Exhibit A, Attachment I
Program Specifications

I. Preamble

A. This Intergovernmental Agreement (hereinafter referred to as Agreement) is entered into by and between the Department of Health Care Services (hereinafter referred to as DHCS, The Department, or the state) and the Contractor for the purpose of identifying and providing covered Drug Medi-Cal Organized Delivery System (DMC-ODS) services for substance use disorder (SUD) treatment in the Contractor's service area pursuant to sections 14021.51–14021.53, 14124.20–14124.25, 14184.100 *et seq.* of the Welfare and Institutions Code (hereinafter referred to as W&I Code), Part 438 of the Code of Federal Regulations (hereinafter referred to as 42 CFR 438); Behavioral Health Information Notice (BHIN) 23-001.

B. The Contractor has elected to opt into the DMC-ODS to provide or arrange covered DMC-ODS services described under this Agreement to eligible Medi-Cal individuals who reside within the Contractor's county borders. The Contractor shall comply with all State and federal statutes and regulations, the terms of this Agreement, BHINs, and any other applicable authorities. In the event of a conflict between the terms of this Agreement and a State or federal statute or regulation, or a BHIN, the Contractor shall adhere to the applicable statue, regulation, or BHIN.

C. It is further agreed this Agreement is controlled by applicable provisions of: (a) the W&I Code, Division 9, Part 3, Chapter 7, sections 14000, et seq., in particular, but not limited to, sections 14100.2, 14021, 14021.5, 14021.6, 14043, et seq., 14184.100 *et seq.*, and (b) Division 4 of Title 9 of the California Code of Regulations (hereinafter referred to as Cal. Code Regs., tit. 9).

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

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

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

G. This Agreement requires the Contractor to ensure the availability and accessibility of adequate numbers of facilities, service locations, service sites, and professional, allied, and supportive personnel to provide medically necessary services, and ensure the authorization of services for urgent conditions. The DMC-ODS provides for automatic mandatory enrollment of all Medi-Cal beneficiaries in the single PIHP operating in the county in which the beneficiary resides. PIHPs in a very small county or in any one geographic area may have a limited number of providers for a particular service. Except as required by 42 CFR 438.206(b)(4), if additional providers are not needed to meet general access requirements, the Contractor is not obligated to subcontract with additional providers to provide more choices for an individual beneficiary.

II. Federal Requirements

A. Waived and Inapplicable Federal Requirements

1. The Contractor is operating as a nonrisk PIHP. Accordingly, the provisions of 42 CFR §438 and other regulations are identified as inapplicable to the DMC-ODS on pages 15-16 of the California Advancing & Innovating Medi-Cal (CalAIM) 1915(b) Waiver (Waiver Control # CA 17.R10). Approved Application and are not applicable to this Agreement.
2. Under DMC-ODS, free choice of providers is restricted. That is, beneficiaries enrolled in this program shall receive DMC-ODS services through the Contractor, operating as a PIHP. Based on this service delivery model, the Department has requested, and Centers for Medicare & Medicaid Services (CMS) has granted approval to waive certain 42 CFR Part 438 provisions identified on pages 12-15 of the CalAIM 1915(b) Waiver Approved Application.

B. General Provisions

1. Standard Contract Requirements (42 CFR §438.3).
    i. CMS shall review and approve this Agreement.
    ii. Enrollment discrimination is prohibited.
        a. The Contractor shall accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under this Agreement.

b. Enrollment is mandatory.
c. The Contractor shall not, based on health status or need for health care services, discriminate against individuals eligible to enroll.
d. The Contractor shall follow all Federal and State civil rights laws. The Contractor shall not unlawfully discriminate, exclude people, or treat them differently, on any ground protected under Federal or State law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.
e. The Contractor will not use any policy or practice that has the effect of discriminating on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.
f. The Contractor shall provide information on how to file a Discrimination Grievance with:
    1. The Contractor and the Department if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.
    2. The United States Department of Health and Human Services Office of Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability.

iii. Services that may be covered by the Contractor.

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

iv. Compliance with applicable laws and conflict of interest safeguards.
    a. The Contractor shall comply with all applicable Federal and state laws and regulations including:
        1. Title VI of the Civil Rights Act of 1964.
        2. Title IX of the Education Amendments of 1972 (regarding education programs and activities).
        3. The Age Discrimination Act of 1975; the Rehabilitation Act of 1973.
        4. The Americans with Disabilities Act of 1990 as amended.
        5. Section 1557 of the Patient Protection and Affordable Care Act.
    b. The Contractor shall comply with the conflict of interest safeguards described in 42 CFR §438.58 and with the prohibitions described in section 1902(a)(4)(C) of the Act applicable to contracting officers, employees, or independent contractors.
    c. Provider-preventable condition requirements:

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

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

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

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

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

vi. Subcontracts.
   a. All subcontracts shall fulfill the requirements or activity delegated under the subcontract in accordance with 42 CFR §438.230.
   b. The Contractor shall require that subcontractors not bill beneficiaries for covered services under a contractual, referral, or other arrangement with the Contractor in excess of the amount that would be owed by the individual if the Contractor had directly provided the services (42 U.S.C. 1396u–2(b)(6)(C)).

vii. Choice of network provider.
   a. The Contractor shall allow each beneficiary to choose their network provider to the extent possible and appropriate.

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

ix. Recordkeeping requirements.

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

2. Information Requirements (42 CFR §438.10).
   i. Basic Rules
      a. The Contractor shall provide all required information in this section to beneficiaries and potential beneficiaries in a manner and format that may be easily understood and is readily accessible by such beneficiaries and potential beneficiaries.
   ii. The Department shall operate a website that provides the content, either directly or by linking to the Contractor's website.
   iii. For consistency in the information provided to beneficiaries, the Contractor shall use:
      a. The Department developed definitions for managed care terminology, including appeal, emergency medical condition, excluded services, grievance, health insurance, hospitalization, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services, and urgent care.
      b. The Department developed model beneficiary handbooks and beneficiary notices.
   iv. The Contractor shall provide the required information in this section to each beneficiary.
   v. Beneficiary information required in this section may not be provided electronically by the Contractor or subcontractor unless all the following are met:
      a. The format is readily accessible.

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

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

vii. The Contractor shall comply with all requirements set forth under 42 CFR §438.10(d) and Article II.K of this Agreement.

viii. Information for potential beneficiaries.
a. The Contractor shall provide the information specified in this section to each potential beneficiary, either in paper or in electronic format, at the time that the potential beneficiary is first required to enroll in the Contractor's program.
b. The information for potential beneficiaries shall include, at a minimum, all the following:
1. The basic features of managed care.
2. Which populations are subject to mandatory enrollment and the length of the enrollment period.
3. The service area covered.
4. Covered benefits including:
i. Which benefits are provided by the Contractor.
ii. Which, if any, benefits are provided directly by the Department.
5. The provider directory and formulary information.

6. The requirements for each Contractor to provide adequate access to covered services, including the network adequacy standards established in 42 CFR §438.68.
7. The Contractor's entities responsible for coordination of beneficiary care.
8. To the extent available, quality and performance indicators for the Contractor, including beneficiary satisfaction.

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

x. Beneficiary handbook.
   a. The Contractor shall provide beneficiaries with a copy of the handbook and provider directory when the beneficiary first accesses services and thereafter upon request (BHIN 22-060).
   b. The Contractor shall ensure that the handbook includes the current toll- free telephone number(s) that provides information in threshold languages and is available twenty-four hours a day, seven days a week (BHIN 22-060).
   c. The beneficiary handbook shall include information that enables the beneficiary to understand how to effectively use the managed care program. This information shall include, at a minimum:
      1. Benefits provided by the Contractor. (42 C.F.R. § 438.10(g)(2)(i)).
      2. How and where to access any benefits provided by the Contractor, including any cost sharing, and how transportation is provided. (42 C.F.R. § 438.10(g)(2)(ii)).

i. The amount, duration, and scope of benefits available under the Contract in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled. (42 C.F.R. § 438.10(g)(2)(iii)).
ii. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the beneficiary's provider. (42 C.F.R. § 438.10(g)(2)(iv)).
iii. Any restrictions on the beneficiary's freedom of choice among network providers. (42 C.F.R. § 438.10(g)(2)(vi)).
iv. The extent to which, and how, beneficiaries may obtain benefits from out-of-network providers. (42 C.F.R. § 438.10(g)(2)(vii)).
v. Cost sharing, if any, consistent with the State Plan. (42
vi. C.F.R. § 438.10(g)(2)(viii); State Plan § 4.18).
vii. Beneficiary rights and responsibilities, including the elements specified in § 438.100 as specified in Section 7 of this Attachment. (42 C.F.R. § 438.10(g)(2)(ix)).
viii. The process of selecting and changing the beneficiary's provider. (42 C.F.R. § 438.10(g)(2)(x)).

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

a) The right to file grievances and appeals;

1. 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 beneficiary 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.

b) The requirements and timeframes for filing a grievance or appeal;

c) The availability of assistance in the filing process;

d) The right to request a State Hearing after the Contractor has made a determination on a beneficiary's appeal which is adverse to the beneficiary;
e) The fact that, when requested by the beneficiary, benefits that the Contractor seeks to reduce or terminate will continue if the beneficiary files an appeal or a request for State Hearing within the timeframes specified for filing, and that the beneficiary may, consistent with state policy, be required to pay the cost of services furnished while the appeal or State Hearing is pending if the final decision is adverse to the beneficiary. (42 C.F.R. § 438.10(g)(2)(xi)).

x. How to exercise an advance directive, as set forth in 42 C.F.R. 438.3(j). (42 C.F.R. § 438.10(g)(2)(xii).)
xi. 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)).
xii. The Contractor's toll-free telephone number for member services, medical management, and any other unit providing services directly to beneficiaries. (42 C.F.R. § 438.10(g)(2)(xiv)).
xiii. Information on how to report suspected fraud or abuse. (42 C.F.R § 438.10(2)(xv)).

xiv. Additional information that is available upon request, includes the following:
   a) Information on the structure and operation of the Contractor.
   b) Physician incentive plans as set forth in 42 C.F.R. § 438.3(i). (42 C.F.R. § 438.10(f)(3)).

d. The Contractor shall give each beneficiary 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 Code of Federal Regulations part 438.10(g)(3), BHIN 22-060 and the handbook must be provided to each beneficiary at the time the beneficiary first accesses services. The handbook will be considered provided if the Contractor:
   1. Mails a printed copy of the information upon the beneficiary's request to the beneficiary's mailing address;
   2. Provides the information by email after obtaining the beneficiary's agreement to receive the information by email;
   3. Posts the information on the Contractor's website and advises the beneficiary in paper or electronic form that the information is available on the internet and includes the applicable internet addresses, provided that beneficiaries 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 beneficiary receiving that information.

xi. Provider Directory.

a. The Contractor shall make available in electronic form and, upon request, in paper form, the following information about its network providers:
    1. The provider's name as well as any group affiliation.
    2. Street address(s).
    3. Telephone number(s).
    4. Email address(es), as appropriate.
    5. Website URL, as appropriate.
    6. Services/modalities provided, including information about populations served.
    7. Specialty, in terms of training, experience and specialization, including board certification as appropriate.
    8. The provider's cultural capabilities (e.g., veterans, older adults, Transitional Age Youth, Lesbian, Gay, Bisexual, Transgender).
    9. Whether the provider will accept new beneficiaries.
    10. The provider's capabilities including languages offered by the provider or a skilled medical interpreter at the provider's office and whether the provider has completed cultural competence training.
    11. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) In addition to the information listed above, the provider directory must also include the following information for each rendering provider:
        i. Type of practitioner, as appropriate.
        ii. National Provider Identifier number.
        iii. California license number and type of license.
    12. and equipment.

13. In addition to the information listed above, the provider directory must also include the following information for each rendering provider:
    i. Type of practitioner, as appropriate.
    ii. National Provider Identifier number.
    iii. California license number and type of license.

b. The Contractor shall include the following provider types covered under this Agreement in the provider directory:
    1. Physicians, including specialists.
    2. Hospitals
    3. Pharmacies
    4. Behavioral health providers

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

d. Provider directories shall be made readily accessible on the Contractor and subcontractor's website in a machine-readable file and format as specified by the Secretary of Health and Human Services.

xii. Provider Directory Application Programming Interface (API)

a. The Contractor shall implement and maintain a publicly accessible standards-based Provider Directory API as described in 42 CFR section 431.70, and meet the same technical standards of the Patient Access API, excluding the security protocols related to user authentication and authorization. The Contractor is required to update the Provider Directory API no later than 30 calendar days after the Contractor receives the provider information, or is notified of a change.

b. The Contractor shall ensure the Provider Directory API include the following information about the Contractor's network providers for behavioral health providers, hospitals, and any other providers or facilities contracted for Medi-Cal covered services under this DMC- ODS Intergovernmental Agreement (IA):
    1. Name of provider, medical group/foundation, independent physician/provider associations, or site as well as any group affiliation;
    2. National Provider Identifier number;
    3. Street address(es);
    4. All telephone numbers associated with the practice site;
    5. Website URL for each service location or physician provider, as appropriate;
    6. Specialty, as applicable;
    7. Hours and days when each service location is open, including the availability of evening and/or weekend hours;
    8. Services and benefits available;
    9. Whether the provider will accept new beneficiaries;
    10. Cultural and linguistic capabilities, including whether non-English languages and American Sign Language are offered by the provider or a skilled medical interpreter at the provider's office, and if the provider has completed cultural competence training;
    11. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s), and equipment; and
    12. Telephone number to call the 24/7 access line.

c. If the Contractor is currently maintaining an electronic provider directory on its website as required by 42 CFR 438.10(h) and this IA, and are meeting the required provider directory data elements above, then the Contractor may transfer the information to the Provider Directory API. However, if any of the required data elements are missing from the electronic provider directory, the Contractor shall take appropriate steps to ensure the Provider Directory API includes all required data elements.

xiii. 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. What tier each medication resides.
b. Formulary drug lists shall be made available on the Contractor's website in a machine-readable file and format as specified by the Secretary.

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

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

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

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

iv. This section may not be construed to:

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

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

4. Requirements that Apply to American Indian and Alaska Native (AI/AN), Indian Health Care Providers (IHCPs), and Indian Managed Care Entities (IMCEs) (42 CFR §438.14; BHIN 23-001 and BHIN 22-053).
   i. In order to receive reimbursement from a county or the state for the provision of DMC-ODS services (whether or not the IHCP is contracted with the Contractor), an IHCP shall be enrolled as a DMC provider and certified by DHCS to provide those services.
   ii. The Contractor shall demonstrate that there are sufficient IHCPs participating in the provider network to ensure timely access to DMC-ODS services available. The Contractor shall adhere to all 42 CFR 438.14 requirements.
   iii. The Contractor shall ensure contracts with DMC-certified IHCPs permit both AI/AN and non-AI/AN beneficiaries to obtain DMC-ODS services from the IHCPs. The Contractor shall reimburse DMC-certified IHCPs for the provision of DMC-ODS services to AI/AN Medi-Cal beneficiaries, even if the Contractor does not have a contract with the IHCP. The rates that the county must pay to an IHCP for services rendered by contracting IHCPs to non-AI/AN beneficiaries is the same as the rates paid for services rendered to AI/AN beneficiaries.
   iv. The Contractor shall pay DMC-certified IHCPs at rates consistent with the requirements of 42 CFR §438.14, the State Plan, and Department Information Notices and guidance.

v. The Contractor shall make payment to all DMC-certified IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR 447.45 and 447.46.

vi. The Contractor shall permit AI/AN beneficiaries to obtain services covered under this Agreement between the State and the Contractor from out-of-network DMC-certified IHCPs from whom the beneficiary is otherwise eligible to receive such services.

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

viii. The Contractor shall permit an out-of-network DMC-certified IHCP to refer an AI/AN beneficiary to a network provider.

ix. All AI/AN Medi-Cal beneficiaries whose county of responsibility is a DMC-ODS County may choose to receive DMC-ODS services at any DMC-certified IHCP, whether or not the IHCP has a current contract with the Contractor and whether or not the IHCP is located in the beneficiary's county of responsibility. The Contractor shall reimburse DMC-certified IHCPs for the provision of these services to AI/AN Medi-Cal beneficiaries, even if the Contractor does not have a contract with the IHCP. The Contractor is not obligated to pay for services provided to non-AI/AN beneficiaries by IHCPs that are not contracted with the Contractor.

x. AI/AN individuals who are eligible for Medicaid and reside in counties that have opted into the DMC-ODS can also receive DMC-ODS services through IHCPs.

C. State Responsibilities

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

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

2. Prohibition of Additional Payments (42 CFR §438.60).
   i. The Department shall ensure that no payment is made to a network provider other than by the Contractor's subcontractor for services covered under this Agreement, except when these payments are specifically required to be made by the Department in Title XIX of the Act, in 42 CFR chapter IV.
3. Continued Services to Beneficiaries (42 CFR §438.62).
   i. The Department shall arrange for Medicaid services to be provided without delay to any Medicaid beneficiary of the Contractor if this Agreement is terminated.
   ii. The Department shall have in effect a transition of care policy to ensure continued access to services during a transition from Fee-For-Service (FFS) to the Contractor or transition from one Contractor to another when a beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.
   iii. The Contractor shall implement a transition of care policy consistent with the requirements of the Department's transition of care policy.
   iv. The Department shall make its transition of care policy publicly available and provide instructions on how beneficiaries and potential beneficiaries access continued services upon transition. At a minimum, the Contractor shall provide the transition of care policy to beneficiaries and potential beneficiaries in the beneficiary handbook and notices.
4. Beneficiary Support System (42 C.F.R. § 438.71(a)-(b))

i. The Department shall develop and implement a beneficiary support system that provides support to beneficiaries both prior to and after enrollment. The beneficiary support system must perform outreach to beneficiaries and/or authorized representatives and be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.

5. State Monitoring Requirements (42 CFR §438.66).
   i. The Department shall have in effect a monitoring system for the Contractor.
   ii. The Department's monitoring system is outlined in Article III.KK of this Agreement.
   iii. The Department shall use data collected from its monitoring activities to improve the performance of the Contractor. That data shall include, at minimum:
      a. Beneficiary grievance and appeal logs.
      b. Provider complaint and appeal logs.
      c. Findings from the State's External Quality Review process.
      d. Results from any beneficiary or provider satisfaction survey conducted by the State or the Contractor.
      e. Performance on required quality measures.
      f. Medical management committee reports and minutes.
      g. The annual quality improvement plan for the Contractor.
      h. Customer service performance data submitted by the Contractor and performance data submitted by the beneficiary support system.
6. Network Adequacy Standards (42 CFR §438.68).
   i. The Contractor shall adhere to, in all geographic areas within the county, all applicable time or distance standards for network providers, including those set forth in W&I Code section 14197 and any Information Notices issued pursuant to that section.

a. Pursuant to W&I Code section 14197(d)(1)(A), the Contractor shall ensure that all beneficiaries seeking outpatient and intensive outpatient (non-NTP) services be provided with an appointment within ten business days of a non-NTP service request.
b. Pursuant to W&I Code section 14197(d)(3), the Contractor shall ensure that all beneficiaries seeking NTP services are provided with an appointment within three business days of a service request.
c. If the Contractor cannot meet the time or distance standards set forth in this section, the Contractor shall submit a request for alternative access standards to the Department.
d. Pursuant to W&I Code section 14197(d)(1)(A), under Health and Safety Code (H&S Code) section 1367.03, commencing on January 1, 2022, unless otherwise specified, the Contractor shall:
    1. Provide or arrange for the provision of covered substance use disorder services in a timely manner appropriate for the nature of the beneficiary's condition consistent with good professional practice (H&S Code section 1367.03(a)(1)).
    2. Establish and maintain provider networks, policies, procedures, and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard (H&S Code section 1367.03(a)(1)).

3. Ensure that all plan and provider processes necessary to obtain covered substance use disorder services, including, but not limited to, prior authorization processes, are completed in a manner that assures the provision of covered substance use disorder services to a beneficiary in a timely manner appropriate for the beneficiary's condition and in compliance with H&S Code section 1367.03 (H&S Code section 1367.03(a)(2)).
4. Ensure that, if it is necessary for a provider or a beneficiary to reschedule an appointment, the appointment is promptly rescheduled in a manner that is appropriate for the beneficiary's health care needs, and ensures continuity of care consistent with good professional practice, and consistent with H&S Code section 1367.03 and the regulations adopted thereunder (H&S Code section 1367.03(a)(3)).
5. Ensure that interpreter services required by H&S Code section 1367.04 of and Cal. Code Regs., tit. 28, § 1300.67.0428 are coordinated with scheduled appointments for covered substance use disorder services in a manner that ensures the provision of interpreter services at the time of the appointment without imposing delay on the scheduling of the appointment (H&S Code section 1367.03(a)(4)).
6. Ensure a non-urgent appointment with a non-physician substance use disorder provider within ten business days of the request for the appointment (H&S Code section 1367.03(a)(5)(E)), except under the following circumstances:

i. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the beneficiary's health (H&S Code section 1367.03(a)(5)(H)).

ii. Preventive care services and periodic follow-up care, including standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac, mental health, or substance use disorder conditions, and laboratory and radiological monitoring for recurrence of disease, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice (H&S Code section 1367.03(a)(5)(I)).

7. Ensure that, commencing July 1, 2022, non-urgent follow up appointments with a non-physician substance use disorder provider: within ten business days of the prior appointment for those undergoing a course of treatment for an ongoing substance use disorder condition (H&S Code section 1367.03(a)(5)(F)), except under the following circumstance:

i. The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of their practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the beneficiary's health (H&S Code section 1367.03(a)(5)(H)).

8. Ensure it has sufficient numbers of contracted providers to maintain compliance with the standards established by H&S Code section 1367.03 (H&S Code section 1367.03(a)(7)).
9. Arrange for the coverage outside the Contractor's network in accordance with subdivision H&S Code section 1374.72(d) to ensure timely access to medically necessary covered substance use disorder services that are not available in network within the geographic and timely access standards set by law or regulation (H&S Code section 1367.03(a)(7)(B)).
10. Arrange for the provision, 24 hours per day, 7 days per week, of triage or screening services by telephone, as defined in H&S Code section 1367.03(e) and in accordance with the requirements set forth in H&S Code section 1367.03(a)(8).

11. Ensure that, during normal business hours, the waiting time for a beneficiary to speak by telephone with a plan customer service representative knowledgeable and competent regarding the beneficiary's questions and concerns shall not exceed ten minutes (H&S Code section 1367.03(a)(10).
12. Ensure that contracting providers and employees are not prevented, discouraged, or disciplined for informing a beneficiary about the timely access standards (H&S Code section 1367.03(d)).
13. Shall comply with the requirements under H&S Code sections 1367.03(f)(1) and 1367.03(f)(2).

e. Pursuant to W&I Code section 14197(e), the Department may grant requests for alternative access standards if the Contractor has exhausted all other reasonable options to obtain providers to meet the applicable standard or if the Department determines that the Contractor has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.
    1. The Contractor shall include a description of the reasons justifying the alternative access standards.
        i. Requests for alternative access standards shall be approved or denied on a zip code and service type basis.

f. Pursuant to W&I Code section 14197(f)(3), the Contractor shall submit a description on how they intend to arrange for beneficiaries to access covered services if the provider is located outside of the time or distance standards. Requests for alternative access standards may include seasonal considerations (e.g., winter road conditions), when appropriate. Furthermore, the Contractor shall include an explanation about gaps in the county's geographic service area, including information about uninhabitable terrain within the county (e.g., desert, forestland), as appropriate. The use of clinically appropriate telecommunications technology may be considered in determining compliance with the applicable standards established in W&I Code section 14197(e)(4) and other guidance or BHINs issued by DHCS and/or for approving an alternative access request.

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

h. If the Contractor does not comply with the applicable standards at any time, DHCS may impose additional corrective actions, including sanctions, special requirements, probationary or corrective actions, or any other actions deemed necessary to ensure compliance.

i. Sanctions shall be imposed in accordance with guidance issued in accordance with W&I Code section 14197.7 (d)-(f) by the Department.

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

D. Beneficiary Rights and Protections

1. Beneficiary Rights (42 CFR §438.100).
    i. The Contractor shall have written policies guaranteeing the beneficiary's rights specified in 42 CFR 438.100.
    ii. The Contractor shall comply with any applicable Federal and state laws that pertain to beneficiary rights, and ensures that its employees, the subcontractor, and network providers observe and protect those rights.
    iii. Specific rights.
        a. The Contractor shall ensure that its beneficiaries have the right to:
            1. Receive information regarding the Contractor's PIHP and plan in accordance with 42 CFR §438.10.
            2. Be treated with respect and with due consideration for their dignity and privacy.
            3. Receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand.
            4. Participate in decisions regarding their health care, including the right to refuse treatment.
            5. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
            6. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of their medical records, and request that they be amended or corrected, as specified in 45 CFR § 164.524 and 164.526.
        b. The Contractor shall ensure that its beneficiaries have the right to be furnished health care services in accordance with 42 CFR §§438.206 through 438.210.

iv. Free exercise of rights.
    a. The Contractor shall ensure that each beneficiary is free to exercise their rights, and that the exercise of those rights does not adversely affect the way the Contractor, the subcontractor, and its network providers treat the beneficiary.
v. Compliance with other Federal and state laws.
    a. The Contractor shall comply with any other applicable Federal and state laws, including, but not limited to:
        1. Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80.
        2. The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91.
        3. The Rehabilitation Act of 1973.
        4. Title IX of the Education Amendments of 1972 (regarding education programs and activities).
        5. Titles II and III of the Americans with Disabilities Act.
        6. Section 1557 of the Patient Protection and Affordable Care Act.

2. Provider-Beneficiary Communications (42 CFR §438.102).
    i. The Contractor or subcontractor shall not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a beneficiary who is their patient, for the following:
        a. The beneficiary's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
        b. Any information the beneficiary needs to decide among all relevant treatment options.
        c. The risks, benefits, and consequences of treatment or non-treatment.

d. The beneficiary's right to participate in decisions regarding their health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3. Liability for Payment (42 CFR §438.106).
   i. The Contractor shall ensure that its beneficiaries are not held liable for any of the following:
      a. The Contractor's debts, in the event of the Contractor's insolvency.
      b. Covered services provided to the beneficiary, for which:
         1. The state does not pay the Contractor; or
         2. The Contractor or the Department does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.
      c. Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the beneficiary would owe if the Contractor covered the services directly.

E. Contractor Standards as a PIHP

1. Availability of Services (42 CFR §438.206).
   i. The Contractor shall ensure that all services covered under the State Plan are available and accessible to its beneficiaries in a timely manner. Covered services delivered by network providers under this Agreement shall meet the standards developed by the Department in accordance with 42 CFR §438.68.
   ii. The Contractor shall, consistent with the scope of its contracted services, ensure the following requirements are met:

a. Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under this Agreement for all beneficiaries, including those with limited English proficiency or physical or mental disabilities.
b. Provide for a second opinion from a network provider or arrange for the beneficiary to obtain one outside the network, at no cost to the beneficiary.
c. If the provider network is unable to provide necessary services, covered under this Agreement, to a particular beneficiary, the Contractor shall adequately and timely cover these services out-of-network for the beneficiary, for as long as the Contractor's provider network is unable to provide them.
d. Require out-of-network providers to coordinate with the Contractor for payment and ensures the cost to the beneficiary is no greater than it would be if the services were furnished within the network.
e. Demonstrate that its network providers are credentialed as required by 42 CFR §438.214.

iii. The Contractor shall comply with the following timely access requirements:
a. Meet and require its network providers to meet Department standards for timely access to care and services, taking into account the urgency of the need for services.
b. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid FFS, if the provider serves only Medicaid beneficiaries.
c. Make services included in this Agreement available 24 hours a day, 7 days a week, when medically necessary.

d. Establish mechanisms to ensure compliance by network providers.
e. Monitor network providers regularly to determine compliance.
f. Take corrective action if there is a failure to comply by a network provider.

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

v. Accessibility considerations
a. The Contractor shall ensure that its network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid beneficiaries with physical or mental disabilities.

2. Assurances of Adequate Capacity and Services (42 CFR §438.207).
i. The Contractor shall give assurances to the Department and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the Department's standards for access and timeliness of care under this part, including the standards at 42 CFR §438.68 and 42 CFR §438.206(c)(1).
ii. The Contractor shall ensure submission of documentation to the Department to demonstrate that it complies with the following requirements:
a. Offers an appropriate range of specialty services that are adequate for the anticipated number of beneficiaries in compliance with applicable network adequacy standards.

b. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in compliance with applicable network adequacy standards.

iii. The Contractor shall ensure submission of network adequacy documentation to the Medi-Cal Behavioral Health Division (MCBHD) via DHCS' established method of submitting documentation:
   a. Upon entering into this Agreement with the Department.
   b. On an annual basis, at a date determined by the Department and communicated to Contractor with at least 60 days notice.
   c. Within ten business days of a significant change in the Contractor's operations that would affect the adequacy and capacity of services, including composition of the Contractor's provider network.
   d. As requested by the Department.

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

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

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

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

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

a. Sanctions shall be imposed in accordance with guidance issued in accordance with W&I Code section 14197.7 (d)-(f) by the Department.

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

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

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

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

b. Coordinate the services the Contractor furnishes to the beneficiary:

1. Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.

2. With the services the beneficiary receives from any other managed care organization.
3. With the services the beneficiary receives in FFS Medicaid.
4. With the services the beneficiary receives from community and social support providers.

c. Share with the Department or other managed care organizations serving the beneficiary, the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities.
d. Ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards.
e. Ensure that in the process of coordinating care, each beneficiary's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E and 42 CFR Part 2, to the extent that they are applicable.

4. Coverage and Authorization of Services (42 CFR §438.210).
   i. The Contractor shall furnish medically necessary services covered by this Agreement in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in 42 CFR §440.230, and for beneficiaries under the age of 21, as set forth in 42 CFR §441, subpart B.
   ii. The Contractor:
      a. Shall ensure that the medically necessary services provided are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
      b. Shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of diagnosis, type of illness, or condition of the beneficiary.

iii. The Contractor shall limit services in accordance with the criteria established under the State Plan, including medical necessity. The Contractor may place appropriate limits on a service for the purpose of utilization control, provided that:
   a. The services furnished can reasonably achieve their purpose.
   b. The services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the beneficiary's ongoing need for such services and supports.

iv. Authorization of services.
   a. The Contractor and its subcontractor shall have in place, and follow, written authorization policies and procedures.
   b. The Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.
   c. The Contractor shall consult with the requesting provider for medical services when appropriate.
   d. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by an individual who has appropriate expertise in addressing the beneficiary's medical and behavioral health.
   e. Notice of Adverse Benefit Determination (NOABD).
      1. The Contractor's subcontractor shall notify the requesting provider, and give the beneficiary written notice of any decision by the Contractor or subcontractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The beneficiary's notice shall meet the requirements of 42 CFR §438.404.

v. Standard authorization decisions.

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

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

vii. Compensation for utilization management activities.
a. Consistent with 42 CFR §438.3(i) and 42 CFR §422.208, compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

5. Provider Selection (42 CFR §438.214).

i. The Contractor shall implement written policies and procedures for selection and retention of network providers and the implemented policies and procedures, at a minimum, meet the following requirements:
    a. Credentialing and re-credentialing requirements.
        1. The Contractor shall follow the state's established uniform credentialing and re-credentialing policy that addresses behavioral, and substance use disorders, outlined in DHCS Information Notice 18-019.
        2. The Contractor shall follow a documented process for credentialing and re-credentialing of network providers.
    b. Nondiscrimination.
        1. The Contractor's network provider selection policies and procedures, consistent with 42 CFR §438.12, shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.
    c. Excluded providers.
        1. The Contractor shall screen and periodically revalidate all network providers in accordance with the requirements of 42 Code of Federal Regulations, part 455, subparts B and E. (42 C.F.R. §438.602(b)).

2. Consistent with the requirements of 42 Code of Federal Regulations, part 455.436, the Contractor must confirm the identity and determine the exclusion status of all providers (employees and network providers) and any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the of the DMC-ODs Network Provider 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)).
3. If the Contractor find a party that is excluded, it must promptly notify the Department (42 C.F.R. §438.608(a)(2),(4)) and the Department will take action consistent with 42 C.F.R. §438.610((d). 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.

d. Additional Department requirements.
    1. The Contractor shall comply with any additional requirements established by the Department.

6. CMS Interoperability Rule

i. The Contractor shall implement and maintain a secure, standards-based Patient Access API and a publicly accessible, standards-based Provider Directory API that can connect to mobile applications and be available through a public-facing digital endpoint on each Contractor's website.
ii. The Contractor must also comply with 42 Code of Federal Regulations (CFR) 438.242, 45 CFR 170.215, the provider directory information requirements specified in 42 CFR 438.10, and the public reporting and information blocking components of the CMS Interoperability Rule 45 CFR Part 171.
iii. The Contractor shall implement and maintain a Patient Access API that can connect to provider electronic health records and practice management systems, in accordance with requirements specified at 42 CFR section 431.60. The Patient Access API shall permit third-party applications to retrieve, with the approval and at the direction of a beneficiary or beneficiary's authorized representative, data specified in guidance provided by the Department, including, but not limited to BHIN 22-068 through the use of common technologies and without special effort from the beneficiary.
iv. The Contractor shall make individual-level United States Core Data for Interoperability (USCDI) data that they maintain for dates of services on, or after, January 1, 2016, available to the beneficiary or their authorized representative as follows:
    a. Adjudicated claims data, including claim data for payment decisions that may be appealed, were appealed, or in the process of appeal, provider remittances, and beneficiary cost- sharing pertaining to such claims within one business day after a claim is processed.
    b. Clinical data, including diagnoses and related codes, and laboratory test results within one business day after receiving data from providers.

c. Information about covered outpatient drugs and updates to such information, including formulary of prescription drugs, costs to the beneficiary, and preferred drug list information, if applicable within one business day after the effective date of any such information or updates to such information.
d. Encounter data from providers compensated on the basis of risk-based capitation payments, as defined in 42 CFR 438.2 within one business day after receiving data from providers.
    1. If the Contractor does not reimburse providers using risk-based capitation payments, then Article II.E.5.iv.d of this Agreement does not apply.

v. In accordance with 42 CFR 431.60(f), the Contractor shall provide, in an easily accessible location on their public websites and/or through other appropriate mechanisms through which they ordinarily communicate with current and former Beneficiary seeking to access their health information, educational resources in non-technical, simple and easy-to-understand language explaining at a minimum:
    a. General information on steps the Beneficiary may consider taking to help protect the privacy and security of their health information, including factors to consider in selecting an application including secondary uses of data, and the importance of understanding the security and privacy practices of any application to which they entrust their health information; and

b. An overview of which types of organizations or individuals are and are not likely to be Health Insurance Portability and Accountability Act of 1996 (HIPAA) covered entities, the oversight responsibilities of the Health and Human Services Office for Civil Rights (OCR) and the Federal Trade Commission (FTC), and how to submit a complaint to the OCR and FTC. Educational resources must be provided to beneficiaries according to the information requirements of CFR 438.10.

7. Confidentiality (42 CFR §438.224).
   i. For medical records and any other health and enrollment information that identifies a particular beneficiary, the Contractor shall use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E and 42 CFR Part 2, to the extent that these requirements are applicable.
8. Grievance and Appeal Systems (42 CFR §438.228).
   i. The Contractor shall have in effect, a grievance and appeal system that meets the requirements outlined in Article.II.G of this Agreement.
   ii. The Contractor shall ensure the issuance any NOABD under 42 CFR Part 431, subpart E. The Department shall conduct random reviews of the Contractor, network providers and subcontractor to ensure that they are notifying beneficiaries in a timely manner.
9. Subcontractual Relationships and Delegation (42 CFR §438.230).
   i. The requirements of this section apply to any contract or written arrangement between the Contractor and subcontractor, or subcontractor and providers.

ii. Unless specifically prohibited by this Agreement or by federal or state law, the Contractor may delegate duties and obligations of the Contractor under this Agreement to a subcontractor if the Contractor determines that the subcontractor selected is able to perform the delegated duties in an adequate manner in compliance with the requirements of this Agreement. The Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Agreement.

iii. All contracts or written arrangements between the Contractor and subcontractor, or subcontractor and providers, shall specify the following:

   a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.
   b. The subcontractor or provider agrees to perform the delegated activities and reporting responsibilities specified in compliance with the Contractor's Agreement obligations.
   c. The contract or written arrangement shall either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the Department or the Contractor determine that the subcontractor or network provider has not performed satisfactorily.
   d. The subcontractor or network provider agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.
   e. The subcontractor or network provider agrees that:

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

10. Practice Guidelines (42 CFR §438.236).
    i. The Contractor shall adopt practice guidelines that meet the following requirements:
        a. Are based on valid and reliable clinical evidence or a consensus of providers in the particular field.
        b. Consider the needs of the Contractor's beneficiaries.

c. Are adopted in consultation with network providers.
d. Are reviewed and updated periodically as appropriate.

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

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

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

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

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

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

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

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

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

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

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

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

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

F. Quality Measurement and Improvement External Quality Review

1. Quality Assessment and Performance Improvement Program (PIP) (42 CFR §438.330).
   i. The Contractor shall ensure the establishment and implementation of an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its beneficiaries.
   ii. After consulting with states and other stakeholders and providing public notice and opportunity to comment, CMS may specify performance measures and performance improvement projects (PIPs), which shall be included in the standard measures identified and PIPs required by the Department. The Department may request an exemption from including the performance measures or PIPs established under this section by submitting a written request to CMS explaining the basis for such request.
   iii. The Contractor's comprehensive quality assessment and performance improvement program shall include at least the following elements:
      a. Performance improvement projects.

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

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

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

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

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

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

2. Department Review of the Contractor's Accreditation Status (42 CFR §438.332).
   i. The Contractor shall inform the Department if it has been accredited by a private independent accrediting entity. The Contractor is not required to obtain accreditation by a private independent accrediting entity.
   ii. If the Contractor has received accreditation by a private independent accrediting entity, then the Contractor shall authorize the private independent accrediting entity to provide the Department a copy of its most recent accreditation review, including:
      a. Accreditation status, survey type, and level (as applicable).
      b. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings.
      c. Expiration date of the accreditation.
   iii. The Department shall:
      a. Make the accreditation status for the Contractor available on the website required under 42 CFR §438.10(c)(3), including whether the Contractor has been accredited and, if applicable, the name of the accrediting entity, accreditation program, and accreditation level.
      b. Update this information at least annually.

G. Grievance and Appeal System

1. General Requirements (42 CFR §438.402).
   i. The Contractor shall have a grievance and appeal system in place for beneficiaries.

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

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

b. Timing:
    1. Grievance:
        i. The beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, may file a grievance with the Contractor at any time.
    2. Appeal:
        i. The Contractor shall allow the beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, to file a request for an appeal to the Contractor within 60 calendar days from the date on the NOABD.
c. Procedures:
    1. Grievance:
        i. The beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, may file a grievance either orally or in writing and, as determined by the Department, either with the Department or with the Contractor.
    2. Appeal:

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

2. Timely and Adequate Notice of Adverse Benefit Determination (42 CFR §438.404).
   i. Notice.
      a. The Contractor shall ensure beneficiaries receive timely and adequate notice of an adverse benefit determination, in writing, and consistent with the requirements below and in 42 CFR §438.10.
   ii. Content of notice.
      a. The notice shall explain the following:
         1. The adverse benefit determination the Contractor has made or intends to make.
         2. The reasons for the adverse benefit determination, including the right of the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination. Such information includes DMC-ODS criteria for services, and any processes, strategies, or evidentiary standards used in setting coverage limits.

3. The beneficiary's right to request an appeal of the Contractor's adverse benefit determination, including information on exhausting the Contractor's one level of appeal described at 42 CFR §438.402(b) and the right to request a state hearing consistent with 42 CFR §438.402(c).
4. The procedures for exercising these appeal rights.
5. The circumstances under which an appeal process can be expedited and how to request it.
6. The beneficiary's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the beneficiary may be required to pay the costs of these services.

iii. Timing of notice.

a. The Contractor shall ensure the notice is mailed within the following timeframes:
    1. At least ten days before the date of the adverse benefit determination, when the adverse benefit determination is a termination, suspension, or reduction of previously authorized Medicaid-covered services.
    2. For denial of payment, at the time of any adverse benefit determination affecting the claim.
    3. For standard authorization decisions that deny or limit services, as expeditiously as the beneficiary's condition requires within state-established timeframes that shall not exceed 14 calendar days following receipt of the request for service.

i. The Contractor shall be allowed to extend the 14calendar day NOABD timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the beneficiary or the provider requests an extension.

ii. The Contractor shall be allowed to extend the 14 calendar day NOABD timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the Contractor justifies a need (to the Department, upon request) for additional information and shows how the extension is in the beneficiary's best interest. Consistent with 42 CFR §438.210(d)(1)(ii), the Contractor shall:

   a) Give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if they disagree with that decision.

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

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

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

b. The Contractor shall be allowed to mail the NOABD as few as five days prior to the date of action if the Contractor has facts indicating that action should be taken because of probable fraud by the beneficiary, and the facts have been verified, if possible, through secondary sources.
c. The Contractor shall mail the NOABD by the date of the action when any of the following occur:
    1. The recipient has died.
    2. The beneficiary submits a signed written statement requesting service termination.
    3. The beneficiary submits a signed written statement including information that requires service termination or reduction and indicates that they understand that service termination or reduction will result.
    4. The beneficiary has been admitted to an institution where they are ineligible under the plan for further services.
    5. The beneficiary's address is determined unknown based on returned mail with no forwarding address.
    6. The beneficiary is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
    7. A change in the level of medical care is prescribed by the beneficiary's physician.
    8. The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act.
    9. The transfer or discharge from a facility will occur in an expedited fashion.

3. Handling of Grievances and Appeals (42 CFR §438.406).
    i. In handling grievances and appeals, the Contractor shall give beneficiaries any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
    ii. The Contractor's process for handling beneficiary grievances and appeals of adverse benefit determinations shall:
        a. Acknowledge receipt of each grievance and appeal within five calendar days.
        b. Ensure that the individuals who make decisions on grievances and appeals are individuals:
            1. Who were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.
            2. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the Department, in treating the beneficiary's condition or disease.
                i. An appeal of a denial that is based on lack of medical necessity.
                ii. A grievance regarding denial of expedited resolution of an appeal.
                iii. A grievance or appeal that involves clinical issues.
            3. Who, take into account all comments, documents, records, and other information submitted by the beneficiary or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

c. Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals.
d. Provide the beneficiary a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor shall inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution.
e. Provide the beneficiary and their representative the beneficiary's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor (or at the direction of the Contractor) in connection with the appeal of the adverse benefit determination. This information shall be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c).
f. Include, as parties to the appeal:
    1. The beneficiary and their representative.
    2. The legal representative of a deceased beneficiary's estate.

4. Resolution and Notification: Grievances and Appeals (42 CFR §438.408).
    i. The Contractor shall resolve each grievance and appeal, and provide notice, as expeditiously as the beneficiary's health condition requires, within the following timeframes:
        a. Standard resolution of grievances: 90 calendar days from the day the Contractor receives the grievance.
        b. Standard resolution of appeals: 30 calendar days from the day the Contractor receives the appeal. This timeframe may be extended in the manner described below.

c. Expedited resolution of appeals: 72 hours after the Contractor receives the appeal. This timeframe may be extended under in the manner described below.

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

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

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

v. Format of notice:
   a. Grievances.
      1. The Contractor shall notify the beneficiary of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR §438.10.
   b. Appeals.

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

vi. The written notice of the resolution shall include the following:
   a. The results of the resolution process and the date it was completed.
   b. For appeals not resolved wholly in favor of the beneficiaries:
      1. The right to request a state hearing.
      2. How to make the request a state hearing.
      3. The right to request and receive benefits, while the hearing is pending and how to make the request.
      4. That the beneficiary may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the Contractor's adverse benefit determination.

vii. Requirements for state hearings:
   a. A beneficiary may request a state hearing only after receiving notice that the Contractor is upholding the adverse benefit determination.
   b. If the Contractor fails to adhere to the notice and timing requirements in 42 CFR §438.408, then the beneficiary is deemed to have exhausted the Contractor's appeals process. The beneficiary may initiate a state hearing.
   c. The Department shall offer and arrange for an external medical review when the following conditions are met:

1. The review shall be at the beneficiary's request and shall not be required before, or used as a deterrent to, proceeding to the state hearing.
2. The review shall be independent of both the Department and the Contractor.
3. The review shall be offered without any cost to the beneficiary.
4. The review shall not extend any of the timeframes specified in 42 CFR §438.408 and shall not disrupt the continuation of benefits in 42 CFR §438.420.

d. State hearing.

1. The beneficiary shall have no less than 90 calendar days and no more than 120 calendar days from the date of the Contractor's Notice of Appeal Resolution to request a state hearing.
2. The parties to the state hearing include the Contractor, as well as the beneficiary and their representative or the representative of a deceased beneficiary's estate.

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

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

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

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

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

6. Information About the Grievance and Appeal System to Providers and Subcontractors (42 CFR §438.414).
   i. The Contractor shall provide the information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all network providers and the subcontractor at the time they enter into a contract.
7. Recordkeeping Requirements (42 CFR §438.416).
   i. The Contractor shall ensure records of grievances and appeals are maintained and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the Department quality strategy.
   ii. The record of each grievance or appeal shall contain, at a minimum, all the following information:
      a. A general description of the reason for the appeal or grievance.
      b. The date received.
      c. The date of each review or, if applicable, review meeting.
      d. Resolution at each level of the appeal or grievance, if applicable.
      e. Date of resolution at each level, if applicable.
      f. Name of the covered person for whom the appeal or grievance was filed.
   iii. The record shall be accurately maintained in a manner accessible to the Department and available upon request to CMS.
8. Continuation of Benefits While the Contractor's Appeal and the State Hearing Are Pending (42 CFR §438.420).
   i. Timely files mean files for continuation of benefits on or before the later of the following:
      a. Within ten calendar days of Contractor sending the NOABD.

b. The intended effective date of the Contractor's proposed adverse benefit determination.

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

iii. At the beneficiary's request, the Contractor shall continue or reinstate the beneficiary's benefits while the appeal or state hearing is pending, the benefits shall be continued until one of following occurs:
   a. The beneficiary withdraws the appeal or request for state hearing.
   b. The beneficiary fails to request a state hearing and continuation of benefits within ten calendar days after the Contractor sends the notice of an adverse resolution to the beneficiary's appeal under 42 CFR §438.408(d)(2).
   c. A state hearing officer issues a hearing decision adverse to the beneficiary.

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

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

H. Additional Program Integrity Safeguards

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

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

iv. Federal database checks.

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

v. Periodic audits.

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

vi. Whistleblowers.

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

vii. Transparency.

a. The Department shall post on its website, as required in 42 CFR §438.10(c)(3), the following documents and reports:
    1. This Agreement.
    2. The data at 42 CFR §438.604(a)(5).
    3. The name and title of individuals included in 42 CFR §438.604(a)(6).
    4. The results of any audits performed pursuant Article II.H.2.v of this Agreement.

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

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

3. Data, Information, and Documentation that shall be submitted (42 CFR §438.604).
i. The Contractor shall ensure the submission to the Department the following data:
    a. Encounter data in the form and manner described in 42 CFR §438.818.
    b. Documentation described in 42 CFR §438.207(b) on which the Department bases its certification that the Contractor has complied with the Department's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR §438.206.

c. Information on ownership and control described in 42 CFR §455.104 from the Contractor's subcontractors as governed by 42 CFR §438.230.
d. The annual report of overpayment recoveries as required in 42 CFR §438.608(d)(3).

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

4. Source, Content, and Timing of Certification (42 CFR §438.606).
   i. The data, documentation, or information specified in 42 CFR §438.604, shall be certified by either the Contractor's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.
   ii. The certification shall attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR §438.604 is accurate, complete, and truthful.
   iii. The Contractor shall ensure the submission of the certification concurrently with the submission of the data, documentation, or information required in 42 CFR §438.604(a) and (b).
5. Program Integrity Requirements (42 CFR §438.608).
   i. The Contractor, and its subcontractor, to the extent that the subcontractor is delegated responsibility by the Contractor for coverage of services and payment of claims under this Agreement, shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, or abuse.
   ii. The arrangements or procedures shall include the following:

a. A compliance program that includes, at a minimum, all the following elements:
    1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements.
    2. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Agreement and who reports directly to the County Behavioral Health Director and the Board of Supervisors.
    3. The establishment of a Regulatory Compliance Committee on the Board of Supervisors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under this Agreement.
    4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and state standards and requirements under this Agreement.
    5. Effective lines of communication between the compliance officer and the organization's employees.
    6. Enforcement of standards through well-publicized disciplinary guidelines.

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

b. Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the Department.
c. Provision for prompt notification to the Department when it receives information about changes in a beneficiary's circumstances that may affect the beneficiary's eligibility including all the following:
    1. Changes in the beneficiary's residence.
    2. The death of a beneficiary.
d. Provision that the Contractor shall submit a notification to the Department when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor.
e. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by beneficiaries and the application of such verification processes on a regular basis.

f. If the Contractor makes or receives annual payments under this Agreement of at least $5,000,000, provision for written policies for all employees of the entity, and of any subcontractor or agent, that provide detailed information about the False Claims Act and other Federal and state laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.
g. Provision for the prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the Department Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.
h. Provision for the Contractor's suspension of payments to a network provider for which the Department determines there is a credible allegation of fraud in accordance with 42 CFR §455.23.

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

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

v. Treatment of recoveries made by the Contractor of overpayments to providers.
   a. The Contractor shall specify in accordance with this Exhibit A, Attachment I and Exhibit B of this Agreement:

1. 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.
2. The process, timeframes, and documentation required for reporting the recovery of all overpayments.
3. The process, timeframes, and documentation required for payment of recoveries of overpayments to the state in situations where the Contractor is not permitted to retain some or all the recoveries of overpayments.
4. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

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

6. Prohibited Affiliations (42 CFR §438.610).
   i. The Contractor, subcontractor, and network providers shall not knowingly have a relationship of the type described in paragraph (iii) of this subsection with the following:

a. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
b. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in paragraph (a)(1) of this section.

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

iii. The relationships described in paragraph (i) of this section, are as follows:
a. A director, officer, or partner of the Contractor.
b. A subcontractor of the Contractor, as governed by 42 CFR §438.230.
c. A person with beneficial ownership of five percent or more of the Contractor's equity.
d. A network provider or person with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Agreement.

iv. If the Department finds that the Contractor is not in compliance, the Department:
a. Shall notify the Secretary of the noncompliance.
b. May continue an existing Agreement with the Contractor unless the Secretary directs otherwise.

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

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

7. Disclosures on Information and Ownerships Control (42 CFR §455.104**)**
   i. The Contractor, subcontractor, and network providers shall provide the following disclosures through the DMC certification process described in Article III.K of the Agreement:
      a. The name and address of any person (individual or corporation) with an ownership or control interest in the Contractor. The address for corporate entities shall include as applicable primary business address, every business location, and P.O. Box address.
      b. Date of birth and Social Security Number (in the case of an individual).
      c. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a five percent or more interest.

d. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a five percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
e. The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.
f. The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

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

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

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

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

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

I. Conditions for FFP

1. Costs under this Nonrisk Contract (42 CFR §438.812).
   i. The amount the Department pays for the furnishing of medical services to eligible beneficiaries is a medical assistance cost.
   ii. The amount the Department pays for the Contractor's performance of other functions is an administrative cost.

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

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

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

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

2. Quantitative Limitations
   i. The Contractor shall not apply any cumulative financial requirement for substance use disorder services in a classification that accumulates separately from any established for medical/surgical services in the same classification (42 CFR 438.910(c)(3)).
3. Non-Quantitative Limitations
   i. The Contractor shall not impose a non-quantitative treatment limitation for substance use disorder benefits in any classification unless, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification (42 CFR §438.910(d)).

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

K. Nondiscrimination Requirements, Language Assistance, and Information Access for Individuals with Limited English Proficiency and/or Disabilities (42 CFR § 438.10; W&I Code section 14029.91; Government Code (Gov. Code) § 11135; 28 CFR §§ 35.160-35.164; 28 CFR § 36.303; 45 CFR § 92.101; 45 CFR § 92.102; 45 CFR § 92.202)

1. The Contractor, network providers, and network provider 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, section 1557 of the Patient Protection and Affordable Care Act, the Americans with Disabilities Act, and Section 504 of the Rehabilitation Act.
2. DHCS shall use the following methodology to identify the prevalent non–English languages spoken by beneficiaries and potential beneficiaries throughout the State, and in the Contractor's service area:
    i. A population group of mandatory eligible beneficiaries 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 beneficiary population, whichever is lower; and
    ii. A population group of mandatory eligible beneficiaries residing in the Contractor's service area who indicate their primary language as a language other than English and who meet the concentration standards of 1,000 in a single zip code or 1,500 in two contiguous zip codes.
3. Nondiscrimination Notice

i. The Contractor shall post a DHCS-approved nondiscrimination notice that informs beneficiaries, potential beneficiaries, and the public about nondiscrimination, protected characteristics, and accessibility requirements, and conveys the Contractor's compliance with the requirements.
ii. 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 beneficiaries, potential beneficiaries, 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.
iii. 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.
iv. The nondiscrimination notice shall include all legally required elements under the applicable subsections of W&I Code section 14029.91 and Gov. Code section 11135.
v. The nondiscrimination notice shall include information on how to file a discrimination grievance directly with the DHCS Office of Civil Rights, in addition to information about how to file a discrimination grievance with the County and the U.S. Health and Human Services Office for Civil Rights.
vi. The Contractor is not prohibited from posting the nondiscrimination notice in additional publications and communications.

4. Language Assistance Taglines

i. The Contractor shall post 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 DHCS), informing beneficiaries, potential beneficiaries, 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.

ii. 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 beneficiary information and other information notice, in accordance with federal and state requirements.

5. Language Assistance Services

i. Language assistance services shall be provided free of charge, be accurate and timely, and protect the privacy and independence of the limited English proficiency (LEP) individual. There are two primary types of language assistance services: oral and written. LEP individuals are not required to accept language assistance services, although a qualified interpreter may be used to assist in communicating with an LEP individual who has refused language assistance services.

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

a. 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 beneficiaries. Key points of contact may include medical care settings and non-medical care settings.

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

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

e. 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.
f. 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.

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

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

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

6. Effective Communication with Individuals with Disabilities
   i. The Contractor shall comply with all applicable requirements of federal and state disability law and take appropriate steps to ensure effective communication with individuals with disabilities.
   ii. 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 enjoy the benefits of, the Contractor's covered services, programs, and activities.

iii. 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.

iv. Auxiliary aids and services include:

a. 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.

b. 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.

v. 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 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).

vi. 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.

vii. 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 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.

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

L. Discrimination Grievances (W&I Code section 14029.91; 45 CFR § 84.7; 34 CFR §106.8; 28 CFR § 35.107; Government Code § 11135)

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.

2. The Contractor shall adopt Discrimination Grievance procedures that ensure the prompt and equitable resolution of discrimination-related complaints. The Contractor shall not require a beneficiary to file a Discrimination Grievance with the Contractor before filing the grievance directly with DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights.
3. The Discrimination Grievance Coordinator shall be available to:
    i. Answer questions and provide appropriate assistance to the Contractor staff and members regarding the Contractor's state and federal nondiscrimination legal obligations.
    ii. Advise the Contractor about nondiscrimination best practices and accommodating persons with disabilities.
    iii. Investigate and process any Americans with Disabilities Act, Section 504 of the Rehabilitation Act, section 1557 of the Affordable Care Act, and/or Gov. Code section 11135 grievances received by the Contractor.
4. The Contractor shall comply with the following discrimination grievances reporting requirements.
    i. Within ten calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary, the Contractor shall submit detailed information regarding the grievance to DHCS Office of Civil Rights' designated Discrimination Grievance email box. The Contractor shall submit the following detailed information in a secure format to DHCS.DiscriminationGrievances@dhcs.ca.gov:
        a. The original complaint.
        b. The provider's or other accused party's response to the grievance.
        c. Contact information for the Contractor's personnel responsible for the Contractor's investigation and response to the grievance.
        d. Contact information for the beneficiary filing the grievance and for the provider or other accused party that is the subject of the grievance.

e. All correspondence with the beneficiary regarding the grievance, including, but not limited to, the Discrimination Grievance acknowledgment and resolution letter(s) sent to the beneficiary.
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.

III. Program Specifications

A. General Requirements

1. The Contractor has elected to opt into the DMC-ODS to provide or arrange for covered DMC-ODS services described under this Agreement to eligible Medi-Cal individuals residing within the Contractor's county borders.
2. The Contractor shall comply with all State and federal statutes and regulations, the terms of this Agreement, BHINs, and any other applicable authorities.
3. In the event of a conflict between the terms of this Agreement and a State or federal statute or regulation, or a BHIN, the Contractor shall adhere to the applicable statute, regulation, or BHIN.

B. Provision of Services

1. Provider Specifications
   i. 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.
   ii. Professional staff means any of the following:
      a. Licensed Practitioners of the Healing Arts (LPHA), including:
         1. Physicians
         2. Nurse Practitioners
         3. Physician Assistants
         4. Registered Nurses
         5. Registered Pharmacists

6. Licensed Clinical Psychologists
7. Licensed Clinical Social Workers
8. Licensed Professional Clinical Counselors
9. Licensed Marriage and Family Therapists
10. Licensed-eligible practitioners registered with the Board of Psychology or Behavioral Science Board working under the supervision of a licensed clinician

b. An Alcohol or other drug (AOD) counselor that is 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, Cal. Code Regs., tit. 9, Div. 4, chapter 8.
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 meets all other applicable California state requirements, including ongoing education requirements.

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

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

C. Organized Delivery System (ODS) Timely Coverage

1. Non-Discrimination - Member Discrimination Prohibition
   i. Contractor shall accept individuals eligible for enrollment in the order in which they apply without restriction in accordance with this Agreement. Contractor shall take affirmative action to ensure that beneficiaries are provided covered services and will not discriminate against individuals eligible to enroll under the laws of the United States and the State of California. Contractor shall not unlawfully discriminate against any person pursuant to:
      a. Title VI of the Civil Rights Act of 1964.
      b. Title IX of the Education Amendments of 1972 (regarding education and programs and activities).
      c. The Age Discrimination Act of 1975.
      d. The Rehabilitation Act of 1973.
      e. The Americans with Disabilities Act.
2. DMC-ODS services shall be available as a Medi-Cal benefit for individuals in accordance with this Agreement, BHIN 23-001, the applicable statutes and regulations, and any other relevant information notices issued by the Department.
   i. The Contractor, subcontractor, or network providers shall verify the Medicaid eligibility determination of an individual. When the network providers conduct the initial eligibility verification, that verification shall be reviewed and approved by the Contractor prior to payment for services.

ii. In accordance with the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate under section 1905(r) of the Act, the Contractor shall ensure that all beneficiaries under age 21 receive all applicable SUD services needed to correct or ameliorate health conditions that are coverable under section 1905(a) of the Act. Nothing in the DMC-ODS limits or modifies the scope of the EPSDT mandate, and a participating DMC-ODS County is responsible for the provision of SUD services pursuant to the EPSDT mandate.

iii. DMC-ODS services must be medically necessary. Pursuant to W&I Code section 14059.5(a) for individuals 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.

iv. For individuals under 21 years of age, a service is “medically necessary” or a “medical necessity” if the service is necessary to correct or ameliorate screened health conditions. 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. (Section 1396d(r)(5) of Title 42 of the United States Code; W&I Code section 14059.5(b)(1)).

v. The Contractor shall update policies and procedures, provider contracts, beneficiary handbooks, and related material to ensure the medical necessity standard is accurately reflected in all materials consistent with W&I Code section 14059.5, the terms of BHIN 23-001, and any other applicable authorities.

vi. To receive DMC-ODS services, a beneficiary shall be enrolled in Medi-Cal, and reside in a participating county. DMC-ODS services shall be consistent with the following assessment, access, and level of care determination criteria:

a. Initial Assessment and Services Provided During the Assessment Process:
   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 beneficiary is under age 21, or if a provider documents that the beneficiary is experiencing homelessness and therefore requires additional time to complete the assessment. If a beneficiary 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. 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 beneficiary 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. DMC-ODS Access for Beneficiaries After Assessment:

1. For beneficiaries 21 years and older, to qualify for DMC-ODS services after the initial assessment process, beneficiaries 21 years of age and older shall 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.

2. Beneficiaries under age 21 qualify to receive all medically necessary DMC-ODS services as required pursuant to section 1396d(r) of Title 42 of the United States Code. Federal EPSDT statutes and regulations require States to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of covered in the state's Medicaid State Plan. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental 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.

c. Additional Coverage Requirements and Clarifications
Consistent with W&I Code section 14184.402(f), covered SUD prevention, screening, assessment, treatment, or recovery services are reimbursable Medi-Cal services when:
    1. Services are provided prior to determination of a diagnosis or prior to determination of whether DMC-ODS criteria are met, as described above; or

i. Clinically appropriate and covered DMC-ODS services provided to beneficiaries over 21 shall be reimbursable during the assessment process as described above under the “Initial Assessment and Services Provided During the Assessment Process”. In addition, the Contractor shall not disallow reimbursement for clinically appropriate and covered DMC-ODS services provided during the assessment process if the assessment determines that the beneficiary does not meet the DMC-ODS access criteria for beneficiaries after assessment.

ii. This does not eliminate the requirement that all Medi-Cal claims, which include DMC-ODS claims, include a CMS approved International Classification of Diseases, Tenth Revision (ICD-10-CM). In cases where services are provided due to a suspected SUD that has not yet been diagnosed or due to trauma as noted above, 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, for additional information regarding code selection during the assessment period for outpatient behavioral health services.

2. Prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan; or

i. The Contractor shall implement the guidance in BHIN 22-019 related to documentation requirements that took effect as of July 1, 2022.

3. The beneficiary has a co-occurring mental health condition.
   i. Medically necessary covered DMC-ODS delivered by DMC-ODS providers shall be covered and reimbursable Medi-Cal services whether or not the beneficiary has a co-occurring mental health condition. DMC-ODS counties shall not disallow reimbursement for covered DMC-ODS services provided to a beneficiary who has a co-occurring mental health condition if the beneficiary meets the DMC-ODS Access Criteria for Beneficiaries After Assessment pursuant to BHIN 22-011.

d. Level of Care Determination: The ASAM Criteria shall be used to determine placement into the appropriate level of care for all beneficiaries and is separate and distinct from determining medical necessity.
   1. For beneficiaries 21 and over, a full assessment using the ASAM Criteria shall be completed within 30 days of the beneficiary's first visit with an LPHA or registered/certified counselor.
   2. For beneficiaries under 21, or for adults experiencing homelessness, a full assessment using the ASAM Criteria shall be completed within 60 days of the beneficiary's first visit with an LPHA or registered/certified counselor.

3. A full ASAM Criteria assessment is not required to deliver prevention and early intervention services for beneficiaries under 21; a brief screening ASAM Criteria tool is sufficient for these services (see below regarding details about ASAM level of care 0.5).
4. If a beneficiary withdraws from treatment prior to completing the ASAM Criteria assessment and later returns, the time period starts over.
5. 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.
6. A full ASAM assessment does not need to be repeated unless the beneficiary's condition changes.
7. These requirements for ASAM Level of Care assessments apply to NTP clients and settings.

e. Beneficiary placement and level of care determinations shall ensure that beneficiaries are able to receive care in the least restrictive level of care that is clinically appropriate to treat their condition.

D. Covered Services

1. In addition to the coverage and authorization of services requirements set forth in Article II.E.4 of this Agreement, the Contractor shall:
   i. Identify, define, and specify the amount, duration, and scope of each DMC-ODS service that the Contractor is required to offer.

ii. Require that DMC-ODS services identified be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in 42 CFR 440.230.
iii. Specify the extent to which the Contractor is responsible for covering DMC-ODS services related to the following:
    a. The prevention, diagnosis, and treatment of health impairments.
    b. The ability to achieve age-appropriate growth and development.
    c. The ability to attain, maintain, or regain functional capacity.

2. The Contractor shall delivery the DMC-ODS Covered Services within a continuum of care as defined in the ASAM Criteria.
3. The mandatory and optional DMC-ODS services can be found under Article III.C.4 of this Agreement. The Contractor shall provide all mandatory DMC-ODS services identified and may provide all optional DMC-ODS services identified under Article V, in accordance with the applicable requirements set forth in this Agreement.
4. The following are the mandatory and optional DMC-ODS Covered Services:
    i. Screening, Brief Intervention, Referral to Treatment and Early Intervention Services (for beneficiaries under age 21) (mandatory).
    ii. Withdrawal Management Services (a minimum of one level is mandatory).
    iii. Intensive Outpatient Treatment Services (mandatory).
    iv. Outpatient Treatment Services (mandatory).
    v. Narcotic Treatment Programs (mandatory).
    vi. Recovery Services (mandatory).
    vii. Care Coordination (mandatory).
    viii. Clinician Consultation (mandatory).

ix. Medications for Addiction Treatment (also known as Medication Assisted Treatment or MAT). This is defined as facilitating access to MAT off-site for beneficiaries while they are receiving DMC-ODS treatment services if not provided on-site. Providing a beneficiary, the contact information for a treatment program is insufficient.
x. Residential Treatment Services (ASAM Levels 3.1, 3.3, and 3.5 shall be made available within the timeframes outlined in Article III, Section S.7.v).
xi. Partial Hospitalization (Optional).
xii. Medi-Cal Peer Support Services Optional). (
xiii. Contingency Management Services (Optional).
xiv. 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).

5. Contractor, to the extent applicable, shall comply with "Sobky v. Smoley" (Document 2A), 855 F. Supp. 1123 (E.D. Cal 1994), incorporated by this reference.
6. Contractor shall comply with federal and state mandates to provide SUD treatment services deemed medically necessary for Medi-Cal eligible: (1) pregnant and postpartum beneficiaries, and (2) adolescents under age 21 who are eligible under EPSDT.

E. Financing

1. Payment for Services
   i. The Contractor shall pay the subcontractor the total per utilizer per month rate identified in Exhibit B, Part V, Provision A for each beneficiary who receives at least one service in a month. This total per utilizer per month rate is an interim reimbursement rate subject to reconciliation.
   ii. The Contractor or its subcontractor shall submit a claim to the Department's Short-Doyle Medi-Cal claiming system for each DMC ODS service the subcontractor provides to a Medi-Cal beneficiary.

iii. DHCS shall reimburse the Contractor the Medical Assistance per utilizer per month rate contained in Exhibit B, Part V, Provision A in accordance with the sharing ratios identified in Exhibit B, Part V, Provision C to this Agreement.

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

v. The Contractor shall only provide State Plan DMC services until DHCS and CMS approve of this Agreement and the approved Agreement is executed by the Contractor's County Board of Supervisors.

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

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

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

vii. If the Contractor or subcontractor submits a claim for OHC and receives partial payment of the claim, the Contractor may submit the claim to the Department's Short-Doyle Medi-Cal claiming system. DHCS will reduce Contractor's per utilizer per month payment by the amount of the payment made by the OHC.

2. Rate Setting

i. The Contractor shall obtain DHCS' approval of the per utilizer per month rate the Contractor pays the subcontractor.

ii. The Contractor shall require the subcontractor to reimburse network providers no more than the prevailing charges in the locality for comparable services under comparable circumstances.

F. Availability of Services

1. In addition to the availability of services requirements set forth in Article II.E.1 of this Agreement, the Contractor shall:

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

G. Access to Services

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

2. When a beneficiary makes a request for covered services, the Contractor shall require services to be initiated with reasonable promptness. Contractor shall have a documented system for monitoring and evaluating the quality, appropriateness, and accessibility of care, including a system for addressing problems that develop regarding waiting times and appointments.
3. In addition to the coverage and authorization of service requirements set forth in Article II.E.4 of this Agreement, the Contractor shall:
    i. Authorize DMC-ODS services in accordance with the Expanded Substance Use Disorder Services coverage provisions of the approved Medicaid State Plan.
    ii. Make all medical necessity determinations in accordance with W&I Code section 14059.5, except as provided W&I Code section 14184.402 and any written instructions issued by the department pursuant to subdivision (d) of that Section.
    iii. Inform the beneficiary in accordance with Article II.G.2 of this Agreement if services are denied.
    iv. Provide prior authorization for residential services within 24 hours of the prior authorization request being submitted by the provider.
        a. Prior authorization is prohibited for non-residential DMC-ODS services.
        b. The Contractor's prior authorization process shall comply with the parity requirements set forth in 42 CFR §438.910(d).
    v. Review the DSM and ASAM Criteria documentation to ensure that the beneficiary meets the requirements for the service.
    vi. Have written policies and procedures for processing requests for initial and continuing authorization of services.
    vii. Have a mechanism in place to ensure that there is consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate.

viii. Track the number, percentage of denied, and timeliness of requests for authorization for all DMC-ODS services that are submitted, processed, approved, and denied.
ix. Pursuant to 42 CFR 438.3(l), allow each beneficiary to choose their health professional to the extent possible and appropriate.
x. Require that treatment programs are accessible to people with disabilities in accordance with CFR Title 45, Part 84 and the Americans with Disabilities Act.
xi. Have a 24/7 toll free number for prospective beneficiaries to call to access DMC-ODS services and make oral interpretation services available for beneficiaries, as needed.
xii. Shall guarantee that it will not avoid costs for services covered in this Agreement by referring beneficiaries to publicly supported health care resources.

4. Covered services, whether provided directly by the Contractor, through the subcontractor, or network providers, shall be provided to beneficiaries in the following manner:
   i. DMC-ODS services shall be available to all beneficiaries who reside in the ODS County.
5. Access to State Plan services shall remain at the current, pre-implementation level or expand upon implementation.
   The Contractor is responsible for ensuring that its beneficiaries can receive all medically necessary DMC-ODS services. beneficiaries can receive all medically necessary DMC-ODS services. The Contractor shall not deny access to medically necessary services, including all FDA-approved medications for OUD if a beneficiary meets the medical necessity criteria for DMC-ODS services. Beneficiaries shall not be put on a wait list to access any medically necessary services. If the Contractor's provider network is unable to provide necessary services to a particular beneficiary, the Contractor shall adequately and timely cover these services out-of-network for as long as the Contractor's network is unable to provide them.

6. Only Medi-Cal beneficiaries for whom the county of responsibility is a DMC-ODS county are entitled to DMC-ODS services. This applies to AI/AN Medi-Cal beneficiaries as well as non-AI/AN Medi-Cal beneficiaries (BHIN 21-032 and any subsequently issued BHINs that supersede BHIN 21-032).
7. The Contractor shall ensure that a beneficiary that resides in a county that does not participate in DMC-ODS does not experience a disruption of NTP services. The Contractor shall require all NTP subcontractors to provide any medically necessary DMC NTP services covered by the California Medi-Cal State Plan to beneficiaries that reside in a county that does not participate in DMC-ODS. The Contractor shall require all NTP subcontractors that provide services to an out-of-county beneficiary to submit the claims for those services to the county in which the beneficiary resides (according to MEDS).
8. If a beneficiary 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).

H. Coordination with Managed Care Programs

1. The Contractor shall require the subcontractor to include in its contracts with all network providers the following elements which should be implemented at the point of care to ensure clinical integration:
    i. Comprehensive substance use, physical, and mental health screening, including ASAM Level 0.5 SBIRT services.
    ii. Beneficiary engagement and participation in an integrated care program as needed.
    iii. Shared development of care plans by the beneficiary, caregivers, and all providers where applicable.

iv. Collaborative care planning with managed care where applicable.
v. Delineation of case management responsibilities.
vi. A process for resolving disputes between the Contractor and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved.
vii. Availability of clinical consultation, including consultation on medications.
viii. Care coordination and effective communication among providers including procedures for exchanges of medical information.
ix. Navigation support for patients and caregivers.
x. Facilitation and tracking of referrals.

I. Authorization of Services – Residential Programs

1. The Contractor shall implement residential treatment program standards that comply with the authorization of services requirements set forth in Article II.E.4 and shall:
   i. Establish, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services for residential programs.
   ii. Ensure that residential services are provided in DHCS or Department of Social Services (DSS) licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM criteria.
   iii. Ensure that residential services may be provided in facilities with no bed capacity limit.
   iv. 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.
   v. Ensure that the length of residential services comply with the following:

a. 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.
b. Lengths of stay in residential treatment settings shall be determined by individualized clinical need.
c. The Contractor shall ensure that beneficiaries receiving residential treatment are transitioned to another level of care when clinically appropriate based on treatment progress.
d. 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.
e. Nothing in the DMC-ODS overrides any EPSDT requirements. EPSDT beneficiaries may receive a longer length of stay based on medical necessity.
f. If determined to be medically necessary, perinatal beneficiaries may receive a longer length of stay than those described above.

vi. 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.

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

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

J. Provider Selection and Certification

Exhibit A, Attachment I
Program Specifications

1. In addition to complying with the provider selection requirements set forth in Article II.E.5 and the provider discrimination prohibitions in Article II.B.3, the Contractor shall:
   i. Have written policies and procedures for selection and retention of providers that comply with the terms and conditions of this Agreement and applicable federal and state laws and regulations.
   ii. Apply those policies and procedures equally to all providers regardless of public, private, for-profit or non-profit status, and without regard to whether a provider treats persons who require high-risk or specialized services.
   iii. Not discriminate against persons who require high-risk or specialized services.
   iv. Subcontract with providers in another state where out-of-state care or treatment is rendered on an emergency basis or is otherwise in the best interests of the person under the circumstances.
   v. Select only providers that have a license and/or certification issued by the state that is in good standing.
   vi. Select only providers that, prior to the furnishing of services under this Agreement, have enrolled with, or revalidated their current enrollment with, DHCS as a DMC provider under applicable federal and state regulations.

vii. Select only providers that have been screened in accordance with 42 CFR 455.450 prior to furnishing services under this Agreement, have signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107, and have complied with the ownership and control disclosure requirements of 42 CFR 455.104. DHCS shall deny enrollment and DMC certification to any provider (as defined in W&I Code section 14043.1), or a person with ownership or control interest (as defined in 42 CFR 455.101) in the provider, that, at the time of application, is under investigation for fraud, waste or abuse pursuant to Part 455 of Title 42 of the Code of Federal Regulations, unless DHCS determines that there is good cause not to deny enrollment upon the same bases enumerated in 42 CFR 455.23(e). If a provider is under investigation for fraud or abuse, that provider shall be subject to temporary suspension pursuant to W&I Code section 14043.36. Upon receipt of a credible allegation of fraud, a provider shall be subject to a payment suspension pursuant to W&I Code section 14107.11 and DHCS may thereafter collect any overpayment identified through an audit or examination. During the time a provider is subject to a temporary suspension pursuant to W&I Code section 14043.36, the provider, or a person with ownership or control interest (as defined in 42 CFR 455.101), in the provider may not receive reimbursement for services provided to a DMC-ODS beneficiary. A provider shall be subject to suspension pursuant to W&I Code section 14043.61 if claims for payment are submitted for services provided to a Medi-Cal beneficiary by an individual or entity that is ineligible to participate in the Medi-Cal program. A provider will be subject to termination of provisional provider status pursuant to W&I Code section 14043.27 if the provider has a debt due and owing to any government entity that relates to any federal or state health care program and has not been excused by legal process from fulfilling the obligation. Only providers newly enrolling or revalidating their

current enrollment on or after January 1, 2015, would be required to undergo fingerprint-based background checks required under 42 CFR 455.434.

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

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

K. DMC Certification and Enrollment

1. DHCS shall certify eligible providers to participate in the DMC program.
2. The DHCS shall certify any network providers. This certification shall be performed prior to the date on which the Contractor begins to deliver services under this Agreement at these sites.
3. Contractor shall require that providers of perinatal DMC services are properly certified to provide these services and comply with the applicable requirements contained in Article III.PP of this Exhibit A, Attachment I.
4. Contractor shall require all the network providers of services to be licensed, registered, DMC certified and/or approved in accordance with applicable laws and regulations. Contractor's subcontracts shall require that providers comply with all applicable regulations and guidelines, including:
   i. Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8.
   ii. Cal. Code Regs., tit. 22, § 51490(a).
   iii. Exhibit A, Attachment I, Article III.XX – Requirements for Services.
   iv. Cal. Code Regs., tit. 9, Div. 4, chapter 4, subchapter 1, sections 10000, et seq.
   v. Cal. Code Regs., tit. 22, Div. 3, chapter 3, §§ 51000 et. seq.
   vi. W&I Code section 14184.100 *et seq*.
5. The Contractor shall ensure the Provider Enrollment Division (PED) is notified 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.

6. 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.
7. The Contractor shall notify DHCS PED by e-mail at DHCSDMCRecert@dhcs.ca.gov within two business days of learning that a subcontractor's license, registration, certification, or approval to operate an SUD program or provide a covered service is revoked, suspended, modified, or not renewed by entities other than DHCS.
    i. A provider's certification to participate in the DMC program shall automatically terminate in the event that the provider, or its owners, officers or directors are convicted of Medi-Cal fraud, abuse, or malfeasance. For purposes of this section, a conviction shall include a plea of guilty or nolo contendere.

L. Continued Certification

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

M. Laboratory Testing Requirements

1. 42 CFR Part 493 sets forth the conditions that all laboratories shall meet to be certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Except as specified in paragraph (2) of this section, a laboratory will be cited as out of compliance with section 353 of the Public Health Service Act unless it:
    i. Has a current, unrevoked or unsuspended certificate of waiver, registration certificate, certificate of compliance, certificate for provider-performed microscopy procedures, or certificate of accreditation issued by HHS applicable to the category of examinations or procedures performed by the laboratory; or
    ii. Is CLIA-exempt.
2. These rules do not apply to components or functions of:
    i. Any facility or component of a facility that only performs testing for forensic purposes.
    ii. Research laboratories that test human specimens but do not report patient specific results for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of individual patients.
    iii. Laboratories certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), in which drug testing is performed which meets SAMHSA guidelines and regulations. However, all other testing conducted by a SAMHSA-certified laboratory is subject to this rule.
3. Laboratories under the jurisdiction of an agency of the Federal Government are subject to the rules of 42 CFR 493, except that the Secretary may modify the application of such requirements as appropriate.

N. Recovery from Other Sources or Providers

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

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

1. Beneficiaries 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, to include DMC-ODS claims, include a CMS approved ICD-10-CM code. In cases where services are provided due to a suspected SUD that has not yet been diagnosed or due to trauma, options are available in the CMS approved ICD-10-CM code list.
2. 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 beneficiary under age 21 is not participating in the full array of outpatient treatment services.

3. A full assessment utilizing the ASAM criteria is not required for a DMC beneficiary under the age of 21 to receive early intervention services; an abbreviated ASAM screening tool may be used. If the beneficiary under 21 meets diagnostic criteria for SUD, a full ASAM assessment shall be performed, and the beneficiary shall receive a referral to the appropriate level of care indicated by the assessment.
4. Early intervention services may be delivered in a wide variety of settings, and can be provided in person, by telehealth, or by telephone.
5. Nothing in this section shall limit or modify the scope of the EPSDT mandate.

P. Outpatient Treatment Services (ASAM Level 1.0)

1. Outpatient treatment services (also known as Outpatient Drug Free or ODF) are provided to beneficiaries when medically necessary. 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 beneficiary may exceed the maximum based on individual medical necessity. Outpatient Treatment Services may be provided in person, by telehealth, or by telephone.
2. 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) beneficiaries.
3. 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.

4. 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 beneficiaries while they are receiving outpatient treatment services if not provided on-site. Providing a beneficiary, the contact information for a treatment program is insufficient).

Q. Intensive Outpatient Treatment Services (ASAM Level 2.1)

1. Intensive Outpatient Treatment Services are provided to beneficiaries when medically necessary in a structured programming environment. 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 the individual beneficiary may exceed the maximum based on individual medical necessity. Intensive Outpatient Treatment Services may be provided in person, by telehealth, or by telephone.
2. Group size is limited to no less than two (2) and no more than twelve (12) beneficiaries.
    i. Network providers may provide more than 19 hours per week to adults when determined by a Medical Director or an LPHA to be medical necessary.
    ii. Network providers may extend a beneficiary's length of treatment when determined by a Medical Director or an LPHA to be medically necessary.
3. Intensive 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, and SUD crisis intervention services.

4. 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 beneficiaries while they are receiving intensive outpatient treatment services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient).

R. Partial Hospitalization (ASAM Level 2.5) (Optional) – If Contractor agrees to provide Partial Hospitalization Services, as identified under Article V, Contractor shall comply with the following requirements:

1. Partial Hospitalization Services are clinically intensive programming designed to address the treatment needs of beneficiaries 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 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 beneficiaries 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 beneficiaries 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 beneficiaries while they are receiving withdrawal management

services if not provided on-site. Providing a beneficiary, the contact information for a treatment program is insufficient).

S. Residential Treatment (ASAM Levels 3.1 – 3.5); and Inpatient Services (ASAM 3.7 and 4.0) (Optional)

1. Residential Treatment Services are delivered to beneficiaries when medically necessary in a short-term residential program corresponding to at least one of the following levels:
    i. Level 3.1 - Clinically Managed Low-Intensity residential Services.
    ii. Level 3.3 - Clinically Managed Population-Specific High Intensity Residential Services.
    iii. Level 3.5 - Clinically Managed High Intensity Residential Services.
2. Inpatient Treatment Services are delivered to beneficiaries when medically necessary in a short-term inpatient program corresponding to at least one of the following levels:
    i. Level 3.7 - Medically Monitored Intensive Inpatient Services.
    ii. Level 4.0 - Medically Managed Intensive Inpatient Services.
3. Residential services are provided in DHCS or DSS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.
4. All Residential and Inpatient Treatment services shall be provided to a beneficiary 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.

5. A beneficiary 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 beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems.
6. Providers 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 beneficiaries while they are receiving residential treatment services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient).
7. Residential Treatment Services
    i. 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:
        a. Residential facilities licensed by DHCS.
        b. Residential facilities licensed by the Department of Social Services.
        c. Chemical Dependency Recovery Hospitals (CDRHs) licensed by the Department of Public Health (DPH).
        d. Freestanding Acute Psychiatric Hospitals (FAPHs) licensed by DPH.
    ii. 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, 3.3, 3.5, and 3.2-WM 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.

iii. To participate in the DMC-ODS program and offer ASAM Levels of Care 3.1, 3.3, or 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, 3.3 or 3.5 obtain an ASAM LOC Certification for each level of care provided effective January 1, 2024.

iv. Residential Treatment services can be provided in facilities of any size. Contractor shall comply with the length of stay requirements set forth in Article III.I.1(iv)-(v) of this Agreement.

v. The Contractor shall implement coverage and ensure access for residential SUD treatment services as follows:
    a. 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.
    b. 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.
    c. Within three years of implementation, the Contractor shall provide in-network access to ASAM Levels 3.3.

vi. If, at any point in time, the Contractor's provider network is unable to provide any residential level of care to a particular beneficiary that meets medical necessity for that residential level of care, the Contractor shall adequately and timely cover these residential services out-of-network for the beneficiary, for as long as the Contractor's provider network is unable to provide them.

vii. 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.

viii. Nothing in the DMC-ODS shall override any EPSDT requirements.

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

8. Inpatient Services

i. 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.

ii. 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.

iii. 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.

T. Withdrawal Management

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

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

ii. 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).
iii. Level 3.2-WM: Clinically managed residential withdrawal management (24-hour support for moderate withdrawal symptoms that are not manageable in outpatient setting).
iv. Level 3.7-WM: Medically Managed Inpatient Withdrawal Management (24-hour care for severe withdrawal symptoms requiring 24-hour nursing care and physician visits).
v. 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).

2. 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.
3. 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 beneficiary's first visit with an LPHA or registered/certified counselor for non-Withdrawal Management services (or 60 days for beneficiaries under 21, or beneficiaries experiencing homelessness), as described above.

4. 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.
5. The Contractor shall ensure that all beneficiaries receiving withdrawal management services are provided in an outpatient, residential or inpatient setting. If beneficiary is receiving withdrawal management in a residential or inpatient setting, each beneficiary shall reside at the facility. All beneficiaries receiving Withdrawal Management services, regardless in which type of setting, shall be monitored during the detoxification process.
    i. 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 beneficiary's health status.
6. 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.
7. Providers 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 beneficiaries while they are receiving withdrawal management services if not provided on-site). Providing a beneficiary the contact information for a treatment program is insufficient.

U. Narcotic Treatment Program

1. 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 beneficiaries covered under the DMC-ODS formulary including methadone, buprenorphine (transmucosal and long-acting injectable), naltrexone (oral and long-acting injectable), naloxone and disulfiram.

   i. 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 beneficiary to a provider capable of dispensing the medication.
2. NTPs shall comply with all federal and state NTP licensing requirements.
   i. If the NTP cannot comply with all federal and state NTP requirements, then the NTP must assist the beneficiary in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement.
3. The NTP shall offer the beneficiary a minimum of fifty minutes of counseling services per calendar month.
4. NTP services shall be provided in DHCS-licensed NTP facilities pursuant to the Cal. Code Regs., tit. 9, div. 4, chapter 4, and title 42 of the CFR. 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.
5. 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.
6. Pursuant to W&I Code section 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 beneficiaries 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 beneficiaries that are enrolled in managed care plans to their respective managed care plan to receive medically necessary medical treatment of their concurrent health conditions.

7. The diagnosis and treatment of concurrent health conditions of Medi-Cal beneficiaries 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 section 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:
    i. Medical treatment visits.
    ii. Diagnostic blood, urine, and X-rays.
    iii. Psychological and psychiatric tests and services.
    iv. Quantitative blood and urine toxicology assays.
    v. Medical supplies.
8. An NTP provider who is enrolled as a Medi-Cal fee-for-service provider shall not seek reimbursement from a beneficiary for SUD treatment services, if the NTP provider bills the services for treatment of concurrent health conditions to the Medi-Cal fee-for-service program.
9. The Contractor shall subcontract with licensed NTPs to offer services to beneficiaries as medically necessary.
10. Services shall be provided in accordance with an individualized beneficiary plan determined by a licensed prescriber.

V. Recovery Services

1. Beneficiaries may receive Recovery Services based on self-assessment or provider assessment of relapse risk. Beneficiaries do not need to be diagnosed as being in remission to access Recovery Services. Beneficiaries may receive Recovery Services while receiving MAT services, including NTP services. Beneficiaries may receive Recovery Services immediately after incarceration with a prior diagnosis of SUD.
2. 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.

3. 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 beneficiary's SUD) and relapse prevention (which includes interventions designed to teach beneficiaries with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the beneficiary's SUD).
4. Recovery Services may be provided in person, by telehealth, or by telephone.

W. Medi Cal Peer Support Services (Optional)

1. If Contractor agrees to provide Medi-Cal Peer Support Services as identified under Article V of this agreement; has opted to provide Medi-Cal Peer Support Services; and has been approved by DHCS; the Contractor shall comply with the Medi-Cal Peer Support Services provisions in Article V.

X. Contingency Management Services (Optional)

1. If Contractor agrees to provide Contingency Management Services as identified under Article V of this agreement, has opted to provide Contingency Management Services, and has been approved by DHCS, then the Contractor shall comply with the Contingency Management Services provisions in Article V.

Y. Care Coordination

1. Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary 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.
2. Care coordination shall be provided to a beneficiary 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 beneficiary-centered and whole-person approach to wellness.

3. Care coordination services shall be provided by an LPHA or a registered/certified counselor.
4. Care coordination services shall include one or more of the following components:
    i. Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.
    ii. 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.
    iii. 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.

Z. Clinician Consultation Services

1. Clinician Consultation Services consist of LPHAs, such as addiction medicine physicians, licensed clinicians, addiction psychiatrists, or clinical pharmacists, to support the provision of care.
2. Clinician Consultation is not a direct service provided to beneficiaries. 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 beneficiaries.
3. 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.

4. The Contractor shall only allow DMC providers to bill for clinician consultation services.

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

1. Medications for addiction treatment 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 Article III.D.4 of this Agreement.
2. When MAT is being provided as a standalone service, MAT includes the following components: assessment; care coordination; counseling (individual and 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.
3. The Contractor shall require that all DMC-ODS providers, at all levels of care, demonstrate that they either directly offer or have an effective referral mechanisms/process to MAT to beneficiaries 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 beneficiaries while they are receiving treatment services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient. A facilitated referral to any Medi-Cal provider rendering MAT to the beneficiary is compliant whether or not they seek reimbursement through DMC-ODS. Beneficiaries 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.

4. 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.
5. 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.
6. Beneficiaries 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 discharge a beneficiary 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 beneficiary, 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.

BB. Cultural Competence Plan

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

CC. Implementation Plan

1. The Contractor shall comply with the provisions of the Contractor's Implementation Plan (IP) as approved by DHCS.

DD. Additional Provisions

1. Additional Agreement Restrictions
   i. This Agreement is subject to any additional restrictions, limitations, conditions, or statutes enacted or amended by the federal or state governments, which may affect the provisions, terms, or funding of this Agreement in any manner.
2. Voluntary Termination of DMC-ODS Services
   i. The Contractor may terminate this Agreement at any time, for any reason, by giving 60 days written notice to DHCS. The Contractor shall be paid for DMC-ODS services provided to beneficiaries up to the date of termination. Upon termination, the Contractor shall immediately begin providing DMC services to beneficiaries in accordance with the State Plan.
3. Nullification of DMC-ODS Services
   i. The parties agree that failure of the Contractor, or its subcontractor, to comply with W&I Code section 14124.24, 14184.100 *et seq.*, BHIN 23-001, this Agreement, and any other applicable statutes, regulations or guidance issued by DHCS, shall be deemed a breach that results in the termination of this Agreement for cause.
   ii. In the event of a breach, DMC-ODS services shall terminate. The Contractor shall immediately begin providing DMC services to the beneficiaries in accordance with the State Plan.

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

i. If any of the work performed under this Agreement is subject to the HIPAA, Contractor shall ensure the work is performed in compliance with all applicable provisions of HIPAA. As identified in Exhibit F, DHCS and the Contractor shall cooperate to ensure mutual agreement as to those transactions between them, to which this Provision applies. Refer to Exhibit F for additional information.

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

iii. Concurrence for Test Modifications to HHS Transaction Standards

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

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

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

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

vii. Data Transmission Log

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

9. Counselor Certification
    i. Any counselor or registrant providing intake, assessment of need for services, treatment or recovery planning, individual or group counseling to participants, patients, or residents in a DHCS licensed or certified program is required to comply with the requirements in Cal. Code Regs., tit. 9, div. 4, chapter 8. (Document 3H)
10. Cultural and Linguistic Proficiency
    i. To ensure equal access to quality care by diverse populations, each service provider receiving funds from this Agreement shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards (Document 3V) and comply with 42 CFR 438.206(c)(2).
11. Trafficking Victims Protection Act of 2000

i. Contractor, its subcontractor, and network providers that provide services covered by this Agreement shall comply with section 106(g) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(g)) as amended by section 1702. For full text of the award term, go to: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title22-section7104d&num=0&edition=prelim.

12. Participation in the County Behavioral Health Director's Association of California.
    i. The Contractor's County Administrator or designee shall participate and represent the county in meetings of the County Behavioral Health Director's Association of California for the purposes of representing the counties in their relationship with DHCS with respect to policies, standards, and administration for SUD services.
    ii. The Contractor's County Administrator or designee shall attend any special meetings called by the Director of DHCS.
13. Adolescent Substance Use Disorder Best Practices Guide
    i. 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 Youth Treatment Guidelines are established and adopted. No formal amendment of this Agreement is required for new guidelines to be incorporated into this Agreement.
14. Nondiscrimination in Employment and Services
    i. By signing this Agreement, Contractor certifies that under the laws of the United States and the State of California, incorporated into this Agreement by reference and made a part hereof as if set forth in full, Contractor shall not unlawfully discriminate against any person.
15. Federal Law Requirements:
    i. Title VI of the Civil Rights Act of 1964, section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in federally funded programs.

ii. Title IX of the Education Amendments of 1972 (regarding education and programs and activities), if applicable.
iii. Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.
iv. Age Discrimination Act of 1975 (45 CFR Part 90), as amended (42 USC sections 6101 – 6107), which prohibits discrimination on the basis of age.
v. Age Discrimination in Employment Act (29 CFR Part 1625).
vi. Title I of the Americans with Disabilities Act (29 CFR Part 1630) prohibiting discrimination against the disabled in employment.
vii. Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities.
viii. Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.
ix. Rehabilitation Act of 1973, as amended (29 USC section 794), prohibiting discrimination on the basis of individuals with disabilities.
x. Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than $10,000 funded by federal financial assistance.
xi. Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.
xii. The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.
xiii. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism.

16. State Law Requirements:

i. Fair Employment and Housing Act (Gov. Code section 12900 et seq.) and the applicable regulations promulgated thereunder (Cal. Code Regs., tit. 2, Div. 4 § 7285.0 et seq.).
ii. Title 2, Division 3, Article 9.5 of the Gov. Code, commencing with Section 11135.
iii. Cal. Code Regs., tit. 9, div. 4, chapter 8, commencing with § 10800.
iv. No state or Federal funds shall be used by the Contractor, or its subcontractors, for sectarian worship, instruction, and/or proselytization. No state funds shall be used by the Contractor, or its subcontractors, to provide direct, immediate, or substantial support to any religious activity.
v. Noncompliance with the requirements of nondiscrimination in services shall constitute grounds for state to withhold payments under this Agreement or terminate all, or any type, of funding provided hereunder.

17. Investigations and Confidentiality of Administrative Actions
    i. Contractor acknowledges that if a DMC provider is under investigation by DHCS or any other state, local or federal law enforcement agency for fraud or abuse, DHCS may temporarily suspend the provider from the DMC program, pursuant to W&I Code section 14043.36(a). Information about a provider's administrative sanction status is confidential until such time as the action is either completed or resolved. DHCS may also issue a payment suspension to a provider pursuant to W&I Code section 14107.11 and Code of Federal Regulations, Title 42, section 455.23. The Contractor or subcontractor is to withhold payments from a DMC provider during the time a payment suspension is in effect.
    ii. Contractor shall execute the Confidentiality Agreement, attached as Document 5A. The Confidentiality Agreement permits DHCS to communicate with Contractor concerning network providers that are subject to administrative sanctions.

18. Subcontract Provisions
    i. Contractor shall include all of the foregoing provisions in all of its subcontracts.
    ii. Contractor must ensure the subcontractor includes all the foregoing provisions in its contracts with providers.

EE. Beneficiary Problem Resolution Process

1. The Contractor shall establish and comply with a beneficiary problem resolution process.
2. Contractor shall inform the subcontractor and network providers at the time they enter into a subcontract about:
    i. The beneficiary's right to a state hearing, how to obtain a hearing and the representation rules at the hearing.
    ii. The beneficiary's right to file grievances and appeals and the requirements and timeframes for filing.
    iii. The beneficiary's right to give written consent to allow a provider, acting on behalf of the beneficiary, to file an appeal. A provider may file a grievance or request a state hearing on behalf of a beneficiary, if the state permits the provider to act as the beneficiary's authorized representative in doing so.
    iv. The beneficiary may file a grievance, either orally or in writing, and, as determined by DHCS, either with DHCS or with the Contractor.
    v. The availability of assistance with filing grievances and appeals.
    vi. The toll-free number to file oral grievances and appeals.
    vii. The beneficiary's right to request continuation of benefits during an appeal or state hearing filing although the beneficiary may be liable for the cost of any continued benefits if the action is upheld.
    viii. Any state determined provider's appeal rights to challenge the failure of the Contractor to cover a service.

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

FF. Selective Provider Contracting Requirements for DMC-ODS Counties

1. The Contractor shall select the DMC-certified providers with whom they contract to establish their DMC-ODS provider networks, with the exception of IHCPs as described in the Article II.B.4 of the Agreement. DMC-certified providers that do not receive a DMC-ODS County contract cannot receive a direct contract with the State to provide services to residents of DMC-ODS Counties.

GG. Contract Denial and Appeal Process

1. The Contractor shall serve providers that apply to be a DMC-ODS contract provider but are not selected a written decision including the basis for the denial. Any solicitation document utilized by the Contractor for the selection of DMC providers must include a protest provision. The Contractor shall have a protest procedure for providers that are not awarded a contract. The protest procedure shall include requirements outlined in Article III.J.5 of this Agreement. Providers that submit a bid to be a contract provider, but are not selected, must exhaust the Contractor's protest procedure if a provider wishes to challenge the denial to DHCS. If the Contractor does not render a decision within 30 calendar days after the protest was filed with the Contractor, the protest shall be deemed denied and the provider may appeal the failure to DHCS. A provider may appeal to DHCS as outlined in Enclosure 4 of BHIN 23-001.

HH. Subcontracts

1. In addition to complying with the subcontractual relationship requirements set forth in Article II.E.9 of this Agreement, the Contractor shall ensure that all subcontracts require that the Contractor oversee and is held accountable for any functions and responsibilities that the Contractor delegates to any subcontractor.
2. Each subcontract shall:
   i. Fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract.
   ii. Ensure that the Contractor evaluates the prospective subcontractor's ability to perform the activities to be delegated.
   iii. Require a written agreement between the Contractor and the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

iv. Ensure the Contractor monitors the subcontractor's performance on an ongoing basis and subject it to an annual onsite review, consistent with statutes, regulations, and Article III.XX of this Agreement.
v. Ensure the Contractor identifies deficiencies or areas for improvement, the subcontractor shall take corrective actions and the Contractor shall ensure that the subcontractor implements these corrective actions.

3. The Contractor shall ensure the following provider requirements are included in all subcontracts with providers:
   i. Culturally Competent Services: Providers are responsible to provide culturally competent services. Providers shall ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations. Translation services shall be available for beneficiaries, as needed.
   ii. Medication Assisted Treatment: DMC-ODS 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 beneficiaries with SUD diagnoses that are treatable with medications or biological products (defined as facilitating access to MAT off-site for beneficiaries if not provided on-site. Providing a beneficiary the contact for information for a treatment program is insufficient). An appropriate facilitated referral to any Medi-Cal provider rendering MAT to the beneficiary is compliant whether or not that provider seeks reimbursement through DMC-ODS. The Contractor shall monitor the referral process or provision of MAT services.

iii. 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 beneficiary-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on beneficiaries' past successes.
b. Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
c. Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use 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 beneficiaries about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries' lives, to instill self- awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

II. Program Integrity Requirements

1. Service Verification. To assist DHCS in meeting its obligation under 42 CFR 455.1(a)(2), the Contractor shall establish a mechanism to verify whether services were actually furnished to beneficiaries.
2. DMC Claims and Reports
   i. The Contractor, subcontractor, or network providers that bill DHCS or the Contractor for DMC-ODS services shall submit claims in accordance with the current DHCS Drug Medi-Cal ODS Billing Manual. The DMC-ODS billing manual will be updated to align with new policies. If the billing manual conflicts with guidance outlined in BHIN 23-001, BHIN 23-001 shall be the governing authority.
   ii. The Contractor, subcontractor, or network providers that provide DMC services shall be responsible for verifying the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for DMC services to that beneficiary for that month. Medi-Cal eligibility verification should be performed prior to rendering service, in accordance with and as described in the DHCS Drug Medi-Cal ODS Billing Manual. Options for verifying the eligibility of a Medi-Cal beneficiary are described in the Department of Health Care Services Drug Medi-Cal ODS Billing Manual.

iii. Claims for DMC reimbursement shall include DMC-ODS services covered under BHIN 23-001 any State Plan services covered under Cal. Code Regs., tit. 22, § 51341.1(c-d) and administrative charges.
   a. Contractor shall ensure submission to DHCS the Drug Medi-Cal Claim Submission Certification DHCS 100186 for each 837P transaction approved for reimbursement of the federal Medicaid funds.
   b. DMC service claims shall be submitted electronically in a HIPAA-compliant format (837P). All adjudicated claim information shall be retrieved by the Contractor or subcontractor via an 835 HIPAA compliant format (Health Care Claim Payment/Advice).

iv. The following forms shall be prepared as needed and retained by the provider for review by state staff:
   a. Good Cause Certification (6065A), Document 2L(a)
   b. Good Cause Certification (6065B), Document 2L(b)
   c. In the absence of good cause documented on the Good Cause Certification (6065A or 6065B) form, claims that are not submitted within six months of the end of the month of service shall be denied. The existence of good cause shall be determined by DHCS in accordance with Cal. Code Regs., tit. 22, § 51008 and 51008.5.

3. Certified Public Expenditure - County Administration
   i. Separate from direct service claims as identified above, the Contractor may submit Form MC 5312 for administrative costs for administering the DMC-ODS program on a quarterly basis. The form MC 5312 requesting reimbursement shall be submitted to DHCS via email to: BHFSOps@dhcs.ca.gov.
   ii. By November 1st following the close of each fiscal year, the Contract shall submit a final invoice on Form MC 5312 for administrative costs incurred in the prior fiscal year for administering the DMC-ODS program. The final invoice shall be submitted to BHFSOps@dhcs.ca.gov

iii. **DHCS shall reconcile all quarterly payments to the final payment due.**

4. Certified Public Expenditure –Quality Assurance and Utilization Review (QA/UR)
   i. Separate from direct service claims as identified above, the Contractor may submit an invoice on Form DHCS 5311 for QA/UR for administering the DMC-ODS quality management program on a quarterly basis. The Form DHCS 5311 requesting reimbursement shall be submitted to DHCS via email to: BHFSOps@dhcs.ca.gov.
   ii. By November 1st following the close of each fiscal year, the Contract shall submit a final invoice on Form DHCS 5311 for costs incurred in the prior fiscal year for QA/UR for administering the DMC-ODS program. The final invoice shall be submitted to BHFSOps@dhcs.ca.gov.
   iii. DHCS shall reconcile all quarterly payments to the final payment due.

JJ. Quality Management (QM) Program

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

iv. Evaluate and update the QM Program annually as necessary as set forth in Article II.F.1 of this Agreement.

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

ii. Evaluating beneficiary grievances, appeals and hearings at least annually.
iii. Evaluating requests to change persons providing services at least annually.
iv. The Contractor shall inform providers of the results of beneficiary/family satisfaction activities.

9. The Contractor shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. Monitoring shall occur at least annually.
10. The Contractor shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The Contractor shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the Contractor at least annually.
11. The Contractor shall have a QM Work Plan covering the current Agreement cycle with documented annual evaluations and documented revisions as needed. The Contractor's QM Work Plan shall evaluate the impact and effectiveness of its quality assessment and performance improvement program. The QM Work Plan shall include:
    i. Evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, state hearings, expedited state hearings, provider appeals, and clinical records review as required by Article II.F.1 and Article II.G.7 of this Agreement.
    ii. Evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service.
    iii. A description of completed and in-process QM activities, including performance improvement projects. The description shall include:
        a. Monitoring efforts for previously identified issues, including tracking issues over time.

b. Objectives, scope, and planned QM activities for each year.
c. Targeted areas of improvement or change in service delivery or program design.

iv. A description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area. This shall include goals for responsiveness for the Contractor's 24-hour toll-free telephone number, timeliness for scheduling of routine appointments, timeliness of services for urgent conditions, and access to after-hours care.

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

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

1. DHCS shall conduct Postservice Postpayment and Postservice Prepayment Utilization Reviews of the network providers to determine whether the DMC services were provided in accordance with Article III.XX of this exhibit. DHCS shall issue the PSPP report to the Contractor with a copy to the subcontractor and network provider. The Contractor shall be responsible for their subcontractor and network providers to ensure any deficiencies are remediated pursuant to Article III.KK.2. The Contractor shall attest the deficiencies have been remediated and are complete, pursuant to Article III.LL.3.iv of this Agreement.
2. The Department shall recover payments made if subsequent investigation uncovers evidence that the claim(s) should not have been paid, DMC-ODS services have been improperly utilized, and requirements of Article III.XX were not met.
   i. All deficiencies identified by PSPP reports, whether or not a recovery of funds results, shall be corrected and the Contractor shall submit a Contractor-approved CAP. The CAP shall be submitted using a Secure Managed File Transfer system specified by DHCS within 60 days of the date of the PSPP report.

a. The CAP shall:
    1. Be documented on the DHCS CAP template.
    2. Provide a specific description of how the deficiency shall be corrected.
    3. Identify the title of the individual(s) responsible for:
        i. Correcting the deficiency.
        ii. Ensuring on-going compliance.
    4. Provide a specific description of how the provider will ensure on-going compliance.
    5. Specify the target date of implementation of the corrective action.
b. DHCS shall provide written approval of the CAP to the Contractor with a copy to the provider. If DHCS does not approve the CAP, DHCS shall provide guidance on the deficient areas and request an updated CAP from the Contractor with a copy to the provider. Contractor shall submit an updated CAP to the DHCS using a Secure Managed File Transfer system specified by DHCS, within 30 days of notification.
c. If a CAP is not submitted, or, the provider does not implement the approved CAP provisions within the designated timeline, then DHCS may withhold funds from the Contractor until the entity that provided the services complies with this Exhibit A, Attachment I. DHCS shall inform the Contractor when funds shall be withheld.

3. The Contractor may appeal DMC dispositions concerning demands for recovery of payment and/or programmatic deficiencies of specific claims. Such appeals shall be handled as follows:
    i. Requests for first-level appeals:
        a. The Contractor shall initiate action by submitting a letter to:
            Behavioral Health Compliance Section Chief

Medical Review Branch, Audits and Investigations Division
DHCS
PO Box 997413, MS 2621

1. Sacramento, CA 95899-7413The Contractor shall submit the letter on the official stationery of the Contractor and it shall be signed by an authorized representative of the Contractor.
2. The letter shall identify the specific claim(s) involved and describe the disputed (in) action regarding the claim.

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

4. A Contractor may initiate a second level appeal to the Office of Administrative Hearings and Appeals (OAHA).
   i. The second level process may be pursued only after complying with first-level procedures and only when:
      a. The MCBHD has failed to acknowledge the grievance or complaint within 15 calendar days of its receipt, or
      b. The Contractor is dissatisfied with the action taken by the MCBHD where the conclusion is based on the MCBHD's evaluation of the merits.
   ii. The second-level appeal shall be submitted to the Office of Administrative Hearings and Appeals within 30 calendar days from the date the MCBHD failed to acknowledge the first-level appeal or from the date of the MCBHD's first-level appeal decision letter.

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

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

iv. In referring an appeal to the OAHA, the Contractor shall submit all of the following:

a. A copy of the original written appeal sent to the MCBHD.
b. A copy of the MCBHD's report to which the appeal applies.

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

5. The appeal process listed here shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of DHCS pursuant to Exhibit B of this Agreement.
6. State shall monitor the subcontractor's compliance with Contractor utilization review requirements, as specified in Article III.LL. Counties are also required to monitor the subcontractor's compliance pursuant to Article III.HH of this Agreement. The federal government may also review the existence and effectiveness of DHCS' utilization review system.
7. Contractor shall, at a minimum, implement and maintain compliance with the requirements described in Article III.XX for the purposes of reviewing the utilization, quality, and appropriateness of covered services and ensuring that all applicable Medi-Cal requirements are met.

8. Contractor shall ensure that subcontractor's sites shall keep a record of the beneficiaries/patients being treated at that location. Contractor shall retain beneficiary records for a minimum of ten years, in accordance with 42 CFR 438.3(h), from the finalized cost settlement process with the Department. When an audit by the Federal Government or DHCS has been started before the expiration of the ten-year period, the beneficiary records shall be maintained until completion of the audit and the final resolution of all issues.

LL. Contractor Oversight Monitoring

1. Interoperability Monitoring
   i. The Contractor shall ensure that data received from its Network Providers and Subcontractors is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in standardized formats to the extent feasible and appropriate. The Contractor shall make all collected data available to DHCS and CMS, upon request.
   ii. The Contractor shall conduct routine testing and monitoring, and update their systems as appropriate, to ensure the APIs function properly, including conducting assessments to verify that the APIs are fully and successfully implementing privacy and security features such as those required to comply with the HIPAA Security Rule requirements in 45 CFR parts 160 and 164, 42 CFR parts 2 and 3, and other applicable laws protecting the privacy and security of individually identifiable data.
   iii. The Contractor may deny or discontinue any third-party application's connection to an API if it reasonably determines, consistent with its security risk analysis under the HIPAA Security Rule, that continued access presents an unacceptable level of risk to the security of protected health information on its systems. The determination must be made using objective verifiable criteria that are applied fairly and consistently across all applications and developers, including

but not limited to criteria that may rely on automated monitoring and risk mitigation tools.

iv. The Contractor shall:
   a. Comply with the requirements for the Patient Access API and Provider Directory API and must demonstrate their compliance by submitting deliverables as directed by DHCS.
   b. Update policies and procedures to ensure compliance with this policy.
   c. Communicate the requirements listed above to all of their Subcontractors and Network Providers.
   d. DHCS may impose a CAP, as well as administrative and/or monetary sanctions for non-compliance.

2. Utilization Monitoring
   i. Contractor shall conduct, at least annually, a utilization review of network providers to ensure covered services are being appropriately rendered. The annual review shall include an on-site visit of the service provider. Reports of the annual review shall be provided to DHCS' County/Provider Operations and Monitoring Branch at:

      Department of Health Care Services
      Medi-Cal Behavioral Health Division
      1501 Capitol Avenue, MS-2621
      Sacramento, CA 95814

      Or by using a Secure Managed File Transfer system specified by DHCS.

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

      Technical assistance is available to counties from MCBHD.

3. Other Contractor Monitoring

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

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

iii. Contractor shall ensure that DATAR submissions, detailed in Article III.MM of this Exhibit, are complied with by the subcontractor and network providers. Contractor shall attest that each network provider is enrolled in DATAR at the time of execution of the subcontract.

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

v. Contractor shall attest that DMC claims submitted to DHCS have been subject to review and verification process for accuracy and legitimacy (45 CFR 430.30, 433.32, 433.51). Contractor shall not knowingly submit claims for services rendered to any beneficiary after the beneficiary's date of death, or from uncertified or decertified providers.

MM. Reporting Requirements

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

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

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

5. CalOMS-Tx General Information
   i. If the Contractor experiences system or service failure or other extraordinary circumstances that affect its ability to timely submit CalOMS-Tx data, and or meet other CalOMS-Tx compliance requirements, Contractor shall report the problem in writing by secure, encrypted e-mail to DHCS at: ITServiceDesk@dhcs.ca.gov, before the established data submission deadlines. The written notice shall include a remediation plan that is subject to review and approval by DHCS. A grace period of up to 60 days may be granted, at DHCS' sole discretion, for the Contractor to resolve the problem before non-DMC payments are withheld.
   ii. If DHCS experiences system or service failure, no penalties shall be assessed to the Contractor for late data submission.
   iii. Contractor shall comply with the treatment data quality standards established by DHCS. Failure to meet these standards on an ongoing basis may result in withholding non-DMC funds.
   iv. If the Contractor submits data after the established deadlines, due to a delay or problem, the Contractor shall still be responsible for collecting and reporting data from time of delay or problem.

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

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

7. Year-End Cost Settlement Reports
   i. The Contractor shall submit, by November 1 of each year, the following year-end claims for reimbursement of administrative and utilization review and quality assurance costs to **BHFSOps@dhcs.ca.gov.**
      a. Per Utilizer Per Month Reconciliation Report: Submit the CMS approved Per Utilizer Per Month Reconciliation Report to DHCS via e-mail by December 31 following the close of the fiscal year.
8. Failure to Meet Reporting Requirements
   i. Failure to meet required reporting requirements shall result in:
      a. DHCS shall issue a Notice of Deficiency to Contractor regarding specified providers with a deadline to submit the required data and a request for a CAP to ensure timely reporting in the future. DHCS shall approve or reject the CAP or request revisions to the CAP, which shall be resubmitted to DHCS within 30 days.
      b. If the Contractor has not ensured compliance with the data submission or CAP request within the designated timeline, then DHCS may withhold funds until all data is submitted. DHCS shall inform the Contractor when funds shall be withheld.

NN. Training

1. The Contractor shall ensure their staff, including subcontracted staff providing or administering the DMC-ODS program are trained on the compliance requirements of applicable statutes, regulations, and BHINs.
2. Contractor may request additional Technical Assistance or training from MCBHD on an ad hoc basis.
3. Training to DMC Subcontractors:

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

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

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

b. The Contractor shall ensure that all residential service providers meet the established ASAM criteria for each level of residential care they provide, 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 21-0001 and its accompanying exhibits.

c. 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.

OO. Program Complaints

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

2. Complaints for Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities, and counselor complaints may be made by using the Complaint Form, which is available and may be submitted online: http://www.dhcs.ca.gov/individuals/Pages/Sud-Complaints.aspx
3. Suspected Medi-Cal fraud, waste, or abuse shall be reported to DHCS Medi-Cal Fraud: (800) 822-6222 or Fraud@dhcs.ca.gov.

PP. Record Retention

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

QQ. Subcontract Termination

1. The Contractor shall notify the Department of the termination of any subcontract, or subcontractor's agreement with a network provider, and the basis for termination of the subcontract or agreement, within two business days. The Contractor shall submit the notification using a Secure Managed File Transfer system specified by DHCS.

RR. Corrective Action Plan (CAP)

1. Unless the Department has specified an applicable CAP process elsewhere in this IA or in a BHIN issued by the DHCS, the Contractor shall comply with the following CAP process if DHCS determines that the Contractor has failed to comply with the terms of this IA, a BHIN issued by the DHCS, the State Plan, 1115 or 1915 Waiver, or any other applicable State or Federal statute or regulation.
2. If DHCS determines that the Contractor has failed to comply with any of the requirements listed above, then DHCS may request a CAP from the Contractor to address those deficiencies within a specified timeframe. The Contractor shall submit a CAP to DHCS within the timeframe required by DHCS.
3. The Contractor's CAP shall:
   i. Be documented on the DHCS CAP template.

ii. Provide a specific description of how the deficiency shall be corrected.
iii. Identify the title of the individual(s) responsible for:
    a. Correcting the deficiency
    b. Ensuring on-going compliance
iv. Provide a specific description of how the provider will ensure on-going compliance.
v. Specify the target date of implementation of the corrective action.

4. DHCS shall provide written approval of the CAP to the Contractor. If DHCS does not approve the CAP submitted by the Contractor, DHCS shall either: 1) provide guidance on the deficient areas and request an updated CAP from the Contractor with a new deadline for submission; or 2) provide the Contractor with a revised CAP that the Contractor shall comply with.
5. If the Contractor fails to submit a CAP or if the Contractor does not implement the approved CAP provisions within the designated timeline, then DHCS may withhold funds or issue sanctions until the Contractor is in compliance, terminate this Agreement and remove the Contractor from the DMC-ODS Waiver, or take any other actions it deemed necessary to resolve the Contractor's deficiencies. DHCS shall inform the Contractor when funds shall begin to be withheld or when sanctions will begin to be issued.

SS. Quality Improvement (QI) Program

1. Contractor shall establish an ongoing quality assessment and performance improvement program consistent with Article II.F.1 of this Agreement.
2. The Contractor shall oversee subcontractors' compliance through on-site monitoring reviews and monitoring report submissions to DHCS. The Contractor shall comply with compliance monitoring reviews conducted by DHCS and are responsible to develop and implement CAPs as needed.
3. CMS, in consultation with DHCS and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by DHCS in this Agreement.

4. Performance improvement projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and beneficiary satisfaction.
5. The monitoring of accessibility of services outlined in the Quality Improvement (QI) Plan will at a minimum include:
    i. Timeliness of first initial contact to face-to-face appointment.
    ii. Frequency of follow-up appointments.
    iii. Timeliness of services of the first dose of NTP services.
    iv. Access to after-hours care.
    v. Responsiveness of the beneficiary access line.
    vi. Strategies to reduce avoidable hospitalizations.
    vii. Coordination of physical and mental health services with waiver services at the provider level.
    viii. Assessment of the beneficiaries' experiences.
    ix. Telephone access line and services in the prevalent non-English languages.
6. The Contractor's QI program shall monitor the Contractor's service delivery system with the aim of improving the processes of providing care and better meeting the needs of its beneficiaries. The QI Program shall be accountable to the Contractor's Director.
7. The Contractor shall establish a QI Committee to review the quality of SUD treatment services provided to beneficiaries. The QI Committee shall recommend policy decisions; review and evaluate the results of QI activities, including performance improvement projects; institute needed QI actions; ensure follow-up of QI processes; and document QI Committee meeting minutes regarding decisions and actions taken.
8. The Contractor's QI Committee shall review the following data at a minimum on a quarterly basis since external quality review (EQR) site reviews will begin after county implementation. The External Quality Review Organization (EQRO) shall measure defined data elements to assess the quality of service provided by the Contractor. These data elements shall be incorporated into the EQRO protocol:

   i. Number of days to first DMC-ODS service at appropriate level of care after referral.
   ii. Existence of a 24/7 telephone access line with prevalent non-English language(s).
   iii. Access to DMC-ODS services with translation services in the prevalent non-English language(s).
9. Operation of the QI program shall include substantial involvement by a licensed SUD staff person.
10. The QI Program shall include active participation by the Contractor's practitioners and providers, as well as beneficiaries and family members, in the planning, design and execution of the QI Program.
11. The Contractor shall maintain a minimum of two active Performance Improvement Projects (PIPs) that meet the criteria in 42 CFR 438.330(b)(1) and (d). Performance improvement projects shall focus on a clinical area, as well as one non-clinical area.
12. PIPs shall:
   i. Measure performance using required quality indicators.
   ii. Implement system interventions to achieve improvement in quality.
   iii. Evaluate the effectiveness of interventions.
   iv. Plan and initiate activities for increasing or sustaining improvement.
13. The Contractor shall report the status and results of each PIP to DHCS, as requested.
14. 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.

TT. Utilization Management (UM) Program

1. The Contractor shall have a Utilization Management (UM) Program assuring that beneficiaries have appropriate access to SUD services, that services are medically necessary, that the ASAM Criteria shall be used to determine placement into the appropriate level of care, and that the interventions are appropriate for the diagnosis and level of care. The Contractor shall have a documented system for collecting, maintaining and evaluating accessibility to care and waiting list information, including tracking the number of days to first DMC-ODS service at an appropriate level of care following initial request or referral for all DMC-ODS services.

UU. Formation and Purpose

1. Authority
   i. The state and the Contractor enter into this Agreement, by authority of Chapter 3 of Part 1, Division 10.5 of the H&S Code and with approval of Contractor's County Board of Supervisors (or designee) for the purpose of providing alcohol and drug services, which shall be reimbursed pursuant to Exhibit B. The state and the Contractor identified in the State Standard (STD) Form 213 are the only parties to this Agreement. This Agreement is not intended, nor shall it be construed, to confer rights on any third party.
2. Control Requirements
   i. Performance under the terms of this Exhibit A, Attachment I, is subject to all applicable federal and state laws, regulations, and standards. The Contractor shall:
      a. Require its subcontractor to establish written policies and procedures consistent with the requirements listed in 2(c).
      b. Monitor for compliance with the written procedures.
      c. Be held accountable for audit exceptions taken by DHCS against the Contractor and its subcontractor for any failure to comply with these requirements:
         1. H&S Code, Div. 10.5, Part 2, commencing with section 11760.

2. Cal. Code Regs., tit. 9, div. 4, chapter 8, commencing with § 13000.
3. Gov. Code section 16367.8.
4. Title 42, CFR, sections 8.1 through 8.6.
5. Title 21, CFR, sections 1301.01 through 1301.93, Department of Justice, Controlled Substances.
6. State Administrative Manual (SAM), Chapter 7200 (General Outline of Procedures).

3. The Contractor shall be familiar with the above laws, regulations, and guidelines and shall ensure that its subcontractors are also familiar with such requirements.
4. The provisions of this Exhibit A, Attachment I are not intended to abrogate any provisions of law or regulation, or any standards existing or enacted during the term of this Agreement.

VV. Performance Provisions

1. Monitoring
   i. The Contractor's performance under this Exhibit A, Attachment I, shall be monitored by DHCS annually during the term of this Agreement. Monitoring criteria shall include, but not be limited to:
      a. Whether the quantity of work or services being performed conforms to this Exhibit.
      b. Whether the Contractor has established and is monitoring appropriate quality standards.
      c. Whether the Contractor is abiding by all the terms and requirements of this Agreement.
      d. The Contractor shall conduct annual onsite monitoring reviews of services and subcontracted services for programmatic and fiscal requirements. Contractor shall submit copy of their monitoring and audit reports to DHCS within two weeks of issuance. Reports should be sent by using a Secure Managed File Transfer system specified by DHCS.

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

2. Performance Requirements
   i. The Contractor shall provide services based on funding set forth in Exhibit B, Attachment I, and under the terms of this Agreement.
   ii. The Contractor shall provide services to all eligible persons in accordance with federal and state statutes and regulations.
   iii. The Contractor shall ensure that in planning for the provision of services, the following barriers to services are considered and addressed:
      a. Lack of educational materials or other resources for the provision of services.
      b. Geographic isolation and transportation needs of persons seeking services or remoteness of services.
      c. Institutional, cultural, and/or ethnicity barriers.
      d. Language differences.
      e. Lack of service advocates.
      f. Failure to survey or otherwise identify the barriers to service accessibility.
      g. Needs of persons with a disability.
3. The Contractor shall comply with any additional requirements of the documents that have been incorporated by reference, including, but not limited to, those in the Exhibit A – Statement of Work.
4. Amounts awarded pursuant to Exhibit B, Attachment I shall be used exclusively for providing DMC-ODS services consistent with the purpose of the funding.

5. DHCS shall issue a report to Contractor after conducting monitoring or utilization reviews of the subcontractor or network providers. When the DHCS report identifies non-compliant services or processes, it shall require a CAP. The Contractor, or in coordination with its subcontractor, shall submit a CAP using a Secure Managed File Transfer system specified by DHCS, within 60 calendar days from the date of the report.
6. The CAP shall follow the requirements in Article III.RR.2.

WW. Documentation Requirements

1. The Contractor shall comply with all State and federal statutes and regulations, the terms of this Agreement relating to documentation, BHIN 22-019, and any additional BHINs issued pursuant to W&I Code section 14184.402.
2. In the event of a conflict between the terms of this Agreement relating to documentation and a State or federal statute or regulation, or a BHIN issued pursuant to W&I Code section 14184.402, the Contractor shall adhere to the applicable statue, regulation, BHIN 22-019, or any other applicable BHINs issued pursuant to W&I Code section 14184.402.

XX. Requirements for Services

1. Confidentiality.
    i. All SUD treatment services shall be provided in a confidential setting in compliance with 42 CFR, Part 2 requirements.
2. Perinatal Services.
    i. Perinatal services shall address treatment and recovery issues specific to pregnant and postpartum beneficiaries, such as relationships, sexual and physical abuse, and development of parenting skills.
    ii. 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 H&S Code Section 1596.792).

b. Service access (i.e., provision of or arrangement for transportation to and from medically necessary treatment).
c. Education to reduce harmful effects of alcohol and drugs on the 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).

iii. Medical documentation that substantiates the beneficiary's pregnancy and the last day of pregnancy shall be maintained in the beneficiary record.
iv. Contractor shall comply with the perinatal program requirements as outlined in the Perinatal Practice Guidelines. The Perinatal Practice Guidelines are attached to this Agreement as Document 1G, incorporated by reference. The Contractor shall comply with the current version of these guidelines until new Perinatal Practice Guidelines are established and adopted. The incorporation of any new Perinatal Practice Guidelines into this Agreement shall not require a formal amendment.

3. Substance Use Disorder Medical Director.
   i. The SUD Medical Director's responsibilities shall, at a minimum, include all of the following:
      a. Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
      b. Ensure that physicians do not delegate their duties to non-physician personnel.
      c. Develop and implement written medical policies and standards for the provider.
      d. Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
      e. Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.

f. Ensure that provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries, and determine services are medically necessary.
g. Ensure that provider's physicians are adequately trained to perform other physician duties, as outlined in this section.

ii. The SUD Medical Director may delegate 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.

4. Provider Personnel.
   i. Personnel files shall be maintained on all employees, contracted positions, volunteers, and interns, and shall contain the following:
      a. Application for employment and/or resume.
      b. Signed employment confirmation statement/duty statement.
      c. Job description.
      d. Performance evaluations.
      e. Health records/status as required by the provider, AOD Certification or Cal. Code Regs., tit. 9.
      f. Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries).
      g. Training documentation relative to substance use disorders and treatment.
      h. Current registration, certification, intern status, or licensure.
      i. Proof of continuing education required by licensing or certifying agency and program.
      j. Provider’s Code of Conduct.
      k. Documentation of completion of personnel requirements set forth in BHIN 21-001 for personnel providing detoxification checks.
   ii. Job descriptions shall be developed, revised as needed, and approved by the provider’s governing body. The job descriptions shall include:

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

iii. Written provider code of conduct for employees and volunteers/interns shall be established which addresses at least the following:
   a. Use of drugs and/or alcohol.
   b. Prohibition of social/business relationship with beneficiaries or their family members for personal gain.
   c. Prohibition of sexual contact with beneficiaries.
   d. Conflict of interest.
   e. Providing services beyond scope.
   f. Discrimination against beneficiaries or staff.
   g. Verbally, physically, or sexually harassing, threatening or abusing beneficiaries, family members or other staff.
   h. Protection of beneficiary confidentiality.
   i. Cooperate with complaint investigations.

iv. If a provider utilizes the services of volunteers and/or interns, written procedures shall be implemented which address:
   a. Recruitment.
   b. Screening and Selection.
   c. Training and orientation.
   d. Duties and assignments
   e. Scope of practice.
   f. Supervision.
   g. Evaluation.
   h. Protection of beneficiary confidentiality.

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

IV. Definitions

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

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

2. ***"Adolescents"*** means beneficiaries under age 21.

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

4. ***"Adult"*** means beneficiaries 21 years of age or over.

5. ***"Adverse benefit determination"*** means, in the case of an MCO, PIHP, or PAHP, any of the following:

   (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for DMC-ODS criteria for services, appropriateness, setting, or effectiveness of a covered benefit.

(2) The reduction, suspension, or termination of a previously authorized service.

(3) The denial, in whole or in part, of payment for a service.

(4) The failure to provide services in a timely manner, as defined by the state.

(5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

(6) For a resident of a rural area with only one MCO, the denial of beneficiary's request to exercise their right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network.

(7) The denial of a beneficiary's request to dispute a financial liability, copayments, premiums, deductibles, coinsurance, and other beneficiary financial liabilities.

6. ***"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, Cal. Code Regs., tit. 9, div. 4, chapter 8.

7. ***"American Indian and Alaska Native (AI/AN)"*** means any person defined in 25 United States Code sections 1603(13), 1603(28), or section 1679(a), or who has been determined eligible as an Indian under 42 CFR section 136.12.

8. ***"Ancillary Service"*** means to include individualized connection, referral, and linkages to community-based services and supports.

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

10. ***"ASAM Criteria"*** means comprehensive set of guidelines for placement, continued stay, transfer, or discharge of patients with addiction and co-occurring conditions.

11. ***"Assessment"*** means activities to evaluate or monitor the status of a beneficiary's behavioral health and determine the appropriate level of care and course of treatment for that beneficiary. 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 beneficiary. Assessment services may include one or more of the following components:

    (1) Collection of information for assessment used in the evaluation and analysis of the cause or nature of the substance use disorder.

    (2) 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.

    (3) Treatment planning, a service activity that consists of development and updates to documentation needed to plan and address the beneficiary's needs, planned interventions and to address and monitor a beneficiary's progress and restoration of a beneficiary to their best possible functional level.

12. ***"Authorization"*** is the approval process for DMC-ODS Services prior to the submission of a DMC claim.

13. ***"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.

14. ***"Beneficiary"*** means a person who: (a) has been determined eligible for Medi-Cal; (b) is not institutionalized; (c) has a substance-related disorder per the current "Diagnostic and Statistical Manual of Mental Disorders (DSM)" criteria; and (d) meets the admission criteria to receive DMC covered services.
15. ***"Beneficiary/Enrollee Encounter Data"*** means the information relating to the receipt of any item(s) or service(s) by a beneficiary under a contract between a state and a MCO, PIHP, or PAHP that is subject to the requirements of 42 CFR §§438.242 and 438.818.
16. ***"Beneficiary Handbook"*** is the state developed model beneficiary handbook.
17. ***"Calendar Week"*** means the seven-day period from Sunday through Saturday.
18. ***"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 Cal Code Regs., tit. 22, section 51341.1.
19. ***"Complaint"*** means requesting to have a problem solved or have a decision changed because you are not satisfied. A complaint is sometimes called a grievance or an appeal.
20. ***"Contractor"*** means the county identified in this Agreement and responsible for adhering to and ensuring full compliance with all terms and conditions of this Agreement.
21. ***"Corrective Action Plan (CAP)"*** means the written plan of action document which the Contractor or its subcontractor develops and submits to DHCS to address or correct a deficiency or process that is non-compliant with laws, regulations or standards.
22. ***"County"*** means the county in which the Contractor physically provides covered substance use treatment services.
23. ***"County of Responsibility"*** means the field in MEDS that indicates the county that has control of the case record in MEDS and is the county that can make eligibility and demographic

information updates to the MEDS record. This county has financial responsibility for behavioral health services, consistent with the county contract with DHCS. Providers can verify Medi-Cal eligibility in three ways: POS system (BIC Card reader), Automated Eligibility Verification system (AEVS) 1 or the Medi-Cal website.

24. ***"County Realignment Funds"*** means Behavioral Health Subaccount funds received by the County as per Gov. Code, § 30025.

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

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

27. ***"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.

28. ***"DMC-ODS Services"*** means DMC-ODS services authorized by Title XIX or Title XXI of the Social Security Act; Title 22 Section 51341.1; W&I Code sections 14124.24, 14184.100 *et* seq.; California's Medicaid State Plan; the CalAIM Section 1115 Demonstration Renewal Waiver; Section 1915(b) Waiver; BHIN 23-001.

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

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

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

32. ***"Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT)"*** means the federal mandate under Section 1905(r) of the Act, which requires the Contractor ensure that all beneficiaries under age 21 receive all applicable SUD services needed to correct or ameliorate health conditions that are coverable under Section 1905(a) of the Act. Nothing in the DMC-ODS limits or modifies the scope of the EPSDT mandate.

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

34. ***"Emergency medical condition"*** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

    (1) Placing the health of the individual (or, for a pregnant beneficiary, the health of the beneficiary or their unborn child) in serious jeopardy.

    (2) Serious impairment to bodily functions.

    (3) Serious dysfunction of any bodily organ or part.

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

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

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

38. ***"Family Therapy"*** means a rehabilitative service that includes family members in the treatment process, providing education about factors that are important to the beneficiary's recovery as well as the holistic recovery of the family system. Family members can provide social support to the beneficiary and help motivate their loved one to remain in treatment. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of this service, but the service is for the direct benefit of the beneficiary.

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

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

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

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

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

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

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

46. ***"Individual Counseling"*** consists of contacts with a beneficiary. 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 beneficiary by supporting the achievement of the beneficiary's treatment goals.

47. ***"Key Points of Contact"*** means common points of access to substance use treatment services from the county, including but not limited to the county's beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the county.

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

49. ***"Licensed Practitioners of the Healing Arts (LPHA)"*** includes: includes any of the following: Physician, Nurse Practitioner (NP), Physician Assistant (PA), Registered Nurse, Registered Pharmacist, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT), and licensed-eligible practitioner registered with the Board of Psychology or Behavioral Science Board working under the supervision of a licensed clinician.

50. ***"Managed Care Organization (MCO)"*** means an entity that has, or is seeking to qualify for, comprehensive risk contract under Title 42 CFR part 438, and that is:

(1) A Federally qualified HMO that meets the advance directives requirements of subpart l of part 489 of Title 42 CFR, Chapter 4, Subchapter G; or

(2) Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:

(i) Makes the services it provides to its Medicaid beneficiaries as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.

(ii) Meets the solvency standards of the §438.116.

51. ***"Managed Care Program"*** means a managed care delivery system operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act.

52. ***"Maximum Payable"*** means the encumbered amount reflected on the Standard Agreement of this Agreement and supported by Exhibit B, Attachment I.

53. ***"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 beneficiary.

54. ***"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.

55. **"Medications for Addiction Treatment 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.

56. **"*Medications for Addiction Treatment 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.

57. ***"Modality"*** means those necessary overall general service activities to provide substance use disorder services as described in Division 10.5 of the H&S Code.

58. ***"Network"*** means the group of entities that have been contracted to provide services under this Agreement.

59. ***"Network Provider"*** means any provider, group of providers, or entity that has a network provider agreement with a MCO, PIHP, PAHP, or a subcontract, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP or PAHP. A network provider is not a subcontractor by virtue of the network provider agreement. ~~means any provider, group of providers, or entity that has a network provider agreement with the Subcontractor, Partnership HealthPlan of California, to provide covered services to beneficiaries, and receives Medicaid funding directly or indirectly to order, refer, or render covered services as a result of the State's agreement with the Contractor.~~

60. ***"Non-participating provider"*** means a provider that is not engaged in the continuum of services under this Agreement.

61. ***"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.

62. ***"Non-Quantitative Treatment Limitation (NQTL)"*** means a limit on the scope or duration of benefits that is not expressed numerically. Non-quantitative treatment limitations include:

    i. Medical management standards limiting or excluding benefits based on DMC-ODS criteria for services or medical appropriateness, or based on whether the treatment is experimental or investigative.
    ii. Formulary design for prescription drugs.
    iii. Network tier design.
    iv. Standards for provider admission to participate in a network, including reimbursement rates.
    v. Methods for determining usual, customary, and reasonable charges.
    vi. Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols.
    vii. Exclusions based on failure to complete a course of treatment.
    viii. Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services.
    ix. Standards for providing access to out-of-network providers.

63. ***"Nonrisk Contract"*** means a contract between the state and a PIHP or PAHP under which the Contractor:

    (1) Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR 447.362.

    (2) May be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits.

64. ***"Notice of Adverse Benefit Determination (NOABD)"*** means a formal communication of any action and consistent with 42 CFR 438.404 and 438.10.

65. ***"Observation"*** means the process of monitoring the beneficiary's course of withdrawal. The Contractor shall ensure observation be conducted at the frequency required by applicable state and federal laws, regulations, and standards. This may include but is not limited to observation of the beneficiary's health status.

66. ***"Overpayment"*** means any payment made to a subcontractor or network provider by a MCO, PIHP, or PAHP to which the subcontractor or network provider is not entitled to under Title XIX of the Act or any payment to a MCO, PIHP, or PAHP by a state to which the MCO, PIHP, or PAHP is not entitled to under Title XIX of the Act.

67. ***"Patient Education"*** means education for the beneficiary on addiction, treatment, recovery and associated health risks.

68. ***"Participating Provider"*** means a provider that is engaged in the continuum of services under this Agreement.

69. ***"Payment Suspension"*** means the Drug Medi-Cal 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.

70. ***"Peer Support Services"*** means 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 beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery. Medi-Cal Peer Support Services consist of Educational Skill Building Groups, Engagement and Therapeutic Activity services.

71. ***"Peer Support Specialist"*** means an individual in recovery with a current State-approved Medi-Cal Peer Support Specialist Certification Program certification and must meet all other applicable California state requirements, including ongoing education requirements. Medi-Cal Peer Support Specialists provide services under the direction of a Behavioral Health Professional.

72. ***"Performance"*** means providing the dedicated capacity in accordance with Exhibit B, Attachment I, and abiding by the terms of this Exhibit A, including all applicable state and federal statutes, regulations, and standards, including Alcohol and/or Other Drug Certification Standards (Document 1P), if applicable, in expending funds for the provision of SUD services hereunder.

73. ***"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)).

74. ***"Physician"*** as it pertains to the supervision, collaboration, and oversight requirements in sections 1861(aa)(2)(B) and (aa) (3) of the Act, a doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the State in which the function is performed.

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

76. ***"Plan"*** means any written arrangement, by one or more entities, to provide health benefits or medical care or assume legal liability for injury or illness.

77. ***"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.

78. ***"Postservice Postpayment (PSPP) Utilization Review"*** means the review for 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 Article III.XX of this Agreement.

79. ***"Potential Beneficiary/Enrollee"*** means a Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given MCO, PIHP, PAHP, PCCM or PCCM entity, but is not yet a beneficiary of a specific MCO, PIHP, PAHP, PCCM, or PCCM entity.

80. ***"Preauthorization"*** means approval by the Plan that a covered service is medically necessary.

81. ***"Prepaid Ambulatory Health Plan (PAHP)"*** means an entity that:

    (1) Provides services to beneficiaries under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State Plan payment rates.

    (2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its beneficiaries; and

    (3) Does not have a comprehensive risk contract.

82. ***"Prepaid Inpatient Health Plan (PIHP)"*** means an entity that:

    (1) Provides services to beneficiaries under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State Plan payment rates.

    (2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its beneficiaries.

    (3) Does not have a comprehensive risk contract.

83. ***"Prescription drugs"*** means simple substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are:

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

(2) Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act.

(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.

84. ***"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.

85. ***"Primary Care Case Management Entity (PCCM entity)"*** means an organization that provides any of the following functions, in addition to primary care case management services, for the state:

(1) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line.

(2) Development of beneficiary care plans.

(3) Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program.

(4) Provision of payments to FFS providers on behalf of the State.

(5) Provision of beneficiary outreach and education activities.

(6) Operation of a customer service call center.

(7) Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement.

(8) Implementation of quality improvement activities including administering beneficiary satisfaction surveys or collecting data necessary for performance measurement of providers.

(9) Coordination with behavioral health systems/providers.

(10) Coordination with long-term services and supports systems/providers.

86. ***"Primary Care Case Manager (PCCM)"*** means a physician, a physician group practice or, at State option, any of the following:

(1) A physician assistant

(2) A nurse practitioner

(3) A certified nurse-midwife

87. ***"Primary care physician (PCP)"*** means a Physician responsible for supervising, coordinating, and providing initial and Primary Care to patients and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist.

88. ***"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.

89. ***"Provider"*** means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services.

90. ***"Provider-preventable condition"*** means a condition that meets the definition of a health care-acquired condition a condition occurring in any inpatient hospital setting, identified as a health care-acquired condition by the Secretary under section 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State Plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis /Pulmonary Embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients — or an "other provider-preventable condition," which is defined as a condition occurring in any health care setting that meets the following criteria:

(1) Is identified in the State Plan.

(2) Has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.

(3) Has a negative consequence for the beneficiary.

(4) Is auditable.

(5) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

91. **"Quality Assessment/Utilization Review (QA/UR)"** activities are reviews of physicians, health care practitioners and providers of health care services in the provision of health care services and items for which payment may be made to determine whether:

(1) Such services are or were reasonable and medically necessary and whether such services and items are allowable.
(2) The quality of such services meets professionally recognized standards of health care.

92. ***"Quantitative Treatment Limitation (QTL)"*** means a limit on the scope or duration of a benefit that is expressed numerically.

93. ***"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.

94. ***"Recovery monitoring"*** means recovery coaching, monitoring designed for the maximum reduction of the beneficiary's SUD.

95. ***"Recovery Services"*** means a DMC-ODS service designed to support recovery and prevent relapse with the objective of restoring the beneficiary to their best possible functional level. Recovery Services emphasize the beneficiary'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 beneficiaries.

96. ***"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 beneficiary to their best possible functional level.

97. ***"Relapse"*** means a single instance of a beneficiary's substance use or a beneficiary's return to a pattern of substance use.

98. ***"Relapse Trigger"*** means an event, circumstance, place or person that puts a beneficiary at risk of relapse.

99. ***"Revenue"*** means Contractor's income from sources other than the state allocation.

100. ***"Safeguarding medications"*** means facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.

101. ***"Service Area"*** means the geographical area under the jurisdiction of this Agreement.

102. ***"Service Authorization Request"*** means a beneficiary's request for the provision of a service.

103. ***"Short-Term Resident"*** means any beneficiary receiving residential services pursuant to DMC-ODS, regardless of the length of stay, is a "short-term resident" of the residential facility in which they are receiving the services.

104. ***"Significant Change"*** means a when there is an increase or decrease in the amount or types of services that are available, or if there is an increase or decrease in the number of network providers, or if there is any other change that would impact the benefits available through this contract, or when there is a change in the scope of Drug Medi-Cal ODS services covered by this contract.

105. ***"State"*** means the Department of Health Care Services or DHCS.

106. ***"State Hearing"*** means a hearing provided by the State to beneficiaries 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.

107. ***"Subcontract"*** means an agreement between the Contractor and its subcontractors.

108. ***"Subcontractor"*** means an individual or entity that has a contract with the Contractor that relates directly or indirectly to the performance of the Contractor's obligations under its agreement with the State. For the purposes of this Agreement, Partnership HealthPlan of California is the sole subcontractor.

109. ***"Substance Use Disorder Crisis Intervention Services"*** means contacts with a beneficiary in crisis. A crisis means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. SUD Crisis Intervention Services shall focus on alleviating the crisis problem, be limited to the stabilization of the beneficiary's immediate situation and be provided in the least intensive level of care that is medically necessary to treat their condition.

110. ***"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.

111. ***"Substance Use Disorder Medical Director"*** has the same meaning as in Cal. Code Regs., tit. 22, § 51000.24.4.

112. ***"Support Groups"*** means linkages to self-help and support, spiritual and faith-based support.

113. ***"Support Plan"*** means a list of individuals and/or organizations that can provide support and assistance to a beneficiary to maintain sobriety.

114. ***"Telehealth"*** means contact with a beneficiary via synchronous audio and video by an LPHA or registered or certified counselor and may be done in the community or the home.

115. ***"Telephone"*** means contact with a beneficiary via synchronous, real-time audio-only telecommunications systems.

116. ***"Temporary Suspension"*** means the provider is temporarily suspended from participating in the DMC program as authorized by W&I Code section 14043.36(a). The provider cannot bill for DMC services from the effective date of the temporary suspension.

117. ***"Threshold Language"*** means a language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

118. ***"Transportation Services"*** means provision of or arrangement for transportation to and from medically necessary treatment.

119. ***"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) Tribal 638 providers enrolled in Medi-Cal as an Indian Health Services-Memorandum of Agreement (IHS-MOA) provider shall 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 this IN.

(2) Tribal 638 providers enrolled in Medi-Cal as a Tribal Federally Qualified Health Center FQHC provider, shall do so 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 shall appear on the "List of Tribal Federally Qualified Health Center Providers".

120. "Urban Indian Organizations (UIO)" – Means 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 U.S. Code, tit. 25, chapter 18, § 1653(a).

121. ***"Urgent care"*** means a condition perceived by a beneficiary as serious, but not life threatening. A condition that disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 24-72 hours.

122. ***"Utilization"*** means the total actual units of service used by beneficiaries and participants.

V. Contractor Specific Requirements

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

A. Covered Services

The Contractor shall arrange, provide, or subcontract for the following medically necessary DMC-ODS Covered Services, as they are outlined in Article III.D of Exhibit A, Attachment I, in the Contractor's service area, and in compliance with all State and federal statutes and regulations, the terms of this Agreement, 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. 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 Article III, Section S.7.v.

5. Withdrawal Management (ASAM Levels 1.0, 2.0 and 3.2).
6. Opioid (Narcotic) Treatment Program Services (OTP/NTP).
7. Recovery Services.
8. Peer Support Services.
9. Care Coordination.
10. Clinician Consultation Services.
11. Medications for Addiction Treatment (also known as Medication Assisted Treatment or MAT).

B. Access to Services

1. In addition to the general access to services requirements outlined in Article III.F of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific access to services requirements: Beneficiary Access Line (BAL):
    i. The Contractor shall provide a toll-free 24/7 BAL to beneficiaries seeking access to covered DMC-ODS services.
    ii. The Contractor's BAL shall provide oral and audio-logical (TTY/TDY) translations in the beneficiary's primary language.
    iii. The Contractor shall publish the BAL information on the Contractor's web page, on all information brochures, and prevention materials in all threshold languages.
    iv. The BAL shall provide 24/7 referrals to services for urgent conditions and medical emergencies.
2. The Contractor shall allow the beneficiary point of entry through the BAL. Alternatively, the Contractor shall allow beneficiaries to appear in person at any Contractor-operated or subcontracted DMC-ODS service provider.
    i. BAL Point of Entry
        a. The Contractor shall screen beneficiaries over the phone to determine whether there is sufficient information to make a referral to the appropriate level of care.
    ii. In the event the referral cannot be determined through the BAL, the Contractor's BAL shall refer and coordinate the beneficiary to a contractor-operated SUD site or subcontracted DMC-ODS service provider for a face-to-face determination.
        a. Beneficiaries screened as having an urgent need

(non-emergency) will be referred for an appointment with a qualified staff within 48 hours.

b. The BAL shall be staffed by registered or certified alcohol or other drug counselors or LPHAs during normal business hours.
c. The Contractor shall provide eligible, non-urgent beneficiaries a face-to-face appointment with the appropriate LOC provider within 10 business days from the initial referral.

iii. Contractor-operated and subcontracted DMC-ODS service provider Point of Entry.

a. The Contractor shall ensure beneficiaries:
    1. May receive in person screening, assessment, and referral at designated contractor-operated or subcontracted DMC-ODS provider sites.
    2. May be referred by:
        i. The BAL
        ii. County behavioral health site(s)
        iii. DMC-ODS subcontracted providers
        iv. Community Partners
b. The contractor-operated and subcontracted DMC-ODS provider site(s) shall be staffed by AOD counselors or LPHAs.
c. The Contractor shall ensure the ASAM Criteria level of care determination is used to obtain relevant information to identify initial treatment needs to link beneficiaries to the most appropriate LOC.
    1. The beneficiary may choose to receive DMC-ODS services at the designated contacted DMC-ODS provider or choose to be referred to another appropriate DMC-ODS provider offering the initial LOC determined by the ASAM screening.
    2. In all cases, DMC-ODS provider staff shall consider geographic location, language needs and individual preference when making placement and referrals.
    3. If the beneficiary appears in person, the contractor-operated or subcontracted DMC-ODS providers shall allow beneficiaries to

receive same-day screenings, assessments, and referral, if available.

4. In the event the beneficiary's ASAM screening determines the need for a LOC not offered by the DMC-ODS provider, the contractor-operated or subcontracted DMC-ODS provider shall provide:
   i. The beneficiary a warm hand-off to the appropriate DMC-ODS provider.
   ii. The completed ASAM tool to the appropriate DMC-ODS provider.

C. Coordination of Care

In addition to the general coordination and continuity of care requirements outlined in Article III.G of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific coordination and continuity of care requirements:

1. Transitions to Other Levels of Care:
   i. The Contractor's and/or subcontractor's care coordinators shall ensure the transition of the beneficiaries to 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.
   ii. The Contractor's and/or subcontractor's care coordinators shall ensure transitions to other LOCs occur no later than 10 days from the time of assessment or reassessment with no interruption of current treatment services.
   iii. The initial treating provider shall be responsible for arranging care coordination services and communicating with the next provider to ensure smooth transitions between LOCs.
   iv. The Contractor shall manage a beneficiary's transition of care to a DMC-ODS provider when that beneficiary has received, and no longer requires, inpatient SUD services (ASAM level 3.7 and 4.0 services) in an acute care hospital, or another Fee for Service (FFS) facility.
   v. The Contractor shall manage a beneficiary's transition of care to a DMC-ODS provider when that beneficiary has received, and no longer requires, inpatient SUD services (ASAM level 3.7 and 4.0 services) in a subcontracted

Chemical Dependency Recovery Hospital (CDRH) or Acute Freestanding Psychiatric hospital.

D. Inpatient Services

1. 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 CFR Part 2 compliant releases are in place to coordinate care with inpatient facilities.

E. Medi-Cal Peer Support Services

1. The Contractor shall provide, or arrange, and pay for Peer Support Services to Medi-Cal beneficiaries. Contractor's provision of Medi-Cal 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. Contractor's provision of Peer Support Services and implementation of a Medi-Cal Peer Support Specialist Certification Program shall further 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 Welfare & Institutions Code section § 14045.21.
2. Voluntary Participation and Funding
    i. The Contractor shall fund the nonfederal share of any applicable expenditures, since the Contractor has opted to implement Peer Support Services and participate in the Peer Support Specialist Certification Program set forth in Article 1.4 of Chapter 7, Part 3, of Division 9 of the Welfare and Institutions Code. The Contractor’s local share utilized to fund Peer Support Services and the Contractor’s participation in the Peer Support Specialist Certification Program shall not be considered an increase in costs mandated by the 2011 realignment legislation.
3. Provision of Medi-Cal Peer Support Services
    i. Medi-Cal Peer Support Services may be provided face-to-face, by telephone or by telehealth with the beneficiary or significant support person(s) and may be provided anywhere in the community.
    ii. 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 beneficiary may not present during the delivery of Peer Support Services but remains the focus of the service.

4. Medi-Cal Peer Support Specialists
    i. Contractor shall ensure that Medi-Cal Peer Support Services are provided by certified Medi-Cal Peer Support Specialists as established in BHIN 21-041.
5. Behavioral Health Professional and Medi-Cal Peer Support Specialist Supervisors
    i. The Contractor shall ensure that Medi-Cal Peer Support Specialists provide services under the direction of a Behavioral Health Professional.
6. 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.
    i. Peer Support Specialists may also be supervised by Peer Support Specialist Supervisors, as established in BHIN 21-041.
7. Practice Guidelines
    i. Counties shall require Medi-Cal 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.
8. 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 Welfare and Institutions Code and departmental guidance, including BHIN 21-041. Contractor] shall ensure that the Medi-Cal Peer Support Specialist Certification Program:
    i. Submits to the department a Medi-Cal 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.

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

iii. 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.

9. Effective January 1, 2022, as described in SPA 21-0058, and BHIN 23-001 peer-to-peer services or services delivered by peers are no longer covered or reimbursable as a component of Recovery Services.