STATE OF CALIFORNIA
STANDARD AGREEMENT
STD 213_DHCS (Rev. 06/16)

REGISTRATION NUMBER	AGREEMENT NUMBER
	16-93236

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

STATE AGENCY'S NAME (Also known as DHCS, CDHS, DHS or the State)
Department of Health Care Services

CONTRACTOR'S NAME (Also referred to as Contractor)
County of Santa Clara

2. The term of this Agreement is: June 15, 2017 through June 30, 2019

3. The maximum amount of this Agreement is: $ 130,951,922
One Hundred Thirty Million, Nine Hundred Fifty-One Thousand, Nine Hundred Twenty-Two Dollars

4. The parties agree to comply with the terms and conditions of the following exhibits, which are by this reference made a part of this Agreement.

Exhibit A – Scope of Work	5 pages
Exhibit A, Attachment I – Program Specifications	112 pages
Exhibit B – Budget Detail and Payment Provisions	20 pages
Exhibit B, Attachment I – Funding Amounts	1 page
Exhibit C * – General Terms and Conditions	GTC 610
Exhibit D (F) – Special Terms and Conditions	26 pages
Exhibit E – Additional Provisions	4 pages
Exhibit F – Privacy and Information Security Provisions	29 pages
Exhibit F, Attachment I – Social Security Administration Agreement	92 Pages

Attest:
Original Signed By:
Megan Doyle, Clerk
Board of Supervisors

Items shown above with an Asterisk (*), are hereby incorporated by reference and made part of this agreement as if attached hereto.
These documents can be viewed at http://www.dgs.ca.gov/ols/Resources/StandardContractLanguage.aspx.

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

CONTRACTOR

CONTRACTOR'S NAME *(if other than an individual, state whether a corporation, partnership, etc.)*
County of Santa Clara

DATE SIGNED *(Do not type)*: 5/1/2017

Dave Cortese, President, Board of Supervisors

ADDRESS
976 Lenzen Avenue, 3rd Floor
San Jose CA 95126-2737

STATE OF CALIFORNIA

AGENCY NAME
Department of Health Care Services

BY *(Authorized Signature)*: Kelley Domina

DATE SIGNED *(Do not type)*: 5/15/17

PRINTED NAME AND TITLE OF PERSON SIGNING
~~Kelley Domina~~
~~Don Rodriguez, C~~

ADDRESS
1501 Capitol Avenue, Suite 71.2048, MS 1400, P.O. Box 997413, Sacramento, CA 95899-7413

California Department of General Services Use Only

[X] Exempt per: DGS memo dated 07/10/96 and Welfare and Institutions Code 14087.4

Original Signed by: Toni Tullys, Director, Behavioral Health Services; John Cookinham, Santa Clara Valley Health and Hospital System's Chief Financial Officer; and Lorraine Van Kirk, County Counsel for the BHSD Department on 5/1/2017.

VENDOR'S COPY

APR 25 2017

85270

Exhibit A
Scope of Work

1. Service Overview

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

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

State and the Contractor enter into this Intergovernmental 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. State and the Contractor identified in the Standard Agreement are the only parties to this Intergovernmental Agreement. This Intergovernmental Agreement is not intended, nor shall it be construed, to confer rights on any third party.

State and the Contractor enter into this Intergovernmental Agreement for the purpose of identifying and providing for covered Drug Medi-Cal (DMC) services for substance use treatment in the Contractor's service area pursuant to Sections 11848.5(a) and (b) of the Health and Safety Code (hereinafter referred to as HSC), Sections 14021.51 – 14021.53, and 14124.20 – 14124.25 of the Welfare and Institutions Code (hereinafter referred to as W&IC), and Title 22 of the California Code of Regulations (hereinafter referred to as Title 22), Sections 51341.1, 51490.1, and 51516.1, and Part 438 of the Code of Federal Regulations, hereinafter referred to as 42 CFR 438.

State and the Contractor enter into this Intergovernmental Agreement by authority of Title 45 of the Code of Federal Regulations Part 96 (45 CFR Part 96), Substance Abuse Prevention and Treatment Block Grants (SAPT Block Grant) for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse. SAPT Block Grant recipients must adhere to Substance Abuse and Mental Health Administration's (SAMHSA) National Outcome Measures (NOMs).

The objective is to make substance use treatment services available to Medi-Cal and other non-DMC beneficiaries through utilization of federal and state funds available pursuant to Title XIX and Title XXI of the Social Security Act and the SAPT Block Grant for reimbursable covered services rendered by certified DMC providers.

2. Service Location

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

3. Service Hours

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

Exhibit A
Scope of Work

4. Project Representatives

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

Department of Health Care Services	**Contractor's/Grantee's Name**
Contract/Grant Manager: Alice Trujillo Telephone: (916) 327-2696 Fax: (916) 322-1176 Email: Alice.Trujillo@dhcs.ca.gov	County Administrator: Bruce Copley, Director Telephone: (408) 792-5692 Fax: (408) 947-8703

B. Direct all inquiries to:

Department of Health Care Services	**Contractor's/Grantee's Name**
Department of Health Care Services SUD PPFD - PSGMB Attention: Robert Strom Mail Station Code 2624 P.O. Box 997413 Sacramento, CA, 95899-7413 Telephone: (916) 327-2701 Fax: (916) 322-1176 Email: Robert.Strom@dhcs.ca.gov	Santa Clara County Alcohol and Drug Services Attention: County AOD Program Administrator 976 Lenzen Avenue, 3rd Floor San Jose, CA 95126-2737 Telephone: (408) 792-5692 Fax: (408) 947-8703

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

5. Americans with Disabilities Act

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

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

7. Reference Documents

The following documents are hereby incorporated by reference into the DMC-ODS Waiver

Exhibit A
Scope of Work

contract though they may not be physically attached to the contract but will be issued in a CD under separate cover:

Document 1A: Title 45, Code of Federal Regulations 96, Subparts C and L, Substance Abuse Prevention and Treatment Block Grant Requirements

https://www.gpo.gov/fdsys/granule/CFR-2005-title45-vol1/CFR-2005-title45-vol1-part96

Document 1B: Title 42, Code of Federal Regulations, Charitable Choice Regulations

https://www.law.cornell.edu/cfr/text/42/part-54

Document 1C: Driving-Under-the-Influence Program Requirements

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

Document 1G: Perinatal Services Network Guidelines 2016

Document 1H(a): Service Code Descriptions

Document 1J(a): Non-Drug Medi-Cal Audit Appeals Process

Document 1J(b): DMC Audit Appeals Process

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

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

Document 1P: Alcohol and/or Other Drug Program Certification Standards (March 15, 2004)

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

Document 1T: CalOMS Prevention Data Quality Standards

Document 1V: Youth Treatment Guidelines

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

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

Document 2C: Title 22, California Code of Regulations

http://ccr.oal.ca.gov

Document 2E: Drug Medi-Cal Certification Standards for Substance Abuse Clinics (Updated July 1, 2004)

http://www.dhcs.ca.gov/services/adp/Documents/DMCA_Drug_Medi-Cal_Certification_Standards.pdf

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

http://www.dhcs.ca.gov/services/adp/Documents/DMCA_Standards_for_Drug_Treatment_Programs.pdf

Document 2G Drug Medi-Cal Billing Manual

http://www.dhcs.ca.gov/formsandpubs/Documents/Info%20Notice%202015/DMC_Billing_Manual%20FINAL.pdf

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

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

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

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

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

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

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

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

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

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

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

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

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

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

http://www.calregs.com

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

http://www.calregs.com

Document 3J: CalOMS Treatment Data Collection Guide

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

Document 3O: Quarterly Federal Financial Management Report (QFFMR) 2014-15

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

Document 3S CalOMS Treatment Data Compliance Standards

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

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

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

Document 5A : Confidentiality Agreement

Exhibit A, Attachment I
Program Specifications

1. Provision of Services

This Intergovernmental Agreement is entered into by and between the Department of Health Care Services (DHCS) and the Contractor for the purpose of identifying and providing for covered Drug Medi-Cal (DMC) services for substance use disorder (SUD) treatment in the Contractor's service area pursuant to Sections 11848.5(a) and (b) of the Health and Safety Code (hereinafter referred to as HSC), Sections, 14021.51 – 14021.53, and 14124.20 – 14124.25 of the W&I Code, Sections and Title 22 of the California Code of Regulations (hereinafter referred to as Title 22), Sections 51341.1, 51490.1, and 51516.1, and Part 438 of the Code of Federal Regulations (hereinafter referred to as 42 CFR 438).

A. It is further agreed this Intergovernmental Agreement is controlled by applicable provisions of: (a) the W&I Code, Chapter 7, Sections 14000, et seq., in particular, but not limited to, Sections 14100.2, 14021, 14021.5, 14021.6, 14043, et seq., (b) Title 22, including but not limited to Sections 51490.1, 51341.1 and 51516.1; and (c) Division 4 of Title 9 of the California Code of Regulations (hereinafter referred to as Title 9).

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

C. The objective of this Intergovernmental Agreement is to make SUD treatment services available to Medi-Cal beneficiaries through utilization of federal and state funds available pursuant to Title XIX or Title XXI of the Social Security Act for reimbursable covered services rendered by certified DMC providers. These services shall be provided through a Prepaid Inpatient Hospital Plan (PIHP) as defined in 42 CFR 438.2.

D. Awards under the Medical Assistance Program (CFDA 93.778) are no longer excluded from coverage under the Health and Human Services (HHS) implementation of the A-102 Common Rule, 45 CFR part 92 (*Federal Register*, September 8, 2003, 68 FR 52843-52844). This change is effective for any grant award under this program made after issuance of the initial awards for the second quarter of Federal Fiscal Year 2004. This program also is subject to the requirements of 45 CFR part 95 and the cost principles under Office of Management and Budget Circular A-87 (as provided in *Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government*, HHS Publication ASMB C-10, available on the Internet at http://www.dol.gov/oasam/boc/ASMB C-10.pdf.

E. The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a Medi-Cal benefit provided by, and within, this county (Contractor) through a county operated PIHP as defined in 42 CFR 438.2. The Medi-Cal DMC-ODS waiver program covers only drug Medi-Cal services and is limited to the coverage of DMC-ODS services. Accordingly, the following provisions of 42 CFR 438 are not applicable to the DMC-ODS waiver: 1) obtaining information regarding advanced directives (42 CFR 438.6(i), 2) marketing activities (42 CFR 438.104), 3) providing emergency post-stabilization services (42 CFR 438.114), 4) solvency standards (42 CFR 438.116), 5) women's health services (42 CFR 438.206(b)(2) and 6) identification of individuals with special health care needs (42 CFR 438.208(c)(1) (there is no difference in the provision of services for special needs populations and any other covered population under the DMC-ODS waiver program). In

addition, no family planning services, including abortion procedures, are provided through the DMC-ODS waiver; therefore 42 CFR 431.51(b)(2) and 441.202 are not applicable. Finally, the disclosure requirements set forth in 42 CFR 455.100-104 are not applicable to the DMC-ODS waiver given that each PIHP is county owned and operated.

Under this DMC-ODS waiver program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive DMC-ODS services through a single county operated PIHP. Based on this service delivery model, DHCS has requested, and CMS has granted approval to waive the following provisions for the DMC-ODS delivery model: 1) choice of PIHP (42 CFR 438.52), 2) allowance of disenrollment (42 CFR 438.56) (beneficiaries shall be provided with a choice of providers within the PIHP and an opportunity to change providers whenever feasible), and 3) notice required by 42 CFR 438.10(f)(3).

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

This Agreement requires Contractor to provide all information that meets the content requirements of 42 CFR 438.10. This Agreement also requires Contractor to provide this information to all potential and actual beneficiaries upon their request, when they first access services under the DMC-ODS waiver and, within 30 days of any change. Any additional information distribution requirements are not required under this Agreement.

Pursuant to 42 CFR 438.100, the Contractor shall comply with any applicable Federal and State laws that pertain to beneficiary rights and shall ensure that its staff and affiliated providers take those rights into account when furnishing services under this Agreement to beneficiaries. Contractor shall provide information regarding these rights to potential and current beneficiaries as specified in Section 14 of this Agreement since the notice required by 42 CFR 438.10(f)(3) has been waived.

DHCS shall have in effect safeguards against conflicts of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to this Agreement or the default enrollment process as described by 42 CFR 438.58.

F. Contractor shall not receive payment for services not available under this Agreement in accordance with 42 CFR 438.60:

1) DHCS must ensure that no payment is made to a provider other than the Contractor for services available under the Intergovernmental Agreement between the DHCS and the Contractor, except when these payments are provided for in Title XIX of the Act, in 42 CFR, or when DHCS has adjusted the capitation rates paid under the Intergovernmental Agreement, in accordance with §438.6(c)(5)(v), to make payments for graduate medical education.

G. Provider Specifications

The following requirements shall apply to Contractor and subcontractor staff:

1) Professional staff must be licensed, registered, certified or recognized under California scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioner of the Healing Arts (LPHA):

   a) Physician
   b) Nurse Practitioners
   c) Physician Assistants
   d) Registered Nurses
   e) Registered Pharmacists
   f) Licensed Clinical Psychologists
   g) Licensed Clinical Social Worker
   h) Licensed Professional Clinical Counselor
   i) Licensed Marriage and Family Therapists
   j) License Eligible Practitioners working under the supervision of Licensed Clinicians

2) Non Professional staff shall receive appropriate onsite orientation and training prior to performing assigned duties. Non-professional staff shall be supervised by professional and/or administrative staff.

3) Professional and Non-Professional staff are required to have appropriate experience and any necessary training at the time of hiring.

4) Registered and certified SUD counselors shall adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8.

H. Services for Adolescents and Youth

At a minimum, assessment and services for adolescents will follow the American Society of Addiction Medicine (ASAM) adolescent treatment criteria.

1.1 Organized Delivery System (ODS) Timely Coverage

A. Non-Discrimination

Member Discrimination Prohibition

Exhibit A, Attachment I
Program Specifications

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

1) Title VI of the Civil Rights Act of 1964

2) Title IX of the Education Amendments of 1972 (regarding education and programs and activities)

3) The Age Discrimination Act of 1975

4) The Rehabilitation Act of 1973

5) The Americans with Disabilities Act

6) Enrollment discrimination prohibited. Intergovernmental Agreements with Managed Care Organizations (MCOs), PIHPs, Prepaid Ambulatory Health Plans (PAHPs), and Primary Care Case Managers (PCCMs) must provide as follows:

   (a) The Contractor accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by the Regional Administrator), up to the limits set under the Intergovernmental Agreement.

   (b) Enrollment is voluntary, except in the case of mandatory enrollment programs that meet the conditions set forth in §438.50(a).

   (c) The Contractor will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll.

   (d) The Contractor will not discriminate against individuals eligible to enroll under the laws of the United States and the State of California, and will not use any policy or practice that has the effect of discriminating on the basis of this section.

B. DMC-ODS services shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in this opt in County. Determination of who may receive the DMC-ODS benefit shall be performed as follows (ODS Standard Terms and Conditions (STC) 128(e) pursuant to 42 CFR 438.210: (STC's found at: http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_FINAL_STC_12-30-15.pdf)

1) The Contractor or its subcontracted provider must verify the Medicaid eligibility determination of an individual. When the subcontracted provider conducts the initial eligibility verification, that verification shall be reviewed and approved by the Contractor prior to payment for services, unless the individual is eligible to receive services from tribal health programs operating under the Indian Self Determination and Education Assistance Act (ISDEAA – Pub.L 93-638, as amended) and urban Indian organizations operating under Title V of the IHCIA. If the individual is eligible

to receive services from tribal health programs operating under the ISDEAA, then the determination shall be conducted as set forth in the Tribal Delivery System - Attachment BB to the STCs.

2) The initial medical necessity determination for an individual to receive a DMC-ODS benefit must be performed through a face-to-face review or telehealth by a Medical Director, licensed physician, or Licensed Practitioner of the Healing Arts (LPHA) as defined in Section 142(a) of the STCs. After establishing a diagnosis, the American Society of Addiction Medicine (ASAM) Criteria shall be applied by the diagnosing individual to determine placement into the level of assessed services.

    a) Medical necessity for an adult (an individual age 21 and over) is determined using the following criteria:

        i. The individual must have received at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders;

        ii. The individual must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.

    b) Individuals 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 the age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Nothing in the DMC-ODS Pilot overrides any EPSDT requirements.

    Medical necessity for an adolescent individual (an individual under the age of 21) is determined using the following criteria:

        i. The adolescent individual must be assessed to be at risk for developing a SUD; and

        ii. The adolescent individual must meet the ASAM adolescent treatment criteria.

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

C. Beneficiaries shall be mandatorily enrolled in the Contractor's PIHP and the Contractor's enrollment process shall be consistent with 42 CFR 438.6(d); 42 CFR 438.50(a).

D. Contractor shall notify all beneficiaries of their disenrollment rights annually in accordance with 42 CFR 438.10(f)(1).

1.2 Covered Services

A. The Contractor shall provide the Covered Services as a Prepaid Inpatient Hospital Plan (PIHP) pursuant to 42 CFR 438.210(a)(1) and (2), and 42 CFR 438.210(a)(3)(i), (ii), and (iii). Additionally, the Contractor shall:

1) Identify, define, and specify the amount, duration, and scope of each service that the Contractor is required to offer.

2) Require that the services identified in paragraph (1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in 42 CFR 440.230.

3) Provide that the Contractor:

a) Shall ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

b) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

c) May place appropriate limits on a service

i. On the basis of criteria applied under the State plan, such as medical necessity; or

ii. For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (A)(3)(a) of this section.

4) Specify what constitutes "medically necessary services" in a manner that:

a) Is no more restrictive than that used in the State Medicaid program as indicated in California State statutes and regulations, the California State Plan, and other California State policy and procedures; and

b) Addresses the extent to which the Contractor is responsible for covering services related to the following:

i. The prevention, diagnosis, and treatment of health impairments.

ii. The ability to achieve age-appropriate growth and development.

iii. The ability to attain, maintain, or regain functional capacity.

B. Contractor shall establish assessment and referral procedures and shall arrange, provide, or subcontract for medically necessary Mandatory 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). The Contractor shall deliver the Covered Services within a continuum of care as defined in the ASAM criteria. Mandatory Covered Services include:

1) Withdrawal Management (minimum one level);

2) Intensive Outpatient;

3) Outpatient;

4) Opioid (Narcotic) Treatment Programs;

5) Recovery Services;

6) Case Management;

7) Physician Consultation;

8) Perinatal Residential Substance Abuse Services (excluding room and board); and

a) Room and board shall be reimbursable through the Substance Abuse Prevention and Treatment Block Grant (SAPT BG) treatment funding allocated to the Contractor.

9) Nonperinatal Residential Substance Abuse Services (excluding room and board);

a) Room and board shall be reimbursable through the SAPT BG treatment funding allocated to the Contractor.

C. In the event of a conflict between the definition of services contained in this Section of the Intergovernmental Agreement, and the definition of services in Title 22, Sections 51341.1, 51490.1, and 51516.1, the provisions of Title 22 shall govern.

D. Contractor, to the extent applicable, shall comply with "Sobky v. Smoley" (Document 2A), 855 F. Supp. 1123 (E.D. Cal 1994), incorporated by this reference.

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

1) If DMC services are provided to Minor Consent beneficiaries, Contractor shall comply with California Family Code Section 6929, and California Code of Regulations, Title 22, Sections 50147.1, 50030, 50063.5, 50157(f)(3), 50167(a)(6)(D), and 50195(d).

1.3 Financing

A. Payment for Services

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

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

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

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

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

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

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

B. Rate Setting

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

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

2) OTP/NTP reimbursement rate shall be set by the DHCS Rate Setting Work Group pursuant to the process set forth in W&I Code, Section 14021.51. The Contractor shall reimburse all OTP/NTP providers at this rate.

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

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

3) Pursuant to W&I Code, Section 14124.24(h), the Contractor shall not require OTP/NTP providers to submit cost reports to the Contractor for the purpose of cost settlement.

2. Availability and Accessibility of Service

2.1 Availability of Services

A. Pursuant to 42 CFR 438.206(a) and (b), the Contractor shall consider the numbers and types (in terms of training, experience and specialization) of providers required to ensure the availability and accessibility of medically necessary services. At a minimum, the Contractor shall meet the following requirements:

1) The Contractor shall maintain and monitor a network of appropriate providers that is supported by written agreements for subcontractors and that is sufficient to provide its beneficiaries with adequate access to all services covered under this Intergovernmental Agreement. In establishing and monitoring the network, the Contractor must document the following:

a) The anticipated number of Medi-Cal eligible beneficiaries;

b) The expected utilization of services, taking into account the characteristics and SUD treatment needs of beneficiaries;

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

d) The numbers of network providers who are not accepting new beneficiaries;

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

f) To the extent required by 42 CFR 438.206(b)(4), if the Contractor is unable to provide necessary medical services covered under the Intergovernmental Agreement to a particular beneficiary, the Contractor must adequately and timely cover these services out of network for the beneficiary, for as long as the Contractor is unable to provide them;

g) Pursuant to 42 CFR 438.206(b)(5) the Contractor shall require that out-of-network providers coordinate authorization and payment with the Contractor. As is consistent with 42 CFR 438.106, the Contractor must ensure that the cost to the beneficiary for services provided out of network pursuant to an authorization is no greater than it would be if the services were furnished within the Contractor's network; and

h) The Contractor shall demonstrate that its providers are credentialed according to Section 1(G) of this Agreement and pursuant to 42 CFR 438.214.

2.2 Access to Services

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

1) When a request for covered services is made by a beneficiary, Contractor shall require services to be initiated with reasonable promptness. Contractor shall have a documented system for monitoring and evaluating the quality, appropriateness and accessibility of care, including a system for addressing problems that develop regarding waiting times and appointments.

2) The contractor shall authorize DMC-ODS services in accordance with the medical necessity criteria specified in Title 22, Section 51303 and the coverage provisions of the approved state Medi-Cal Plan. For residential services, room and board are not reimbursable DMC services. If services are denied, the provider shall inform the beneficiary in accordance with Title 22, Section 51341.1 (p) and 42 CFR 438.404.

a) The Contractor must provide prior authorization for residential services within 24 hours of the prior authorization request being submitted by the provider,

i. Prior authorization is not required for non-residential DMC-ODS services.

b) The Contractor shall review the DSM and ASAM Criteria to ensure that the beneficiary meets the requirements for the service.

c) The Contractor shall have written policies and procedures for processing requests for initial and continuing authorization of services.

d) The Contractor shall have a mechanism in place to ensure that there is consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate.

e) The Contractor shall meet the following timelines for decisions for service
f) authorization.

i. Contractor must provide for the following decisions and notices:

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

(i) The beneficiary, or the provider, requests extension; or

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

b. Expedited authorization decisions.

(i) For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the beneficiary’s life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than 3 working days after receipt of the request for service.

(ii) The Contractor may extend the 3 working days time period by up to 14 calendar days if the beneficiary requests an extension, or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the beneficiary's best interest.

g) The Contractor shall track the number, percentage of denied requests, and timeliness of requests for authorization for all DMC-ODS services that are submitted, processed, approved and denied.

3) Contractor shall provide notice to the beneficiary that the timeframe was not met, as required above, on the date that the timeline was not met.

4) Pursuant to 42 CFR 438.6(m), the Contractor shall allow each beneficiary to choose his or her health professional to the extent possible and appropriate.

5) The Contractor shall require that treatment programs are accessible to people with disabilities in accordance with Title 45, Code of Federal Regulations (hereinafter referred to as CFR), Part 84 and the Americans with Disabilities Act.

6) Pursuant to 42 CFR 438.206(b)(3), when requested by the beneficiary, the Contractor must provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the beneficiary to obtain one outside the network, at no cost to the beneficiary.

7) The Contractor shall have a 24/7 toll free number for prospective beneficiaries to call to access DMC-ODS services. The Contractor shall make oral interpretation services available for beneficiaries, as needed.

8) Covered services, whether provided directly by the Contractor or through subcontractor with DMC certified and enrolled programs, shall be provided to beneficiaries in the following manner:

   a) Standard DMC services approved through the State Plan Benefit shall be available to all beneficiaries regardless of county of residence.

   b) Access to State Plan services must remain at the current, pre-implementation level or expand upon implementation of the Pilot.

9) The failure of the Contractor or its subcontractor to comply with Section 2.2 shall be deemed a breach of this Intergovernmental Agreement resulting in the termination of this Intergovernmental Agreement for cause. In the event the Intergovernmental Agreement is terminated, the provision of this Exhibit, Attachment I, Section 17(B), shall apply.

2.3 Timely Access

A. In accordance with 42 CFR 438.206(c)(1), the Contractor shall comply with the following requirements:

1) Meet and require its providers to meet DHCS standards for timely access to care and services, taking into account the urgency of need for services;

2) Require subcontracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. If the provider only serves Medi-Cal beneficiaries, the Contractor shall require that hours of operation are comparable to the hours the provider makes available for Medi-Cal services that are not covered by the Contractor;

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

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

access requirements;

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

6) Take corrective action if there is a failure to comply with timely access requirements.

2.4 Adequate Capacity and Standards

A. The Contractor shall assure adequate network capacity within the standards prescribed by 42 CFR 438.207.

1) Pursuant to 42 CFR 438.207(b), the Contractor shall, when requested by the DHCS, submit documentation to the DHCS, in a format specified by the DHCS, and after receiving reasonable advance notice of its obligation, to demonstrate that the Contractor:

a) Offers an appropriate range of SUD treatment services that is adequate for the anticipated number of beneficiaries for the service area;

b) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area; and

c) Consistent with 42 CFR 438.207(c)(2), whenever there is a change in the Contractor's operation that would cause a decrease of 2 or more in services or providers available to beneficiaries, the Contractor shall report this to the DHCS-SUD-PPFD (DHCSMPF@DHCS.CA.GOV), including details regarding the change and plans to maintain adequate services and providers available to beneficiaries within 24 hours.

2.5 Coordination and Continuity of Care

A. The Contractor shall assure coordination and continuity of care within the standards prescribed by 42 CFR 438.208.

1) The Contractor shall coordinate the services that the Contractor either furnishes or arranges to be furnished to the beneficiary with services that the beneficiary receives from any other Medi-Cal managed care plan or subcontractor in accordance with 42 CFR 438.208(b)(2).

2) The Contractor shall ensure that, in the course of coordinating care, each beneficiary's privacy is protected in accordance with all federal and state privacy laws, including but not limited to 45 CFR 160 and 164, to the extent that such provisions are applicable.

3) The Contractor shall enter into a Memorandum of Understanding (MOU) with any Medi-Cal managed care plan serving the Contractor's beneficiaries in accordance

with 42 CFR 438.208.

a) The Contractor shall notify the DHCS in writing if the Contractor is unable to enter into an MOU or if an MOU is terminated, providing a description of the Contractor's good faith efforts to enter into or maintain the MOU. The contractor shall monitor the effectiveness of its MOU with Physical Health Care Plans.

4) Pursuant to 42 CFR 438.208(b)(1), (2), and (3), the Contractor must implement procedures to:

a) Ensure that each beneficiary has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the beneficiary;

b) Coordinate the services the Contractor furnishes to the beneficiary with the services the beneficiary receives from any other health plan;

c) Share with other health plans serving the beneficiary the results of its identification and assessment of any beneficiary with special health care needs (as defined by DHCS) so that those activities need not be duplicated; and

d) At State discretion, exceptions may exist for health plans that serve dually eligible beneficiaries.

5) Beneficiaries with special health care needs:

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

b) The Contractor shall implement mechanisms to assess each Medicaid beneficiary identified as having special health care needs in order to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring. The assessment mechanisms must:

i. Use appropriate health care professionals;

ii. Assess the quality and appropriateness of care furnished to beneficiaries with special health care needs.

c) The Contractor shall produce a treatment plan for beneficiaries determined to need a course of treatment or regular care monitoring, the treatment plan must be:

i. Developed by the beneficiary's primary care provider with beneficiary participation, and in consultation with any specialists caring for the beneficiary;

ii. Approved by the entity in a timely manner, if this approval is required; and

iii. In accordance with any applicable State quality assurance and utilization review standards.

d) Pursuant to 42 CFR 438.206(b)(2), the Contractor shall ensure that female beneficiaries have direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the beneficiaries designated source of primary care if that source is not a women's health specialist.

B. Care Coordination within DMC-ODS levels of care

1) Contractor shall develop a care coordination plan that provides for seamless transitions of care for beneficiaries with the DMC-ODS system of care. Contractor is responsible for developing a structured approach to care coordination to ensure that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient) without disruptions to services.

2) In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, the Contractor shall ensure that beneficiaries have access to recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.

C. Contractor shall enter into a Memorandum Of Understanding (MOU) with any Medi-Cal managed care plan that enrolls beneficiaries served by the DMC-ODS. This requirement can be met through an amendment to the Specialty Mental Health Managed Care Plan MOU.

1) The following elements in the MOU should be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers:

a) Comprehensive substance use, physical, and mental health screening, including ASAM Level 0.5 SBIRT services;

b) Beneficiary engagement and participation in an integrated care program as needed;

c) Shared development of care plans by the beneficiary, caregivers and all providers;

d) Collaborative treatment planning with managed care;

e) Delineation of case management responsibilities;

f) A process for resolving disputes between the county and the Medi-Cal managed

care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved;

g) Availability of clinical consultation, including consultation on medications;

h) Care coordination and effective communication among providers including procedures for exchanges of medical information;

i) Navigation support for patients and caregivers; and

j) Facilitation and tracking of referrals between systems including bidirectional referral protocol.

2.6 Authorization of Services – Residential Programs

A. Pursuant to 42 CFR 438.210(b), the Contractor shall implement mechanisms to assure residential treatment program authorization decision standards are met.

B. The Contractor's residential treatment program standards shall:

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

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

b) Ensure that residential services may be provided in facilities with no bed capacity limit;

c) Ensure that the length of residential services comply with the following time restrictions:

i. Adults, ages 21 and over, may receive up to two (2) continuous short-term residential regimens per 365 day period. A short-term residential regimen is defined as one (1) residential stay in a DHCS licensed facility for a maximum of ninety (90) days per 365 day period.

An adult beneficiary may receive one thirty (30) day extension, if that extension is medically necessary, per 365 day period.

ii. Adolescents, under the age of 21, shall receive continuous residential services for a maximum of 30 days. 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 year. Adolescent beneficiaries receiving residential treatment shall be stabilized as soon as possible and moved down to a less intensive level of treatment. Nothing in the DMC-ODS Pilot or in this

paragraph overrides any EPSDT requirements.

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

d) Ensure that at least one ASAM level of Residential Treatment Services is available to beneficiaries in the first year of implementation; and

e) 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 Intergovernmental Agreement and describe coordination for ASAM Levels 3.7 and 4.0.

2) 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.

3) 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.

4) Have decisions made within the timeframes outlined for service authorizations in 42 CFR 438.210(d), and notices of action related to such decisions provided within the timeframes set forth in 42 CFR 438.404(c).

C. 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. See General Definitions in Exhibit A, Attachment I for the definition of "Service Authorization Request".

3. Provider Selection and Certification

A. Pursuant to 42 CFR 438.12(a)(2), all Contractor contracts with providers shall comply with the requirements set forth in 42 CFR 438.214.

B. The Contractor shall ensure that its providers are credentialed as required by 42 CFR 438.214.

C. Consistent with 42 CFR 438.214, the contractor shall have written policies and procedures for selection, retention, credentialing and re-credentialing of providers; the provider selection policies and procedures shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

D. Selection Criteria and Provider Contracting Requirements: In selecting providers to furnish services under DMC-ODS, Contractor must:

1) Have written policies and procedures for selection and retention of providers that

are in compliance with the terms and conditions of this amendment and applicable federal laws and regulations.

2) 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.

3) Must not discriminate against persons who require high-risk or specialized services.

4) May contract 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.

5) Select only providers that have a license and/or certification issued by the state that is in good standing.

E. Select only providers that, prior to the furnishing of services under this pilot, have enrolled with, or revalidated their current enrollment with, DHCS as a DMC provider under applicable federal and state regulations, have been screened in accordance with 42 CFR 455.450(c) as a "high" categorical risk prior to furnishing services under this pilot, 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 Welfare and Institutions Code section 14043.61 if claims for payment are submitted for services provided to a Medi-Cal beneficiary by an individual or entity that is ineligible to participate in the Medi-Cal program. A provider will be subject to termination of provisional provider status pursuant to Welfare and Institutions Code section 14043.27 if the provider has a debt due and owing to any government entity that relates to any federal or state health care program, and has not been excused by legal process from fulfilling the obligation. Only providers newly enrolling or revalidating their current enrollment on or after January 1, 2015 would be required to undergo fingerprint-based background checks required under 42 CFR 455.434.

1) When the disclosures must be provided.

a) Disclosures from providers or disclosing entities. Disclosure from any provider or disclosing entity is due at any of the following times:

i. Upon the provider or disclosing entity submitting the provider application.

ii. Upon the provider or disclosing entity executing the provider agreement.

iii. Upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414.

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

b) All disclosures must be provided to the Medicaid agency.

c) Consequences for failure to provide required disclosures. 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.

F. The Contractor shall only select providers that have a Medical Director who, prior to the delivery of services under this pilot, 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 pilot, and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107.

G. The Contractor may contract individually with licensed LPHAs to provide DMC-ODS services in the network.

H. Pursuant to 42 CFR 438.12(a)(1), the Contractor shall not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

I. Consistent with 42 CFR 438.12(a)(1) and (b)(1), if the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This section shall not be construed to:

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

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

3) Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to beneficiary.

J. The Contractor shall have a protest procedure for providers that are not awarded an Intergovernmental Agreement. The Contractor's protest procedure shall ensure that:

1) Providers that submit a bid to be a contract provider, but are not selected, must exhaust the Contractor's protest procedure if a provider wishes to challenge the denial to DHCS; and

2) 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.

3.1 DMC Certification and Enrollment

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

B. 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 Intergovernmental Agreement at these sites.

C. Contractor shall require that providers of perinatal DMC services are properly certified to provide these services and comply with the requirements contained in Title 22, Section 51341.1, Services for Pregnant and Postpartum Women.

D. 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:

1) Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8;

2) Drug Medi-Cal Certification Standards for Substance Abuse Clinics (Document 2E);

3) Title 22, CCR, Sections 51341.1, 51490.1, and 51516.1, (Document 2C);

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

5) Title 9, CCR, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq.; and

6) Title 22, CCR, Division 3, Chapter 3, sections 51000 et. seq.

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

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

F. The Contractor is responsible for ensuring that any reduction of covered services or relocations by providers are not implemented until 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 must be submitted to PED 60 days prior to the desired effective date of the reduction of covered services or relocation.

G. If, at any time, a subcontractor's license, registration, certification, or approval to operate a substance use disorder program or provide a covered service is revoked, suspended, modified, or not renewed outside of DHCS, the Contractor must notify DHCS Fiscal Management & Accountability Branch by e-mail at DHCSMPF@dhcs.ca.gov within two business days of knowledge of Section 3.1(G).

1) 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.

3.2 Continued Certification

A. 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.

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

3.3 Laboratory Testing Requirements

A. This part sets forth the conditions that all laboratories must meet to be certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Except as specified in paragraph (B) of this section, a laboratory will be cited as out of compliance with section 353 of the Public Health Service Act unless it:

1) Has a current, unrevoked or unsuspended certificate of waiver, registration certificate, certificate of compliance, certificate for Provider Performed Microscopy (PPM) procedures, or certificate of accreditation issued by HHS applicable to the category of examinations or procedures performed by the laboratory; or

2) Is CLIA-exempt.

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

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

purposes;

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

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

C. Federal laboratories. 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.

4. Recovery from Other Sources or Providers

A. The Contractor shall recover the value of covered services rendered to beneficiaries whenever the beneficiaries are covered for the same services, either fully or partially, under any other state or federal medical care program or under other contractual or legal entitlement including, but not limited to, a private group or indemnification program, but excluding instances of the tort liability of a third party or casualty liability insurance.

B. The monies recovered are retained by the Contractor. However, Contractor's claims for FFP for services provided to beneficiaries under this Intergovernmental Agreement shall be reduced by the amount recovered.

C. The Contractor shall maintain accurate records of monies recovered from other sources.

D. Nothing in this section supersedes the Contractor's obligation to follow federal requirements for claiming FFP for services provided to beneficiaries with other coverage under this Intergovernmental Agreement.

4.1 Beneficiary Liability for Payment

A. Pursuant to 42 CFR 438.106, the Contractor or an affiliate, vendor, contractor, or sub-subcontractor of the Contractor shall not submit a claim to, or demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any SUD or related administrative services provided under this Intergovernmental Agreement, except to collect other health insurance coverage, share of cost, and co-payments. Consistent with 42 CFR 438.106, the Contractor or an affiliate, vendor, contractor, or sub-subcontractor of the Contractor shall not hold beneficiaries liable for debts in the event that the Contractor becomes insolvent, for costs of covered services for which DHCS does not pay the Contractor, for costs of covered services for which DHCS or the Contractor does not pay the Contractor's providers, for costs of covered services provided under an Intergovernmental

Agreement, referral or other arrangement rather than from the Contractor, or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a beneficiary with an emergency condition.

B. Pursuant to 42 CFR 438.6(l) and 438.230 the Contractor and subcontractor shall not bill beneficiaries for covered services, any amount greater than would be owed if the Contractor provided the services directly.

C. Pursuant to 438.108, Contractor shall provide that any cost sharing imposed on beneficiaries is in accordance with Medicaid fee for service requirements (Section 447.50 – 447.60)

5. Early Intervention (ASAM Level 0.5)

A. Contractor's staff shall provide Screening, Brief Intervention, and Referral to Treatment (SBIRT) for all substance use conditions.

B. Contractor shall identify beneficiaries at risk of developing a SUD or those with an existing SUD 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.

6. Outpatient Services (ASAM Level 1.0)

A. Outpatient services consist of up to nine (9) hours per week of medically necessary services for adults and less than six (6) hours per week of services for adolescents.

B. Contractor shall ensure that its providers will offer ASAM Level 1 services including: assessment, treatment planning; individual and group counseling; family therapy; patient education; medication services; collateral services; crisis intervention services; and discharge planning and coordination.

C. Services may be provided in-person, by telephone, or by telehealth in any appropriate setting in the community.

7. Intensive Outpatient Services (ASAM Level 2.1)

A. Intensive outpatient involves structured programming provided to beneficiaries as medically necessary for a minimum of nine (9) hours and a maximum of 19 hours per week for adult perinatal and non-perinatal beneficiaries. Adolescents are provided a minimum of six (6) and a maximum of 19 services per week.

B. Intensive outpatient services shall include: assessment, treatment planning, individual and/or group counseling, patient education, family therapy, medication services, collateral services, crisis intervention services, treatment planning, and discharge planning and coordination.

C. Services may be provided in-person, by telephone, or by telehealth in any appropriate setting in the community.

8. Residential Treatment Services

A. 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.

1) Residential services can be provided in facilities with no bed capacity limit.

2) 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 days period; unless medical necessity authorizes a one-time extension of up to 30 days per 365 day period.

a) Only two non-continuous 90-day regimens may be authorized in a one-year period (365 days.) The average length of stay for residential services is 30 days.

b) Perinatal beneficiaries may receive a longer length of stay based on medical necessity.

c) Adolescents require shorter lengths of stay and should be stabilized and then moved down to a less intensive level of treatment.

9. Case Management

A. 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.

B. The Contractor shall:

1) Ensure that case management services focus on coordination of SUD care, integration around primary care especially for beneficiaries with a chronic SUD, and interaction with the criminal justice system, if needed.

2) The Contractor shall be responsible for determining which entity monitors the case management activities.

3) Case management services may be provided by a Licensed Practitioner of the Healing Arts or certified counselor.

4) The Contractor shall coordinate a system of case management services with physical and/or mental health in order to ensure appropriate level of care.

5) 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.

10. Physician Consultation

A. 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 with regards to designing 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.

B. Contractor may contract with one or more physicians or pharmacists in order to provide consultation services.

C. The Contractor shall only allow DMC providers to bill for physician consultation services.

11. Recovery Services

A. Recovery Services shall

1) Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care;

2) Recovery Monitoring: Recovery coaching, monitoring via telephone and internet;

3) Substance Abuse Assistance: Peer-to-peer services and relapse prevention;

4) Education and Job Skills: Linkages to life skills, employment services, job training, and education services;

5) Family Support: Linkages to childcare, parent education, child development support services, family/marriage education;

6) Support Groups: Linkages to self-help and support, spiritual and faith-based support; and

7) Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

B. Recovery services can 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.

C. Additionally, the Contractor shall:

1) Provide recovery services to beneficiaries as medically necessary.

2) Provide beneficiaries with access to recovery services after completing their course

of treatment.

3) Provide recovery services either face-to-face, by telephone, or by telehealth with the beneficiary.

12. Withdrawal Management

A. The Contractor shall provide at least one of the five levels of withdrawal management (WM) services according to the ASAM Criteria, when determined by a Medical Director or Licensed Practitioner of the Healing Arts as medically necessary, and in accordance with the beneficiary's individualized beneficiary plan.

B. The Contractor shall ensure that all beneficiaries that are receiving both residential services and WM services are monitored during the detoxification process.

C. 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.

13. Opioid (Narcotic) Treatment Program Services (NTP)

A. Pursuant to W&I Code, Section 14124.22, a Narcotic Treatment Program 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. Narcotic treatment 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.

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

1) Medical treatment visits;

2) Diagnostic blood, urine, and X-rays;

3) Psychological and psychiatric tests and services;

4) Quantitative blood and urine toxicology assays; and

5) Medical supplies.

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

program.

D. The Contractor shall contract with licensed NTP to offer services to beneficiaries who meet medical necessity criteria requirements.

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

F. Offer and prescribe medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone, and disulfiram.

G. Services provided as part of an 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.

1) 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.

14. Beneficiary Brochure and Provider List

The Contractor shall be responsible for ensuring that the following requirements are met and notice thereof is provided in the beneficiary brochure upon automatic mandatory enrollment of the beneficiaries. The production and update of its booklet section(s) and provider list in accordance with 42 CFR 438.10. The Contractor shall establish criteria to update its booklet and provider list.

A. Contractor shall provide all enrollment notices, informational materials and instructional materials in a manner and format that may be easily understood in language and format. Contractor shall provide notice to all potential beneficiaries and beneficiaries regarding the availability of materials in alternative formats to ensure comprehension and understanding of the requirements and benefits of the plan. Contractor shall provide instructions on how to access those alternative format materials.

1) Contractor shall make oral interpretation services available and provide those services free of charge to each potential beneficiary and beneficiary.

2) Contractor shall ensure written materials:

a. Use easily understood language and format; and

b. Be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

3) All enrollees and potential enrollees shall be informed by the Contractor that information is available in alternative formats and how to access those formats.

B. Pursuant to 42 CFR 438.10(e)(2)(i), upon automatic mandatory enrollment, the Contractor shall provide the following information to potential beneficiaries:

1) The basic features of managed care;

2) Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program; and

3) The Contractor's responsibility for coordination of the beneficiary's care.

C. Pursuant to 42 CFR 438.10(e)(2)(ii), upon automatic mandatory enrollment, the Contractor shall provide potential beneficiaries with a summary of the following information:

1) Benefits covered;

2) Cost sharing, if any;

3) Service area;

4) Names, locations, telephone numbers of, and non-English language spoken by current contracted providers, and including identification of providers that are not accepting new patients. For MCOs, PIHPs, and PAHPs this includes at a minimum information on primary care physicians, specialists and hospitals;

5) Benefits that are available under the state plan but are not covered under the Intergovernmental Agreement, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided; and

6) Counseling and referral services that are not covered under the Intergovernmental Agreement because of moral or religious objections.

D. Pursuant to 42 CFR 438.10(f)(2) and (6), upon automatic mandatory enrollment, and/or upon request, the Contractor shall provide the following information to beneficiaries:

1) Their right to change providers;

2) Their right to request and receive a copy of his or her medical records, and to request that they be amended or corrected;

3) Their right to obtain the following information:

a) Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the beneficiary's service area, including identification of providers that are not accepting new patients.

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

c) Beneficiary rights and protections, as specified in 42 CFR 438.100, as follow:

   i. To receive information in accordance with 42 CFR 438.10.

   ii. To be treated with respect and with due consideration for his/her dignity and privacy.

   iii. To receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's conditions and ability to understand.

   iv. To participate in decisions regarding his or health care, including the right to refuse treatment.

   v. To be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

   vi. To request and receive a copy of his/her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.

   vii. To exercise his/her rights, and that the exercised of those rights will not adversely affect the way the Contractor and its providers treat the beneficiary.

d) Information on grievance and State level fair hearing procedures in accordance with Title 22, California Code of Regulations 50951 and 50953.

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

f) Procedures for obtaining benefits, including authorization requirements.

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

h) The extent to which, and how, after-hours and emergency coverage are provided, including:

   i. What constitutes an emergency medical condition, emergency services, and post-stabilization services, with reference to the definitions in 42 CFR 438.114(a).

   ii. The fact that prior authorization is not required for emergency services.

   iii. The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.

iv. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the Intergovernmental Agreement.

v. The fact that, subject to the provisions of 42 CFR 438.10(f)(6), the beneficiary has a right to use any hospital or other setting for emergency care.

vi. The post-stabilization care services rules set forth in 42 CFR 422.113(c).

vii. Policy on referrals for specialty care and for other benefits not furnished by the beneficiary's primary care provider (42 CFR 438.10(f)(6)(x)).

i) Cost sharing, if any.

i. How and where to access any benefits that are available under the State Plan but are not covered under this Intergovernmental Agreement, including any cost sharing, and how any necessary transportation is provided.

ii. Pursuant to 42 CFR 438.102(a)(2), for a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service; however, Pursuant to 42 CFR 438.102(b)(1), the Contractor must provide notice to DHCS and beneficiaries about counseling and/or referral services it will not continue to provide on moral or religious grounds: 1) upon initial application to provide services under this Agreement and, 2) in the event of any discontinuation.

a. DHCS shall provide beneficiaries information on how and where to obtain services not provided by Contractor based on moral or religious grounds.

E. The Contractor shall ensure that the general program literature it uses to assist beneficiaries in accessing services including, but not limited to, the booklet required by 42 CFR 438.10, materials explaining the beneficiary problem resolution and fair hearing processes, and SUD education materials used by the Contractor, are available in the threshold languages of the Contractor's county in compliance with 42 CFR 438.10(c)(3).

F. Pursuant to 42 CFR 438.10(c)(1), the State shall identify the threshold non-English languages spoken by beneficiaries and potential beneficiaries and provides that information to the Contractor in the manner and format that may be easily understood as described in the Threshold Language Translation Requirements:

1) Pursuant to Government Code Section 7290-7299.8, Contractor shall comply with the linguistic requirements included in this Section. Contractor shall have:

a) A methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the County. “Prevalent” means a non-English 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.

b) Oral interpreter services in threshold languages at key points of contact available to assist beneficiaries whose primary language is a threshold language to access the substance use treatment services or related services through that key point of contact. The threshold languages shall be determined on a countywide basis. Counties may limit the key points of contact at which interpreter services in a threshold language are available to a specific geographic area within the county when:

i. The County has determined, for a language that is a threshold language on a countywide basis, that there are geographic areas of the county where that language is a threshold language, and other areas where it is not; and

ii. The Contractor provides referrals for beneficiaries who prefer to receive services in that threshold language, but who initially access services outside the specified geographic area, to a key point of contact that does have interpreter services in that threshold language.

c) Policies and procedures in place to assist beneficiaries who need oral interpreter services in languages other than threshold languages to access the substance use treatment services or related services available at the key points of contact.

d) General program literature used by the Contractor to assist beneficiaries in accessing services available in threshold languages, based on the threshold languages in the county as a whole.

G. Pursuant to 42 CFR 438.10(c)(4) and (5), the Contractor must make oral interpretation and sign language services available free of charge to each beneficiary. This applies to all non-English languages and not just those identified as prevalent. The Contractor must notify beneficiaries that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services.

H. Pursuant to 42 CFR 438.10(g), the booklet shall include grievance, appeal and fair hearing procedures and timeframes, as provided in 42 CFR 438.400 through 438.424, using a DHCS-developed or DHCS-approved description that must include the following:

1) For State Fair Hearing

a) The right to hearing;

b) The method for obtaining a hearing; and

c) The rules that govern representation at the hearing.

2) The right to file grievances and appeals.

3) The requirements and timeframes for filing a grievance or appeal

4) The availability of assistance in the filing process.

5) The toll-free numbers that the beneficiary can use to file a grievance or an appeal by phone.

6) The fact that, when requested by the beneficiary:

a) Benefits shall continue if the beneficiary files an appeal or a request for State Fair Hearing within the timeframes specified for filing.

7) The appeal rights that the DHCS has chosen to make available to providers consistent with in 42 CFR 438.10 (g)(1)(vii), to challenge the Contractor's failure to cover a service.

8) Additional information that is available upon request, includes the following:

a) Information on the structure and operation of the Contractor.

b) Physician incentive plans as set forth in 42 CFR 438.6(h).

I. The Contractor shall provide beneficiaries with a copy of the booklet and provider list upon automatic mandatory enrollment and shall notify beneficiaries of their right to request and obtain this information at least once a year and thereafter upon request in accordance with 42 CFR 438.10.

J. The Contractor shall ensure that the booklet above includes the current toll-free telephone number(s) that provides information in threshold languages and is available twenty-four hours a day, seven days a week.

K. The Contractor shall ensure that provider directories:

1) Include information on the category or categories of services available from each provider;

2) Contain the names, locations, and telephone numbers of current contracted providers by category;

3) Identify options for services in languages other than English and services that are designed to address cultural differences and;

4) Provide a means by which a beneficiary can identify which providers are not accepting new beneficiaries.

L. As required by 42 CFR 438.10(f)(4), when there is a change that DHCS defines as significant in the scope of SUD treatment services covered by the Contractor, the update, in the form of a booklet insert, shall be provided to beneficiaries at least 30 days prior to the change.

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

15. Cultural Competence Plan

A. The Contractor shall develop a cultural competency plan and subsequent plan updates.

B. 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.

16. Implementation Plan

A. The Contractor shall comply with the provisions of the Contractor's Implementation Plan as approved by DHCS, including the administration of beneficiary problem resolution processes as required by 42 CFR 438.10.

B. The Contractor shall not provide DMC-ODS services without: 1) an approved Implementation Plan approved by DHCS and CMS; and 2) a CMS approved State/County Intergovernmental Agreement executed by DHCS and the Contractor's Board of Supervisors.

C. The Contractor shall obtain written approval by DHCS prior to making any changes to the Implementation Plan.

17. Additional Provisions

A. Additional Intergovernmental Agreement Restrictions

This Intergovernmental Agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress, or any statute enacted by the Congress, which may affect the provisions, terms, or funding of this Intergovernmental Agreement in any manner including, but not limited to, 42 CFR 438.610(c)(3).

B. Nullification of DMC Treatment Program SUD services (if applicable)

The parties agree that if the Contractor fails to comply with the provisions of W&I Code, Section 14124.24, all areas related to the DMC Treatment Program SUD services shall be null and void and severed from the remainder of this Intergovernmental Agreement.

In the event the DMC Treatment Program Services component of this

Intergovernmental Agreement becomes null and void, an updated Exhibit B, Attachment I shall take effect reflecting the removal of federal Medicaid funds and DMC State General Funds from this Intergovernmental Agreement. All other requirements and conditions of this Intergovernmental Agreement shall remain in effect until amended or terminated.

C. Hatch Act

Contractor agrees to comply with the provisions of the Hatch Act (Title 5 USC, Sections 1501-1508), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.

D. No Unlawful Use or Unlawful Use Messages Regarding Drugs

Contractor agrees that information produced through these funds, and which pertains to drug and alcohol - related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug or alcohol- related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (HSC Section 11999-11999.3). By signing this Intergovernmental Agreement, Contractor agrees that it shall enforce***,*** and shall require its subcontractors to enforce, these requirements.

E. Noncompliance with Reporting Requirements

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.

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

None of the funds made available through this Intergovernmental 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).

G. Restriction on Distribution of Sterile Needles

No Substance Abuse Prevention and Treatment (SAPT) Block Grant funds made available through this Intergovernmental Agreement shall be used to carry out any program that includes the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug unless DHCS chooses to implement a demonstration syringe services program for injecting drug users.

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

If any of the work performed under this Intergovernmental 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 Contractor shall cooperate to assure

mutual agreement as to those transactions between them, to which this Provision applies. Refer to Exhibit F for additional information.

1) 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))

2) Concurrence for Test Modifications to HHS Transaction Standards

   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.

3) Adequate Testing

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

4) Deficiencies

   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.

5) Code Set Retention

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

6) Data Transmission Log

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

I. Nondiscrimination and Institutional Safeguards for Religious Providers

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

J. Counselor Certification

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

K. Cultural and Linguistic Proficiency

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

L. Intravenous Drug Use (IVDU) Treatment

Contractor shall ensure that individuals in need of IVDU treatment shall be encouraged to undergo SUD treatment (42 USC 300x-23 and 45 CFR 96.126(e)).

M. Tuberculosis Treatment

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

1) Routinely make available TB services to each individual receiving treatment for SUD use and/or abuse;

2) Reduce barriers to patients' accepting TB treatment; and,

3) Develop strategies to improve follow-up monitoring, particularly after patients leave treatment, by disseminating information through educational bulletins and technical assistance.

N. Trafficking Victims Protection Act of 2000

Contractor and its subcontractors that provide services covered by this Intergovernmental 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

O. Tribal Communities and Organizations

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

P. Participation of County Alcohol and Drug Program Administrators Association of California and California Behavioral Health Director's Association of California.

1) Pursuant to HSC Section 11801(g), the Contractor's County AOD Program Administrator shall participate and represent the County in meetings of the County Alcohol and Drug Program Administrators Association of California for the purposes of representing the counties in their relationship with DHCS with respect to policies, standards, and administration for SUD abuse services. Participation and representation shall also be provided by the County Behavioral Health Director's Association of California.

2) Pursuant to HSC Section 11811.5(c), the Contractor's County AOD Program Administrator shall attend any special meetings called by the Director of DHCS. Participation and representation shall also be provided by the County Behavioral Health Director's Association of California.

Q. Youth Treatment Guidelines

Exhibit A, Attachment I
Program Specifications

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 Intergovernmental Agreement is required for new guidelines to be incorporated into this Intergovernmental Agreement.

R. Restrictions on Grantee Lobbying – Appropriations Act Section 503

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

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

S. Nondiscrimination in Employment and Services

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

T. Federal Law Requirements:

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

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

3) 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.

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

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

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

7) Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against

the disabled by public entities.

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

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

10) 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.

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

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

13) 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.

U. State Law Requirements:

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

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

3) Title 9, Division 4, Chapter 8 of the CCR, commencing with Section 10800.

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

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

V. Investigations and Confidentiality of Administrative Actions

1) Contractor acknowledges that if a DMC provider is under investigation by DHCS or any other state, local or federal law enforcement agency for fraud or abuse, DHCS may temporarily suspend the provider from the DMC program, pursuant to W&I Code, Section 14043.36(a). Information about a provider's administrative sanction status is confidential until such time as the action is either completed or resolved. The DHCS may also issue a Payment Suspension to a provider pursuant to W&I

Code, Section 14107.11 and Code of Federal Regulations, Title 42, section 455.23. The Contractor is to withhold payments from a DMC provider during the time a Payment Suspension is in effect.

2) 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.

W. This Intergovernmental Agreement is subject to any additional restrictions, limitations, or conditions enacted by the federal or state governments that affect the provisions, terms, or funding of this Intergovernmental Agreement in any manner.

X. Subcontract Provisions

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

Y. Conditions for Federal Financial Participation

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

2) Pursuant to 42 CFR 438.808, Federal Financial Participation (FFP) is not available to the Contractor if the Contractor:

a) Is an entity that could be excluded under section 1128(b)(8) as being controlled by a sanctioned individual;

b) Is an entity that has a substantial contractual relationship as defined in section 431.55(h)(3), either directly or indirectly, with an individual convicted of certain crimes described in section 1128(8)(B); or

c) Is an entity that employs or contracts, directly or indirectly, for the furnishing of health care utilization review, medical social work, or administrative services, with one of the following:

i. Any individual or entity excluded from participation in federal health care programs under section 1128 or section 1126A; or

ii. An entity that would provide those services through an excluded individual or entity.

18. Beneficiary Problem Resolution Processes

The Contractor shall establish and comply with a beneficiary problem resolution process.

A. General Provisions

Contractor shall inform subcontractors and providers at the time they enter into a

contract about:

1) The beneficiary's right to a State fair hearing, how to obtain a hearing and the representation rules at the hearing.

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

3) 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 enrollee's authorized representative in doing so.

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

5) The availability of assistance with filing grievances and appeals.

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

7) 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.

8) Any State determined provider's appeal rights to challenge the failure of the Contractor to cover a service.

B. 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 Intergovernmental Agreement. Nothing in this section is intended to prevent the Contractor from pursuing any options available for appealing a fair hearing decision.

1) Pursuant to 42 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.

2) The Contractor's beneficiary problem resolution processes shall include:

a) A grievance process;

b) An appeal process; and

c) An expedited appeal process.

3) For the grievance, appeal, and expedited appeal processes, described in 42 CFR.

438 Subpart F, the Contractor shall comply with all of the following requirements:

a) Dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the beneficiary's health condition requires, within the DHCS established timeframes;

b) Assure that each beneficiary has adequate information about the Contractor's problem resolution processes by taking at least the following actions;

   i. Including information describing the grievance, appeal, and expedited appeal processes in the Contractor's beneficiary booklet and providing the beneficiary booklet to beneficiaries as described in Section 14 of this Intergovernmental Agreement;

   ii. Posting notices explaining grievance, appeal, and expedited appeal process procedures in locations at all Contractor provider sites. Notices shall be sufficient to ensure that the information is readily available to both beneficiaries and provider staff. The posted notice shall also explain the availability of fair hearings or expedited appeal process, including information that a fair hearing may be requested whether or not the beneficiary has received a notice of action pursuant to 42 CFR 438.404. For the purposes of this Section, a Contractor provider site means any office or facility owned or operated by the Contractor or a provider contracting with the Contractor at which beneficiaries may obtain SUD treatment services; and

   iii. Pursuant to 42 CFR 438.10, making available forms that may be used to file grievances, appeals, and expedited appeals and self-addressed envelopes that beneficiaries can access at all Contractor provider sites without having to make a verbal or written request to anyone.

c) Pursuant to 42 CFR 438.406(a)(1), giving beneficiaries any reasonable assistance in completing the forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability;

d) Pursuant to 42 CFR 438.406(a)(2), the Contractor shall acknowledge receipt of each grievance, appeal, and request for expedited appeal to the beneficiary in writing regardless of whether the appeal was received in writing or orally;

e) Consistent with 42 CFR 438.402(b)(1)(ii), a beneficiary may authorize, in writing, another person to act on the beneficiary's behalf. The beneficiary may select a provider as his or her representative in the appeal or expedited appeal process, if the provider consents;

f) Consistent with 42 CFR 438.402(b)(2), 42 CFR 438.408(f)(1), California Welfare and Institutions Code section 10951, the beneficiary, or provider acting on behalf of the beneficiary, may file an appeal within 90 days of the date on the notice of action was taken;

g) A beneficiary's legal representative may use the grievance, appeal, or expedited appeal processes on the beneficiary's behalf.

h) At the beneficiary's request, the Contractor shall identify staff or another individual, such as a legal guardian, to be responsible for assisting a beneficiary with these processes, including providing assistance in writing the grievance, appeal, or expedited appeal. If the individual identified by the Contractor is the person providing SUD treatment services to the beneficiary requesting assistance, the Contractor shall identify another individual to assist that beneficiary;

i) A beneficiary shall not be subject to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal;

j) Procedures for these beneficiary problem resolution processes shall maintain the confidentiality of each beneficiary's information;

k) A procedure shall be included by which issues identified as a result of the grievance, appeal or expedited appeal processes are transmitted to the Contractor's Quality Improvement Committee, the Contractor's administration or another appropriate body within the Contractor's operations. These issues shall be considered in the Contractor's Quality Improvement Program, as required by 42 CFR 438.240;

l) Individuals involved in any previous review or decision-making on the issue(s) presented in a problem resolution process shall not participate in making the decision on the grievance, appeal, or expedited appeal pursuant to 42 CFR 438.406(a)(3)(i); and

m) The individual making the decision on the grievance, appeal, or expedited appeal shall have the appropriate clinical expertise, as determined by the Contractor, required to treat the beneficiary's condition, if the grievance concerns the denial of a request for an expedited appeal or if the grievance, appeal, or expedited appeal addresses any clinical issue, including a lack of medical necessity pursuant to Title per 42, CFR 438.406(a)(3)(ii) or Title 22, Sections 51303 and 51340.1.

4) Pursuant to record keeping and review requirements in 42 CFR 438.416, and to facilitate monitoring consistent with 42 CFR 438.240 the Contractor shall:

a) Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance or appeal. The log entry shall include, but not be limited to, the name of the beneficiary, the date of receipt of the grievance, appeal, or expedited appeal, and the nature of the problem;

b) Record in the grievance and appeal log or another central location determined by the Contractor, the final dispositions of grievances, appeals, and expedited

appeals, including the date the decision is sent to the beneficiary. If there has not been final disposition of the grievance, appeal, or expedited appeal, the reason(s) shall be included in the log;

c) Provide a staff person or other individual with responsibility to provide information requested by the beneficiary or the beneficiary's representative regarding the status of the beneficiary's grievance, appeal, or expedited appeal;

d) Acknowledge the receipt of each grievance, appeal, and expedited appeal to the beneficiary in writing;

e) Identify in its grievance, appeal, and expedited appeal documentation, the roles and responsibilities of the Contractor, the provider, and the beneficiary;

f) Notify the beneficiary, in writing, of the final disposition of the problem resolution process including the reasons for the disposition; and

g) Notify, in writing, any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal.

C. Notice to Beneficiaries

Notice to beneficiaries shall be in writing and shall explain the following:

1) The action that the Contractor or its subcontractor has taken or intends to take;

2) The reasons for the action;

3) The beneficiary's or the provider's right to file a PIHP appeal;

4) The beneficiary's right to request a State fair hearing;

5) The procedures for exercising a grievance and/or appeal;

6) The circumstances under which expedited resolution is available and how to request it; and

7) The beneficiary's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the beneficiary may be required of these services.

Notices shall be available in the State-established prevalent non-English language in Contractor's service area and be available in alternative formats for persons with special needs, and use easily understood language and format.

D. Grievance Process

Consistent with 42 CFR §§ 438.400, 438.402, 438.406, the Contractor shall ensure that its

grievance process contains provisions that, at a minimum:

1) Allow beneficiaries or Contractor to present their grievance orally, or in writing;

2) Provide for a decision on the grievance, as expeditiously as the enrollee's health condition requires, and notify the affected parties within 60 calendar days of receipt of the grievance. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or if the Contractor determines that there is a need for additional information and that the delay is in the beneficiary's interest. If the Contractor extends the timeframe, the Contractor shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in 42 CFR 438.210; and

3) Provide for notification of the beneficiary or the appropriate representative in writing of the grievance decision and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted.

E. Appeal Process

1) Consistent with 42 CFR 438.408, the Contractor shall ensure that its appeal process, at a minimum:

   a) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution pursuant to 42 CFR 438.406(b)(1);
   .

   b) Allow a beneficiary to file an appeal orally or in writing pursuant to 42 CFR 438.402(b)(3)(ii);

   c) Pursuant to 42 CFR 438.402(b)(3)(ii), require a beneficiary who makes an oral appeal, that is not an expedited appeal, to subsequently submit the appeal in writing. The date the Contractor receives the oral appeal shall be considered the filing date for the purpose of applying the appeal timeframes;

   d) Pursuant to 42 CFR 438.408(b) and (c), provide for a decision on the appeal and notify the affected parties within 45 calendar days of receipt of the appeal, or as expeditiously as the enrollee's health condition requires. This timeframe may be extended by up to 14 calendar days, if the beneficiary requests an extension or the Contractor determines that there is a need for additional information and that the delay is in the beneficiary's interest. If the Contractor extends the timeframes, the Contractor shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in 42 CFR 438.210;

   e) Consistent with 42 CFR 438.408(f), inform the beneficiary of his or her right to request a fair hearing;

f) Allow the beneficiary to have a reasonable opportunity to present evidence and arguments of fact or law, in person and/or in writing, in accordance with the beneficiary's election;

g) Allow the beneficiary and/or his or her representative to examine the beneficiary's case file, including medical records, and any other documents or records considered before and during the appeal process, provided that there is no disclosure of the protected health information of any individual other than the beneficiary; and

h) Allow the beneficiary and/or his or her representative, or the legal representative of a deceased beneficiary's estate, to be included as parties to the appeal.

2) Pursuant to 42 CFR 438.420(a) and (b), the Contractor shall continue the beneficiary's benefits while an appeal is in process if all of the following conditions are met:

a) The appeal was filed on or before the later of the following: within 10 days of the Contractor mailing the notice of action; or the intended effective date of the Contractor's proposed action;

b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

c) The services were ordered by an authorized provider;

d) The authorization period has not expired; and

e) The beneficiary requests an extension of benefits.

3) Pursuant to 42 CFR 438.420(c), the Contractor shall continue the beneficiary's benefits while an appeal is pending until one of the following occurs:

a) The beneficiary withdraws the appeal;

b) The beneficiary does not request a State Fair Hearing with continuation of benefits within 10 days from the date the Contractor mails an adverse appeal decision;

c) A State Fair Hearing decision adverse to the beneficiary is made; or

d) The service authorization expires or authorization limits are met.

4) Pursuant to 42 CFR 438.408(e), the Contractor shall notify the beneficiary, and/or his or her representative, of the resolution of the appeal in writing. The notice shall contain:

a) The results of the appeal resolution process;

b) The date that the appeal decision was made;

c) If the appeal is not resolved wholly in favor of the beneficiary, the notice shall also contain:

i. Information regarding the beneficiary's right to a fair hearing and the procedure for filing for a fair hearing, if the beneficiary has not already requested a fair hearing on the issue involved in the appeal; and

ii. Information on the beneficiary's right to continue to receive benefits while the fair hearing is pending and how to request the continuation of benefits.

5) If the decision of the appeal resolution process reverses a decision to deny, limit or delay services, the Contractor shall promptly provide or arrange and pay for the services at issue in the appeal.

6) Pursuant to 42 CFR 438.420(d), the Contractor may recover the cost of the continued services furnished to the beneficiary while the appeal was pending if the final resolution of the appeal upholds the Contractor's action.

F. Expedited Appeal Process

As defined in 42 CFR 438.400, to the expedited appeal process shall be used when the Contractor determines or the beneficiary and/or the beneficiary's provider certifies that following the timeframe for an appeal as established in 42 CFR 438.408, would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

In addition to meeting the requirements of 42 CFR 438.410(a), 42 CFR 438.406(b), the Contractor shall ensure that its expedited appeal process, at a minimum:

1) Be used when the Contractor determines or the beneficiary and/or the beneficiary's provider certifies that taking the time for a standard appeal resolution could seriously jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function.

2) Pursuant to 42 CFR 438.402(b)(3), allow the beneficiary to file the request for an expedited appeal orally without requiring that the request be followed by a written appeal.

3) Pursuant to 42 CFR 438.410(b), ensure that punitive action is not taken against a beneficiary or a provider because they request an expedited appeal or support a beneficiary's request for an expedited appeal.

4) Pursuant to 42 CFR 438.406(b)(4), provide the beneficiary a reasonable opportunity to present evidence, allegations of fact or law, in person as well as in writing and inform the beneficiary of the limited time available for the presentation of evidence.

5) Pursuant to 42 CFR 438.408(b)(3), resolve an expedited appeal, and notify, as expeditiously as the enrollee's health condition requires, the affected parties in writing, no later than three working days after the Contractor receives the appeal. Pursuant to 42 CFR 438.408(c) this timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or the Contractor determines that there is need for additional information and that the delay is in the beneficiary's interest. If the Contractor extends the timeframes, the Contractor shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in 42 CFR 438.210.

6) Pursuant to 42 CFR 438.408(d)(2), provide a beneficiary with a written notice of the expedited appeal disposition and make reasonable efforts to provide oral notice to the beneficiary and/or his or her representative.

7) Pursuant to 42 CFR 438.410(c), if the Contractor denies a request for expedited appeal resolution:

   a) Transfer the expedited appeal request to the timeframe for appeal resolution Pursuant to 42 CFR 438.408(b)(2), that timeframe shall not be longer than 45 days from the day the Contractor receives the appeal with a possible 14 day extension under the circumstances outlined in 42 CFR 438.408(c).

   b) Make reasonable efforts to give the beneficiary and his or her representative prompt oral notice of the denial of the request for an expedited appeal and provide written notice within two calendar days of the date of the denial. The written notice of the denial of the request for an expedited appeal is not a Notice of Action as defined in 42 CFR 438.210.

   c) Pursuant to 42 CFR 438.408(a)-(b), the Contactor shall dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the beneficiary’s health condition requires, within DHCS established timeframes that shall not exceed 3 working days after the Contractor receives the appeal request.

G. Beneficiary Problem Resolution Processes Established by Providers

Nothing in 42 CFR 438.10, 438.400, 438.402, 438.406, and 438.408 precludes a provider other than the Contractor from establishing beneficiary problem resolution processes for beneficiaries receiving services from that provider. When such processes exist, the Contractor shall not require that beneficiaries use or exhaust the provider's processes prior to using the Contractor's beneficiary problem resolution process, unless the following conditions have been met:

1) The Contractor delegates the responsibility for the beneficiary problem resolution process to the provider in writing, specifically outlining the provider's responsibility under the delegation;

2) The provider's beneficiary problem resolution process fully complies with this Section of the Intergovernmental Agreement, the relevant provisions of 42 CFR Subpart F, 438.400, and depending on processes delegated, 42 CFR 438.406, 42 CFR 438.408, and/or 42 CFR 438.410; and

3) No beneficiary is prevented from accessing the grievance, appeal or expedited appeal processes solely on the grounds that the grievance, appeal or expedited appeal was incorrectly filed with either the Contractor or the provider.

H. Fair Hearing

"Fair Hearing" means the State hearing provided to beneficiaries pursuant to Title 22, CCR, Sections 50951 and 50953. All fair hearings requested by beneficiaries shall comply with 42 CFR §§ 431.220(a)(5), 438.408(f), 438.414, and 438.10(g)(1).

1) If a beneficiary requests a State Fair Hearing, DHCS (not the Contractor) shall grant the request. The right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the beneficiary and provider by Contractor in its notice of decision or notice of action. Beneficiaries and providers shall also be informed of the following:

   a) A beneficiary may request a State Fair Hearing.

   b) The provider may request a State Fair Hearing only if DHCS permits the provider to act as the beneficiary's authorized representative.

   c) DHCS must permit the beneficiary to request a State Fair Hearing within a reasonable time period specified by DHCS, but not less than 20 or in excess of 90 days, from whichever of the following dates applies:

      i. From the date indicated on the Contractor's notice of action, if the beneficiary appeals directly to DHCS for a fair hearing.

      ii. From the date indicated on the Contractor's notice of resolution, if the beneficiary exhausts the Contractor-level appeals.

2) DHCS must reach its decisions within the specified timeframes:

   a) Standard resolution: within 90 days of the date the beneficiary filed the appeal with the Contractor, if the beneficiary filed initially with the Contractor (excluding the days the beneficiary took to subsequently file for a State Fair Hearing), or the date the beneficiary filed for direct access to a State Fair Hearing.

   b) Expedited resolution:

      i. If the appeal was heard first through the Contractor appeal process DHCS shall reach a decision within 3 working days from agency receipt of a hearing request for a denial of a service that meets the criteria for an

expedited appeal process but was not resolved using the Contractor's expedited appeal timeframes, or

ii. Was resolved wholly or partially adversely to the beneficiary using the Contractor's expedited appeal timeframes.

iii. If the appeal was made directly to the State Fair Hearing process without accessing the Contractor's appeal process, DHCS shall reach a decision as expeditiously as the beneficiary's health condition requires, but no later than 3 working days from state receipt of a hearing request for a denial of a service that meets the criteria for an expedited resolution.

3) Pursuant to 42 CFR 438.408(f)(2), the parties to the State Fair Hearing include the Contractor as well as the beneficiary and his or her representative or the representative of a deceased beneficiary's estate.

I. Expedited Fair Hearing

As described in 42 CFR 438.410(a), an expedited fair hearing shall be used when the Contractor determines, or the beneficiary and/or the beneficiary's provider certifies, that the following the timeframe for a fair hearing as established in 42 CFR 431.244(f)(1) would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

J. Continuation of Services Pending Fair Hearing Decision

1) A beneficiary receiving SUD treatment services shall have a right to file for continuation of SUD treatment services pending the outcome of a fair hearing pursuant to 42 CFR 438.420, and Cal. Code Regs., Title 22., § 51014.2.

2) The Contractor shall continue to provide SUD treatment services pending the outcome of a fair hearing in accordance with 42 CFR 438.420(c) and Cal. Code Regs., Title 22, § 51014.2. If the Contractor allows providers to deliver SUD treatment services for a set number of visits or a set duration of time without prior authorization, the Contractor shall continue to provide SUD treatment services pending the outcome of a fair hearing when the Contractor denies a payment authorization request from a provider requesting continuation of services beyond the number or duration permitted without prior authorization and the beneficiary files a timely request for fair hearing.

3) If the beneficiary utilizes the Contractor's problem resolution processes, that process shall be conducted as described in this Exhibit A, Attachment I (18)(B)(C), and (D), and in 42 CFR 438.400.

K. Provision of Notice of Action

1) Consistent with 42 CFR 438.400(b), 42 CFR 438.52, and 42 CFR 438.56 "Action," in the case of a contractor, means:

a) A denial, modification, reduction or termination of a provider's request for contractor payment authorization of a SUD treatment service covered by the contractor;

b) A determination by the contractor or its providers that the medical necessity criteria in 42 CFR 438.210(a)(4), or for EPSDT, Title 22, Sections 51303 and51340.1 have not been met and the beneficiary is not entitled to any SUD treatment services from the Contractor;

c) A failure by the Contractor to provide a SUD treatment service covered by the Contractor within the timeframe for delivery of the service established by the Contractor; or

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

2) Pursuant to 42 CFR 438.404(a), the Notice of Action (NOA) shall be in writing and shall meet the language and format requirements of 42 CFR 438.10(c) and (d) as specified in Section 14 paragraphs (A) and (F) to ensure ease of understanding. The NOA shall contain the items specified in 42 CFR 438.404 (b).

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

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

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

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

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

8) A NOA is required when the Contractor denies or modifies a payment authorization request from a provider for a SUD treatment service that has already been provided to the beneficiary when the denial or modification is a result of post-service,

prepayment determination by the Contractor that the service was not medically necessary or otherwise was not a service covered by the Contractor.

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

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

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

12) The Contractor shall comply with the requirements of 42 CFR 438.404(b), regarding the content of NOAs and with the following timeframes for mailing of NOAs:

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

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

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

13) When a NOA would not be required as described in (3)-(5) above, the Contractor shall provide a beneficiary with a NOA when the Contractor or its providers determine that the medical necessity criteria in 42 CFR 438.210(a)(4) or in Title 22, Sections 51303 and 51340.1 have not been met and that the beneficiary is not entitled to any SUD treatment services from the Contractor. A NOA is not required when a provider, including the Contractor acting as a provider, determines that a beneficiary does not qualify for a specific service covered by the Contractor, including but not limited to: crisis intervention, crisis stabilization, crisis residential treatment services, or any SUD treatment service to treat a beneficiary's urgent condition, provided that the determination does not apply to any other SUD treatment service covered by the Contractor. The NOA shall, at the election of the Contractor, be hand-delivered to the beneficiary on the date of the action or mailed

to the beneficiary in accordance with 42 CFR 438.404.

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

15) For the purposes of this Section, “medical service”, as used in Cal. Code Regs., Title 22, § 51014.1, shall mean SUD residential treatment services that are subject to prior authorization by a Contractor pursuant to 42 CFR 438.210.

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

L. Contents of a NOA

1) The NOA issued in writing pursuant to Section I of this Intergovernmental Agreement and 42 CFR 438.404(b), shall contain the following information:

a) The action taken or intends to take by the Contractor;

b) The reason for the action taken;

c) Citations to the regulations or Contractor payment authorization procedures supporting the action;

d) The beneficiary's or the provider's right to file an appeal or expedited appeal with the Contractor;

e) The procedures for exercising the rights specified in this paragraph;

f) Beneficiary’s rights to continue benefits are pursuant to subsection C, paragraph 7 of this section;

g) The circumstances under which an expedited resolution is available, and how to request it; and,

h) Information about the beneficiary's right to request a state fair hearing or an expedited fair hearing, including:

i. The method by which a hearing may be obtained;

ii. A statement that the beneficiary may be either self-represented, or represented by an authorized third party such as legal counsel, a relative, friend or any other person;

iii. An explanation of the circumstances under which a SUD treatment service shall be continued if a fair hearing is requested; and,

iv. The time limits for requesting a fair hearing or an expedited fair hearing.

2) A NOA issued pursuant to 42 CFR 438.404, relating to denials for lack of medical necessity, shall specify the following:

a) The reason that the medical necessity criteria were not met, including a citation to the applicable regulation;

b) The beneficiary's options for obtaining care from sources other than the Contractor, if applicable;

c) The beneficiary's right to request a second opinion on the determination;

d) The beneficiary's right to file an appeal or expedited appeal with the Contractor; and,

e) The beneficiary's right to request a fair hearing or an expedited fair hearing, including:

i. The method by which a hearing may be obtained;

ii. The time period in which the request for a fair hearing or expedited fair hearing must be filed; and,

iii. That the beneficiary may be either self–represented, or represented by an authorized third party such as legal counsel, a relative, friend or any other person;

M. Consistent with 42 CFR 438.404(c), the Contractor shall give notice at least 10 days before the effective date of action when the action is a termination, suspension, or reduction of previously authorized Medi-Cal-covered services, except:

1) The period of advanced notice is shortened to 5 days if:

a. The agency has facts indicating that action should be taken because of probable fraud by the beneficiary.

2) The Contractor shall give notice of adverse action by the date of the action when any of the following occur:

a) The death of a beneficiary;

b) Receipt of a signed written beneficiary statement requesting service termination or giving information requiring termination or reduction of services (provided the beneficiary understands that this shall be the result of supplying that information);

c) The beneficiary's admission to an institution where he or she is ineligible for further services;

d) The beneficiary's whereabouts are unknown and mail directed to him or her has

no forwarding address;

e) Notice that the beneficiary has been accepted for Medicaid services by another local jurisdiction;

f) A change in the beneficiary's physician's prescription for the level of medical care; or

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

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

N. Pursuant to 42 CFR 438.416, the Contractor is required to submit to DHCS a report that summarizes beneficiary grievances, appeals and expedited appeals filed from July 1 of the previous year through June 30 of that year by October 1 of each year. The report shall include the total number of grievances, appeals and expedited appeals by type, by subject areas established by DHCS, and by disposition.

O. Effectuation of reversed appeal resolutions.

1) If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires (42 CFR 438.424(a)).

2) If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the beneficiary received the disputed services while the appeal was pending, the Contractor shall pay for those services, in accordance with State policy and regulations (42 CFR 438.424(b)).

19. Subcontracts

A. The Contractor shall ensure that all of its subcontract requires that the Contractor oversees and is held accountable for any functions and responsibilities that it delegates to any subcontractor consistent with 42 CFR 438.6(l); 42 CFR 438.230(a); 42 CFR 438.230(b)(1), (2), (3), including:

1) All subcontracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract.

2) Each Intergovernmental Agreement must ensure that the Contractor evaluates the prospective subcontractor's ability to perform the activities to be delegated.

3) The Intergovernmental Agreement must 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.

4) Each Intergovernmental Agreement must ensure that the Contractor monitor the subcontractor's performance on an ongoing basis and subject it to an annual onsite review, consistent with statutes and regulations.

5) Each Intergovernmental Agreement must ensure that the Contractor identifies deficiencies or areas for improvement, the subcontractor must take corrective actions and the Contractor shall ensure that the subcontractor implements these corrective actions.

B. Contractor shall include the following provider requirements in their subcontracts with providers:

1) Culturally Competent Services: Providers are responsible to provide culturally competent services. Providers must 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 must be available for beneficiaries, as needed.

2) 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.

3) Evidenced Based Practices: Providers will implement at least two of the following evidenced based treatment practices (EBPs) based on the timeline established in the county implementation plan. The two EBPs are per provider per service modality. Counties will ensure the providers have implemented EBPs. The State will monitor the implementation of EBP's during reviews. The required EBP 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 must 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.

C. Subcontractor Documentation

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

20. Program Integrity Requirements

A. The Contractor shall comply with state and federal law and regulations, including, but not limited to, 42 CFR 433.32, 42 CFR 433.51, 42 CFR 431.800 et. seq., 42 CFR 440.230, 42 CFR 440.260, 42 CFR 455 et. seq., 42 CFR 456 et. seq., 42 CFR 456.23, 22 CCR 51490, 22 CCR 51490.1, 22 CCR 51341.1, 22 CCR 51159, WIC 14124.1, and WIC 14124.2; 42 CFR 438.600, 42 CFR 438.602, 42 CFR 438.608.

B. The Contractor shall comply with the provisions of 42 CFR 438.600(a), (b), and (c), 438.604, 438.606 and 438.608, regarding the certification of accurate data submitted by the Contractor to DHCS and which require the Contractor to have administrative or management arrangements or procedures and a mandatory compliance plan designed to guard against fraud and abuse.

1) The management arrangements or procedures shall include:

a) Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards;

b) The designation of a compliance officer and a compliance committee that are accountable to senior management;

c) Effective training and education for the compliance officer, the Contractor's employees and all subcontractor;

d) Effective lines of communication between the compliance officer and the Contractor's employees and subcontractor;

e) Enforcement of standards through well publicized disciplinary guidelines;

f) Provision for internal and subcontractor monitoring and auditing; and

g) Provision for prompt response to detected offenses and for development of corrective action initiatives relating to this Agreement and any subcontracts relating to this Agreement,

i. The Contractor's shall provide the following data certified by the Contractor's Chief Executive Officer, Chief Financial Officer or an individual who has delegated authority to sign for and reports directly to the CEO or CFO:

a. Enrollment information;

b. Encounter data;

c. Other information required by DHCS and contained in Intergovernmental Agreements, proposals and related documents for purposes of developing MCE payments; and

d. The certification of this information must attest, based on best knowledge, information and belief as follows:

(i) To the accuracy, completeness and truthfulness of the data;

(ii) To the accuracy, completeness and truthfulness of the documents specified by DHCS; and

(iii) The certification must be submitted concurrently with the certified data.

C. The Contractor shall comply with the provisions of 42 CFR 438.610:

1) The Contractor may not knowingly have a relationship of the type described in paragraph (2)(i) of this section with the following:

i. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

ii. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (1)(i) of this section.

2) Specific requirements. The relationships described in this paragraph are as follow:

i. A director, officer, or partner of the Contractor.

ii. A person with beneficial ownership of five percent or more of the Contractor's equity.

iii. A person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under its Intergovernmental Agreement with the State.

3) Effect of Noncompliance. If a DHCS finds that a Contractor is not in compliance with paragraphs (1) and (2) of this section, DHCS:

i. Must notify the Secretary of the noncompliance.

ii. May continue an existing agreement with the Contractor unless the Secretary directs otherwise.

iii. May not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary provides to DHCS and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

4) Consultation with the Inspector General. Any action by the Secretary described in paragraphs (3)(ii) or (3)(iii) of this section is taken in consultation with the Inspector General.

D. Pursuant to 42 CFR 438.214(d), the Contractor shall not employ or contract with providers or other individuals and entities excluded from participation in federal health care programs (as defined in section 1128B(f) of the Social Security Act) under either Section 1128, 1128A, or 1156 of the Social Security Act. FFP is not available for amounts expended for providers excluded by Medicare, Medicaid, or the State Children's Health Insurance Program, except for emergency services. DHCS shall submit, as part of its waiver request, assurance that the entities described in paragraph (D)(2) of this section will be excluded from participation under an approved waiver.

1) FFP is available in payments to an entity that furnishes services under a section 1915(b)(1) waiver only if the agency excludes from participation any entity described in paragraph (D)(2) of this section.

2) Entities that must be excluded. DHCS shall exclude an entity that meets any of the following conditions:

a) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual.

b) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes, as described in section 1128(b)(8)(B) of the Act.

c) Employs or contracts directly or indirectly with one of the following:

i. Any individual or entity that, under section 1128 or section 1128A of the Act, is precluded from furnishing health care, utilization review, medical social services, or administrative services.

ii. Any entity described in paragraph (D)(2)(a) of this section.

E. The Contractor shall periodically check the Office of the Inspector General's List of Excluded Individuals/Entities and the Medi-Cal Suspended and Ineligible Provider List (S & I List) to prevent employment of, or payments to, any individuals or entities on those lists, this must be satisfied prior to Medi-Cal certification of any individual or organizational provider. If the provider is listed on either the Office of the Inspector General's List of Excluded Individuals/Entities or the Medi-Cal S & I List, the Contractor shall not certify or pay any provider with Medi-Cal funds, and any such inappropriate payments or overpayments may be subject to recovery and/or be the basis for other sanctions by the appropriate authority.

F. Report. Pursuant to 42 CFR 455.1(a)(1), the Contractor must report fraud and abuse information to DHCS.

1) If the Contractor identifies an issue or receives notification of a complaint concerning an incident of possible potential fraud or abuse, the Contractor shall conduct an internal investigation to determine the validity of the issue/complaint, regarding potential fraud and/or abuse, and develop and implement corrective action, if needed. The majority of potential fraud or abuse issues are expected to be resolved at the Contractor level.

2) If the Contractor's internal investigation concludes that fraud or abuse has occurred or is suspected, the issue is egregious, or beyond the scope of the Contractor's ability to pursue, the Contractor shall report the issue to DHCS for review and disposition.

3) DHCS is to be notified if the Contractor discontinues a provider contract or disciplines a provider due to a fraud or abuse issue.

G. Service Verification. To assist DHCS in meeting its obligation under 42 CFR 455.1(a)(2), the Contractor shall have a way to verify whether services were actually furnished to beneficiaries.

H. DMC Claims and Reports

Contractor or providers that bill DHCS or the Contractor for services identified in Section 51516.1 of Title 22 shall submit claims in accordance with DHCS's DMC Provider Billing Manual.

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's DMC Provider Billing Manual. Options for verifying the eligibility of a Medi-Cal beneficiary are described in the DHCS's DMC Provider Billing Manual.

Claims for DMC reimbursement shall include DMC-ODS services covered under the 1115 terms and conditions, and any State Plan services covered under Title 22, Section 51341.1(c-d) and administrative charges that are allowed under W&I Code, Sections 14132.44 and 14132.47.

1) 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.

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

3) The following forms shall be prepared as needed and retained by the provider for review by State staff:

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

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

   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, CCR, Sections 51008 and 51008.5.

4) Certified Public Expenditure County Administration

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

5) Utilization Review and Quality Assurance

   If while completing the Utilization Review and Quality Assurance requirements of this Exhibit A, Attachment I, any of the Contractor's skilled professional medical and personnel directly supporting staff meet the criteria set forth in 42 CFR 432.50(d)(1), then the Contractor shall submit a written request that specifically demonstrates how the skilled professional medical personnel and directly supporting staff meet all of the applicable criteria set forth in 42 CFR 432.50(d)(1) and outlines the duties they shall perform to assist DHCS, or DHCS's skilled professional medical personnel, in

activities that are directly related to the administration of the DMC Program. DHCS shall respond to the Contractor's written request within 20 days with either a written agreement pursuant to 42 CFR 432.50(d)(2) approving the request or a written explanation as to why DHCS does not agree that the Contractor's skilled professional medical personnel and directly supporting staff do not meet the criteria set forth in 42 CFR 432.50(d)(1).

21. Additional Requirements

A. Confidentiality Requirements

1) The Contractor shall ensure that each beneficiary's privacy is protected in accordance with all federal and state privacy laws, including but not limited to 45 CFR 160 and 164, 42 CFR 438.208(b)(4), and 42 CFR 438.224, to the extent that such provisions are applicable.

B. Sharing of Information with Beneficiaries

1) Sharing of Information with Beneficiaries. The Contractor shall not prohibit nor otherwise restrict, a licensed, or registered professional, who is acting within the lawful scope of practice (pursuant to 42 CFR. 438.102(a)(1) and Title 9, Section 13015), from advising or advocating on behalf of a beneficiary for whom the provider is providing SUD treatment services for any of the following:

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

b) Any information the beneficiary needs in order to decide among all relevant treatment options,

c) The risks, benefits and consequences of treatment or non-treatment

d) The beneficiary's right to participate in decisions regarding his/her healthcare including the right to refuse treatment and to express preference regarding future treatment decisions.

2) Pursuant to 42 CFR 438.102(a)(2), for a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service. Pursuant to 42 CFR 438.102(b)(1), the Contractor must provide information about the services it does not cover on moral or religious grounds. A Contractor that elects the option provided in paragraph (A)(2) of this section must furnish information about the services it does not cover as follows:

a) To DHCS:

i. With its application for a Medicaid Intergovernmental Agreement; and

ii. Whenever it adopts the policy during the term of the Intergovernmental Agreement.

b) Consistent with the provisions of §438.10:

i. To potential enrollees, before and during enrollment; and

ii. To enrollees, within 90 days after adopting the policy with respect to any particular service. (Although this timeframe would be sufficient to entitle the Contractor to the option provided in paragraph (A)(2) of this section, the overriding rule in §438.10(f)(4) requires DHCS, its contracted representative, or the Contractor to furnish the information at least 30 days before the effective date of the policy.)

3) Information requirements: State responsibility. For each service excluded by the Contractor under paragraph (a)(2) of this section, DHCS must provide information on how and where to obtain the service, as specified in 438.10, paragraphs (e)(2)(ii)(E) and (f)(6)(xii).

4) Notice of provider termination. Pursuant to 42 CFR 438.10(f)(5) the Contractor must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each beneficiary who received his or her SUD treatment services from, or was seen on a regular basis by, the terminated provider.

a) When one of the Contractor's subcontracted SUD service providers is terminated, the Contractor shall transfer all of its beneficiaries to another SUD service provider.

5) Pursuant to 42 CFR 438.100, the Contractor shall have written policies and procedures in place for beneficiaries to request and receive copies of their medical records, and to request that they be amended or corrected.

C. Health Information System

Pursuant to 42 CFR 438.242, the Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas including, but not limited to, utilization, grievances, disenrollments, and appeals.

1) The Contractor's health information system shall, at a minimum:

a) Collect data on beneficiary and provider characteristics as specified by DHCS, and on services furnished to beneficiaries as specified by DHCS in the Cal OMS Data Collection Guide (attached as Document 3J); http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf

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

i. Verifying the accuracy and timeliness of reported data;

ii. Screening the data for completeness, logic, and consistency; and

iii. Collecting service information in standardized formats to the extent feasible and appropriate.

c) Make all collected data available to DHCS and, upon request, to CMS.

D. Share of Cost

1) Share of Cost. Pursuant to 42 CFR 438.108, any sharing of cost imposed on DMC beneficiaries shall be in accordance with 42 CFR 447.50 through 447.60.

E. Physician Incentive Plans

1) The Contractor shall obtain approval from DHCS prior to implementing a Physician Incentive Plan. A Physician Incentive Plan is any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any beneficiary. For purposes of this definition, the words shall have the meanings set forth in 42 CFR 422.208(a). DHCS shall approve the Contractor's request only if the proposed Physician Incentive Plan complies with all applicable federal and state regulations.

a) Pursuant to 42 CFR 438.6(h), the Contractor shall comply with the requirements set forth in 42 CFR §§ 422.208 and 422.210.

b) The Contractor may operate a Physician Incentive Plan only if no specific payment can be made directly or indirectly under a Physician Incentive Plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

c) When seeking approval from DHCS for its Physician Incentive Plan, the Contractor shall disclose the following:

i. Whether services not furnished by physician/group are covered by incentive plan. No further disclosure required if the Physician Incentive Plan does not cover services not furnished by physician/group;

ii. The type of incentive arrangement, e.g. withhold, bonus, capitation;

iii. The percentage of funds withheld or bonus provided (if applicable);

iv. The size of the panel, and, if patients are pooled, the approved method used for pooling; and

v. If the physician/group is at substantial financial risk, proof that the physician/group has adequate stop loss coverage, including amount and

type of stop-loss.

d) If a physician or physician group is put at substantial financial risk for services not provided by the physician/group, the Contractor shall ensure adequate stop-loss protection to individual physicians and conduct annual beneficiary surveys.

e) The Contractor shall provide information on its Physician Incentive Plan to any Medicaid beneficiary upon request (this includes the right to adequate and timely information on a Physician Incentive Plan).

f) If required to conduct beneficiary survey, survey results shall be disclosed to DHCS and, upon request, to beneficiaries, per the Social Security Act (SSA) 1903(m)(2)(A)(x); 42 CFR §§ 422.208; 422.210;438.6(h); and SSA 1876(i)(8)(A)(ii)(II).

22. Quality Management (QM) Program

A. 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.

B. The Contractor shall have a written description of the QM Program which clearly defines the QM Program's structure and elements, assigns responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement.

C. Annually, each Contractor must:

1) Measure and report to DHCS its performance using standard measures required by DHCS including those that incorporate the requirements of section 438.204(c) and 438.240(a)(2);

2) Submit to DHCS data specified by DHCS that enables DHCS to measure the Contractor's performance; or

3) Perform a combination of the activities described above.

D. The QM Program shall be evaluated annually and updated by the Contractor as necessary per 42 CFR 438.240(e).

E. Triennial Review

1) During the triennial reviews, DHCS shall review the status of the Quality Improvement Plan and the Contractor's monitoring activities.

a) 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.

b) This triennial review shall provide DHCS with information as to whether the counties are complying with their responsibility to monitor their service delivery capacity.

c) The counties shall receive a final report summarizing the findings of the triennial review and if out of compliance, the Contractor must submit a plan of correction (POC) within 60 days of receipt of the final report. DHCS shall follow-up with the POC to ensure compliance.

F. 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.

G. 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.

H. The Contractor shall have mechanisms to detect both underutilization of services and overutilization of services, as required by 42 CFR 438.240(b)(3).

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

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

2) Evaluating beneficiary grievances, appeals and fair hearings at least annually;

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

4) The Contractor shall inform providers of the results of beneficiary/family satisfaction activities.

J. 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.

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

L. 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.

M. The Contractor shall have a QM Work Plan covering the current Intergovernmental 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:

1) Evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by 42 CFR 438.240 and 42 CFR 438.416;

2) Evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service;

3) A description of completed and in-process QM activities, including performance improvement projects. The description shall include:

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

b) Objectives, scope, and planned QM activities for each year; and

c) Targeted areas of improvement or change in service delivery or program design.

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

5) Evidence of compliance with the requirements for cultural competence and linguistic competence specified in 42 CFR 438.10 and 42 CFR 438.206.

23. State Monitoring

A. DHCS Monitoring Reviews and Financial Audits of Contractor

DHCS shall monitor the Contractor's operations for compliance with the provisions of this Intergovernmental Agreement and applicable federal and state law and regulations, including 42 CFR 438.66, 42 CFR 438.200, 42 CFR 438.202, 42 CFR 438.204, and 42 CFR 438.6(g). Such monitoring activities shall include, but not be limited to, inspection and auditing of Contractor services, management systems and procedures, and books and records, as DHCS deems appropriate, at any time during the Contractor's or facility's normal business hours. When monitoring activities identify areas of non-compliance, DHCS shall issue reports to the Contractor detailing findings, recommendations, and corrective action. DHCS shall specifically monitor the following in accordance with 42 CFR 438.66:

1) Beneficiary enrollment and disenrollment

2) Processing of grievances and appeals

3) Violations subject to intermediate sanctions

4) Violations of the conditions for FFP

5) All other provisions of the Agreement, as appropriate.

B. DHCS Imposition of Sanctions Upon the Contractor

1) Pursuant to 42 CFR 438.700, DHCS may impose sanctions upon the Contractor if DCHS makes any of the following determinations:

a) The Contractor acted or failed to act as follows:

i. Fails substantially to provide medically necessary services that the Contractor is required to provide, under law or under its Intergovernmental Agreement with DHCS, to a beneficiary covered under the Intergovernmental Agreement.

ii. Imposes on beneficiaries premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

iii. Acts to discriminate among beneficiaries on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.

iv. Misrepresents or falsifies information that it furnishes to CMS or to DHCS.

v. Misrepresents or falsifies information that it furnishes to a beneficiary, potential beneficiary, or health care provider.

2) DHCS may base its determinations of violations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

3) The types of intermediate sanctions that DHCS may impose upon the Contractor the above listed violations include the following:

a) Civil money penalties in the amounts specified in 42 CFR §438.704.

b) Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until CMS or DHCS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

4) DHCS retains authority to impose additional sanctions under State statutes or State

regulations that address areas of noncompliance specified in 42 CFR §438.700, as well as additional areas of noncompliance. Nothing in this subsection prevents DHCS from exercising that authority.

C. Postservice Postpayment Utilization Reviews

1) After the DMC services have been rendered and paid, DHCS shall conduct Postservice Postpayment (PSPP) Utilization Reviews of the subcontracted DMC providers to determine whether the DMC services were provided in accordance with Title 22, Section 51341.1. 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 Sections 1 and 2 herein. The Contractor shall attest the deficiencies have been remediated and are complete, pursuant to Section 23.1 (E).

2) State shall take appropriate steps in accordance with Title 22, CCR, Section 51341.1 to recover payments made if subsequent investigation uncovers evidence that the claim(s) should not have been paid or that DMC services have been improperly utilized, and/or shall take the corrective action as appropriate. If programmatic or fiscal deficiencies are identified, the Provider shall be required to submit a Corrective Action Plan (CAP) to the Contractor for review and approval prior to submission to DHCS for final approval.

a) Pursuant to CCR, Title 22, Section 51341.1(o), all deficiencies identified by the PSPP-review, whether or not a recovery of funds results, must be corrected and the entity that provided the services must submit a Contractor-approved CAP to the PSPP Unit within 60 days of the date of the PSPP report.

i. The plan shall:

a. Address each demand for recovery of payment and/or programmatic deficiency;

b. Provide a specific description of how the deficiency shall be corrected;

c. Specify the date of implementation of the corrective action; and

d. Identify who will be responsible for correction and who will be responsible for on-going compliance.

ii. 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. The entity that provided the services must submit an updated CAP to the DMC PSPP Unit within 30 days of notification.

iii. If the entity that provided the services, does not submit a CAP, or, 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 Exhibit A, Attachment I, Section 23.1 (E). DHCS shall inform the Contractor when funds shall be withheld.

3) Contractor and/or subcontractor may appeal DMC dispositions concerning demands for recovery of payment and/or programmatic deficiencies of specific claims. Such appeals shall be handled pursuant to Title 22, CCR, Section 51341.1(q). This section shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of DHCS pursuant to Exhibit B, Part II, Section 3, of this Contract.

4) State shall monitor the subcontractor's compliance with PSPP utilization review requirements in accordance with Title 22. Counties are also required to monitor of the subcontractor's compliance pursuant to Section 23 (C), of this Intergovernmental Agreement. The federal government may also review the existence and effectiveness of DHCS's utilization review system.

5) Contractor shall implement and maintain compliance with the system of review described in Title 22, Section 51341.1, for the purposes of reviewing the utilization, quality, and appropriateness of covered services and ensuring that all applicable Medi-Cal requirements are met.

6) Contractor shall assure that subcontractor sites must keep a record of the beneficiaries/patients being treated at that location. Contractor shall retain beneficiary records for a minimum of three (3) years from the date of the last face-to-face contact. When an audit by the Federal Government or DHCS has been started before the expiration of the three-year period, the beneficiary records shall be maintained until completion of the audit and the final resolution of all issues as a result of the audit.

23.1 Contractor Monitoring

A. EQRO Monitoring Plan: Beginning in Intergovernmental Agreement year two, DHCS shall monitor the counties at least once per year through the External Quality Review Organizations (EQRO) pursuant to 42 CFR 438.350:

1) Except as provided in §438.362, a qualified EQRO performs an annual EQR for each contracting MCO or PIHP;

2) The EQRO has sufficient information to use in performing the review;

a) The contractor shall make the following data elements available, including but not limited to;

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); and

iv. Number, percentage of denied and time period of authorization requests approved or denied.

3) The information used to carry out the review must be obtained from the EQR-related activities described in §438.358.

a) A detailed technical report that describes the manner in which the data from all activities conducted in accordance with § 438.358 were aggregated and analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP. The report must also include the following for each activity conducted in accordance with § 438.358:

i. Objectives.

ii. Technical methods of data collection and analysis.

iii. Description of data obtained.

iv. Conclusions drawn from the data.

b) An assessment of each PIHP's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.

c) Recommendations for improving the quality of health care services furnished by each PIHP.

d) As the State determines, methodologically appropriate, comparative information about all PIHPs.

e) An assessment of the degree to which each PIHP has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

4) The information provided to the EQRO in accordance with paragraph (c) of this section is obtained through methods consistent with the protocols established under §438.352; and

5) The results of the reviews are made available as specified in §438.364(a)(1)(i) through (a)(1)(iv).

B. Contractor shall conduct, at least annually, a utilization review of DMC providers to

assure covered services are being appropriately rendered. The annual review must include an on-site visit of the service provider. Reports of the annual review shall be provided to DHCS's Performance Management Branch at:

Substance Use Disorder – Program, Policy, and Fiscal Division
Performance Management Branch
Department of Health Care Services
PO Box 997413, MS-2621
Sacramento, CA 95899-7413;

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

Review reports shall be provided to DHCS within 2 weeks of completion by the Contractor.

Technical assistance is available to counties from DHCS SUD PPFD.

C. 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 their challenges that can be addressed with facilitation and technical assistance. If the Contractor remains noncompliant, the Contractor shall submit a corrective action plan (CAP) to DHCS. The CAP must 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.

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

D. Contractor shall ensure that DATAR submissions, detailed in Section 23.2 (E) of this Intergovernmental Agreement 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.

E. Contractor must monitor and attest compliance and/or completion by Providers with CAP requirements (detailed in Section 23 (C)(2)(a)(i)) of this Exhibit as required by any PSPP review. 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 must be accomplished within the timeline specified in the approved CAP, as noticed by DHCS.

F. 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.

G. Contractor shall comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR 434.6(a)(12) and 42 CFR 447.26.

1) Contractor shall report all identified provider preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available as specified by DHCS in accordance with 42 CFR 438.6(f)(2)(ii). The contractor must use and submit the report using the DHCS Drug Medi-Cal Organized Delivery System Provider Preventable Conditions (PPC) Reporting Form at the time of discovery of any provider preventable conditions that are covered under this provision to:

   Substance Use Disorder – Program, Policy, and Fiscal Division, Performance Management Branch
   Department of Health Care Services
   PO Box 997413, MS-2621
   Sacramento, CA 95899-7413;

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

23.2 Reporting Requirements

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.

A. Contractor shall submit documentation to DHCS in a format specified by DHCS that complies with the following requirements:

   1) Offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service area,

   2) Maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of beneficiaries in the area,

   3) Submits the documentation described in paragraph (B) of this section as specified by DHCS, but no less frequently than the following:

      a) At the time it enters into an Intergovernmental Agreement with DHCS.

      b) At any time there has been a significant change (as in the Contractor's operations that would affect adequate capacity and services, including:

         i. Changes in Contractor services, benefits, geographic service area or payments; or

         ii. Enrollment of a new population in the Contractor.

   4) DHCS review and certification to CMS. After DHCS reviews the documentation submitted by the Contractor, DHCS must certify to CMS that the Contractor has complied with the State's requirements for availability of services, as set forth in

§438.206.

5) CMS' right to inspect documentation. DHCS must make available to CMS, upon request, all documentation collected by DHCS from the Contractor.

B. California Outcomes Measurement for Prevention (CalOMS-Pv)

The CalOMS-Pv Business Rules and Requirements are:

1) Contractor and/or subcontractors receiving Substance Abuse Prevention and Treatment (SAPT) Primary Prevention Set-Aside funding shall input planning, service/activity and evaluation data into CalOMS Pv. When submitting data, Contractor shall comply with the CalOMS Pv Data Quality Standards (Document 1T).

2) Contractor shall report services/activities by the date of occurrence on an ongoing basis throughout each month. All data for each month must be input no later than the 10th day of the following month.

3) Contractor shall review all data input into CalOMS Pv on a quarterly basis. Contractor shall verify that the data meets the CalOMS Pv Data Quality Standards by reviewing and releasing the data. Certification is due by the last day of the month following the end of the quarter.

4) Contractor shall report progress to DHCS via CalOMS Pv for the goals and objectives in the County Strategic Prevention Plan (as described in Exhibit A, Attachment I, Section 27(B)(2) on an annual basis by September 30th of each fiscal year.

5) If Contractor cannot meet the established due dates, a written request for an extension shall be submitted to DHCS 10-days prior to the due date.

6) In order to ensure that all persons responsible for CalOMS Pv data entry have sufficient knowledge of the CalOMS Pv Data Quality Standards, all new CalOMS Pv users, whether employed by the Contractor or its subcontractors, shall participate in CalOMS Pv trainings prior to inputting data into the system.

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

The CalOMS-Tx business rules and requirements are:

1) 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.

2) Contractor shall conduct information technology (IT) systems testing and pass State certification testing before commencing submission of CalOMS-Tx data. If the

Contractor subcontracts with vendor for IT services, Contractor is responsible for ensuring that the subcontracted IT system is tested and certified by the DHCS prior to submitting CalOMS-Tx data. If Contractor changes or modifies the CalOMS-Tx IT system, then Contractor shall re-test and pass state re-certification prior to submitting data from new or modified system.

3) Electronic submission of CalOMS-Tx data shall be submitted by Contractor within 45 days from the end of the last day of the report month.

4) Contractor shall comply with data collection and reporting requirements established by the DHCS CalOMS-Tx Data Collection Guide (Document 3J) and all former Department of Alcohol and Drug Programs Bulletins and DHCS Information Notices relevant to CalOMS-Tx data collection and reporting requirements.

5) Contractor shall submit CalOMS-Tx admission, discharge, annual update, resubmissions of records containing errors or in need of correction, and "provider no activity" report records in an electronic format approved by DHCS.

6) Contractor shall comply with the CalOMS-Tx Data Compliance Standards established by DHCS identified in (Document 3S) for reporting data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method.

7) Contractor shall participate in CalOMS-Tx informational meetings, trainings, and conference calls.

8) Contractor shall implement and maintain a system for collecting and electronically submitting CalOMS-Tx data.

9) Contractor shall meet the requirements as identified in Exhibit F, Privacy and Information Security Provisions and Exhibit F, Attachment I – SSA Agreement.

D. CalOMS-Tx and CalOMS-Pv General Information

1) If the Contractor experiences system or service failure or other extraordinary circumstances that affect its ability to timely submit CalOMS-Tx and/or CalOMS-Pv data, and or meet other CalOMS-Tx and/or CalOMS-Pv compliance requirements, Contractor shall report the problem in writing before the established data submission deadlines. The written notice shall include a remediation plan that is subject to review and approval by DHCS. A grace period of up to sixty (60) days may be granted, at DHCS's sole discretion, for the Contractor to resolve the problem before non-DMC payments are withheld.

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

3) Contractor shall comply with the treatment and prevention data quality standards established by DHCS. Failure to meet these standards on an ongoing basis may

result in withholding non-DMC funds.

4) If the Contractor submits data after the established deadlines, due to a delay or problem, Contractor is still responsible for collecting and reporting data from time of delay or problem.

E. Drug and Alcohol Treatment Access Report (DATAR)

The DATAR business rules and requirements are:

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

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.

2) 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.

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

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

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

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

F. Charitable Choice

Contractor shall document the total number of referrals necessitated by religious objection to other alternative substance abuse providers. The contractor shall annually

submit this information to DHCS by October 1st. The annual submission shall contain all substantive information required by DHCS and be formatted in a manner prescribed by DHCS,

G. Quarterly Federal Financial Management Report (QFFMR)

The QFFMR must be submitted to reflect quarterly SAPTBG expenditures.

For the beginning of each federal award year, the due dates are:

March 1 for the period October through December
June 1 for the period January through March
September 1 for the period April through June
December 1 for the period July through September

H. Year-End Cost Settlement Reports

Pursuant to W&I Code, Section 14124.24 (g(1)) Contractor shall submit to DHCS, on November 1 of each year, the following year-end cost settlement documents by paper or electronic format submission as prescribed by DHCS for the previous fiscal year:

1) Document 2P, County Certification Year-End Claim for Reimbursement

2) Document 2P(a) and 2P(b), Drug Medi-Cal Cost Report Forms for Intensive Outpatient Treatment for Non-Perinatal or Perinatal (if applicable)

3) Document 2P(c) and 2P(d), Drug Medi-Cal Cost Report Forms for Outpatient Drug Free Individual Counseling for Non-Perinatal or Perinatal (if applicable)

4) Document 2P(e) and 2P(f), Drug Medi-Cal Cost Report Forms for Outpatient Drug Free Group Counseling for Non-Perinatal or Perinatal (if applicable)

5) Document 2P(g), Drug Medi-Cal Cost Report Forms for Residential for Perinatal (if applicable)

6) Document 2P(h) and 2P(i), Drug Medi-Cal Expenditure Forms for Narcotic Treatment Programs, Non-Perinatal or Perinatal (if applicable)

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

1) The 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 Corrective Action Plan (CAP) to ensure timely reporting in the future. DHCS shall approve or reject the CAP or request revisions to the CAP which shall be resubmitted to DHCS within thirty (30) days.

2) 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.

23.3 Training

A. DHCS SUD - Program, Policy, and Fiscal Division (SUD PPFD) shall provide mandatory annual training to the Contractor on the requirements of Title 22 and the DMC program requirements.

B. Contractor may request additional Technical Assistance or training from SUD-PPFD on an ad hoc basis.

C. Training to DMC Subcontractors

1) Contractor shall ensure that all subcontractors receive training on the requirements of Title 22 regulations and DMC requirements at least annually. Documented attendance of any subcontracted provider at the annual trainings offered by DHCS (specified in Section 23.3, of this Intergovernmental Agreement) shall suffice to meet the requirements of this provision. Contractor shall report compliance with this section to DHCS annually as part of the DHCS County monitoring process.

2) The Contractor shall require subcontractors to be trained in the ASAM Criteria prior to providing services.

a) The Contractor shall ensure that, at a 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 Pilot program services.

23.4 Monthly Monitoring

A. Contractor shall check the status of all providers monthly to ensure that they are continuing active participation in the DMC program. Any subcontracted provider who surrenders their certification or closes their facility must be reported by the Contractor to DHCS's County Monitoring Unit within two (2) business days of notification or discovery.

B. During the monthly status check, the Contractor shall monitor for a triggering recertification event (change in ownership, change in scope of services, remodeling of facility, or change in location) and report any triggering events to DHCS's County Monitoring Unit within two (2) business days of notification or discovery.

23.5 Program Complaints

A. All complaints received by Contractor regarding a DMC certified facility shall be forwarded to:

Drug Medi-Cal Complaints are to be submitted to:

Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413
Call the Hotline
Phone Toll-Free: (800) 822-6222

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

SUD Compliance Division:

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

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

B. Counties shall be responsible for investigating complaints and providing the results of all investigations to DHCS's e-mail address by secure, encrypted e-mail to: SUDCountyReports@dhcs.ca.gov within two (2) business days of completion;

23.6 Record Retention

A. Contractor shall include instructions on record retention and include in any subcontract with providers the mandate to keep and maintain records for each service rendered, to whom it was rendered, and the date of service, pursuant to W&I Code, Section 14214.1 and 42 CFR 433.32; and 22 CCR section 51341.1.

1) Subcontract Termination

a) The Contractor must notify DHCS' County Monitoring Unit of the termination of any Intergovernmental Agreement with a certified subcontracted provider, and the basis for termination of the Intergovernmental Agreement, within two (2) business days.

2) Corrective Action Plan

a) 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 withhold of funds allocated to Contractor for the provision of services, and/or termination of this

Intergovernmental Agreement for cause

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

i. DHCS shall issue a report to Contractor after conducting monitoring, utilization, or fiscal auditing reviews of 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 include:

(i) A statement of the deficiency;

(ii) A list of action steps to be taken to correct the deficiency;

(iii) Date of completion of each deficiency corrected; and

(iv) Who will be responsible for correction and ongoing compliance.

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

24. Quality Improvement (QI) Program

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

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.

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.

A. The monitoring of accessibility of services outlined in the Quality Improvement Plan will at a minimum include:

1) Timeliness of first initial contact to face-to-face appointment “frequency of follow-up

appointments in accordance with individualized treatment plans”

2) Timeliness of services of the first dose of NTP services

3) Access to after-hours care

4) Responsiveness of the beneficiary access line
5) Strategies to reduce avoidable hospitalizations

6) Coordination of physical and mental health services with waiver services at the provider level

7) Assessment of the beneficiaries’ experiences

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

B. 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.

C. 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.

D. 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. These data elements shall be incorporated into the EQRO protocol:

1) Number of days to first DMC-ODS service at appropriate level of care after referral

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

3) Access to DMC-ODS services with translation services in the prevalent

E. Operation of the QI program shall include substantial involvement by a licensed SUD staff person.

F. 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.

G. 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.

H. PIPs shall:

1) measure performance using objective quality indicators;

2) implement system interventions to achieve improvement in quality;

3) evaluate the effectiveness of interventions;

4) plan and initiate activities for increasing or sustaining improvement;

I. The Contractor shall report the status and results of each PIP to DHCS as requested

J. Each PIP must 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.

25. Utilization Management (UM) Program

A. 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.

B. Pursuant to 42 CFR 438.210(e) the Contractor shall ensure that, consistent with 42 CFR 438.6(h), and 42 CFR 422.208, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

26. Practice Guidelines

The Contractor shall comply with 42 CFR 438.236(b) which requires the adoption of practice guidelines.

The Contractor shall comply with the practice guidelines established in Exhibit A, Attachment I Section 1.2(B).

A. The Contractor's practice guidelines shall:

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

2) consider the needs of the beneficiaries;

3) be adopted in consultation with contracting health care professionals; and

4) be reviewed and updated periodically as appropriate.

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

C. The Contractor shall take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other areas to which the guidelines apply shall be consistent with the guidelines.

27. Non-DMC/SAPT

A. Restrictions on Salaries

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

B. Primary Prevention

1) The SAPT Block Grant regulation defines "Primary Prevention Programs" as those programs directed at "individuals who have not been determined to require treatment for substance abuse" (45 CFR 96.121). Primary Prevention includes strategies, programs and initiatives which reduce both direct and indirect adverse personal, social, health, and economic consequences resulting from problematic AOD availability, manufacture, distribution, promotion, sales, and use. The desired result of primary prevention is to promote safe and healthy behaviors and environments for individuals, families and communities. The Contractor shall expend not less than its allocated amount of the Substance Abuse Prevention and Treatment (SAPT) Block Grant on primary prevention as described in the SAPT Block Grant requirements (45 CFR 96.125).

2) The Contractor is required to have a current and DHCS approved County Strategic Prevention Plan (SPP) County Prevention Plan. The SPP must demonstrate use of the Substance Abuse and Mental Health Services Administration's Strategic Prevention Framework (SPF) in developing the plan as described at http://www.dhcs.ca.gov/provgovpart/Pages/Strategic-Prevention-Framework-State-Incentive-Grant-GPAC-Workgroup.aspx. DHCS shall only approve SPP's that demonstrate that the Contractor utilized the SPF. Contractor must:

a) Follow the DHCS guidelines provided in the Strategic Prevention Framework

Plan Resource Document located in the CalOMS Pv Library at https://caprev.onmosaix.com/caprevent2016/pLibDialog.aspx.

b) Begin preparing a new SPP at least 9-months prior to the expiration date of the current SPP.

c) Submit a timeline to DHCS for completion of the SPP that includes proposed dates for submitting each section of the SPP. The sections are outlined in the Strategic Prevention Framework Plan Resource Document.

d) Submit a draft to DHCS, based on the timeline, for each section of the SPP for review and approval.

e) Submit to DHCS the final draft of the SPP no later than 30-days prior to the start date of the new SPP.

f) Upload an electronic copy of the approved SPP into CalOMS Pv within 10-days of approval.

g) Input the Problem Statements, Goals and Objectives from the SPP into CalOMS Pv no later than 10-days after the start date of the SPP.

3) The Contractor shall submit a Prevention Mid-Year Budget to DHCS by January 31 of each fiscal year. The budget shall indicate how the SAPT Block Grant Primary Prevention Set-Aside shall be expended for the fiscal year.

4) Friday Night Live

The Contractor and any subcontractors receiving SAPT Friday Night Live funding must meet the following:

a) Engage in programming that meets the FNL Youth Development Standards of Practice, Operating Principles and Core Components outlined at http://fridaynightlive.org/about-us/cfnlp-overview/;

b) Use CalOMS Pv for all reporting including Chapter Profiles, FNL County Profiles and chapter activity;

c) Follow the FNL Data Entry Instructions for CalOMS Pv as provided by DHCS in the CalOMS Pv Library;

d) Meet the Member in Good Standing (MIGS) requirements, as determined by DHCS in conjunction with the California Friday Night Live Partnership. If the Contractor does not meet the MIGS requirements, then the Contractor shall submit counties fail to a technical assistance plan detailing how the Contractor intends to ensure satisfaction of the MIGS requirements to DHCS for approval.

C. Perinatal Services Network Guidelines 2016

Pursuant to 45 CFR 96.124 ((c)(1-3)) the Contractor shall expend the specified percentage of SAPT Block Grant funds, as calculated by said regulations, on perinatal services, pregnant women, and women with dependent children each state fiscal year (SFY). The Contractor shall expend these funds either by establishing new programs or expanding the capacity of existing programs. The Contractor shall calculate the appropriate expenditure amount by using Generally Accepted Accounting Principles and the composition of the base shall be applied consistently from year to year. (See the County Share of SAPT Block Grant Women Services Expenditure Requirement: http://www.dhcs.ca.gov/formsandpubs/Pages/Information_Notices_2016.aspx)

Contractor shall comply with the perinatal programs requirements as outlined in the Perinatal Services Network Guidelines, promulgated to 45 CFR 96.137. The "Perinatal Services Network Guidelines 2016" are attached to this Intergovernmental Agreement as Document 1G, incorporated by reference. The Contractor shall comply with the "Perinatal Services Network Guidelines 2016" until new Perinatal Services Network Guidelines are established and adopted. The incorporation of any new Perinatal Service Network Guidelines into this Intergovernmental Agreement shall not require a formal amendment.

All SAPT BG-funded programs providing treatment services designed for pregnant women and women with dependent children will treat the family as a unit and therefore will admit both women and their children into treatment services, if appropriate.

The Contractor must directly provide, or provide a referral for, the following services:

1) Primary medical care for women, including referral for prenatal care and, while the women are receiving such services, child care;

2) Primary pediatric care, including immunization, for their children;

3) Gender specific substance abuse treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse and parenting, and child care while the women are receiving these services;

4) Therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, their issues of sexual and physical abuse, and neglect; and

5) Sufficient case management and transportation to ensure that women and their children have access to services.

D. Recovery Services shall include:

1) Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care;

2) Recovery Monitoring: Recovery coaching, monitoring via telephone and internet;

3) Substance Abuse Assistance: Peer-to-peer services and relapse prevention;

4) Education and Job Skills: Linkages to life skills, employment services, job training, and education services;

5) Family Support: Linkages to childcare, parent education, child development support services, family/marriage education;

6) Support Groups: Linkages to self-help and support, spiritual and faith-based support;

7) Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

8) Recovery Residences

E. Funds identified in this Intergovernmental Agreement shall be used exclusively for county alcohol and drug abuse services to the extent activities meet the requirements for receipt of federal block grant funds for prevention and treatment of substance abuse described I subchapter XVII of Chapter 6A of Title 42 of the United State Code.

28. Formation and Purpose

A. Authority

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

B. Control Requirements

1) Performance under the terms of this Exhibit A, Attachment I, is subject to all applicable federal and state laws, regulations, and standards. In accepting DHCS drug and alcohol combined program allocation pursuant to HSC Sections 11814(a) and (b), Contractor shall: (i) establish, and shall require its subcontractors to establish, written policies and procedures consistent with the following requirements; (ii) monitor for compliance with the written procedures; and (iii) be held accountable for audit exceptions taken by DHCS against the Contractor and its subcontractors for any failure to comply with these requirements:

a) HSC, Division 10.5, commencing with Section 11760;

b) Title 9, California Code of Regulations (CCR) (herein referred to as Title 9), Division 4, commencing with Section 9000;

c) Government Code Section 16367.8;

d) Government Code, Article 7, Federally Mandated Audits of Block Grant Funds Allocated to Local Agencies, Chapter 1, Part 1, Division 2, Title 5, commencing at Section 53130;

e) Title 42 United State Code (USC), Sections 300x-21 through 300x-31, 300x-34, 300x-53, 300x-57, and 330x-65 and 66;

f) The Single Audit Act Amendments of 1996 (Title 31, USC Sections 7501-7507) and the Office of Management and Budget (OMB) Circular A-133 revised June 27, 2003 and June 26, 2007.

g) Title 45, Code of Federal Regulations (CFR), Sections 96.30 through 96.33 and Sections 96.120 through 96.137;

h) Title 42, CFR, Sections 8.1 through 8.6;

i) Title 21, CFR, Sections 1301.01 through 1301.93, Department of Justice, Controlled Substances; and,

j) State Administrative Manual (SAM), Chapter 7200 (General Outline of Procedures).

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

2) 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 Intergovernmental Agreement.

3) Contractor shall adhere to the applicable provisions of Title 45, CFR, Part 96, Subparts C and L, as applicable, in the expenditure of the SAPTBG funds. Document 1A, 45 CFR 96, Subparts C and L, is incorporated by reference.

4) Documents 1C incorporated by this reference, contains additional requirements that shall be adhered to by those Contractors that receive Document 1C. This document is:

a) Document 1C, Driving-Under-the-Influence Program Requirements;

C. In accordance with the Fiscal Year 2011-12 State Budget Act and accompanying law (Chapter 40, Statues of 2011 and Chapter 13, Statues of 2011, First Extraordinary Session), contractors that provide Women and Children's Residential Treatment Services shall comply with the program requirements (Section 2.5, Required Supplemental/Recovery Support Services) of the Substance Abuse and Mental Health Services Administration's Grant Program for Residential Treatment for Pregnant and

Postpartum Women, RFA found at http://www.samhsa.gov/grants/grant-announcements/ti-14-005.

28.1 Performance Provisions

A. Monitoring

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

a) Whether the quantity of work or services being performed conforms to Exhibit B;

b) Whether the Contractor has established and is monitoring appropriate quality standards;

c) Whether the Contractor is abiding by all the terms and requirements of this Intergovernmental Agreement;

d) Whether the Contractor is abiding by the terms of the Perinatal Services Network Guidelines 2016 (Document 1G); and

e) Contractor shall conduct annual onsite monitoring reviews of services and subcontracted services for programmatic and fiscal requirements. Contractor shall submit copy of their monitoring and audit reports to DHCS within two weeks of issuance. Reports should be sent by secure, encrypted e-mail to:

SUDCountyReports@dhcs.ca.gov

or

Substance Use Disorder - Prevention, Treatment and Recovery Services
Division, Performance Management Branch
Department of Health Care Services
PO Box 997413, MS-2627
Sacramento, CA 95899-7413;

2) 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 the Intergovernmental Agreement or both.

B. Performance Requirements

1) Contractor shall provide services based on funding set forth in Exhibit B, Attachment I, and under the terms of this Intergovernmental Agreement.

2) Contractor shall provide services to all eligible persons in accordance with federal and state statutes and regulations. Contractor shall assure that in planning for the provision of services, the following barriers to services are considered and

addressed:

a) Lack of educational materials or other resources for the provision of services;

b) Geographic isolation and transportation needs of persons seeking services or remoteness of services;

c) Institutional, cultural, and/or ethnicity barriers;

d) Language differences;

e) Lack of service advocates;

f) Failure to survey or otherwise identify the barriers to service accessibility; and,

g) Needs of persons with a disability.

3) Contractor shall comply with any additional requirements of the documents that have been incorporated herein by reference, including, but not limited to, those in the Exhibit A – Scope of Work, Provision 6.

4) Amounts awarded pursuant to Exhibit A, Attachment I shall be used exclusively for providing alcohol and/or drug program services consistent with the purpose of the funding.

5) DHCS shall issue a report to Contractor after conducting monitoring, utilization, or auditing reviews of county or county subcontracted providers. When the DHCS report identifies non-compliant services or processes, it shall require a CAP. The Contractor, or in coordination with its subcontracted provider, shall submit a CAP to DHCS within 60 calendar days from the date of the report to:

Substance Use Disorder – Program, Policy and Fiscal Division, Performance Management Branch
Department of Health Care Services
PO Box 997413, MS-2621
Sacramento, CA 95899-7413;

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

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

a) Address the specific actions to correct deficiency or non-compliance

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

c) Provide a timeline to complete the actions.

Exhibit A, Attachment I
Program Specifications

29. Definitions

29.1 General Definitions.

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

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

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

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

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

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

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

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

H. **"Final Allocation"** means the amount of funds identified in the last allocation letter issued by the State for the current fiscal year.

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

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

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

Attachment I.

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

M. **"Non-Drug Medi-Cal Amount"** means the contracted amount of SAPT Block Grant funds for services agreed to by the State and the Contractor.

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

O. **"Preliminary Settlement"** means the settlement of only SAPT funding for counties that do include DMC funding.

P. **"Revenue"** means Contractor's income from sources other than the State allocation.

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

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

S. **"Service Element"** is the specific type of service performed within the more general service modalities. A list of the service modalities and service elements and service elements codes is incorporated into this Intergovernmental Agreement as Document 1H(a) "Service Code Descriptions".

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

U. **"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.

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

29.2 Definitions Specific to Drug Medi-Cal

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, and/or Title 22. Definitions of covered treatment modalities and services are found in Title 22 (Document 2C) and are incorporated by this reference.

A. **"Action**" - (1) The denial or limited authorization of a requested service, including the type or level of service; (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; or (5) The failure of a Contractor to act within the timeframes provided in §438.408(b).

B. **"Administrative Costs"** means the Contractor's actual direct costs, as recorded in the Contractor's financial records and supported by source documentation, to administer the program or an activity to provide service to the DMC program. Administrative costs do not include the cost of treatment or other direct services to the beneficiary. Administrative costs may include, but are not limited to, the cost of training, programmatic and financial audit reviews, and activities related to billing. Administrative costs may include Contractor's overhead per the approved indirect cost rate proposal pursuant to OMB Circular A-87 and the State Controller's Office Handbook of Cost Plan Procedures.

C. "**Appeal**" is the request for review of an "action".

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

E. **"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.

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

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

H. **"Covered Services"** means those DMC services authorized by Title XIX or Title XXI of the Social Security Act; Title 22 Section 51341.1; W&I Code, Section 14124.24; and California's Medicaid State Plan, including the DMC ODS 1115 Demonstration Waiver standard terms and conditions.

I. **"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.

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

K. **"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.

L. **"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.

M. **"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 must comply with 42 CFR 431.220(a)(5), 438.408(f), 438.414, and 438.10(g)(1).

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

O. **"Grievance"** means an expression of dissatisfaction about any matter other than an "action".

P. **"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.

Q. **"Medical Necessity"** means those substance use treatment services that are reasonable and necessary to protect life, prevent significant illness or disability, or alleviate severe pain through the diagnosis and treatment of a disease, illness or injury consistent with and 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.

R. **"Minor Consent DMC Services"** are those covered services that, pursuant to Family Code Section 6929, may be provided to persons 12-20 years old without parental consent.

S. **"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.

T. **"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.

U. **"Notice of Action"** means a formal communication of any action, as defined above and

consistent with 42 CFR 438.404 and 438.10.

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

W. **"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).

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

Y. **"Post Service Post Payment (PSPP) Utilization Review"** means the review for program compliance and medical necessity conducted by the State after service was rendered and paid. State may recover prior payments of Federal and State funds if such review determines that the services did not comply with the applicable statutes, regulations, or standards (Cal. Code Regs. CCR, Title 22, Section 51341.1 (k)).

Z. **"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.

AA. **"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.

BB. **"Provider Certification"** means the provider must be certified in order to participate in the Medi-Cal program.

CC. **"Provider of DMC Services"** means any person or entity that provides direct substance use treatment services and has been certified by the State as meeting the standards for participation in the DMC program set forth in the "DMC Certification Standards for Substance Abuse Clinics", Document 2E and "Standards for Drug Treatment Programs (October 21, 1981)", Document 2F.

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

EE. **"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.

FF. **"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.

GG. **"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.

HH. **"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.

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

JJ. **"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.

30. Contractor Specific Requirements

Beginning June 15, 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 Section 1.2(B) 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 ASAM criteria.

2) Contractor Specific Covered Services include:

a) Additional Medication Assisted Treatment (MAT);

b) Partial Hospitalization; and

c) Transitional Housing.

B. Access to Services

In addition to the general access to services requirements outlined in Section 2.2 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific access to services requirements:

1) Beneficiaries shall access the Contractor's treatment services through the Behavioral Health Services Gateway Call Center (Gateway Call Center or Gateway), or through referral made by one of the post-authorization sites.

2) Gateway Call Center*:*

a) The Gateway Call Center shall be the entry point for beneficiaries seeking Substance Use Disorder Services (SUDS). Beneficiaries shall be able to call a toll-free line as the first step toward admission in the substance use treatment system. Beneficiaries shall be referred to the Gateway Call Center from the courts, probation, parole, doctors, social workers, Child Protective Services (CPS), friends, family, and word of mouth.

b) The Gateway Call Center shall provide beneficiaries with 24/7 access and/or referral for outpatient screening, triage, residential, and detoxification services. The 24/7 access is for the continuum of care within the Substance Use Treatment system.

c) The Gateway Call Center staff shall conduct a brief substance use and risk screening to determine an initial Level of Care (LOC) placement. A comprehensive ASAM assessment shall subsequently be conducted at the treatment site. All provider sites shall be assessment sites. Thus, a beneficiary may be admitted to the LOC to which they were referred to by Gateway, or be moved to a higher or lower LOC.

d) In-custody beneficiaries shall have access to two dedicated phone lines in the jails that connect directly to the Gateway Call Center at no cost to in-custody callers. In-custody callers shall receive the same standards of service as other callers to the Gateway Call Center.

3) Referrals*:*

a) Referrals for service are made in four different ways: 1) appointment-based referrals; 2) post-authorization referrals; 3) care coordination referrals determined by the Quality Improvement Coordinators (QICs); and 4) same day intake or walk-in referrals*.*

b) Appointment-based referrals*:*

i. Treatment providers shall allow beneficiaries to schedule their admission into treatment.

ii. Treatment providers shall attempt to reschedule “no shows” to the initial appointment.

c) Post-authorization referrals:

i. A post-authorization site is located in agencies that require the ability to directly screen and refer beneficiaries to treatment providers. Post-authorization locations include specific courts, a centralized facility for serving criminal justice beneficiaries, and withdrawal management services providers.

ii. Beneficiaries shall access post-authorization sites as walk-ins or referrals from the courts or other agencies, such as the Probation Department. The post-authorization site shall then directly refer the beneficiary to treatment.

iii. The primary purpose of post-authorization sites is to provide better services for beneficiaries by not requiring them to repeat information to the Gateway Call Center, already collected at a post-authorization site.

d) Care Coordination referrals:

i. Beneficiaries with special needs or that present with special circumstances, such as high use of treatment services, shall be reviewed by the QICs and placed in an appropriate LOC. Beneficiaries with special needs shall be referred to the Quality Improvement Division by the Gateway Call Center and Mental Health Department. Beneficiaries identified as high users enter the system of care via Care Coordination service through the Quality Improvement and Data Standards (QIDS) Division.

e) Same-day referrals:

i. When beneficiaries call the residential placement coordinator (after their Gateway Call Center screening), the residential placement coordinator shall offer the beneficiary a bed for intake that same day (if capacity permits) to reduce early terminations.

ii. Same-day access in outpatient shall include a scheduled rotation of “on-call” outpatient providers. Beneficiaries referred by the Gateway Call Center to an “on-call” outpatient treatment provider shall be offered an intake/assessment appointment on the same day.

f) Youth and MAT System Referrals

i. This basic referral process detailed above shall be in the Youth and MAT systems with some variations required by the specific needs of the target populations.

ii. Beneficiaries can enter the youth system directly through the QIC who manages the treatment referrals for youth and transitional aged youth (up to 26 years), or from a third party such as the Probation Department, Social Services Department, juvenile justice system, community based organizations, high schools, parents and family members.

iii. Referrals for youth outpatient services shall be distributed to the appropriate county or community provider, based on the transportation needs, geographic needs, and gang affiliation.

iv. Referrals to the youth system shall receive individualized assistance through the post-authorization referral coordinator or will be channeled directly through the Gateway Call Center.

v. Beneficiaries shall be screened and referred to MAT through the Gateway Call Center. Adult beneficiaries shall be screened for eligibility appropriateness for MAT and referred to one of methadone clinics depending on the beneficiary's place of residence.

4) Location and staff conducting ASAM assessments

a) Intake is the first session at all treatment sites across the system of care.

b) An in-depth LOC assessment shall be conducted with each beneficiary using the American Society of Addiction Medicine's (ASAM) Criteria at each treatment site.

c) The ASAM 6-dimensional (DIM) assessment shall be conducted by licensed, licensed-waivered, or state certified AOD counselors working under the direction of the clinic's Licensed Practitioner of the Healing Arts (LPHAs).

d) LPHA staff shall review and sign all placement decisions that meet the medical necessity criteria.

e) When a beneficiary needs a LOC not currently available in the System, such as partial hospitalization or medically monitored Intensive Inpatient Treatment, they shall be referred to the most appropriate level available or given community referrals to those services.

C. Timely Access

In addition to the general timely access requirements outlined in Section 2.3 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific timely access requirements:

1) For new referrals, appointments shall be made five days a week during normal business hours.

2) Outpatient providers shall be open Monday through Friday from 8 AM to 6 PM.

Evening outpatient services are provided. The Santa Clara County Behavioral Health Department (SCCBHD) shall review hours of operation and make changes that best meet the needs of the Medi-Cal beneficiaries.

3) The Contractor shall provide beneficiaries with entry to treatment seven days a week when medically necessary.

4) The Contractor shall ensure a maximum of fourteen days between referral (including from the Gateway Call Center) and first appointment for a face-to-face visit, which is the standard for outpatient placements.

5) All outpatient treatment agencies shall provide at least four face-to-face treatment sessions within the first thirty days of admission. The average length of stay for outpatient services is 90 days. Additional sessions may be scheduled based on individual needs.

6) Detoxification services shall be available seven days a week.

7) Beneficiaries that need afterhours care shall be referred to an on call clinician for immediate clinical disposition and/or care coordination.

8) Beneficiaries with an urgent condition shall receive services or attention from Care Coordination staff within 24 hours.

9) Residential providers shall take weekend admissions and evening admissions for beneficiary convenience.

D. Coordination and Continuity of Care

In addition to the general coordination and continuity of care requirements outlined in Section 2.5 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor coordination and continuity of care requirements:

1) The Quality Improvement Division shall manage transitions among different levels of care.

2) The QIDS shall also authorize extensions of stay in residential treatment. This function includes successful transitions of beneficiaries that have been designated as “high utilizers” and other beneficiaries that have been transitioned to lower LOC but need upgrades to more intensive services. The QIDS staff shall manage these designated beneficiaries to ensure appropriate assessment and placement in treatment. QIDS staff shall also provide additional case management services necessary to address the individual special needs of this population.

   a) Routine movement:

      i. Once a beneficiary is admitted, movement from within the continuum will be routine.

ii. Providers shall be responsible for moving beneficiaries between providers (direct referral), which typically occurs when beneficiaries are discharged from a higher LOC to a lower LOC.

iii. Direct referrals shall also occur when a beneficiary requests a move to a different provider within the same LOC.

b) Non-routine movement:

i. Consultation and authorization from QICs shall be required to move a beneficiary to a higher LOC (e.g., outpatient to residential). ASAM 6 DIM and LOC Criteria shall be utilized to determine whether the move should be authorized.

ii. Extension of residential stays shall require consultation with and authorization by a QIC prior to the transfer. ASAM 6 DIM and LOC Criteria, along with relevant clinical information, shall be utilized to determine authorizations for extensions of lengths of stay.

3) Care Coordination shall be offered by the Quality Improvement Division staff in special instances where there are provider-beneficiary issues, beneficiary-specific needs, or other unique circumstances. In all these instances, transfers shall require prior consultation and authorization with QICs.

4) Beneficiaries can be assessed as often as necessary; however, an ASAM assessment is generally valid for 180 days. Beneficiaries who return to the system following a break in treatment (discharge) require a re-assessment before they are placed in a LOC.

5) When a beneficiary receives inpatient substance use disorder (SUD) services (ASAM level 3.7 and 4.0 services) in an acute care hospital, or another 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.

6) When a beneficiary requires inpatient substance use disorder (SUD) services (ASAM level 3.7 and 4.0 services) in an acute care hospital, or another Fee for Service (FFS) facility, the Contractor shall manage the needed transition of care up to the medically necessary LOC. 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.

7) Case managers:

a) The Quality Improvement Division shall be responsible for managing beneficiary flow between levels of care after admission for all beneficiaries, including routine

and non-routine transitions. QICs shall oversee the beneficiary transfer process, authorize extensions of stay in treatment, trouble-shoot for solutions for specific beneficiary problems and other beneficiary-related issues that arise during treatment. The actual decision to move from one LOC to another shall be overseen by a QIC.

b) Case managers shall not be involved in decisions related to transition between LOC. Case managers may be involved in transporting beneficiaries from level to level. The case management program focuses on providing linkages to community services, assisting beneficiaries with applications for benefits and housing, and assisting beneficiaries in accessing food stamps, medical and dental care, clothing, transportation and other ancillary services.

E. Memorandum of Understanding

In addition to the general Memorandum of Understanding (MOU) requirements outlined in Section 2.5(C) of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor memorandum of understanding requirements:

1) The Contractor shall enter into MOUs with the subcontracted health plan providers. The MOUs shall outline mechanisms for sharing information and coordination of service delivery.

2) The following elements shall be covered in the MOUs:

a) Comprehensive substance use, physical, and mental health screening;

b) Beneficiary engagement and participation in an integrated care program as needed;

c) Shared development of care plans by the beneficiary, caregivers and all providers;

d) Collaborative treatment planning with managed care;

e) Care coordination and effective communication among providers;

f) Navigation support for patients and caregivers; and

g) Facilitation and tracking of referrals between systems.

3) The following policies and procedures shall be incorporated into the MOUs:

a) Information sharing policies and procedures;

b) Agreed upon roles and responsibilities for sharing personal health information (PHI) for the purposes of medical and behavioral health care coordination; and

c) Coordinating medical and behavioral health care for beneficiaries enrolled in

Medi-Cal Managed Care Plans that are receiving Medi-Cal specialty mental health or Drug Medi-Cal services through the SCCBHD.

4) The MOUs with health plans shall contain language that covers:

   a) Plan for a fair hearing for denial of service; and

   b) Provisions for a protocol to resolve issues related to denial of coverage or payment for services rendered.

5) The grievance system in the MOUs shall include:

   a) Procedures for beneficiaries, providers, and MCOs to file grievances and appeal grievances;

   b) Time frames for reasonable action;

   c) Fair hearing procedures; and

   d) Protocols for filing grievances.

6) All MOUs with MCOs shall be approved by the Contractor's counsel.

F. Authorization of Services – Residential Programs

In addition to the general authorization of residential services requirements outlined in Section 2.6 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific authorization of residential services requirements:

1) Residential capacity in the system of care shall be managed by the QIDS Division.

2) When beneficiaries call the Gateway Call Center, they shall be triaged to the most appropriate modality using the Gateway Call Center screening tool. The triage determination at the Gateway Call Center shall constitute an authorization for Residential Treatment and the beneficiary shall be referred to the Residential Placement Coordination List managed by QIDS Division.

3) The Residential Placement Coordinator and support staff shall be responsible for matching beneficiaries on the list to appropriate residential beds in accordance with established timeliness standards.

4) Providers shall contact the QIDS Division after completing a standardized intake assessment and request a formal authorization. The intake assessment will be electronically transmitted to the QIDS Division for record keeping and utilization management.

5) Beneficiaries shall be offered same day admissions if beds are available. Beneficiaries can also make an appointment and choose to schedule their admission day in advance. Post-authorizations sites shall offer assessment and

screening on-site (e.g., Re-Unification Court, Assembly Bill (AB) 109, Juvenile Justice Court, and Parolee Re-Entry Centers, etc.) and shall directly refer beneficiaries to a residential bed (offering them an appointment or same day intake appointment).

6) The QIDS Division shall coordinate the placement of beneficiaries in residential treatment when the initial assessment requires it. If the recommendation involves an "upgrade" to a more intensive LOC, then the provider shall obtain an authorization through the QIDS Division. In instances where transfers cannot be arranged on the same day, the first provider shall admit the beneficiary and provide them with the intensity of services necessary to prevent their condition from deteriorating until a transfer can be arranged. Upgrades from outpatient to residential shall be given a high priority by QICs. Transfers between levels of care shall be documented both on paper and in the electronic health record.

7) In the Adult system, residential treatment shall be initially authorized for 45 days, and stays beyond 45 days shall be authorized by the Quality Improvement Division. The same full 6 DIM ASAM assessment shall be used at intake, and shall be used on the 35th day to determine re-authorizations for stays anticipated beyond 45 days.

8) In the Youth system, the residential length of stay shall be 30 days. Extensions shall be granted by QIC consultation based on an individual's current clinical needs and ASAM assessment in keeping with a chronic care management philosophy where beneficiaries are stabilized at higher levels of care and then moved to lower levels of care within the community.

G. Early Intervention (ASAM Level 0.5)

The Contractor shall provide early intervention services in the manner described in Section 5 of Exhibit A, Attachment I.

H. Outpatient Services (ASAM Level 1)

In addition to the general outpatient services requirements outlined in Section 6 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific outpatient services requirements:

1) There are minor differences in the ASAM Level 1 services provided to youth and adults, and age-appropriate treatment shall be provided to each beneficiary.

2) Youth Outpatient Services

a) Outpatient services shall be available for youth under age 21 with a substance use diagnosis or are at-risk for developing a SUD.

b) The frequency of individual services, documented in the treatment plan, shall be based on the ASAM assessment and individual needs. The duration of ASAM Level 1 outpatient services for youth shall be no more than 6 hours per week.

c) Group Counseling shall be recommended for beneficiaries and shall be included in the treatment plan, based on individual needs.

d) These services shall be delivered in person, by phone or a tele-health medium.

e) There shall not be a minimum number of treatment sessions per month for a youth to remain in treatment. Therefore, if a youth is detained in Juvenile Hall his/her case will be kept open for up to one year in order to maintain continuity of care. Modifications of this treatment standard shall be clinically determined based on beneficiary progress, as documented in the clinical record.

f) Youth shall be referred to ancillary services, such as educational support, when indicated by their ASAM assessment.

3) Adult Outpatient Services

a) ASAM Level 1 services for adults shall be provided in regularly scheduled sessions of fewer than nine contact hours a week.

b) Treatment shall address major lifestyle, attitudinal and behavioral issues that could potentially undermine the goals of treatment or to impair the individual's ability to cope with major life tasks without the use of alcohol, and/or other drugs. Treatment shall include individual counseling, family therapy and case management.

c) These services shall be tailored to each beneficiary's level of clinical severity as determined by the ASAM 6 DIM treatment assessment and are focused on helping the beneficiary make changes in their drug use or addiction.

d) In the event, an adult is known to be incarcerated, his/her case will be kept open for up to one year in order to maintain continuity of care. (DMC services cannot be reimbursed while a beneficiary is incarcerated under the DMC-ODS system.)

I. Intensive Outpatient Services (ASAM Level 2.1)

In addition to the general intensive outpatient services requirements outlined in Section 7 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific intensive outpatient services requirements:

1) ASAM Level 2.1 shall provide adult outpatient services for between 9 to 19 hours per week and between 6 and 19 hours per week for youth and young adults. Youth, transitional aged youth and adults who exhibit more severe symptomology and needs that do not respond to less than 6 hours per week of treatment in outpatient settings shall be offered Level 2.1 Intensive Outpatient Services (IOP). Services may be provided up to 6 days a week for youth (including weekend activities) for up to a maximum 19 hours per week.

2) The target population for ASAM Level 2.1 services include youth and adults who exhibit impaired functioning at home, school (for youth), work, or in the community but do not require treatment in a residential setting.

3) ASAM Level 2.1 treatment shall include counseling and education about addiction-related and co-occurring disorders.

4) ASAM Level 2.1 treatment shall be offered during regular business hours and after-school/work hours for school-aged and employed beneficiaries. Beneficiaries may be stepped down to ASAM Level 1 or up to Residential Treatment as needed.

5) Perinatal Services:

   a) The primary counselor shall coordinate the treatment episode for beneficiaries and will provide targeted case-management for services such as housing, psychiatric or primary medical care.

   b) Perinatal beneficiaries shall receive appropriate intensity of care within the outpatient spectrum, based on an assessment and discussion with the beneficiaries.

   c) Beneficiaries may be referred to other more intensive treatment levels such as Women's Residential and Detoxification services, based on beneficiary need and ASAM assessment.

J. Residential Treatment Services

In addition to the general residential treatment services requirements outlined in Section 8 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific residential treatment services requirements:

1) Three levels of ASAM residential services shall be available to adults: ASAM Levels 3.3 and 3.5 in the second-year. Level 3.1 shall be available to adults in the first-year of this Intergovernmental Agreement.

2) The youth residential system shall provide ASAM Level 3.1 for residential treatment. The Youth System will offer Residential Level 3.5 as part of the ODS implementation in the second-year of this Intergovernmental Agreement.

3) Both gender-specific and mixed-gender residential services shall be offered.

4) Clinically Managed Low-Intensity Residential Services (ASAM Level 3.1)

   a) Residential Services ASAM Level 3.1 shall be available for youth 18 years and younger. ASAM Level 3.1 shall be available to adults in the first-year of this Intergovernmental Agreement.

b) The goal of the residential therapeutic milieu is to promote the development of: (a) a youth's interpersonal and independent living skills at a pace that matches the youth's cognitive abilities, and (b) behavior patterns and habits designed to help youth successfully re-integrate back into the community. Residential treatment services involve a minimum of five hours of clinical services each week during the 30-day average length of stay.

c) Following residential treatment, youth shall be stepped down to Wraparound services, Full Service Partnership (FSP) services, intensive outpatient, outpatient services, or other community services, based on individual needs to ensure the appropriate level of support for maintaining sobriety after discharge from treatment.

5) Clinically Managed Population-Specific High-Intensity Residential Services (ASAM Level 3.3)

a) Residential ASAM Level 3.3 shall be available for adults in the second-year, and is not a part of the adolescent continuum of care in the ASAM continuum.
.

b) ASAM Level 3.3 residential services shall be available to beneficiaries with cognitive limitations, medical conditions, and/or are elderly and require treatment at a slower pace. Services are slower paced, more concrete, and more repetitive.

c) Medical, psychiatric, psychological, laboratory, and toxicology services shall be available through consultation or referral.

6) Clinically Managed High-Intensity Residential Services (ASAM Level 3.5)

a) Residential ASAM Level 3.5 services shall be available for adults in the second-year. The Youth System will offer Residential Level 3.5 as part of the ODS implementation in the second-year of this Intergovernmental Agreement.

b) ASAM level 3.5 shall focus on stabilization of signs and symptoms of high risk addiction, initiation or restoration of the recovery process and preparation for ongoing recovery in the broad continuum of care.

c) This level of treatment shall rely on the treatment community as a therapeutic agent.

d) ASAM Level 3.5 services will be added to the continuum of care for youth in the second year of the ODS implementation. ASAM Level 3.5 provides 24-hour care by clinical staff for beneficiaries in a therapeutic milieu. Level 3.5 services will be used to provide services to youth and young adults, who face imminent danger with co-occurring issues, require stabilization of their symptoms, and require services to re-integrate into the community with adequate levels of support.

e) Perinatal residential treatment for women and their children under age 5, shall

be provided at ASAM Level 3.5. This program shall comply with the Perinatal Services Network Guidelines. In addition to recovery, treatment shall focus on parenting and child development. Length of stay can extend up to 6 months when necessary.

7) Medically Monitored Intensive Inpatient Services – Adult/High Intensity Inpatient Services – Adolescent/Medically Managed Intensive Inpatient Services (Adult & Adolescent) (ASAM Level 3.7 and 4.0)

   a) The Contractor shall establish an MOU with a local provider to provide ASAM 3.7 and 4.0 services. Beneficiaries shall receive services from these providers until they can be discharged to a lower LOC provided by the SCCBHD network.

K. Case Management

In addition to the general case management requirements outlined in Section 9 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific case management requirements:

1) Programs at all ASAM Levels of Care for youth and adults shall offer case management services by on-site staff.

2) Services shall include, but will not be limited to, linking beneficiaries to other levels of care for substance use treatment, primary care, mental health, vocational, legal and housing resources, as well as case consultation services.

3) There is no designated length of stay for case management services. Individual needs shall be periodically assessed to determine the need for continued case management services.

4) Case management services shall be provided by licensed or credentialed staff persons.

5) Case management services for all beneficiaries shall be integrated with the treatment plan.

6) Case management services shall focus on addressing tangible needs such as shelter, employment, transportation, academic needs, and support beneficiaries' engagement and treatment progress.

7) The Youth System of Care shall utilize a clinical/rehabilitation approach to case management in which the therapist provides the therapy as well as the case management activities.

8) In the adult system, the primary treatment counselor/therapist may also provide case management services. When the case manager is not the primary treatment provider, he/she shall work closely with the primary counselor to support the treatment plan. Specific tasks such as transportation, assistance completing applications, or accompanying the beneficiary for appointments and other tasks

shall be assigned to a community-worker or peer mentor. Adult system community-workers and peer mentors shall work under the direction of the credentialed or licensed counselor to provide a range of services, depending on the beneficiary's needs.

L. Physician Consultation

In addition to the general physician consultation requirements outlined in Section 10 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific physician consultation requirements:

1) The DMC provider's physician/s will be able to consult for complex cases with addiction medicine specialists at the established physician consultation rate. Physician consultation may include; medication selection, dosing, side effect management, adherence, drug-drug interactions, or LOC considerations.

2) Services shall be delivered by phone, fax, email, and/or onsite-live-interactive videoconferencing.

M. Recovery Services

In addition to the general recovery services requirements outlined in Section 11 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific recovery services requirements:

1) Beneficiaries shall be offered this service if they have relapsed.

2) Recovery services shall address the needs identified in ASAM 6 DIM, and services shall be provided face-to-face, by phone or via a tele-health medium.

3) Relapse education and warning sign identification shall occur throughout the duration of recovery services.

4) Youth shall be linked to recovery services that will address their psychosocial issues, help them develop self-management skills, and reinforce skills gained during treatment.

5) Recovery Services shall be available for adult beneficiaries with a SUD in remission but exhibit a high risk for relapse potential on ASAM DIMs 3 to 6.

6) Recovery Services shall be available for beneficiaries after completing the course of treatment if they are struggling with triggers, they relapse, or as a preventative measure. These services may be provided face-to-face or by telephone and may include, but are not limited to, Wellness Recovery Action Plan (WRAP) groups, Continuous Recovery Monitoring (CRM), drop-in support groups, and relapse prevention groups. WRAP is a wellness and recovery approach that is self-directed that involves peer-led groups. CRM was a pilot project that provided telephone check-ups after discharge for treatment to beneficiaries who had successfully completed treatment.

7) Recovery Services shall be available to beneficiaries upon the completion of treatment to prevent relapse.

8) Early Recovery Services for Youth

   a) Youth and young adults who are eligible for the early recovery services shall be either vulnerable to future substance use problems or at immediate risk for meeting the criteria for a SUD.

   b) Referrals for service shall be made by the beneficiary, school staff (Multi-Service Team (MST) coordinator, discipline officer), parent or other third parties, such as, truancy court.

   c) Primary Care Physicians shall screen young adults age 18 and older for substance use issues. Following the referral, the clinician shall meet with the youth or young adult to assess substance use related risk factors such as possessing substances on the school campus or in the home environment, associating with known substance users, sudden poor academic performance and other problematic behaviors.

   d) Early recovery services for youth shall be delivered in clinic and/or school settings. Services in this level shall include individualized-brief intervention sessions. Content of these sessions shall include counseling interventions and psycho-education regarding the harmful effects of substances. Youth may be seen for up to ten sessions and then referred to mental health or SUD services as is medically necessary.

N. Withdrawal Management

In addition to the general withdrawal management requirements outlined in Section 12 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific withdrawal management services requirements:

1) ASAM Level 3.2 shall be available to adult beneficiaries who meet the necessary ASAM criteria.

2) The components of withdrawal management services shall include intake and observation (Clinical Institute Withdrawal Assessment/CIWA).

3) At discharge from ASAM Level 3.2, beneficiaries shall be referred to either residential or outpatient services based on an assessment of individual needs.

O. Opioid (Narcotic) Treatment Program Services

In addition to the general opioid (narcotic) treatment program services requirements outlined in Section 13 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific opioid (narcotic) treatment program services requirements:

Exhibit A, Attachment I
Program Specifications

1) The Contractor's Narcotic Treatment Program is referred to as Medication Assisted Treatment (MAT), which provides treatment using approved medications for treating substance use.

2) Beneficiaries referred to the MAT program shall be screened for eligibility for MAT.

3) Both adults and youths shall receive MAT services if they meet the criteria for admission.

4) MAT services shall be provided in clinics licensed and accredited by Commission on Accreditation of Rehabilitating Facilities (CARF) and staffed by board certified physicians specializing in Addiction Medicine, and licensed master's level clinicians or certified counselors.

5) MAT shall offer medications (e.g., methadone, naloxone, disulfiram, Suboxone and Vivitrol), counseling, case management, medical consultation, confidential human immunodeficiency virus (HIV) and tuberculosis (TB) testing and counseling to beneficiaries who meet the medical necessity criteria.

6) MAT prescriptions shall be provided through the patient's local or county pharmacies.

7) Methadone

    a) Beneficiaries referred to methadone shall meet the admission and medical necessity criteria established by the California Code of Regulations (CCR) Title 9 and Federal regulations.

    b) Beneficiaries who meet admission criteria shall be admitted within 72 hours of the intake appointment.

    c) Admission to the methadone program involves two phases: Induction (including titration) and Stabilization.

    d) The induction phase (initial methadone dosing) is designed to attenuate withdrawal symptoms as quickly as is medically appropriate.

    e) In the stabilization phase, the goal is to establish the dose of daily methadone that provides clinical efficacy, along with a margin of safety, for an appropriate duration of time.

    f) Methadone stabilization dosages shall be determined individually, within the limits stipulated by State and Federal regulations and MAT Policy and Procedures. If medically appropriate, higher initial dosage may be prescribed.

8) Suboxone

    a) Admission to the Suboxone program shall require an evaluation by a program physician to establish medical necessity.

b) Induction phase shall occur during the first week of treatment and involves onsite treatment and monitoring. Individuals are required to keep a follow up appointment for refilling their prescription. Individuals can be referred to counseling in accordance with State and Federal regulations.

c) Youth shall be referred to Suboxone services.

d) Assessment using ASAM criteria shall be used to determine whether youths are eligible for Suboxone treatment and if the following criteria are met: diagnosis of opioid dependence or opioid use disorder, at least a one-year history of opioid dependence, and parental permission and involvement.

e) Opiate-addicted youth who are referred to MAT shall be evaluated by a MAT physician to determine if the youth meets the criteria for addiction medicine treatment.

P. Additional Medication Assisted Treatment

As stated in Section 30(A) of Exhibit A, Attachment I, the Contractor has elected to provide MAT services as a Contractor specific service. Therefore, the Contractor shall comply with the following Contractor specific MAT requirements:

1) Vivitrol treatment shall be available to out-patient beneficiaries at all MAT clinics.

2) Patients may refer themselves for Vivitrol treatment, but admission shall require an assessment by a licensed physician to determine whether the beneficiary is a good match for this medication.

3) Vivitrol shall be administered to volunteers from Substance Use Treatment System (SUTS) treatment programs with alcohol and/or opiate dependency upon consent to treatment.

4) The Vivitrol Treatment Program shall provide monthly assessments, reassessments, and medical services including evaluations, monthly injections follow up visits, and counseling.

Q. Partial Hospitalization

As stated in Section 30(A) of Exhibit A, Attachment I, the Contractor has elected to provide Partial Hospitalization services as a Contractor specific service. Therefore, the Contractor shall comply with the following Contractor Partial Hospitalization requirements:

1) Partial hospitalization (ASAM Level 2.5) shall be available to beneficiaries with unstable medical and psychiatric problems in the second year.

2) A minimum of 20 or more hours of service per week shall be provided in Level 2.5.

3) Beneficiaries shall have access to medical, psychological, psychiatric and toxicology services through consultation or referral. Psychiatric and other medical consultation will be available within 8 hours by phone and within 48 hours by person. Emergency services will be available 7 days a week and 24 hours a day, when the treatment program is not in session.

4) Beneficiaries may live in a residential facility, such as transitional housing with 24-hour supervision.

R. Transitional Housing

As stated in Section 30(A) of Exhibit A, Attachment I, the Contractor elects to provide Transitional Housing services as a Contractor specific service. Accordingly, the Contractor shall comply with the following Transitional Housing requirements: (Transitional Housing shall not be paid for under the DMC-ODS system.)

1) The Contractor shall make available Transitional Housing Units (THUs) to beneficiaries that are homeless, at risk for homelessness or living in unstable housing that may affect the beneficiaries' SUD recovery outcomes.

2) At-risk beneficiaries that have been placed in outpatient treatment shall be offered THUs for the duration of their outpatient treatment.

3) The average length of stay in a THU shall be between 90-180 days based on the treatment process.

4) THUs shall be provided by vendors that have contracts with the Contractor. THU vendors shall comply with the THU policies and procedures developed by the Contractor. The Contractor's THU policies and procedures shall govern the cleanliness and maintenance of the THUs.

5) The housing vendors shall work closely with the treatment providers.

6) Beneficiaries shall be required to pay up to 35 percent of their income for THUs services. Beneficiaries with food stamps are expected to use these benefits to partially cover their food costs.

7) The costs associated with THUs shall not be reimbursed through the DMC-ODS Waiver; therefore, the Contractor shall use other funding sources to pay for THU costs.

Exhibit B
Budget Detail and Payment Provisions

Part I – General Fiscal Provisions

Section 1 – General Fiscal Provisions

A. Fiscal Provisions

For services satisfactorily rendered, and upon receipt and approval of documentation as identified in Exhibit A, Attachment I, Section 23.2, DHCS agrees to compensate the Contractor for actual expenditures incurred in accordance with the rates and/or allowable costs specified herein.

B. Use of State General Funds

Contractor may not use allocated Drug Medi-Cal State General Funds to pay for any non-Drug Medi-Cal services.

C. Funding Authorization

Contractor shall bear the financial risk in providing any substance use disorder services covered by this Intergovernmental Agreement.

D. Availability of Funds

It is understood that, for the mutual benefit of both parties, this Intergovernmental Agreement may have been written before ascertaining the availability of congressional appropriation of funds in order to avoid program and fiscal delays that would occur if this Intergovernmental Agreement were not executed until after that determination. If so, State may amend the amount of funding provided for in this Intergovernmental Agreement based on the actual congressional appropriation.

E. Subcontractor Funding Limitations

Pursuant to HSC Section 11818 (b)(2)(A), Contractor shall reimburse its Subcontractors that receive a combination of Drug Medi-Cal funding and other federal or county realignment funding for the same service element and location based on the Subcontractor's actual costs in accordance with Medicaid reimbursement requirements as specified in Title XIX or Title XXI of the Social Security Act; Title 22, and the State's Medicaid Plan. Payments at negotiated rates shall be settled to actual cost at year-end.

Exhibit B
Budget Detail and Payment Provisions

F. Budget Contingency Clause

It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this Intergovernmental Agreement does not appropriate sufficient funds for the program, this Intergovernmental Agreement shall be of no further force and effect. In this event, DHCS shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Intergovernmental Agreement and Contractor shall not be obligated to perform any provisions of this Intergovernmental Agreement.

If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, DHCS shall have the option to either cancel this Intergovernmental Agreement with no liability occurring to DHCS, or offer an amended Intergovernmental Agreement to Contractor to reflect the reduced amount.

G. Expense Allowability / Fiscal Documentation

1. Invoices, received from a Contractor and accepted and/or submitted for payment by DHCS, shall not be deemed evidence of allowable Intergovernmental Agreement costs.

2. Contractor shall maintain for review and audit and supply to DHCS upon request, adequate documentation of all expenses claimed pursuant to this Intergovernmental Agreement to permit a determination of expense allowability.

3. If the allowability or appropriateness of an expense cannot be determined by DHCS because invoice detail, fiscal records, or backup documentation is nonexistent or inadequate according to generally accepted accounting principles, and generally accepted governmental audit standards, all questionable costs may be disallowed and payment may be withheld by DHCS. Upon receipt of adequate documentation supporting a disallowed or questionable expense, reimbursement may resume for the amount substantiated and deemed allowable.

4. Costs and/or expenses deemed unallowable are subject to recovery by DHCS.

H. Maintenance of Effort for SAPT Block Grant

1. Notwithstanding any other provision in this Intergovernmental Agreement, the Director may reduce federal funding allocations, on a dollar-for-dollar basis, to a county that has a reduced or anticipates reduced expenditures in a way that would result in a decrease in California's receipt of federal Substance Abuse Prevention and Treatment Block Grant funds (42 U.S.C. Sect 300x-30).

2. Prior to making any reductions pursuant to this subdivision, the Director shall notify all counties that county underspending will reduce the federal Substance Abuse Prevention and Treatment Block Grant maintenance of effort (MOE). Upon receipt of notification, a county may submit a revision to the county budget initially submitted pursuant to subdivision (a) of Section 11798 in an effort to maintain the statewide SAPT Block Grant MOE.

Exhibit B
Budget Detail and Payment Provisions

3. Pursuant to 45 CFR 96.124 C 1-3 the Contractor shall expend a specified percentage of SAPT Block Grant funds for perinatal services, pregnant women, and women with dependent children each state fiscal year (SFY). The Contractor shall expend that percentage of SAPT Block Grant funds by, either establishing new programs or expanding the capacity of existing programs. In accordance with 45 CFR 96.124 (c)(1-3), the Contractor shall calculate the percentage of funds to be expended for perinatal services, pregnant women, and women with dependent children in the manner described in Exhibit G: County Share of SAPT Block Grant Women Services Expenditure Requirement.
http://www.dhcs.ca.gov/formsandpubs/Pages/Information_Notices_2016.aspx

4. Pursuant to subdivision (b) of Section 11798.1, a county shall notify the Department in writing of proposed local changes to the county's expenditure of funds. The Department shall review and may approve the proposed local changes depending on the level of expenditures needed to maintain the statewide SAPT Block Grant MOE.

Section 2 – General Fiscal Provisions – Non-Drug Medi-Cal

A. Revenue Collection

Contractor shall conform to revenue collection requirements in Division 10.5 of the HSC, Sections 11841, by raising revenues in addition to the funds allocated by the State. These revenues include, but are not limited to, fees for services, private contributions, grants, or other governmental funds. These revenues shall be used in support of additional alcohol and other drug services or facilities. Each alcohol and drug program shall set and collect client fees based on the client's ability to pay. The fee requirement shall not apply to prevention and early intervention services. Contractor shall identify in its annual cost report the types and amounts of revenues collected.

B. Cost Efficiencies

It is intended that the cost to the Contractor in maintaining the dedicated capacity and units of service shall be met by the non-DMC funds allocated to the Contractor and other Contractor or Subcontractor revenues. Amounts awarded pursuant to Exhibit A, Attachment I, Section 27, shall not be used for services where payment has been made, or can reasonably be expected to be made under any other state or federal compensation or benefits program, or where services can be paid for from revenues.

Section 3 – General Fiscal Provisions – Drug Medi-Cal

A. Return of Unexpended Funds

Contractor assumes the total cost of providing covered services on the basis of the payments delineated in this Exhibit B, Part II. Any State General Funds or federal Medicaid funds paid to the Contractor, but not expended for DMC services shall be returned to the State.

Exhibit B
Budget Detail and Payment Provisions

B. Amendment or Cancellation Due to Insufficient Appropriation

This Intergovernmental Agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the purpose of the DMC program. It is mutually agreed that if the Congress does not appropriate sufficient funds for this program, State has the option to void this Intergovernmental Agreement or to amend the Intergovernmental Agreement to reflect any reduction of funds.

C. Exemptions

Exemptions to the provisions of Item B above, of this Exhibit, may be granted by the California Department of Finance provided that the Director of DHCS certifies in writing that federal funds are available for the term of the Intergovernmental Agreement.

D. Allowable costs

Allowable costs, as used in Section 51516.1 of Title 22 shall be determined in accordance with Title 42, CFR Parts 405 and 413, CMS-Pub 15-1 and 15-2, 2 CFR Part 200 Subpart E, CMS non-institutional reimbursement policy, and Centers for Medicare and Medicaid Services (CMS), "Medicare Provider Reimbursement Manual (Publication Number 15)," which can be obtained from the Centers for Medicare & Medicaid Services, or www.cms.hhs.gov." In accordance with W&IC Sections 14132.44 and 14132.47, funds allocated to the Contractor for DMC services, including funding for alcohol and other drug services for pregnant and postpartum women pursuant to Title 22, Section 51341.1(c), may not be used as match for targeted case management services or for Medi-Cal administrative activities.

Exhibit B
Budget Detail and Payment Provisions

Part II – Reimbursements

Section 1. General Reimbursement

A. Prompt Payment Clause

Payment will be made in accordance with, and within the time specified in, Government Code Chapter 4.5, commencing with Section 927.

B. Amounts Payable

1. The amount payable under this Intergovernmental Agreement shall not exceed the amount identified on the Standard Intergovernmental Agreement.

2. Reimbursement shall be made for allowable expenses up to the amount annually encumbered commensurate with the state fiscal year in which services are performed and/or goods are received.

3. The funds identified for the fiscal years covered by under this Section, within this Exhibit, are subject to change depending on the availability and amount of funds appropriated by the Legislature and the Federal Government. The amount of funds available for expenditure by the Contractor shall be limited to the amount identified in the final allocations issued by the State for that fiscal year or the non-DMC amount, whichever is less. Changes to allocated funds will require written amendment to the Intergovernmental Agreement.

4. For each fiscal year, the State may settle costs for services based on each fiscal year year-end cost settlement report as the final amendment for the specific fiscal year cost settlement report to the approved single state/county Intergovernmental Agreement.

Section 2. Non-Drug Medi-Cal

A. Amounts Payable for Non-Drug Medi-Cal

1. State shall reimburse the Contractor monthly in arrears an amount equal to one-twelfth of the maximum amount allowed pursuant to Exhibit B of the Intergovernmental Agreement or the most recent allocation based on the Budget Act Allocation, whichever is less. Final allocations will reflect any increases or reductions in the appropriations as reflected in the State Budget Act allocation and any subsequent allocation revisions.

2. Monthly disbursement to the Intergovernmental Agreement at the beginning of each fiscal year of the Intergovernmental Agreement shall be based on the preliminary allocation of funds, as detailed in this Exhibit.

3. However, based on the expenditure information submitted by the counties in the Quarterly Federal Financial Management Report (QFFMR) (Document 3O), State may adjust monthly payments of encumbered block grant federal funds to extend

the length of time (not to exceed 21 months) over which payments of federal funds will be made.

4. Monthly disbursements to the Contractor at the beginning of each fiscal year of the Intergovernmental Agreement shall be based on the preliminary allocation of funds, as detailed in Exhibit B.

5. State may withhold monthly non-DMC payments if the Contractor fails to:

   (a) submit timely reports and data required by the State, including but not limited to, reports required pursuant to Exhibit A, Attachment I, Section 23.2.

   (b) submit the Intergovernmental Agreement amendment within 90 days from issuance from the State to the Contractor.

   (c) submit and attest the completion of Corrective Action Plans for services provided pursuant to this Intergovernmental Agreement.

6. Upon the State's receipt of the complete and accurate reports, data, or signed Intergovernmental Agreement, the Contractor's monthly payment shall commence with the next scheduled monthly payment, and shall include any funds withheld due to late submission of reports, data and/or signed Intergovernmental Agreement.

7. Adjustments may be made to the total of the Intergovernmental Agreement and amounts may be withheld from payments otherwise due to the Contractor hereunder, for nonperformance to the extent that nonperformance involves fraud, abuse, or failure to achieve the objectives of the provisions of Exhibit A, Attachment I, Section 27.

B. Payment Provisions

For each fiscal year, the total amount payable by the State to the Contractor for services provided under Exhibit A, Attachment I, Section 27, shall not exceed the encumbered amount. The funds identified for the fiscal years covered by Exhibit A, Attachment I, Section 27, are subject to change depending on the availability and amount of funds appropriated by the Legislature and the Federal Government. Changes to encumbered funds will require written amendment to the Intergovernmental Agreement. State may settle costs for non-DMC services based on the year-end cost settlement report as the final amendment to the approved single state/county Intergovernmental Agreement.

C. In the event of an Intergovernmental Agreement amendment, as required by the preceding paragraph, Contactor shall submit to the State information as identified in Exhibit E, Section 1.D. To the extent the Contractor is notified of the State Budget Act allocation prior to the execution of the Intergovernmental Agreement, the State and the Contractor may agree to amend the Intergovernmental Agreement after the issuance of the first Budget Act allocation.

D. Accrual of Interest

Exhibit B
Budget Detail and Payment Provisions

Any interest accrued from State-allocated funds and retained by the Contractor must be used for the same purpose as the State allocated funds from which the interest was accrued.

E. Expenditure Period

Substance Abuse Prevention and Treatment (SAPT) Block Grant funds are allocated based upon the Federal Grant award period. These funds must be expended for activities authorized pursuant to 42 USC Sections 300x-21(b) through 300x-66; and Title 45, CFR, Subpart L, within the availability period of the grant award. Any SAPT Block Grant funds that have not been expended by a Contractor at the end of the expenditure period identified below shall be returned to the State for subsequent return to the Federal government.

1. The expenditure period of the FFY 2016 award is October 1, 2015 through June 30, 2017.

2. The expenditure period of the FFY 2017 award is October 1, 2016 through June 30, 2018.

3. The expenditure period of the FFY 2018 award is October 1, 2017 through June 30, 2019.

F. Contractors receiving SAPT Block Grant funds shall comply with the financial management standards contained in Title 45, CFR, Part 92, Sections 92.20(b)(1) through (6), and Title 45, CFR, Part 96, Section 96.30.

G. Non-profit Subcontractors receiving SAPT Block Grant funds shall comply with the financial management standards contained in Title 45, CFR, Part 74, Sections 74.21(b)(1) through (4) and (b)(7), and Part 96, Section 96.30.

H. Contractors receiving SAPT Block Grant funds shall track obligations and expenditures by individual SAPT Block Grant award, including, but not limited to, obligations and expenditures for primary prevention, services to pregnant women and women with dependent children. “Obligation” shall have the same meaning as used in Title 45, CFR, Part 92, Section 92.3.”

I. Restrictions on the Use of SAPT Block Grant Funds

Pursuant to 42 U.S.C. 300x-31, Contractor shall not use SAPT Block Grant funds provided by the Intergovernmental Agreement on the following activities:

1. Provide inpatient services;

2. Make cash payment to intended recipients of health services;

3. Purchase or improve land, purchase, construct or permanently improve (other than minor remodeling) any building or other facility or purchase major medical equipment;

4. Satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;

5. Provide financial assistance to any entity other than a public or nonprofit private entity;

6. Pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of level I of the Executive Salary Schedule for the award year: see http://grants.nih.gov/grants/policy/salcap_summary.htm;

7. Purchase treatment services in penal or correctional institutions of this State of California; and

8. Supplant state funding of programs to prevent and treat substance abuse and related activities.

Section 3. Drug Medi-Cal

A. To the extent that the Contractor provides the covered services in a satisfactory manner and in accordance with the terms and conditions of this Intergovernmental Agreement, the State agrees to pay the Contractor federal Medicaid funds according to Exhibit A, Attachment I, Section 28.1. Subject to the availability of such funds, Contractor shall receive federal Medicaid funds and/or State General Funds for allowable expenditures as established by the federal government and approved by the State, for the cost of services rendered to beneficiaries.

B. Any payment for covered services rendered pursuant to Exhibit A, Attachment I, shall only be made pursuant to applicable provisions of Title XIX or Title XXI of the Social Security Act; the W&IC; the HSC; California's Medicaid State Plan; and Sections 51341.1, 51490.1, 51516.1, and 51532 of Title 22.

C. It is understood and agreed that failure by the Contractor or its Subcontractors to comply with applicable federal and state requirements in rendering covered services shall be sufficient cause for the State to deny payments to and/or recover payments from the Contractor and/or terminate the Contractor or its Subcontractor from DMC program participation. If the State or the Department of Health and Human Services (DHHS) disallows or denies payments for any claim, Contractor shall repay to the State the federal Medicaid funds and/or State General Funds it received for all claims so disallowed or denied. The overpayment shall be recovered by any of the methods allowed in Title 22, CCR, Sections 51047(a) and (b).

D. Before such denial, recoupment, or disallowances are made, State shall provide the Contractor with written notice of its proposed action. Such notice shall include the reason for the proposed action and shall allow the Contractor sixty (60) days to submit additional information before the proposed action is taken, as required in Title 22, CCR, Section 51047(a). This requirement does not apply to the DMC Post Service Post Payment Utilization Reviews.

Exhibit B
Budget Detail and Payment Provisions

E. The State shall refund to the Contractor any recovered Federal Drug Medi-Cal overpayment that is subsequently determined to have been erroneously collected, together with interest, in accordance with Title 22, CCR, Section 51047(e).

F. Contractor shall be reimbursed by the State on the basis of its actual net reimbursable cost, not to exceed the unit of service maximum rate.

G. Claims submitted to the contractor by a sub-contracted provider that is not certified or whose certification has been suspended pursuant to the Welfare and Institutions Code section 14107.11, and Code of Federal Regulations, Title 42, section 455.23 shall not be certified or processed for federal or state reimbursement by the contractor. Payments for any DMC services shall be held by the Contractor until the payment suspension is resolved.

H. In the event an Intergovernmental Agreement amendment is required pursuant to the preceding paragraph, Contractor shall submit to the State information as identified in Exhibit E, Section 1.D. To the extent the Contractor is notified of the State Budget Act allocation prior to the execution of the Intergovernmental Agreement, the State and the Contractor may agree to amend the Intergovernmental Agreement after the issuance of the first revised allocation.

I. Reimbursement for covered services, other than NTP services, shall be limited to the lower of:

1. the provider's usual and customary charges to the general public for the same or similar services;

2. the provider's actual allowable costs.

J. Reimbursement to NTP's shall be limited to the lower of either the USDR rate, pursuant to W&IC Section 14021.51(h), or the provider's usual and customary charge to the general public for the same or similar service. However, reimbursement paid by a county to an NTP provider for services provided to any person subject to Penal Code Sections 1210.1 or 3063.1 and for which the individual client is not liable to pay, does not constitute a usual or customary charge to the general public. (W&IC Section 14021.51(h)(2)(A)).

Exhibit B
Budget Detail and Payment Provisions

K. State shall reimburse the Contractor the State General Funds and/or federal Medicaid amount of the approved DMC claims and documents submitted in accordance with Exhibit A, Attachment I, Section 23.2.

L. State will adjust subsequent reimbursements to the Contractor to actual allowable costs. Actual allowable costs are defined in the Medicare Provider Reimbursement Manual (CMS-Pub.15), which can be obtained from the Centers for Medicare & Medicaid Services, Baltimore, Maryland, or www.cms.hhs.gov.

M. Contractors and Subcontractors must accept, as payment in full, the amounts paid by the State in accordance with Title 22, CCR, Section 51516.1, plus any cost sharing charges (deductible, coinsurance, or copayment) required to be paid by the client. However, Contractors and Subcontractors may not deny services to any client eligible for DMC services on account of the client's inability to pay or location of eligibility. Contractors and Subcontractors may not demand any additional payment from the State, client, or other third party payers.

Exhibit B
Budget Detail and Payment Provisions

Part III - Financial Audit Requirements

Section 1. General Fiscal Audit Requirements

A. In addition to the requirements identified below, the Contractor and its Subcontracts are required to meet the audit requirements as delineated in Exhibit C, General Terms and Conditions, and Exhibit D(F), Special Terms and Conditions, of this Intergovernmental Agreement.

B. All expenditures of county realignment funds, state and federal funds furnished to the Contractor and its Subcontractors pursuant to this Intergovernmental Agreement are subject to audit by the State. Such audits shall consider and build upon external independent audits performed pursuant to audit requirements of the Office of Management and Budget (OMB) Circular A-133 (Revised December 2013) and/or any independent Contractor audits or reviews. Objectives of such audits may include, but not limited to, the following:

1. To determine whether units of service claimed/reported are properly documented by service records and accurately accumulated for claiming/reporting;

2. To validate data reported by the Contractor for prospective Intergovernmental Agreement negotiations;

3. To provide technical assistance in addressing current year activities and providing recommendation on internal controls, accounting procedures, financial records, and compliance with laws and regulations;

4. To determine the cost of services, net of related patient and participant fees, third-party payments, and other related revenues and funds;

5. To determine that expenditures are made in accordance with applicable state and federal laws and regulations and Intergovernmental Agreement requirements, and/or;

6. To determine the facts in relation to analysis of data, complaints, or allegations, which may be indicative of fraud, abuse, willful misrepresentation, or failure to achieve the Intergovernmental Agreement objectives of Exhibit C and D(F).

C. Unannounced visits may be made at the discretion of the State.

D. The refusal of the Contractor or its Subcontractors to permit access to and inspection of electronic or print books and records, physical facilities, and/or refusal to permit interviews with employees, as described in this part constitutes an express and immediate material breach of this Intergovernmental Agreement and will be sufficient basis to terminate the Intergovernmental Agreement for cause or default.

E. Reports of audits conducted by the State shall reflect all findings, recommendations, adjustments and corrective action as a result of it's finding in any areas.

Exhibit B
Budget Detail and Payment Provisions

Section 2. Non-Drug Medi-Cal Financial Audits

A. Pursuant to OMB Circular A-133 §.400(d)(3), Contractor shall monitor the activities of all of its Subcontractors to ensure that:

1. Subcontractors are complying with program requirements and achieving performance goals

2. Subcontractors are complying with fiscal requirements, such as having appropriate fiscal controls in place, and are using awards for authorized purposes.

B. Contractor can use a variety of monitoring mechanism, including limited scope audits, on-site visits, progress reports, financial reports, and review of documentation support requests for reimbursement, to meet the Contractor's monitoring objectives. The Contractor may charge federal awards for the cost of these monitoring procedures as outlined in OMB Circular A-133.

C. The Contractor shall submit to the State a copy of the procedures and any other monitoring mechanism used to monitor non-profit Subcontracts at the time of the County's annual site visit or within 60 days thereafter. Contractor shall state the frequency that non-profit Subcontracts are monitored.

D. Limited scope audits, as defined in the OMB Circular A-133, only include agreed-upon engagements that are (1) conducted in accordance with either the American Institute of Certified Public Accountants generally accepted auditing standards or attestation standards; (2) paid for and arranged by pass-through entities (counties); and (3) address one or more of the following types of compliance requirements: (i) activities allowed or unallowed; (ii) allowable costs/cost principals; (iii) eligibility; (9v) matching, level of effort and earmarking; and (v) reporting.

E. On-site visits focus on compliance and controls over compliance areas. The reviewer must make site visits to the subcontractor locations(s), and can use a variety of monitoring mechanism to document compliance requirements. The finding and the corrective action will require follow-up by the Contractor.

F. Contractor shall be responsible for any disallowance taken by the Federal Government, the State, or the California State Auditor, as a result of any audit exception that is related to the Contractor's responsibilities herein. Contractor shall not use funds administered by the State to repay one federal funding source with funds provided by another federal funding source, to repay federal funds with state funds, or to repay state funds with federal funds. State shall invoice Contractor 60 days after issuing the final audit report or upon resolution of an audit appeal. Contractor agrees to develop and implement any corrective action plans in a manner acceptable to the State in order to comply with recommendations contained in any audit report. Such corrective action plans shall include time-specific objectives to allow for measurement of progress and are subject to verification by the state within one year from the date of the plan.

Exhibit B
Budget Detail and Payment Provisions

If differences cannot be resolved between the State and Contractor regarding the terms of the financial audit settlements for funds expended under Exhibit A, Attachment I, Section 27, Contractor may request an appeal in accordance with the appeal process described in Document 1J(a), "Non-DMC Audit Appeal Process," incorporated by this reference. When a financial audit is conducted by the Federal Government, the State, or the California State Auditor directly with a Subcontractor of the Contractor, and if the Subcontractor disagrees with audit disallowances related to its programs, claims or services, Contractor shall, at the Subcontractor's request, request an appeal to the State in accordance with Document 1J(a). Contractor shall include a provision in its subcontracts regarding the process by which its Subcontractors may file an appeal via the Contractors.

G. Contractors that conduct financial audits of Subcontractors, other than a Subcontractor whose funding consists entirely of non-Department funds, shall develop a process to resolve disputed financial findings and notify Subcontractors of their appeal rights pursuant to that process. This section shall not apply to those grievances or compliances arising from the financial findings of an audit or examination made by or on behalf of the State.

H. Pursuant to OMB Circular A-133, State may impose sanctions against the Contractor for not submitting single or program-specific audit reports, or failure to comply with all other audit requirements. The sanctions shall include:

1. Withholding a percentage of federal awards until the audit is completed satisfactorily

2. Withhold or disallowing overhead costs

3. Suspending federal awards until the audit is conducted; or

4. Terminating the federal award

Section 3. Drug Medi-Cal Financial Audits

A. In addition to the audit requirements set forth in Exhibit D(F), State may also conduct financial audits of DMC programs, exclusive of NTP services, to accomplish any of, but not limited to, the following audit objectives:

1. To review reported costs for validity, appropriate allocation methodology, and compliance with Medicaid laws and regulations;

2. To ensure that only the cost of allowable DMC activities are included in reported costs;

3. To determine the provider's usual and customary charge to the general public in accordance with CMS (The Medicare Provider Reimbursement Manual) (CMS-Pub.15), which can be obtained from the Centers for Medicare & Medicaid Services, Baltimore, Maryland, or www.cms.hhs.gov, for comparison to the DMC cost per unit;

4. To review documentation of units of service and determine the final number of approved units of service;

Exhibit B
Budget Detail and Payment Provisions

5. To determine the amount of clients' third-party revenue and Medi-Cal share of cost to offset allowable DMC reimbursement; and,

6. To compute final settlement based on the lower of actual allowable cost, the usual and customary charge, or the maximum allowance, in accordance with Title 22, Section 51516.1.

B. In addition to the audit requirements set forth in Exhibit D(F), State may conduct financial audits of NTP programs. For NTP services, the audits will address items A(3) through A(5) above, except that the comparison of the provider's usual and customary charge in A(3) will be to the DMC USDR rate in lieu of DMC cost per unit. In addition, these audits will include, but not be limited to:

1. For those NTP providers required to submit a cost report pursuant to W&IC Section 14124.24, a review of cost allocation methodology between NTP and other service modalities, and between DMC and other funding sources;

2. A review of actual costs incurred for comparison to services claimed;

3. A review of counseling claims to ensure that the appropriate group or individual counseling rate has been used and that counseling sessions have been billed appropriately;

4. A review of the number of clients in group sessions to ensure that sessions include no less than two and no more than twelve clients at the same time, with at least one Medi-Cal client in attendance;

5. Computation of final settlement based on the lower of USDR rate or the provider's usual and customary charge to the general public; and,

6. A review of supporting service, time, financial, and patient records to verify the validity of counseling claims.

C. Contractor shall be responsible for any disallowances taken by the Federal Government, the State, or the Bureau of State Audits as a result of any audit exception that is related to its responsibilities. Contractor shall not use funds administered by the State to repay one federal funding source with funds provided by another federal funding source, or to repay federal funds with state funds, or to repay state funds with federal funds

D. Contractor agrees to promptly develop and implement any corrective action plans in a manner acceptable to the State in order to comply with recommendations contained in any audit report. Such corrective action plans shall include time-specific objectives to allow for measurement of progress and are subject to verification by the State within six months from the date of the plan.

E. Contractor, in coordination with the State, must provide follow-up on all significant findings in the audit report, including findings relating to a Subcontractor, and submit the results to the State.

Exhibit B
Budget Detail and Payment Provisions

If differences cannot be resolved between the State and the Contractor regarding the terms of the final financial audit settlements for funds expended under Exhibit B, Contractor may request an appeal in accordance with the appeal process described in the "DMC Audit Appeal Process," Document 1J(b), incorporated by this reference. When a financial audit is conducted by the Federal Government, the State, or the Bureau of State Audits directly with a Subcontractor of the Contractor, and if the Subcontractor disagrees with audit disallowances related to its programs, claims or services, Contractor shall, at the Subcontractor's request, request an appeal to the State in accordance with Document 1J(b). Contractor shall include a provision in its subcontracts regarding the process by which a Subcontractor may file an audit appeal via the Contractor.

F. Providers of DMC services shall, upon request, make available to the State their fiscal and other records to assure that such provider have adequate recordkeeping capability and to assure that reimbursement for covered DMC services are made in accordance with Title 22, CCR, Section 51516.1. These records include, but are not limited to, matters pertaining to:

1. Provider ownership, organization, and operation;

2. Fiscal, medical, and other recordkeeping systems;

3. Federal income tax status;

4. Asset acquisition, lease, sale, or other action;

5. Franchise or management arrangements;

6. Patient service charge schedules;

7. Costs of operation;

8. Cost allocation methodology;

9. Amounts of income received by source and purpose; and,

10. Flow of funds and working capital.

G. Contractor shall retain records of utilization review activities required for a minimum of three (3) years.

Exhibit B
Budget Detail and Payment Provisions

Part IV – Records

Section 1. General Provisions

A. Maintenance of Records

Contractor shall maintain sufficient books, records, documents, and other evidence necessary for the State to audit Intergovernmental Agreement performance and Intergovernmental Agreement compliance. Contractor shall make these records available to the State, upon request, to evaluate the quality and quantity of services, accessibility and appropriateness of services, and to ensure fiscal accountability. Regardless of the location or ownership of such records, they shall be sufficient to determine if costs incurred by contractor are reasonable, allowable and allocated appropriately. All records must be capable of verification by qualified auditors.

1. Contractor shall include in any Intergovernmental Agreement with an audit firm a clause to permit access by the State to the working papers of the external independent auditor, and require that copies of the working papers shall be made for the State at its request.

2. Contractor shall keep adequate and sufficient financial records and statistical data to support the year-end documents filed with the State. All records must be capable of verification by qualified auditors.

3. Accounting records and supporting documents shall be retained for a three-year period from the date the year-end cost settlement report was approved by the State for interim settlement. When an audit by the Federal Government, the State, or the California State Auditor has been started before the expiration of the three-year period, the records shall be retained until completion of the audit and final resolution of all issues that arise in the audit. Final settlement shall be made at the end of the audit and appeal process. If an audit has not been completed within three years, the interim settlement shall be considered as the final settlement.

4. Financial records shall be kept so that they clearly reflect the source of funding for each type of service for which reimbursement is claimed. These documents include, but are not limited to, all ledgers, books, vouchers, time sheets, payrolls, appointment schedules, client data cards, and schedules for allocating costs. All records must be capable of verification by qualified auditors.

5. Contractor's subcontracts shall require that all Subcontractors comply with the requirements of Exhibit A, Attachment I, Section 19.

Exhibit B
Budget Detail and Payment Provisions

6. Should a Subcontractor discontinue its contractual agreement with the Contractor, or cease to conduct business in its entirety, Contractor shall be responsible for retaining the Subcontractor's fiscal and program records for the required retention period. The State Administrative Manual (SAM) contains statutory requirements governing the retention, storage, and disposal of records pertaining to state funds. Contractor shall follow SAM requirements located at http://sam.dgs.ca.gov/TOC/1600.aspx.

   The Contractor shall retain all records required by Welfare and Institutions Code section 14124.1, 42 CFR 433.32, and California Code of Regulations, Title 22, Section 51341.1 et seq. for reimbursement of services and financial audit purposes.

7. In the expenditure of funds hereunder, and as required by 45 CFR Part 96, Contractor shall comply with the requirements of SAM and the laws and procedures applicable to the obligation and expenditure of federal and state funds.

B. Dispute Resolution Process

1. In the event of a dispute, other than an audit dispute, Contractor shall provide written notice of the particulars of the dispute to the State before exercising any other available remedy. Written notice shall include the Intergovernmental Agreement number. The Director (or designee) of the State and the County Drug or Alcohol Program Administrator (or designee) shall meet to discuss the means by which they can effect an equitable resolution to the dispute. Contractor shall receive a written response from the State within sixty (60) days of the notice of dispute. The written response shall reflect the issues discussed at the meeting and state how the dispute will be resolved.

2. In the event of a dispute over financial audit findings between the State and the Contractor, Contractor may appeal the audit in accordance with the "non- DMC Audit Appeal Process" (Document 1J(a)). When a financial audit by the Federal Government, the State, or the California State Auditor is conducted directly with a Subcontractor of the Contractor, and if the Subcontractor disagrees with audit disallowances related to its programs, claims or services, Contractor shall, at the Subcontractor's request, request an appeal to the State in accordance with Document 1J(a). Contractor shall include a provision in its subcontracts regarding the process by which a Subcontractor may file an audit appeal via the Contractor.

3. As stated in Part III, Section 3, of this Exhibit, in the event of a dispute over financial audit findings between the State and the Contractor, Contractor may appeal the audit in accordance with DMC Audit Appeal Process" (Document 1J(b)). When a financial audit by the Federal Government, the State, or the California State Auditor is conducted directly with a Subcontractor of the Contractor, and if the Subcontractor disagrees with audit disallowances related to its programs, claims or services, Contractor shall, at the Subcontractor's request, request an appeal to the State in accordance with DMC Audit Appeal Process" (Document 1J(b)). Contractor shall include a provision in its subcontracts regarding the process by which a Subcontractor may file an audit appeal via the Contractor.

Exhibit B
Budget Detail and Payment Provisions

4. Contractors that conduct financial audits of Subcontractors, other than a Subcontractor whose funding consists entirely of non-Department funds, shall develop a process to resolve disputed financial findings and notify Subcontractors of their appeal rights pursuant to that process. This section shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of the State pursuant to Part II of this Exhibit.

5. To ensure that necessary corrective actions are taken, financial audit findings are either uncontested or upheld after appeal may be used by the State during prospective Intergovernmental Agreement negotiations.

Exhibit B
Budget Detail and Payment Provisions

Part V. Drug Medi-Cal Reimbursement Rates

A. **"Uniform Statewide Daily Reimbursement (USDR) Rate"** means the rate for NTP services based on a unit of service that is a daily treatment service provided pursuant to Title 22, Sections 51341.1 and 51516.1 and Title 9, commencing with Section 10000 (Document 3G), or the rate for individual or group counseling. The following table shows USDR rates.

Service	Type of Unit of Service (UOS)	Non-Perinatal (Regular) Rate Per UOS	Perinatal Rate Per UOS
NTP - Methadone Dosing	Daily	$11.95	$13.80
NTP - Individual Counseling (*)	One 10-minute increment	$13.90	$18.43
NTP - Group Counseling (*)	One 10-minute increment	$3.05	$6.07
NTP - Buprenorphine [1]	Daily	$26.06	$28.50
NTP - Disulfiram [2]	Daily	$10.47	$10.84
NTP - Naloxone [3] (2-pack Nasal Spray)	Dispensed as needed	$150.00	$150.00

(*) The NTP contractors may be reimbursed for up to 200 minutes (20-10 minute increments) of individual and/or group counseling per calendar month. If medical necessity is met that requires additional NTP counseling beyond 200 minutes per calendar month, NTP contractors may bill and be reimbursed for additional counseling (in 10 minute increments). Medical justification for the additional counseling must be clearly documented in the patient record.

Reimbursement for covered NTP services shall be limited to the lower of the NTP's usual and customary charge to the general public for the same or similar services or the USDR rate.

[1] - Buprenorphine: Average daily dose of 16 milligrams, sublingual tablets.

[2] - Disulfiram: Average daily dose between 250 and 500 milligrams.

[3] - Naloxone: One dose equal to 4 milligrams per 0.1 milliliter.

Exhibit B
Budget Detail and Payment Provisions

B. **"Unit of Service"** means a face-to-face contact on a calendar day for outpatient drug free, intensive outpatient treatment, partial hospitalization, and residential treatment services. Units of service are identified in the following table:

Services Provided by Modality (funded by DMC-ODS)	Billing/Unit of Service (minutes, day, hour)	Proposed Rate
Encounter Rates		
Outpatient	15 minute increments	$61.69
Intensive Outpatient	15 minute increments	$23.79
Recovery Services	15 minute increments	$64.41
Case Management	15 minute increments	$37.77
Physician Consultation	15 minute increments	$234.62
Daily Rates		
Level 1-WM	Per Day	N/A
Level 2-WM	Per Day	N/A
Level 3.2-WM	Per Day	$171.16
Level 3.1- Residential	Per Day	$158.88
Level 3.3 - Residential	Per Day	$158.88
Level 3.5 - Residential	Per Day	$158.88
Optional		
Additional Medication Assisted Treatment	15 minute increments	$122.37
Partial Hospitalization	15 minute increments	$26.16

Exhibit B, Attachment I - Funding for Fiscal Year 2016-17 through FY 2018-19

Version:	**Original**
Date:	**6/15/2017**

County: Santa Clara

Contract Number: 16-93236

Fiscal Year 2016-17	2016-17 Funding Amount
State General Funds (7/1/16 to 6/30/17)	
Drug Medi-Cal SGF**	56,538
ODS Waiver SGF**	599,615
TOTAL	**656,153**
SAPT Block Grant - FFY 2017 Award (10/1/16 to 6/30/18)	
- Discretionary	8,135,598
- Prevention Set-Aside	2,398,308
- Friday Night Live/Club Live	30,000
- Perintal	532,405
- Adolescent/Youth	462,745
TOTAL	**11,559,056**
Drug Medi-Cal Federal Share (7/1/16 to 6/30/17)	
- Non Perinatal Federal Share	25,115,742
- Perinatal Federal Share	1,674,383
TOTAL	**26,790,125**
GRAND TOTAL	**39,005,334**

Fiscal Year 2017-18	2017-18 Funding Amount
State General Funds (7/1/17 to 6/30/18)	
Drug Medi-Cal SGF**	0
ODS Waiver SGF**	7,624,113
TOTAL	**7,624,113**
SAPT Block Grant - FFY 2018 Award (10/1/17 to 6/30/19)	
- Discretionary	8,135,598
- Prevention Set-Aside	2,398,308
- Friday Night Live/Club Live	30,000
- Perintal	532,405
- Adolescent/Youth	462,745
TOTAL	**11,559,056**
Drug Medi-Cal Federal Share (7/1/17 to 6/30/18)	
- Non Perinatal Federal Share	25,115,742
- Perinatal Federal Share	1,674,383
TOTAL	**26,790,125**
GRAND TOTAL	**45,973,294**

Fiscal Year 2018-19	2018-19 Funding Amount
State General Funds (7/1/18 to 6/30/19)	
Drug Medi-Cal SGF**	0
ODS Waiver SGF**	7,624,113
TOTAL	**7,624,113**
SAPT Block Grant - FFY 2019 Award (10/1/18 to 6/30/20)	
- Discretionary	8,135,598
- Prevention Set-Aside	2,398,308
- Friday Night Live/Club Live	30,000
- Perintal	532,405
- Adolescent/Youth	462,745
TOTAL	**11,559,056**
Drug Medi-Cal Federal Share (7/1/18 to 6/30/19)	
- Non Perinatal Federal Share	25,115,742
- Perinatal Federal Share	1,674,383
TOTAL	**26,790,125**
GRAND TOTAL	**45,973,294**

THREE-YEAR TOTAL	**130,951,922**

** State General Fund amounts are based on biannual DMC estimates approved by the Department of Finance. DHCS will revise the amounts through the contract amendment process for each new allocation.