and has any required fire clearances. The earliest date the provider may begin delivering covered services at a site subject to on-site review is the latest of these three (3) dates: 1) the date the provider‘s request for certification is received by the Department in accordance with the Contractor's certification procedures; 2) the date the site was operational; or 3) the date a required fire clearance was obtained. The Contractor shall complete any required on-site review of a provider's sites within six months of the date the provider begins delivering covered services to members at the site.

F. The Contractor may allow an organizational provider to continue delivering covered services to members at a site subject to on-site review as part of the recertification process prior to the date of the on-site review, provided the site is operational and has any required fire clearances. The Contractor shall complete any required on-site review of a provider's sites within six months of the date the recertification of the provider is due.

G. On-site reviews. The Contractor is responsible for conducting on-site reviews for their network providers, except that the Department shall conduct on-site reviews for all county-owned and operated providers. The on-site review shall verify that:

1) The organizational provider possesses the necessary license to operate, if applicable, and any required certification.

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2) The space owned, leased or operated by the provider and used for services or staff meets local fire codes.

3) The physical plant of any site owned, leased, or operated by the provider and used for services or staff is clean, sanitary, and in good repair.

4) The organizational provider establishes and implements maintenance policies for any site owned, leased, or operated by the provider and used for services or staff to ensure the safety and well-being of members and staff.

5) The organizational provider has a current administrative manual which includes: personnel policies and procedures, general operating procedures, service delivery policies, any required state or federal notices (DRA), and procedures for reporting unusual occurrences relating to health and safety issues.

6) The organizational provider maintains client records in a manner that meets the requirements of the Contractor, the requirements of Exhibit A, Attachment 10; Exhibit E, Section 4; Exhibit D(F), Section 7; and applicable state and federal standards.

7) The organizational provider has sufficient staff to allow the Contractor to claim federal financial participation (FFP) for the services that the organizational provider delivers to members, as described in 9 C.C.R. sections 1840.344 through 1840.358, as appropriate and applicable.

8) The organizational provider has written procedures for referring individuals to a psychiatrist when necessary, or to a physician, if a psychiatrist is not available.

9) The organizational provider’s head or chief of service, as defined 9 C.C.R. sections 622 through 630, is a licensed mental health professional or other appropriate individual as described in these sections.

10) For organizational providers that provide or store medications, the provider stores and dispenses medications in compliance with all pertinent state and federal standards. In particular:

    a. All drugs obtained by prescription are labeled in compliance with federal and state laws. Prescription labels are altered only by persons legally authorized to do so.

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b. Drugs intended for external use only and food stuffs are stored separately from drugs intended for internal use.

c. All drugs are stored at proper temperatures: room temperature drugs at 59-86 degrees Fahrenheit and refrigerated drugs at 36-46 degrees Fahrenheit.

d. Drugs are stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense or administer medication.

e. Drugs are not retained after the expiration date.

f. Intramuscular multi-dose vials are dated and initialed when opened.

g. A drug log is maintained to ensure the provider disposes of expired, contaminated, deteriorated and abandoned drugs in a manner consistent with state and federal laws.

h. Policies and procedures are in place for dispensing, administering and storing medications.

H. For organizational providers that provide day treatment intensive or day rehabilitation, the provider has a written description of the day treatment intensive and/or day rehabilitation program that complies with Exhibit A, Attachment 2A, Section 4.

I. When an on-site review of an organizational provider would not otherwise be required and the provider offers day treatment intensive and/or day rehabilitation, the Contractor or the Department, as applicable, shall, at a minimum, review the provider's written program description for compliance with the requirements of Exhibit A, Attachment 2A, Section 4.

J. On-site review is required for hospital outpatient departments which are operating under the license of the hospital. Services provided by hospital outpatient departments may be provided either on the premises or off-site.

K. On-site review is not required for primary care and psychological clinics, as defined in Health and Safety Code sections 1204 and 1204.1 and licensed under the Health and Safety Code. Services provided by the clinics may be provided on the premises in accordance with the conditions of the clinic's license.

L. When on-site review of an organizational provider is required, the Contractor or the Department, as applicable, shall conduct an on-site review at least once every three years. Additional certification reviews of

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organizational providers may be conducted by the Contractor or Department, as applicable, at its discretion, if:

1) The provider makes major staffing changes.

2) The provider makes organizational and/or corporate structure changes (example: conversion to non-profit status).

3) The provider adds day treatment or medication support services when medications are administered or dispensed from the provider site.

4) There are significant changes in the physical plant of the provider site (some physical plant changes could require a new fire clearance).

5) There is a change of ownership or location.

6) There are complaints regarding the provider.

7) There are unusual events, accidents, or injuries requiring medical treatment for clients, staff or members of the community.

M. [Reserved]

N. Contractor may accept the certification of an SMHS provider by another SMHS program, or by the Department, in order to meet the Contractor's obligations under this section. However, regardless of any such delegation to a subcontracting entity or acceptance of a certification by another SMHS program, Contractor shall remain ultimately responsible for adequate performance of all duties and obligations under this Contract.

9. DMC-ODS Provider Certification: DMC Certification and Monitoring

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

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

C. Contractor shall require that providers of perinatal DMC services are properly certified to provide these services and comply with the applicable requirements contained in Exhibit A, Attachment 2C, Section 22.

D. The Contractor shall require all the contracted providers of services to be licensed, registered, DMC certified and/or approved in accordance with applicable laws and regulations. Contractor's provider contracts shall require that providers comply with all applicable regulations and guidelines, including:

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1) 21 C.F.R.§ 1300.01, et seq., 42, C.F.R., § 8.1 et seq.

2) 22 C.C.R. § 51490(a).

3) Exhibit A, Attachment 2C, Section 22.

4) 9 C.C.R. § 10000, et seq.

5) 22 C.C.R. § 51000 et. seq.

6) W&I Code § 14184.100 et seq.

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

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

G. The Contractor shall notify DHCS PED by e-mail at DHCSDMCRecert@dhcs.ca.gov within two business days of learning that a subcontractor's license, registration, certification, or approval to operate an SUD program or provide a covered service is revoked, suspended, modified, or not renewed by entities other than DHCS.

1) A provider's certification to participate in the DMC program shall automatically terminate if 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.

H. Continued Certification

1) All DMC-certified providers shall be subject to continuing certification requirements at least once every five years. DHCS may allow the Contractor to continue delivering covered services to members at a site subject to on-site review by DHCS as part of the recertification process prior to the date of the on-site review, provided the site is

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operational, the certification remains valid, and has all required fire clearances.

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

10. Provider Disclosures

A. The Contractor shall comply with the provisions of 42 C.F.R. sections 455.104, 455.105, 1002.203 and 1002.3, which relate to the provision of information about provider business transactions and provider ownership and control, prior to entering into a contract and during certification or re-certification of the provider.

11. Termination of a Provider Contract

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

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

C. The Contractor shall make a good faith effort to give written notice of the termination to each member who was seen on a regular basis by the terminated provider, as described in Exhibit A, Attachment 11, Section 2.B.

12. Provider Member Communications

A. The Contractor shall not prohibit nor otherwise restrict, a licensed, waivered, or registered professional, as defined in Supplement 3 to Attachment 3.1-A, page 2i of the State Plan, or an LPHA, as defined in Exhibit E, Attachment 1, who is acting within the lawful scope of practice, from advising or advocating on behalf of a member for whom the provider is providing mental health and/or SUD services for any of the following:

1) The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

2) Information the member needs in order to decide among all relevant treatment options;

3) The risks, benefits, and consequences of receiving treatment or not receiving treatment; and

4) The member's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express

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preferences about future treatment decisions. (42 C.F.R. § 438.102(a)(1).)

13. Provider Notifications

A. The Contractor shall inform contracted providers, at the time they enter into a contract, about:

1) Member grievance, appeal, and State Hearing procedures and timeframes as specified in 42 C.F.R. sections 438.400 - 438.424.

2) The member's right to file grievances and appeals, orally or in writing, and the requirements and timeframes for filing.

3) The availability of assistance to the member with filing grievances and appeals.

4) The member's right to give written consent to allow a provider, acting on behalf of the member, to file a grievance or appeal.

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

6) The member's right to request continuation of benefits that the Contractor seeks to reduce or terminate during an appeal or State Hearing filing, if filed within the allowable timeframes.

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

Exhibit A – Attachment 9
[RESERVED]

Exhibit A – Attachment 10
COORDINATION AND CONTINUITY OF CARE

1. Coordination of Care

A. The Contractor shall implement procedures to deliver care to and coordinate services for all of its members. (42 C.F.R. § 438.208(b).) These procedures shall meet Department requirements and shall do the following:

1) Ensure that each member has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member shall be provided information on how to contact their designated person or entity. (42 C.F.R. § 438.208(b)(1).) Care Coordination can be provided in clinical or non-clinical settings and can be provided in person, by telehealth, or by telephone.

2) Coordinate the services the Contractor furnishes to the member between settings of care and levels of treatment, including appropriate discharge planning for short term and long-term hospital and institutional stays. (42 C.F.R. § 438.208(b)(2)(i).)

a. Through executed memoranda of understanding (MOUs), coordinate the services the Contractor furnishes to the member with the services the member receives from any other managed care organization, in FFS Medicaid, from community and social support providers, and other human services agencies used by its members to foster a member-centered and whole-person approach to wellness. (42 C.F.R. § 438.208(b)(2)(ii)-(iv), 9 C.C.R. § 1810.415.)

b. Regarding discharge planning, coordinate with SMHS and SUD providers to support transitions between levels of care and to recovery resources, as well as appropriate referrals to providers of SMHS, SUD, primary care, or specialty medical services.

c. Coordinate with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.

3) The Contractor shall share with the Department or other managed care entities serving the member the results of any identification and assessment of that member’s needs to prevent duplication of those activities. (42 C.F.R. § 438.208(b)(4).)

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COORDINATION AND CONTINUITY OF CARE

4) Ensure that each contracted provider maintains and shares, as appropriate, a member health record in accordance with professional standards. (42 C.F.R. § 438.208(b)(5).)

5) Ensure that, in the course of coordinating care, each member's privacy is protected in accordance with all federal and state privacy laws, including but not limited to 45 C.F.R. part 160 and 164, subparts A and E, and 42 C.F.R. Part 2, to the extent that such provisions are applicable. (42 C.F.R. § 438.208(b)(6).)

6) For members receiving SUD services, ensure that care coordination services are provided by an AOD Counselor, Clinical Trainee, LPHA, or Medical Assistant.

2. Screening and Assessment Period

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

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

3. Coordination with Managed Care Plans

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

B. Additional requirements: SMHS MOUs only.

1) If a member eligible for SMHS is also eligible for NSMHS during the course of receiving covered SMHS, the Contractor shall continue to

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COORDINATION AND CONTINUITY OF CARE

cover non-duplicative, Medically Necessary SMHS even if the Member is simultaneously receiving NSMHS.

2) The Contractor must enter into a Memorandum of Understanding with any Medi-Cal Managed Care Plan that enrolls members receiving SMHS from Contractor to ensure Medically Necessary NSMHS and SMHS provided concurrently are coordinated and non-duplicative.

3) If a member is receiving covered SMHS and is determined to meet the criteria for NSMHS covered by Medi-Cal Fee For Service and Managed Care Plans as defined by W&I Code section 14184.402, the Contractor must use DHCS-approved standardized transition tools set forth in BHIN 22-065, and any other applicable DHCS guidance, as required when members who have established relationships with contracted mental health providers experience a change in condition requiring NSMHS. Likewise, if a member is receiving NSMHS and is determined to meet the access criteria for SMHS as defined by W&I Code section 14184.402, the Contractor must use DHCS-approved standardized transition tools set forth in BHIN 22-065, and any other applicable DHCS guidance as required when members who have established relationships with NSMHS providers experience a change in condition requiring SMHS. The Contractor must continue to cover the provision of medically necessary SMHS provided to a member who meets SMHS access criteria who is concurrently receiving NSMHS when those services are not duplicative and provide coordination of care with the Managed Care Plan.

4) The Contractor must develop and implement written policies and procedures to ensure that members meeting criteria for NSMHS, as indicated by a DHCS-approved standardized transition tool (including standardized transition tools specific for adults and standardized transition tools specific for children and youth), are referred to the Managed Care Plan or a Fee For Service provider offering NSMHS. Likewise, the Contractor must develop and implement written policies and procedures to ensure that members meeting access criteria for SMHS and as indicated by a DHCS-approved standardized transition tools (including standardized transition tools specific for adults and standardized transition tools specific for children and youth) are referred by the Managed Care Plan to the Contractor.

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COORDINATION AND CONTINUITY OF CARE

5) 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. Should a conflict arise between the parties to the MOU, the Contractor shall abide by the requirements in BHIN 23-056 and any subsequently issued BHINs that supersede BHIN 23-056. (9 C.C.R. § 1810.370.)

B. Additional requirements: DMC-ODS MOUs only. The Contractor must enter in an MOU with any Medi-Cal Managed Care Plan that enrolls members served by the DMC-ODS. The MOU requirements shall comply with BHIN 23-057 and any subsequently issued BHINs that supersede BHIN 23-057. In addition to any MOU requirements established in Department Information Notices or any other guidance, at a minimum the following elements in the MOU should be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers:

1) Comprehensive substance use, physical, and mental health screening, including ASAM Level 0.5 Screening Brief Intervention, and Referral to Treatment services.

2) Member engagement and participation in an integrated care program as needed.

3) Shared development of care plans by the member, caregivers, and all providers where applicable.

4) Collaborative care planning with managed care where applicable.

5) Delineation of case management responsibilities.

6) A process for resolving disputes between the Contractor and the Medi-Cal managed care plan that includes a means for members to receive medically necessary services while the dispute is being resolved.

7) Availability of clinical consultation, including consultation on medications.

8) Care coordination and effective communication among providers including procedures for exchanges of medical information.

9) Navigation support for patients and caregivers.

10) Facilitation and tracking of referrals.

Exhibit A – Attachment 10
COORDINATION AND CONTINUITY OF CARE

C. [Reserved]

4. Transition of Care

A. The Contractor shall implement a transition of care policy that is in accordance with applicable state and federal regulations, MHSUD IN 18-059, BHIN 23-001, and any BHINs issued by the Department for parity in mental health and substance use disorder benefits subsequent to the effective date of this Contract (42 C.F.R. § 438.62(b)(1)-(2).) At a minimum, the Contractor shall provide the transition of care policy to members and potential members in the member handbook and member notices. (See Exhibit A, Attachment 11 Section 1.E.)

Exhibit A – Attachment 11
INFORMATION REQUIREMENTS

1. Basic Requirements

A. The Contractor shall provide information in a manner and format that is easily understood and readily accessible to members and potential members. (42 C.F.R. § 438.10(c)(1)). The Contractor shall provide all written materials for members and potential members in easily understood language and format, using a font size no smaller than 12-point. (42 C.F.R. § 438.10(d)(6)(i)-(ii)). Contractor shall make written materials available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that take into consideration the special needs of members and potential members with disabilities or limited English proficiency (42 C.F.R. § 438.10(d)(6)(iii)). The Contractor shall inform members that information is available in alternate formats and how to access those formats in compliance with 42 C.F.R. § 438.10.

B. The Contractor shall provide the required information in this section to each member when first receiving specialty mental health or SUD services and upon request. (CalAIM 1915(b) Waiver, § A, Part IV, Subsection B, Part 1 at p.78; C9 C.C.R. § 1810.360(e)).

C. The Contractor shall operate a website that provides the content required in this section and complies with the requirements in 42 C.F.R. section 438.10.

D. In the information provided to members, the Contractor shall use the Department developed definitions for key managed care terminology as set forth in this Contract (including Exhibit E) and the Department's template member handbook, including: appeal, excluded services, grievance, hospitalization, hospital outpatient care, medically necessary, network and out-of-network provider, physician services, plan, prior authorization, prescription drugs, primary care provider, provider, rehabilitation services, prescription drugs, and urgent care (42 C.F.R. § 438.10(c)(4)(i)).

E. The Contractor shall use Department developed model member handbooks and member notices that describe the transition of care policies for members. (42 C.F.R. §§ 438.10(c)(4)(ii) and 438.62(b)(3)).

F. Member information required in this section may only be provided electronically by the Contractor if all of the following conditions are met:

1) The format is readily accessible;

2) The information is placed in a location on the Contractor's website that is prominent and readily accessible;

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INFORMATION REQUIREMENTS

3) The information is provided in an electronic form which can be electronically retained and printed;

4) The information is consistent with the content and language requirements of this Attachment; and

5) The member is informed that the information is available in paper form without charge upon request and Contractor provides it upon request within 5 business days. (42 C.F.R. § 438.10(c)(6)).

G. The Contractor shall have in place mechanisms to help members and potential members understand the requirements and benefits of the plan. (42 C.F.R. § 438.10(c)(7)).

2. Information Provided to Members and Potential Members

A. The Contractor shall provide information to members and potential members, either in paper or electronic format, including, at a minimum, all of the following:

1) The basic features of managed care. (42 C.F.R. § 438.10(e)(2)(ii)).

2) The automatic enrollment process. (42 C.F.R. § 438.10(e)(2)(iii)).

3) The service area covered by the Contractor. (42 C.F.R. § 438.10(e)(2)(iv)).

4) Covered benefits, including:

a. Which benefits are provided by the Contractor; and,

b. Which, if any, benefits are provided directly by the State. (42 C.F.R. § 438.10(e)(2)(v)).

5) The provider directory and formulary information. (42 C.F.R. § 438.10(e)(2)(vi)).

6) Any cost-sharing that will be imposed by the Contractor consistent with the California State Plan § 4.18. (42 C.F.R. § 438.10(e)(2)(vii)).

7) The requirements for the Contractor to provide adequate access to covered services, including the network adequacy standards established in 42 C.F.R. section 438.68. (42 C.F.R. § 438.10(e)(2)(viii)).

8) The Contractor’s responsibilities for coordination of care. (42 C.F.R. § 438.10(e)(2)(ix)).

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9) To the extent available, quality and performance indicators for the Contractor, including member satisfaction. (42 C.F.R. § 438.10(e)(2)(x)).

B. The Contractor shall make a good faith effort to give written notice of termination of a contracted provider, to each member who was seen on a regular basis by the terminated provider. The notice to the member shall be provided 30 calendar days prior to the effective date of the termination or 15 calendar days after receipt or issuance of the termination notice, whichever is later. (42 C.F.R. § 438.10(f)(1)).

3. Language and Format

A. Nondiscrimination Requirements, Language Assistance, and Information Access for Individuals with Limited English Proficiency and/or Disabilities (42 C.F.R. § 438.10; W&I Code § 14029.91; Government Code § 11135; 28 C.F.R. §§ 35.160-35.164; 28 C.F.R. § 36.303; 45 C.F.R. §§ 92.101 and 92.202)).

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

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

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

b. A population group of mandatory eligible members residing in the Contractor's service area who indicate their primary language as a language other than English and who meet the concentration standards of 1,000 in a single zip code or 1,500 in two contiguous zip codes.

3) Nondiscrimination Notice

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a. The Nondiscrimination Notice must be sent in conjunction with each of the following significant notices sent to members:
    i. Notices of Adverse Benefit Determination.
    ii. Grievance acknowledgement letter.
    iii. Appeal acknowledgement letter.
    iv. Grievance resolution letter.
    v. Notice of Appeal Resolution.

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

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

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

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

f. The nondiscrimination notice shall include information on how to file a discrimination grievance with:
    i. The Contractor and the Department's Office of Civil Rights if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability,

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physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

ii. The United States Department of Health and Human Services Office of Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability.

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

4) Language Assistance Taglines

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

i. Notices of Adverse Benefit Determination.

ii. Grievance acknowledgement letter.

iii. Appeal acknowledgement letter.

iv. Grievance resolution letter.

v. Notice of Appeal Resolution.

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

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

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5) Language Assistance Services

a. Language assistance services shall be provided free of charge, be accurate and timely, and protect the privacy and independence of the limited English proficiency (LEP) individual. There are two primary types of language assistance services: oral and written. LEP individuals are not required to accept language assistance services, although a qualified interpreter may be used to assist in communicating with an LEP individual who has refused language assistance services.

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

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

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

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

f. An interpreter is a person who renders a message spoken in one language into one or more languages. An interpreter shall be qualified and have knowledge in both languages of the relevant terms or concepts particular to the program or activity and the dialect spoken by the LEP individual. In order to be considered a qualified interpreter for an LEP individual,

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the interpreter must: 1) have demonstrated proficiency in speaking and understanding both English and the language spoken by the LEP individual; 2) be able to interpret effectively, accurately, and impartially, both receptively and expressly, to and from the language spoken by the LEP individual and English, using any necessary specialized vocabulary, terminology, and phraseology; and 3) adhere to generally accepted interpreter ethics principles, including client confidentiality.

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

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

i. The Contractor is prohibited from relying on an adult or minor child accompanying an LEP individual to interpret or facilitate communication except when: 1) there is an emergency involving an imminent threat to the safety or welfare of the individual or the public and a qualified interpreter is not immediately available; or, 2) the LEP individual specifically requests that an accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide that assistance, and reliance on that accompanying adult for that assistance is appropriate under

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the circumstances. Prior to using a family member, friend or, in an emergency only, a minor child as an interpreter for an LEP individual, the Contractor shall first inform the individual that they have the right to free interpreter services and second, ensure that the use of such an interpreter will not compromise the effectiveness of services or violate the LEP individual's confidentiality. The Contractor shall also ensure that the LEP individual's refusal of free interpreter services and their request to use family members, friends, or a minor child as an interpreter is documented.

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

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

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

6) Effective Communication with Individuals with Disabilities

a. The Contractor shall comply with all applicable requirements of federal and state disability law and take appropriate steps to ensure effective communication with individuals with disabilities.

b. The Contractor shall provide appropriate auxiliary aids and services to persons with impaired sensory, manual, or speaking skills, including the provision of qualified interpreters and written materials in alternative formats, free of charge and in a timely manner, when such aids and services are necessary to ensure that individuals with disabilities have an equal opportunity to participate in, or

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enjoy the benefits of, the Contractor's covered services, programs, and activities.

c. The Contractor shall provide interpretive services and make member information available in the following alternative formats: Braille, audio format, large print (no less than 20-point font), and accessible electronic format (such as a data CD). In determining what types of auxiliary aids and services are necessary, the Contractor shall give "primary consideration" to the individual's request of a particular auxiliary aid or service.

d. Auxiliary aids and services include:

    i. Qualified interpreters on-site or through VRI services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunication products and systems, text telephones (TTYs), videophones, captioned telephones, or equally effective telecommunications devices; videotext displays; accessible information and communication technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing.

    ii. Qualified Readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs; large print materials (no less than 20-point font); accessible information and communication technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision.

e. When providing interpretive services, the Contractor shall use qualified interpreters to interpret for an individual with a disability, whether through a remote interpreting service or an on-site appearance. A qualified interpreter for an individual with a disability is an interpreter who: 1) adheres to

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generally accepted interpreter ethics principals, including client confidentiality; and 2) is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology, and phraseology. For an individual with a disability, qualified interpreters can include, for example, sign language interpreters, oral transliterators (individuals who represent or spell in the characters of another alphabet), and cued language transliterators (individuals who represent or spell by using a small number of handshapes).

f. If a Contractor provides a qualified interpreter for an individual with a disability through VRI services, the Contractor shall provide real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection that delivers high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; a sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers, and the participating individual's face, arms, hands, and fingers, regardless of body position; a clear, audible transmission of voices; and adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the VRI.

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

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interpreter will not compromise the effectiveness of services or violate the individual's confidentiality. The Contractor shall ensure that the refusal of free interpreter services and the individual's request to use a family member, friend, or a minor child as an interpreter is documented.

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

4. Handbook

A. The Contractor shall offer members a physical copy of the handbook and provider directory when the member first accesses services and thereafter upon request, and shall ensure that members receive a link to the online versions of these member materials. (9 C.C.R. § 1810.360(e); BHIN 23-048.)

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

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

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

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

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

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

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

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

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

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

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

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

i. The right to file grievances and appeals;

ii. The Contractor shall include information on filing a Discrimination Grievance with the Contractor, the Department's Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights, and shall specifically include information stating that the Contractor complies with all state and federal civil rights laws. If a member believes they have been unlawfully discriminated against, they have the right to file a Discrimination Grievance with the Contractor, the Department's Office of Civil Rights, and the United States Department of Health and Human Services, Office for Civil Rights;

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

iv. The availability of assistance in the filing process;

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

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

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

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

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

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

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

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

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

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

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

E. Consistent with 42 C.F.R. section 438.10(g)(3) the handbook will be considered provided if the Contractor:

1) Mails a printed copy of the information to the member's mailing address;

2) Provides the information by email after obtaining the member's agreement to receive the information by email;

3) Posts the information on the Contractor's website and advises the member in paper or electronic form that the information is available on the internet and includes the applicable internet addresses,

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

4) Provides the information by any other method that can reasonably be expected to result in the member receiving that information.

5. Provider Directory

A. The Contractor must follow the Department's provider directory policy, as described in MHSUDS IN 18-020, and any subsequently issued BHINs that supersede MHSUDS IN 18-020.

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

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

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

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

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

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

6) Type of practitioner as appropriate.

7) National Provider Identifier number.

8) California License number and type of license.

9) Whether the provider has completed cultural competence training.

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

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

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

E. [Reserved]

6. Advance Directives

A. For purposes of this Contract, advance directives means a written instruction, such as a living will or durable power of attorney for health care, recognized under California law, relating to the provision of health care when the individual is incapacitated. (42 C.F.R. § 489.100).

B. The Contractor shall maintain written policies and procedures on advance directives, which include a description of applicable California law. (42 C.F.R. §§ 438.3(j)(1) and (3), and 422.128). Any written materials prepared by the Contractor for members shall be updated to reflect changes in state laws governing advance directives as soon as possible, but no later than 90 days after the effective date of the change. (42 C.F.R. § 438.3(j)(4)).

C. The Contractor shall provide adult members with the written information on advance directives. (42 C.F.R. § 438.3(j)(3)).

D. The Contractor shall not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual

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has executed an advance directive. (42 C.F.R. §§ 422.128(b)(1)(ii)(F), and 438.3(j)).

E. The Contractor shall educate staff concerning its policies and procedures on advance directives. (42 C.F.R. §§ 422.128(b)(1)(ii)(H), and 438.3(j)(1)).

7. Member Rights

A. The parties to this Contract shall comply with applicable laws and regulations relating to patients' rights, including but not limited to W&I Code section 5325, 9 C.C.R. sections 862 through 868, and 42 C.F.R. section 438.100. The Contractor shall ensure that its subcontractors and contracted providers comply with all applicable patients' rights laws and regulations.

B. The Contractor shall have written policies regarding the member rights specified in this section and ensure that its staff, subcontractors, and contracted providers take those rights into account when providing services, including the right to:

1) Receive information in accordance with 42 C.F.R. section 438.10. (42 C.F.R. § 438.100(b)(2)(i)).

2) Be treated with respect and with due consideration for their dignity and privacy. (42 C.F.R. § 438.100(b)(2)(ii)).

3) Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. (42 C.F.R. § 438.100(b)(2)(iii)).

4) Participate in decisions regarding their health care, including the right to refuse treatment. (42 C.F.R. § 438.100(b)(2)(iv)).

5) Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. (42 C.F.R. § 438.100(b)(2)(v)).

6) Request and receive a copy of their medical records, and to request that they be amended or corrected. (42 C.F.R. § 438.100(b)(2)(vi); 45 C.F.R. §§ 164.524, and 164.526).

7) Be furnished services in accordance with 42 C.F.R. sections 438.206 through 438.210. (42 C.F.R. § 438.100(b)(3)).

8) Freely exercise their rights without adversely affecting the way the Contractor, subcontractor, or contracted provider treats the member. (42 C.F.R. § 438.100(c)).

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8. DMC-ODS Formulary

A. The Contractor shall make available in electronic or paper form, the following information about its formulary:

1) Which medications are covered (both generic and name brand).

2) On what tier each medication resides.

B. Formulary drug lists shall be made available on the Contractor's website in a machine-readable file and format as specified by the Secretary.

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MEMBER PROBLEM RESOLUTION

1. General Provisions

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

1) A grievance process;

2) An appeal process; and,

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

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

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

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

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

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

ii. Make available forms that may be used to file grievances, appeals, and expedited appeals and self-addressed

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envelopes that members can access, without having to make a verbal or written request to anyone. (9 C.C.R. § 1850.205(c)(1)(C).)

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

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

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

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

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

6) The Contractor shall allow a provider, or authorized representative, acting on behalf of the member and with the member's written consent to request an appeal or expedited appeal, file a grievance, or request a State Hearing, with the exception that providers cannot request continuation of benefits. (42 C.F.R. § 438.402(c)(1)(i)-(ii); 9 C.C.R. § 1850.205(c)(2).)

7) [Reserved]

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MEMBER PROBLEM RESOLUTION

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

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

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

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

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

13) The Contractor shall ensure that individuals making decisions on grievances and appeals have the appropriate clinical expertise, as determined by the Department, in treating the member's condition or disease, if the decision involves an appeal based on a denial of medical necessity, a grievance regarding denial of a request for an expedited appeal, or if the grievance or appeal involves clinical issues.(42 C.F.R. § 438.406(b)(2)(ii)(A)-(C); 42 C.F.R. § 438.228(a).)

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

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

16) The Contractor shall provide the member and their representative the member's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor (or at the direction of the Contractor) in connection with the appeal of the adverse benefit determination. (42 C.F.R. § 438.406(b)(5).)

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

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

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

2. Handling of Grievances and Appeals

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

A. Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance, appeal, or expedited appeal. (42 C.F.R. § 438.416(a); 9

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C.C.R. § 1850.205(d)(1).) Each record shall include, but not be limited to: a general description of the reason for the appeal or grievance the date received, the date of each review or review meeting, resolution information for each level of the appeal or grievance, if applicable, and the date of resolution at each level, if applicable, and the name of the covered person whom the appeal or grievance was filed. (42 C.F.R. § 438.416(b)(1)-(6).)

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

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

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

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

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

3. Grievance Process

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

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

B. The Contractor shall provide to the member written acknowledgement of receipt of the grievance. The acknowledgment letter shall include the date of receipt, as well as the name, telephone number, and address of the Plan representative who the member may contact about the grievance. The written acknowledgement to the member must be postmarked within five calendar days of receipt of the grievance. Grievances received over the telephone or in-person by the Contractor or a contracted provider that

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are resolved to the member's satisfaction by the close of the next business day following receipt are exempt from the requirement to send a written notification of resolution using the Written Notification of Grievance Resolution form.

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

D. [Reserved]

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

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

4. Discrimination Grievances

A. For Discrimination Grievances:

1) The Contractor shall designate a Discrimination Grievance Coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements, and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law. (W&I Code § 14727(a)(4); 45 C.F.R. § 84.7; 28 C.F.R. § 35.107; see 42 U.S.C. § 18116(a); California's Medicaid State Plan, Section 7, Attachments 7.2-A and 7.2-B.) The Discrimination Grievance Coordinator shall be available to:

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

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

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

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

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

   a. The original complaint.

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

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

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

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

   f. The results of the Contractor's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

5. Appeals Process

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

1) Allow a member, or a provider or authorized representative acting on the member's behalf, to file an appeal orally or in writing. (42 C.F.R. § 438.402(c)(3)(ii).) The member may file an appeal within

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60 calendar days from the date on the adverse benefit determination notice (42 C.F.R. § 438.402(c)(2)(ii).);

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

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

4) [Reserved]

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

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

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

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

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

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

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

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6. Expedited Appeal Process

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

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

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

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

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

4) [Reserved]

5) Resolve an expedited appeal as expeditiously as the member's health condition requires and no later than 72 hours after the day Contractor receives the appeal. (42 C.F.R. § 438.408(b)(3).)

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

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

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

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

7. Contractor Obligations Related to State Hearing

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

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

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

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

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

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

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

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

8. Expedited Hearing

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

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

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

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

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

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

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

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

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

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

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

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

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

10. Provision of Notice of Adverse Benefit Determination

A. The Contractor shall notify the requesting provider within 24 hours, and give the member written notice as specified below, of any decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. (42 C.F.R. § 438.210(c); 42 C.F.R. § 438.404.) The Contractor shall provide a member with a Notice of Adverse Benefit Determination (NOABD) under the circumstances defined in 42 C.F.R. § 438.400 under Adverse Benefit Determination.

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

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

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

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

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

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

6) [Reserved]

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

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

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

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

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

11. Contents and Timing of NOABD

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3) For standard service authorizations that deny or limit services, as expeditiously as the member's condition requires not to exceed 14 calendar days following the receipt for request for services. (42 C.F.R. § 438.404(c)(3); 42 C.F.R. § 438.210(d)(1).)

4) [Reserved]

5) [Reserved]

6) [Reserved]

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

8) If a provider indicates, or the Contractor determines, that following the standard service authorization timeframe could seriously jeopardize the member's life or health or their ability to attain,

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maintain, or regain maximum function, the Contractor must make an expedited service authorization decision and provide notice as expeditiously as the member's health condition requires and no later than 72 hours after receipt of the request for service. (42 C.F.R. § 438.404(c)(6); 42 C.F.R. 438.210(d)(2)(i).)

9) [Reserved]

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

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

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

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

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

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

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

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

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

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

12. Annual Grievance and Appeal Report

The Contractor is required to submit to the Department a report that summarizes member grievances, appeals and expedited appeals, in accordance with BHIN 22-036, filed from July 1 of the previous year through June 30 of that year by

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September 1 of each year. The report shall include the total number of grievances, appeals and expedited appeals by type, by subject areas established by the Department, and by disposition. (42 C.F.R. § 438.66(e).)

Exhibit A – Attachment 13
PROGRAM INTEGRITY

1. General Requirements

A. As a condition for receiving payment under a Medi-Cal managed care program, the Contractor shall comply with the provisions of 42 C.F.R. sections 438.604, 438.606, 438.608, and 438.610. (42 C.F.R. § 438.600(b)).

B. The Department shall ensure that the Contractor is not located outside of the United States. (42 C.F.R. § 438.602(i)).

C. [Reserved]

2. Periodic Audits

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

3. Excluded Providers

A. The Contractor shall screen and periodically revalidate all network providers that have not enrolled in Medi-Cal pursuant to 42 C.F.R. § 455.410(b), in accordance with the requirements of 42 C.F.R. part 455, subparts B and E. (42 C.F.R. § 438.602(b)).

B. Consistent with the requirements of 42 CC.F.R. § 455.436, the Contractor must confirm the identity and determine the exclusion status of all network providers that have not enrolled in Medi-Cal pursuant to 42 C.F.R. § 455.410(b), and any subcontractor, or who is an agent or managing employee of the Contractor, through routine checks of Federal and State databases. This includes the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the Office of Inspector General's List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), as well as the Department's Medi Cal Suspended and Ineligible Provider List (S & I List). (42 C.F.R. § 438.602(d)).

C. If the Contractor finds a party that is excluded, it must promptly notify the Department and the Department will take action consistent with 42 C.F.R. section 438.610(d). (42 C.F.R. § 438.608(a)(2) and (4)). The Contractor shall not certify or pay any excluded 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.

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4. Compliance Program

A. Pursuant to 42 C.F.R. section 455.1(a)(1), the Contractor must report fraud and abuse information to the Department.

B. The Contractor, or any subcontractor, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract, shall implement and maintain a compliance program designed to detect and prevent fraud, waste and abuse that must include:

1) Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Contract, and all applicable Federal and state requirements.

2) A Compliance Officer (CO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the Contract and who reports directly to the Behavioral Health Director and Board of Supervisors, or CEO and the Board of Directors (BoD).

3) A Regulatory Compliance Committee (RCC) on the BoD and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Contract.

4) A system for training and education for the CO, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the Contract.

5) Effective lines of communication between the CO and the organization's employees.

6) Enforcement of standards through well-publicized disciplinary guidelines.

7) The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the Contract. (42 C.F.R. § 438.608 (a)(1)).

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5. Fraud Reporting Requirements

A. The Contractor, or any subcontractor, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract, shall implement and maintain arrangements or procedures designed to detect and prevent fraud, waste and abuse that include prompt reporting to the Department Medicaid program integrity unit about the following:

1) Any potential fraud, waste, or abuse. (42 C.F.R. § 438.608(a)(7)).

2) All overpayments identified or recovered, specifying the overpayments due to potential fraud. (42 C.F.R. § 438.608 (a)(2)).

3) Information about changes in a member's circumstances that may affect the member's eligibility including changes in the member's residence or the death of the member. (42 C.F.R. § 438.608 (a)(3)).

4) Information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor. (42 C.F.R. § 438.608(a)(4)).

B. If the Contractor identifies an issue or receives notification of a complaint concerning an incident of potential fraud, waste or abuse, in addition to notifying the Department, the Contractor shall conduct an internal investigation to determine the validity of the issue/complaint, and develop and implement corrective action, if needed.

C. The Contractor shall implement and maintain written policies for all employees of the Contractor, and of any subcontractor or agent, that provide detailed information about the False Claims Act and other Federal and state laws, including information about rights of employees to be protected as whistleblowers. (42 C.F.R. § 438.608 (a)(6)).

D. Suspected Medi-Cal fraud, waste, or abuse shall be reported to DHCS Medi-Cal Fraud: (800) 822-6222 or Fraud@dhcs.ca.gov.

6. Suspension of Provider Payments

A. If a provider is under investigation by DHCS or any other state, local or federal law enforcement agency for fraud or abuse, DHCS may temporarily suspend the provider pursuant to W&I Code sections 14043.36(a). DHCS may also issue a payment suspension to a provider pursuant to W&I Code § 14107.11 and 42 C.F.R. section 455.23.

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1) The Contractor shall implement and maintain arrangements or procedures that include providing for the Contractor's suspension of payments to a contracted provider for which there is a credible allegation of fraud. (42 C.F.R. §§ 455.23 and 438.608 (a)(8)).

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

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

7. Service Verification

Pursuant to 42 C.F.R. section 438.608(a)(5), the Contractor, and/or any subcontractor, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Contract, shall implement and maintain arrangements or procedures designed to detect and prevent fraud, waste and abuse that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by members and the application of such verification processes on a regular basis. (42 C.F.R. § 438.608 (a)(5)).

8. Disclosures

A. Disclosure of 5% or More Ownership Interest:

1) Pursuant to 42 C.F.R. section 455.104, Medicaid managed care entities must disclose certain information related to persons who have an ownership or control interest in the managed care entity, as defined in 42 C.F.R. section 455.101. The parties hereby acknowledge that because the Contractor is a political subdivision of the State of California, there are no persons who meet such definition and therefore there is no information to disclose.

a. In the event that, in the future, any person obtains an interest of 5% or more of any mortgage, deed of trust, note or other obligation secured by Contractor, and that interest equals at least 5% of Contractor's property or assets, then the Contractor will make the disclosures set forth in this section, and subsection 2(a), below.

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b. The Contractor will disclose the name, address, date of birth, and Social Security Number of any managing employee, as that term is defined in 42 C.F.R. section 455.101. For purposes of this disclosure, Contractor may use the business address for any member of its Board of Supervisors.

c. The Contractor shall provide any such disclosure upon execution of this Contract, upon its extension or renewal, and within 35 days after any change in Contractor ownership or upon request of the Department.

2) The Contractor shall ensure that its subcontractors and network providers submit the disclosures below to the Contractor regarding the network providers' and subcontractors (disclosing entities') ownership and control.

a) The Contractor's providers must submit disclosures to the Contractor upon submitting the provider application, before entering into a provider agreement with Contractor, before renewing a provider agreement with Contractor and within 35 days after any change in the subcontractor/network provider's ownership, annually and upon request during the re-validation of enrollment process under 42 C.F.R. section 455.104. The information included in the disclosures shall be current as of the time submitted.

b) For providers of SUD services, these disclosures shall be provided through the DMC certification process as described in Exhibit A, Attachment. 8, Section 9.

c) Disclosures to be Provided:

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

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

iii. Other tax identification number in the case of a corporation with an ownership or control interest in the disclosing entity (or fiscal agent or managed care

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entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest;

iv. Whether the person (individual or corporation) with an ownership or control interest in the Contractor's network provider is related to another person with ownership or control interest in the same or any other network provider of the Contractor as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the managed care entity as a spouse, parent, child, or sibling;

v. The name of any other disclosing entity (or fiscal agent or managed care entity) in which the Contractor, subcontractor, or network provider has an ownership or control interest; and

vi. The name, address, date of birth, and Social Security Number of any managing employee of the managed care entity.

3) For each provider in Contractor's provider network, the Contractor shall provide the Department with all disclosures before entering into a network provider contract with the provider and annually thereafter and upon request from the Department during the re-validation of enrollment process under 42 C.F.R. section 455.104.

4) Federal Financial Participation (FFP) shall be withheld from the Contractor if it fails to disclose ownership or control information as required by this section. (42 C.F.R. § 455.104(f)).

B. Disclosures Related to Business Transactions – the Contractor must submit disclosures and updated disclosures to the Department or HHS including information regarding certain business transactions within 35 days, upon request.

1) The following information must be disclosed:

a) The ownership of any subcontractor with whom the Contractor has had business transactions totaling more than

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$25,000 during the 12-month period ending on the date of the request; and

b) Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the 5-year period ending on the date of the request.

c) The Contractor must obligate Network Providers to submit the same disclosures regarding network providers as noted under subsection 1(a) and (b) within 35 days upon request.

C. Disclosures Related to Persons Convicted of Crimes

1) The Contractor shall submit the following disclosures to the Department regarding the Contractor's management:

a) The identity of any person who has an ownership interest in or is a managing employee of the Contractor who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1) and (2)).

b) The identity of any person who is an agent of the Contractor who has been convicted of a crime related to federal health care programs. (42 C.F.R. § 455.106(a)(1) and (2)). For this purpose, the word "agent" has the meaning described in 42 C.F.R. section455.101.

2) The Contractor shall supply the disclosures before entering into the Contract and at any time upon the Department's request.

3) Network providers should submit the same disclosures to the Contractor regarding the network providers' owners, persons with controlling interest, agents, and managing employees' criminal convictions. Network providers shall supply the disclosures before entering into the contract and at any time upon the Department's request.

9. Contractor Monitoring of Contracted Providers

A. Contractor shall conduct ongoing monitoring of contracted providers (except out-of-network providers) for compliance with the terms of this contract. Contractor must, at a minimum:

1) Monitor compliance for each provider on an annual basis; and

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2) Perform on-site monitoring at least once every three years for each organizational provider. (No on-site reviews are required for individual SMHS practitioners who contract directly with the Contractor.)

B. Contractor shall submit a copy of their monitoring and audit reports to DHCS within two weeks of issuance. Reports should be sent by using a Secure Managed File Transfer system specified by DHCS.

C. If the Contractor identifies deficiencies or areas for improvement in a contracted provider's performance, the Contractor and the contracted provider shall take corrective action. For any identified compliance deficiencies, the Contractor shall submit to DHCS a Contractor-approved corrective action plan (CAP) for the contracted provider.

1) The CAP shall include:

a. A description of corrective actions that will be taken by the Contractor to address findings, including actions required of contracted providers when applicable, and incremental milestones the Contractor will achieve in order to reach full compliance;

b. The timeline for implementation and/or completion of corrective actions;

c. Proposed evidence of correction that will be submitted to DHCS;

1. If the Contractor has evidence to support correction at the time the CAP is due, the Contractor shall submit the actual evidence of correction to DHCS.

d. A mechanism for monitoring the effectiveness of corrective actions over time; and

e. Behavioral Health Director or designee (e.g., compliance administrator) name, and the date of their approval of the CAP.

2) The Contractor shall submit the Contractor-approved provider CAP to DHCS for approval using a Secure Managed File Transfer system specified by DHCS.

3) DHCS will provide an Acknowledgement Letter within five business days to the Contractor with a copy to the provider. If DHCS does not approve the CAP, DHCS shall provide guidance on the deficient areas. Contractor shall submit an updated CAP to DHCS using a Secure Managed File Transfer system specified by DHCS., with a copy to the provider.

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

D. [Reserved]

10. DMC-ODS: State Monitoring - Postservice Postpayment and Postservice Prepayment Utilization Reviews

A. DHCS shall conduct Postservice Postpayment and Postservice Prepayment Utilization Reviews of the contracted DMC-Certified Providers to determine whether the services were provided in accordance with Exhibit A, Attachment 2C, Section 22 ("Requirements for Services"). DHCS shall issue the PSPP report to the Contractor with a copy to the provider. The Contractor shall be responsible for their contracted providers and Contractor-operated programs to ensure any deficiencies are remediated pursuant to subsection B, below. The Contractor shall attest the deficiencies have been remediated and are complete, pursuant to section 9, above.

B. The Department shall recover payments made if Postservice Postpayment Utilization Review uncovers evidence that the claim(s) should not have been paid, services have been improperly utilized, or requirements of Exhibit A, Attachment 2C, Section 22 were not met.

1) All deficiencies identified by PSPP reports, whether or not a recovery of funds results, shall be corrected and the Contractor shall submit a Contractor-approved CAP, as described above in Section 9.C. The CAP shall be submitted using a Secure Managed File Transfer system specified by DHCS within 60 days of the date of the PSPP report.

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

1) Requests for first-level appeals:

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

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

a) The Contractor shall submit the letter on the official stationery of the Contractor and it shall be signed by an authorized representative of the Contractor.

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

ii. The letter shall be submitted to the address listed in subsection (a) above within 90 calendar days from the date the Contractor received written notification of the decision to disallow claims.

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

iv. The Department shall inform the Contractor of the Department's decision and the basis for the decision within 15 calendar days after the Department's acknowledgement notification. The Department shall have the option of extending the decision response time if additional information is required from the Contractor. The Contractor will be notified if the Department extends the response time limit.

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

1) The second level process may be pursued only after complying with first-level procedures and only when:

a. The Department has failed to acknowledge the grievance or complaint within 15 calendar days of its receipt, or

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

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

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or from the date of the Department's first-level appeal decision letter.

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

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

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

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

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

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

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

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

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

11. DMC-ODS: Reporting Complaints

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

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

Exhibit A

Attachment 14
REPORTING REQUIREMENTS

1. Data Submission/ Certification Requirements

A. The Contractor shall submit any data, documentation, or information relating to the performance of the entity's obligations as required by the State or the United States Secretary of Health and Human Services. (42 C.F.R. § 438.604(b).) The individual who submits this data to the state shall concurrently provide a certification, which attests, based on best information, knowledge and belief that the data, documentation and information is accurate, complete and truthful. (42 C.F.R. § 438.606(b) and (c).) The data, documentation, or information submitted to the state by the Contractor shall be certified by one of the following:

1) The Contractor's Chief Executive Officer (CEO).

2) The Contractor's Chief Financial Officer (CFO).

3) An individual who reports directly to the CEO or CFO with delegated authority to sign for the CEO or CFO so that the CEO or CFO is ultimately responsible for the certification. (42 C.F.R. § 438.606(a).)

2. Encounter Data

The Contractor shall submit encounter data to the Department at a frequency and level specified by the Department and CMS, including as specified in Exhibit A, Attachment 4, Section 2. (42 C.F.R. § 438.242(c)(2).)

3. [Reserved]

4. Network Adequacy and Timely Access

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

5. Information on Ownership and Control

The Contractor shall submit for state review information on ownership and control for the Contractor, subcontractors, and network providers, as described in 42 C.F.R. section 455.104 and Exhibit A, Attachment 13, Section 8. (42 C.F.R § 438.604(a)(6).)

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REPORTING REQUIREMENTS

6. Annual Report of Overpayment Recoveries

The Contractor shall submit an annual report of overpayment recoveries in a manner and format determined by the Department. (MHSUDS IN 19-034; 42 C.F.R §§ 438.604(a)(7), 438.608(d)(3).)

7. Performance Data

A. In an effort to improve the performance of the State's managed care program, in accordance with 42 C.F.R. section 438.66(c), the Contractor will submit the following to the Department (42 C.F.R. § 438.604(b).):

1) Enrollment data;

2) Member grievance and appeal logs;

3) Provider complaint and appeal logs;

4) The results of any member satisfaction survey;

5) The results of any provider satisfaction survey;

6) Performance on required quality measures;

7) Medical management committee reports and minutes;

8) The Contractor's annual quality improvement plan;

9) Audited financial and encounter data; and

10) Customer service performance data.

B. The Contractor shall cooperate with DHCS to provide and report quality measures per the 1915(b) Special Terms and Conditions and the Comprehensive Quality Strategy.

8. Parity in Mental Health and Substance Use Disorder Services

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

9. Additional Reporting Requirements Regarding DMC-ODS Services

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

1) Contractor shall comply with the CalOMS-Tx data collection system requirements for submission of CalOMS-Tx data or contract with a

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REPORTING REQUIREMENTS

software vendor that complies with this requirement. If applicable, a Business Associate Agreement (BAA) shall be established between the Contractor and the software vendor. The BAA shall state that DHCS is allowed to return the processed CalOMS-Tx data to the vendor that supplied the data to DHCS.

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

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

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

5) Contractor shall submit CalOMS-Tx admission, discharge, annual update, resubmissions of records containing errors or in need of correction, and “provider no activity” report records in an electronic format approved by DHCS.

6) Contractor shall comply with the CalOMS-Tx Data Compliance Standards established by DHCS identified in (Document 3S) for reporting data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method.

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

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

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

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REPORTING REQUIREMENTS

B. CalOMS-Tx General Information.

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

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

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

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

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

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

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

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

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

5) If the Contractor or its subcontractor experiences system or service failure or other extraordinary circumstances that affect its ability to

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timely submit a monthly DATAR report, and/or to meet data compliance requirements, the Contractor shall report the problem in writing before the established data submission deadlines by writing a secure, encrypted email to SUDDATARSupport@dhcs.ca.gov.

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

7) [Reserved]

D. Provider-Preventable Conditions

1) The Contractor shall comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions. The Contractor shall report all identified provider-preventable conditions to the Department.

2) The Contractor shall not make payments to a contracted provider for provider-preventable conditions that meet the following criteria:

i. Is identified in the State Plan.

ii. Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.

iii. Has a negative consequence for the member beneficiary.

iv. Is auditable.

3) The Contractor shall use and submit the report using the DHCS DMC-ODS Provider Preventable Conditions Reporting Form at the time of discovery of any provider preventable conditions that are covered under this provision to:

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

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

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REPORTING REQUIREMENTS

10. Failure to Meet Reporting Requirements

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

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

C. If the Contractor has not ensured compliance with the data submission or CAP request within the designated timeline, then DHCS may withhold funds until all data is submitted. DHCS shall inform the Contractor 30 days in advance of when funds will be withheld. (BHIN 22-045.)

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

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

1. Medical Assistance Payment Provisions

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

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

2. Budget Contingency Clause

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

A. Federal Budget

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

B. Delayed Federal Funding

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

3. Contractor Claims and Federal Financial Participation

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

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

Exhibit B
BUDGET DETAIL AND PAYMENT PROVISIONS

4. Audits and Recovery of Overpayments

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

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

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

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

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

D. If the adjustments result in the Department owing payments to the Contractor, the Department shall submit a claim to the federal government

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for the related FFP within 30 days contingent upon sufficient budget authority.

5. Claims Adjudication Process

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

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

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

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

D. If the Department or the Contractor determines that changes must be made relating to either the Department's or the Contractor's claims

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submission and adjudication systems due to federal or state law changes or business requirements, both the Department and the Contractor agree to provide notice to the other party as soon as practicable prior to implementation. This notice shall include information and comments regarding the anticipated requirements and impacts of the projected changes. The Department and the Contractor agree to meet and discuss the design, development, and costs of the anticipated changes prior to implementation.

6. Payment Data Certification

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

7. System Changes

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

8. Administrative Reimbursement

A. SMHS only: Mental Health Medi-Cal Administrative Activities

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

2) Claims for reimbursement of MHMAA may be submitted to the Department on a quarterly basis. The Contractor shall submit a final annual claim for costs incurred in a state fiscal year to the Department by December 31st following the close of that fiscal year. The Department shall reconcile all quarterly payments with

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the final annual claim. If the total quarterly payments are greater than the total payments due to the Contractor based upon the final annual claim, the Department shall recoup the difference from the Contractor and return the overpayment to the Federal government pursuant to 42 C.F.R. 433.316. If the total quarterly payments are less than the total payments due to the Contractor based upon the final annual claim, the Department shall make an adjusting payment to the Contractor. The Contractor may e-mail DHCS at MHMAA@dhcs.ca.gov to request the MHMAA invoice template.

B. Other Medi-Cal Administrative Activities

Administrative activities that do not qualify for MHMAA may potentially qualify for reimbursement as County-Based Medi-Cal Administrative Activities (CMAA) pursuant to W & I Code section 14132.47 and applicable Department guidance.

C. Administrative Costs and UR/QA

1) Administrative costs that are not claimed as MH MAA or CMAA shall be claimed separately in a manner consistent with federal Medicaid requirements and the approved Medical Assistance Program Cost Allocation Plan and shall be limited to 15 percent of the total approved and paid claims to the Contractor for Medical Assistance. The cost of performing UR/QA activities shall be reimbursed separately and shall not be included in administrative costs.

2) The Contractor may submit claims for reimbursement of Administrative Costs and UR/QA costs to the Department on a quarterly basis. The Contractor shall submit a final annual claim for administrative costs and UR/QA costs incurred in a state fiscal year to the Department by December 31st following the close of that fiscal year. The Department shall reconcile all quarterly payments for administrative costs and UR/QA costs with the final annual claims. If the total quarterly payments are greater than the total payments due to the Contractor based upon the final annual claims, the Department shall recoup the difference from the Contractor and return the overpayment to the Federal government pursuant to 42 C.F.R. Part 433, Subpart F. If the total quarterly payments are less than the total payments due to the Contractor based upon the final annual claims, the Department shall make an adjusting payment to

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the Contractor. The Contractor shall use the MC 1982 B-1 to claim reimbursement for administrative costs and the MC 1982 C-1 to claim reimbursement for UR/QA costs.

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

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1. Contract Amendment Process

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

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

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

2) Any proposed amendments requested by the Contractor must be submitted to DHCS by October 1 of each year in order for the amendment to be effective for the following Contract year, beginning on January 1. These proposed amendments shall be duly approved by the County Board of Supervisors or its authorized designee and signed by a duly authorized representative.

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

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

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

2. Contract Renewal; Contract Cancellation/Termination

A. Contract Renewal

This Contract may be renewed if the Contractor continues to meet the requirements under this Contract and applicable law. Failure to meet

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

B. Contract Termination or Nonrenewal by Contractor

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

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

C. Contract Termination or Nonrenewal by the Department

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

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

ii. Upon at least 60 calendar days' written notice, DHCS shall terminate this Contract if the United States Secretary of Health and Human Services has determined the Contractor does not meet the federal requirements for participation in the Medicaid program. (W&I Code § 14197.7(i))

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

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1. A finding of deficiency that results in improper denial or delay in the delivery of health care services, potential endangerment to patient care, disruption in the Contractor's provider network, failure to approve continuity of care, that claims accrued or to accrue have not or will not be recompensed, or a delay in required Contractor report to the department. (W&I Code § 14197.7(a))
2. A failure of the Contractor, or its subcontractors or contracted providers, to comply with W&I Code sections 14124.24 or 14184.100 et seq., or BHIN 24-001.

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

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

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

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

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

i. Prior to January 1, 2027, in lieu of pursuing the termination procedures in this section, the Department may permit Contractor to transition from an integrated Medi-Cal behavioral health contract to separate contracts for SMHS and/or DMC/DMC-ODS services (as applicable), only if the Department concludes that Contractor meets all applicable requirements for those contracts.

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

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of invoices and statements for covered services provided to members prior to such expiration or termination.

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

4) Transfer of Records; Continuity of Care

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

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

iii. The preceding sections i and ii shall not apply with respect to the Contractor's SMHS and/or DMC/DMC-ODS program operations if:

1. The Contractor will continue providing SMHS and/or DMC/DMC-ODS services under a new agreement with the Department with substantially similar requirements, as determined by the Department; or

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

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5) The Department shall notify members of their Medi-Cal SMHS and DMC/DMC-ODS benefits and options available upon termination or expiration of this Contract.

3. Contract Disputes

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

4. Fulfillment of Obligation

A. All Attachments and Sections within Exhibit E apply to the delivery of both SMHS and DMC/DMC-ODS services (as applicable). The presence of a citation that applies to only one delivery system does not limit application of the corresponding requirements to only that delivery system, except as expressly otherwise indicated in this Exhibit.

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

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

5. Additional Provisions

A. SMHS and DMC-ODS only: Inspection Rights/Record Keeping Requirements

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

2) The Contractor, and subcontractors, shall allow the Department, CMS, the Office of the Inspector General, the Comptroller General of the United States, and other authorized federal and state

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agencies, or their duly authorized designees, to evaluate Contractor's, and subcontractors', performance under this Contract, including the quality, appropriateness, and timeliness of services provided, and to inspect, evaluate, and audit any and all records, documents, and the premises, equipment and facilities maintained by the Contractor and its subcontractors pertaining to such services at any time. The Contractor shall allow such inspection, evaluation and audit of its records, documents and facilities, and those of its subcontractors, for 10 years from the term end date of this Contract or in the event the Contractor has been notified that an audit or investigation of this Contract has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later. (See 42 C.F.R. §§ 438.3(h) and 438.230(c)(3)(i-iii)).

3) The Contractor, and subcontractors, shall retain, all records and documents originated or prepared pursuant to the Contractor's or subcontractor's performance under this Contract, including member grievance and appeal records identified in Exhibit A, Attachment 12, Section 2 and the data, information and documentation specified in (or that demonstrates compliance with) 42 C.F.R. §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years from the term end date of this Contract or in the event the Contractor has been notified that an audit or investigation of this Contract has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later. (42 C.F.R. § 438.3(u); see also § 438.3(h)).

4) "Records and documents" include but are not limited to all physical and electronic records and documents originated or prepared pursuant to the Contractor's or subcontractor's performance under this Contract including working papers, reports, financial records and documents of account, member records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for members.

B. Notices

Unless otherwise specified in this Contract, all notices to be given under this Contract shall be in writing and shall be deemed to have been given when

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mailed, to the Department or the Contractor at the following addresses, unless the Contract explicitly requires notice to another individual or organizational unit:

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

C. Nondiscrimination

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

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

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

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

D. Relationship of the Parties

The Department and the Contractor are, and shall at all times be deemed to be, independent agencies. Each party to this Contract shall be wholly responsible for the manner in which it performs the obligations and services required of it by the terms of this Contract. Nothing herein contained shall be construed as creating

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the relationship of employer and employee, or principal and agent, between the parties or any of their agents or employees. Each party assumes exclusively the responsibility for the acts of its employees or agents as they relate to the services to be provided during the course and scope of their employment. The Department and its agents and employees shall not be entitled to any rights or privileges of the Contractor's employees and shall not be considered in any manner to be Contractor employees. The Contractor and its agents and employees shall not be entitled to any rights or privileges of state employees and shall not be considered in any manner to be state employees.

E. [Reserved]

F. Freeze Exemptions

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

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

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

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

G. Force Majeure

Neither party shall be responsible for delays or failures in performance resulting from acts beyond the control of either party. Such acts shall include but not be limited to acts of God, fire, flood, earthquake, other natural disaster, nuclear accident, strike, lockout, riot, freight-embargo, related-utility, or governmental statutes or regulations super-imposed after the fact. If a delay or failure in performance by the Contractor arises out of a default of its subcontractor or contracted provider, and if such default arises out of causes beyond the control of both the Contractor and subcontractor or contracted provider, and without the fault or negligence of either of them, the Department shall not sanction the Contractor because of such delay or failure. In the event of such acts, the Contractor shall take reasonable steps to perform under this Contract.

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

1) The Contractor's County Administrator or designee shall participate and represent the county in meetings of the County Behavioral Health

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Director's Association of California for the purposes of representing the counties in their relationship with DHCS with respect to policies, standards, and administration for SUD services.

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

6. Duties of the State

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

A. Payment for Services

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

B. Reviews

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

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

C. Monitoring for Compliance; Corrective Action; Sanctions

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

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

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

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

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

i. This review shall include the Contractor's service delivery system, member protections, access to services, authorization for services,

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compliance with regulatory and contractual requirements of the waiver, and a member records review.

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

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

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

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

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

ii. The Contractor's CAP shall:

A. Be documented on the DHCS CAP template.

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

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

a. Correcting the deficiency; and

b. Ensuring on-going compliance.

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

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

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

iv. If the Contractor fails to submit a CAP or if the Contractor does not implement the approved CAP provisions within the designated timeline,

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then the Department may withhold funds or issue monetary sanctions until the Contractor is in compliance, terminate this Contract for cause, remove the Contractor from the DMC-ODS Waiver (if applicable), or take any other actions it deems necessary to resolve the Contractor's deficiencies. The Department shall inform the Contractor 30 calendar days in advance of when funds will be withheld.

4) The Department may impose administrative and monetary sanctions, including the temporary withhold of federal financial participation and realignment payments, on the Contractor for:

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

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

   iii. for other good cause,

in accordance with W&I Code section 14197.7 and guidance issued by the Department pursuant to W&I Code section 14197.7, subdivision (r).

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

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

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

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

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accordance with procedures established by the Department, the date the site was operational, or the date a required fire clearance was obtained, whichever date is latest.

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

4) Nothing in this section precludes the Department from establishing procedures for issuance of separate provider identification numbers for each of the organizational provider sites operated by the Contractor to facilitate the claiming of FFP by the Contractor and the Department's tracking of that information.

E. Excluded Providers

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

2) Consistent with the requirements in 42 C.F.R. section 455.436, the Department shall confirm the identity and determine the exclusion status of the Contractor, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the Contractor through routine checks of Federal databases.

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

F. Performance Measurement

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

G. Website Transparency

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

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

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

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7. State and Federal Law Governing this Contract

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

B. The Contractor agrees to comply with all applicable federal and state law, including but not limited to the statutes and regulations incorporated by reference below, any applicable federal and state laws that pertain to member rights, and applicable sections of the State Plan, applicable federal waivers, and applicable Behavioral Health Information Notices (BHINs) in its provision of services as an integrated county behavioral health plan.

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

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

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

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

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

1) Title 42 United States Code;

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

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

b. 42 C.F.R. § 455.

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

d. 42 C.F.R. Part 2.

3) [Reserved];

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

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

6) Title VII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.

7) Title IX of the Education Amendments of 1972;

8) Age Discrimination Act of 1975;

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

10) Rehabilitation Act of 1973;

11) Americans with Disabilities Act;

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

13) Deficit Reduction Act of 2005;

14) Balanced Budget Act of 1997;

15) Section 106(g) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(g)) as amended by section 1702. For full text of the award term, go to: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title22-section7104d&num=0&edition=prelim.

16) The provisions of the Hatch Act (Title 5 USC, sections 1501-1508), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.

17) Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and

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construction contracts greater than $10,000 funded by federal financial assistance.

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

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

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

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

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

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

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

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

1) W&I Code, division 5

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

a. Sections 14021, 14021.5, 14021.6

b. Sections 14043 et seq.

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c. Sections 14059.5, 14184.402, and 14184.403

d. Section 14100.2

e. Sections 14680-14685.1

f. Sections 14700-14727

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

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

5) Government Code section 16367.8.

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

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

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

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

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

d. Sections 9000-14240

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

a. Sections 50951 and 50953

b. Sections 51014.1 and 51014

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

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

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

G. No state funds, Federal funds, or mental health or substance use disorder realignment funds (e.g., Behavioral Health Subaccount of the Local Revenue Fund 2011, Mental Health Subaccount of the Local Revenue Fund) shall be used

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

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

1. "Advance Directives" means a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of the health care when the individual is incapacitated.

2. "Abuse" means provider practices that are inconsistent with sound, fiscal, business, or medical practices, and result in an unnecessary cost to the Medi-Cal program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medi-Cal program. (See 42 C.F.R. §§ 438.2, 455.2)

3. "Adolescents" means members under age 21.

4. "Adult" means members 21 years of age or over.

5. "Alcohol or other Drug (AOD) Counselor" means: 1) either certified or registered by an organization that is recognized by the Department of Health Care Services and accredited with the National Commission for Certifying Agencies (NCCA); and 2) meets all California State education, training, and work experience requirements set forth in the Counselor Certification Regulations, 9 C.C.R., division 4, chapter 8.

6. "American Indian/Alaska Native (AI/AN)" means any person defined in Title 25 United States Code sections 1603(13), 1603(28), or section 1679(a), or who has been determined eligible as an Indian under 42 C.F.R. section 136.12.

7. "Ancillary Service" means to include individualized connection, referral, and linkages to community-based services and supports.

8. "Appeal" means a review by the Contractor of an adverse benefit determination or a denial to expedite an authorization decision.

9. "Available Capacity" means the total number of units of service (bed days, hours, slots, etc.) that a Contractor actually makes available in the current fiscal year.

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

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

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

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

14. "Contracted Provider” means:

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

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

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

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

17. "Covered Services" refer to:

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

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

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

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

19. “Dedicated Capacity” means the historically calculated service capacity, by modality, adjusted for the projected expansion or reduction in services, which the Contractor agrees to make available to provide SUD services to persons eligible for Contractor services.

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

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

22. "Director" means the Director of DHCS.

23. "Discrimination Grievance" means a complaint concerning the unlawful discrimination on the basis of any characteristic protected under federal or state law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

24. "DMC-Certified Provider" means a substance use disorder clinic location that has received certification to be reimbursed as a DMC clinic by the state to provide services as described in 22 C.C.R. section 51341.1.

25. "DMC Re-certification" means the process by which the DMC-certified clinic is required to submit an application and specified documentation, as determined by DHCS, to remain eligible to participate in and be reimbursed through the DMC program. Re-certification shall occur no less than every five years from the date of previous DMC certification or re-certification.

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

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

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

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

30. "Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)" means the federal mandate under Section 1905(r) of the Act, which requires the Contractor to ensure that all members under age 21 receive all applicable mental health or SUD services needed to correct or ameliorate health conditions that are coverable under Section 1905(a) of the Act. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a health condition. Services that sustain, support, improve, or make more tolerable a

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health condition are considered to ameliorate the condition and are thus covered as EPSDT services.

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

32. "Emergency" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

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

    B. Serious impairment to bodily functions;

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

    D. Death.

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

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

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

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

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

38. "Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination or an appeal of a denial to expedite an authorization decision. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the member's rights regardless of whether remedial action is requested. (42 C.F.R. § 438.400)

39. "Grievance and Appeal System" means the processes the Contractor implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them, as described in Exhibit A, Attachment 12.

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

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

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

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

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

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

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

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

48. "Managed Care Program" means a managed care delivery system operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Social Security Act.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

62. "Postpartum" as defined for DMC purposes, means the 60-day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility for perinatal services shall end on the last day of the calendar month in which the 60th day occurs.

63. "Postservice Postpayment (PSPP) Utilization Review" means the review for DMC/DMC-ODS program compliance conducted by the state after service was rendered and paid. The Department may recover prior payments of Federal and state funds if such a review determines that the services did not comply with the applicable statutes, regulations, or terms as specified in this Contract.

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

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

66. "Primary Care" means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

67. "Primary care provider" means a person responsible for supervising, coordinating, and providing initial and primary care to patients, for initiating referrals, and for maintaining the continuity of patient care. A primary care provider may be a primary care physician or non-physician medical practitioner.

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

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

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

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

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

70. “Utilization Review/Quality Assessment (UR/QA)” activities are reviews of physicians, health care practitioners and providers of health care services in the provision of health care services and items for which payment may be made to determine whether:

    1) Such services are or were reasonable and medically necessary and whether such services and items are allowable; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

84. “Substance Use Disorder Diagnoses” are those set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.

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

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

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

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

89. "Telephone" means contact with a member via synchronous, real-time audio-only telecommunications systems.

90. "Therapy" means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal, strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a member in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a member or group of members and may include family therapy directed at improving the member's functioning and at which the member is present. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].)

91. "Threshold Language" means a language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility System (MEDS), of 3,000 members or five percent of the member population, whichever is lower, in an identified geographic area.

92. "Transportation Services" means provision of or arrangement for transportation to and from medically necessary treatment.

93. "Treatment Planning" means a service activity to develop or update a member's course of treatment, documentation of the recommended course of treatment, and monitoring a member's progress. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].)

94. "Tribal 638 Providers" –means Federally recognized Tribes or Tribal organizations that contract or compact with IHS to plan, conduct and administer one or more individual programs, functions, services or activities under Public Law 93-638.

    1) A Tribal 638 provider enrolled in Medi-Cal as an Indian Health Services-Memorandum of Agreement (IHS-MOA) provider must appear on the "List of American Indian Health Program Providers" set forth in APL 17-020, Attachment 1 in order to qualify for reimbursement as a Tribal 638 Provider under BHIN 22-020.

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2) A Tribal 638 provider enrolled in Medi-Cal as a Tribal Federally Qualified Health Center (FQHC) provider is governed by and must enroll in Medi-Cal consistent with the Tribal FQHC criteria established in the California State Plan, the Tribal FQHC section of the Medi-Cal provider manual, and APL 21-008. Tribal 638 providers enrolled in Medi-Cal as a Tribal FQHC must appear on the "List of Tribal Federally Qualified Health Center Providers," which is set forth on Attachment 2 to APL 21-008.

95. "Urban Indian Organizations (UIO)" – A Nonprofit corporate body situated in an urban center, governed by an urban Indian controlled board of directors, and providing for the maximum participation of all interested Indian groups and individuals, which body is capable of legally cooperating with other public and private entities for the purpose of performing the activities described in section 1653(a) of Title 25 of the Code of Federal Regulations.

96. "Urgent care" means a condition perceived by a member as serious, but not life threatening. A condition that disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 24-72 hours.

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1. "Assessment" means a service activity designed to collect information and evaluate the current status of a member's mental, emotional, or behavioral health to determine whether Rehabilitative Mental Health Services are medically necessary and to recommend or update a course of treatment for that member. Assessments shall be conducted and documented in accordance with applicable State and Federal statutes, regulations, and standards. (State Plan, Supplement 3 to Attachment 3.1-A, page 1 [TN 22-0023].)

2. "Adult Residential Treatment Services" are recovery focused rehabilitative services provided in a non-institutional, residential setting for members who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program. The service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days. Adult residential treatment services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone. Services will not be claimable unless the member has been admitted to the program and there is face-to-face contact between the member and a treatment staff person of the facility on the day of the service. This service includes one or more of the following components: assessment, treatment planning, therapy, and psychosocial rehabilitation. (State Plan, Supplement 3 to Attachment 3.1-A, page 2f [TN 22-0023].)

3. "Community-Based Mobile Crisis Intervention Services (also referred to as "Mobile Crisis Services")" are services that provide rapid response, individual assessment and community-based stabilization to Medi-Cal members who are experiencing a behavioral health crisis. Mobile Crisis Services are designed to provide relief to members experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care, psychiatric inpatient hospitalizations, and law enforcement involvement. Mobile Crisis Services include warm handoffs to appropriate settings and providers when the member requires additional stabilization and/or treatment services; coordination with and referrals to appropriate health, social and other services and supports, as needed, and short-term follow-up support to help ensure the crisis is resolved and the member is connected to ongoing care. Mobile Crisis Services are directed toward the member in crisis but may include contact with a family member(s) or other significant support collateral(s) if the purpose of the collateral's participation is to assist the member in addressing their behavioral health crisis and restoring the member to the highest possible functional level. Mobile crisis services are provided by a multidisciplinary mobile crisis team at the location where the member is experiencing the behavioral health crisis. Locations may include, but are not limited to, the member's home,

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school, or workplace, on the street, or where a member socializes. Mobile Crisis Services claimed under this option cannot be provided in hospitals or other facility settings. Mobile crisis services shall be available to members experiencing behavioral health crises 24 hours a day, 7 days a week, and 365 days a year.

4. "Crisis Intervention" is an unplanned, expedited service to or on behalf of, a member to address a condition that requires more timely response than a regularly scheduled visit. Crisis intervention is an emergency response service enabling a member to cope with a crisis, while assisting the member in regaining their status as a functioning community member. The goal of crisis intervention is to stabilize an immediate crisis within a community or clinical treatment setting. It may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. This service includes one or more of the following service components: assessment, therapy, and referral and linkages. Crisis Intervention services may either be face-to-face or by telephone or telehealth and may be provided in a clinic setting or anywhere in the community. (State Plan, Supplement 3 to Attachment 3.1-A, page 2d [TN 22-0023].)

5. "Crisis Residential Treatment Services" are therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program (short term-3 months or less) as an alternative to hospitalization for members experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. This service is available 24 hours a day, seven days a week and structured day and evening services are available all seven days. Crisis residential treatment services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone. Services will not be claimable unless the member has been admitted to the program and there is face-to-face contact between the member and a treatment staff person of the facility on the day of the service. This service includes one or more of the following: assessment, treatment planning, therapy, psychosocial rehabilitation, and crisis intervention. (State Plan, Supplement 3 to Attachment 3.1-A, page 2g [TN 22-0023].)

6. "Crisis Stabilization" is an unplanned, expedited service lasting less than 24 hours, to or on behalf of, a member to address an urgent condition that requiring immediate attention that cannot be adequately or safely addressed in a community setting. The goal of crisis stabilization is to avoid the need for inpatient services which, if the condition and symptoms are not treated, present an imminent threat to the member or others, or substantially increase the risk of the member becoming gravely disabled. Crisis stabilization must be provided on site at a licensed 24-hour health care facility, at a hospital based outpatient

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program (services in a hospital based outpatient program are provided in accordance with 42 CFR 440.20), or at a provider site certified by the Department of Health Care Services to perform crisis stabilization and some service components may be delivered through telehealth or telephone. Crisis stabilization is an all-inclusive program and no other Rehabilitative Mental Health Services are reimbursable during the same time period this service is reimbursed. Crisis stabilization may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member.

Medical backup services must be available either on site or by written contract or agreement with a general acute care hospital. Medical backup means immediate access within reasonable proximity to health care for medical emergencies. Medications must be available on an as needed basis and the staffing pattern must reflect this availability. All members receiving crisis stabilization must receive an assessment of their physical and mental health. This may be accomplished using protocols approved by a physician. If outside services are needed, a referral that corresponds with the member 's needs will be made, to the extent resources are available. This service includes one or more of the following service components: assessment, therapy, crisis intervention, medication support services, referral and linkages. (State Plan, Supplement 3 to Attachment 3.1-A, page 2e [TN 22-0023].)

7. “Day Rehabilitation” is a structured program which provides services to a distinct group of individuals. Day rehabilitation is intended to improve or restore personal independence and functioning necessary to live in the community or prevent deterioration of personal independence consistent with the principles of learning and development. Services are available for at least three hours each day. Day rehabilitation is a program that lasts less than 24 hours each day. Day rehabilitation may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. This service includes one or more of the following service components: assessment, treatment planning, therapy, and psychosocial rehabilitation. (State Plan, Supplement 3 to Attachment 3.1-A, page 2c [TN 22-0023].)

8. “Day Treatment Intensive” is a structured, multi-disciplinary program of therapy that may be used as an alternative to hospitalization, or to avoid placement in a more restrictive setting, or to maintain the client in a community setting and which provides services to a distinct group of members who receive services for a at least three hours per day and lasts less than 24 hours each day. This service includes one or more of the following service components: assessment, treatment planning, therapy, and psychosocial rehabilitation. This service may include contact with significant support persons or other collaterals if the purpose

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of their participation is to focus on the treatment of the member. Day treatment intensive services must have a clearly established site for services although all services need not be delivered at that site and some service components may be delivered through telehealth or telephone. (State Plan, Supplement 3 to Attachment 3.1-A, page 2c [TN 22-0023].)

9. "Intensive Care Coordination (ICC)" is a targeted case management service that facilitates assessment of care planning for and coordination of services to members under age 21 who are eligible for the full scope of Medi-Cal services and who meet medical criteria to access SMHS. ICC service components include: assessing; service planning and implementation; monitoring and adapting; and transition. ICC services are provided through the principles of the Integrated Core Practice Model (ICPM), including the establishment of the Child and Family Team (CFT) to ensure facilitation of a collaborative relationship among a child, their family and involved child-serving systems. The CFT is comprised of – as appropriate, both formal supports, such as the care coordinator, providers, case managers from child-serving agencies, and natural supports, such as family members, neighbors, friends, and clergy and all ancillary individuals who work together to develop and implement the client plan and are responsible for supporting the child and family in attaining their goals. ICC also provides an ICC coordinator who:

    1) Ensures that medically necessary services are accessed, coordinated and delivered in a strength-based, individualized, family/child driven and culturally and linguistically competent manner and that services and supports are guided by the needs of the child;

    2) Facilitates a collaborative relationship among the child, their family and systems involved in providing services to the child;

    3) Supports the parent/caregiver in meeting their child's needs;

    4) Helps establish the CFT and provides ongoing support; and

    5) Organizes and matches care across providers and child serving systems to allow the child to be served in their community.

10. "Intensive Home Based Services (IHBS)" are individualized, strength-based interventions designed to ameliorate mental health conditions that interfere with a child's functioning and are aimed at helping the child build skills necessary for successful functioning in the home and community and improving the child's family's ability to help the child successfully function in the home and community. IHBS services are provided in accordance with the Integrated Core Practice Model (ICPM) by the Child and Family Team (CFT) in coordination with the family's overall service plan which may include IHBS. Service activities may

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include, but are not limited to assessment, treatment plan, therapy, rehabilitation and include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. IHBS is provided to members under 21 who are eligible for the full scope of Medi-Cal services and who meet the access criteria for SMHS.

11. "Medication Support Services" include prescribing, administering, dispensing and monitoring of psychiatric medications or biologicals that are necessary to alleviate the symptoms of mental illness. This service includes one or more of the following service components: evaluation of the need for medication; evaluation of clinical effectiveness and side effects; medication education including instruction in the use, risks and benefits of, and alternatives for medication; treatment planning. Medication support services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. This service may also include assessing the appropriateness of reducing medication usage when clinically indicated. Medication support services may be provided face-to-face, by telephone or by telehealth, and may be provided anywhere in the community. Medication support services may be delivered as a standalone service or as a component of crisis stabilization.

12. "Mental Health Services" are individual, group, or family-based interventions that are designed to provide a reduction of the member's mental or emotional disability, and restoration, improvement and/or preservation of individual and community functioning, and continued ability to remain in the community consistent with the goals of recovery, resiliency, learning, development, independent living, and enhanced self-sufficiency and that are not provided as components of adult residential services, crisis residential services, crisis intervention, crisis stabilization, day rehabilitation, or day treatment intensive. Mental health services may include contact with significant support persons or other collateral if the purpose of their participation is to focus on the treatment of the member. This service includes one or more of the following service components: assessment, treatment planning, therapy, and psychosocial rehabilitation. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].)

13. "Peer Support Services" are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower members through strength-based coaching, support linkages to community resources, and to educate members and their families about their

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conditions and the process of recovery. Peer support services may be provided with the member or significant support person(s) and may be provided in a clinical or non-clinical setting. Peer support services can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member by supporting the achievement of the member's treatment goals.

1) Peer support services are based on an approved plan of care and may be delivered as a standalone service. Peer support services include one or more of the following service components:

2) Educational Skill Building Groups, which are groups provided in a supportive environment in which members and their families learn coping mechanisms and problem-solving skills in order to help the members achieve desired outcomes. These groups promote skill building for the members in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

3) Engagement, which means Peer Support Specialist led activities and coaching to encourage and support members to participate in behavioral health treatment. Engagement may include supporting members in their transitions and supporting members in developing their own recovery goals and processes.

4) Therapeutic Activity, which means structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the member's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the member; promotion of self-advocacy; resource navigation; and collaboration with the members and others providing care or support to the member, family members, or significant support persons. (State Plan, Supplement 3 to Attachment 3.1-A, page 2 [TN 22-0023].)

14. "Psychiatric Health Facility Services" are therapeutic and/or rehabilitative services provided in a psychiatric health facility licensed by DHCS. Psychiatric health facilities are licensed to provide acute inpatient psychiatric treatment to individuals with major mental disorders. Psychiatric health facility services may include contact with significant support persons or other collaterals if the purpose of their participation is to focus on the treatment of the member. Services are provided in a psychiatric health facility under a multidisciplinary model and some

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service components may be delivered through telehealth or telephone. Psychiatric health facilities may only admit and treat patients who have no physical illness or injury that would require treatment beyond what ordinarily could be treated on an outpatient basis. Services include the following components: assessment, treatment planning, therapy, psychosocial rehabilitation, and crisis intervention. These services are separate from those categorized as "Psychiatric Inpatient Hospital". (State Plan, Supplement 3 to Attachment 3.1-A, page 2g [TN 22-0023].)

15. "Psychiatric Inpatient Hospital Services" include both acute psychiatric inpatient hospital services and administrative day services. Acute psychiatric inpatient hospital services are provided to members for whom the level of care provided in a hospital is medically necessary to diagnose or treat a covered mental illness. Administrative day services are inpatient hospital services provided to members who were admitted to the hospital for an acute psychiatric inpatient hospital service and the member's stay at the hospital must be continued beyond the member's need for acute psychiatric inpatient hospital services due to lack of residential placement options at non-acute residential treatment facilities that meet the needs of the member.

    Psychiatric inpatient hospital services are provided by SD/MC hospitals and FFS/MC hospitals. SMHS programs claim reimbursement for the cost of psychiatric inpatient hospital services provided by SD/MC hospitals through the SD/MC claiming system. FFS/MC hospitals claim reimbursement for the cost of psychiatric inpatient hospital services through the Fiscal Intermediary. SMHS programs are responsible for authorization of psychiatric inpatient hospital services reimbursed through either billing system. For SD/MC hospitals and FFS/MC hospitals, the daily rate does not include professional services, which are billed separately from the SD/MC and FFS/MC inpatient hospital services via the SD/MC claiming system.

16. "Psychosocial Rehabilitation" means a recovery or resiliency focused service activity which addresses a mental health need. This service activity provides assistance in restoring, improving, and/or preserving a member's functional, social, communication, or daily living skills to enhance self-sufficiency or self-regulation in multiple life domains relevant to the developmental age and needs of the member. Psychosocial rehabilitation includes assisting members to develop coping skills by using a group process to provide peer interaction and feedback in developing problem-solving strategies. In addition, psychosocial rehabilitation includes therapeutic interventions that utilize self-expression such as art, recreation, dance or music as a modality to develop or enhance skills. These interventions assist the member in attaining or restoring skills which enhance community functioning including problem solving, organization of

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thoughts and materials, and verbalization of ideas and feelings. Psychosocial rehabilitation also includes support resources, and/or medication education. Psychosocial rehabilitation may be provided to a member or a group of members. (State Plan, Supplement 3 to Attachment 3.1-A, page 2a [TN 22-0023].)

17. "Referral and Linkages" are services and supports to connect a member with primary care, specialty medical care, SUD treatment providers, mental health providers, and community-based services and supports. This includes identifying appropriate resources, making appointments, and assisting a member with a warm handoff to obtain ongoing support. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].)

18. "Targeted case management" is a service that assists a member in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. The service activities may include, but are not limited to, communication, coordination and referral; monitoring service delivery to ensure member access to services and the service delivery system; monitoring of the member's progress, placement services, and plan development. TCM services may be face-to-face or by telephone with the client or significant support persons and may be provided anywhere in the community. Additionally, services may be provided by any person determined by the SMHS program to be qualified to provide the service, consistent with the scope of practice and state law.

19. "Therapeutic Behavioral Services (TBS)" are intensive, individualized, short-term outpatient treatment interventions for members up to age 21. Individuals receiving these services have serious emotional disturbances (SED), are experiencing a stressful transition or life crisis and need additional short-term, specific support services.

20. "Therapeutic Foster Care (TFC) Services" model allows for the provision of short-term, intensive, highly coordinated, trauma informed and individualized specialty mental health services activities (plan development, rehabilitation and collateral) to children up to age 21 who have complex emotional and behavioral needs and who are placed with trained, intensely supervised and supported TFC parents. The TFC parent serves as a key participant in the therapeutic treatment process of the child. The TFC parent will provide trauma informed interventions that are medically necessary for the child. TFC is intended for children youth who require intensive and frequent mental health support in a family environment. The TFC service model allows for the provision of certain specialty mental health services activities (plan development, rehabilitation and collateral) available under the EPSDT benefit as a home-based alternative to high level care in institutional settings such as group homes and an alternative to Short Term Residential Therapeutic Programs (STRTPs).

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21. “Therapy” means a service activity that is a therapeutic intervention that focuses primarily on symptom reduction and restoration of functioning as a means to improve coping and adaptation and reduce functional impairments. Therapeutic intervention includes the application of cognitive, affective, verbal or nonverbal, strategies based on the principles of development, wellness, adjustment to impairment, recovery and resiliency to assist a member in acquiring greater personal, interpersonal and community functioning or to modify feelings, thought processes, conditions, attitudes or behaviors which are emotionally, intellectually, or socially ineffective. These interventions and techniques are specifically implemented in the context of a professional clinical relationship. Therapy may be delivered to a member or group of members and may include family therapy directed at improving the member's functioning and at which the member is present. (State Plan, Supplement 3 to Attachment 3.1-A, page 2b [TN 22-0023].)

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1. "Assessment" means activities to evaluate or monitor the status of a member's behavioral health and determine the appropriate level of care and course of treatment for that member. Assessments shall be conducted in accordance with applicable State and Federal laws, and regulations, and standards. Assessment may be initial and periodic, and may include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member. Assessment services may include one or more of the following components:

    A. Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder.

    B. Diagnosis of substance use disorders utilizing the current DSM and assessment of treatment needs for medically necessary treatment services. This may include a physical examination necessary for treatment and evaluation.

    C. Treatment planning, a service activity that consists of development and updates to documentation needed to plan and address the member's needs, planned interventions and to address and monitor a member's progress and restoration of member to their best possible functional level.

2. "Family Therapy" means a rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the member's recovery as well as the holistic recovery of the family system. Family members can provide social support to the member and help motivate their loved one to remain in treatment. There may be times when, based on clinical judgment, the member is not present during the delivery of this service, but the service is for the direct benefit of the member.

3. "Group Counseling" consists of contacts with multiple members at the same time. Group Counseling shall focus on the needs of the participants. Group counseling means contacts in which one or more therapists or counselors treat two or more members at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served. A member that is 17 years of age or younger shall not participate in group counseling with any participants who are 18 years of age or older. However, a member who is 17 years of age or younger may participate in group counseling with participants who are 18 years of age or older when the counseling is at a provider's certified school site.

4. "Individual Counseling" consists of contacts with a member. Individual counseling can include contact with family members or other collaterals if the purpose of the collateral's participation is to focus on the treatment needs of the member by supporting the achievement of the member's treatment goals. Individual

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counseling also includes preparing the beneficiary to live in the community, and providing linkages to treatment and services available in the community.

5. "Medical psychotherapy" means a counseling service to treat SUDs other than OUD conducted by the medical director of a Narcotic Treatment Program on a one-to-one basis with the member.

6. "Medication Services" means the prescription or administration of medication related to substance use disorder services, or the assessment of the side effects or results of the medication. Medication Services does not include MAT for Opioid Use Disorders (OUD) or MAT for Alcohol Use Disorders (AUD) and other Non-Opioid Substance Use Disorders. Medication Services includes prescribing, administering, and monitoring medications used in the treatment or management of SUD and/or withdrawal management not included in the definitions of MAT for OUD or MAT for AUD services.

7. "Medications for Addiction Treatment (also known as medication assisted treatment (MAT)) for Alcohol Use Disorders (AUD) and Non-Opioid Substance Use Disorders" includes all FDA-approved drugs and services to treat AUD and other non-opioid SUDs involving FDA-approved medications to treat AUD and non-opioid SUDs.

8. "Medications for Addiction Treatment (also known as medication assisted treatment (MAT)) for Opioid Use Disorders (OUD)" includes all medications approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262) to treat opioid use disorders.

9. "Narcotic Treatment Program" or "NTP means an outpatient program that provides FDA-drugs approved to treat SUDs when ordered by a physician as medically necessary. NTPs are required to offer and prescribe medications including methadone, buprenorphine, naloxone and disulfiram. A member must receive at minimum fifty minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided as medically necessary.

10. "Non-Perinatal Residential Program" services are provided in DHCS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria. These residential services are provided to the non-perinatal population and do not require the enhanced services found in the perinatal residential programs.

11. "Observation" means the process of monitoring the member's course of withdrawal. The Contractor shall ensure observation be conducted at the frequency required by applicable state and federal laws, regulations, and

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standards. This may include but is not limited to observation of the member's health status.

12. "Patient Education" means education for the member on addiction, treatment, recovery and associated health risks.

13. "Perinatal DMC Services" means covered services as well as parent/child habilitative and rehabilitative services; services access (i.e., provision or arrangement of transportation to and from medically necessary treatment); education to reduce harmful effects of alcohol and drugs on the parent and fetus or infant; and coordination of ancillary services (Cal. Code Regs., tit. 22, § 51341.1(c)(4)).

14. "Recovery monitoring" means recovery coaching, monitoring designed for the maximum reduction of the member's SUD.

15. "Recovery Services" means a DMC-ODS service designed to support recovery and prevent relapse with the objective of restoring the member to their best possible functional level. Recovery Services emphasize the member's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to members.

16. "Substance Use Disorder Crisis Intervention Services" means contacts with a member in crisis. A crisis means an actual relapse or an unforeseen event or circumstance which presents to the member an imminent threat of relapse. SUD Crisis Intervention Services shall focus on alleviating the crisis problem, be limited to the stabilization of the member's immediate situation, and be provided in the least intensive level of care that is medically necessary to treat their condition.

17. "Unit of Service" means:

    a. For care coordination, intensive outpatient treatment, outpatient services, Naltrexone treatment services, and recovery services contact with a member in 15-minute increments on a calendar day.

    b. For additional medication assisted treatment, physician services that includes ordering, prescribing, administering, and monitoring of all medications for SUDs per visit or in 15-minute increments.

    c. For narcotic treatment program services, a calendar month of treatment services provided pursuant to this section and 9 C.C.R., chapter 4, commencing with § 10000.

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d. For clinician consultation services, consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists in 15-minute increments.

e. For residential services, providing 24-hour daily service, per member, per bed rate.

f. For withdrawal management per member per visit/daily unit of service.