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

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

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

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

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

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

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

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

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

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

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

**I. Provider Selection and Certification**

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

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

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

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

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

iii. Consequences for failure to provide required disclosures.

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

3. The Contractor shall only select providers that have a Medical Director who, prior to the delivery of services under this Agreement, has enrolled with DHCS under applicable state regulations, has been screened in accordance with 42 CFR 455.450(a) as a "limited" categorical risk within a year prior to serving as a Medical Director under this Agreement, and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107.
4. The Contractor may contract individually with LPHAs to provide DMC-ODS services in the network.
5. The Contractor shall have a protest procedure for providers that are not awarded a subcontract. The Contractor's protest procedure shall ensure that:

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

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

**J. DMC Certification and Enrollment**

1. DHCS shall certify eligible providers to participate in the DMC program.
2. The DHCS shall certify any Contractor-operated or non-governmental providers. This certification shall be performed prior to the date on which the Contractor begins to deliver services under this Agreement at these sites.
3. Contractor shall require that providers of perinatal DMC services are properly certified to provide these services and comply with

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

4. Contractor shall require all the subcontracted providers of services to be licensed, registered, DMC certified and/or approved in accordance with applicable laws and regulations. Contractor's subcontracts shall require that providers comply with the following regulations and guidelines:
   i. Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8
   ii. Title 22, Sections 51490.1(a)
   iii. Exhibit A, Attachment I, Article III.PP – Requirements for Services
   iv. Title 9, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq
   v. Title 22, Division 3, Chapter 3, sections 51000 et. seq
5. In the event of conflicts, the provisions of Title 22 shall control if they are more stringent.
6. The Contractor shall notify Provider Enrollment Division (PED) of an addition or change of information in a providers pending DMC certification application within 35 days of receiving notification from the provider. The Contractor shall ensure that a new DMC certification application is submitted to PED reflecting the change.
7. The Contractor shall be responsible for ensuring that any reduction of covered services or relocations by providers are not implemented until the approval is issued by DHCS. Within 35 days of receiving notification of a provider's intent to reduce covered services or relocate, the Contractor shall submit, or require the provider to submit, a DMC certification application to PED. The DMC certification application shall be submitted to PED 60 days prior to the desired effective date of the reduction of covered services or relocation.
8. The Contractor shall notify DHCS PED by e-mail at DHCSDMCRecert@dhcs.ca.gov within two business days of learning that a subcontractor's license, registration, certification, or approval to operate an SUD program or provide a covered service is revoked, suspended, modified, or not renewed by entities other than DHCS.
   i. A provider's certification to participate in the DMC program shall automatically terminate in the event that the provider, .

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

**K. Continued Certification**

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

**L. Laboratory Testing Requirements**

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

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

**M. Recovery from Other Sources or Providers**

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

**N. Early Intervention (ASAM Level 0.5)**

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

**O. Outpatient Services (ASAM Level 1.0)**

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

**P. Intensive Outpatient Services (ASAM Level 2.1)**

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

**Q. Residential Treatment Services**

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

**R. Case Management**

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

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

**S. Physician Consultation Services**

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

**T. Recovery Services**

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

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

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

**U. Withdrawal Management**

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

**Exhibit A, Attachment I A2**
Program Specifications

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

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

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

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

8. **Courtesy Dosing**

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

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

**W. Cultural Competence Plan**

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

**X. Implementation Plan**

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

**Y. Additional Provisions**

1. **Additional Intergovernmental Agreement Restrictions**

**Exhibit A, Attachment I A2**
Program Specifications

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

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

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

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

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

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

**iii. Concurrence for Test Modifications to HHS Transaction Standards**

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

**iv. Adequate Testing**

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

**v. Deficiencies**

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

**vi. Code Set Retention**

**Exhibit A, Attachment I A2**
Program Specifications

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

**vii. Data Transmission Log**

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

**9. Counselor Certification**

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

**10. Cultural and Linguistic Proficiency**

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

**11. Trafficking Victims Protection Act of 2000**

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

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

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

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

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

**13. Youth Treatment Guidelines**

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

**14. Nondiscrimination in Employment and Services**

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

**15. Federal Law Requirements:**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**16. State Law Requirements:**

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

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

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

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

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

**17. Investigations and Confidentiality of Administrative Actions**

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

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

**18. Subcontract Provisions**

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

**Z. Beneficiary Problem Resolution Process**

1. The Contractor shall establish and comply with a beneficiary problem resolution process.
2. Contractor shall inform subcontractors and providers at the time they enter into a subcontract about:
   i. The beneficiary's right to a state fair hearing, how to obtain a hearing and the representation rules at the hearing.

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

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

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

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

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

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

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

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

ii. An appeal process
iii. An expedited appeal process

**AA. Subcontracts**

1. In addition to complying with the subcontractual relationship requirements set forth in Article II.E.8 of this Agreement, the Contractor shall ensure that all subcontracts require that the Contractor oversee and is held accountable for any functions and responsibilities that the Contractor delegates to any subcontractor.
2. Each subcontract shall:
   i. Fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract.
   ii. Ensure that the Contractor evaluates the prospective subcontractor's ability to perform the activities to be delegated.
   iii. Require a written agreement between the Contractor and the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor, and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
   iv. Ensure the Contractor monitors the subcontractor's performance on an ongoing basis and subject it to an annual onsite review, consistent with statutes, regulations, and Article III.PP.
   v. Ensure the Contractor identifies deficiencies or areas for improvement, the subcontractor shall take corrective actions and the Contractor shall ensure that the subcontractor implements these corrective actions.
3. The Contractor shall include the following provider requirements in all subcontracts with providers:
   i. Culturally Competent Services: Providers are responsible to provide culturally competent services. Providers shall ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations. Translation services shall be available for beneficiaries, as needed.

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

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

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

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

**BB. Program Integrity Requirements**

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

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

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

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

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

**3. Certified Public Expenditure - County Administration**

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

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

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

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

**CC. Quality Management (QM) Program**

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

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i. This review shall include the counties service delivery system, beneficiary protections, access to services, authorization for services, compliance with regulatory and contractual requirements of the waiver, and a beneficiary records review.
ii. This triennial review shall provide DHCS with information as to whether the counties are complying with their responsibility to monitor their service delivery capacity.
iii. The counties shall receive a final report summarizing the findings of the triennial review, and if out of compliance, the Contractor shall submit a corrective action plan (CAP) within 60 days of receipt of the final report. DHCS shall follow-up with the CAP to ensure compliance.

5. The QM Program shall conduct performance-monitoring activities throughout the Contractor's operations. These activities shall include, but not be limited to, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, and resolution of beneficiary grievances.
6. The Contractor shall ensure continuity and coordination of care with physical health care providers. The Contractor shall coordinate with other human services agencies used by its beneficiaries. The Contractor shall assess the effectiveness of any MOU with a physical health care plan.
7. The Contractor shall have mechanisms to detect both underutilization of services and overutilization of services, as required by Article II.F.1 of this Agreement.
8. The Contractor shall implement mechanisms to assess beneficiary/family satisfaction. The Contractor shall assess beneficiary/family satisfaction by:
    a. Surveying beneficiary/family satisfaction with the Contractor's services at least annually.
    b. Evaluating beneficiary grievances, appeals and fair hearings at least annually.
    c. Evaluating requests to change persons providing services at least annually.
    d. The Contractor shall inform providers of the results of beneficiary/family satisfaction activities.

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9. The Contractor shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. Monitoring shall occur at least annually.
10. The Contractor shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The Contractor shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the Contractor at least annually.
11. The Contractor shall have a QM Work Plan covering the current Agreement cycle with documented annual evaluations and documented revisions as needed. The Contractor's QM Work Plan shall evaluate the impact and effectiveness of its quality assessment and performance improvement program. The QM Work Plan shall include:
    - i. Evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Article II.F.1 and Article II.G.7 of this Agreement.
    - ii. Evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service.
    - iii. A description of completed and in-process QM activities, including performance improvement projects. The description shall include:
        a. Monitoring efforts for previously identified issues, including tracking issues over time.
        b. Objectives, scope, and planned QM activities for each year.
        c. Targeted areas of improvement or change in service delivery or program design.
    - iv. A description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area. This shall include goals for responsiveness for the Contractor's 24-hour toll-free

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

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

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

1. DHCS shall conduct Postservice Postpayment and Postservice Prepayment (PSPP) Utilization Reviews of the contracted DMC providers to determine whether the DMC services were provided in accordance with Article III.PP of this exhibit. DHCS shall issue the PSPP report to the Contractor with a copy to subcontracted DMC provider. The Contractor shall be responsible for their subcontracted providers and their Contractor run programs to ensure any deficiencies are remediated pursuant to Article III.DD.2. The Contractor shall attest the deficiencies have been remediated and are complete, pursuant to Article III.EE.5 of this Agreement.
2. The Department shall recover payments made if subsequent investigation uncovers evidence that the claim(s) should not have been paid, DMC-ODS services have been improperly utilized, and requirements of Article III.PP were not met.
   i. All deficiencies identified by PSPP reports, whether or not a recovery of funds results, shall be corrected and the Contractor shall submit a Contractor-approved CAP. The CAP shall be submitted to the DHCS Analyst that conducted the review, within 60 days of the date of the PSPP report.
      a. The CAP shall:
         i. Be documented on the DHCS CAP template.
         ii. Provide a specific description of how the deficiency shall be corrected.
         iii. Identify the title of the individual(s) responsible for:
            1. Correcting the deficiency
            2. Ensuring on-going compliance
         iv. Provide a specific description of how the provider will ensure on-going compliance.

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

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

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

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

**i.** Requests for first-level appeals:

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

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

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

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

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

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

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

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

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

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

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

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

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

5. The appeal process listed here shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of DHCS pursuant to Exhibit B of this Agreement.
6. State shall monitor the subcontractor's compliance with Contractor utilization review requirements, as specified in Article III.EE. Counties are also required to monitor the subcontractor's compliance pursuant to Article III.AA of this Agreement. The federal government may also review the existence and effectiveness of DHCS' utilization review system.
7. Contractor shall, at a minimum, implement and maintain compliance with the requirements described in Article III.PP for the purposes of reviewing the utilization, quality, and appropriateness of covered services and ensuring that all applicable Medi-Cal requirements are met.
8. Contractor shall ensure that subcontractor sites shall keep a record of the beneficiaries/patients being treated at that location. Contractor shall retain beneficiary records for a minimum of 10 years, in accordance with 438.3(h), from the finalized cost settlement process with the Department. When an audit by the Federal Government or DHCS has been started before the expiration of the 10-year period, the beneficiary records shall be maintained until completion of the audit and the final resolution of all issues.

**EE. Contractor Monitoring**

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

Department of Health Care Services

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

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

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

Technical assistance is available to counties from SUD-PPFD.

2. If significant deficiencies or significant evidence of noncompliance with the terms of the DMC-ODS waiver, or this Agreement, are found in a county, DHCS shall engage the Contractor to determine if there are challenges that can be addressed with facilitation and technical assistance. If the Contractor remains noncompliant, the Contractor shall submit a CAP to DHCS. The CAP shall detail how and when the Contractor shall remedy the issue(s). DHCS may remove the Contractor from participating in the Waiver if the CAP is not promptly implemented.
3. If the Contractor is removed from participating in the Waiver, the county shall provide DMC services in accordance with the California Medi-Cal State Plan.
4. Contractor shall ensure that DATAR submissions, detailed in Article III.FF of this Exhibit, are complied with by all treatment providers and subcontracted treatment providers. Contractor shall attest that each subcontracted provider is enrolled in DATAR at the time of execution of the subcontract.
5. The Contractor shall monitor and attest compliance and/or completion by providers with CAP requirements (detailed in Article III.DD) of this Exhibit as required by any PSPP review. The Contractor shall attest to DHCS, using the form developed by DHCS that the requirements in the CAP have been completed by the Contractor and/or the provider. Submission of DHCS Form 8049 by Contractor shall be accomplished within the timeline specified in the approved CAP, as noticed by DHCS.
6. Contractor shall attest that DMC claims submitted to DHCS have been subject to review and verification process for accuracy and legitimacy. (45 CFR 430.30, 433.32, 433.51). Contractor shall not

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

**FF. Reporting Requirements**

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

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

4. **California Outcomes Measurement System (CalOMS) for Treatment (CalOMS-Tx)**
   i. The CalOMS-Tx business rules and requirements are:
      a. Contractor shall contract with a software vendor that complies with the CalOMS-Tx data collection system requirements for submission of CalOMS-Tx data. A Business Associate Agreement (BAA) shall be established between the Contractor and the software vendor. The BAA shall state that DHCS is allowed to return the processed CalOMS-Tx data to the vendor that supplied the data to DHCS.
      b. Contractor shall conduct information technology (IT) systems testing and pass state certification testing before commencing submission of CalOMS-Tx data. If the Contractor subcontracts with vendor for IT services, Contractor is responsible for ensuring that the subcontracted IT system is tested and certified by the DHCS prior to submitting CalOMS-Tx data. If Contractor changes or modifies the CalOMS-Tx IT system, then Contractor shall re-test and pass state re-certification prior to submitting data from new or modified system.
      c. Electronic submission of CalOMS-Tx data shall be submitted by Contractor within 45 days from the end of the last day of the report month.
      d. Contractor shall comply with data collection and reporting requirements established by the DHCS CalOMS-Tx Data Collection Guide (Document 3J) and all former Department of Alcohol and Drug Programs Bulletins and DHCS Information Notices relevant to CalOMS-Tx data collection and reporting requirements.
      e. Contractor shall submit CalOMS-Tx admission, discharge, annual update, resubmissions of records containing errors or in need of correction, and

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

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

**5. CalOMS-Tx General Information**

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

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

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

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

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**6. Drug and Alcohol Treatment Access Report (DATAR)**

**i.** The DATAR business rules and requirements:

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

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

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

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

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

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

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

**7. Year-End Cost Settlement Reports**

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

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

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

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

**8. Failure to Meet Reporting Requirements**

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

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

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

**GG. Training**

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

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

**HH. Program Complaints**

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

   SUD Compliance Division:

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

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

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

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

**II. Record Retention**

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

**JJ. Subcontract Termination**

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

**KK. Corrective Action Plan**

1. If the Contractor fails to ensure any of the foregoing oversight through an adequate system of monitoring, utilization review, and fiscal and programmatic controls, DHCS may request a CAP from the Contractor to address these deficiencies and a timeline for implementation. Failure to submit a CAP or adhere to the provisions in the CAP can result in a withholding of funds allocated to Contractor for the provision of services, and/or termination of this Agreement for cause.
2. Failure to comply with Monitoring requirements shall result in:
   i. DHCS shall issue a report to Contractor after conducting monitoring or utilization reviews of the Contractor. When the DHCS report identifies non-compliant services or processes, it shall require a CAP. The Contractor shall submit a CAP to DHCS within the timeframes required by DHCS.
      a. The CAP shall:
         i. Be documented on the DHCS CAP template.
         ii. Provide a specific description of how the deficiency shall be corrected.

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

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

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

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

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

**LL. Quality Improvement (QI) Program**

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

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

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

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

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

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

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

**iv.** Access to after-hours care.

**v.** Responsiveness of the beneficiary access line.

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

5. The Contractor's QI program shall monitor the Contractor's service delivery system with the aim of improving the processes of providing care and better meeting the needs of its beneficiaries. The QI Program shall be accountable to the Contractor's Director.
6. The Contractor shall establish a QI Committee to review the quality of SUD treatment services provided to beneficiaries. The QI Committee shall recommend policy decisions; review and evaluate the results of QI activities, including performance improvement projects; institute needed QI actions; ensure follow-up of QI processes; and document QI Committee meeting minutes regarding decisions and actions taken. The QI committee shall recommend policy decisions; review and evaluate the results of QI activities; institute needed QI actions, ensure follow-up of QI process and document QI committee minutes regarding decisions and actions taken.
7. Each Contractor's QI Committee shall review the following data at a minimum on a quarterly basis since external quality review (EQR) site reviews will begin after county implementation. The External Quality Review Organization (EQRO) shall measure defined data elements to assess the quality of service provided by the Contractor. These data elements shall be incorporated into the EQRO protocol:
   i. Number of days to first DMC-ODS service at appropriate level of care after referral.
   ii. Existence of a 24/7 telephone access line with prevalent non-English language(s).
   iii. Access to DMC-ODS services with translation services in the prevalent non-English language(s).
8. Operation of the QI program shall include substantial involvement by a licensed SUD staff person.
9. The QI Program shall include active participation by the Contractor's practitioners and providers, as well as beneficiaries

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

10. The Contractor shall maintain a minimum of two active Performance Improvement Projects (PIPs) that meet the criteria in 42 CFR 438.240(b)(1) and (d). Performance improvement projects shall focus on a clinical area, as well as one non-clinical area.
11. PIPs shall:
    i. Measure performance using required quality indicators.
    ii. Implement system interventions to achieve improvement in quality.
    iii. Evaluate the effectiveness of interventions.
    iv. Plan and initiate activities for increasing or sustaining improvement.
12. The Contractor shall report the status and results of each PIP to DHCS, as requested.
13. Each PIP shall be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care annually.

**MM. Utilization Management (UM) Program**

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

**NN. Formation and Purpose**

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

**Exhibit A, Attachment I A2**
Program Specifications

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

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

**OO. Performance Provisions**

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

**Exhibit A, Attachment I A2**
Program Specifications

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

SUDCountyReports@dhcs.ca.gov

Alternatively, mail to:

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

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

**2. Performance Requirements**

i. Contractor shall provide services based on funding set forth in Exhibit B, Attachment I, and under the terms of this Agreement.
ii. Contractor shall provide services to all eligible persons in accordance with federal and state statutes and regulations.
iii. Contractor shall ensure that in planning for the provision of services, the following barriers to services are considered and addressed:
    a. Lack of educational materials or other resources for the provision of services.
    b. Geographic isolation and transportation needs of persons seeking services or remoteness of services.

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

3. Contractor shall comply with any additional requirements of the documents that have been incorporated by reference, including, but not limited to, those in the Exhibit A – Statement of Work.
4. Amounts awarded pursuant to Exhibit B, Attachment I shall be used exclusively for providing DMC-ODS services consistent with the purpose of the funding.
5. DHCS shall issue a report to Contractor after conducting monitoring or utilization reviews of county or county subcontracted providers. When the DHCS report identifies non-compliant services or processes, it shall require a CAP. The Contractor, or in coordination with its subcontracted provider, shall submit a CAP to the DHCS Analyst that conducted the review, within 60 calendar days from the date of the report. The CAP shall be electronically submitted, directly to the DHCS analyst who conducted the review.
6. The CAP shall follow the requirements in Article III.KK.2.

**PP. Requirements for Services**

1. **Confidentiality.**
   i. All SUD treatment services shall be provided in a confidential setting in compliance with 42 CFR, Part 2 requirements.
2. **Perinatal Services.**
   i. Perinatal services shall address treatment and recovery issues specific to pregnant and postpartum women, such as relationships, sexual and physical abuse, and development of parenting skills.
   ii. Perinatal services shall include:
      a. Mother/child habilitative and rehabilitative services (i.e., development of parenting skills, training in child development, which may include the provision of cooperative child care pursuant to Health and Safety Code Section 1596.792).

b. Service access (i.e., provision of or arrangement for transportation to and from medically necessary treatment).
c. Education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant.
d. Coordination of ancillary services (i.e., assistance in accessing and completing dental services, social services, community services, educational/vocational training and other services which are medically necessary to prevent risk to fetus or infant).

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

3. **Narcotic Treatment Programs.**
   i. OTP/NTP services and regulatory requirements shall be provided in accordance with Title 9, Chapter 4.
4. **OTP/NTP Courtesy Dosing Documentation Requirements**
   i. The Contractor shall require the referring OTP/NTP to maintain documentation of the referral, and treatment by a Dosing OTP/NTP, in the beneficiary medical record for each day of courtesy dosing. The Contractor shall also require the Referring OTP/NTP to maintain a record of the invoice and payment for the courtesy dosing for each claim submitted for reimbursement. The invoice shall include all information needed to complete a claim, including dates of service, type of service, and units of service.
   ii. If applicable, the Contractor shall require an OTP/NTP provider include entries on a cost report to capture the revenue and expenses related to courtesy dosing for the purpose of cost settlement.
5. **Naltrexone Treatment Services.**

**Exhibit A, Attachment I A2**
Program Specifications

i. For each beneficiary, all of the following shall apply:
   a. The provider shall confirm and document that the beneficiary meets all of the following conditions:
ii. Has a documented history of opiate addiction.
iii. Is at least 18 years of age.
iv. Has been opiate free for a period of time to be determined by a physician based on the physician's clinical judgment. The provider shall administer a body specimen test to confirm the opiate free status of the beneficiary.
v. Is not pregnant and is discharged from the treatment if she becomes pregnant.
vi. The physician shall certify the beneficiary's fitness for treatment based upon the beneficiary's physical examination, medical history, and laboratory results.
vii. The physician shall advise the beneficiary of the overdose risk should the beneficiary return to opiate use while taking Naltrexone and the ineffectiveness of opiate pain relievers while on Naltrexone.

6. **Substance Use Disorder Medical Director.**
   i. The SUD Medical Director's responsibilities shall, at a minimum, include all of the following:
      a. Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
      b. Ensure that physicians do not delegate their duties to non-physician personnel.
      c. Develop and implement written medical policies and standards for the provider.
      d. Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
      e. Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
      f. Ensure that provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries, and determine the medical necessity of treatment for beneficiaries.
      g. Ensure that provider's physicians are adequately trained to perform other physician duties, as outlined in this section.

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

7. **Provider Personnel.**
   i. Personnel files shall be maintained on all employees and volunteers/interns and shall contain the following:
      a. Application for employment and/or resume
      b. Signed employment confirmation statement/duty statement
      c. Job description
      d. Performance evaluations
      e. Health records/status as required by the provider, AOD Certification or Title 9
      f. Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries)
      g. Training documentation relative to substance use disorders and treatment
      h. Current registration, certification, intern status, or licensure
      i. Proof of continuing education required by licensing or certifying agency and program
      j. Provider's Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying/licensing body's code of conduct as well
   ii. Job descriptions shall be developed, revised as needed, and approved by the provider's governing body. The job descriptions shall include:
      a. Position title and classification
      b. Duties and responsibilities
      c. Lines of supervision
      d. Education, training, work experience, and other qualifications for the position
   iii. Written provider code of conduct for employees and volunteers/interns shall be established which addresses at least the following:
      a. Use of drugs and/or alcohol

b. Prohibition of social/business relationship with beneficiaries or their family members for personal gain
c. Prohibition of sexual contact with beneficiaries
d. Conflict of interest
e. Providing services beyond scope
f. Discrimination against beneficiaries or staff
g. Verbally, physically, or sexually harassing, threatening or abusing beneficiaries, family members or other staff
h. Protection of beneficiary confidentiality
i. Cooperate with complaint investigations

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

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

8. **Beneficiary Admission.**

i. Each provider shall include in its policies, procedures, and practice, written admission and readmission criteria for determining beneficiary's eligibility and the medical necessity for treatment. These criteria shall include, at a minimum:
a. DSM diagnosis
b. Use of alcohol/drugs of abuse
c. Physical health status
d. Documentation of social and psychological problems.

ii. If a potential beneficiary does not meet the admission criteria, the beneficiary shall be referred to an appropriate service provider.

iii. If a beneficiary is admitted to treatment, the beneficiary shall sign a consent to treatment form.

iv. The Medical Director or LPHA shall document the basis for the diagnosis in the beneficiary record.

v. All referrals made by the provider staff shall be

documented in the beneficiary record.

vi. Copies of the following documents shall be provided to the beneficiary upon admission:
   a. Beneficiary rights, share of cost if applicable, notification of DMC funding accepted as payment in full, and consent to treatment.

vii. Copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries:
   a. A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay.
   b. Complaint process and grievance procedures.
   c. Appeal process for involuntary discharge.
   d. Program rules and expectations.

viii. Where drug screening by urinalysis is deemed medically appropriate the program shall:
   a. Establish written procedures, which protect against the falsification and/or contamination of any urine sample.
   b. Document urinalysis results in the beneficiary's file.

**9. Assessment.**

i. The provider shall ensure a counselor or LPHA completes a personal, medical, and substance use history for each beneficiary upon admission to treatment.
   a. Assessment for all beneficiaries shall include at a minimum:
      i. Drug/Alcohol use history
      ii. Medical history
      iii. Family history
      iv. Psychiatric/psychological history
      v. Social/recreational history
      vi. Financial status/history
      vii. Educational history
      viii. Employment history
      ix. Criminal history
      x. Legal status
      xi. Previous SUD treatment history
   b. The Medical Director or LPHA shall review each beneficiary's personal, medical, and substance use history if completed by a counselor within 30 calendar days of each beneficiary's admission to treatment date.

**Exhibit A, Attachment I A2**
Program Specifications

**10. Beneficiary Record.**

i. In addition to the requirements of 22 CCR § 51476(a), the provider shall:
   a. Establish, maintain, and update as necessary, an individual beneficiary record for each beneficiary admitted to treatment and receiving services.
   b. Each beneficiary's individual beneficiary record shall include documentation of personal information.
   c. Documentation of personal information shall include all of the following:
      i. Information specifying the beneficiary's identifier (i.e., name, number).
      ii. Date of beneficiary's birth, the beneficiary's sex, race and/or ethnic background, beneficiary's address and telephone number, and beneficiary's next of kin or emergency contact.

ii. Documentation of treatment episode information shall include documentation of all activities, services, sessions, and assessments, including, but not limited to all of the following:
   a. Intake and admission data including, a physical examination, if applicable.
   b. Treatment plans.
   c. Progress notes.
   d. Continuing services justifications.
   e. Laboratory test orders and results.
   f. Referrals.
   g. Discharge plan.
   h. Discharge summary.
   i. Contractor authorizations for Residential Services.
   j. Any other information relating to the treatment services rendered to the beneficiary.

**10. Diagnosis Requirements.**

i. The Medical Director or LPHA shall evaluate each beneficiary's assessment and intake information if completed by a counselor through a face-to-face review or telehealth with the counselor to establish a beneficiary meets the medical necessity criteria in Article III.B.2.ii.
   a. The Medical Director or LPHA shall document separately from the treatment plan the basis for the

diagnosis in the beneficiary's record within 30 calendar days of each beneficiary's admission to treatment date.

i. The basis for the diagnosis shall be a narrative summary based on DSM-5 criteria, demonstrating the Medical Director or LPHA evaluated each beneficiary's assessment and intake information, including their personal, medical, and substance use history.
ii. The Medical Director or LPHA shall type or legibly print their name, and sign and date the diagnosis narrative documentation. The signature shall be adjacent to the typed or legibly printed name.

**11. Physical Examination Requirements.**

i. If a beneficiary had a physical examination within the twelve-month period prior to the beneficiary's admission to treatment date, the physician or registered nurse practitioner or physician's assistant (physician extenders) shall review documentation of the beneficiary's most recent physical examination within 30 calendar days of the beneficiary's admission to treatment date.
   a. If a provider is unable to obtain documentation of a beneficiary's most recent physical examination, the provider shall describe the efforts made to obtain this documentation in the beneficiary's individual patient record.
ii. As an alternative to complying with paragraph (i) above or in addition to complying with paragraph (i) above, the physician or physician extender may perform a physical examination of the beneficiary within 30 calendar days of the beneficiary's admission to treatment date.
iii. If the physician or a physician extender, has not reviewed the documentation of the beneficiary's physical examination as provided for in paragraph (i), or the provider does not perform a physical examination of the beneficiary as provided for in paragraph (ii), then the LPHA or counselor shall include in the beneficiary's initial and updated treatment plans the goal of obtaining a physical examination, until this goal has been met and the physician has reviewed the physical examination results. The physician shall type or

legibly print their name, sign, and date documentation to support they have reviewed the physical examination results. The signature shall be adjacent to the typed or legibly printed name.

12. **Treatment Plan.**
    i. For each beneficiary admitted to treatment services, the LPHA or counselor shall prepare an individualized written initial treatment plan, based upon the information obtained in the intake and assessment process.
        a. The LPHA or counselor shall attempt to engage the beneficiary to meaningfully participate in the preparation of the initial treatment plan and updated treatment plans.
            i. The initial treatment plan and updated treatment plans shall include all of the following:
                1. A statement of problems identified through the ASAM, other assessment tool(s) or intake documentation.
                2. Goals to be reached which address each problem.
                3. Action steps that will be taken by the provider and/or beneficiary to accomplish identified goals.
                4. Target dates for the accomplishment of action steps and goals.
                5. A description of the services, including the type of counseling, to be provided and the frequency thereof.
                6. The assignment of a primary therapist or counselor.
                7. The beneficiary's diagnosis as documented by the Medical Director or LPHA.
                8. If a beneficiary has not had a physical examination within the 12-month period prior to the beneficiary's admission to treatment date, a goal that the beneficiary have a physical examination.
                9. If documentation of a beneficiary's physical examination, which was

performed during the prior 12 months, indicates a beneficiary has a significant medical illness, a goal that the beneficiary obtain appropriate treatment for the illness.

b. The provider shall ensure that the initial treatment plan meets all of the following requirements:
    i. The LPHA or counselor shall complete, type or legibly print their name, and sign and date the initial treatment plan within 30 calendar days of the admission to treatment date. The signature shall be adjacent to the typed or legibly printed name.
    ii. The beneficiary shall review, approve, type, or legibly print their name, sign and date the initial treatment plan, indicating whether the beneficiary participated in preparation of the plan, within 30 calendar days of the admission to treatment date.
        1. If the beneficiary refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment.
    iii. If a counselor completes the initial treatment plan, the Medical Director or LPHA shall review the initial treatment plan to determine whether services are medically necessary (as defined in Article IV) and appropriate for the beneficiary.
        1. If the Medical Director or LPHA determines the services in the initial treatment plan are medically necessary, the Medical Director or LPHA shall type or legibly print their name, and sign and date the treatment plan within 15 calendar days of signature by the counselor. The signature shall be adjacent to the typed or legibly printed name.

ii. The provider shall ensure that the treatment plan is reviewed and updated as described below:

a. The LPHA or counselor shall complete, type, or legibly print their name, sign and date the updated treatment plan no later than 90 calendar days after signing the initial treatment plan, and no later than every 90 calendar days thereafter, or when there is a change in treatment modality or significant event, whichever comes first. The signature shall be adjacent to the typed or legibly printed name. The updated treatment plan shall be updated to reflect the current treatment needs of the beneficiary.
b. The beneficiary shall review, approve, type, or legibly print their name and, sign and date the updated treatment plan, indicating whether the beneficiary participated in preparation of the plan, within 30 calendar days of signature by the LPHA or counselor.
    i. If the beneficiary refuses to sign the updated treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment.
c. If a counselor completes the updated treatment plan, the Medical Director or LPHA shall review each updated treatment plan to determine whether continuing services are medically necessary (as defined in Article IV) and appropriate for the beneficiary.
    i. If the Medical Director or LPHA determines the services in the updated treatment plan are medically necessary, they shall type or legibly print their name and, sign and date the updated treatment plan, within 15 calendar days of signature by the counselor. The signature shall be adjacent to the typed or legibly printed name.

**13. Sign-in Sheet.**

i. Establish and maintain a sign-in sheet for every group counseling session, which shall include all of the following:
    a. The LPHA(s) and/or counselor(s) conducting the counseling session shall type or legibly print their name(s), sign, and date the sign-in sheet on the same day of the session. The signature(s) must be adjacent to the typed or legibly printed name(s). By signing the

sign-in sheet, the LPHA(s) and/or counselor(s) attest that the sign-in sheet is accurate and complete.

b. The date of the counseling session.
c. The topic of the counseling session.
d. The start and end time of the counseling session.
e. A typed or legibly printed list of the participants' names and the signature of each participant that attended the counseling session. The participants shall sign the sign-in sheet at the start of or during the counseling session.

**14. Progress Notes.**

i. Progress notes shall be legible and completed as follows:
   a. For outpatient services, Naltrexone treatment services, and recovery services, each individual and group session, the LPHA or counselor who conducted the counseling session or provided the service shall record a progress note for each beneficiary who participated in the counseling session or treatment service.
      i. The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven calendar days of the counseling session. The signature shall be adjacent to the typed or legibly printed name.
      ii. Progress notes are individual narrative summaries and shall include all of the following:
         1. The topic of the session or purpose of the service.
         2. A description of the beneficiary's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals.
         3. Information on the beneficiary's attendance, including the date, start and end times of each individual and group counseling session or treatment service.
         4. Identify if services were provided in-person, by telephone, or by telehealth.

5. If services were provided in the community, identify the location and how the provider ensured confidentiality.

b. For intensive outpatient services and residential treatment services, the LPHA or counselor shall record, at a minimum, one progress note, per calendar week, for each beneficiary participating in structured activities including counseling sessions or other treatment services.
   i. The LPHA or counselor shall type or legibly print their name, and sign and date progress notes within the following calendar week. The signature shall be adjacent to the typed or legibly printed name.
   ii. Progress notes are individual narrative summaries and shall include all of the following:
      1. A description of the beneficiary's progress on the treatment plan, problems, goals, action steps, objectives, and/or referrals.
      2. A record of the beneficiary's attendance at each counseling session including the date, start and end times and topic of the counseling session.
      3. Identify if services were provided in-person, by telephone, or by telehealth.
      4. If services were provided in the community, identify the location and how the provider ensured confidentiality.

c. For each beneficiary provided case management services, the LPHA or counselor who provided the treatment service shall record a progress note.
   i. The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven calendar days of the case management service. The signature shall be adjacent to the typed or legibly printed name.
   ii. Progress notes shall include all of the following:
      1. Beneficiary's name.
      2. The purpose of the service.

3. A description of how the service relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referrals.
4. Date, start and end times of each service.
5. Identify if services were provided in-person, by telephone, or by telehealth.
6. If services were provided in the community, identify the location and how the provider ensured confidentiality.

d. For physician consultation services, additional medication assisted treatment, and withdrawal management, the Medical Director or LPHA working within their scope of practice who provided the treatment service shall record a progress note and keep in the beneficiary's file.
   i. The Medical Director or LPHA shall type or legibly print their name, and sign and date the progress note within seven calendar days of the service. The signature shall be adjacent to the typed or legibly printed name.
   ii. Progress notes shall include all of the following:
      1. Beneficiary's name.
      2. The purpose of the service.
      3. Date, start and end times of each service.
      4. Identify if services were provided face-to-face, by telephone or by telehealth.

**15. Continuing Services.**

i. Continuing services shall be justified as shown below:
   a. For outpatient services, intensive outpatient services, Naltrexone treatment, and case management:
      i. For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the LPHA or counselor shall review the beneficiary's progress and eligibility to continue to receive treatment services, and recommend whether the beneficiary should or should not continue to receive treatment services at the same level of care.

ii. For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the Medical Director or LPHA shall determine medical necessity for continued services for the beneficiary. The determination of medical necessity shall be documented by the Medical Director or LPHA in the beneficiary's individual patient record and shall include documentation that all of the following have been considered:
   1. The beneficiary's personal, medical and substance use history.
   2. Documentation of the beneficiary's most recent physical examination.
   3. The beneficiary's progress notes and treatment plan goals.
   4. The LPHA's or counselor's recommendation pursuant to Paragraph (i) above.
   5. The beneficiary's prognosis.
      i. The Medical Director or LPHA shall type or legibly print their name, and sign and date the continuing services information when completed. The signature shall be adjacent to the typed or legibly printed name.

iii. If the Medical Director or LPHA determines that continuing treatment services for the beneficiary is not medically necessary, the provider shall discharge the beneficiary from the current LOC and transfer to the appropriate services.

b. Residential services length of stay shall be in accordance with Article III.H of this Agreement.

**16. Discharge.**

i. Discharge of a beneficiary from treatment may occur on a voluntary or involuntary basis. For outpatient services, intensive outpatient services and residential services, in

addition to the requirements of this subsection, an involuntary discharge is subject to the requirements set forth in Article II.G.2. of this Agreement.

ii. An LPHA or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom the provider loses contact.
   a. The discharge plan shall include, but not be limited to, all of the following:
      i. A description of each of the beneficiary's relapse triggers.
      ii. A plan to assist the beneficiary to avoid relapse when confronted with each trigger.
      iii. A support plan.
   b. The discharge plan shall be prepared within 30 calendar days prior to the scheduled date of the last face-to-face treatment with the beneficiary.
      i. If a beneficiary is transferred to a higher or lower level of care based on ASAM criteria within the same DMC certified program, they are not required to be discharged unless there has been more than a 30-calendar day lapse in treatment services.
   c. During the LPHA's or counselor's last face-to-face treatment with the beneficiary, the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. The signatures shall be adjacent to the typed or legibly printed name. A copy of the discharge plan shall be provided to the beneficiary and documented in the beneficiary record.

iii. The LPHA or counselor shall complete a discharge summary, for any beneficiary with whom the provider lost contact, in accordance with all of the following requirements:
   a. The LPHA or counselor shall complete the discharge summary within 30 calendar days of the date of the last face-to-face treatment contact with the beneficiary.
   b. The discharge summary shall include all of the following:

i. The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment.
ii. The reason for discharge.
iii. A narrative summary of the treatment episode.
iv. The beneficiary's prognosis.

**17. Reimbursement of Documentation.**

i. If the Contractor allows for the inclusion of the time spent documenting when billing for a unit of service delivered, the Contractor shall require its subcontracted providers to include the following information in their progress notes:
   a. The date the progress note was completed.
   b. The start and end time of the documentation of the progress note.
ii. Documentation activities shall be billed as a part of the covered service unit.

## IV. Definitions

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

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

2. ***"Adolescents"*** means beneficiaries between the ages of twelve and under the age of twenty-one.

3. ***"Administrative Costs"*** means the Contractor's actual direct costs, as recorded in the Contractor's financial records and supported by source documentation, to administer the program or an activity to provide service to the DMC program. Administrative costs do not include the cost of treatment or other direct services to the beneficiary. Administrative costs may include, but are not limited to, the cost of training, programmatic and financial audit

reviews, and activities related to billing. Administrative costs may include Contractor's overhead per the approved indirect cost rate proposal pursuant to OMB Omni-Circular and the State Controller's Office Handbook of Cost Plan Procedures.

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

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

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

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

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

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

   (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.

   (7) The denial of an enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

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

6. ***"ASAM Assessment"*** means an assessment that utilizes the published ASAM criteria for the purpose of determining a level of care.

7. ***"ASAM Criteria-Medical Necessity"*** pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. It should not be restricted to acute care and narrow

medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs (as in Dimension 2); or Dimension 3 psychiatric issues (such as imminent suicidality). Rather, "medical necessity" encompasses all six assessment dimensions so that a more holistic concept would be "Clinical Necessity," "necessity of care," or "clinical appropriateness."

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

9. ***"Available Capacity"*** means the total number of units of service (bed days, hours, slots, etc.) that a Contractor actually makes available in the current fiscal year.

10. ***"Beneficiary"*** means a person who: (a) has been determined eligible for Medi-Cal; (b) is not institutionalized; (c) has a substance-related disorder per the current "Diagnostic and Statistical Manual of Mental Disorders (DSM)" criteria; and (d) meets the admission criteria to receive DMC covered services.

11. ***"Beneficiary/Enrollee Encounter Data"*** means the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a state and a MCO, PIHP, or PAHP that is subject to the requirements of §§438.242 and 438.818.

12. ***"Beneficiary Handbook"*** is the state developed model enrollee handbook.

13. ***"Calendar Week"*** means the seven-day period from Sunday through Saturday.

14. ***"Case Management"*** means a service to assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

15. ***"Certified Provider"*** means a substance use disorder clinic location that has received certification to be reimbursed as a DMC clinic by the state to provide services as described in Title 22, California Code of Regulations, Section 51341.1.

16. ***"Collateral Services"*** means sessions with therapists or counselors and significant persons in the life of a beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals.

Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.

17. ***"Complaint"*** means requesting to have a problem solved or have a decision changed because you are not satisfied. A complaint is sometimes called a grievance or an appeal.

18. ***"Contractor"*** means the county identified in the Standard Agreement or DHCS authorized by the County Board of Supervisors to administer substance use disorder programs.

19. ***"Corrective Action Plan (CAP)"*** means the written plan of action document which the Contractor or its subcontracted service provider develops and submits to DHCS to address or correct a deficiency or process that is non-compliant with laws, regulations or standards.

20. ***"County"*** means the county in which the Contractor physically provides covered substance use treatment services.

21. ***"County Realignment Funds"*** means Behavioral Health Subaccount funds received by the County as per California Code Section 30025.

22. ***"Crisis Intervention"*** means a contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance, which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the beneficiary's emergency situation.

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

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

25. ***"Delivery System"*** DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program. DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a

county that opts into the Pilot program. Upon approval of an implementation plan, the state shall contract with the county to provide DMC-ODS services. The county shall, in turn, contract with DMC certified providers or provide county-operated services to provide all services outlined in the DMC-ODS. Counties may also contract with a managed care plan to provide services. Participating counties with the approval from the state may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design or comparability of services. Counties may act jointly in order to deliver these services.

26. ***"Discharge services"*** means the process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

27. ***"DMC-ODS Services"*** means those DMC services authorized by Title XIX or Title XXI of the Social Security Act; Title 22 Section 51341.1; WIC 14124.24; and California's Medicaid State Plan, including the DMC ODS 1115 Demonstration Waiver special terms and conditions.

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

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

30. ***"Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)"*** means the federally mandated Medicaid benefit that entitles full-scope Medi-Cal-covered beneficiaries less than 21 years of age to receive any Medicaid service necessary to correct or ameliorate a defect, mental illness, or other condition,

    such as a substance-related disorder, that is discovered during a health screening.

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

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

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

    (2) Serious impairment to bodily functions.

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

33. ***"Emergency services"*** means covered inpatient and outpatient services that are as follows:

    (1) Furnished by a provider that is qualified to furnish these services under this Title.

    (2) Needed to evaluate or stabilize an emergency medical condition.

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

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

36. ***"Family Support"*** means linkages to childcare, parent education, child development support services, and family and marriage education.

37. ***"Family Therapy"*** means including a beneficiary's family members and loved ones in the treatment process, and education about factors that are important to the beneficiary's recovery as well as their own recovery can be conveyed. Family members may provide social support to beneficiaries, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

38. ***"Fair Hearing"*** means the state hearing provided to beneficiaries

upon denial of appeal pursuant to 22 CCR 50951 and 50953 and 9 CCR 1810.216.6. Fair hearings shall comply with 42 CFR 431.220(a)(5), 438.408(f), 438.414, and 438.10(g)(1).

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

40. ***"Final Settlement"*** means permanent settlement of the Contractor's actual allowable costs or expenditures as determined at the time of audit, which shall be completed within three years of the date the year-end cost settlement report was accepted for interim settlement by the state. If the audit is not completed within three years, the interim settlement shall be considered as the final settlement.

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

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

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

44. ***"Group Counseling"*** means contacts in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served. A beneficiary that is 17 years of age or younger shall not participate in-group counseling with any participants who are 18 years of age or older. However, a beneficiary who is 17 years of age or younger may participate in group counseling with

participants who are 18 years of age or older when the counseling is at a provider's certified school site.

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

46. ***"Individual Counseling"*** means contact between a beneficiary and a therapist or counselor. Services provided in-person, by telephone or by telehealth qualify as Medi-Cal reimbursable units of service, and are reimbursed without distinction.

47. ***"Intake"*** means the process of determining a beneficiary meets the medical necessity criteria and a beneficiary is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for substance use disorder treatment and evaluation.

48. ***"Intensive Outpatient Services"*** means (ASAM Level 2.1) structured programming services consisting primarily of counseling and education about addiction-related problems a minimum of nine (9) hours with a maximum of 19 hours per week for adults, and a minimum of six (6) hours with a maximum of 19 hours per week for adolescents. Services may be provided in any appropriate setting in the community. Services may be provided in-person, by telephone or by telehealth. Also known as Intensive Outpatient Treatment.

49. ***"Interim Settlement"*** means temporary settlement of actual allowable costs or expenditures reflected in the Contractor's year-end cost settlement report.

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

51. ***"Long-Term Services and Supports (LTSS)"*** means services and supports provided to beneficiaries of all ages who have

functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

52. ***"Licensed Practitioners of the Healing Arts (LPHA)"*** includes: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

53. ***"Managed Care Organization (MCO)"*** means an entity that has, or is seeking to qualify for, comprehensive risk contract under this part, and that is-

    (1) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 of this chapter; or

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

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

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

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

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

56. ***"Medical Necessity" and "Medically Necessary Services"*** means those SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or

treatment of a disease, illness, or injury consistent with 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.

57. ***"Medical Necessity Criteria"*** means adult beneficiaries must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, and must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria. Adults shall meet the ASAM Adult Dimensional Admission Criteria. Youth under 21 may be assessed to be at risk for developing a substance use disorder, and if applicable, must meet the ASAM adolescent diagnostic admission criteria. Beneficiaries under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health.

58. ***"Medical psychotherapy"*** means a type of counseling service that has the same meaning as defined in 9 CCR § 10345.

59. ***"Medication Services"*** means the prescription or administration of medication related to substance use disorder treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services.

60. ***"Modality"*** means those necessary overall general service activities to provide substance use disorder services as described in Division 10.5 of the HSC.

61. ***"Opioid (Narcotic) Treatment Program"*** means an outpatient clinic licensed by the state to provide narcotic replacement therapy directed at stabilization and rehabilitation of persons who are opiate-addicted and have a substance use diagnosis.

62. ***"Naltrexone Treatment Services"*** means an outpatient treatment service directed at serving detoxified opiate addicts by using the drug Naltrexone, which blocks the euphoric effects of opiates and helps prevent relapse to opiate addiction.

63. ***"Network"*** means the group of entities that have contracted with the PIHP to provide services under this Agreement.

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

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

66. ***"Non-Perinatal Residential Program"*** services are provided in DHCS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria. These residential services are provided to the non-perinatal population and do not require the enhanced services found in the perinatal residential programs.

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

    a. Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
    b. Formulary design for prescription drugs;
    c. Network tier design;
    d. Standards for provider admission to participate in a network, including reimbursement rates;
    e. Methods for determining usual, customary, and reasonable charges;
    f. Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
    g. Exclusions based on failure to complete a course of treatment;

h. Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services; and
i. Standards for providing access to out-of-network providers.

68. ***"Nonrisk Contract"*** means a contract between the state and a PIHP or PAHP under which the contractor-

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

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

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

70. ***"Observation"*** means the process of monitoring the beneficiary's course of withdrawal. It is to be conducted as frequently as deemed appropriate for the beneficiary and the level of care the beneficiary is receiving. This may include but is not limited to observation of the beneficiary's health status.

71. ***"Outpatient Services"*** means (ASAM Level 1.0) outpatient service directed at stabilizing and rehabilitating persons up to nine hours of service per week for adults, and less than six hours per week for adolescents.

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

73. ***"Patient Education"*** means providing research based education on addiction, treatment, recovery and associated health risks.

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

**Exhibit A, Attachment I A2**
Program Specifications

75. ***"Payment Suspension"*** means the Drug Medi-Cal certified provider has been issued a notice pursuant to WIC 14107.11 and is not authorized to receive payments after the payment suspension date for DMC services, regardless of when the service was provided.

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

77. ***"Perinatal DMC Services"*** means covered services as well as mother/child habilitative and rehabilitative services; services access (i.e., provision or arrangement of transportation to and from medically necessary treatment); education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant; and coordination of ancillary services (Title 22, Section 51341.1(c) 4).

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

79. ***"Physician Consultation"*** services are to support DMC physicians with complex cases, which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

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

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

82. ***"Postpartum"*** as defined for DMC purposes, means the 60-day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility for perinatal services shall end on the last day of the calendar month in which the 60th day occurs.

83. ***"Postservice Postpayment (PSPP) Utilization Review"*** means the review for program compliance and medical necessity, conducted by the state after service was rendered and paid. The Department may recover prior payments of Federal and state funds if such a review determines that the services did not comply with the applicable statutes, regulations, or terms as specified in Article III.PP of this Agreement.

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

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

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

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

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

(3) Does not have a comprehensive risk contract.

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

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

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

(3) Does not have a comprehensive risk contract.

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

(1) Prescribed by a physician or other licensed practitioner of the

healing arts within the scope of this professional practice as defined and limited by Federal and State law

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

(3) Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

89. ***"Primary Care"*** means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

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

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

(2) Development of enrollee care plans.

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

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

(5) Provision of enrollee outreach and education activities.

(6) Operation of a customer service call center.

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

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

(9) Coordination with behavioral health systems/providers.

(10) Coordination with long-term services and supports

systems/providers.

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

    (1) A physician assistant

    (2) A nurse practitioner

    (3) A certified nurse-midwife

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

93. ***"Primary care provider"*** means a person responsible for supervising, coordinating, and providing initial and Primary Care to patients, for initiating referrals, and for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.

94. ***"Projected Units of Service"*** means the number of reimbursable DMC units of service, based on historical data and current capacity, the Contractor expects to provide on an annual basis.

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

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

    (1) Is identified in the State Plan.

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

(3) Has a negative consequence for the beneficiary.

(4) Is auditable.

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

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

98. ***"Re-certification"*** means the process by which the DMC certified clinic is required to submit an application and specified documentation, as determined by DHCS, to remain eligible to participate in and be reimbursed through the DMC program. Re-certification shall occur no less than every five years from the date of previous DMC certification or re-certification.

99. ***"Recovery monitoring"*** means recovery coaching, monitoring via telephone and internet. Recovery monitoring is only available in Recovery services.

100. ***"Recovery Services"*** are available after the beneficiary has completed a course of treatment. Recovery services emphasize the patient's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to patients.

101. ***"Rehabilitation Services"*** includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.

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

**Exhibit A, Attachment I A2**
Program Specifications

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

**104.** ***"Residential Treatment Services"*** means a non-institutional, 24-hour non-medical, short-term residential program of any size that provides rehabilitation services to beneficiaries. Each beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills, and access community support systems. Programs shall provide a range of activities and services. Residential treatment shall include 24-hour structure with available trained personnel, seven days a week, including a minimum of five hours of clinical service a week to prepare beneficiary for outpatient treatment.

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

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

**107.** ***"Service Area"*** means the geographical area under Contractor's jurisdiction.

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

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

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

**111.** ***"Subcontract"*** means an agreement between the Contractor and its subcontractors. A subcontractor shall not delegate its obligation to provide covered services or otherwise subcontract for the provision of direct patient/beneficiary services.

**112.** ***"Subcontractor"*** means an individual or entity that is DMC certified and has entered into an agreement with the Contractor to be a provider of covered services. It may also mean a vendor who has entered into a procurement agreement with the Contractor to

provide any of the administrative functions related to fulfilling the Contractor's obligations under the terms of this Exhibit A, Attachment I.

113. ***"Substance Abuse Assistance"*** means peer-to-peer services and relapse prevention. Substance abuse assistance is only available in Recovery services.

114. ***"Substance Use Disorder Diagnoses"*** are those set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.

115. ***"Substance Use Disorder Medical Director"*** has the same meaning as in 22 CCR § 51000.24.4.

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

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

118. ***"Telehealth Between Provider and Beneficiary"*** means office or outpatient visits via interactive audio and video telecommunication systems.

119. ***"Telehealth Between Providers"*** means communication between two providers for purposes of consultation, performed via interactive audio and video telecommunications systems.

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

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

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

123. ***"Unit of Service"*** means:

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(A) For case management, intensive outpatient treatment, outpatient services, Naltrexone treatment services, and recovery services contact with a beneficiary in 15-minute increments on a calendar day.

(B) For additional medication assisted treatment, physician services that includes ordering, prescribing, administering, and monitoring of all medications for substance use disorders per visit or in 15-minute increments.

(C) For narcotic treatment program services, a calendar month of treatment services provided pursuant to this section and Chapter 4 commencing with 9 CCR § 10000.

(D) For physician consultation services, consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists in 15-minute increments.

(E) For residential services, providing 24-hour daily service, per beneficiary, per bed rate.

(F) For withdrawal management per beneficiary per visit/daily unit of service.

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

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

**126.** ***"Withdrawal Management"*** means detoxification services provided in either an ambulatory or non-ambulatory setting consistent with the ASAM level of care criteria to DMC ODS beneficiaries.

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## V. Contractor Specific Requirements

Beginning February 1, 2017 and ending June 30, 2019, in addition to the general requirements outlined in Exhibit A, Attachment I, the Contractor agrees to the following Contractor specific requirements:

### A. Covered Services

In addition to the Mandatory Covered Services outlined in Article III.C of Exhibit A, Attachment I, the Contractor shall establish assessment and referral procedures and shall arrange, provide, or subcontract for medically necessary Contractor specific covered services in the Contractor's service area in compliance with 42 CFR 438.210(a)(1), 438.210(a)(2), and 438.210(a)(3).

1. The Contractor shall deliver the Contractor Specific Covered Services within a continuum of care as defined in the American Society of Addiction Medicine (ASAM) criteria.

2. Contractor Specific Covered Services include:

   a. Additional Medication Assisted Treatment (MAT)

   b. Recovery Residences.

### B. Access to Services

In addition to the general access to services requirements outlined in Article III.F of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific access to services requirements:

#### 1. County Toll-Free Informational Phone Line:

   a. The Contractor shall maintain an information phone line during regular business hours for all community substance use, abuse, and prevention needs.

   b. Beneficiaries seeking services shall be immediately transferred to the Substance Use County Community Access, Referral, Evaluation and Support (SU CARES) screening counselors, or directed to the nearest clinic of their choice.

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2. **Beneficiary Access Line:**

   a. Beneficiaries and community members shall have access to the toll free SU CARES phone line, which shall have phone trees operated by personnel able to communicate in the applicable threshold languages.

   b. The toll free number shall offer general information about services, locations, and phone numbers to clinic locations. The SU CARES staff shall answer the beneficiary access line 24/7.

   c. The on-call staff shall be AOD counselors on rotation. Safety and detoxification needs shall be assessed immediately.

   d. Screenings shall either be conducted on the phone or in person at the assessment center.

   e. If after hours, on-call counseling personnel shall provide a screening by phone and utilize a laptop to document the screening responses and referrals.

   f. Once the predetermination of the ASAM Level of Care (LOC) is made the beneficiary shall be scheduled with a clinic for a complete assessment to determine diagnosis and medical necessity. For beneficiaries who are seeking treatment and would like to be screened by a clinician, the call shall be directly transferred to the SU CARES Team clinicians.

3. **Beneficiary point of entry:**

   a. Beneficiaries shall be able to utilize the SU CARES toll-free phone number to receive a phone screening. Alternatively, the beneficiaries shall be able to appear in person at a clinic, a school site (for an adolescent), and a court facility (for drug court beneficiaries).

4. **Initial Screening:**

   a. A Certified Substance Use Counselor, or Licensed Clinician shall be available at the SU CARES Assessment Center, Contractor Clinics, School Sites, and Drug Court Facilities to screen beneficiaries, enter beneficiary information into the Contractor's Electronic Health Record (EHR) system, and place the beneficiary in an appropriate ASAM LOC, including pre-treatment education classes and individual prevention services. The initial screening shall include American Society of Addiction Medicine Patient Placement Criteria (ASAM PPC).

b. The process for walk-in screenings and call-in screenings shall be identical. When a beneficiary calls the line they shall receive a complete ASAM based screening. Once the predetermination of the ASAM LOC is made the beneficiary shall be scheduled with a clinic or provider for a complete assessment to determine diagnosis and medical necessity. The ASAM screening and predetermination LOC shall be entered into the EHR at that time, and the beneficiary shall be linked to an appointment before the call is terminated.

c. For those in custody, jail screenings shall be conducted prior to release for timely and fluid beneficiary placement. (In-custody screenings are not reimbursable under the DMC-ODS system.)

**5. Complete ASAM Assessment:**

a. Once referred to a contracted provider or Contractor operated clinic the ASAM LOC, medical necessity, and diagnosis shall be completed by a Medical Director, Licensed Physician, or Licensed Practitioner of the Healing Arts (LPHA). This assessment shall include a face-to-face appointment within the time-frame required by Title 22 of the California Code of Regulations. If at that time the ASAM predetermination level and the ASAM level assessed by LPHA or Medical Director do not match, Care Coordination staff and clinic staff shall work on case management of the beneficiary to determine the appropriate LOC where the process shall repeat.

b. If a beneficiary does not meet medical necessity, they shall be referred to receive individual prevention services.

**C. Timely Access**

In addition to the general timely access requirements outlined in Article II.E of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific timely access requirements:

**1.** All beneficiaries requesting Substance Use Disorder (SUD) screening services shall be screened for need and ASAM LOC the same day, or given an appointment for screening the next business day. The beneficiary shall complete the ASAM 6-DIM screening during the initial phone call, initial face-to-face interaction, or during the scheduled appointment.

**2.** Once the ASAM predetermination LOC is made through the screening tool,

the beneficiary shall be scheduled for an appointment with a clinic or contracted provider for a complete intake and assessment to determine diagnosis and medical necessity.

3. Beneficiaries shall receive an intake assessment within 14 calendar days (goal in year one), and seven calendar days (goal in year two) for Contractor and subcontracted providers, dependent on modality after initial screening contact or request for service. Beneficiary preferences shall be considered such as cultural, geographical, gender, language and personal schedule. These variances and special circumstances shall be documented in the EHR contact log by the care coordinator assigned to the beneficiary.

4. The Care Coordination Team shall follow-up and guide the beneficiary to assist in engagement and ease of access.

5. Urgent conditions shall be addressed by the counselor while in contact with beneficiary. Counselor shall reach out to police, a 24/7 behavioral health team, or emergency personnel as the need arises.

**D. Coordination and Continuity of Care**

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

1. Beneficiaries shall be re-assessed using the ASAM criteria as the beneficiary moves through each modality of care. Each case shall be individualized based on the beneficiary's progress or lack of progress. Re-assessment can take place at any time, as deemed appropriate. At a minimum, assessment and/or reassessment, using ASAM criteria shall take place at the onset of each modality and every 90 days thereafter for outpatient, and every 30 days thereafter for residential, as well as at the conclusion of the modality to assess the next step in the continuum of treatment.

2. Care transition support teams shall be used for Mental Health Court and the County Substance Use Treatment Team (START) program. START works directly with hospitalized individuals with co-occurring disorders, or when hospitalization appears imminent, for psychiatric issues directly related, or exasperated, by dependency to chemicals, including alcohol.

3. The Contractor's Case Managers (certified counselors) shall work directly with providers and clinics to assist in linkage between modalities.

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4. All residential providers shall be contractually bound to contact the Contractor's Regional Care Coordination Team (CCT) staff when beneficiaries complete residential care, to aid beneficiary in linkage to outpatient services.

5. Case managers shall focus on collaborating with beneficiaries to:

   a. Establish accountability and beneficiary responsibility;

   b. Help with transitions of care;

   c. Create a proactive treatment plan with staff upon arrival at next modality; and

   d. Monitor and follow up as needed for beneficiary success and support of beneficiary's self-management goals.

6. Peer Support staff shall be used in the recovery services modality. Peer support staff shall not be used for reimbursable case management services.

7. Beneficiaries shall move through levels of care as individual progress takes place.

8. When a beneficiary receives inpatient substance use disorder (SUD) services (ASAM level 3.7 and 4.0 services) in an acute care hospital, or other Fee for Service (FFS) facility, the Contractor shall manage the needed transition of care to any lower level of care provided by a DMC-ODS provider. If the Contractor has subcontracted with either a Chemical Dependency Recovery Hospital (CDRH) or Acute Freestanding Psychiatric hospital for inpatient SUD services using other county funds, the same transition of care coordination is required.

9. Transitions for high-utilizers or individuals at risk of unsuccessful transitions shall be addressed in the following manner:

   a. Implement the high-utilizer's report and have care coordinators reach out to beneficiaries;

   b. Identify high-utilizers within the managed care system and work with them in the monthly case management meetings; and

c. Care Coordinators are to keep beneficiaries engaged, advocate on behalf of beneficiary, and provide linkages to levels of treatment and services.

## E. Memorandum of Understanding

In addition to the general memorandum of understanding requirements outlined in Article III.G.3 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor memorandum of understanding requirements:

1. The Contractor shall have Memorandums of Understanding (MOU's) with managed care plans, and shall use the MOU's to meet the requirements of the DMC-ODS Waiver implementation:

2. In addition to the MOU's with managed care plans, the Contractor also has MOU's in place with the following Riverside County agencies:

   a. Probation Department;

   b. Riverside University Health System – Public Health (RUHS-PH); and

   c. Department of Public Social Services.

## F. Authorization of Services – Residential Programs

In addition to the general authorization of residential services requirements outlined in Article III.H of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific authorization of residential services requirements:

1. Placement in a residential bed shall require a physician, medical director, or LPHA to authorize medical necessity once placed with provider.

2. Screening and the subsequent referral shall be the first approval for services. Admission pre-authorization paperwork from provider shall be confirmation of the authorization and that the beneficiary appeared for their appointment and was admitted. Pre-authorization paperwork shall be submitted within 24 hours of beneficiary's admission. Substance Use Administration shall review, approve, pend, or deny within 24 hours of receipt of preauthorization paperwork so that treatment services are not interrupted or withheld without notice.

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## G. Early Intervention (ASAM Level 0.5)

In addition to the general early intervention services requirements outlined in Article III.N of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific early intervention services requirements:

1. A collaboration to provide Screening, Brief Intervention and Referral to Treatment (SBIRT) shall be made for the adult and adolescent populations. This collaboration shall be with the existing managed care plans through MOU's and Riverside County Office of Education. (SBIRT services shall not be paid for under the DMC-ODS system.)

2. Additionally, each Contractor operated Substance Use Clinic shall have a Prevention Specialist assigned to facilitate this LOC.

3. Screening and education shall be provided for at-risk individuals who do not meet medical necessity for SUD treatment. Services may include individual prevention services, recovery and education services, and Driving Under the Influence Programs.

4. Programs at this level shall be designed to explore services and address problems or risk factors, related to the use of alcohol or other drugs and addictive behaviors, and to help recognize consequences of high-risk use and behaviors.

5. School sites shall be utilized to offer early intervention services to adolescents.

6. Prevention Curriculum: (SAPT programs shall not be paid for under DMC-ODS system.)

    a. The Contractor shall utilize its Individual Prevention Services (IPS) program. The IPS program is designed to work with the indicated prevention population, which consists of those individuals that have started experimenting with the use of alcohol and/or other drugs, and are beginning to experience some negative consequences, but are not yet at a level where they meet the diagnostic criteria for a SUD. This program shall use the Brief Risk Reduction Interview and Intervention Model (BRRIIM) as the foundation of the intervention.

b. The Contractor shall utilize its Friday Night Live (FNL) program The FNL program shall utilize the following standards of practice:

i. Providing youth with a safe environment;

ii. Providing youth with the opportunity for developing meaningful relationships with adults and their peers;

iii. Providing youth with the opportunity for community engagement;

iv. Providing youth with the opportunity for skill development; and

v. Providing youth with the opportunity for leadership advocacy.

**H. Outpatient Services (ASAM Level 1)**

In addition to the general outpatient services requirements outlined in Article III.O of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific outpatient services requirements:

**1.** The Contractor's outpatient services shall treat the individual's level of problem severity, assist in achieving permanent change in behaviors, and improve mental functioning (conducted in less than 9 hours per week for adults and less than 6 hours per week for adolescents).

**2.** The Contractor's outpatient services shall address personal lifestyles, attitudes and behaviors that can impact or prevent accomplishing the goals of treatment.

**3.** Outpatient Service Curriculum:

a. The following Evidenced Based Practices (EBPs) shall be utilized in outpatient clinics:

i. Cognitive Behavioral Therapy (CBT);

ii. Motivational Interviewing;

iii. Stages of Change;

iv. Seeking Safety;

v. Dialectical Behavioral Therapy (DBT); and

vi. BRRIIM.

4. The Contractor shall have training line staff and "Train the Trainers" for the following EBPs:

   a. Living in Balance;

   b. A New Direction, A CBT Curriculum;

   c. CBT for Post-Traumatic Stress Disorder (PTSD) for Addiction Professionals;

   d. Coping with Stress: Trauma for Youth; and

   e. The Matrix Model for Adults and Adolescents.

**I. Intensive Outpatient Services (ASAM Level 2.1)**

In addition to the general intensive outpatient services requirements outlined in Article III.P of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific intensive outpatient services requirements:

1. The Contractor's intensive outpatient services shall provide weekly structured treatment for a minimum of nine 9 and maximum of 19 hours per week for adults, and a minimum of 6 and maximum of nineteen 19 hours per week for adolescents to treat multidimensional instability.

2. Intensive outpatient services shall be provided at Contractor's clinics, contracted provider sites, satellite school sites, or school district offices, pursuant to needs of the specific school.

3. Intensive outpatient services shall consist of counseling and education relating to substance-presented and mental health problems and/or disorders, and gender/age specific needs.

4. Psychiatric and medical services shall be addressed through consultation and referral arrangements depending on the stability of the individual.

5. Intensive Outpatient Curriculum:

   a. The Contractor shall have clinic counselors trained in the following EBPs for Intensive Outpatient services:

      i. The Matrix Model Training: A treatment that is delivered in individual and group sessions that focuses on addressing important issues in the areas of initial stabilization, abstinence, maintenance, and relapse prevention during the recovery process; and

      ii. CBT for PTSD for Addiction Professionals: An approach for people with trauma-related psychological symptoms.

**J. Residential Treatment Services**

In addition to the general residential treatment services requirements outlined in Article III.Q of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific residential treatment services requirements:

1. Residential treatment services shall be provided in a 24-hour residential setting and are staffed 24-hours a day.

2. Individuals meeting this LOC have functional deficits and require a safe and stable living environments to assist in developing their recovery skills.

3. The residential treatment program daily regimen and structured activities shall be intended to restore cognitive functioning and build behavioral patterns.

4. Goals for residential treatment services include sustaining abstinence, preparing for relapse triggers, improving personal health and social functioning, and engaging in continuing care.

5. Residential treatment levels 3.1 and 3.5 shall be made available in the Contractor's system of care in year-one.

6. Residential treatment level 3.3 shall be made available in the Contractor's system of care in year-two.

7. Coordination of Care for 3.7- WM and 4.0-WM and Residential 3.7 and 4.0 will be managed by the Contractor's Regional CCT and Managed Care Behavioral Health (BH) case managers.

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## K. Case Management

In addition to the general case management requirements outlined in Article III.R of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific case management requirements:

1. All mandated case management functions shall be monitored by the Contractor's Quality Improvement (QI) personnel, in accordance with the Contractor's QI plan.

2. The Contractor shall utilize case management services to help beneficiaries achieve their goals throughout treatment.

3. Case management shall begin as soon as a beneficiary engages in the Contractor's initial screening process.

4. Case Management Services shall be provided to all beneficiaries, with a strong emphasis on high-utilizers to avoid hospitalization and higher medical costs. Beneficiaries shall be guided through the system of care, linkages shall be made to ancillary services, and beneficiaries shall be guided in connecting the next needed ASAM LOC from detoxification through recovery services (aftercare).

5. Case Management shall be utilized as a method to provide thorough discharge planning, implementing Aftercare Plans that include access to on-going Recovery Support Services, vocational rehabilitation, sober housing, access to childcare, and parenting services to enhance the capacity of each beneficiary to achieve long-term recovery.

6. The emphasis of Case Management services shall be to:

    a. Target beneficiaries who have had multiple treatment attempts;

    b. Make sure the stages of their recovery are being managed at the appropriate level for that beneficiary; and

    c. Ensure the beneficiary has a 'Risk and Protective Factors' assessment and an Aftercare Plan that addresses 'risks' and enhances 'protective' factors.

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7. Each Case Manager shall be trained to avail needed knowledge, skills, and attitudes, which prepare them to provide more treatment-specific services.

8. Effective practice of case management includes the ability to establish rapport quickly, an awareness of how to maintain appropriate boundaries in the fluid case management relationship, and the willingness to be nonjudgmental towards beneficiaries.

9. Care Coordination Teams shall take part in case management, care coordination, and movement through modalities by ASAM reassessment. Providers and Contractor clinic staff may also use case management services as adjunct services to outpatient and intensive outpatient to improve beneficiary's ability to navigate their active treatment episode.

10. Linkage and support from assigned case management staff can include needs such as:

    a. Chemical dependency and rehabilitative needs;

    b. Medical;

    c. Legal;

    d. Social;

    e. Education;

    f. Employment; and

    g. Financial.

11. Case managers' duties may also include beneficiary advocacy with the following referring agencies: (Disclosure of beneficiary information shall comply with HIPAA and 42 CFR Part 2.)

    a. County courts;

    b. Department of Public Social Services;

    c. Probation Department;

d. Beneficiary employers; and

e. Parole officers.

## L. Physician Consultation

In addition to the general physician consultation requirements outlined in Article III.S of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific physician consultation requirements:

1. DMC physicians requesting physician consultation services with complex cases shall be available for MAT services, medication issues, and LOC recommendations.

## M. Recovery Services

In addition to the general recovery services requirements outlined in Article III.T of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific recovery services requirements:

1. Continuing care is the stage following discharge, when the beneficiary no longer requires services at the intensity required during primary treatment. Beneficiaries shall continue to reorient their behavior to the ongoing reality of a pro-social, sober lifestyle.

2. Aftercare shall occur in a variety of settings, such as periodic outpatient aftercare, relapse/recovery groups, and linkage to 12-Step and self-help groups, as well as linkage to sober living housing through case management. (Non-DMC recovery services will not be reimbursable under the DMC-ODS system.)

3. Whether individuals completed primary treatment in a residential or outpatient program, they shall develop the skills to maintain sobriety and begin work on remediating various areas of their lives. This work shall be intrapersonal and interpersonal, and environmental. Case management areas that relate to environmental issues shall include vocational rehabilitation, finding employment, and securing safe housing.

4. Linkages to these recovery services shall be provided in clinics by certified substance abuse counselors, licensed clinicians, and peer support specialists.

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**5.** Some of the components of the Contractor's Recovery Services model include:

a. Outpatient Counseling and Reassessment

i. Drop in assessment, individual, and group counseling shall be available for beneficiaries who feel triggered or may have relapsed;

ii. Evidenced based curriculum shall be used in both individual and group formats. The topics shall include building self-esteem, ambivalence or acceptance, process of change, spirituality, serenity, cognitive distortions, stress management, anger control plans, assertiveness, anger and the family, challenging relapse factors, warning signs and life and addiction;

b. Recovery Monitoring

i. Coaching shall be used to assist beneficiaries who may feel they are in danger of relapsing or participating in destructive behaviors. Peer Specialists shall follow up with beneficiary graduates regularly to offer re-lapse prevention support and encouragement; and

ii. Training and education for the individual and/or family on the effects of drug and alcohol use.

c. Education & Job Skills

i. Assistance with developing education objectives and filling out forms shall be provided; and

ii. Training on life and living skills including managing money, hygiene, self-care, refusal skills, looking for work, making decisions, values, and personal responsibility.

d. Family Support

i. Assistance and education for beneficiaries and their families to understand triggers and cravings, stages of family recovery, coping with relapse, medical aspects of dependency and living with addiction; and