RESOLUTION No. 25-036

OF THE BOARD OF SUPERVISORS OF THE COUNTY OF NEVADA

RESOLUTION APPROVING EXECUTION OF STANDARD AGREEMENT NUMBER 24-40138 WITH THE DEPARTMENT OF HEALTH CARE SERVICES FOR THE PURPOSE OF IDENTIFYING AND PROVIDING DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS) SERVICES AND SPECIALTY MENTAL HEALTH SERVICES IN NEVADA COUNTY FOR THE TERM OF JANUARY 1, 2025, THROUGH DECEMBER 31, 2026

WHEREAS, Welfare & Institutions Code (hereafter W&I Code) sections 14680 -14727, and 14184.100 et seq. W&I Code section 14712 requires the Department of Health Care Services (DHCS) to implement managed mental health care for Medi-Cal members through contracts with mental health plans; and

WHEREAS, under authority of chapter 3 (§11758.10 et seq.) of Part 1, Division 10.5 of the Health & Safety (H&S) Code and with approval of the Nevada County Board of Supervisors (or designee), DHCS can contract with counties to provide Drug Medi-Cal Organized Delivery System substance use disorder treatment services; and

WHEREAS, DHCS, pursuant to the Behavioral Health Administrative integration initiative under CalAIM, is providing Nevada County the opportunity to enter into one integrated contract for the provision of specialty mental health and substance use disorder treatment services; and

WHEREAS, this integrated agreement will allow Nevada County Behavioral Health to move towards providing more integrated care to community members who often have need for both mental health and substance use disorder treatment services to attain recovery, as well as lessen the administrative and data reporting requirements; and

WHEREAS, this agreement with DHCS is required for Nevada County to be able to participate in the Medi-Cal program and to receive State General Fund dollars.

NOW, THEREFORE, BE IT HEREBY RESOLVED by the Board of Supervisors of the County of Nevada, State of California, that Standard Agreement Number 24-40138 by and between the County and the California Department of Health Care Services for the purpose of identifying and providing Drug Medi-Cal Organized Delivery System services and Specialty Mental Health Services in Nevada County for the term of January 1, 2025, through December 31, 2026, be and hereby is approved in substantially the form attached hereto, and that the Chair of the Board of Supervisors be and is hereby authorized to execute the Agreement and authority documentation on behalf of the County of Nevada.

PASSED AND ADOPTED by the Board of Supervisors of the County of Nevada at a regular meeting of said Board, held on the 11th day of February 2025, by the following vote of said Board:

Ayes: Supervisors Heidi Hall, Robb Tucker, Lisa Swarthout, and Hardy Bullock.

Noes: None.

Absent: Susan Hoek.

Abstain: None.

Recuse: None.

ATTEST:

TINE MATHIASEN
Chief Deputy Clerk of the Board of Supervisors

By: _____

Heidi Hall

Heidi Hall, Chair

D: 4260-2440138

STATE OF CALIFORNIA - DEPARTMENT OF GENERAL SERVICES

STANDARD AGREEMENT

STD 213 (Rev. 04/2020)

AGREEMENT NUMBER	PURCHASING AUTHORITY NUMBER (If Applicable)
24-40138	

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

CONTRACTING AGENCY NAME

Department of Health Care Services

CONTRACTOR NAME

County of Nevada

2. The term of this Agreement is:

START DATE

January 1, 2025

THROUGH END DATE

December 31, 2026

3. The maximum amount of this Agreement is:

$0 (Zero 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 the Agreement.

Exhibits		Title	Pages
	Exhibit A	Scope of Work	6
	Exhibit A, Attachment 1	Organization and Administration	8
	Exhibit A, Attachment 2A	SMHS: Scope of Services	7
+ -	Exhibit A, Attachment 2B	SMHS: Peer Support Services	2
+ -	Exhibit A, Attachment 2C	DMC-ODS: SCOPE OF SERVICES	28
+ -	Exhibit A, Attachment 2D	DMC-ODS: CONTRACTOR-SPECIFIC REQUIREMENTS	6
+ -	Exhibit A, Attachment 2E	[Reserved]	1
+ -	Exhibit A, Attachment 2F	[Reserved]	1
+ -	Exhibit A, Attachment 3	Financial Requirements	4
+ -	Exhibit A, Attachment 4	Management Information Systems	5
+ -	Exhibit A, Attachment 5	Quality Improvement System	6
+ -	Exhibit A, Attachment 6	Utilization Management Program	4

STATE OF CALIFORNIA - DEPARTMENT OF GENERAL SERVICES
STANDARD AGREEMENT
STD 213 (Rev. 04/2020)

AGREEMENT NUMBER	PURCHASING AUTHORITY NUMBER (If Applicable)
24-40138	

Exhibits	Title	Pages
+ - Exhibit A, Attachment 7	Access and Availability of Services	6
+ - Exhibit A, Attachment 8	Provider Network, Contracted Providers, and Timely Access	15
+ - Exhibit A, Attachment 9	[Reserved]	1
+ - Exhibit A, Attachment 10	Coordination and Continuity of Care	5
+ - Exhibit A, Attachment 11	Information Requirements	17
+ - Exhibit A, Attachment 12	Member Problem Resolution	17
+ - Exhibit A, Attachment 13	Program Integrity	11
+ - Exhibit A, Attachment 14	Reporting Requirements	6
+ - Exhibit B	Budget Detail and Payment Provisions	6
+ - Exhibit C *	General Terms and Conditions	04/2017
+ - Exhibit D	Special Terms and Conditions	40
+ - Exhibit E	Additional Provisions	17
+ - Exhibit E, Attachment 1	General Definitions	12
+ - Exhibit E, Attachment 2	SMHS: Service Definitions	9
+ - Exhibit E, Attachment 3	DMC and DMC-ODS: Service Definitions	4
+ - Exhibit F	Business Associate Addendum	6

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

D: 4260-2440138

STATE OF CALIFORNIA - DEPARTMENT OF GENERAL SERVICES

STANDARD AGREEMENT

STD 213 (Rev. 04/2020)

AGREEMENT NUMBER	PURCHASING AUTHORITY NUMBER (If Applicable)
24-40138	

IN WITNESS WHEREOF, THIS AGREEMENT HAS BEEN EXECUTED BY THE PARTIES HERETO.

CONTRACTOR

CONTRACTOR NAME (if other than an individual, state whether a corporation, partnership, etc.)

County of Nevada

CONTRACTOR BUSINESS ADDRESS	CITY	STATE	ZIP
500 Crown Point Circle	Grass Valley	CA	95945

PRINTED NAME OF PERSON SIGNING	TITLE
Heidi Hall	Supervisor

CONTRACTOR AUTHORIZED SIGNATURE	DATE SIGNED
Signed by: Heidi Hall 1FD75EB32434445...	February 12, 2025

STATE OF CALIFORNIA

CONTRACTING AGENCY NAME

Department of Health Care Services

CONTRACTING AGENCY ADDRESS	CITY	STATE	ZIP
1501 Capitol Avenue, MS 4200	Sacramento	CA	95814

PRINTED NAME OF PERSON SIGNING	TITLE
Nga Pham	Chief, Contract Services Sect

CONTRACTING AGENCY AUTHORIZED SIGNATURE	DATE SIGNED
DocuSigned by: Nga Pham 98FC14C0A962465...	February 12, 2025

CALIFORNIA DEPARTMENT OF GENERAL SERVICES APPROVAL	EXEMPTION (If Applicable)
	WIC 14184.102(e) & 14703

Exhibit A
SCOPE OF WORK

1. Service Overview

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

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

2. Service Location

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

3. Service Hours

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

4. Project Representatives

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

Department of Health Care Services	**County of Nevada**
Contract Manager: Donnie Boyett Telephone: 209-261-0085 Email: Donnie.Boyett@DHCS.ca.gov	Phebe Bell, Director Telephone: (530) 470-2784 Fax: (530) 271-0257 Email: Phebe.Bell@co.nevada.ca.us

Exhibit A
SCOPE OF WORK

B. Direct all inquiries to:

Department of Health Care Services Medi-Cal Behavioral Health Division/Program Policy Section Attention: Sarah Rougeux 1501 Capitol Avenue, MS 2702 Sacramento, CA, 95814 Telephone: 916-345-8472 Email: Sarah.Rougeux@DHCS.ca.gov	**County of Nevada** Phebe Bell, Director 500 Crown Point Circle, Suite 120 Grass Valley, CA 95945 Telephone: (530) 470-2784 Fax: (530) 271-0257 Email: Phebe.Bell@co.nevada.ca.us

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

5. General Authority

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

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

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

1) The Contractor shall comply with federal requirements for nonrisk PIHPs as set forth in 42 C.F.R. part 438, except insofar as those requirements have been deemed inapplicable to county behavioral health programs under the

Exhibit A
SCOPE OF WORK

Department's federally approved 1915(b) waiver. See pages 18–19 of the Department's June 23, 2023 amendment to the 1915(b) waiver, or the equivalent pages under any successor amendment.

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

D. No provision of this Contract is intended to obviate or waive any requirements of applicable law or regulation. In the event a provision of this Contract is open to varying interpretations, the Contract provision shall be interpreted in a manner that is consistent with applicable law and regulation. In the event of a conflict between the terms of this Contract and a State or federal statute or regulation, or a BHIN, the Contractor shall adhere to the applicable statute, regulation, or BHIN.

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

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

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

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

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

Exhibit A
SCOPE OF WORK

7. Services to be Performed

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

8. Loss of Federal Authority

Should any part of the scope of work under this Contract relate to a state program receiving Federal Financial Participation (FFP) that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of such program authority. DHCS will adjust payments that are specific to any state program or activity receiving FFP that is no longer authorized by law. If Contractor works on a state program or activity receiving FFP that is no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If DHCS has paid Contractor in advance to work on a no-longer-authorized state program or activity receiving FFP and under the terms of this Contract the work was to be performed after the date the legal authority ended, the payment for that work shall be returned to DHCS. However, if Contractor worked on a state program or activity receiving FFP prior to the date legal authority ended for that state program or activity, and DHCS paid Contractor for that work, Contractor may keep the payment for that work even if the payment was made after the date the state program or activity receiving FFP lost legal authority. DHCS will attempt to provide Contractor with timely notice of the loss of program authority, however, failure by DHCS to provide notice of the loss of program authority shall not constitute a basis for Contractor to retain payments made for work performed following the date of the loss of program authority.

9. Americans with Disabilities Act

Contractor agrees to ensure that deliverables developed and produced, pursuant to this Agreement must comply with the accessibility requirements of Sections 7405 and 11135 of the California Government Code, Section 508 of the Rehabilitation Act of 1973 as amended (29 U.S.C. § 794d), regulations implementing the Rehabilitation Act of 1973 as set forth in Part 1194 of Title 36 of the Code of Federal Regulations, and the Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 et seq.). 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

Exhibit A
SCOPE OF WORK

Code Sections 7405 and 11135 codifies Section 508 of the Rehabilitation Act of 1973 requiring accessibility of EIT.

10. Executive Order N-6-22 – Russia Sanctions

On March 4, 2022, Governor Gavin Newsom issued Executive Order N-6-22 (the EO) regarding Economic Sanctions against Russia and Russian entities and individuals. "Economic Sanctions" refers to sanctions imposed by the U.S. government in response to Russia's actions in Ukraine, as well as any sanctions imposed under state law. The EO directs state agencies to terminate contracts with, and to refrain from entering any new contracts with, individuals or entities that are determined to be a target of Economic Sanctions. Accordingly, should the State determine Contractor is a target of Economic Sanctions or is conducting prohibited transactions with sanctioned individuals or entities, that shall be grounds for termination of this agreement. The State shall provide Contractor advance written notice of such termination, allowing Contractor at least 30 calendar days to provide a written response. Termination shall be at the sole discretion of the State.

11. GenAI Technology Use & Reporting

A. During the term of the contract, Contractor must notify the State in writing if their services or any work under this contract includes, or makes available, any previously unreported GenAI technology, including GenAI from third parties or subcontractors. Contractor shall immediately complete the GenAI Reporting and Factsheet (STD 1000) to notify the State of any new or previously unreported GenAI technology. At the direction of the State, Contractor shall discontinue the use of any new or previously undisclosed GenAI technology that materially impacts functionality, risk or contract performance, until use of such GenAI technology has been approved by the State.

B. Failure to disclose GenAI use to the State and submit the GenAI Reporting and Factsheet (STD 1000) may be considered a breach of the contract by the State at its sole discretion and the State may consider such failure to disclose GenAI and/or failure to submit the GenAI Reporting and Factsheet (STD 1000) as grounds for the immediate termination of the contract. The State is entitled to seek any and all relief it may be entitled to as a result of such non-disclosure.

Exhibit A
SCOPE OF WORK

C. The State reserves the right to amend the contract, without additional cost, to incorporate GenAI Special Provisions into the contract at its sole discretion and/or terminate any contract that presents an unacceptable level of risk to the State.

Exhibit A – Attachment 1
ORGANIZATION AND ADMINISTRATION

1. Implementation Plan

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

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

2. Prohibited Affiliations

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

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

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

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

Exhibit A – Attachment 1
ORGANIZATION AND ADMINISTRATION

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

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

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

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

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

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

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

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

3. Delegation

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

Exhibit A – Attachment 1
ORGANIZATION AND ADMINISTRATION

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

4. Subcontracts and Provider Contracts

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

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

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

C. All subcontracts shall be in writing.

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

E. Each subcontract and provider contract shall contain:

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

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

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

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

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

Exhibit A – Attachment 1
ORGANIZATION AND ADMINISTRATION

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

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

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

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

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

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

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

Exhibit A – Attachment 1
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requirement that the Contractor monitor the subcontractor's or contracted provider's compliance with the provisions of the subcontract or provider contract and this Contract and a requirement that the subcontractor or contracted provider provide a corrective action plan if deficiencies are identified.

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

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

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

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

5. Accreditation Status

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

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

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

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

Exhibit A – Attachment 1
ORGANIZATION AND ADMINISTRATION

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

6. Conflict of Interest

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

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

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

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

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

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

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

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

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

Exhibit A – Attachment 1
ORGANIZATION AND ADMINISTRATION

E. Additional Requirements.

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

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

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

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

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

7. Documentation Standards

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

Exhibit A – Attachment 1
ORGANIZATION AND ADMINISTRATION

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

8. Laboratory Testing Requirements

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

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

2) Is CLIA-exempt.

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

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

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

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

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

Exhibit A – Attachment 2A
SMHS: SCOPE OF SERVICES

1. Criteria for Members to Access Specialty Mental Health Services

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

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

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

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

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

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

AND

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

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

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

(W&I Code § 14814.402, subd. (c).)

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

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

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

Exhibit A – Attachment 2A
SMHS: SCOPE OF SERVICES

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

OR

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

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

i. A significant impairment;

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

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

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

AND

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

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

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

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

(W&I Code § 14184.402, subd. (d).)

2. Provision of Services

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

Exhibit A – Attachment 2A
SMHS: SCOPE OF SERVICES

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

1) Mental Health Services;
2) Medication Support Services;
3) Day Treatment Intensive;
4) Day Rehabilitation;
5) Crisis Intervention;
6) Crisis Stabilization;
7) Adult Residential Treatment Services;
8) Crisis Residential Treatment Services;
9) Psychiatric Health Facility Services;
10) Intensive Care Coordination (for members under the age of 21);
11) Intensive Home Based Services (for members under the age of 21);
12) Therapeutic Behavioral Services (for members under the age of 21);
13) Therapeutic Foster Care (for members under the age of 21);
14) Psychiatric Inpatient Hospital Services;
15) Targeted Case Management;
16) Peer Support Services (if the Contractor has opted to provide Peer Support Services and has been approved by DHCS, the Contractor shall comply with the peer support services provisions in Attachment 2B); and

Exhibit A – Attachment 2A
SMHS: SCOPE OF SERVICES

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

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

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

3. Requirements for Emergency and Post-Stabilization Services

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

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

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

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

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

Exhibit A – Attachment 2A
SMHS: SCOPE OF SERVICES

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

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

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

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

4. Requirements for Day Treatment Intensive and Day Rehabilitation

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

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

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

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

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

Exhibit A – Attachment 2A
SMHS: SCOPE OF SERVICES

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

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

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

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

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

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

Exhibit A – Attachment 2A
SMHS: SCOPE OF SERVICES

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

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

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

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

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

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

5. Therapeutic Behavioral Services

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

Exhibit A – Attachment 2B
SMHS: PEER SUPPORT SERVICES

1. MEDI-CAL PEER SUPPORT SERVICES

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

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

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

D. Voluntary Participation and Funding

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

E. Provision of Peer Support Services

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

F. Peer Support Specialists

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

G. Behavioral Health Professional and Peer Support Specialist Supervisors

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

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

Exhibit A – Attachment 2B
SMHS: PEER SUPPORT SERVICES

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

H. Practice Guidelines

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

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

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

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

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

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

1. General Requirements

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

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

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

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

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

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

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

2. Provision of Services

A. Provider Specifications

1) Professional staff shall:

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

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

2) Professional staff means any of the following:

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

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

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

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

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

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

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

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

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

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

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

3. Organized Delivery System (ODS) Timely Coverage

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

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

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

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

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

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

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

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

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

      ii. Have had at least one diagnosis from the DSM for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated

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

or during incarceration, determined by substance use history.

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

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

a. The services are provided prior to determination of a diagnosis or prior to determination of whether DMC-ODS access criteria are met, as described above. For services provided to members over the age of 21 during the assessment process as described above under the "Initial Assessment and Services Provided During the Assessment Process," the services must be clinically appropriate to be reimbursed. In addition, the Contractor shall not disallow reimbursement for clinically appropriate and covered DMC-ODS services provided during the assessment process if the assessment subsequently determines that the member does not meet the DMC-ODS access criteria for members after assessment. (See Exhibit A, Attachment. 2C, section 3, A., 1), c. above for duration limitations on reimbursement for the initial assessment.)

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

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

additional information regarding code selection during the assessment period for outpatient behavioral health services.

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

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

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

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

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

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

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

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

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

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

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

4. Covered Services

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

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

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

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

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

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

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

3) Intensive Outpatient Treatment Services (mandatory).

4) Outpatient Treatment Services (mandatory).

5) Narcotic Treatment Programs (mandatory).

6) Recovery Services (mandatory).

7) Care Coordination (mandatory).

8) Clinician Consultation (mandatory).

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

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

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

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

12) Partial Hospitalization (Optional).

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

14) Contingency Management Services (Optional).

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

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

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

5. Access to Services

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

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

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

6. Authorization of Services – Residential Programs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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8. Outpatient Treatment Services (ASAM Level 1.0)

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

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

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

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

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

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

9. Intensive Outpatient Treatment Services (ASAM Level 2.1)

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

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

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

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

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

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

10. Partial Hospitalization (ASAM Level 2.5)

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

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

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

3) The Contractor shall ensure:

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

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

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in Level 2.5.

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

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

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

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

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

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

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

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

1) Level 3.7 - Medically Monitored Intensive Inpatient Services.

2) Level 4.0 - Medically Managed Intensive Inpatient Services.

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

1) A DHCS or DSS license;

2) DMC certification; and

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

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

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

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

G. Residential Treatment Services

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

   i. Residential facilities licensed by DHCS.

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

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

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

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

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

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

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

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

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

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

6) [Reserved]

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

8) [Reserved]

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

H. Inpatient Services

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

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

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

12. Withdrawal Management

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

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

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

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

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

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

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

C. A full ASAM Criteria assessment shall not be required as a condition of admission to a facility providing Withdrawal Management. To facilitate an appropriate care transition, a full ASAM assessment, brief screening, or other tool to support referral to additional services is appropriate.

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

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

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

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

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

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13. Narcotic Treatment Program

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

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

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

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

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

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

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

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

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

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

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

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

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

14. Recovery Services

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

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

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

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

15. Medi-Cal Peer Support Services (Optional)

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

16. Contingency Management Services (Optional)

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

17. Care Coordination

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

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

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

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

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

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

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

18. Clinical Consultation Services

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

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

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

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

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

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

B. When MAT is being provided as a standalone service, MAT includes the following components: assessment; care coordination; counseling (individual and group counseling); family therapy; medication services; patient education; prescribing and monitoring for MAT for OUD and AUD and non-opioid SUDs which is prescribing, administering, dispensing, ordering, monitoring, and/or managing the medications used for MAT for OUD, AUD and non-opioid SUDs; recovery services; SUD crisis intervention services; and withdrawal management services.

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

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

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

F. Members needing or utilizing MAT shall be served and cannot be denied treatment services or be required to decrease dosage or be tapered off medications as a condition of entering or remaining in the program. DMC-ODS providers offering MAT shall not deny access to medication or administratively discharge a member who declines counseling services. For patients with lack of connection to psychosocial services, more rigorous attempts at engagement in care may be indicated, such as using different evidence-based practices, different modalities (e.g., telehealth), different staff, and/or different services (e.g., Medi-Cal Peer Support Services). If the DMC-ODS provider is not capable of continuing to treat the member, the DMC-ODS provider shall assist the

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member in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement.

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

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

21. Training

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

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

D. Training for DMC-ODS network providers:

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

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

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

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

22. Requirements for Services

A. Confidentiality.

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

B. Perinatal Services.

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

2) Perinatal services shall include:

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

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

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

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

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

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

C. Substance Use Disorder Medical Director.

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

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

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

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

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

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

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

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

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

D. Network Provider Personnel.

1) Personnel files shall be maintained on all employees, contracted positions, volunteers, and interns, and shall contain the following:

a. Application for employment and/or resume.

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b. Signed employment confirmation statement/duty statement.

c. Job description.

d. Performance evaluations.

e. Health records/status as required by the provider, AOD Certification or Title 9 of the California Code of Regulations.

f. Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries).

g. Training documentation relative to substance use disorders and treatment.

h. Current registration, certification, intern status, or licensure.

i. Proof of continuing education required by licensing or certifying agency and program.

j. Provider's Code of Conduct.

k. Documentation of completion of personnel requirements set forth in BHIN 21-001 and any subsequently issued BHINs that supersede BHIN 21-001 for personnel providing detoxification checks.

2) Job descriptions shall be developed, revised as needed, and approved by the provider's governing body. The job descriptions shall include:

a. Position title and classification.

b. Duties and responsibilities.

c. Lines of supervision.

d. Education, training, work experience, and other qualifications for the position.

3) Written provider code of conduct for employees and volunteers/interns shall be established which addresses at least the following:

a. Use of drugs and/or alcohol.

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

c. Prohibition of sexual contact with members.

d. Conflict of interest.

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

e. Providing services beyond scope.

f. Discrimination against members or staff.

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

h. Protection of member confidentiality.

i. Cooperate with complaint investigations.

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

a. Recruitment.

b. Screening and Selection.

c. Training and orientation.

d. Duties and assignments.

e. Scope of practice.

f. Supervision.

g. Evaluation.

h. Protection of member confidentiality.

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

23. No Unlawful Use or Unlawful Use Messages Regarding Drugs

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

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

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

None of the funds made available through this Contract may be used for any activity that promotes the legalization of any drug or other substance included in Schedule I of § 202 of the Controlled Substances Act (21 U.S.C. § 812).

25. DMC-ODS Reference Documents

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

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

B. Document 1G: Perinatal Practice Guidelines

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

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

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

F. Document 1V: Youth Treatment Guidelines

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

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

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

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

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

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

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

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

O. Document 3J: CalOMS Treatment Data Collection Guide

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

P. Document 3S: CalOMS Treatment Data Compliance Standards

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

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

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

T. Document 5A: Confidentiality Agreement

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

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

A. Covered Services

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

1. Alcohol and Drug Screening, Assessment, Brief Intervention, Referral to Treatment and Early Intervention Services (ASAM Level 0.5).
2. Outpatient Treatment Services (ASAM Level 1.0).
3. Intensive Outpatient Treatment Services (ASAM Level 2.1).
4. Residential Treatment Services (ASAM Levels 3.1 – 3.5).
    i. ASAM Levels 3.1, 3.3, and 3.5 shall be made available within the timeframes outlined in Article III, Section S.7.v.
5. Inpatient Treatment Services (ASAM 3.7).
6. Withdrawal Management (ASAM 3.2-WM).
7. Opioid (Narcotic) Treatment Program Services (OTP/NTP)
8. Recovery Services.
9. Medi-Cal Peer Support Services.
10. Care Coordination.
11. Clinician Consultation Services.
12. Medications for Addiction Treatment (also known as Medication Assisted Treatment or MAT).
13. Contingency Management Services.

B. Access to Services

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

1. Beneficiary Access Line (BAL)
    i. The Contractor shall provide a toll-free 24/7 BAL to beneficiaries seeking access to covered DMC-ODS services.
    ii. The Contractor's BAL shall provide oral and audio-logical (TTY/TDY) translations in the beneficiary's primary language.
    iii. The Contractor shall publish the BAL information on the Contractor's web page, on all information brochures, and prevention materials in all threshold languages.
    iv. The BAL shall provide 24/7 referrals to services for urgent conditions and medical emergencies.
2. The Contractor shall allow the beneficiary point of entry through