SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

ITEM
21.1
(ID # 8660)

FROM : TLMA-PLANNING:

MEETING DATE:
Tuesday, January 8, 2019

SUBJECT: TRANSPORTATION & LAND MANAGEMENT AGENCY/PLANNING: Public Hearing on GPA No. 1217 CZ No. 7936 PM36804 TR36805 – Adoption of a Mitigated Negative Declaration – Applicant: Palm Creek Ranch, LLC – 4th District -Thousand Palms Zoning District - Location: North of Ramon Road, west of Vista Del Sol, east of Desert Moon Drive - REQUEST: General Plan Amendment No. 1217 (Entitlement/Policy Amendment) proposes to change the General Plan Land Use Designation on properties totaling 108 gross acres from Community Development: Very Low Density Residential (CD: VLDR) (1 Acre Minimum) to Community Development: Medium Density Residential (CD: MDR) (2-5 D.U./Ac.) on an approximate 101-acre portion of 108 gross acres and to Community Development: Highest Density Residential (CD:HHDR) (20+ D.U./Ac.) on approximate 7.1 acre portion of the 108 gross acres along the Ramon Road frontage. Change of Zone No. 7936 proposes to amend the zoning classification for a 7.1 acre portion of 108 gross acre site along the Ramon Road frontage portion of the subject property from Scenic Highway Commercial (C-P-S) to General Residential (R-3). Tentative Parcel Map No. 36804 proposes a Schedule J subdivision to divide 108 gross acres into four (4) parcels with Parcel 1 at 30.75 acres, Parcel 2 at 39.20 acres, Parcel 3 at 31.15 acres, and Parcel 4 at 7.10 acres. Tentative Tract Map No. 36805 proposes a phased Schedule A subdivision to divide 108 gross acres into 371 single-family residential lots with lot sizes ranging from 6,000 sq. ft. min to 14,000 sq. ft. max, with private streets, retention areas, tot lots, walking and jogging trails, training track, BBQ areas, and water features, as well as vacant 7.1 acre multiple family residential lot along Ramon Road frontage. Unit phasing consists of TR36805-1 with 130 residential lots and vacant multiple-family residential lot, TR36805-2 consists of 137 residential lots, and TR36805-3 (Final Phase) consists of 104 residential lots. [Applicant Fees 100%]

RECOMMENDED MOTION: That the Board of Supervisors:
Continued on page 2
ACTION:

Charissa Leach, Assistant TLMA Director 1/2/2019

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Perez, seconded by Supervisor Hewitt and duly carried by unanimous vote, IT WAS ORDERED that the above matter is tentatively approved as recommended, and staff is directed to prepare the necessary documents for final action.

Ayes:	Jeffries, Spiegel, Washington, Perez and Hewitt
Nays:	None
Absent:	None
Date:	January 8, 2019
xc:	Planning

Kecia Harper
Clerk of the Board
By: _____ Deputy

RECOMMENDED MOTION: That the Board of Supervisors:

ADOPT a **MITIGATED NEGATIVE DECLARATION** for **ENVIRONMENTAL ASSESSMENT NO. 42751**, based on the findings incorporated in the initial study, included herein, and the conclusion that the project will not have a significant effect on the environment; and,

TENTATIVELY APPROVE GENERAL PLAN AMENDMENT NO. 1217, to change the General Plan Land Use Designations on properties totaling 108 gross acres from Community Development: Very Low Density Residential (CD: VLDR) (1 Acre Minimum) to Community Development: Medium Density Residential (CD: MDR) (2-5 D.U./Ac.) on an approximately 101-acre portion of the 108 gross acres, and to Community Development: Highest Density Residential (CD:HHDR) (20+ D.U./Ac.) on an approximately 7.0-acre portion of 108 gross acres, in accordance with attached Exhibit 5, based on the findings and conclusions incorporated in the staff report, subject to adoption of the General Plan Amendment resolution by the Board of Supervisors; and,

TENTATIVELY APPROVE CHANGE OF ZONE NO. 7936 amending the zoning classification for the subject properties from Scenic Highway Commercial (C-P-S) to General Residential (R-3) along a 7.10-acre portion of 108 gross acre site along the Ramon Road frontage, in accordance with attached Exhibit 2, based upon the findings and conclusions incorporated in the staff report; and subject to adoption of the zoning ordinance by the Board of Supervisors; and,

APPROVE TENTATIVE PARCEL MAP NO. 36804, subject to the attached advisory notification document and conditions of approval, and based upon the findings and conclusions incorporated into the staff report; and,

APPROVE TENTATIVE TRACT MAP NO. 36805, subject to the attached advisory notification document and conditions of approval, and based upon the findings and conclusions incorporated into the staff report.

FINANCIAL DATA	Current Fiscal Year:	Next Fiscal Year:	Total Cost:	Ongoing Cost
COST	$ N/A	$ N/A	$ N/A	$ N/A
NET COUNTY COST	$ N/A	$ N/A	$ N/A	$ N/A
SOURCE OF FUNDS: Applicant Fees 100%			**Budget Adjustment:**	No
			For Fiscal Year:	2018

C.E.O. RECOMMENDATION: Approve

BACKGROUND:

Summary

The project proposes **General Plan Amendment No. 1217 (Entitlement/Policy Amendment)** to change the General Plan Land Use Designation on properties totaling 108 gross acres from Community Development: Very Low Density Residential (CD: VLDR) (1 Acre Minimum) to

Community Development: Medium Density Residential (CD: MDR) (2-5 D.U./Ac.) on an approximate 101-acre portion of 108 gross acres and to Community Development: Highest Density Residential (CD:HHDR) (20+ D.U./Ac.) on an approximate 7.10 acre portion of the 108 gross acres along the Ramon Road frontage.

The project also proposes **Change of Zone No. 7936** to amend the zoning classification for a 7.10 acre portion of 108 gross acre site along the Ramon Road frontage portion of the subject property from Scenic Highway Commercial (C-P-S) to General Residential (R-3).

Additionally, the project proposes two (2) tentative maps as follows: 1) **Tentative Parcel Map No. 36804** is for a Schedule J subdivision to divide 108 gross acres into four (4) parcels with Parcel 1 at 30.75 acres, Parcel 2 at 39.20 acres, Parcel 3 at 31.15 acres, and Parcel 4 at 7.10 acres, and, 2) **Tentative Tract Map No. 36805** is for a phased Schedule A subdivision to divide 108 gross acres into 371 single-family residential lots with common open space.

Planning Commission Revisions and Action

The Project proposed by Palm Creek Ranch, LLC, was heard by the Planning Commission on December 5, 2018. The owner/applicant and the public, provided testimony. One member of the public spoke in favor and two members of the public provided testimony with questions concerning the general plan history and regional drainage as summarized in Attachment B, Planning Commission Memo. Based on staff's presentation, discussion from the Commission after the public testimony, and evidence of conceptual regional drainage being resolved, the Commission is recommending project approval to the Board of Supervisors.

At the December 5, 2018 hearing, the Commission also amended the Hold Harmless Condition of Approval per the current hold harmless language requirements as noted by County Counsel for both PM36804 and TR36805. Additionally, the developer has completed Indemnification Agreement dated September 14, 2017, as included in Attachment C, Planning Commission Staff Report.

The developer also inquired about the proposed Project being geared toward "active adults" at the hearing. Based on review of the proposed Project and current Exhibits leading up to the Commission hearing, there have been no formal written proposals for "active adults" or Planned Residential Development – Senior Citizens as outlined under Section 18.6 of Zoning Ordinance No. 348. However, the developer may be able to propose Covenants, Conditions, and Restrictions (CC&Rs) to address "active adults" or senior housing as a private matter with a future Homeowner's Association (HOA) at a later date. The current Project as proposed is not considered a planned residential development including for senior citizens, and is recommended for approval as a standard tentative tract map with 371-single-family dwellings.

General Plan Amendment

The project proposes General Plan Amendment No. 1217 to modify the Land Use Designation from Very Low Density Residential (VLDR) (1 Acre Minimum) to Medium Density Residential (MDR) (2-5 D.U./Ac.). Prior to GPA 1217, Countywide GPA 960 was adopted on December 8,

2015, which modified the Land Use Designation from Medium Density Residential (2-5 D.U./Ac.) to Very Low Density Residential (1-Acre Minimum) due to regional drainage concerns in the area which includes the three (3) Project APNs 650-310-001, 650-310-002, 650-230-002. However, after discussions with Palm Creek Ranch, LLC, in late 2016, the developer proposed GPA 1217 to modify the Land Use Designation from VLDR back to MDR since the area has been historically MDR, and due to the developer's engineering team being able to resolve regional drainage concerns with the Coachella Valley Water District (CVWD) on a conceptual basis based on the CVWD letter dated October 10, 2018. Therefore, the Project can accommodate a residential development within a density range of 2-5 dwelling units to the acre as indicated by MDR based on findings in the attached staff report. The project currently proposes 3.6 dwelling units within the allowed density range of MDR. Therefore, the Commission is recommending approval based on the recommended findings, environmental review, and conditions.

Regional Drainage

The proposed project by Palm Creek Ranch, LLC, has been extensively conditioned for regional and local drainage measures such as with retention basins and system of drainage channels to handle current and future maximum potential levels of Regional water flows to the project site and the immediate surrounding area which will improve Flood Control and maintain or improve Water Quality in the area. Additionally, covering and boxing of the drainage channels will improve the aesthetics of the neighborhood and minimize future cleaning and maintenance issues.

Local drainage conditions and measures have also been conditioned by the Transportation Department, and planning staff received a regional drainage clearance letter dated October 10, 2018, from the Coachella Valley Water District outlining the conceptually approved regional hydraulic design for the overall project.

Residential Design & Landscaping

Based on the submitted Design Manual, the development is a gated single-family residential community with interior private streets, along with widening of Ramon Road, Desert Moon Drive and Via Del Sol. Up to eight (8) single-story residential models are proposed in the current Design Manual at the tentative map stage, with a Final Design Manual required as a condition of approval prior to map recordation. Concept Landscape Plans are also proposed with a desert theme to include trees, hedges, water features, community trails, pocket park and tot lot.

Palm Creek Ranch has more than 20% Open Space devoted to active and passive Recreation. These include Walking and Jogging Trails, BBQ areas, Pocket Parks, Tot Lot, Arbors, Gazebos, and Ponds (Irrigation) with Water Features. Should a decision be made to devote one or two of the Subdivisions to Active Adults, a small Clubhouse with fitness center, a Resort-Style pool and Pickle Ball courts would be added to or replace some of the above amenities by separate entitlement at a later date.

Housing Element/Economic Feasibility

Palm Creek Ranch, LLC, and planning staff previously discussed rezoning the parcel frontage along Ramon Road from CPS (Scenic Highway Commercial) to R-3 (General Residential) to coincide with Highest Density Residential (HHDR) (20+ D.U./Ac.) proposed under GPA No. 1217. This was proposed to potentially create an R-3 parcel for future multiple-family residential development by separate entitlement at a later date, which could potentially be a future project that could implement the Housing Element. No multiple-family residential projects are currently proposed within this Project.

In terms of economic feasibility, even without the commercial tax revenue under the current CPS zone and prior Commercial Retail land use designation, the following list of elements will contribute to Economic Feasibility: Increased Property Taxes, Income taxes (passive and active), Direct and Indirect (services) Job Creation, and potential New Business startups.

SB18/AB52 Tribal Consultation

SB 18 Tribal Consultation

Pursuant to SB 18 requirements, Riverside County staff previously requested a list from the Native American Heritage Commission ("NAHC") of tribes whose historical extent includes the project site. On April 21, 2017, consultation request notices were sent to each of the Native American Tribes noted on the list. Noticed tribes had 90 days in which to request consultation regarding the proposed project. No consultation requests were received by July 20, 2017, the end of the 90-day noticing period.

AB 52 Tribal Consultation

In compliance with Assembly Bill 52 (AB52), notices regarding this project were mailed to all requesting tribes on July 27, 2015. No request for consultation was received. Condition of approval 60. PLANNING 4 requires that prior to any ground disturbing activity, a Native American Monitor be retained on site to ensure the protection of tribal resources should any be encountered.

City of Cathedral City Sphere of Influence

The project was transmitted to the City of Cathedral City with email transmittal on November 6, 2018, and no comments from the City have been received as of this writing. The project was also presented to the Thousand Palms Community Council on November 20, 2014, for informational purposes.

Impact on Residents and Businesses

All potential project impacts have been studied under CEQA and noticed to the public pursuant to the requirements of the County.

ATTACHMENTS:

A. Planning Commission Report of Actions
B. Planning Commission Memo

C. Planning Commission Staff Report
D. Tentative Parcel Map No. 36804
E. Tentative Tract Map No. 36805
F. Concept Landscape Plans
G. Design Manual

Scott Bruckner 1/2/2019

STATE OF CALIFORNIA
STANDARD AGREEMENT AMENDMENT
STD. 213A_DHCS (Rev. 03/18)

☒ Check here if additional pages are added: 259 Page(s)

Agreement Number	Amendment Number
16-93238	A02
Registration Number:	

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

State Agency's Name (Also known as DHCS, CDHS, DHS or the State)
Department of Health Care Services

Contractor's Name (Also referred to as Contractor)
County of Riverside

2. The term of this Agreement is: February 1, 2017 through June 30, 2019

3. The maximum amount of this Agreement after this amendment is: $ 220,214,435 Two Hundred Twenty Million, Two Hundred Fourteen Thousand, Four Hundred Thirty-Five Dollars

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

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

II. **Purpose of amendment:** This amendment 1) modifies the terms and conditions; and 2) increases the budget in year 3 to compensate the Contractor for performing additional services, and identifies the changes in Exhibit B, Attachment I A2 - Funding Amounts.

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

IV. Paragraph 3 (maximum amount payable) on the face of the original STD 213 is increased by $11,433,256 and is amended to read: ~~$208,781,179 (Two Hundred Eight Million, Seven Hundred Eighty-One Thousand, One Hundred Seventy-Nine Dollars)~~ **$220,214,435 (Two Hundred Twenty Million, Two Hundred Fourteen Thousand, Four Hundred Thirty-Five Dollars).**

(Continued on next page)

All other terms and conditions shall remain the same.

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

CONTRACTOR

Contractor's Name *(If other than an individual, state whether a corporation, partnership, etc.)*
County of Riverside

By *(Authorized Signature)* ✍ | Date Signed *(Do not type)*

Printed Name and Title of Person Signing
Matthew Chang, MD RUHS Behavioral Health Director

Address
4095 County Circle, PO Box 7549
Riverside, CA 92503-7549

STATE OF CALIFORNIA

Agency Name
Department of Health Care Services

By *(Authorized Signature)* ✍ | Date Signed *(Do not type)*

Printed Name and Title of Person Signing
Carrie Talbot, Chief, Contract Management Unit

Address
1000 G Street, 4th Floor, MS 4200, P.O. Box 997413,
Sacramento, CA 95899-7413

CALIFORNIA Department of General Services Use Only

☒ Exempt per **W&I Code 14087.4**

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

Exhibit A A2 – Scope of Work (4 pages)

All references to Exhibit A A1 in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit A A2. The attached revised exhibit hereby amends Exhibit A A1.

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

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

All references to Exhibit A, Attachment I A1, in any exhibit incorporated into this agreement, are hereby replaced in its entirety by the attached exhibit.

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

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

All references to Exhibit B A1 in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit B A2. The attached revised exhibit hereby amends Exhibit B A1.

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

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

All references to Exhibit B, Attachment I A1, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit B, Attachment I A2. The attached revised exhibit hereby amends Exhibit B, Attachment I A1.

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

Exhibit D(F) – Special Terms and Conditions (26 pages)

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

Exhibit E A2 - Additional Provisions (4 pages)

All references to Exhibit E A1, in any exhibit incorporated into this agreement shall hereinafter be deemed to read Exhibit E A2. The attached revised exhibit hereby amends Exhibit E A1.

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

Exhibit F A1 – Privacy and Information Security Provisions (32 pages)

All references to Exhibit F, in any exhibit incorporated into this agreement, are hereby replaced in its entirety by the attached exhibit.

CCC 04/2017

CERTIFICATION

I, the official named below, CERTIFY UNDER PENALTY OF PERJURY that I am duly authorized to legally bind the prospective Contractor to the clause(s) listed below. This certification is made under the laws of the State of California.

Contractor/Bidder Firm Name (Printed)	*Federal ID Number*
County of Riverside	95-6000930
By (Authorized Signature)	
Printed Name and Title of Person Signing	
Date Executed	*Executed in the County of* Riverside

CONTRACTOR CERTIFICATION CLAUSES

1. STATEMENT OF COMPLIANCE: Contractor has, unless exempted, complied with the nondiscrimination program requirements. (Gov. Code §12990 (a-f) and CCR, Title 2, Section 11102) (Not applicable to public entities.)

2. DRUG-FREE WORKPLACE REQUIREMENTS: Contractor will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:

a. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.

b. Establish a Drug-Free Awareness Program to inform employees about:

1) the dangers of drug abuse in the workplace;
2) the person's or organization's policy of maintaining a drug-free workplace;
3) any available counseling, rehabilitation and employee assistance programs; and,
4) penalties that may be imposed upon employees for drug abuse violations.

c. Every employee who works on the proposed Agreement will:

1) receive a copy of the company's drug-free workplace policy statement; and,
2) agree to abide by the terms of the company's statement as a condition of employment on the Agreement.

Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both and Contractor may be ineligible for award of any future State agreements if the department determines that any of the following has occurred: the Contractor has made false certification, or violated the

certification by failing to carry out the requirements as noted above. (Gov. Code §8350 et seq.)

3. NATIONAL LABOR RELATIONS BOARD CERTIFICATION: Contractor certifies that no more than one (1) final unappealable finding of contempt of court by a Federal court has been issued against Contractor within the immediately preceding two-year period because of Contractor's failure to comply with an order of a Federal court, which orders Contractor to comply with an order of the National Labor Relations Board. (Pub. Contract Code §10296) (Not applicable to public entities.)

4. CONTRACTS FOR LEGAL SERVICES $50,000 OR MORE- PRO BONO REQUIREMENT: Contractor hereby certifies that Contractor will comply with the requirements of Section 6072 of the Business and Professions Code, effective January 1, 2003.

Contractor agrees to make a good faith effort to provide a minimum number of hours of pro bono legal services during each year of the contract equal to the lessor of 30 multiplied by the number of full time attorneys in the firm's offices in the State, with the number of hours prorated on an actual day basis for any contract period of less than a full year or 10% of its contract with the State.

Failure to make a good faith effort may be cause for non-renewal of a state contract for legal services, and may be taken into account when determining the award of future contracts with the State for legal services.

5. EXPATRIATE CORPORATIONS: Contractor hereby declares that it is not an expatriate corporation or subsidiary of an expatriate corporation within the meaning of Public Contract Code Section 10286 and 10286.1, and is eligible to contract with the State of California.

6. SWEATFREE CODE OF CONDUCT:

a. All Contractors contracting for the procurement or laundering of apparel, garments or corresponding accessories, or the procurement of equipment, materials, or supplies, other than procurement related to a public works contract, declare under penalty of perjury that no apparel, garments or corresponding accessories, equipment, materials, or supplies furnished to the state pursuant to the contract have been laundered or produced in whole or in part by sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor, or with the benefit of sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor. The contractor further declares under penalty of perjury that they adhere to the Sweatfree Code of Conduct as set forth on the California Department of Industrial Relations website located at www.dir.ca.gov, and Public Contract Code Section 6108.

b. The contractor agrees to cooperate fully in providing reasonable access to the contractor's records, documents, agents or employees, or premises if reasonably required by authorized officials of the contracting agency, the Department of Industrial Relations,

or the Department of Justice to determine the contractor's compliance with the requirements under paragraph (a).

7. DOMESTIC PARTNERS: For contracts of $100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.3.

8. GENDER IDENTITY: For contracts of $100,000 or more, Contractor certifies that Contractor is in compliance with Public Contract Code section 10295.35.

DOING BUSINESS WITH THE STATE OF CALIFORNIA

The following laws apply to persons or entities doing business with the State of California.

1. CONFLICT OF INTEREST: Contractor needs to be aware of the following provisions regarding current or former state employees. If Contractor has any questions on the status of any person rendering services or involved with the Agreement, the awarding agency must be contacted immediately for clarification.

Current State Employees (Pub. Contract Code §10410):

1). No officer or employee shall engage in any employment, activity or enterprise from which the officer or employee receives compensation or has a financial interest and which is sponsored or funded by any state agency, unless the employment, activity or enterprise is required as a condition of regular state employment.

2). No officer or employee shall contract on his or her own behalf as an independent contractor with any state agency to provide goods or services.

Former State Employees (Pub. Contract Code §10411):

1). For the two-year period from the date he or she left state employment, no former state officer or employee may enter into a contract in which he or she engaged in any of the negotiations, transactions, planning, arrangements or any part of the decision-making process relevant to the contract while employed in any capacity by any state agency.

2). For the twelve-month period from the date he or she left state employment, no former state officer or employee may enter into a contract with any state agency if he or she was employed by that state agency in a policy-making position in the same general subject area as the proposed contract within the 12-month period prior to his or her leaving state service.

If Contractor violates any provisions of above paragraphs, such action by Contractor shall render this Agreement void. (Pub. Contract Code §10420)

Members of boards and commissions are exempt from this section if they do not receive payment other than payment of each meeting of the board or commission, payment for preparatory time and payment for per diem. (Pub. Contract Code §10430 (e))

2. LABOR CODE/WORKERS' COMPENSATION: Contractor needs to be aware of the provisions which require every employer to be insured against liability for Worker's Compensation or to undertake self-insurance in accordance with the provisions, and Contractor affirms to comply with such provisions before commencing the performance of the work of this Agreement. (Labor Code Section 3700)

3. AMERICANS WITH DISABILITIES ACT: Contractor assures the State that it complies with the Americans with Disabilities Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA. (42 U.S.C. 12101 et seq.)

4. CONTRACTOR NAME CHANGE: An amendment is required to change the Contractor's name as listed on this Agreement. Upon receipt of legal documentation of the name change the State will process the amendment. Payment of invoices presented with a new name cannot be paid prior to approval of said amendment.

5. CORPORATE QUALIFICATIONS TO DO BUSINESS IN CALIFORNIA:

a. When agreements are to be performed in the state by corporations, the contracting agencies will be verifying that the contractor is currently qualified to do business in California in order to ensure that all obligations due to the state are fulfilled.

b. "Doing business" is defined in R&TC Section 23101 as actively engaging in any transaction for the purpose of financial or pecuniary gain or profit. Although there are some statutory exceptions to taxation, rarely will a corporate contractor performing within the state not be subject to the franchise tax.

c. Both domestic and foreign corporations (those incorporated outside of California) must be in good standing in order to be qualified to do business in California. Agencies will determine whether a corporation is in good standing by calling the Office of the Secretary of State.

6. RESOLUTION: A county, city, district, or other local public body must provide the State with a copy of a resolution, order, motion, or ordinance of the local governing body which by law has authority to enter into an agreement, authorizing execution of the agreement.

7. AIR OR WATER POLLUTION VIOLATION: Under the State laws, the Contractor shall not be: (1) in violation of any order or resolution not subject to review promulgated by the State Air Resources Board or an air pollution control district; (2) subject to cease and desist order not subject to review issued pursuant to Section 13301 of the Water Code for violation of waste discharge requirements or discharge prohibitions; or (3) finally determined to be in violation of provisions of federal law relating to air or water pollution.

8. PAYEE DATA RECORD FORM STD. 204: This form must be completed by all contractors that are not another state agency or other governmental entity.

CALIFORNIA CIVIL RIGHTS LAWS CERTIFICATION

Pursuant to Public Contract Code section 2010, if a bidder or proposer executes or renews a contract over $100,000 on or after January 1, 2017, the bidder or proposer hereby certifies compliance with the following:

1. CALIFORNIA CIVIL RIGHTS LAWS: For contracts over $100,000 executed or renewed after January 1, 2017, the contractor certifies compliance with the Unruh Civil Rights Act (Section 51 of the Civil Code) and the Fair Employment and Housing Act (Section 12960 of the Government Code); and

2. EMPLOYER DISCRIMINATORY POLICIES: For contracts over $100,000 executed or renewed after January 1, 2017, if a Contractor has an internal policy against a sovereign nation or peoples recognized by the United States government, the Contractor certifies that such policies are not used in violation of the Unruh Civil Rights Act (Section 51 of the Civil Code) or the Fair Employment and Housing Act (Section 12960 of the Government Code).

CERTIFICATION

<table>
<tr><td colspan="2">I, the official named below, certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
Proposer/Bidder Firm Name (Printed)
County of Riverside</td><td>Federal ID Number
95-6000930</td></tr>
<tr><td colspan="3">By (Authorized Signature)</td></tr>
<tr><td colspan="3">Printed Name and Title of Person Signing</td></tr>
<tr><td>Date Executed</td><td colspan="2">Executed in the County and State of
Riverside, California</td></tr>
</table>

Exhibit A A2
Scope of Work

1. Service Overview

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

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

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

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

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

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

2. Service Location

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

3. Service Hours

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

4. Project Representatives

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

Exhibit A A2
Scope of Work

Department of Health Care Services	County of Riverside
Contract/Grant Manager: Robert Strom Telephone: (916) 713-8553 Fax: (916) 322-1176 Email: Robert.Strom@dhcs.ca.gov	County Administrator: Rhyan Miller Telephone: (951) 782-2410 Fax: (951) 358-4513 Email: RHMiller@rcmhd.org

B. Direct all inquiries to:

Department of Health Care Services	County of Riverside
Department of Health Care Services SUD PPFD - PSGMB Attention: Nancy Shinn Mail Station Code 2624 P.O. Box 997413 Sacramento, CA, 95899-7413 Telephone: (916) 713-8554 Fax: (916) 322-1176 Email: nancy.shinn@dhcs,ca,gon	Riverside County Department of Mental Health Attention: Rhyan Miller 4095 County Circle Drive P.O. Box 7549 Riverside, CA 92513-7549 Telephone: (951) 782-2410 Fax: (951) 358-4513 Email: RHMiller@rcmhd.org

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

5. Americans with Disabilities Act

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

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

Exhibit A A2
Scope of Work

7. Reference Documents

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

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

Document 1G: Perinatal Practice Guidelines

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

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

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

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

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

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

Document 1V: Youth Treatment Guidelines

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

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

Document 2G Drug Medi-Cal Billing Manual

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

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

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

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

Exhibit A A2
Scope of Work

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

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

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

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

Document 3H: California Code of Regulations, Title 9 – Rehabilitation and Developmental Services, Division 4 – Department of Alcohol and Drug Programs, Chapter 8 – Certification of Alcohol and Other Drug Counselors

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

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

Document 3J: CalOMS Treatment Data Collection Guide

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

Document 3S CalOMS Treatment Data Compliance Standards

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

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

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

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

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

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

Document 5A : Confidentiality Agreement

Exhibit A, Attachment I A2
Program Specifications

I. Preamble

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

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

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

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

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

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

Exhibit A, Attachment I A2
Program Specifications

II. Federal Requirements

A. Waived and Inapplicable Federal Requirements

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

Exhibit A, Attachment I A2
Program Specifications

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

B. General Provisions

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

i. CMS shall review and approve this Agreement.

ii. Enrollment discrimination is prohibited.

a. The Contractor shall accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under this Agreement.
b. Enrollment is mandatory.
c. The Contractor shall not, based on health status or need for health care services, discriminate against individuals eligible to enroll.
d. The Contractor shall not discriminate against individuals eligible to enroll based on race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. (WIC 14029.91 (e)(3))
e. The Contractor will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.
f. The Contractor shall provide information on how to file a discrimination complaint with the United States Department of Health and Human Services Office of Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex. (WIC 14029.91(e)(5))

iii. Services that may be covered by the Contractor.

a. The Contractor may cover, for beneficiaries, services that are in addition to those covered under the State Plan as follows:
    i. Any services that the Contractor voluntarily agrees to provide.
    ii. Any services necessary for compliance by the Contractor with the parity requirements set

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

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

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

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

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

procedures supported by evidence-based guidelines.
3. Has a negative consequence for the beneficiary.
4. Is auditable.

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

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

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

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

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

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

vii. Choice of network provider.

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

viii. Audited financial reports.

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

ix. Recordkeeping requirements.

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

2. Information Requirements (42 CFR §438.10).

i. Basic Rules

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

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

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

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

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

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

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

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

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

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

vi. Language and format:

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

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

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

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

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

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

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

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

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

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

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

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

Exhibit A, Attachment I A2
Program Specifications

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

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

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

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

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

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

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

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

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

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

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

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

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

ix. Beneficiary rights and responsibilities, including:

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

Exhibit A, Attachment I A2
Program Specifications

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

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

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

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

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

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

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

xviii. Provider Directory.

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

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

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

xix. Formulary.

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

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

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

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

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

iv. This section may not be construed to:

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

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

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

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

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

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

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

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

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

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

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

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

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

v. Payment requirements.

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

Exhibit A, Attachment I A2
Program Specifications

C. State Responsibilities

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

i. The Department shall have in effect a monitoring system for the Contractor.
ii. The Department's monitoring system is outlined in Article III.DD of this Agreement.
iii. The Department shall use data collected from its monitoring activities to improve the performance of the Contractor. That data shall include, at minimum:
    a. Beneficiary grievance and appeal logs
    b. Provider complaint and appeal logs
    c. Findings from the State's External Quality Review process
    d. Results from any beneficiary or provider satisfaction survey conducted by the State or the Contractor
    e. Performance on required quality measures
    f. Medical management committee reports and minutes
    g. The annual quality improvement plan for the Contractor
    h. Customer service performance data submitted by the Contractor and performance data submitted by the beneficiary support system

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

i. Beginning on July 1, 2018, the Contractor shall comply with the Department's network adequacy standards.
ii. The Department's network adequacy standards are as follows:
    a. Pursuant to WIC Section 14197(c)(4), the Contractor shall maintain a network of outpatient and intensive outpatient (non-OTP) providers that are located within the following applicable time and distance standards:
        i. Up to 15 miles or 30 minutes from the beneficiary's place of residence for Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara counties.
        ii. Up to 30 miles or 60 minutes from the beneficiary's place of residence for Marin, Placer, Riverside, San Joaquin, Santa Cruz,

Solano, Sonoma, Stanislaus, and Ventura counties.

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

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

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

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

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

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

Exhibit A, Attachment I A2
Program Specifications

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

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

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

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

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

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

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

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

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

D. Beneficiary Rights and Protections

1. Beneficiary Rights (42 CFR §438.100).

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

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

iii. Specific rights.

Exhibit A, Attachment I A2
Program Specifications

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

iv. Free exercise of rights.

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

v. Compliance with other Federal and state laws.
   a. The Contractor shall comply with any other applicable Federal and state laws, including, but not limited to:
      i. Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80.
      ii. The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91.
      iii. The Rehabilitation Act of 1973.
      iv. Title IX of the Education Amendments of 1972 (regarding education programs and activities).
      v. Titles II and III of the Americans with Disabilities Act.
      vi. Section 1557 of the Patient Protection and Affordable Care Act.

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

i. The Contractor shall not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a beneficiary who is his or her patient, for the following:
   a. The beneficiary's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
   b. Any information the beneficiary needs to decide among all relevant treatment options.
   c. The risks, benefits, and consequences of treatment or non-treatment.
   d. The beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatment.
   e. To express preferences about future treatment decisions.

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

iii. Information requirements.

Exhibit A, Attachment I A2
Program Specifications

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

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

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

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

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

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

4. Cost Sharing (42 CFR §438.108).

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

E. Contractor Standards as a PIHP

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

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

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

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

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

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

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

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

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

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

a. Meet and require its network providers to meet Department standards for timely access to care and services, taking into account the urgency of the need for services.

b. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid FFS, if the provider serves only Medicaid beneficiaries.

c. Make services included in this Agreement available 24 hours a day, 7 days a week, when medically necessary.

d. Establish mechanisms to ensure compliance by network providers.

e. Monitor network providers regularly to determine compliance.

f. Take corrective action if there is a failure to comply by a network provider.

iv. Access and cultural considerations (WIC 14029.91).

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

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

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

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

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

2. **Assurances of Adequate Capacity and Services (42 CFR §438.207).**
   i. The Contractor shall give assurances to the Department and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the Department's standards for access and timeliness of care under this part, including the standards at 42 CFR §438.68 and 42 CFR §438.206(c)(1).

Exhibit A, Attachment I A2
Program Specifications

ii. The Contractor shall submit documentation to the Department to demonstrate that it complies with the following requirements:
   a. Offers an appropriate range of specialty services that are adequate for the anticipated number of beneficiaries for the service area.
   b. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area.

iii. The Contractor shall submit network adequacy documentation to the SUD Program, Policy and Fiscal Division (PPFD) via email to ODSSubmissions@dhcs.ca.gov:
   a. Upon entering into this Agreement with the Department.
   b. On an annual basis, on or before April 1.
   c. Within 10 business days of a significant change in the Contractor's operations that would affect the adequacy and capacity of services, including composition of the Contractor's provider network.
   d. As requested by the Department.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Exhibit A, Attachment I A2
Program Specifications

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

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

v. The Contractor shall produce a treatment or service plan meeting the criteria below for beneficiaries with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan shall be:
   a. Developed with beneficiary participation, and in consultation with any providers caring for the beneficiary.
   b. Developed by a person trained in person-centered planning using a person-centered process and plan, as defined in 42 CFR §441.301(c)(1).
   c. Approved by the Contractor in a timely manner, if this approval is required by the Contractor.
   d. In accordance with any applicable Department quality assurance and utilization review standards.
   e. Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the beneficiary's circumstances or needs change significantly, or at the request of the beneficiary per 42 CFR §441.301(c)(3).

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

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

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

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

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

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

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

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

a. The services furnished can reasonably achieve their purpose.

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

v. Authorization of services.

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

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

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

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

e. Notice of adverse benefit determination.

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

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

vi. Standard authorization decisions.

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

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

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

vii. Expedited authorization decisions.

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

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

viii. Compensation for utilization management activities.

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

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

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

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

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

applicable sub-regulatory guidance and contract provisions.

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

9. Practice Guidelines (42 CFR §438.236).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

F. Quality Measurement and Improvement External Quality Review

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

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

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

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

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

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

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

v. Annually, the Contractor shall:

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

vi. Performance improvement projects.

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

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

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

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

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

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

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

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

c. Expiration date of the accreditation.

iii. The Department shall:

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

b. Update this information at least annually.

G. Grievance and Appeal System

1. General Requirements (42 CFR §438.402).

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

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

iii. Filing requirements:

a. Authority to file.

Exhibit A, Attachment I A2
Program Specifications

i. A beneficiary may file a grievance and request an appeal with the Contractor. A beneficiary may request a state fair hearing after receiving notice under 42 CFR §438.408 that the adverse benefit determination is upheld.
    1. In the case that the Contractor fails to adhere to the notice and timing requirements in 42 CFR §438.408, the beneficiary is deemed to have exhausted the Contractor's appeals process. The beneficiary may initiate a state fair hearing.
    2. The Department may offer and arrange for an external medical review if the following conditions are met.
        a. The review shall be at the beneficiary's option and shall not be required before, or used as a deterrent to, proceeding to the state fair hearing.
        b. The review shall be independent of both the Department and the Contractor.
        c. The review shall be offered without any cost to the beneficiary.
        d. The review shall not extend any of the timeframes specified in 42 CFR §438.408 and shall not disrupt the continuation of benefits in 42 CFR §438.420.
ii. With the written consent of the beneficiary, a provider or an authorized representative may request an appeal or file a grievance, or request a state fair hearing, on behalf of a beneficiary, with the exception that providers cannot request continuation of benefits as specified in 42 CFR §438.420(b)(5).

b. Timing:
    i. Grievance:
        1. The beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, may file a grievance with the Contractor at any time.
    ii. Appeal:
        1. The Contractor shall allow the beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, to file a request for an appeal to the Contractor within 60 calendar days from the date on the adverse benefit determination notice.

c. Procedures:
    i. Grievance:
        1. The beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, may file a grievance either orally or in writing and, as determined by the Department, either with the Department or with the Contractor.
    ii. Appeal:
        1. The beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, may request an appeal either orally or in writing. Further, unless an expedited resolution is requested, an oral appeal shall be followed by a written, signed appeal.

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

i. Notice.

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

ii. Content of notice.

a. The notice shall explain the following:

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

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

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

iv. The procedures for exercising these appeal rights.

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

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

iii. Timing of notice.

Exhibit A, Attachment I A2
Program Specifications

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

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

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

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

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

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

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

i. The recipient has died.

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

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

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

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

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

3. **Handling of Grievances and Appeals (42 CFR §438.406).**
   i. In handling grievances and appeals, the Contractor shall give beneficiaries any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
   ii. The Contractor's process for handling beneficiary grievances and appeals of adverse benefit determinations shall:
      a. Acknowledge receipt of each grievance and appeal within five calendar days.
      b. Ensure that the individuals who make decisions on grievances and appeals are individuals—
         i. Who, were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.
         ii. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the Department, in treating the beneficiary's condition or disease.
            1. An appeal of a denial that is based on lack of medical necessity.
            2. A grievance regarding denial of expedited resolution of an appeal.
            3. A grievance or appeal that involves clinical issues.

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

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

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

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

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

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

Exhibit A, Attachment I A2
Program Specifications

i. The Contractor shall resolve each grievance and appeal, and provide notice, as expeditiously as the beneficiary's health condition requires, within the following timeframes:
   a. Standard resolution of grievances: 90 calendar days from the day the Contractor receives the grievance.
   b. Standard resolution of appeals: 30 calendar days from the day the Contractor receives the appeal. This timeframe may be extended in the manner described below.
   c. Expedited resolution of appeals: 72 hours after the Contractor receives the appeal. This timeframe may be extended under in the manner described below.

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

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

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

v. Format of notice:
   a. Grievances.

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

b. Appeals.

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

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

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

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

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

i. The right to request a state fair hearing.

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

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

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

vii. Requirements for state fair hearings—

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

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

c. The Department shall offer and arrange for an external medical review when the following conditions are met:
   i. The review shall be at the beneficiary's request and shall not be required before, or used as a deterrent to, proceeding to the state fair hearing
   ii. The review shall be independent of both the Department and the Contractor.
   iii. The review shall be offered without any cost to the beneficiary.
   iv. The review shall not extend any of the timeframes specified in 42 CFR §438.408 and shall not disrupt the continuation of benefits in 42 CFR §438.420.

d. State fair hearing.
   i. The beneficiary shall request a state fair hearing no later than 120 calendar days from the date of the Contractor's Notice of Appeal Resolution.
   ii. The parties to the state fair hearing include the Contractor, as well as the beneficiary and his or her representative or the representative of a deceased beneficiary's estate.

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

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

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

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

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

6. **Information About the Grievance and Appeal System to Providers and Subcontractors (42 CFR §438.414).**
   i. The Contractor shall provide the information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.
7. **Recordkeeping Requirements (42 CFR §438.416).**
   i. The Contractor shall maintain records of grievances and appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the Department quality strategy.
   ii. The record of each grievance or appeal shall contain, at a minimum, all of the following information:
      a. A general description of the reason for the appeal or grievance.
      b. The date received.
      c. The date of each review or, if applicable, review meeting.
      d. Resolution at each level of the appeal or grievance, if applicable.
      e. Date of resolution at each level, if applicable.
      f. Name of the covered person for whom the appeal or grievance was filed.
   iii. The record shall be accurately maintained in a manner accessible to the Department and available upon request to CMS.
8. **Continuation of Benefits While the Contractor's Appeal and the State Fair Hearing Are Pending (42 CFR §438.420).**
   i. Timely files mean files for continuation of benefits on or before the later of the following:
      a. Within 10 calendar days of Contractor sending the NOABD.
      b. The intended effective date of the Contractor's proposed adverse benefit determination.

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

iii. At the beneficiary's request, the Contractor shall continue or reinstate the beneficiary's benefits while the appeal or state fair hearing is pending, the benefits shall be continued until one of following occurs:
   a. The beneficiary withdraws the appeal or request for state fair hearing.
   b. The beneficiary fails to request a state fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the beneficiary's appeal under 42 CFR §438.408(d)(2).
   c. A state fair hearing officer issues a hearing decision adverse to the beneficiary.

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

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

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

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

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

H. Additional Program Integrity Safeguards

1. Basic Rule (42 CFR §438.600).

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

2. State Responsibilities (42 CFR §438.602).

i. Monitoring Contractor compliance.

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

ii. Screening, enrollment, and revalidation of providers.

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

iii. Ownership and control information.

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

iv. Federal database checks.

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

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

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

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

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

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

viii. **Contracting integrity.**

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

ix. **Entities located outside of the U.S.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

a. The Contractor shall specify in accordance with this Exhibit A, Attachment I and Exhibit B of this Agreement:
   i. The retention policies for the treatment of recoveries of all overpayments from the Contractor to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.
   ii. The process, timeframes, and documentation required for reporting the recovery of all overpayments.
   iii. The process, timeframes, and documentation required for payment of recoveries of overpayments to the state in situations where the Contractor is not permitted to retain some or all of the recoveries of overpayments.
   iv. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

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

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

6. Prohibited Affiliations (42 CFR §438.610).

Exhibit A, Attachment I A2
Program Specifications

i. The Contractor and its subcontractors shall not knowingly have a relationship of the type described in paragraph (iii) of this subsection with the following:
   a. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
   b. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in paragraph (a)(1) of this section.

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

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

iv. If the Department finds that the Contractor is not in compliance, the Department:
   a. Shall notify the Secretary of the noncompliance.
   b. May continue an existing agreement with the Contractor unless the Secretary directs otherwise.
   c. May not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary provides to the state and to Congress a

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

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

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

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

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

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

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

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

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

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

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

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

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

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

v. For the purposes of this section "person with an ownership or control interest" means a person or corporation that -
a. Has an ownership interest totaling five percent or more in a disclosing entity.
b. Has an indirect ownership interest equal to five percent or more in a disclosing entity.
c. Has a combination of direct and indirect ownership interests equal to five percent or more in a disclosing entity.
d. Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of the disclosing entity.

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

I. Conditions for Federal Financial Participation (FFP)

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

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

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

1. General Parity Requirement

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

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

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

2. Quantitative Limitations

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

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

3. **Non-Quantitative Limitations**
   i. The Contractor shall not impose a non-quantitative treatment limitation for substance use disorder benefits in any classification unless, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. (42 CFR §438.910(d))
   ii. The Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for substance use disorder services that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits. (42 CFR §438.910(d)(3))

III. Program Specifications

A. Provision of Services

1. Provider Specifications

i. The following requirements shall apply to the Contractor, the provider, and the provider staff:
   a. Professional staff shall be licensed, registered, certified, or recognized under California scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioners of the Healing Arts (LPHA) include:
      i. Physician
      ii. Nurse Practitioners

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

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

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

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

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

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

2. Services for Adolescents and Youth

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

B. Organized Delivery System (ODS) Timely Coverage

1. Non-Discrimination - Member Discrimination Prohibition

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

Exhibit A, Attachment I A2
Program Specifications

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

2. DMC-ODS services shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in this opt-in County. Determination of who may receive the DMC-ODS benefits shall be performed in accordance with DMC-ODS Special Terms and Conditions (

3.) 132(d), Article II.E.4 of this Agreement, and as follows:

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

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

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

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

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

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

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

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

C. Covered Services

Exhibit A, Attachment I A2
Program Specifications

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

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

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

D. Financing

1. Payment for Services

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

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

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

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

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

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

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

2. Rate Setting

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

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

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

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

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

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

E. Availability of Services

Exhibit A, Attachment I A2
Program Specifications

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

F. Access to Services

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

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

3. In addition to the coverage and authorization of service requirements set forth in Article II.E.4 of this Agreement, the Contractor shall:
   - i. Authorize DMC-ODS services in accordance with the medical necessity requirements specified in Title 22, Section 51303 and the coverage provisions of the approved State Medi-Cal Plan.
   - ii. If services are denied, inform the beneficiary in accordance with Article II.G.2 of this Agreement.
   - iii. Provide prior authorization for residential services within 24 hours of the prior authorization request being submitted by the provider.
     a. Prior authorization is prohibited for non-residential DMC-ODS services.
     b. The Contractor's prior authorization process shall comply with the parity requirements set forth in 42 CFR §438.910(d).
   - iv. Review the DSM and ASAM Criteria documentation to ensure that the beneficiary meets the requirements for the service.
   - v. Have written policies and procedures for processing requests for initial and continuing authorization of services.
   - vi. Have a mechanism in place to ensure that there is consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate.
   - vii. Track the number, percentage of denied, and timeliness of requests for authorization for all DMC-ODS services that are submitted, processed, approved, and denied.
   - viii. Pursuant to 42 CFR 438.3(l), allow each beneficiary to choose his or her health professional to the extent possible and appropriate.
   - ix. Require that treatment programs are accessible to people with disabilities in accordance with Title 45, Code of Federal Regulations (hereinafter referred to as CFR), Part 84 and the Americans with Disabilities Act.

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

4. Covered services, whether provided directly by the Contractor or through subcontractor with DMC certified and enrolled programs, shall be provided to beneficiaries in the following manner:
   i. DMC-ODS services approved through the Special Terms and Conditions shall be available to all beneficiaries that reside in the ODS County and enrolled in the ODS Plan.
   ii. Access to State Plan services shall remain at the current, pre-implementation level or expand upon implementation.

G. Coordination of Care

1. In addition to meeting the coordination and continuity of care requirements set forth in Article II.E.3, the Contractor shall develop a care coordination plan that provides for seamless transitions of care for beneficiaries with the DMC-ODS system of care. Contractor is responsible for developing a structured approach to care coordination to ensure that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient) without disruptions to services.
2. In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, the Contractor shall ensure that beneficiaries have access to recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.
3. Contractor shall enter into a Memorandum Of Understanding (MOU) with any Medi-Cal managed care plan that enrolls beneficiaries served by the DMC-ODS. This requirement may be met through an amendment to the Specialty Mental Health Managed Care Plan MOU.
   i. The following elements in the MOU should be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers:
      a. Comprehensive substance use, physical, and mental health screening.

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

H. Authorization of Services – Residential Programs

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

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

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

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

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

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