San Francisco Department of Public Health

San Francisco Health Network
Behavioral Health Services

Drug Medi-Cal-Organized-Delivery System Substance Use Disorder Treatment Documentation Manual

DPH Office of Compliance & Privacy Affairs
Behavioral Health Services Compliance Office
Version 1.0/April 2019

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Letter from the County Alcohol and Drug Administrator

March 2019

Drug Medi-Cal-Organized Delivery System

The Drug Medi-Cal Organized Delivery System (DMC-ODS) provides a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions for substance use disorder (SUD) treatment services (www.asam.org). The goal is to provide clients diagnosed with substance use disorders access to the care and the services systems needed in order to achieve sustainable recovery.

San Francisco submitted its DMC-ODS implementation plan in 2015 (click here for electronic copy) and began live DMC-ODS services on July 1, 2017, in partnership with our SUD treatment provider network. It is the expectation that all of our DMC certified programs will 'go live' by July 1, 2019, with few exceptions.

The *DMC-ODS Substance Use Disorder Treatment Documentation Manual* is intended to support our treatment programs in meeting DMC-ODS documentation requirements and standards. This includes offering documentation tools such as the monitoring checklists used by the S.F. Department of Public Health Office of Compliance and Privacy Affairs during site visits to funded SUD treatment programs (see next section).

Recent DMC-ODS implementation activities include the development of the "*SUD Level of Care Recommendation Form*" to document and summarize the ASAM assessment required as part of medical necessity under the DMC-ODS Pilot program available in AVATAR. This form also will be used by residential treatment programs to communicate with the Treatment Authorization Program (TAP) to document central authorization as required under the DMC-ODS. Additionally, the AVATAR electronic health record has been adjusted to offer a treatment plan page consistent with DMC-ODS requirements.

The San Francisco Department of Public Health is fortunate to partner with many experienced and skilled community SUD treatment partners and looks forward to working with each of our providers to meet the DMC-ODS standard of care for San Francisco residents who seek treatment for substance use disorders.

Judith Martin, MD
Deputy Medical Director, Behavioral Health Services
Medical Director, Substance Use Services
County Alcohol and Drug Administrator
S.F. Department of Public Health

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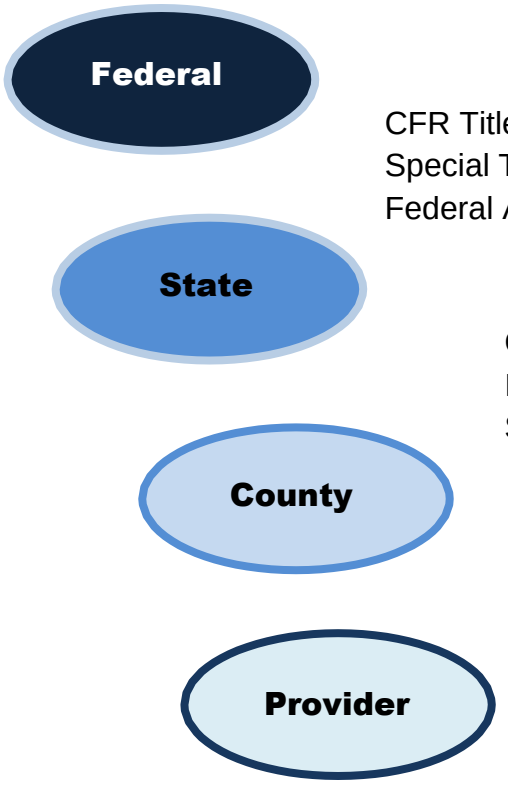
Section 1: Statutory, Regulatory and Contractual Sources

San Francisco substance use disorder (SUD) treatment services are funded through the Drug Medi-Cal-Organized Delivery System (DMC-ODS) pilot program and County General Fund. To receive Drug Medi-Cal reimbursement for qualifying SUD treatment services, the City and County of San Francisco Department of Public Health (DPH), Behavioral Health Services (DPH-BHS), has entered into a County Contract with the California Department of Health Care Services (DHCS), also referred to as the Drug Medi-Cal-Organized Delivery System "Intergovernmental Agreement". This agreement conforms to federal and state regulations that govern DMC-ODS documentation requirements found under Title 42 of the Code of Federal Regulations (CFR), the Welfare and Institutions Code (W&I Code), Titles 9 and 22 of the California Code of Regulations (CCR), and the Special Terms and Conditions of the DMC-ODS pilot program.

The Intergovernmental Agreement also aligns with the DHCS contract (Special Terms and Conditions) with the Centers for Medicare and Medicaid Services (CMS) under the CMS Medicaid Managed Care delivery system. Compliant documentation of services in a client's record is one of many requirements counties must meet to receive DMC-ODS funding for billable services. When contractual requirements for documentation are not met, it can result in increased State oversight of a county and/or the return of DMC funds to the State. Please see figure below that illustrates levels of authority and sources of guidance for the DMC-ODS pilot program.

Levels of Authority & Sources of Guidance for DMC-ODS Pilot Program



CFR Titles 21, 24, 42, 45 (Regulation)
Special Terms and Conditions (Contract)
Federal Authority for States

CCR Titles 9 and 22 (Regulation)
Intergovernmental Agreement (Contract)
State Authority for Counties

DPH-BHS Contract, Policies & Manuals
DMC-ODS Pilot Program Authority for Providers

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Section 2: DPH Office of Compliance and Privacy Affairs (OCPA), Behavioral Health Services Compliance Office (BHSCO)

The San Francisco Department of Public Health (DPH) Office of Compliance and Privacy Affairs (OCPA), Behavioral Health Services Compliance Office (BHSCO) Office, is an independent office within DPH that is responsible for monitoring local compliance with DMC-ODS pilot program requirements and promoting compliant client record keeping in partnership with DPH administrators and the SUD treatment provider network.

The DPH OCPA BHSCO has modeled its compliance program after guidance and standards established by the Office of the Inspector General (OIG), U.S. Department of Health and Human Services. In cultivating a culture of compliance, we have embraced the OIG's seven fundamental elements of an effective compliance program for healthcare:

1. Implementing written policies, procedures and standards of conduct;
2. Designating a compliance officer and compliance committee;
3. Conducting effective training and education;
4. Developing effective lines of communication;
5. Conducting internal monitoring and auditing;
6. Enforcing standards through well-publicized disciplinary guidelines; and
7. Responding promptly to detected offenses and undertaking corrective action.

The *San Francisco Department of Public Health Drug-Medi-Cal-Organized Delivery System Pilot Program Substance Use Disorder Treatment Documentation Manual, Version 1.0* is intended to be a *living* document that is regularly updated as future guidance is provided by the State of California on DMC-ODS documentation standards, as well as to serve as a teaching, training, and documentation resource for staff that serve clients receiving substance use disorder (SUD) treatment services.

As an additional resource to assist our SUD treatment providers in meeting DMC-ODS documentation standards, we have included a set of Behavioral Health Services SUD Chart Review Protocol for Outpatient Services, Intensive Outpatient Treatment, Residential Treatment Services, and Narcotic Treatment Program services. The Chart Audit Review Protocols represent one of many resources available to support documentation compliance activities. See following pages for SUD Chart Review Protocol.

Compliant documentation is more than just a contractual requirement or the subject of an audit; it's an important record of an individual's recovery journey. Whether a provider has worked in the behavioral health system for many years or has just started a career at a treatment program, reviewing this manual and regularly visiting the DPH website (DPH DMC-ODS Resources) for documentation updates reflect good practice.

Working Draft 3.2019

City and County of San Francisco
Department of Public Health
BEHAVIORAL HEALTH SERVICES
COMPLIANCE OFFICE
OFFICE OF COMPLIANCE & PRIVACY AFFAIRS

BEHAVIORAL HEALTH SERVICES
SUBSTANCE USE DISORDER
OS/IOT/RES

OS – OUTPATIENT SERVICES
IOT – INTENSIVE OUTPATIENT TREATMENT
RES – RESIDENTIAL

CHART REVIEW PROTOCOL
FY - _____

Program name/RU	Clinician:	Reviewer:	Review date:
Client name:	BIS#:		Review period:
Admission date:	Discharge date:		DSM code:

Deficiencies/Feedback:

BHS COMPLIANCE

Confidential and Privileged for Quality Improvement and Risk Management Purposes per Evidence Code §1157.6,
HIPAA, 42 CFR Part 2 and Physician-Patient Privilege.
Not to be placed in chart.

I. MEDICAL NECESSITY			
Standard	**Yes**	**No**	**N/A**
1. Diagnosis			
A. Does the client have a valid DSM-5 Substance-Related and Addictive Disorder, other than a tobacco-related or non-substance related disorder? (IA Exhib. A Att. I A2 (III)(B)(2)(ii)(a))	☐	☐	☐
B. Has an LPHA supported the basis for this diagnosis separately from the treatment plan? (IA Exhib. A Att. I A2 (III)(PP)(10)(i)(a))	☐	☐	☐
i. Is diagnosis within the LPHA's scope of practice?			
ii. Are the client-specific facts supporting this basis found in either the assessment or the diagnosis?	☐	☐	☐
iii. **If the client's intake was during the audit period:** Was this diagnosis made within 30 days of the client's admission, but after the client's assessment? (IA Exhib. A Att. I A2 (III)(PP)(10)(i)(a))	☐	☐	☐
C. **As an alternative to A and B**, is the client under 21, and services are appropriate and necessary to correct and ameliorate health conditions? (IA Exhib. A Att. I A2 (III)(B)(2)(iii))	☐	☐	☐
D. Is there documentation of the LPHA meeting with the counselor who conducted the assessment, or did the LPHA conduct the assessment? (IA Exhib. A Att. I A2 (III)(PP)(10)(i))	☐	☐	☐
2. ASAM Placement			
A. Do the client-specific facts cited in each dimension support the severity rating chosen for that dimension?	☐	☐	☐
B. Is the indicated level of care supported by the severity ratings in each of the dimensions?	☐	☐	☐
C. Is the actual level of care either the same as the indicated level of care, or is the change sufficiently justified?	☐	☐	☐
D. Has the ASAM placement been determined by an LPHA? (IA Exhib. A Att. I A2 (III)(B)(2)(iv))	☐	☐	☐
E. If necessary, has pre-authorization been obtained for treatment?	☐	☐	☐
F. Timing of the ASAM placement:			
i. **If the most recent ASAM placement was done during the client's intake**, was the placement made after the diagnosis (IA Exhib. A Att. I A2 (III)(B)(2)(iv))	☐	☐	☐
ii. **Otherwise**, are all the billable services in the audit period no more than 6 months after an ASAM placement? (IA Exhib. A Att. I A2 (III)(B)(2)(v))	☐	☐	☐

BHS COMPLIANCE

3. Treatment Plan A. Timing of the treatment plan i. **If the treatment plan was completed during intake**, was that treatment plan signed by: (IA Exhib. A Att. I A2 (III)(PP)(12)(i)(b))	☐	☐	☐
a. The counselor or LPHA within 30 days of admission.	☐	☐	☐
b. The client within 30 days of admission. If the client refuses to sign the treatment plan, has the provider documented why and what the provider's plan is to engage the client in treatment?	☐	☐	☐
c. The LPHA within 15 days of the counselor's signature in order to attest that the services are medically necessary and appropriate for the client.	☐	☐	☐
ii. **Otherwise**, were the treatment plans signed by: (IA Exhib. A Att. I A2 (III)(PP)(12)(ii))			
a. The counselor or LPHA.	☐	☐	☐
b. The client within 30 days of the counselor or LPHA's signature. If the client refuses to sign the treatment plan, has the provider documented why and what the provider's plan is to engage the client in treatment?	☐	☐	☐
c. The LPHA within 15 days of the counselor's signature in order to attest that the services are medically necessary and appropriate for the client.	☐	☐	☐
B. Contents of the treatment plan (IA Exhib. A Att. I A2 (III)(PP)(12)(i)(a)(i)			
i. Does the treatment plan have a statement of problems identified through the ASAM, other assessment tools, or intake documentation?	☐	☐	☐
ii. Are there goals to be reached which address each problem?	☐	☐	☐
iii. Are there action steps that will be taken by the provider and/or beneficiary to accomplish identified goals?	☐	☐	☐
iv. Are there target dates for the accomplishment of action steps and goals?	☐	☐	☐
v. Is there a description of the services, including type of counseling, to be provided and the frequency thereof?	☐	☐	☐
	☐	☐	☐

BHS COMPLIANCE

Confidential and Privileged for Quality Improvement and Risk Management Purposes per Evidence Code §1157.6,
HIPAA, 42 CFR Part 2 and Physician-Patient Privilege.
Not to be placed in chart.

vi. Is there an assignment of a primary therapist or counselor?	☐	☐	☐
vii. Is the client's diagnosis as documented by the LPHA recorded?	☐	☐	☐
viii. Has the physical examination requirement been met?	☐	☐	☐
ix. Do the services planned meet the requirements of the client's level of care?	☐	☐	☐
4. Continuing Services Justification (IA Exhib. A Att. I A2 (III)(B)(2)(v))			
A. **If the client has been in treatment for more than six months,** has an LPHA reevaluated the medical necessity of the client and documented that the services are still clinically appropriate?	☐	☐	☐

II. PROGRESS NOTES

Standard	Yes	No	N/A
1. Is the note supported by a valid treatment plan (if necessary)? (IA Exhib. A Att. I A2 (III)(PP)(12)(i)(a)(i)(5))	☐	☐	☐
2. Was the note completed within seven calendar days of service? (IA Exhib. A Att. I A2 (III)(PP)(14)(i)(a)(i))	☐	☐	☐
3. Do OS counseling notes contain: (IA Exhib. A Att. I A2 (III)(PP)(14)(i)(a))	☐	☐	☐
A. The topic of the session or purpose of the service.	☐	☐	☐
B. A description of the client's progress on the treatment plan problems, goals, action steps, objectives, or referrals.	☐	☐	☐
C. Information on the client's attendance, including date, start and end times of each service.	☐	☐	☐
D. Whether the services were provided in person, by telephone, or by telehealth.	☐	☐	☐
E. If services were provided in the community, identify the location and how confidentiality was ensured.	☐	☐	☐
4. Are any group progress notes supported by group sign-in sheet that contains: (IA Exhib. A Att. I A2 (III)(PP)(13)			
A. A name, signature, and date from the LPHA or counselor conducting the session.	☐	☐	☐
B. The date of the counseling session.	☐	☐	☐

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C. The topic of the counseling session.	☐	☐	☐
D. The start and end time of the counseling session.	☐	☐	☐
E. The typed or legibly printed name of each participant with their signatures.	☐	☐	☐
5. Instead of a progress note for each session, IOS and RES programs may have one progress note a week that contains: (IA Exhib. A Att. I A2 (III)(PP)(14)(i)(b))			
A. A printed name, signature, and date for the LPHA or counselor who wrote the note within the following calendar week of services.	☐	☐	☐
B. A description of the client's progress on the treatment plan, problems, goals, action steps, objectives, or referrals.	☐	☐	☐
C. A record of the client's attendance at each counseling session including the start and end times and topic of the counseling session.	☐	☐	☐
D. A billable service for each day that was charged to Medi-Cal.	☐	☐	☐
E. Whether the services were provided in person, by telephone, or by telehealth.	☐	☐	☐
F. If services were provided in the community, the location and how the provider ensured confidentiality.	☐	☐	☐
6. For case management progress notes, the note must be completed, signed, and dated within seven calendar days of the service and must contain: (IA Exhib. A Att. I A2 (III)(PP)(14)(i)(c))			
A. The beneficiary's name.	☐	☐	☐
B. The purpose of the service.	☐	☐	☐
C. A description of how the service relates to the client's treatment plan problems, goals, action steps, objectives, or referrals.	☐	☐	☐
D. The date, start and end times of each service.	☐	☐	☐
E. Whether the services were provided in-person, by telephone, or by telehealth.	☐	☐	☐
F. If services were provided in the community, the location and how the provider ensured confidentiality.	☐	☐	☐

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NOTES:

- In order to be valid, signatures for LPHAs and counselors must be next to the typed or written version of the person's name.
- All mention of days refers to calendar days.
- The treatment plan's "physical examination requirement" means that either:
  - A program physician or physician extender has reviewed a physical examination from within 12 months of admission.
  - A program physician or physician extender has performed a physical examination on the client within 30 days of admission, or
  - A goal to obtain a physical examination is included on the client's treatment plan until it is met, and has been reviewed by a program physician. (IA Exhib. A Att. I A2 (III)(PP)(11))
- Treatment requirements for adults:
  - OS: Up to 9 hours a week
  - IOT: 9-19 hours a week
  - RES: At least 5 hours of clinical services per week, and a billable service for each day that is billed.
- Treatment requirements for adolescents
  - OS: Less than 6 hours a week
  - IOT: 6-19 hours a week
  - RES: At least 5 hours of clinical services per week, and a billable service for each day that is billed.
- Billable residential services
  - Transportation services
  - Patient education
  - Clinical services
    - Intake
    - Individual counseling
    - Group counseling
    - Family therapy
    - Collateral services
    - Crisis intervention services
    - Treatment planning
    - Discharge services

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City and County of San Francisco
Department of Public Health
BEHAVIORAL HEALTH SERVICES
COMPLIANCE OFFICE
OFFICE OF COMPLIANCE & PRIVACY AFFAIRS

BEHAVIORAL HEALTH SERVICES SUBSTANCE USE DISORDER NARCOTIC TREATMENT PROGRAM (NTP) CHART REVIEW PROTOCOL FY _____

Program name/RU#	Clinician:	Reviewer:	Review date:
Client name:	BIS#:	Review period:	
Admission Date:	Discharge Date:	DSM Code:	

Feedback/ Overall Comments:

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I. PRE-ADMISSION: CRITERIA FOR PATIENT SELECTION (Only required if the episode was opened within a year of the audit period)			
Pre-admit/pre-episode opening (Non-billable/Mandatory)			
	Yes	**No**	**N/A**
1. The initial assessment must include the following elements: a) Substance use history ❑ b) Medical history ❑ c) Lab tests (including narcotic drug use, tuberculosis, and syphilis.) ❑ *[9 CCR §10270(a)(1-2)]*	❑	❑	❑
2. The physical exam must include the following elements: a) An evaluation of the applicant's organ systems (pulmonary, liver, cardiac abnormalities, and skin) ❑ b) Vital signs (temperature, pulse, blood pressure, and respiratory rate) ❑ c) Visual exam (head, ears, eyes, nose, throat (thyroid), chest (including heart, lungs, and breasts), abdomen, extremities, skin, and general appearance) ❑ d) Neurological system ❑ e) An overall impression which identifies any medical or health problem for which treatment is warranted ❑ *[9 CCR §10270(a)(3)(A-E)]*	❑	❑	❑
3. MD statement of **evidence** of physical dependence reviewed and documented before admission (e.g., symptoms, lab results) *[9 CCR, §10270(b)(1)]*	❑	❑	❑
4. MD statement of final **determination** of physical dependence/addiction to opiates prior to admission *[9 CCR, §10270(b)(2)]*	❑	❑	❑
5. Individual medical necessity summary describing the basis for diagnosis *[Intergovernmental Agreement: Exhibit A, Attachment I A2[(III)(B)(2)(ii)]*	❑	❑	❑

II. CONTINUING SERVICES JUSTIFICATION (CSJ) - MEDICAL NECESSITY				
		Yes	**No**	**N/A**
1. ASAM SUD Level of Care (LOC) Form completed and used to generate continuing services justification *[Intergovernmental Agreement: Exhibit A, Attachment I A2 (III)(B)(2)(iii)]*	**CSJ #1** CSJ #2	❑ ❑	❑ ❑	❑ ❑
2. MD evaluates client's progress or lack of progress on achieving treatment plan goals *[9 CCR §10410(a)(1)]*		❑	❑	❑
3. MD determines discontinuance of treatment would lead to relapse *[9 CCR §10410(a)(2)]*		❑	❑	❑
4. MD evaluates client's medical necessity qualification annually *[Intergovernmental Agreement: Exhibit A, Attachment I A2 (III)(B)(2)(iii)]*	**CSJ #1** CSJ #2	❑ ❑	❑ ❑	❑ ❑
5. MD documents facts justifying decision to continue client's treatment *[9 CCR §10410(C)]*	**CSJ #1** CSJ #2	❑ ❑	❑ ❑	❑ ❑

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III. NEEDS ASSESSMENT (Only required if admission is within a year of audit period)			
Admit episode opening			
	Yes	**No**	**N/A**
1. Is there an Admission Date?	❑	❑	❑
2. Is the Primary Counselor's name and date assigned present? *[9 CCR §10305(a)]*	❑	❑	❑
3. Is the needs assessment conducted by Primary Counselor prior to or on the day of completion of Initial Treatment Plan (**within 28 calendar days of admission**) *[9 CCR §10305(d)]*	❑	❑	❑
4a. The needs assessment must include the following: a) A summary of the patient's psychological and sociological background b) Educational and vocational experience c) Needs for health care as recorded in the physical examination d) Needs for employment e) Needs for education f) Needs for psychosocial, vocational rehab, economic, and legal services *[9 CCR §10305(d)]*	❑	❑	❑
4b. Supervising Counselor's signature within 14 calendar days from the effective date *[9 CCR §10305(g)]*	❑	❑	❑
4c. MD's signature within 14 calendar days from the effective date. *[9 CCR §10305(h)]*	❑	❑	❑
5. ASAM LOC Form completed within 30 calendar days of episode opening *[Intergovernmental Agreement: Exhibit A, Attachment I A2 (V)(2)(g)(iv)]*	❑	❑	❑

IV. TREATMENT PLAN OF CARE (TPOC) - MEDICAL NECESSITY			
Initial Treatment Plan (Only required if services in the audit period are covered by this plan)			
	Yes	**No**	**N/A**
1. Initial Treatment Plan signed by the Primary Counselor within 28 calendar days from admission *[9 CCR §10305(e)]*	❑	❑	❑
2. Individualized Treatment Plan (no cloning) *[9 CCR §10305(c)]*	❑	❑	❑
3. Initial Treatment Plan must include the following: a) Goals that address initial assessment with target dates ❑ b) Short term goals that may take 90 days or less to attain ❑ c) Long term goals that may take 90 days or more to attain ❑ d) Specific behavioral task need to accomplish goals ❑ *[9 CCR §10305(1 - 2)]*	❑	❑	❑
4. Description of type and frequency of counseling services **(Note:** Frequency ranges <u>are</u> acceptable [i.e., 2 to 3 group counseling sessions per week]). [Waiver Requirement Recommendation: Please document evidence based practices in the type and frequency area (motivational interviewing, cognitive-behavioral therapy, relapse prevention, trauma-informed treatment, psychoeducation)] *[9 CCR §10305(3)] & [CMS Special Terms & Conditions (X)(127) and (X)(145)(d)]*	❑	❑	❑

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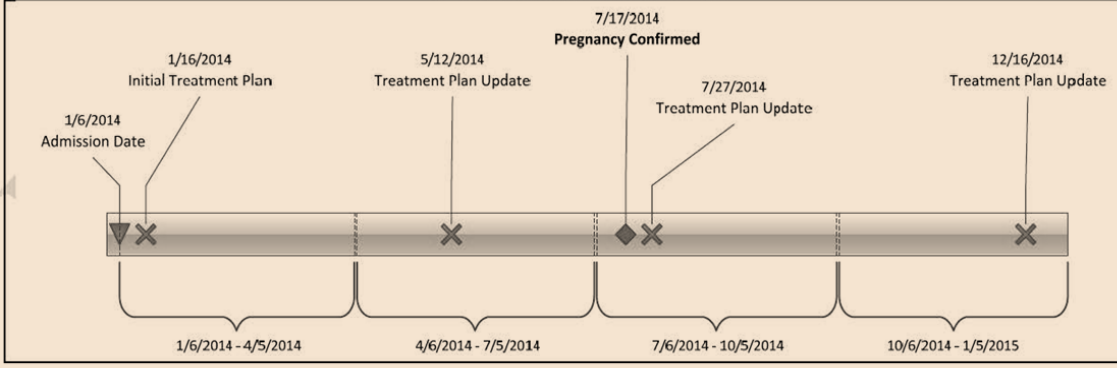
4a. Effective date, based on Primary Counselor signature *[9 CCR §10305(4)]*	❑	❑	❑	
4b. Supervising Counselor's signature within 14 calendar days of Primary Counselor' signature *[9 CCR §10305(g)]*	❑	❑	❑	
4c. MD's signature within 14 calendar days of Primary Counselor's signature *[9 CCR §10305(h)]*	❑	❑	❑	
Updated Treatment Plans			**Yes**	**No**
5. Individualized Treatment Plan(no cloning) *[9 CCR §10305(c)]*	**UTREATMENTP #1**		❑	❑
	UTREATMENTP #2		❑	❑
	UTREATMENTP #3		❑	❑
6. Updated Treatment Plan signed by Primary Counselor at least once every 3 months from date of admission *[9 CCR § 10305(e)]*	**UTREATMENTP #1**		❑	❑
	UTREATMENTP #2		❑	❑
	UTREATMENTP #3		❑	❑
7. Updated Treatment Plan must include:				
7a. Client's progress or lack of progress for each goal identified on previous Treatment Plan *[9 CCR §10305(f)(1)]*	**UTREATMENTP #1**		❑	❑
	UTREATMENTP #2		❑	❑
	UTREATMENTP #3		❑	❑
7b. When new needs are identified, new goals and behavioral tasks are documented *[9 CCR §10305(f)(2)]*	**UTREATMENTP #1**		❑	❑
	UTREATMENTP #2		❑	❑
	UTREATMENTP #3		❑	❑
7c. Effective date, based on Primary Counselor's signature *[9 CCR §10305(f)(3)]*	**UTREATMENTP #1**		❑	❑
	UTREATMENTP #2		❑	❑
	UTREATMENTP #3		❑	❑
7d. Supervising Counselor's signature within 14 calendar days of Primary Counselor signature *[9 CCR §10305(g)]*	**UTREATMENTP #1**		❑	❑
	UTREATMENTP #2		❑	❑
	UTREATMENTP #3		❑	❑
7e. MD's signature within 14 calendar days of Primary Counselor signature *[9 CCR §10305(h)]*	**UTREATMENTP #1**		❑	❑
	UTREATMENTP #2		❑	❑
	UTREATMENTP #3		❑	❑

Treatment Windows Example



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Not to be placed in Chart.

V. DOSING			
	Yes	**No**	**N/A**
1. Does an order exist to support the client's doses? *[9 CCR §10355(g)]*	❑	❑	❑
2. MD reviewed client's dosage level every 3 months (See Treatment Plan or Med Orders) *[9 CCR §10355(c)(4)]*	❑	❑	❑
3. Take-home dosing steps are as follows: • Step I: A single take home if determined responsible for state approved holidays; • Step II: After 90 days of continuous maintenance treatment, up to 2 day take home supply, 5 observed doses per week; • Step III: After 180 days of continuous maintenance treatment, up to 3 day take home supply allowed, 4 observed doses per week; • Step IV: After 270 days of continuous maintenance treatment, up to 6 day take home supply allowed, 1 observed dose per week; • Step V: After 1 year of continuous maintenance treatment, up to 2 week take home supply allowed; 2 observed doses a month • Step VI: After 2 years of continuous treatment, up to 1 month take home supply allowed, 1 observed dose per month. *[ADP Bulletin 12-10]*	❑	❑	❑
For Clinic Closures And Federal/State Holidays Only (Skip to #4 if not applicable)			
4. Unsupervised dosing is limited to a single take-home dose or MD must approve take-home dosing based on the following documented items: no recent drug/alcohol use, regular clinic attendance, no serious behavioral problems at clinic, no recent criminal activity, stable home environment/social relationships, length of treatment, client assurance of medication safely at home and whether rehabilitative benefit the client derived decreasing clinic attendance outweighs the potential risk of diversion *[42 CFR §8.12(i)(2)]*	❑	❑	❑
For Newly Admitted Clients Only (Skip #4 and #5 if client admission date was before fiscal year audited)			
	Yes	**No**	**N/A**
5. Initial dose does not exceed 30mg, unless dose is divided and subsequent does is administered separately after prescribed observation period (disregard if client was transferred from a different clinic) *[9 CCR §10355(d)(1)(A)(B)]*	❑	❑	❑
6. Total first day dose does not exceed 40mg, unless MD documents dosage is not sufficient to suppress the client's opiate abstinence symptoms (disregard if client was transferred from a different clinic) *[9 CCR §10355(d)(2)]*	❑	❑	❑

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VI. PROGRESS NOTE DOCUMENTATION			
	Yes	**No**	**N/A**
1. Legible progress notes *[22 CCR §51341.1(h)(3)]*	❑	❑	❑
2. Progress note completed within 14 calendar days of counseling session by counselor conducting session (note date) *[9 CCR §10345(d)]*	❑	❑	❑
3. Progress note must include the following: **a)** Date of service provided ❑ **b)** Type of counseling format (individual/group) ❑ [Waiver Requirement Recommendation: Please document evidence based practices in the applicable progress notes (motivational interviewing, cognitive-behavioral therapy, relapse prevention, trauma-informed treatment, psycho-education)] *[9 CCR §10345(d)(1-3)] & [CMS Special Terms & Conditions (X)(127) and (X)(145)(d)]*	❑	❑	❑
4. Summary of session including *at least* ***ONE*** of the following: **a)** Client's progress towards treatment plan goals ❑ **b)** Drug screening results ❑ **c)** New issues/problems that affect treatment ❑ **d)** Prenatal support provided by program/healthcare provider ❑ **e)** Goals/purpose of session, subjects discussed, client's participation ❑ *[9 CCR §10345(d)(4)(A-E)]*	❑	❑	❑
5. Minimum of **50 minutes** of counseling provided for each calendar month of treatment not to exceed **200 minutes** *[9 CCR §10345(a); MHSUDS INFORMATION NOTICE NO.: 15-028]*	❑	❑	❑

VII. DISCHARGE SUMMARY			
	Yes	**No**	**N/A**
1. Does the discharge summary include the following elements? a) Client's name ❑ **b)** Date of discharge ❑ **c)** Reason for discharge ❑ **d)** A summary of the client's progress during treatment ❑ **e)** Was HIV counseling provided to the client? ❑ *[9 CCR §10415(g)(1-3)] & [42 CFR §8.12(f)(5)(ii)]*	❑	❑	❑

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Section 3: DMC-ODS Pilot Program Overview

The DMC-ODS pilot program transforms how SUD treatment services are delivered by counties that have opted to participate (see DHCS The Drug Medi-Cal Organized Delivery System Pilot Program Fact Sheet). DMC-ODS participating counties must:

1. Use a benefit design modeled after the American Society for Addiction Medicine (ASAM) Criteria, covering a broad continuum of SUD treatment and support services;
2. Specify standards for quality and access;
3. Require providers to deliver evidence-based care, including medication management;
4. Coordinate with physical and mental health services; and
5. Act as a managed care plan for SUD treatment services.

This represents a significant change in how SUD treatment services and supports were delivered in the past, with a new focus on providing clients with access to the care and system interaction needed to achieve sustainable recovery from addiction.

Local Flexibility with Greater Administrative Accountability for Documentation

While the DMC-ODS pilot program offers more local flexibility and oversight of SUD treatment services and supports, it also provides for greater administrative accountability, including documentation requirements for client records. In addition to recordkeeping requirements found under 22 CCR § 51476(a), such as documentation of treatment authorization requests and medications prescribed, counties are required to "establish, maintain and update as necessary" individual client records for each client admitted to treatment and receiving services which includes *all* activities, services, sessions, and assessments provided to a client (22 CCR § 54341.1(g)(1)(A)-(B)).

Documentation of Personal Information in Client Record	Documentation of Treatment Episode Information in Client Record
• Information specifying the client's identifier/Social Security #; • Client's birth date, gender, and race and/or ethnic background; • Client's religious preference;* • Client's address and telephone number, length at current address*, and home ownership;* • Client's next of kin or emergency contact; • Stay in controlled environments in past 30 days.* • For pregnant/postpartum women, medical documentation of pregnancy and last day of pregnancy * = Additional information collected in AVATAR.	• Intake and admission data, including, if applicable, a physical examination; • Initial and updated treatment plans; • Individual and group counseling; • Crisis intervention; • Collateral services; • Progress notes/counseling notes; • Continuing services justifications; • Laboratory test orders and results; • Case management services; • Discharge plan/Discharge summary; • Evidence of compliance with specific treatment modality/LOC requirements; • Any other information relating to treatment services provided.

In addition to this client personal and treatment episode information, there are specific documentation requirements for each ASAM Level of Care treatment service, as well as other documentation requirements such as group counseling sessions sign-in sheet requirements and perinatal requirements.

Standard Drug Medi-Cal vs. DMC-ODS Pilot Program

Prior to the implementation of the DMC-ODS pilot program, Medi-Cal clients in participating counties with substance use disorders were served through the standard Drug Medi-Cal program. This standard program generally covered a limited set of covered services specified in California's Medicaid plan, primarily outpatient and methadone services, but also included intensive outpatient SUD services, perinatal residential SUD treatment (limited to facilities with 16 beds or fewer), and narcotic (opioid) treatment programs.

By contrast, the DMC-ODS pilot program promotes a continuum of care model after the ASAM Criteria for SUD treatment services to create comprehensive, individualized client treatment plans. Access to a wide array of services is provided including case management, multiple levels of residential SUD treatment (not limited to perinatal or to facilities with 16 beds or fewer), withdrawal management, recovery services, physician consultation, and, at county option, additional medication-assisted treatment (MAT) and/or partial hospitalization services. San Francisco has opted to provide additional MAT services.

To illustrate major differences between the standard DMC program and the DMC-ODS pilot program, please see the quick reference tool below.

Standard DMC Program and DMC-ODS Pilot Program Quick Reference Tool

Treatment Modalities	
Standard DMC Program	**DMC-ODS Pilot Program**
Outpatient Drug Free Treatment/ODF	Outpatient Services
Intensive Outpatient Treatment/IOT	Intensive Outpatient Services
Naltrexone Treatment	Naltrexone Treatment
Narcotic Treatment Program (methadone)	Narcotic Treatment Program (methadone + additional medications)
Perinatal Residential SUD Services (limited bed capacity)	Residential Services (not restricted by bed capacity or limited to perinatal)
Detoxification in a Hospital with a treatment authorization request/TAR	Withdrawal Management (at least one level)
	Recovery Services, Case Management, Physician Consultation, Partial Hospitalization (Optional), Additional Medication Assisted Treatment (Optional)

Outpatient Services	
Standard DMC Program	**DMC-ODS Pilot Program**
Referred to as ODF	ASAM Level 1.0
Individual counseling limited	Adults = up to 9 hours
	Adolescents = less than 6 hours
DMC certified sites only	Not limited to DMC certified sites
Intensive Outpatient Services	
Standard DMC Program	**DMC-ODS Pilot Program**
IOT	IOS/ASAM Level 2.1
3 days, 3 hours per week	Adults = min. of 9 hours, max. of 19 hours
	Adolescents = min. of 6 hours, max. of 19 hours
DMC certified sites only	Not limited to DMC certified sites
Residential Services	
Standard DMC Program	**DMC-ODS Pilot Program**
Limited to pregnant/parenting women (Perinatal)	Open to populations in addition to Perinatal: • Non-Perinatal Adults, age 18 and older • Adolescents, up to age 18
Treatment capacity of 16 clients or less	No maximum bed capacity
Limitations on length of stay for perinatal: duration of pregnancy plus 60 days postpartum	Limitations on length of stay: • Adult: 1 to 90 days, up to 90 days maximum with 30-day, one-time extension, per year; maximum of two (2) non-continuous 90-day regimens in a one-year period. • Adult/Perinatal: Duration of pregnancy + 60 days postpartum. • Adolescents: 30 days with 30-day, one-time extension per year; longer length of stay if found to be medically necessary.
	ASAM Designations – Levels 3.1, 3.3, 3.5
Perinatal Network Services Guidelines	Perinatal Practice Guidelines, FY 2018-19

SUD Treatment and Support Services Workforce Expansion	
Standard DMC Program	**DMC-ODS Pilot Program**
By Physicians	By Physicians and other Licensed Practitioners of the Healing Arts (LPHA) acting within their scope of professional practice (see DPH SUD Billing Privileges Matrix under Appendix): • Physician • Nurse Practitioners • Physician Assistants • Registered Nurses • Registered Pharmacists • Licensed Clinical Psychologists • Licensed Clinical Social Workers • Licensed Professional Clinical Counselors • Licensed Marriage & Family Therapists • Licensed Eligible Practitioners working under the supervision of licensed clinicians (Intergovernmental Agreement: 1.G.1

Source: DHCS Drug Medi-Cal-Organized Delivery System Documentation Training, July 2018

What Are the ASAM Criteria?

Founded in 1954, ASAM is a professional society representing over 3,600 physicians, clinicians and associated professionals in the field of addiction medicine dedicated in part to increasing access and improving the quality of addiction treatment and promoting the appropriate role of physicians in the care of clients with addiction. ASAM's criteria define one national set of criteria for providing outcome-orientated and results-based care in the treatment of addiction. The ASAM criteria is most widely used as a comprehensive set of guidelines for placement, continued stay, and the transfer/discharge of clients with addiction and co-occurring conditions (see DHCS Fact Sheet). DMC-ODS treatment services must be consistent with the ASAM Criteria. For more information, visit www.asam.org.

Six Dimensions of the ASAM Level of Care Multi-Dimensional Assessment

The ASAM Criteria use six unique dimensions which represent different areas of a client's life to create a holistic, biopsychosocial assessment of an individual to support service planning and level of care placement decisions for the client.

ASAM Criteria Six Dimensions

ASAM Dimension	Description
Dimension 1: Substance Use, Acute Intoxication, Withdrawal Potential	Exploring an individual's past and current exposure to substance use and withdrawal
Dimension 2: Biomedical Condition and Complications	Exploring an individual's health history and current physical condition

ASAM Dimension	Description
Dimension 3: Emotional, Behavioral, or Cognitive Condition and Complications	Exploring an individual's thoughts, emotions, and mental health issues
Dimension 4: Readiness to Change	Exploring an individual's readiness and interest in changing
Dimension 5: Relapse, Continued Use, or Continued Problem Potential	Exploring an individual's unique relationship with relapse or continued use or problems
Dimension 6: Recovery/Living Environment	Exploring an individual's recovery or living situation and the surrounding people, places and things.

Source: *The ASAM Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition*.

Documentation of the Client Multidimensional Risk Assessment

For each ASAM Dimension, a client is assessed for his or her individual severity and level of function, or in other words, "risk". The risk assessment integrates the client's history, current status, and changing situation:

1. Risk as it relates to the client's history;
2. Risk as expressed in the client's current status answering the question: "how acute, unstable, and active is the client's current clinical presentation";
3. The degree of change from baseline or premorbid functioning to present.

Clients are assigned a Dimension Severity Rating for each of the six ASAM Dimensions to inform level of care placements at admission and during transitions between ASAM Levels of Care (Source: *The ASAM Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition*).

SEVERITY RATING			
	4	This rating would indicate issues of utmost severity. The client would present with critical impairments in coping and functioning with signs and symptoms indicating an "imminent danger" concern.	HIGH
	3	This rating would indicate a serious issue or difficulty coping within a given dimension. A client presenting at this level of risk may be considered in or near "imminent danger."	
	2	This rating would indicate moderate difficulty in functioning. However, even with moderate impairment, or somewhat persistent chronic issues, relevant skills or support systems may be present.	MODERATE
	1	This rating would indicate a mildly difficult issue, or present minor signs and symptoms. Any existing chronic issues or problems would be able to be resolved in a short period of time.	
	0	This rating would indicate a non-issue or very low risk issue. The client would present no current risk and any chronic issues would be mostly or entirely stabilized.	LOW

Below is a table that shows the relationship between the ASAM Dimensions and the ASAM severity rating scales.

Dimension	Severity Rating (based on ratings above)			
Dimension 1 Substance Use, Acute Intoxication, Withdrawal Potential	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe
Dimension 2 Biomedical Condition and Complications	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe
Dimension 3 Emotional, Behavioral, or Cognitive Condition and Complications	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe
Dimension 4 Readiness to Change	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe
Dimension 5 Relapse, Continued Use, or Continued Problem Potential	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe
Dimension 6 Recovery/Living Environment	☐ 0 None	☐ 1 Mild	☐ 2 Moderate	☐ 3-4 Severe

The ASAM Continuum of Care

DMC-ODS covered services are required to be delivered within a continuum of care as defined in the ASAM Criteria (Intergovernmental Agreement, III.C.2.). The diagram at the end of this section is taken from *The ASAM Criteria, Third Edition* and illustrates the ASAM continuum of care, beginning with lower intensive services such as Outpatient Services to higher intensive services such as Residential Treatment.[1]

[1] Drug Medi-Cal Organized Delivery System Documentation Requirement Training, July 2018.

San Francisco is required to provide all DMC-ODS mandatory covered treatment and support services which include:

- 0.5 Early Intervention
- 1.0 Outpatient Services
- 2.1 Intensive Outpatient Treatment
- 3.1, 3.3, and 3.5 Residential Treatment
- 1.0 and 3.2 Withdrawal Management
- Medication Assisted Treatment/Narcotic Treatment Programs,
- Recovery Services
- Case Management Services
- Physician Consultation Services (Intergovernmental Agreement, III.C.3.).

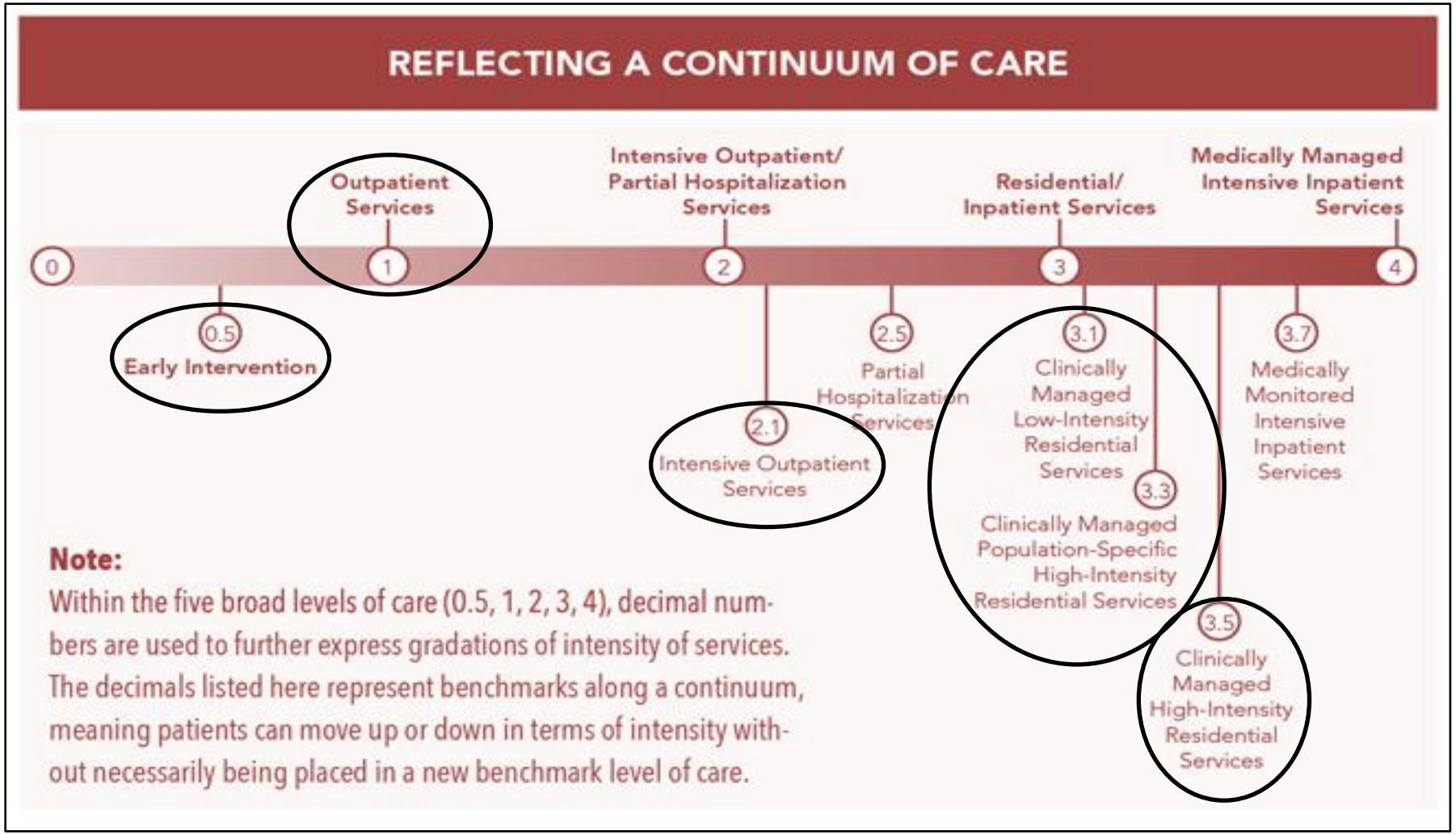
In addition to these DMC-ODS services, San Francisco has contracted with the State to provide Optional Medication Assisted Treatment and support a Recovery Residence which offers residential step-down services.

DMS-ODS Adolescent Treatment Requirements

The California Department of Health Care Services is in the process of establishing new "Youth Treatment Guidelines." Until such time as these new guidelines are adopted, all DPH treatment providers are required to follow the current (August 2002) State "Youth Treatment Guidelines" (Youth Treatment Guidelines) in implementing adolescent treatment programs (Intergovernmental Agreement, Exhibit A, Attachment 1)

In addition, assessment and services for adolescents must follow the ASAM Criteria for adolescent treatment (Intergovernmental Agreement, Exhibit A, Attachment 1, III.A.2), noted as "Adolescent-specific Criteria" throughout "*The ASAM Criteria, Third Edition"* (www.asam.org).

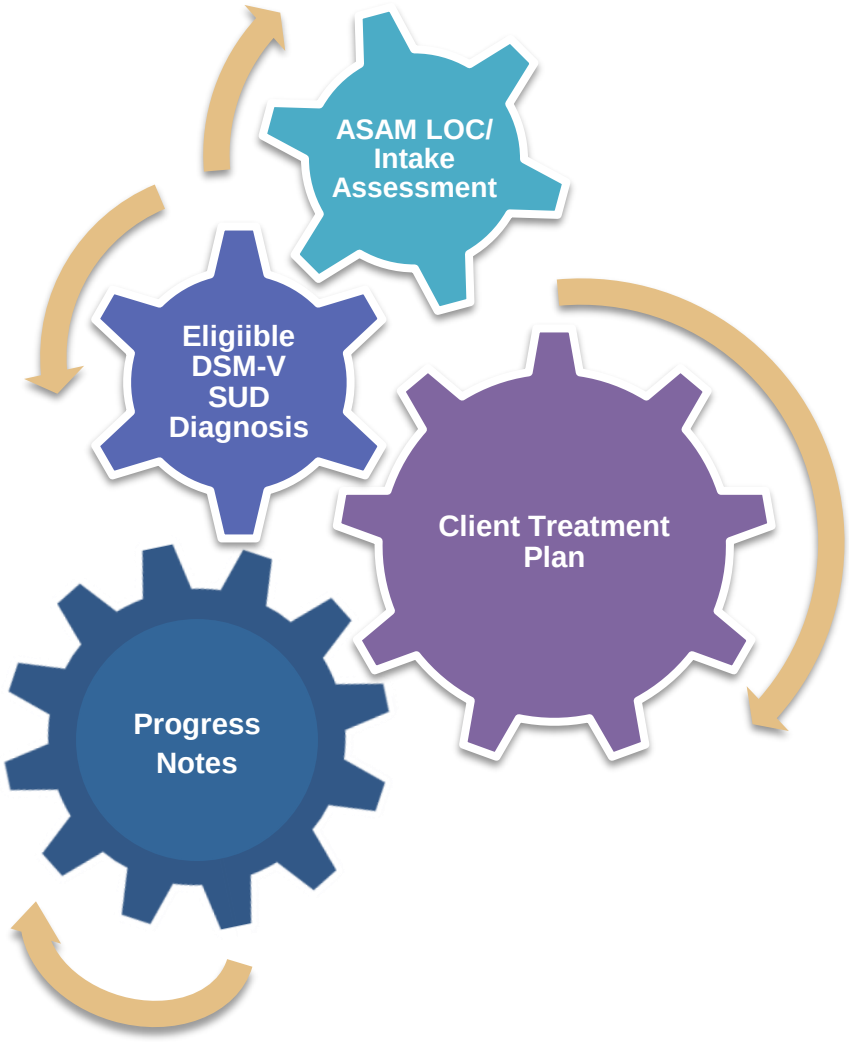
ASAM Continuum of Care



Source: The ASAM Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition

Section 4: The Golden Thread of Documentation

In addition to supporting billing claims, clinical documentation guides the treatment process. The information entered into a client record demonstrates medical necessity for treatment services, reflects individualized client treatment needs and tells a story of a client's progress through treatment.



In other words, there is a "golden thread" of documentation that links the different components of SUD treatment to one another, from the client assessment and diagnosis to the client treatment plan and progress notes (Source: San Francisco DHCS DMC-ODS Documentation Requirement Training, July 2018). The documentation in the client record tells the story and reflects each client's unique journey through recovery

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Section 5: Intake Assessment

The intake assessment is the foundation of a client's treatment plan and informs medical necessity and level of care placement determinations. The chart below includes eleven required assessment elements that must be documented at intake in each client record (Intergovernmental Agreement. III.PP.9). To illustrate how assessment information gathered through the intake assessment supports client level care placement decisions, the table below maps intake assessment elements to corresponding ASAM Dimensions (Source: DHCS DMC-ODS Documentation Requirement Training, July 2018).

Eleven Elements of Client Assessment & Corresponding ASAM Dimensions

Intake Assessment Element	Required Documentation in Client Record	Maps to ASAM Dimension…
1. Drug/Alcohol History	Description of history of present episode including precipitating factors, current symptoms, and pertinent present risks.	**Dimension 1: Acute Intoxication and/or Withdrawal Potential**
2. Medical History	Description of pertinent medical problems and treatment; emergency department visits including those for substance-related problems, surgeries, and head injuries; present medications; allergies; and most recent medical evaluation.	**Dimension 2: Biomedical Condition and Complications**
3. Family History	Description of family alcohol, tobacco, and other drug use and addictive behavior history, including past treatment episodes; family social history including profiles of parents (or guardians or other caregivers), siblings, home atmosphere, economic status, religious affiliation, cultural influences, leisure activities, monitoring and supervision, and relocations; religious, spiritual, or faith background and practice; and family medical and psychiatric history.	**Dimension 6: Recovery/Living Environment**

Intake Assessment Element	Required Documentation in Client Record	Maps to ASAM Dimension…
4. Psychiatric/Psychological History	Description of psychiatric history including symptoms and their relation to substance use and addictive behavior, current and past diagnoses, treatments, and providers.	**Dimension 3: Emotional, Behavioral, or Cognitive Condition and Complications**
5. Social/Recreational History	Description of peer relationships and friends; leisure and recreational activities; sexual activity, including choice of partners, romantic relationships, sexual risk behaviors, relation of sexual activity to substance use and addictive behavior; physical or sexual abuse or other maltreatment either as a victim or perpetrator; disruption of healthy social supports and problems in interpersonal relationships which can impact the development of resiliencies; military service, Veteran status; and religious, spiritual and faith based history.	**Dimension 6: Recovery/Living Environment**
6. Financial Status/History	Description of past and current financial situation.	**Dimension 6: Recovery/Living Environment**
7. Educational History	Description of history.	**Dimension 6: Recovery/Living Environment**
8. Employment History	Description of work history and work situations.	**Dimension 6: Recovery/Living Environment**
9. Criminal History	Description of past behaviors and their relation to substance use and addictive behavior, arrests, adjudications, and details of current status.	**Dimension 6: Recovery/Living Environment**
10. Legal Status	Description of legal status (probation, parole, adjudicated, diversion).	**Dimension 6: Recovery/Living Environment**

Intake Assessment Element	Required Documentation in Client Record	Maps to ASAM Dimension…
11. Previous SUD Treatment History	Description of alcohol, tobacco and other drug use or addictive behavior history including onset and pattern of progression, previous disease or injury resulting from substance use, and past treatment episodes including past successes and barriers to success.	**Dimension 2: Biomedical Condition and Complications** **Dimension 5: Relapse/Continued Use/Continued Problem Potential**

Sources: DHCS DMC-ODS Documentation Training, July 2018 and "*The ASAM Criteria, Third Edition*" found at www.asam.org

Narcotic Treatment Program Additional Client Assessment Requirements
For Narcotic Treatment Programs, there are additional assessment documentation requirements including medical evaluation requirements and administering laboratory tests. These requirements can be found in this manual under Section 9: Narcotic Treatment Programs.

Recovery Services ASAM Requirement
The Department of Health Care Services has provided written guidance to the City and County of San Francisco that an ASAM Level of Care Assessment is required for recovery services clients (Source: J.Rudnick, C.Hudgins, DHCS, March 14, 2019, email to J.Gorndt, DPH).

Assessment Requirements for Clients in Treatment Prior to DMC-ODS
For clients in treatment prior to implementation of the DMC-ODS, an ASAM assessment must be conducted by the due date of the next updated treatment plan or continuing services justification, whichever occurs first. If this assessment determines a different level of care, the provider must refer the client to the appropriate level of care.

Substance Use Disorder Services Level of Care Placement Recommendation Form Completion Requirement & Deadlines
Using information from the client intake assessment, clients must be placed in the appropriate level of care at intake, taking into account client preferences and needs including the intensity of withdrawal services. The Department of Public Health has created the "*Substance Use Disorder Services Level of Care Recommendation Form*" to help guide client level of care placement decisions which has been incorporated within AVATAR, San Francisco's electronic client record. There are different deadlines for completion of the "*Substance Use Disorder Services Level of Care Placement Recommendation Form,*" depending on the treatment service (Interagency Agreement, Exhibit A, Attachment 1, A2: V.B.2.e):

1. Outpatient Services	Within 72 hours of client admission to treatment date
2. Intensive Outpatient Services	Within 72 hours of client admission to treatment date
3. Recovery Services	Within 72 hours of client admission to treatment date
4. Narcotic Treatment Programs	Within 30 days of client admission to treatment date
5. Residential Services	Prior to admission to treatment

Substance Use Disorder Services Level of Care Recommendation Form

San Francisco Health Network
Behavioral Health Services

SUBSTANCE USE DISORDER SERVICES
LEVEL OF CARE (LOC) RECOMMENDATION FORM

Client Name:	Client ID:
Assessment Date:	Time of Assessment:
Practitioner:	
Type of Assessment: □ Initial □ Update (residential) □ Residential Reauthorization □ Update (outpatient) □ Youth □ Withdrawal Mgmt □ Not Applicable/Incomplete	
Why is the client seeking services today?	Collateral Information (Youth):
DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL	
Date of last use:	Number of days used in the past 30 days:
	Number of days injected in the past 30 days:
Current, severe, life-threatening withdrawal symptoms? □ Yes □ No *Further detail:*	
In the absence of current, acute withdrawal, is there a current pattern of substance use that has potential for withdrawal with abrupt reduction or cessation of substances known to be associated with acute withdrawal? □ Yes □ No Further detail:	
Night Sweats: □ Yes □ No	History of Seizure: □ Yes □ No
Hand Tremors: □ Yes □ No	
Dimension 1 Comments/Rationale:	
Dimension 1 Severity Rating: □ 0-None □ 1-Mild □ 2-Moderate □ 3-Substantial □ 4-Very Severe	

DIMENSION 2: BIOMEDICAL CONDITIONS AND COMPLICATIONS
Current severe physical health problems (bleeding, mouth or rectum in last 24 hours; recent unstable hypertension; recent abdominal, head or severe chest pain; significant problems in balance, gait, sensory or motor abilities, not related to intoxication)? □ Yes □ No *Further detail:*
Any chronic health conditions? □ Yes □ No *Further detail:*
Does the client have any of the following? □ HTN □ Diabetes □ Thyroid Disorder □ Seizure Disorder □ Chronic Pain Conditions □ None of the above *Further detail:*
List current physical health medications (including adherence): □ N/A
Does the client have a primary care provider? □ Yes □ No
Dimension 2 Comments/Rationale:
Dimension 2 Severity Rating: □ 0-None □ 1-Mild □ 2-Moderate □ 3-Substantial □ 4-Very Severe
DIMENSION 3: EMOTIONAL, BEHAVIORAL OR COGNITIVE CONDITIONS & COMPLICATIONS
Imminent danger of harming self or another in the past 30 days (e.g. SI with intent, plan & means to succeed; HI or violent ideation; impulses & uncertainty to control impulses, with means to act on)? □ Yes □ No *Further detail:*
Unable to function in activities of daily living or care for self with imminent, dangerous consequences in past 30 days (e.g. unable to bathe, feed, groom & care for self, due to psychosis, organicity or uncontrolled intoxication w/threat to imminent safety of self or others? □ Yes □ No *Further detail:*

Currently receiving mental health services? □ Yes □ No
List current mental health medications (including adherence): □ N/A
Any behaviors or chronic, subacute symptoms that have potential to undermine client's success in treatment that might influence LOC (e.g., anxiety, insomnia, depressive symptoms)? □ Yes □ No *Further detail:*
Dimension 3 Comments/Rationale:
Dimension 3 Severity Rating: □ 0-None □ 1-Mild □ 2-Moderate □ 3-Substantial □ 4-Very Severe

DIMENSION 4: READINESS TO CHANGE	
Does client appear to need SUD treatment and/or MH treatment, but is ambivalent or feels it is unnecessary (e.g. Severe addiction but feels controlled use is still OK; psychotic but blames a conspiracy)? □ Yes □ No	Has been coerced, mandated or required to have assessment/treatment by MH court or criminal justice system, health or social services, work or school, or family/significant other? □ Yes □ No
What does client believe influences their relapse or SUD?	
What does client believe is necessary to be successful in this treatment episode?	
Stage of Change: □ Pre-contemplation □ Contemplation □ Preparation/Determination □ Action/Will Power □ Maintenance □ Relapse	

Dimension 4 Comments/Rationale:
Dimension 4 Severity Rating: □ 0-None □ 1-Mild □ 2-Moderate □ 3-Substantial □ 4-Very Severe

DIMENSION 5: RELAPSE, CONTINUED USE, OR CONTINUED PROBLEM POTENTIAL

Currently under the influence and/or acutely psychotic, manic or suicidal? □ Yes □ No	Are the most troubling presenting problem(s) that brings client in seeking services dangerousness to self or others (see examples in Dimensions 1, 2, 3)? □ Yes □ No
Is client likely to continue to use or have active, acute symptoms in an imminently dangerous manner, without immediate secure placement? □ Yes □ No	
List current addiction treatment medications (including adherence): □ N/A	
Describe current use, including substances used in the past 90 days:	
What factors contributed to the longest periods of abstinence in the past, if any?	
Briefly describe the impact of substance use in functional areas:	
Dimension 5 Comments/Rationale:	
Dimension 5 Severity Rating: □ 0-None □ 1-Mild □ 2-Moderate □ 3-Substantial □ 4-Very Severe	

DIMENSION 6: RECOVERY/LIVING ENVIRONMENT

Immediate threat to client safety, well-being, or abstinence? □ Yes □ No	Is Client at risk or currently homeless? □ Yes □ No

Dimension 6 Comments/Rationale (Family History; Social/Recreational History; Employment History; Criminal History and Legal Status):

Dimension 6 Severity Rating: □ 0-None □ 1-Mild □ 2-Moderate □ 3-Substantial □ 4-Very Severe

PLACEMENT SUMMARY

Substances recommended as focus of treatment:

Indicated LOC:
□ Outpatient Services (ASAM Level 1.0)
□ Opioid Treatment Services/NTP (ASAM Level 1.0)
□ Intensive Outpatient Services (ASAM Level 2.1)
□ Clinically Managed Low-Intensity Residential Services (ASAM Level 3.1)
□ Clinically Managed Population-Specific High Intensity Residential Services (ASAM Level 3.3)
□ Clinically Managed High-Intensity Residential Services (ASAM Level 3.5)
□ Ambulatory Withdrawal Management (ASAM Level 1.0)
□ Clinically Managed Residential Withdrawal Management (ASAM Level 3.2)

Actual LOC Decision:
□ Outpatient Services (ASAM Level 1.0)
□ Opioid Treatment Services/NTP (ASAM Level 1.0)
□ Intensive Outpatient Services (ASAM Level 2.1)
□ Clinically Managed Low-Intensity Residential Services (ASAM Level 3.1)
□ Clinically Managed Population-Specific High Intensity Residential Services (ASAM Level 3.3)
□ Clinically Managed High-Intensity Residential Services (ASAM Level 3.5)
□ Ambulatory Withdrawal Management (ASAM Level 1.0)
□ Clinically Managed Residential Withdrawal Management (ASAM Level 3.2)

Primary reason for difference *(if different):*
□ Service not available
□ Client Preference
□ Service available but no payment source
□ On waitlist for appropriate level
□ Waiting for appropriate language
□ Geographic access
□ Family responsibilities
□ Provider judgement
□ Not listed/Other
□ Language
Not listed/Other detail:

Secondary reason for difference *(if applicable):*
□ Service not available
□ Client Preference
□ Service available but no payment source
□ On waitlist for appropriate level
□ Waiting for appropriate language
□ Geographic access
□ Family responsibilities
□ Provider judgement
□ Not listed/Other
□ Language
Not listed/Other detail:

I attest that either I am a LPHA or if face to face consultation with a LPHA took place: □ Yes □ No

Name of LPHA:_____

If referral is made, is admission likely to be delayed:
□ Yes □ No □ N/A - No Referral Made

If yes, why is admission likely to be delayed:
□ Waiting for level of care availability
□ Waiting for language specific service
□ Hospitalized
□ Incarcerated
□ Patient Preference
□ Other
Other detail:

Anticipated Outcome if service cannot be provided:
□ Admitted to acute care setting
□ Discharge from acute to street/home
□ Continued stay in acute care facility
□ Incarcerated
□ Client will drop out until next crisis
□ Not listed/other
Not listed/other detail:

Plan (include referrals, linkages, further assessments):

Recommended Program:

Addiction Severity Index (ASI) Completion Recommendation
The S.F. Department of Public Health recommends that the Addiction Severity Index (ASI) be completed for each client prior to the client treatment plan or within 30 days of the client's admission to treatment date, whichever comes sooner. The ASI is a semi-structured interview designed to address seven potential problem areas in substance-abusing patients: medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status. The ASI provides an overview of problems related to substance, rather than focusing on any single area (http://www.tresearch.org/products/assessment-and-evaluation).

Deadlines for Completing the Client Assessment
A counselor or LPHA must complete a personal, medical and substance use history for each client at admission to treatment within 30 days of a client's admission to treatment date.

For Narcotic Treatment Programs, the assessment must be completed prior to an individual's admission to treatment services. See Section 8: Narcotic Treatment Programs.

Physician/LPHA Review Requirements for Assessments Completed by Counselors
Where a counselor completes the intake assessment, there must be documentation in the client's record of the review of the personal, medical and substance use history by a physician or LPHA acting within his/her scope of professional practice, (Intergovernmental Agreement: Exhibit A, Attachment I A2, III.1.i.a.) including the signature, or electronic equivalent of the physician/LPHA, date, and printed name.

Physical Examination Requirements
Ensuring that a client's medical issues are addressed as part of the treatment process is an integral part of a client's recovery under the DMC-ODS pilot program. If a client had a physical examination within the twelve-month period prior to the client's admission to treatment date, the physician, registered nurse practitioner or physician's assistant must review documentation of the client's most recent physical examination within 30 calendar days of the client's admission to treatment date (Intergovernmental Agreement, Exhibit A, Attachment I, A2: III.PP.11.i.). If a provider is unable to obtain documentation of a client's most recent physical examination, the provider must describe the efforts made to obtain this documentation in the client's record (Intergovernmental Agreement, Exhibit A, Attachment I, A2: III.PP.11.i.a.).

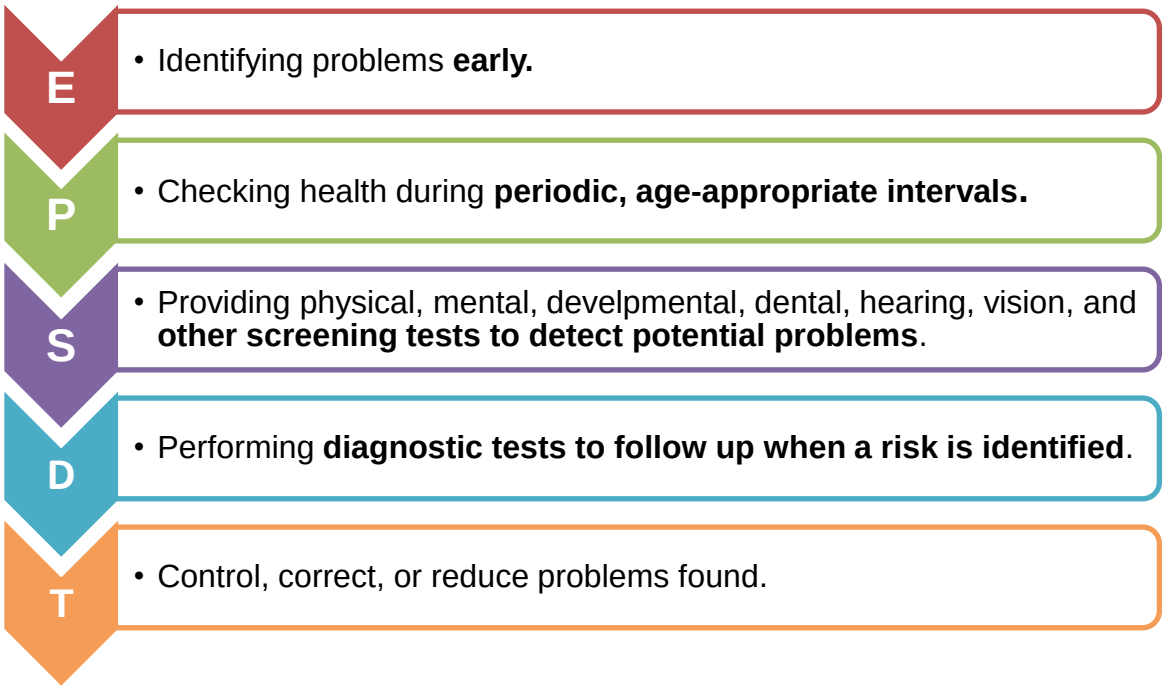
As an alternative or in addition to complying with the physical examination requirement, the physician or physician assistant may perform a physical examination of the client within 30 calendar days of the clients admission to treatment date (Intergovernmental Agreement, Exhibit A, Attachment I, A2: III.PP.11.ii.).

If the physician or a physician assistant has not reviewed the documentation of the client's physical examination, or the provider does not perform a physical examination of the client, then the LPHA or counselor must include in the client's initial and updated treatment plans, the goal of obtaining a physical examination, until this goal has been met and the physician has reviewed the physical examination results. The physician must type or legibly print their name, sign, and date documentation to support he/she

has reviewed the physical examination results. The signature must be adjacent to the typed or legibly printed name (Intergovernmental Agreement, Exhibit A, Attachment I, A2: III.PP.11.iii.).

EPSDT & Special Assessment and Treatment Considerations for Adolescents
The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive screening, diagnostic, treatment and preventive health care services for individuals under the age of 21 who are enrolled in full scope Medicaid (Medi-Cal). Federal EPSDT statutes and regulations require States to furnish all Medicaid coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in the state's Medicaid State Plan. 42 U.S.C. section 1396a(a) (43) and 42 U.S.C. section 1396d(r).

Nothing in the DMC-ODS pilot changes pre-existing EPSDT requirements (DHCS MHSUDS Information Notice No.: 16-063). EPSDT services include five components (22 CFR § 51340):



The full array of services available through Drug Medi-Cal can be found in 22 CFR § 51340.

Prior authorization for these services is not required, with the exception of residential services. When residential services are deemed medically necessary, prior authorization is required (Source: Medicaid State Plan Amendment 13-038 – Limitations on Attachment 3.1-A, page 20a) and the county is responsible for residential authorizations (SAPT and DMC State County Contract – Exhibit A, Attachment I A2, Part V, Section 2 Covered Services, Subsection B(1)(b)).

As with any Medi-Cal service, **physicians** prescribing these services must properly document the medical necessity for the services and meet all other applicable program requirements.

In addition, assessment and treatment services for adolescents must follow the ASAM adolescent treatment criteria. The Department of Public Health is developing assessment elements that meet The ASAM adolescent-specific considerations, as well as ensuring treatment services are appropriate for adolescents. Until such time as further guidance is provided by DPH and DHCS as to specific requirements for documentation of adolescent treatment services, staff should refer to The ASAM Criteria, 3rd Edition (www.asam.org) in documenting developmentally appropriate, adolescent-specific services in the client record. Following is a chart that excerpts several examples of ASAM adolescent treatment criteria.

DMC-ODS Service	**The ASAM Criteria, 3rd Edition Adolescent-specific Considerations**
Assessment	"*Adolescent assessments cannot rely solely on adult assessments but must be augmented by developmentally appropriate, adolescent-specific elements*." Dimension 3 Adolescent-specific Consideration: "*Cognitive abilities, as well as global or focal cognitive impairments, play a large role in an adolescent's functional capacity*." "*Dimension 3 also encompasses the broad consideration of developmental issues, including those reflected in the symptoms of various developmental disabilities or those reflected in the more generic, dimensional consideration of immaturity.*" Dimension 6 Adolescent-specific Consideration: "*Structured, protective living environments are often vital to support ongoing treatment that might be integrated into the living environment itself or coordinated with programming offsite…for younger adolescents, these programs would typically be considered Level 3.1."*
Outpatient Services	< 6 hours/weekly for adolescents (compared to < 9 hours/weekly for adults)
Intensive Outpatient Treatment	Minimum 6 hours to maximum 19 hours weekly for adolescents (compared to minimum of 9 hours to maximum 19 hours weekly for adults)

DMC-ODS Service	The ASAM Criteria, 3rd Edition Adolescent-specific Considerations
Residential Treatment Services	No ASAM 3.3 Residential Services for Youth (ASAM Criteria, 3rd Edition); only 3.1 and 3.5
Withdrawal Management	No unbundled Withdrawal Management services (no differentiated Levels of Care – e.g. Level 1, Level 2, Level 3.2, Level 3.7, Level 4).
Narcotic Treatment Program	**ASAM Recommendations Specific to Adolescents with Opioid Use Disorder**[2] 1. Provider should use a full range of treatment options including pharmacotherapy in treating adolescents; 2. Methadone, buprenorphine, and naltrexone may be used with appropriate justification and parental consent – see note below.[3] 3. Psychosocial treatment is recommended. 4. Concurrent practices to reduce infection (e.g., sexual risk reduction interventions) are recommended as components of comprehensive treatment for the prevention of sexually transmitted infections and blood-borne viruses. 5. Adolescents may benefit from treatment in specialized treatment facilities that provide multidimensional services.

[2] The ASAM National Practice Guideline for the Use of Medication in the Treatment of Addiction Involving Opioid Use, June 1, 2015.

[3] Methadone and buprenorphine are indicated for treatment of patients who are aged 18 years and older. Federal code on opioid treatment offers an exception for youth, aged 16 and 17, who have documented history of at least two prior unsuccessful withdrawal management attempts and have parental consent (42 CFR § 8.12). The client record must provide justification for methadone and buprenorphine treatment along with parental consent.

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Section 6: Medical Necessity/Medically Necessary Services & Diagnosis

Definition of Medical Necessity and Medically Necessary Services

"Medical Necessity" and "Medically Necessary Services" are SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate pain through the diagnosis or treatment of a disease, illness, or injury consistent with Federal (42 CFR 428.210(a)(4)) and State (22 CCR § 51303 and 22 CFR § 51340.1) regulations (Intergovernmental Agreement: Exhibit A, Attachment I A2, IV.56.).

Medical Necessity Determination

The initial medical necessity determination for an individual to receive SUD treatment services must be performed by a Medical Director or an LPHA. The Medical Director or LPHA must evaluate each client's assessment and intake information (Intergovernmental Agreement, Exhibit A, Attachment 1 A2, III.PP.10.i.). When a counselor has conducted a client's intake assessment, the Medical Director or LPHA must meet face-to-face or via telehealth[4] (see note below) with the counselor to establish a client meets medical necessity criteria (Intergovernmental Agreement, Exhibit A, Attachment 1 A2, III.PP.10.i.).

Medical Necessity Criteria

For an individual to receive treatment services, there must be documentation in the client record in the form of a narrative statement to show that s/he/they meet DMC-ODS Medical Necessity Criteria. There are two sets of medical necessity criteria: one for adults, aged 21 and over, and the other for adolescents under 21 years old (Intergovernmental Agreement: Exhibit A, Attachment I A2, IV.57.).

Medical Necessity Criteria - Adults

Adults, aged 21 and over, must meet the following medical necessity criteria (Intergovernmental Agreement: Exhibit A, Attachment 1 A2, IV. 7, 57.):

1. Must have one included ICD-10 diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders, with the exception of Tobacco-Related Disorders and non-Substance-Related Disorders (see table of DHCS list of included ICD 10 SUD diagnoses at end of section);
2. Must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria; and

[4] "Telehealth between providers" means communication between two providers for purposes of consultation, performed via interactive audio **and** video telecommunications systems (Intergovernmental Agreement: Exhibit A, Attachment 1 A2, IV.119.). The same standard applies to "telehealth between providers and clients" (Intergovernmental Agreement: Exhibit A, Attachment 1 A2, IV.118.). In interpreting these standards, DPH has determined that a phone call by itself will not meet these telehealth standards.

3. Must meet the ASAM Adult Dimensional Admission Criteria.

Note: An individual can have more than one diagnosis, but the diagnosis or diagnoses should be based on information collected at intake through the client assessment (Source: DHCS DMC-ODS Documentation Requirement Training, July 2018).

Medical Necessity Criteria for Adolescents
Adolescents under age 21 years old are eligible to receive Medicaid services pursuant to the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) mandate that provides clients under age 21 all appropriate and medically necessary services needed to correct and ameliorate health conditions (Intergovernmental Agreement: Exhibit A, Attachment I A2, IV.57.). Nothing in the DMC-ODS overrides any EPSDT requirements.

In order to receive DMC-ODS Services, adolescents must meet "medical necessity" (DHCS Program Eligibility and the Drug Medi-Cal Organized Delivery System FAQs, April 2018). This is met when:

1. An adolescent has one covered diagnosis from the DSM for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, or is assessed to be at risk for developing a substance use disorder; and
2. An adolescent meets the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.

Early Intervention Services for Adults and Adolescents Not Meeting Medical Necessity Requirement
Adults and adolescents that are assessed to be at risk for developing an SUD, and do not meet the medical necessity criteria for developing an SUD, may qualify for Early Intervention (ASAM Level 0.5) services (Intergovernmental Agreement, Exhibit A, Attachment I, A2: V.G.)
Early Intervention services for adolescents, under age 18, will be provided by DPH civil service behavioral health clinics (Source: Children, Youth and Families System of Care SUD Services Manager, R.Perez). Early Intervention services for adolescents, aged 18 and over, and adults will be available through primary care physicians (Intergovernmental Agreement, Exhibit A, Attachment I, A2: V.G.).

Medical Necessity Requirements for Continuing Services

ASAM Level of Care or Service	Medical Necessity Documentation Requirements
Outpatient Services **Intensive Outpatient Services** **Naltrexone Treatment** **Case Management**	**Step 1: LPHA/Counselor Recommendation** No sooner than five (5) months and no later than every six (6) months after the client's admission to treatment date or the date of completion for the most recent justification for continuing services, the LPHA or counselor must review a client's progress and eligibility to continue to receive services and recommend whether or not a client should continue to receive treatment services at the same level of care. **Step 2: Medical Director/LPHA Medical Necessity Determination** No sooner than five (5) months and no later than every six (6) months after the client's admission to treatment date or the date of completion for the most recent justification for continuing services, the Medical Director or LPHA must determine whether a client meets medical necessity for continued services and document findings in the client medical record. This evaluation must consider all of the following: 1) client personal, medical, and substance use history; 2) documentation of client's most recent physical examination; 3) client's progress notes and treatment plan goals; 4) the LPHA's/ counselor's recommendation; and 5) client's prognosis. **Step 3: Medical Director/LPHA Legible Printed Name, Signature, Date** The Medical Director/LPHA must type or print their name legibly (or electronic equivalent), and sign and date continuing services information when completed. Where continuing treatment services for the client is not medically necessary, the client must be discharged from the current LOC and be transferred to appropriate treatment and/or services.
Opioid Treatment Program/Narcotic Treatment Program	The Medical Director, program physician or LPHA must document in the client record annually that the client continues to meet medical necessity. This includes written documentation in the client record of: 1) his or her evaluation of client progress, or lack of progress in achieving treatment goals; and 2) a determination, in his or her clinical judgment, that the client's status indicates that treatment should be continued for a longer period of time to prevent a return to opiate addiction.

ASAM Level of Care Service	Medical Necessity Documentation Requirements
Residential Services	For Residential Services, if determined to be medically necessary, clients must receive reauthorization every 30 days. Reauthorization requests must be submitted 7-10 days before the current authorized period ends to ensure there is proper time for requests for clarification and transition planning.

Sources: Intergovernmental Agreement, Exhibit A, Attachment I, A2: III.PP.15.i.a, 9 CCR § 10410, and DPH Substance Use Disorder Residential Treatment Authorization Policy, v.11.28.18

Client Diagnosis Documentation Requirements

The Medical Director or LPHA working within the scope of his/her professional practice must document separately from the treatment plan the basis for a client's covered SUD diagnosis in the client record within 30 calendar days of a client's admission to treatment date (Intergovernmental Agreement, Exhibit A, Attachment 1 A2, III.PP.10.i.a.). This must include:

1. The basis for the diagnosis in a narrative summary format based on DSM 5 criteria, demonstrating that the Medical Director or LPHA evaluated each client's assessment and intake information, including their personal, medical, and substance use history (Intergovernmental Agreement, Exhibit A, Attachment 1 A2, III.PP.10.i.a.i.); and
2. Documentation of the Medical Director's or LPHA's typed/legibly printed names, signature (or electronic equivalent), and the date of the diagnosis determination (Intergovernmental Agreement, Exhibit A, Attachment 1 A2, III.PP.10.a.ii.).

DSM-5 Worksheet for Client SUD Diagnosis

On the following page, a worksheet tool is provided to assist with diagnosing client SUD disorders that is aligned with the DSM-5. It contains eleven Diagnostic Criteria that can be used to evaluate clients.

Medical Necessity Face-to-Face Requirement Frequently Asked Questions

The DPH OCPA BHSCO has prepared a frequently asked questions sheet on face-to-face requirements for medical necessity. This document can be found at the end of this section in the manual.

Patient's Name:		**Date of Birth:**
Worksheet for DSM-5 Criteria for Diagnosis of Substance Use Disorder		
Diagnostic Criteria* (SUD requires at least 2 within 12-month period)	**Meets Criteria?** Yes / No	**Notes/Supporting Information**
1. Substance often taken in larger amounts or over a longer period of time than intended.		
2. There is a persistent desire or unsuccessful efforts to cut down or control use.		
3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.		
4. Craving, or a strong desire to use.		
5. Recurrent use resulting in failure to fulfill major role obligations at work, school or home.		
6. Continued use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of use.		
7. Important social, occupational or recreational activities are given up or reduced because of substance use.		
8. Recurrent use in situations in which it is physically hazardous		
9. Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance use.		
10. *Tolerance, as defined by either of the following: (a) A need for markedly increased amounts of the substance to achieve intoxication or desired effect; or (b) Markedly diminished effect with continued use of the same amount.		
11. *Withdrawal, as manifested by either of the following: (a) The characteristic withdrawal syndrome for the substance; or (b) The same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms.		

*This criterion is not considered to be met for those individuals taking opioids solely under appropriate medical supervision.

Severity: **Mild**: 2-3 symptoms, **Moderate**: 4-5 symptoms. **Severe**: 6 or more symptoms.

Signed_____**Date**_____

Criteria from American Psychiatric Association (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition,. Washington, DC, American Psychiatric Association.

DHCS List of Included ICD 10 SUD Diagnosis Codes

Source: DHCS MHSUDS Information Notice No. 19-013

ICD 10 Code	ICD 10 Code Descriptions
F1010	Alcohol abuse, uncomplicated
F1011	Alcohol abuse, in remission
F10120	Alcohol abuse with intoxication, uncomplicated
F10129	Alcohol abuse with intoxication, unspecified
F1020	Alcohol dependence, uncomplicated
F1021	Alcohol dependence, in remission
F10220	Alcohol dependence with intoxication, uncomplicated
F10229	Alcohol dependence with intoxication, unspecified
F10230	Alcohol dependence with withdrawal, uncomplicated
F10239	Alcohol dependence with withdrawal, unspecified
F10920	Alcohol use, unspecified with intoxication, uncomplicated
F10929	Alcohol use, unspecified with intoxication, unspecified
F1110	Opioid abuse, uncomplicated
F1111	Opioid abuse, in remission
F11120	Opioid abuse with intoxication, uncomplicated
F11129	Opioid abuse with intoxication, unspecified
F1120	Opioid dependence, uncomplicated
F1121	Opioid dependence, in remission
F11220	Opioid dependence with intoxication, uncomplicated
F11229	Opioid dependence with intoxication, unspecified
F1123	Opioid dependence with withdrawal
F1190	Opioid use, unspecified, uncomplicated
F11920	Opioid use, unspecified with intoxication, uncomplicated
F11929	Opioid use, unspecified with intoxication, unspecified
F1193	Opioid use, unspecified with withdrawal
F1210	Cannabis abuse, uncomplicated
F1211	Cannabis abuse, in remission
F12120	Cannabis abuse with intoxication, uncomplicated
F12129	Cannabis abuse with intoxication, unspecified
F1220	Cannabis dependence, uncomplicated
F1221	Cannabis dependence, in remission
F1223	Cannabis dependence with withdrawal
F12220	Cannabis dependence with intoxication, uncomplicated
F12229	Cannabis dependence with intoxication, unspecified
F1290	Cannabis use, unspecified, uncomplicated
F12920	Cannabis use, unspecified with intoxication, uncomplicated
F12929	Cannabis use, unspecified with intoxication, unspecified
F1293	Cannabis use, unspecified with withdrawal
F1310	Sedative, hypnotic or anxiolytic abuse, uncomplicated
F1311	Sedative, hypnotic, or anxiolytic abuse, in remission

ICD 10 Code	ICD 10 Code Descriptions
F13120	Sedative, hypnotic or anxiolytic abuse with intoxication, uncomplicated
F13129	Sedative, hypnotic or anxiolytic abuse with intoxication, unspecified
F1320	Sedative, hypnotic or anxiolytic dependence, uncomplicated
F1321	Sedative, hypnotic or anxiolytic dependence, in remission
F13220	Sedative, hypnotic or anxiolytic dependence with intoxication, uncomplicated
F13229	Sedative, hypnotic or anxiolytic dependence with intoxication, unspecified
F13230	Sedative, hypnotic or anxiolytic dependence with withdrawal, uncomplicated
F13239	Sedative, hypnotic or anxiolytic dependence with withdrawal, unspecified
F1390	Sedative, hypnotic, or anxiolytic use, unspecified, uncomplicated
F13920	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, uncomplicated
F13921	Sedative, hypnotic or anxiolytic use, unspecified with intoxication delirium
F13929	Sedative, hypnotic or anxiolytic use, unspecified with intoxication, unspecified
F13930	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, uncomplicated
F13939	Sedative, hypnotic or anxiolytic use, unspecified with withdrawal, unspecified
F1410	Cocaine abuse, uncomplicated
F1411	Cocaine abuse, in remission
F14120	Cocaine abuse with intoxication, uncomplicated
F14129	Cocaine abuse with intoxication, unspecified
F1420	Cocaine dependence, uncomplicated
F1421	Cocaine dependence, in remission
F14220	Cocaine dependence with intoxication, uncomplicated
F14229	Cocaine dependence with intoxication, unspecified
F1423	Cocaine dependence with withdrawal
F1490	Cocaine use, unspecified, uncomplicated
F14920	Cocaine use, unspecified with intoxication, uncomplicated
F14929	Cocaine use, unspecified with intoxication, unspecified
F1510	Other stimulant abuse, uncomplicated
F1511	Other stimulant abuse, in remission
F15120	Other stimulant abuse with intoxication, uncomplicated
F15129	Other stimulant abuse with intoxication, unspecified
F1520	Other stimulant dependence, uncomplicated
F1521	Other stimulant dependence, in remission
F15220	Other stimulant dependence with intoxication, uncomplicated
F15229	Other stimulant dependence with intoxication, unspecified
F1523	Other stimulant dependence with withdrawal
F1590	Other stimulant use, unspecified, uncomplicated
F15920	Other stimulant use, unspecified with intoxication, uncomplicated
F15929	Other stimulant use, unspecified with intoxication, unspecified
F1593	Other stimulant use, unspecified with withdrawal
F1610	Hallucinogen abuse, uncomplicated

ICD 10 Code	ICD 10 Code Descriptions
F1611	Hallucinogen abuse, in remission
F16120	Hallucinogen abuse with intoxication, uncomplicated
F16129	Hallucinogen abuse with intoxication, unspecified
F1620	Hallucinogen dependence, uncomplicated
F1621	Hallucinogen dependence, in remission
F16220	Hallucinogen dependence with intoxication, uncomplicated
F16229	Hallucinogen dependence with intoxication, unspecified
F1690	Hallucinogen use, unspecified, uncomplicated
F16920	Hallucinogen use, unspecified with intoxication, uncomplicated
F16929	Hallucinogen use, unspecified with intoxication, unspecified
F1810	Inhalant abuse, uncomplicated
F1811	Inhalant abuse, in remission
F18120	Inhalant abuse with intoxication, uncomplicated
F18129	Inhalant abuse with intoxication, unspecified
F1820	Inhalant dependence, uncomplicated
F1821	Inhalant dependence, in remission
F18220	Inhalant dependence with intoxication, uncomplicated
F18229	Inhalant dependence with intoxication, unspecified
F1890	Inhalant use, unspecified, uncomplicated
F18920	Inhalant use, unspecified with intoxication, uncomplicated
F18929	Inhalant use, unspecified with intoxication, unspecified
F1910	Other psychoactive substance abuse, uncomplicated
F1911	Other psychoactive substance abuse, in remission
F19120	Other psychoactive substance abuse with intoxication, uncomplicated
F19129	Other psychoactive substance abuse with intoxication, unspecified
F1920	Other psychoactive substance dependence, uncomplicated
F1921	Other psychoactive substance dependence, in remission
F19220	Other psychoactive substance dependence with intoxication, uncomplicated
F19229	Other psychoactive substance dependence with intoxication, unspecified
F19230	Other psychoactive substance dependence with withdrawal, uncomplicated
F19239	Other psychoactive substance dependence with withdrawal, unspecified
F1990	Other psychoactive substance use, unspecified, uncomplicated
F19920	Other psychoactive substance use, unspecified with intoxication, uncomplicated
F19929	Other psychoactive substance use, unspecified with intoxication, unspecified
F19930	Other psychoactive substance use, unspecified with withdrawal, uncomplicated
F19939	Other psychoactive substance use, unspecified with withdrawal, unspecified

Source: DHCS MHSUDS Information Notice No. 19-013

DMC-ODS Non-NTP Medical Necessity Meeting FAQ: Face-to-Face Meetings

When is a face-to-face meeting required?
A face-to-face meeting is required if a counselor conducts the assessment of a newly-admitted client. If an LPHA working within his or her scope of practice assesses the client, then no face-to-face meeting is required; the LPHA simply documents the client's medical necessity determination on his or her own.

When does the face-to-face meeting occur?
The face-to-face meeting relies upon the assessment of the client, so that must be completed first. One of the purposes of the meeting is to establish a diagnosis for the client, and the diagnosis must be documented within 30 days of admission, so the meeting must take place and be documented by the 30-day mark.

Who has to be at the face-to-face meeting?
The counselor who assessed the client and an LPHA working within his or her scope of practice must be at the face-to-face meeting. The client is permitted to be at the meeting, but is not necessary.

What occurs at the face-to-face meeting?
At the face-to-face meeting, the counselor and LPHA will review the client's assessment, and the LPHA will use his or her professional judgment in order to determine the medical necessity criteria for the client.

What are the medical necessity criteria?
The medical necessity criteria are the existence of an appropriate DSM-5 substance use diagnosis and that the client meets the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.

What does the name "face-to-face" mean?
The name "face-to-face" is misleading. While it is possible that this meeting will be with both the counselor and LPHA in the same room, it is also allowable to have the meeting via telehealth.

Is it possible to bill for the face-to-face medical necessity meeting between a counselor and an LPHA?
Yes! If the meeting is properly documented, this meeting may be billed to DMC-ODS by one of the participants as case management.

How should the face-to-face meeting be documented?
The face-to-face meeting should be documented in the same way as any other case management service. There must be a progress note that documents the name of the client, the purpose of the service, a description of how the service relates to the client's treatment plan problems, goals, action steps, objectives, and/or referrals. This documentation must be completed within seven calendar days of the service.

Questions should be directed to joseph.gorndt@sfdph.org Revised 8/16/2018

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Section 7: Individualized Written Treatment Plan

Individualized Written Treatment Plan Required Elements

For each client admitted to treatment services, a LPHA or counselor must prepare an *individualized* (tailored to a client's specific needs) written initial treatment plan based on the information gathered during the intake assessment, including the client diagnosis and the ASAM Level of Care assessment (Intergovernmental Agreement, Exhibit A, Attachment 1 A2, III.PP.12.i.).

All of the following initial and updated treatment plan elements must be documented in the client record (Intergovernmental Agreement, Exhibit A, Attachment 1 A2, III.PP.12.i.a.):

1. Problem Statements:
   A statement of problems identified through the ASAM level of care assessment, other assessment tool(s), or intake documentation.
2. Goals:
   Specific observable and/or quantifiable goals to be reached to address each problem statement.
3. Action Steps
   Action steps to be taken by the client and/or provider to achieve each identified goal.
4. Target Dates:
   Target dates for the achievement of identified actions steps and goals.
5. Description of Services, Type and Frequency:
   Description of services, including the type of counseling, to be provided and frequency of the service(s) to be provided.
6. Assignment of Primary Counselor:
   Identification of a primary therapist or counselor assigned to the client at admission and for the duration of treatment services.
7. Client Diagnosis:
   The client's qualifying diagnosis as documented by the Medical Director or LPHA.
8. Physical Examination Goals
   A goal to have a physical examination where the client has not had a physical examination within the 12-month period prior to the client's admission to treatment date; and a goal for the client to obtain appropriate treatment for any significant medical illness identified during a physical examination that was performed twelve months prior to the client's admission to treatment date.
9. Evidence of Client Participation and Agreement:
   The initial treatment plan must be reviewed, approved and signed by the client, including the date signed and legibly printed name of the client. Where a client refuses to sign the initial treatment plan, there must be written explanation in the client record for the refusal and the provider's strategy to engage the client to participate in treatment.

10. Name, Date, and Signature of LPHA or Counselor:
    LPHA's or counselor's typed or legibly printed name, legible signature (or electronic equivalent) and date the treatment plan was completed. The signature must be adjacent to the typed or legibly printed name.

Narcotic Treatment Program and Withdrawal Management Treatment Plan Requirements

There are specific Narcotic Treatment Program and Withdrawal Management treatment plan requirements which can be found under Section 9: Narcotic Treatment Programs and Section 12: Withdrawal Management respectively.

Initial and Updated Treatment Plans and Continuing Services Responsible Staff, Timelines and Additional Documentation Requirements

The following three tables summarize who completes initial treatment plans (Intergovernmental Agreement, Exhibit A, Attachment 1 A2, III.PP.12.i.b.i-ii.), updated treatment plans (Intergovernmental Agreement, Exhibit A, Attachment 1 A2, III.PP.12.i.b.i-ii.), and continuing services justifications, along with deadlines and documentation requirements (Intergovernmental Agreement, Exhibit A, Attachment 1 A2, III.PP.15.a-b.).

Initial Treatment Plan Completion Deadlines & Documentation Requirements (Intergovernmental Agreement, Exhibit A, Attachment 1 A2, III.PP.12.i.): An initial treatment plan must be completed for each client. Specific timelines and documentation requirements for specific ASAM levels of care are found below.		
What's Documented in Client Record?	**By When?**	**Who Completes?**
Required elements of the treatment plan **plus**: • **Documentation of review of intake information and assessment** by LPHA/counselor, and based on this information, determination that client meets medical necessity and ASAM Criteria for level of care placement. • **When a counselor completes initial treatment plan**, the Medical Director or LPHA must review the initial treatment plan to determine whether services are medically necessary and appropriate for the client. If the Medical Director or LPHA determines that services in the initial treatment plan are medically necessary, the Medical Director or LPHA must type or legibly print their name, and sign (or electronic equivalent) and date the treatment plan **within 15 calendar days** of signature by the counselor. The signature must be adjacent to the typed or legibly printed name. • For Narcotic Treatment Programs, medical director and supervising counselor must review primary counselor's initial treatment plan and corresponding assessment **within 14 calendar days** of the effective date (date primary counselor signed initial treatment plan).	• **Within 30 calendar days** of client admission to treatment date for **Outpatient Services** and **Intensive Outpatient Treatment**. • **Within 10 calendar days** of client admission to treatment date for **3.1, 3.3, 3.5 Residential Treatment**. • **Within 28 days** of the initiation of maintenance treatment date for **Narcotic Treatment Programs**. • **Within 48 hours** of client admission to treatment date **3.2 Residential Withdrawal Management**.	LPHA acting within scope of their professional practice or counselor Primary Counselor assigned to the client for Narcotic Treatment Programs

Updated Treatment Plan Completion Timelines & Documentation Requirements (Intergovernmental Agreement: III.PP.12.ii.): Treatment plans must be reviewed and updated regularly. See completion deadlines and documentation requirements below.		
What's Documented in Client Record?	**By When?**	**Who Completes?**
All required elements plus: • The updated treatment plan must be updated to reflect **current treatment needs of a client**. • **When a counselor completes the updated treatment plan**, the Medical Director or LPHA must review the updated treatment plan to determine whether services are medically necessary and appropriate for the client. If the Medical Director or LPHA determines that continuing services in the updated treatment plan are medically necessary, the Medical Director or LPHA must type or legibly print their name, and sign (or electronic equivalent) and date the treatment plan **within 15 calendar days** of signature by the counselor. The signature must be adjacent to the typed or legibly printed name. • For Narcotic Treatment Programs, Medical Director and supervising counselor must review, make amendments deemed necessary, and sign updated treated plan **within 14 days of the effective date** (date counselor signed updated treatment plan).	• **No later than 90 calendar days** after the signing of the initial treatment plan, and **no later than 90 calendar days thereafter**, **OR** when there is a change in treatment modality **OR** a significant event, **whichever occurs first.** • **Whenever necessary, or at least once every three months from the date of admission** for Narcotic Treatment Programs (9 CCR § 10305)	LPHA acting within scope of their professional practice or counselor Primary Counselor assigned to client for Narcotic Treatment Program

Continuing Services Justifications
On the following page is a chart that shows documentation requirements and completion timelines for Continuing Services Justifications.

Continuing Services Justification Completion Timelines & Documentation Requirements (Intergovernmental Agreement: Exhibit A, Attachment I A2: III.PP.15): Continuing services justifications (lengths of stay) are required for clients. See below.		
What's Documented in Client Record?	**By When?**	**Who Completes?**
• Documentation of LPHA/counselor review of client's progress and eligibility to continue to receive treatment services and a recommendation on whether client should or should not continue to receive treatment services at the same level of care. • Documentation by Medical Director or LPHA whether or not continuing treatment services are medically necessary including documentation that all of the following have been considered in making the determination: 1. Client's personal, medical, substance use history; 2. Documentation of the client's most recent physical examination; 3. Client's progress notes and treatment plan goals; 4. LPHA's/counselor's recommendation; and 5. Client's prognosis. • Legibly printed name and legible signature (or electronic equivalent) of Medical Director/LPHA, and date signed with signature adjacent to the typed or legibly printed name. • If Medical Director or LPHA determines continuing treatment services are **not** medically necessary, documentation required in client record of client discharge OR transfer to the appropriate level of treatment service. • For Narcotic Treatment Programs, Medical Director or program physician must document facts for justifying his/her decision to continued maintenance treatment or determination that client be discharged for cause or threatening behavior	• **No sooner than five (5) months and no later than six (6) months** after the client's admission to treatment date or date of completion of the most recent justification for continuing services for **Outpatient Services, Intensive Outpatient Treatment, Naltrexone Treatment, and Case Management Services.** • **Within 23 calendar days** of an expected Residential Treatment services reauthorization request per the "*DPH SFHN SUD Residential Treatment Authorization* (Rev. 11/28/2018)". • **Annually** for **Narcotic Treatment Programs**/at least every three months for review of patient's dosage level (9 CCR § 10305).	LPHA acting within scope of their professional practice or counselor Medical Director or Program Physician for Narcotic Treatment Programs

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Section 8: Progress Notes

Narrative Summary Documentation Frequency and Content

Depending on the ASAM Level of Care service, documentation frequency and content vary for entering narrative summaries for DMC-ODS treatment services (Intergovernmental Agreement, Exhibit A, Attachment 1 A2: III.PP.14.). See following tables.

DMC-ODS Service	Progress Note Frequency	Documentation Requirements
Outpatient Services **Naltrexone Treatment** **Recovery Services**	**Within seven (7) calendar days of an individual or group counseling session**	The LPHA or counselor who conducted the counseling session or provided the service must record a progress note for each client who participated in the counseling session or treatment service as follows: 1. The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven calendar days of the counseling session with the signature adjacent to the typed or legibly printed name; 2. Progress notes are individual narrative summaries and must include **all** of the following: a. The topic of the session or purpose of the service; b. A description of the beneficiary's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals; c. Information on the beneficiary's attendance, including the date, start and end times of each individual and group counseling session or treatment service; d. Identify if services were provided in-person, by telephone, or by telehealth; **and** e. If services were provided in the community, identify the location and how the provider ensured confidentiality.

DMC-ODS Service	Progress Note Frequency	Documentation Requirements
Intensive Outpatient Treatment **Residential Treatment**	**A minimum of one (1) progress note, per calendar week**	The LPHA or counselor must document for each client participating in structured activities including counseling sessions or other treatment services including: 1. The LPHA or counselor shall type or legibly print their name, and sign and date progress notes **within the following calendar week**. 2. Progress notes are individual narrative summaries and must include **all** of the following: a. A description of the beneficiary's progress on the treatment plan, problems, goals, action steps, objectives, and/or referrals; b. A record of the beneficiary's attendance at each counseling session including the date, start and end times and topic of the counseling session; c. Identify if services were provided in-person, by telephone, or by telehealth; **and** d. If services were provided in the community, identify the location and how the provider ensured confidentiality.
Residential Step-Down Recovery Residence Source: DPH Residential Step-Down (RSD) Service Requirements Fact Sheet, v.8.8.18	**One (1) status note per calendar week**	Staff must enter at least one (1) status note per calendar week, including confirmation of ongoing treatment. This can be an individual note or group check-in note.

DMC-ODS Service	Progress Note Frequency	Documentation Requirements
Case Management Services	**Within seven (7) calendar days of a case management service**	The LPHA or counselor who provided the treatment service must record a progress note **for each client** receiving case management services as follows: 1. The LPHA or counselor must type or legibly print their name, and sign and date the progress note within seven calendar days of the case management service with the signature adjacent to the typed or legibly printed name. 2. Progress notes must include **all** of the following: a. Beneficiary's name; b. The purpose of the service; c. A description of how the service relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referrals; d. Date, start and end times of each service; e. Identify if services were provided in-person, by telephone, or by telehealth; **and** f. If services were provided in the community, identify the location and how the provider ensured confidentiality.

DMC-ODS Service	Progress Note Frequency	Documentation Requirements
Physician Consultation Services **Additional Medication Assisted Treatment** **Withdrawal Management**	**Within seven (7) calendar days of the service**	The Medical Director or LPHA working within their scope of practice who provided the treatment service must record a progress note in the client record for each client as follows: 1. The Medical Director or LPHA must type or legibly print their name, and sign and date the progress note with the signature adjacent to the typed or legibly printed name. 2. Progress notes must include **all** of the following: a. Client's name; b. The purpose of the service; c. Date, start and end times of each service; **and** d. Identify if services were provided face-to-face, by telephone or by telehealth.

DMC-ODS Service	Progress Note Frequency	Documentation Requirements
Narcotic Treatment Program	**Within 14 calendar days of a counseling session**	The counselor conducting a counseling session must document the following in the client record: 1. Date of counseling session; 2. Type of counseling session - individual, group, or medical psychotherapy; 3. Duration of the session; and 4. Summary of the session, which must include at least one of the following: a. Patient's progress toward one or more goals in the treatment plan; b. Response to a drug-screening specimen which is positive for illicit drugs or is negative for the replacement narcotic therapy medication c. New issue or problem that affects the patient's treatment; d. Nature of prenatal support provided by the program or other appropriate health care provider; or e. Goal or purpose of the group session, the subjects discussed, and a brief summary of the client's participation.

Additional Progress Note Documentation Requirements

Documentation of Evidence-Based Practices

Progress notes should document evidence-based practices that were used in treating clients.

Documentation of Client Service Referrals

All referrals for service must be documented in the client record (Intergovernmental Agreement: Exhibit A, Attachment I A2: III.PP.8.v).

Documentation of Client Urinalysis Results

A client's urinalysis results must be documented in the client record where drug screening by urinalysis is deemed medically appropriate (Intergovernmental Agreement: Exhibit A, Attachment I A2: III.PP.8.viii).

Group Counseling Sign-In Sheet Documentation Requirements

For every group counseling session, there must be a sign-in sheet established and created that includes all of the following (Intergovernmental Agreement: Exhibit A, Attachment I, A2: III.PP.13):

1. The typed or legibly printed name and signature (or electronic equivalent) of the LPHA(s) and/or counselor(s) conducting the counseling session. By signing the sign-in sheet, the LPHA(s) and/or counselor(s) attest that the sign-in sheet is accurate and complete;
2. The date of the counseling session;
3. The topic of the counseling session;
4. The start and end time of the counseling session; and
5. A typed or legibly printed list of the participants' names and the signature of each participant who attended the counseling session. The participants must sign the sign-in sheet at the start and the end of the counseling session.

Section 9: Narcotic Treatment Program

DMC-ODS Required Medication Assistance Treatment – Narcotic Treatment Program Services

Required Medication Assisted Treatment (MAT) services under DMC-ODS include Narcotic Treatment Program (NTP) services provided in NTP-licensed settings. NTP services use medication as a narcotic replacement drug to alleviate the symptoms of withdrawal from opioids. Narcotic Treatment Programs participating in DMC-ODS are required to offer and prescribe medication to clients covered under the DMC-ODS formulary, including methadone, buprenorphine, naloxone, and disulfiram, and may opt to provide Expanded MAT services (see DHCS MHSUDS Information Notice No.: 18-004) and (Intergovernmental Agreement, Exhibit A, Attachment I, A2: III.V).

Services are provided in accordance with an individualized treatment plan determined by a licensed prescriber and approved and authorized according to State requirements (Intergovernmental Agreement, Exhibit A, Attachment 1, A2: III.V).

NTP services do not require prior authorization.

Required Components of NTP Services

The required components of NTP services are (Intergovernmental Agreement, Exhibit A, Attachment I, A2: III.V.):

1. Intake/Assessment
2. Individual Counseling
3. Group Counseling
4. Client Education
5. Medication Services
6. Collateral Services
7. Crisis Intervention Services
8. Treatment Planning
9. Medical Psychotherapy (type of counseling consisting of face-to-face discussion conducted by the Medical Director of the NTP on a one-on-one basis with the client)
10. Discharge Services

Special Adolescent Client NTP Requirements

Detoxification treatment for individuals who are under 18 years of age requires written consent of their parent(s) or guardian prior to the administration of the first medication dose (CCR, Title 9 10270(c)(3)). Narcotic Treatment Programs may seek an exception to this requirement on an individual client basis by submitting a temporary exception request to DHCS (see MHSUDS Information Notice No.: 18-061).

State regulations do not allow maintenance treatment for individuals who are under 18 years of age (CCR, Title 9 10270(d)(3)). DHCS will review temporary exceptions to this rule with or without written consent of their parent(s) or guardian.

Daily/Weekly Medication Services and Counseling for NTP Clients with Severe Opioid Disorder

Narcotic Treatment Programs must include daily or several times weekly opioid agonist medication and counseling available for those clients with severe opioid disorder (Intergovernmental Agreement, Exhibit A, Attachment 1, A2: V.O.).

NTP Client Orientation Requirements

Programs must advise clients of the nature and purpose of treatment through an orientation. Client acknowledgement of the orientation must be documented in the client record.

Client orientations must include, but not be limited to, the following information (9 CCR §10280):

1. The addicting nature of medications used in replacement narcotic therapy.
2. The hazards and risks involved in replacement narcotic therapy.
3. The client's responsibility to the program.
4. The program's responsibility to the client.
5. The client's participation in the program is wholly voluntary and the client may terminate his/her participation in the program at any time without penalty.
6. The client will be tested for evidence of use of opiates and other illicit drugs.
7. The client's medically determined dosage level may be adjusted without the client's knowledge, and at some later point the client's dose may contain no medications used in replacement narcotic therapy.
8. Take-home medication which may be dispensed to the client is only for the client's personal use.
9. Misuse of medications will result in specified penalties within the program and may also result in criminal prosecution.
10. The client has a right to a humane procedure of withdrawal from medications used in replacement narcotic therapy and a procedure for gradual withdrawal is available.
11. Possible adverse effects of abrupt withdrawal from medications used in replacement narcotic therapy.
12. Protection under the confidentiality requirements.

NTP Perinatal Orientation Requirements

In addition to the client orientation requirements applicable to all clients (see above), each program must provide a perinatal orientation to female clients of childbearing age that includes the following components **(**9 CCR §10285). Client acknowledgement of orientation must be documented in the client record.

1. Knowledge of the effects of medications used in replacement narcotic therapy on pregnant women and their unborn children is presently inadequate to guarantee that these medications may not produce significant or serious side effects.
2. These medications are transmitted to the unborn child and may cause physical dependence.
3. Abrupt withdrawal from these medications may adversely affect the unborn child.
4. The use of other medications or illicit drugs in addition to medications used in replacement narcotic therapy may harm the client and/or unborn child.
5. The client should consult with a physician before nursing.
6. The child may show irritability or other ill effects from the client's use of these medications for a brief period following birth.

NTP Medical Evaluation

Before admitting an individual to maintenance treatment, the medical director must either conduct a medical evaluation or document his or her review and concurrence of a medical evaluation conducted by a LPHA acting within his/her scope of professional practice. At a minimum, documentation of **all** the following must be in the client record:

1. A medical history which includes the client's history of illicit drug use;
2. Laboratory tests for determination of narcotic drug use, tuberculosis, and syphilis (unless the medical director has determined the individual's subcutaneous veins are severely damaged to the extent that a blood specimen cannot be obtained); and
3. A physical examination which includes:
    a. An evaluation of the client's organ systems for possibility of infectious diseases; pulmonary, liver, or cardiac abnormalities; and dermatologic sequelae of addiction;
    b. A record of the client's vital signs (temperature, pulse, blood pressure, and respiratory rate);
    c. An examination of the client's head, ears, eyes, nose, throat (thyroid), chest (including heart, lungs, and breasts), abdomen, extremities, skin, and general appearance;
    d. An assessment of the client's neurological system; and
    e. A record of an overall impression which identifies any medical condition or health problem for which treatment is warranted.

Before admitting a client to maintenance treatment, the medical director must:

1. Document the evidence, or review and concur with the LPHA's documentation of evidence, used from the medical evaluation to determine physical dependence and addiction to opiates; and
2. Document his or her final determination concerning physical dependence and addiction to opiates.

NTP Client Consent

Each client must attest to voluntary participation in a program by providing written documentation of his/her informed consent (9 CCR § 10290). The program must ensure that the client reads and understands the consent form, explain program rules, and supply the client with copies of the consent form and program rules.

If a client is admitted to a new treatment episode after a previous episode of treatment was terminated by the program physician and the discharge was noted in the client's record, the program client reissue rules and instructions to the client and require that the client resign the consent form.

NTP Intake Screening Criteria

The program must determine which clients with an addiction to opiates are accepted for maintenance treatment subject to the following minimum criteria which must be documented in client records:

1. Confirmed documented history of at least two years of addiction to opiates. The program must maintain in the client record documents, such as records of arrest or treatment failures, which are used to confirm two years of addiction to opiates. Statements of personal friends or family must not be sufficient to establish a history of addiction. With prior Department approval, the program may make an exception to this requirement only if the program physician determines, based on his or her medical training and expertise, that withholding treatment constitutes a life- or health-endangering situation. The program physician must document the reason for this determination in the client record.
2. Confirmed history of two or more unsuccessful attempts in withdrawal treatment with subsequent relapse to illicit opiate use. The methods used to make confirmations and the types of documentation to be maintained in the client's record must be stated in the protocol. At least seven days must have elapsed since completion of the immediately preceding episode of withdrawal treatment if it is to be used to satisfy this subsection.
3. A minimum age of 18 years.[5]
4. Certification by a physician of fitness for replacement narcotic therapy based upon physical examination, medical history, and indicated laboratory findings. Plans for correction of existing medical problems should be indicated.

[5] Methadone and buprenorphine are indicated for treatment of patients who are aged 18 years and older. Federal code on opioid treatment offers an exception for youth, aged 16 and 17, who have documented history of at least two prior unsuccessful withdrawal management attempts and have parental consent (42 CFR § 8.12). The client record must provide justification for methadone and buprenorphine treatment along with parental consent.

5. Evidence of observed signs of physical dependence.
    a. A client who has resided in a penal or chronic care institution for one month or longer may be admitted to maintenance treatment within one month of release without documented evidence to support findings of physical dependence, provided the person would have been eligible for admission before he or she was incarcerated or institutionalized and, in the clinical judgment of the medical director or program physician, treatment is medically justified.

    b. Previously treated client who voluntarily detoxified from maintenance treatment may be admitted to maintenance treatment without documentation of current physical dependence within six months after discharge, if the program is able to document prior maintenance treatment of six months or more and, in the clinical judgment of the medical director or program physician, treatment is medically justified. Clients admitted pursuant to this subsection may, at the discretion of the medical director or program physician, be granted the same take-home step level they were on at the time of discharge.
6. All information relied upon in selection of clients must be documented in client records.

NTP Special Intake Criteria Consideration for Pregnant Women
Pregnant clients who are currently physically dependent on opiates and have had a documented history of addition to opiates in the past may be admitted to maintenance treatment without documentation of a two-year addiction history or two prior treatment failures, provided the medical director or program physician, in his or her clinical judgment, finds treatment to be medically justified (9 CCR § 10270(d)(6)).

Pregnant clients admitted to treatment without documentation of a two-year addiction history or two prior treatment failures must be reevaluated by the program physician not later than 60 days following termination of the pregnancy in order to determine whether continued maintenance treatment is appropriate (9 CCR § 10270(d)(7)).

NTP Needs Assessment
Prior to developing a client's initial maintenance treatment plan, the primary counselor must complete and document in the client's record a needs assessment which must include:

1. A summary of the client's psychological and sociological background, including his or her educational and vocational experience.
2. An assessment of the client's needs for:
    a) Health care as recorded within the overall impression portion of the physical examination;
    b) Employment;
    c) Education;
    d) Psychosocial, vocational rehabilitation, economic, and legal services.

Methadone Maintenance for MAT Client Assessments
The Intergovernmental Agreement between DHCS and DPH requires the following for methadone maintenance assessments for MAT clients (Intergovernmental Agreement, Exhibit A, Attachment I, A2: V.B.2.g)

1. SUD treatment provider medical staff must conduct an assessment according to federal and state regulations which includes: 1) a medical history, including the individual's history of substance use; 2) laboratory tests for determination of narcotic drug use, tuberculosis and syphilis; and 3) physical examination.
2. Transition to levels of care within methadone maintenance shall follow federal and state regulations and include frequency of counseling, as well as need for supervised dosing.
3. Physicians, social workers, clinical pharmacists and nurse practitioners must determine when office-based MAT (primary care) can replace Opioid Treatment Program (OTP) MAT as they work with each patient (Intergovernmental Agreement, Exhibit A, Attachment I, A2: V.B.2.g).
4. ASAM assessment shall be provided as part of OTP treatment planning, within 30 days of admission, and will aid in determining further or higher levels of care that might be needed.
5. For patients on buprenorphine who stabilize, transfer criteria shall be used to decide to move to primary care/Office Based Opioid Treatment (OBOT) setting.
6. Administration of the ASAM assessment shall not delay treatment.

NTP Pregnant Client Special Considerations and Care Requirements
Within fourteen (14) calendar days from the date of the primary counselor's knowledge that the client may be pregnant, as documented in the client's record, the medical director must review, sign, and date a confirmation of pregnancy (9 CCR § 10360). In addition, within this timeframe, the medical director must document his or her:

1. Acceptance of medical responsibility for the client's prenatal care; or
2. Verification that the client is under the care of a physician licensed by the State of California and trained in obstetrics and/or gynecology.

The medical director must document a medical order and his or her rationale for determining LAAM to be the best choice of therapy for the client prior to:

1. Placing a pregnant applicant on LAAM therapy; or
2. Continuing LAAM therapy after confirmation of a client's pregnancy. The medical director shall conduct a physical examination of this client, as specified in Section 10270(a)(3), prior to documenting a medical order to continue LAAM therapy.

Within fourteen (14) calendar days from the date the medical director confirmed the pregnancy, the primary counselor must update the client's treatment plan. The nature of prenatal support reflected in subsequent updated treatment plans must include at least the following services:

1. Periodic face-to-face consultation at least monthly with the medical director or physician assistant designated by the medical director;
2. Collection of patient body specimens at least once each calendar week in accordance with collection procedures.
3. Prenatal instruction.

The medical director or licensed health personnel designated by the medical director must document completion of instruction on each of the following prenatal topics:

1. Risks to the client and unborn child from continued use of both illicit and legal drugs, including premature birth.
2. Benefits of replacement narcotic therapy and risks of abrupt withdrawal from opiates, including premature birth.
3. Importance of attending all prenatal care visits.
4. Need for evaluation for the opiate addiction-related care of both the client and the newborn following the birth.
5. Signs and symptoms of opiate withdrawal in the newborn child and warning that the client not share take-home medication with the newborn child who appears to be in withdrawal.
6. Current understanding related to the risks and benefits of breast-feeding while on medications used in replacement narcotic therapy.
7. Phenomenon of postpartum depression.
8. Family planning and contraception.
9. Basic prenatal care for those patients not referred to another health care provider, which shall include instruction on at least the following:
    a. Nutrition and prenatal vitamins.
    b. Child pediatric care, immunization, handling, health, and safety.

If a client repeatedly refuses referrals offered by the program for prenatal care or refuses direct prenatal services offered by the program, the medical director must document in the client's record these repeated refusals and have the client acknowledge in writing that she has refused these treatment services.

Within fourteen (14) calendar days after the date of birth and/or termination of the pregnancy, the medical director must document in the client's record the following information:

1. The hospital's or attending physician's summary of the delivery and treatment outcome for the client and offspring; or
2. Evidence that a request for information as specified in paragraph (f)(1) of this section was made, but no response was received.

Within fourteen (14) calendar days from the date of the birth and/or termination of the pregnancy, the primary counselor must update the client's treatment plan. The nature of pediatric care and child immunization must be reflected in subsequent updated treatment plans until the child is at least three (3) years of age.

NTP Initial Client Treatment Plan

Programs must develop an individualized treatment plan for each client (9 CCR § 10305). The primary counselor must enter in the client's record his or her name and the date the client was assigned to the counselor.

Within 28 calendar days after initiation of maintenance treatment, the primary counselor must develop the client's initial maintenance treatment plan which must include:

1. Goals to be achieved by the client based on the needs identified in paragraph (d) of this section and with estimated target dates for attainment in accordance with the following:
    a. Short-term goals are those which are estimated to require ninety (90) days or less for the client to achieve; and
    b. Long-term goals are those which are estimated to require a specified time exceeding ninety (90) days for the client to achieve.
2. Specific behavioral tasks the client must accomplish to complete each short-term and long-term goal.
3. A description of the type and frequency of counseling services to be provided to the client.
4. An effective date based on the day the primary counselor signed the initial treatment plan.

The supervising counselor shall review the initial maintenance treatment plan, along with the corresponding needs assessment, and all updated maintenance treatment plans within fourteen (14) calendar days from the effective dates and shall countersign these documents to signify concurrence with the findings.

The medical director shall review the initial maintenance treatment plan, along with the corresponding needs assessment within fourteen (14) calendar days from the effective dates and must record the following in the client record:

1. Countersignature to signify concurrence with the findings; and
2. Amendments to the plan where medically deemed appropriate.

NTP Updated Client Treatment Plan

The primary counselor must evaluate and update the client's maintenance treatment plan whenever necessary or at least once every three (3) months from the date of admission (9 CCR § 10305). This updated treatment plan must include:

1. A summary of the client's progress or lack of progress toward each goal identified on the previous treatment plan.
2. New goals and behavioral tasks for any newly identified needs, and related changes in the type and frequency of counseling services as required.
3. An effective date based on the day the primary counselor signed the updated treatment plan.

The supervising counselor must review the initial maintenance treatment plan, along with the corresponding needs assessment, and all updated maintenance treatment plans within fourteen (14) calendar days from the effective dates and must countersign these documents to signify concurrence with the findings.

The medical director must review the initial maintenance treatment plan, along with the corresponding needs assessment, and all updated maintenance treatment plans within fourteen (14) calendar days from the effective dates and must record the following:

1. Countersignature to signify concurrence with the findings; and
2. Amendments to the plan where medically deemed appropriate.

NTP Ongoing Services Medical Necessity Reevaluation

For an individual to receive ongoing Opioid Treatment Program/Narcotic Treatment Program (OTP/NTP) services, the Medical Director or LPHA must re-evaluate that individual's medical necessity qualification annually through the reauthorization process and determine that services are still clinically appropriate for that individual. This requirement applies to existing and new clients (Intergovernmental Agreement: Exhibit A, Attachment I A2:).

NTP Client Record Documentation Requirements

Each program must document the following information in the individual client's record:

1. The client's birth date.
2. Physical examination data, including laboratory results for required tests and analyses.
3. Evidence of current use of heroin or other opiates.
4. Date of admission to the program, plan of treatment, and medication orders signed by the physician.
5. The program's response to a test or analysis for illicit drug use which discloses the absence of both methadone and its primary metabolite (when prescribed by the medical director and program physician), the presence of any illicit drugs, or abuse of other substances, including alcohol.
6. Incidence of arrest and conviction or any other signs of retrogression.
7. Any other client information which the program finds useful in treating the client.

In addition to the requirements above, client records must contain the following for maintenance treatment:

1. Documentation of prior addiction and prior treatment failure.
2. Documentation of services and treatment provided, as well as progress notes, signed by the physician, nurse, or counselor; test or analysis results for illicit drug use and periodic review or evaluation by the medical director. Such review shall be made not less than annually.
3. For any client who is to be continued on maintenance treatment beyond two years, the circumstances justifying such continued treatment.
4. Reasons for changes in dosage of levels and medications.
5. For clients who have terminated the program, a discharge summary and follow-up notations to allow determination of success or failure of treatment.

Medication Documentation

Each program furnishing maintenance treatment must set forth in its protocol the medical director or program physician's procedures for medically determining a stable dosage level that:

1. Minimizes sedation.
2. Decreases withdrawal symptoms.
3. Reduces the potential for diversion of take-home medication.

Deviations from these planned procedures must be noted by the medical director or program physician with reason for such deviations, in the client's record.

The medical director or program physician must review the most recent approved product labeling for up-to-date information on important treatment parameters for each medication. Deviation from doses, frequencies, and conditions of usage described in the approved labeling shall be justified in the client's record.

The medical director or program physician must review each client's dosage level at least every three months.

Maintenance Dosage Levels Specific to Methadone

The medical director or program physician must ensure that the first-day dose of methadone shall not exceed 30 milligrams unless (9 CCR § 10355):

1. The dose is divided and the initial portion of the dose is not above 30 milligrams; and
2. The subsequent portion is administered to the client separately after the observation period prescribed by the medical director or program physician.

The total dose of methadone for the first day shall not exceed 40 milligrams unless the medical director or program physician determines that 40 milligrams is not sufficient to suppress the client's opiate abstinence symptoms and documents in the client's record the basis for his/her determination.

A daily dose above 100 milligrams must be justified by the medical director or program physician in the client's record.

Maintenance Dosage Levels Specific to LAAM

The medical director or program physician shall ensure that the initial dose of LAAM to a new client whose tolerance for the drug is unknown does not exceed 40 milligrams, unless (9 CCR § 10355):

1. The dose is divided, with the initial portion of the dose not above 40 milligrams and the subsequent portion administered to the client separately after the observation period prescribed by the medical director or program physician; or
2. The client's tolerance for the medication is known by the medical director or program physician and he/she documents in the client's record the basis for this determination.

The medical director or program physician shall ensure that the initial dose of LAAM to a client stabilized on replacement narcotic therapy and administered methadone on the previous day is less than or equal to 1.3 times the client's daily methadone dose, not to exceed 120 milligrams.

After a client's tolerance to LAAM is established, LAAM shall be administered to more frequently than every other day.

A dose above 140 milligrams shall be justified by the medical director or program physician in the patient's record.

NTP Client Take-Home Medication Documentation
Where the medical director or program physician has granted permission for a client to take home medications, the medical director or program physician must document in the client's record the granting of any exception and the facts justifying the exception (9 CCR § 10385).

NTP Client Test or Analysis for Illicit Drug Use Documentation
Each program shall maintain test or analysis records for illicit drug use which contain the following information for each client (9 CCR § 10330):

1. The date the client body specimen was collected;
2. The test or analysis results; and
3. The date the program received the results of the test or analysis.

When a client fails to provide a body specimen when required, the program must proceed as though the client's sample from his or her body specimen disclosed the presence of an illicit drug(s). Such failures must be noted in the client's records (9 CCR § 10335).

NTP Client Hospitalization Documentation
If the program is aware that a client has been hospitalized, the program physician must attempt to cooperate with the attending physician and the hospital staff in order for the hospital to continue a client's replacement narcotic therapy (9 CCR 10185). The client's record must contain documentation of:

1. The program physician's coordination efforts with the attending physician and the hospital staff; and
2. The date(s) of hospitalization, reason(s), and circumstances involved.

NTP Client Incarceration Documentation
If the program is aware that a client has been incarcerated, the program physician must attempt to cooperate with the jail's medical officer in order to ensure the necessary treatment for opiate withdrawal symptoms, whenever it is possible to do so (9 CCR § 10190). The client's record must contain documentation of:

1. The program physician's coordination efforts with the jail; and
2. The date(s) of incarceration, reason(s), and circumstances involved.

NTP Client Attendance Documentation
A client must report to the same program to which he or she was admitted unless prior approval is obtained from the client's medical director or program physician to receive services on a temporary basis from another narcotic treatment program (9 CCR Section 10295 The approval shall be noted in the client's record and must include the following documentation:

1. The client's signed and dated consent for disclosing identifying information to the program which will provide services on a temporary basis;
2. A medication change order by the referring medical director or program physician permitting the client to receive services on a temporary basis from the other program for a length of time not to exceed 30 days; and
3. Evidence that the medical director or program physician for the program contacted to provide services on a temporary basis has accepted responsibility to treat the visiting client, concurs with his or her dosage schedule, and supervises the administration of the medication, subject to Section 10210(d).

NTP Client Absence Documentation
If a client in maintenance treatment misses appointments for two weeks or more without notifying the program, the client's episode of treatment must be terminated by the medical director or program physician and the discharge must be noted in the client's record ((9 CCR § 10300).

If the discharged client returns for care and is accepted into the program, the client must be readmitted as a new client and documentation for the new readmission must be noted in the client's record (9 CCR § 10300).

Extended MAT Documentation
Medications required to be available through NTPs under DMC-ODS include:
1) Methadone; 2) Buprenorphine; 3) Disulfiram; and 4) Naloxone (Intergovernmental Agreement, Exhibit A, Attachment I A2: III.V).

A new state statute (AB 395) allows a licensed NTP to provide non-controlled medications approved by the FDA for providing Medication Assisted Treatment to client with a substance use disorder (Expanded MAT). Any new medications approved by the FDA in the future also would be allowed to be utilized by NTPs. Examples of non-controlled medications approved by the FDA for clients with a substance use disorder include Naltrexone and Acamprosate. Narcotic Treatment Programs dispensing Expanded MAT medications must document in the client record the medications used in Expanded MAT traceable to specific clients, showing dates and quantities dispensed, prescribed, and/or administered (DHCS MHSUDS Information Notice No.: 18-004).

NTP Counseling Services Documentation Requirements

Upon completion of the initial treatment plan, a client must receive at minimum 50 minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity (9 CCR §10345). Counseling sessions must meet the following requirements:

1. The program staff member conducting the session meets minimum counselor qualifications.
2. The session is conducted in a private setting in accordance with all applicable federal and state regulations regarding confidentiality.
3. The format of the counseling session must be one of the following:
    a. Individual session, with face-to-face discussion with the client, on a one-on-one basis, on issues identified in the client's treatment plan.
    b. Group session, with a minimum of four clients and no more than ten clients and having a clear goal and/or purpose that is a common issue identified in the treatment plans of all participating clients.[6]
    c. Medical psychotherapy session, with face-to-face discussion conducted by the medical director on a one-on-one basis with the client, on issues identified in the client's treatment plan.

The following do not qualify as a counseling session:

1. Interactions conducted with program staff in conjunction with dosage administration.
2. Self-help meetings, including the 12-step programs of Narcotics Anonymous, Methadone Anonymous, Cocaine Anonymous, and Alcoholics Anonymous.
3. Educational sessions, including client orientation sessions.
4. Administrative intervention regarding payment of fees.

The counselor conducting the counseling session shall document in the client's record within 14 (fourteen) calendar days of the session the following information:

1. Date of the counseling session;
2. Type of counseling format (i.e., individual, group, or medical psychotherapy);
3. The duration of the counseling session in ten-minute intervals, excluding the time required to document the session as required in Subsection (d)(4) of this regulation; and

[6] While prior group size was two to twelve under DMC services, the DMC-ODS county contract with DHCS requires that: "OTP/NTP services and regulatory requirements shall be provided in accordance with Title 9, Chapter 4 (Intergovernmental Agreement, Attachment I A2: III.PPP.3). 9 CCR § 16345 states that group sessions for NTP have "a minimum of four patients and no more than ten patients."

4. Summary of the session, including one or more of the following:
    a. Client's progress towards one or more goals in the client's treatment plan.
    b. Response to a drug-screening specimen which is positive for illicit drugs or is negative for the replacement narcotic therapy medication dispensed by the program.
    c. New issue or problem that affects the client's treatment.
    d. Nature of prenatal support provided by the program or other appropriate health care provider.
    e. Goal and/or purpose of the group session, the subjects discussed, and a brief summary of the client's participation.

The medical director may adjust or waive at any time after admission, by medical order, the minimum number of minutes of counseling services per calendar month. The medical director shall document the rationale for the medical order to adjust or waive counseling services in the client's treatment plan.

Client Treatment for Concurrent Health Conditions Documentation
For Medi-Cal clients not enrolled in a managed care plan, medically necessary treatment of concurrent health conditions may be provided through NTPs which also are Medi-Cal certified providers. This includes diagnosis and treatment of concurrent health conditions including:

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

Clinical documentation requirements for Medi-Cal must be met in addition to documentation requirements for DMC-ODS.

NTP Client Discharge Documentation
The medical director or program physician must discontinue a client's maintenance treatment within two (2) continuous years after such treatment is begun unless he or she completes the following (9 CCR § 10410):

1. Evaluates the client's progress, or lack of progress in achieving treatment goals; and
2. Determines, in his or her clinical judgment, that the client's status indicates that such treatment should be continued for a longer period of time because discontinuance from treatment would lead to a return to opiate addiction.

Client status relative to continued maintenance must be re-evaluated annually.
The medical director or program physician must document in the client's record the facts justifying his or her decision to continue the client's maintenance treatment.

Voluntary and Involuntary Client Participation & Discharge Summary Documentation

A client may voluntarily terminate participation in a program even though termination may be against the advice of the medical director or program physician (9 CCR § 10415). If the medical director or program director determines that the client's continued participation in the program creates a physically threatening situation for staff or other clients, the client's participation may be terminated immediately.

A client's participation in a program may be involuntarily terminated by the medical director or program physician for cause. If a program utilizes disciplinary proceedings which include involuntary termination for cause, the program shall include in its protocol reasons and procedures for involuntarily terminating a client's participation in the program. The procedures shall provide for:

1. Explanation to the client of when participation may be terminated for cause.
2. Client notification of termination.
3. Client's right to hearing.
4. Client's right to representation.

Either voluntary or involuntary termination must be individualized, under the direction of the medical director or program physician, and take place over a period of time not less than 15 days, unless:

1. The medical director or program physician deems it clinically necessary to terminate participation sooner and documents why in the client's record;
2. The client requests in writing a shorter termination period; or
3. The client is currently within a 21-day detoxification treatment episode.

Discharge Summary Documentation

The program must complete a discharge summary for each client who is terminated from treatment, either voluntarily or involuntarily. The discharge summary must include at least the following:

1. The client's name and date of discharge;
2. The reason for the discharge; and
3. A summary of the client's progress during treatment.

Service Restart Documentation

Clients who previously received at least six months of maintenance treatment before voluntarily detoxifying may be readmitted within 6 months without documenting current physical dependence. However, previous treatment for maintenance treatment must be documented in the client record, in addition to justification by the medical director or program physician that treatment is medically justified (9 CCR § 10270(d)(5)(B))

Section 9: ASAM 1.0 Outpatient Services

ASAM Level 1.0 Outpatient Services & Duration of Services

Outpatient Services (ASAM Level 1) are medically necessary recovery or motivational enhancement therapies/strategies provided to adults for less than nine (9) hours per week and provided to adolescents less than six (6) hours per week (Intergovernmental Agreement, Exhibit A, Attachment 1 A2: V.H). Services are typically provided in regularly scheduled sessions following a defined set of policies and procedures or clinical protocols. All services provided to a client are counted toward the weekly service limits (Sources: DHCS DMC-ODS Documentation Training, July 2018).

Required Service Components of Outpatient Services

The required service components of Outpatient Services include the following (Intergovernmental Agreement, Exhibit A, Attachment I A2: V.H):

1. Intake
2. Individual Counseling
3. Group Counseling (see service location exception & DHCS guidance below)
4. Client Education
5. Family Therapy
6. Medication Services
7. Collateral Services
8. Crisis Intervention Services
9. Treatment Planning
10. Discharge Services

Authorized Providers of Outpatient Services

Outpatient services may be provided by a LPHA or a certified/registered counselor. Eligible entities providing outpatient services must be certified by DHCS to participate in the Drug Medi-Cal program.

Service Locations of Outpatient Services

Outpatient services can be provided in-person, by telephone, or by telehealth in any appropriate setting in the community. Please note the service location exception for Group Counseling: group counseling services must be provided face-to-face.

Outpatient Services for Adolescents

Outpatient Services to adolescents must be provided through DPH behavioral health clinics that serve teenagers and young adults and school-based mental health partnerships (Intergovernmental Agreement, Exhibit A, Attachment I A2: V.H).

DHCS Guidance for Outpatient Services: No Minimum Group Sessions

The DMC-ODS does not require that clients receive a minimum number of group counseling sessions per month (DHCS Outpatient Treatment and Drug Medi-Cal Organized Delivery System Frequently Asked Questions, June 2018).

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Section 11: ASAM 2.1 Intensive Outpatient Treatment

ASAM 2.1 Intensive Outpatient Treatment (IOT) Services

Intensive Outpatient Treatment services (ASAM Level 2.1) are structured programming services to treat multidimensional instability care to clients for a minimum of nine (9) hours with a maximum of nineteen hours a week for adults and for a minimum of six (6) hours with a maximum of nineteen (19) hours a week for adolescents (Intergovernmental Agreement, Exhibit A, Attachment I A2: V.I).

Services consist primarily of counseling and education about addiction-related problems but may include other authorized services. This level of care is appropriate for clients with minimal risk with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions. It is appropriate for clients who need close monitoring and support several times a week in a clinic (non-residential and non-inpatient) setting (see DPH Intensive Outpatient Treatment Guidelines).

Required Service Components of IOT

The required service components of IOT services include the following (Intergovernmental Agreement, Exhibit A, Attachment I, A2: V.I):

1. Intake
2. Individual Counseling
3. Group Counseling
4. Client Education
5. Family Therapy
6. Medication Services
7. Collateral Services
8. Crisis Intervention Services
9. Treatment Planning
10. Discharge Services

Authorized Providers of IOT Services

IOT services may be provided by a LPHA or a certified/registered counselor who are appropriately credentialed and working within their scope of practice when delivering services to clients. Eligible entities providing IOT services must be certified by DHCS to participate in the Drug Medi-Cal program.

Service Locations for IOT Services

IOT services can be provided to a client in the following ways: 1) face-to-face; 2) telephone; 3) telehealth; and/or in the community, (except for group counseling services which must be provided face-to-face. If IOT services are provided in the community, the provider delivering the service must be linked with a physical site/facility that is DMC certified and ensure that client confidentiality is protected. Providers must document in the client record that the service was delivered in the community and how client confidentiality was protected.

IOT Services for Adolescents
IOT services to adolescents are provided through DPH behavioral health clinics that serve teenagers and young adults, and school-based mental health partnerships (Intergovernmental Agreement, Exhibit A, Attachment I, A2: V.I.3).

Extension of Lengths of Treatment for IOT Services
Lengths of treatment in IOT services can be extended when determined to be medically necessary by a Medical Director or LPHA acting within his/her scope of professional services (DHCS Intensive Outpatient Treatment and Drug Medi-Cal Organized Delivery System Frequently Asked Questions, Rev. November 2018).

Special IOT Requirements for Pregnant and Parenting Women
Pregnant and parenting women who meet medical necessity criteria and ASAM Level of Care criteria for IOT services must be provided mother and child habilitative services in addition to other required IOT services (22 CCR § 51341.1(c)(4)(a)).

Group counseling must be conducted with no less than two (2) and no more than twelve (12) perinatal clients at the same time (22 CCR § 51341.1(b)(11)(B) and 22 CCR § 51341.1(d)(3)).

DHCS Guidance for IOT Services: No Minimum Number of Group Sessions
The California Department of Health Care Services has offered guidance that the DMC-ODS does not require that clients receive a minimum number of group counseling sessions per month (DHCS Intensive Outpatient Treatment and Drug Medi-Cal Organized Delivery System Frequently Asked Questions, Rev. November 2018).

DPH Intensive Outpatient Treatment Guidelines

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Intensive Outpatient Treatment Guidelines

(Rev. 11.2018)

ASAM 2.1 treatment services are structured programming services consisting primarily of counseling and education about addiction-related problems. This level of care is appropriate for patients with minimal risk with regard to acute intoxication/withdrawal potential, biomedical, and mental health conditions. It is appropriate for patients who need close monitoring and support several times a week in a clinic (non-residential and non-inpatient) setting.

Services

Treatment services at this level of care include screening, assessment/intake, treatment planning, health status questionnaire and/or physical exam, group counseling, patient education, individual counseling, crisis intervention, family therapy, collateral services, medication services (including referral to MAT for alcohol and opioid users unless patient refusal is documented in progress notes), alcohol/drug testing, discharge services, and case management.

Service Hour Requirements

Treatment services must be provided between:

- Six (6) and 19 hours per week for youth (ages 12 – 17)
- Nine (9) and 19 hours per week for young adults (ages 18 – 20) and adults (ages 21+)
- Six (6) and 30 hours per week for Perinatal youth (ages 12-17)
- Nine (9) and 30 hours per week for Perinatal young adults (ages 18-20) and adults (ages 21+)

If minimum service units are not met for four (4) or more weeks, the patient needs to be stepped down to a lower level of care and further reimbursement will be disallowed.

Location

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

Documentation

For intensive outpatient treatment, documentation requirements include Level of Care Recommendation Form; assessment; treatment planning; continuing service justification; discharge plan; discharge summary; the LPHA or counselor shall record at a minimum one progress note, per calendar week, for each beneficiary participating in structured activities including counseling sessions or other treatment services.

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Section 12: ASAM 3.1, 3.2, and 3.5 Residential Treatment Services

Residential Treatment Services Overview

Residential treatment services are non-institutional, 24-hour, seven days a week, non-medical, short-term residential programs that provide rehabilitation services to clients with a substance use disorder diagnosis that is determined by a Medical Director or LPHA as medically necessary and in accordance with the individual treatment plan. Residential treatment services are provided in a continuum across five levels of ASAM residential treatment (3.1, 3.3, 3.5, 3.7, and 4). In San Francisco, ASAM 3.1, 3.3, and 3.5 residential treatment services are offered (first three levels shaded in chart below), not ASAM Level 3.7 or 4.0, though client services are required to be coordinated with ASAM 3.7 and 4.0 as clients transition. See descriptions of Levels 3.1 through 4 Residential Treatment services below.

ASAM Level of Care Residential Treatment Services Description of Care

ASAM Level of Care	Service Name	Description of Care
3.1	**Clinically Managed Low- Intensity Residential Services**	24-hour structure with available trained personnel; at least 5 hours of clinical service per week and preparation for outpatient treatment.
3.3	**Clinically Managed Population-Specific High-Intensity Residential Services**	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use the full active milieu or therapeutic community and preparation for outpatient treatment. (Note: This level is not designated for adolescents).
3.5	**Clinically Managed High-Intensity Residential Services**	24-hour care with trained counselors to stabilize multidimensional imminent danger and preparation for outpatient treatment. Able to tolerate and use the full milieu or therapeutic community.
3.7	**Medically Monitored Intensive Inpatient Services**	24-hour nursing care with physician availability for significant problems. 16 hour/day counselor availability.
4	**Medically Managed Intensive Inpatient Services**	24-hour nursing care with daily physician care for severe, unstable problems. Counseling available to engage client in treatment.

Required Components of Residential Treatment Services for Adult/Non-Perinatal Clients

Required residential treatment service activities include:

1. Intake
2. Individual
3. Group Counseling
4. Client Education
5. Family Therapy
6. Collateral Services
7. Crisis Intervention Services
8. Treatment Planning
9. Transportation Services to and from medically necessary services
10. Discharge Services

Residential treatment services are billed on a daily basis. At least one required service activity must be provided per each day of billing and documented in the client record.

Participant Limitations in Residential Treatment Activities

Group counseling is described as a face-to-face contact in which one or more therapists or counselors treat two (2) or more clients at the same time with a maximum of twelve (12) in a group, focusing on the therapeutic SUD treatment needs of the individuals served. Group counseling is considered a clinical intervention.

Any structured activity not listed as a required service will not satisfy the requirement for reimbursement for residential treatment (see DHCS MHSUDS Information Notice No.: 18-001).

The other structured activities that are available in residential treatment, including client education, are not considered clinical interventions, and are not subject to a limitation with regard to the number of participants (see DHCS MHSUDS Information Notice No.: 18-001).

In addition to providing required services noted above, residential treatment facilities must safeguard medications by storing all resident medication. Facility staff members may assist with resident's self-administration of medication (DPH BHS Policy 3.01.05).

ASAM Level of Care Assessment for Transitions from Residential Treatment

At the end of residential treatment, the ASAM assessment must be used to guide outpatient placement in level 1 or 2.1 as part of ongoing treatment and transition to community (Intergovernmental Agreement, County Specific Requirements).

Special Perinatal Client Residential Treatment Requirements
Admission Requirements
SUD treatment providers serving pregnant and parenting women (perinatal clients) must provide preference to pregnant women in the following order (45 CFR § 96.131(a)):

1. Pregnant injection drug users;
2. Pregnant substance users;
3. Injection drug users; and
4. All others.

Perinatal Client Service Components
In addition to access to the full range of residential treatment services, perinatal treatment services must address treatment and recovery issues specific to pregnant and postpartum women such as relationships, sexual and physical abuse, and development of parenting skills, as well as provide access to the following including services (22 CCR § 51341.1):

a. Mother/child habilitative and rehabilitative services (i.e., development of parenting skills, training in child development, which may include the provision of cooperative child care pursuant to Health and Safety Code Section 1596.792);
b. Service access (i.e., provision of or arrangement for transportation to and from medically necessary treatment);
c. Education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant; and
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).

Perinatal Practice Guidelines
Documentation Requirements
Treatment services to pregnant and parenting women must be provided in conformance with the *DHCS Perinatal Practice Guidelines FY 2018-19* (DHCS MHSUDS Information Notice No.: 18-042) available day and night, seven days a week (22 CCR § 51341.1(b)(20)).

The client record for perinatal clients must contain medical documentation that substantiates a pregnancy and the last day of pregnancy (Source: DHCS Perinatal Practice Guidelines).

A pregnant woman who was eligible for and received Medi-Cal during the last month of pregnancy, shall continue to be eligible for all pregnancy related and postpartum services, for a 60-day period beginning on the last day of pregnancy, regardless of whether the other conditions of eligibility are met. Eligibility for this program ends on the last day of the month in which the 60th day occurs (22 CCR Section 50260).

DHCS Perinatal Documentation Requirement Highlights

Following are charts that highlights major documentation requirements for perinatal clients, but staff are strongly encouraged to read the *DHCS Perinatal Practice Guidelines FY 2018-19*.

Service	Perinatal Treatment Service Documentation Requirements
Primary Medical Care **45 CFR §96.124(e)(1)**	Evidence of referral/linkages to primary medical care for women including referral for prenatal care and documented client response (best practice).
Primary Pediatric Care **45 CFR §96.124(e)(2)**	Evidence of referral/linkages to pediatric care for their children, including immunization and documented client response (best practice).
Child Care	Evidence of providing child care for women while they are receiving services.
Care Coordination **22 CFR §51341.1(c)(4)(B)** **22 CFR §51341.1(g)(1)(B)**	Evidence in the client record of coordination of treatment services with, and referrals to, other appropriate services including health, criminal justice, social, educational, and vocational rehabilitation, as well as additional services that are medically necessary to prevent risk to a fetus, infant or mother. Client response should be documented in the client record as best practice.
Case Management & Transportation Services **22 CFR §51341.1(c)(4)(B) and** **45 CFR §96.124(e)(5)**	Sufficient case management and transportation services to ensure women and their children have access to services.
Tuberculosis Screening **45 CFR §96.127(a)(3)**	Screening of pregnant and parenting women for tuberculosis.
Gender Specific Treatment & Therapeutic Interventions **45 CFR §96.124(e)(3)**	Access to gender-specific treatment and other therapeutic interventions such as relationships, sexual and physical abuse, and parenting.

Services	Perinatal Treatment Service Documentation Requirements
Child Services **45 CFR §96.124(e)(4)**	Access therapeutic interventions for children of women receiving SUD treatment services which may, among other things include their developmental needs, their issues of sexual and physical abuse and neglect.
Parenting Skills **22 CCR § 51341.1(d)(4)**	Access to parenting skills education on child development, skill-building training, counseling modeling, and problem solving in specific incidences of parent-child interactions.
Substantiation of Pregnancy & Last Day of Pregnancy **22 CFR §51341.1(g)(1)(A)(iii)**	The client record must include medical documentation that substantiates a woman's pregnancy and the date of last day of the woman's pregnancy.
Interim Services **45 CFR §96.131.(d)(2)**	Evidence of providing interim services to pregnant and parenting women awaiting admission into treatment to reduce to adverse health effects of substance use promote the health of the women and reduce the risk of disease transmission.

Prior Authorization Requirement for Residential Treatment Services
Residential treatment services require prior authorization for adult/non-perinatal, perinatal, and adolescent clients from the Treatment Access Program (TAP) Authorization Unit (DHCS MHSUDS Information Notice No.: 16-063 Intergovernmental Agreement, Exhibit A, Attachment I, A2: V.F.). Prior authorizations for residential treatment must be processed within 24 hours of a client presenting for treatment.

At admission and for each additional 30-day authorization request, a client must be assessed to determine whether ASAM 3.1, 3.3, or 3.5 Residential Treatment services are an appropriate placement or whether the client can be transitioned to a lower level of care. The Medical Director or LPHA acting within his/her scope of professional practice must make the medical necessity determination.

Staff also should refer to the "*DPH SFHN San Francisco Health Network Residential Treatment Authorization (Rev. 11/28/18)*" as a reference for additional information on authorization request criteria, reasons for denial, and denial procedures which can be found at the end of this manual section. A "Pre-Admit to Residential User Guide" also can be found at the end of the section.

Residential Treatment Authorization Request Criteria
The following residential treatment authorization criteria must be met by clients and documented in the client record (*DPH SFHN SUD Residential Treatment Authorization, 11/28/18*):

1. Must be a San Francisco resident, as set forth in the BHS Policy 3.03-06: Treatment of non-San Francisco Residents;
2. Requires a DSM-5 diagnosis of a substance use disorder, excluding nicotine, from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition entered in to the diagnosis page in AVATAR;
3. Requires a completed Level of Care Recommendation Form which establishes a moderate to severe need for treatment;
4. The client DSM 5 diagnosis shows a link to either LOC severity ratings, impairments, dimensions, and/or placement summary;
5. Includes a narrative summary that considers the following:
    a. Why is treatment necessary now?
    b. Does a SUD problem exist which may require a solution/treatment now?
    c. If this treatment request follows previous episodes how is this time different?
    d. What is the imminent danger to the client in the next 2 weeks that shows a need for residential care?
6. ASAM Criteria Placement Summary presents clear and concise reasoning for initial or continued treatment; and
7. The Episode Guarantor Information (EGI) form must be complete in AVATAR.

If a client has engaged in two episodes within the past 365-days and is seeking a third episode, the client should be referred to TAP for assessment (something to keep in mind: program may not be aware of client's previous episodes when submitting initial

authorization request if other episodes were in a different organization). Each request for authorization should include clinician's clinical judgement that the specified level of care is needed.

Length of Stay Limitations for DMC Residential Treatment Services Summary
There are different lengths of stay for DMC residential treatment services, linked to client age and/or whether the client is pregnant/postpartum.

Adult/Non-Perinatal (age 21 and over)	**Perinatal**	**Adolescents** (under the age of 21)
• Two non-continuous short-term residential regimens per 365-day period. A short-term residential regimen is defined as one residential stay in a DHCS licensed facility for a maximum of 90 days per 365-day period.	• Duration of pregnancy and an additional 60 days postpartum	• Two 30-day, non-continuous regimens per 365-day period Note: While adolescent clients must be stabilized as soon as possible and moved down to a less intensive level of treatment, a longer length of stay may be received if found to be medically necessary.
Extension of Lengths of Stay		
Adult/Non-Perinatal (age 18 and over)	**Perinatal**	**Adolescents** (under the age of 21)
• 30-day, one-time extension per 365-day period, when determined medically necessary	• Additional lengths of stay may be authorized if determined as medically necessary	• 30-day, one-time extension per 365-day period, when determined to be medically necessary • Note: Under EPSDT, adolescents may receive a longer length of stay, if found to be medically necessary.

DPH SFHN Service Reauthorization Deadlines
Reauthorizations for residential treatment services must be considered and requested within 7-10 calendar days prior to the end of the current authorization period for services to allow for adequate time to conduct a level of care assessment, requests for clarification, and transition planning, if indicated by client assessment ("*DPH San Francisco Health Network Residential Treatment Authorization (Rev. 11.28.18)"*).

Monitored 3.2 Residential Withdrawal Management Protocol, Policies & Procedures
Facilities offering Monitored 3.2 – Withdrawal Management services must meet DPH protocol, policies and procedures for this service, in addition to other application

DMC-ODS requirements. A copy of the "*DPH Residential Withdrawal Management Protocol* (Rev. 2.13.19)" and the "*DPH Monitored Residential Detoxification Policies and Procedures* (Rev. 11.30.18)" follow.

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Monitored 3.2 Residential Withdrawal Management Protocol

Admissions and Intake

Admission to program is open to all adult San Francisco residents needing Withdrawal Management services from alcohol and/or other drugs that meet medical necessity according to ASAM criteria.

For Withdrawal Management services that may be urgently needed as defined by the ASAM criteria dimension 1 severity rating, and are considered "crisis" services, referral to WM program will be available to anyone who needs these services, and qualifies based on medical necessity, including individuals who may not be San Francisco residents.

Withdrawal Management Screening

Screening shall include:

- Basic Demographics
- Recent Drug Use
- Medications
- Withdrawal Symptoms
- ASAM Dimension 1: Acute Intoxication and/or Withdrawal Potential
- ASAM Dimension 2: Medical Conditions and Complications
- ASAM Dimension 3: Emotional Behavioral or Cognitive Conditions & Complications

Participants also take part in a structured interview that yields other information related to behavioral risk, treatment history and housing status. Upon review of the findings participants may be referred for further evaluation to ensure safety of placement in the Withdrawal Management program.

In instances where substance use withdrawal or mental health symptoms indicate possible inappropriateness for admission a full review will occur by the responsible staff member. A Health Coordinator or Licensed Clinician will evaluate persons seeking services who present with unstable or decompensating biomedical or psychiatric conditions or symptoms.

In instances where emergency services are indicated staff will contact 911 to ensure the most appropriate care possible.

Staffing

1. For every 15 clients receiving Withdrawal Management services there shall be a least one staff member or volunteer on duty and awake at all times with a current cardiopulmonary resuscitation certificate and current first aid training.
2. A LPHA and/or the Medical Director will also support or have oversight of Withdrawal Management services.

Practices

1. A Level of Care (LOC) Assessment will be performed for each client upon admission to Withdrawal Management services.
2. Staff will perform a face to face observation of each client receiving Withdrawal Management services at least every 30 minutes during the first 72 hours following admission.
    a) Documentation of observations and physical checks shall be recorded on the log and signed by the program staff.
    b) Only staff that has been trained in the provisions of Withdrawal Management services may conduct and record observations and physical checks. Training shall include information on Withdrawal Management medications, signs and symptoms that require referral to a higher level of care. Copies of training records shall be kept in personnel files.
3. At least one staff member trained to provide Withdrawal Management services shall be assigned to the observation of Withdrawal Management clients at all times.
4. After 24 hours, close observations and physical checks may be discontinued or reduced based upon a determination by the LPHA or Medical Director. Documentation of the information that supports a decrease in close observation and physical checks shall be recorded in the client's file.

Documentation

1. The observation log will be completed by staff and entered in to the client record.
2. Documentation of justification for reduction of observations can be determined by the LPHA or Medical Director. Documentation will be completed by the LPHA or Medical Director who makes the determination.
3. At minimum the following will be documented:
    a. Beneficiary's name
    b. Purpose of service (as it related to LOC)
    c. Description of how service relates to the beneficiary's treatment plan- per a treatment plan progress note.
    d. Date, start and end time of services.
    e. Printed or typed and signed name of Medical Director or LPHA

Discharge Planning

Discharge planning begins at intake, and each client participates in an exit planning counseling session where long-term recovery options are explored and discussed to provide an accurate referral conducive to a clean and sober lifestyle. All clients are referred based on their discharge plan. Clients must be referred to community partners, as appropriate, when discharged.

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Monitored Residential Detoxification Policies and Procedures

Purpose

The goal of the healthRIGHT360 Monitored Residential Detoxification program is to reduce substance abuse and related criminal behavior in individuals referred to healthRIGHT360. To reach this goal, the program provides up to 5 days of monitored detoxification residential services to this population within a licensed treatment facility. This program is specific to clients trying to stabilize from alcohol and other drugs. Participants will be referred to ongoing treatment services if interested.

Admissions and Intake

Admission to the Monitored Residential Detoxification Program is open to all adult San Francisco residents needing detoxification services from alcohol and or other drugs that meet medical necessity according to ASAM criteria.

Participants can access the program by attending a brief orientation Monday through Friday at 8:45am at our 1563 Mission Street intake department or a referral from TAP. During the admission process each participant receives brief screenings for substance use, mental health, and physical problems.

Withdrawal Management Screening:

- Basic Demographics
- Recent Drug Use
- Medications
- Withdrawal Symptoms
- Mental Health
- Medical Conditions

Participants also take part in a structured interview that yields other information related to risk behaviors, housing status, and treatment history. Upon review of the findings participants may be referred for further evaluation to ensure safety of placement in our detoxification program. In instances where substance use withdrawal or mental health symptoms indicate possible inappropriateness for admission a full review will occur by the responsible staff member. A Health Coordinator or Licensed Clinician will evaluate persons seeking services who present with unstable or decompensating biomedical or psychiatric conditions or symptoms. In instances where emergency services are indicated it is the policy of healthRIGHT360 to contact 911 to ensure the most appropriate care possible.

Staffing

For every 15 clients receiving detoxification services, there shall be a least one staff member or volunteer on duty and awake at all times with a current cardiopulmonary resuscitation certificate and current first aid training.

Practices

1. Staff will perform a face-to-face observation of each client receiving detoxification services at least every 30 minutes during the first 72 hours following admission.

    a) Documentation of observations and physical checks shall be recorded on the log and signed by the program staff.

    b) Only staff that has been trained in the provisions of detoxification services may conduct and record observations and physical checks. Training shall include information on detoxification medications, signs and symptoms that require referral to a higher level of care. Copies of training records shall be kept in personnel files.

2. At least one staff member trained to provide detoxification services shall be assigned to the observation of detoxification clients at all times.

3. After 24 hours, close observations and physical checks may be discontinued or reduced based upon a determination by staff. Documentation of the information that supports a decrease in close observation and physical checks shall be recorded in the client's file.

Discharge Planning

Discharge planning begins at intake, and each client participates in an exit planning counseling session where long-term recovery options are explored and discussed to provide an accurate referral conducive to a clean and sober lifestyle. All clients are referred based on their discharge plan. Many clients transfer into other healthRIGHT360 programs while others are referred to community partners when discharged.

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Substance Use Disorder (SUD) Residential Treatment Authorization

(Rev. 11.28.18)

San Francisco is a Drug Medi-Cal Organized Delivery System (DMC-ODS) County. In accordance with waiver provisions from The Department of Healthcare Services (DHCS) State-County contract authorization for placement into residential treatment facilities is required for substance use services. Initial authorization for residential treatment is required for all clients in need of residential level 3.1, 3.3, and 3.5 services. Authorizations are approved in 30-day increments. The general rule is that San Francisco Residents are eligible for up to 2 non-consecutive 90-day residential episodes, which is in line with Drug Medi-Cal, San Francisco Behavioral Health Services (BHS) guidelines and most other counties in California.

Authorization Request Criteria

- Client is a San Francisco resident, as set forth in the BHS Policy 3.03-06: Treatment of non- San Francisco Residents.
- Requires a DSM-5 diagnosis of a substance use disorder, excluding nicotine, from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition entered in to the diagnosis page in AVATAR.
- Requires a Level of Care (LOC) Recommendation Form which establishes a moderate to severe need for treatment.
- DSM 5 diagnosis should show a link to either LOC severity ratings, impairments, dimensions, and/or placement summary.
- Why is treatment necessary now? Does a SUD problem exist which may require a solution/treatment NOW? If this treatment request follows previous episodes how is this time different? What is the imminent danger to the client in the next 2 weeks that shows a need for residential care?
- ASAM Criteria Placement Summary presents clear and concise reasoning for initial or continued treatment.
- The Episode Guarantor Information (EGI) form must be complete in AVATAR.
- If client engaged in two episodes within the past 365-days and is seeking a third episode the client should be referred to TAP for assessment (something to keep in mind: program may not be aware of client's previous episodes when submitting initial authorization request if other episodes were in a different organization).
- Request should include clinician's clinical judgement that the specified level of care is needed.

Reasons for Denial

- Client is not a San Francisco resident, as set forth in the BHS Policy 3.03-06: Treatment of non-San Francisco Residents.
- A DSM 5 diagnosis is missing from diagnosis page in AVATAR.
- Diagnosis is not a substance use disorder diagnosis.
- DSM 5 symptom criteria not linked to any elements in the corresponding Level of Care (LOC) Recommendation Form.
- Answers to LOC dimension questions and/or placement summary do not indicate problems that justify admission into residential treatment.
- Client has multiple previous episodes within the 365-day period and LOC does not demonstrate a strong why now case, "Why is treatment necessary now?"
- Client presents with a primary mental health diagnosis and no evidence of a substance use disorder. Clients with dual diagnosis or co-occurring conditions will still be considered for reauthorization.
- LOC form is incomplete.

Denial Procedures

- Denials shall include reason for denial, steps for appeal, and a referral to a treatment program at the appropriate LOC.
- If authorizer requires further information, they may deny a request pending the further information and would not trigger a Notice of Adverse Benefit Determination (NOAB).
- If a Medi-Cal beneficiary is denied access into residential treatment written notice must be provided to the beneficiary of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. The Care Coordinator denying services must complete a Notice of Adverse Benefit Determination (NOAB) Denial. NOAB Denial submissions must include NOAB "Your Rights", Language Assistance Taglines, Beneficiary Nondiscrimination Notice, and be communicated to Quality Management.
- If a Medi-Cal beneficiary is denied access into residential treatment due to not meeting medical necessity the beneficiary has the right to request a second opinion about their substance use disorder condition.
- Denials shall be entered into AVATAR by SF DPH/BH staff within 24 business hours of submittal (and will be visible on the Residential PreAuth Status Report by that time).

Reauthorization

- If determined to be medically necessary, clients must receive reauthorization every 30 days.
- Program must request reauthorization 7-10 days before the current authorized period ends to ensure there is proper time for requests for clarification and transition planning.
- Approved reauthorizations shall be entered into AVATAR by SF DPH/BH staff within 72 business hours of submission (and will be visible on the ODS Manage Care Authorization Report by that time).
- If determined to be medically necessary, perinatal beneficiaries may receive longer

lengths of stay than non-perinatal adults:

- Perinatal clients can be considered under perinatal authorization for the duration of their pregnancy and for 60 days postpartum.
- Following the 60 days of authorized postpartum treatment, former perinatal clients who continue to meet medical necessity for treatment can be considered for a new treatment episode and subsequent reauthorizations under the above, individual, non-perinatal guidelines.

Other things to Consider

- In cases where treatment is Court ordered, but the client has mild or no medical necessity, the program and BHS should work with the court to try to get client placed in the proper level of care.
- If a client with out-of-county Medi-Cal gets admitted into a residential program using proof that a request had been made to switch Medi-Cal to San Francisco, they would not be eligible for any additional residential treatment episodes in SF until the transfer is complete.

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Pre-Admit to Residential User Guide

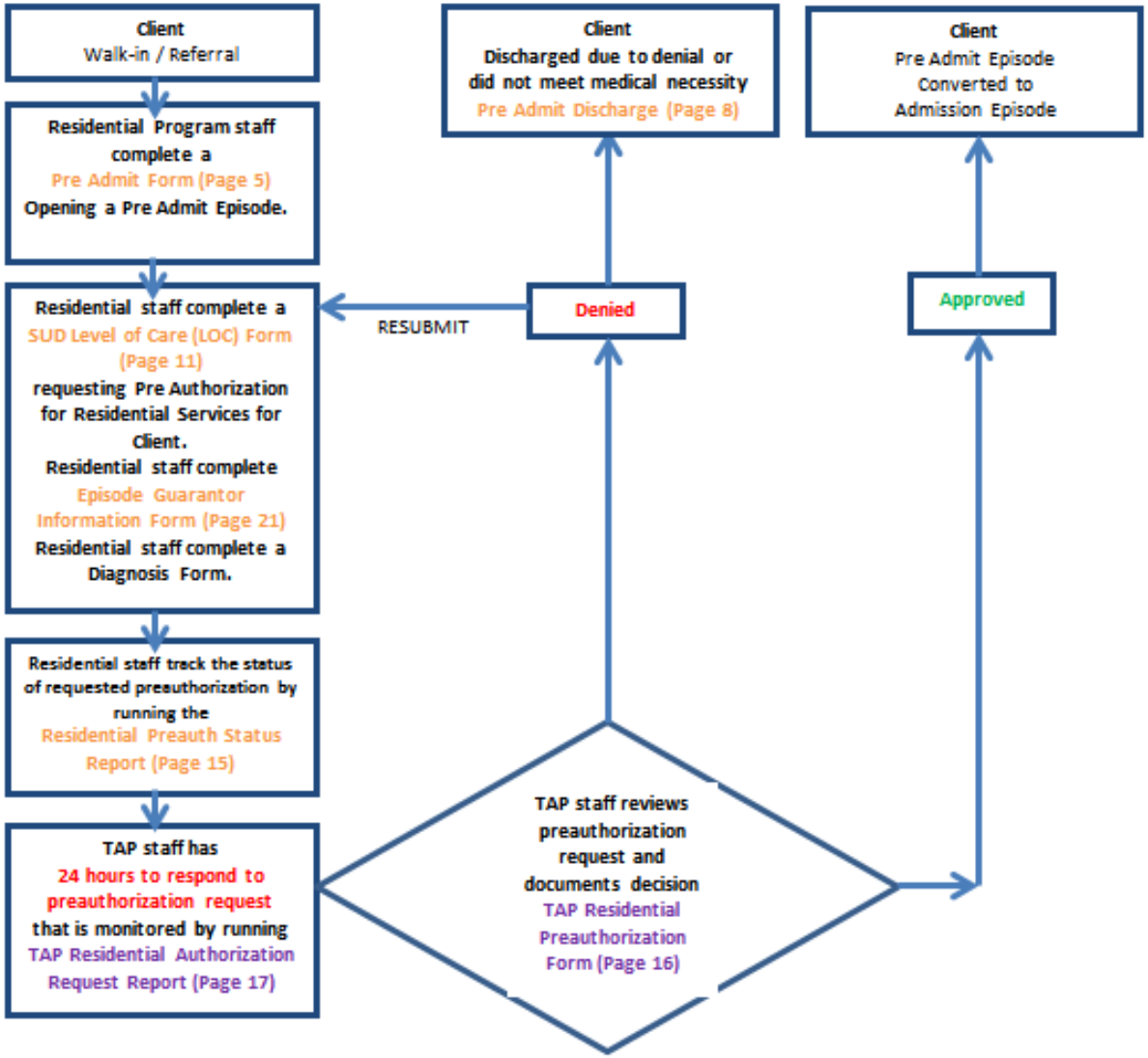
(Avatar Residential Service Authorization Process)

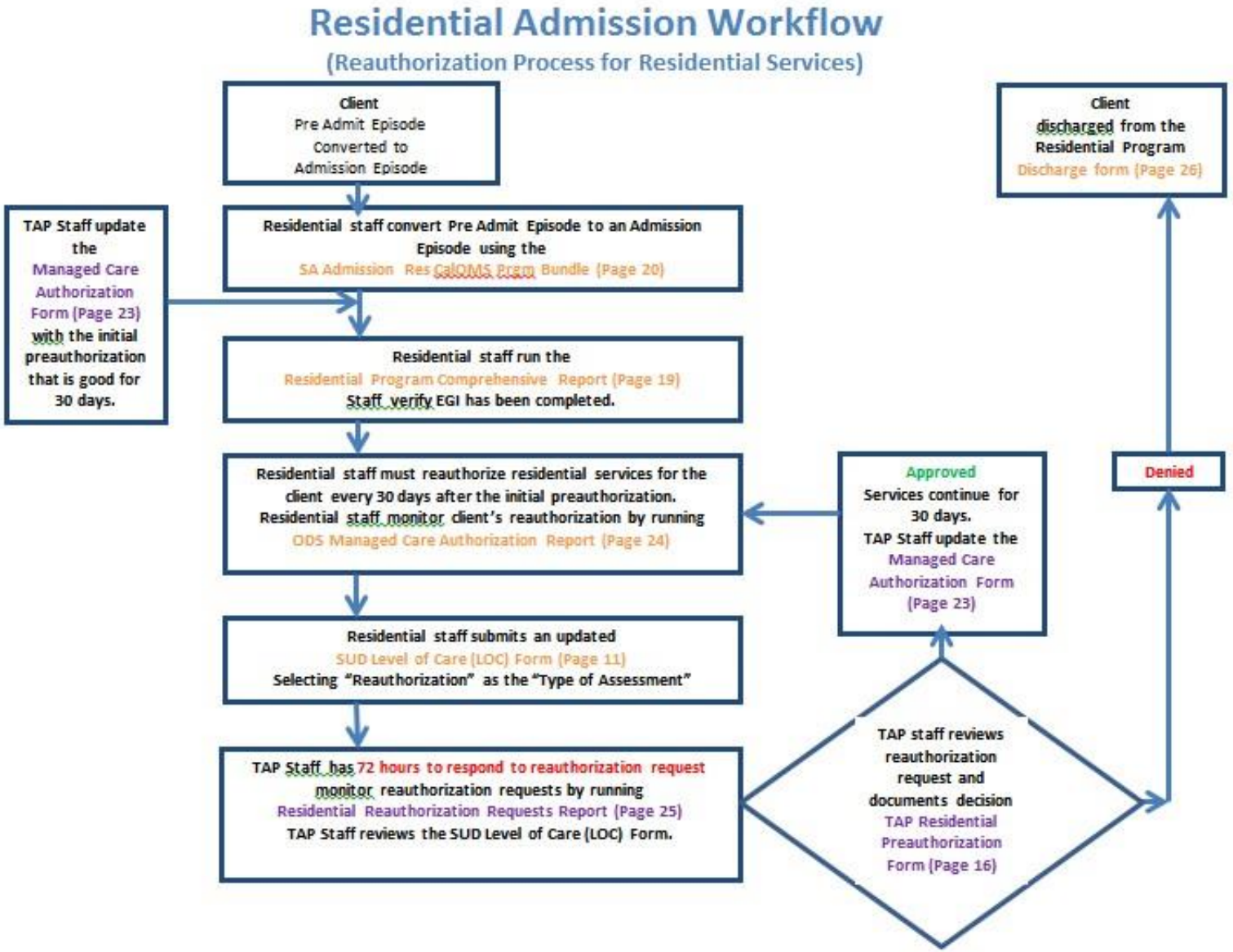
Purpose of this Guide

Catalogue all the forms/reports involved in the process of pre-authorizing / re-authorizing clients

Residential Pre Admit Workflow

(PreAuthorization Process for Residential Services)




Residential Admission Workflow
(Reauthorization Process for Residential Services)
Client
Pre Admit Episode
Converted to
Admission Episode
TAP Staff update the
Managed Care
Authorization
Form (Page 23)
with the initial
preauthorization
that is good for
30 days.
Residential staff convert Pre Admit Episode to an Admission Episode using the
SA Admission Res CalOMS Prgm Bundle (Page 20)
Residential staff run the
Residential Program Comprehensive Report (Page 19)
Staff verify EGI has been completed.
Residential staff must reauthorize residential services for the client every 30 days after the initial preauthorization.
Residential staff monitor client's reauthorization by running
ODS Managed Care Authorization Report (Page 24)
Residential staff submits an updated
SUD Level of Care (LOC) Form (Page 11)
Selecting "Reauthorization" as the "Type of Assessment"
TAP Staff has 72 hours to respond to reauthorization request
monitor reauthorization requests by running
Residential Reauthorization Requests Report (Page 25)
TAP Staff reviews the SUD Level of Care (LOC) Form.
TAP staff reviews reauthorization request and documents decision
TAP Residential Preauthorization Form (Page 16)
Approved
Services continue for 30 days.
TAP Staff update the
Managed Care
Authorization Form
(Page 23)
Denied
Client
discharged from the
Residential Program
Discharge form (Page 26)

Pre Admit Form

This form is used to open a Pre-Admit episode for the client. The Pre-Amit is an opportunity to determine if client meets medical necessity. This form will document initial demographic information for the client along with insurance information.

There are three links to other forms included in this Pre-Admit form.

- MHS140 Report

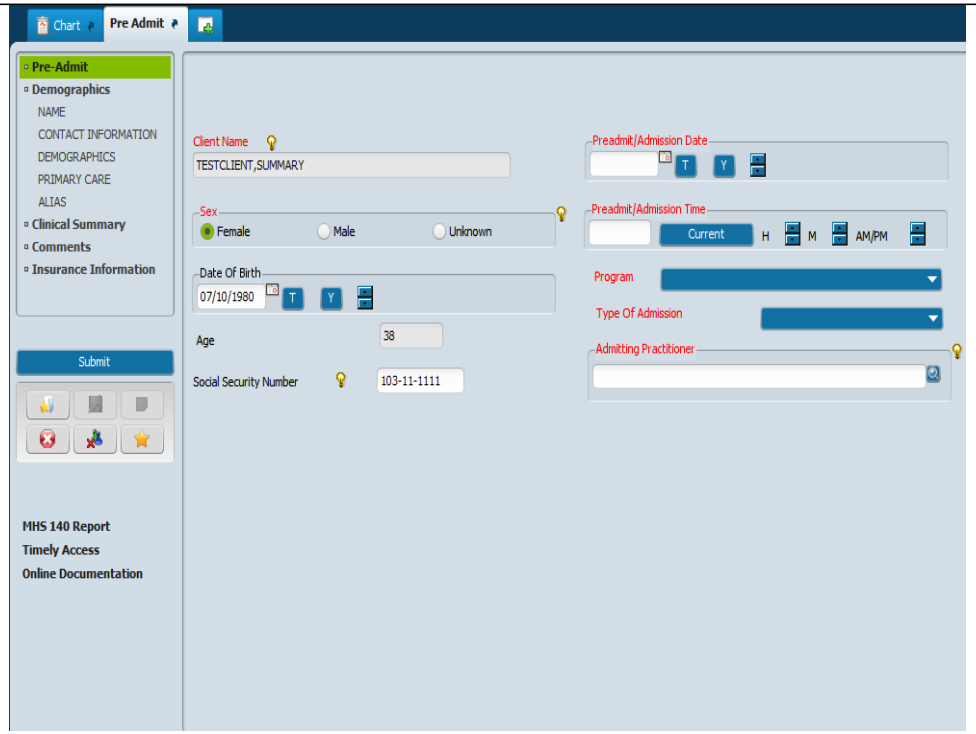
A historical view of client's previous episodes in Avatar.

- Timely Access Form

Document client appointment information/access to services.

- Online Documentation

Takes you to vendor's (Netsmart) wiki page.



Pre Admit Episodes by Clinician Report

This report captures the number of pre admit episodes opened by the clinician for the specified period of time.

Report Criteria

Clinician Name/Staff ID
Start Date

End Date

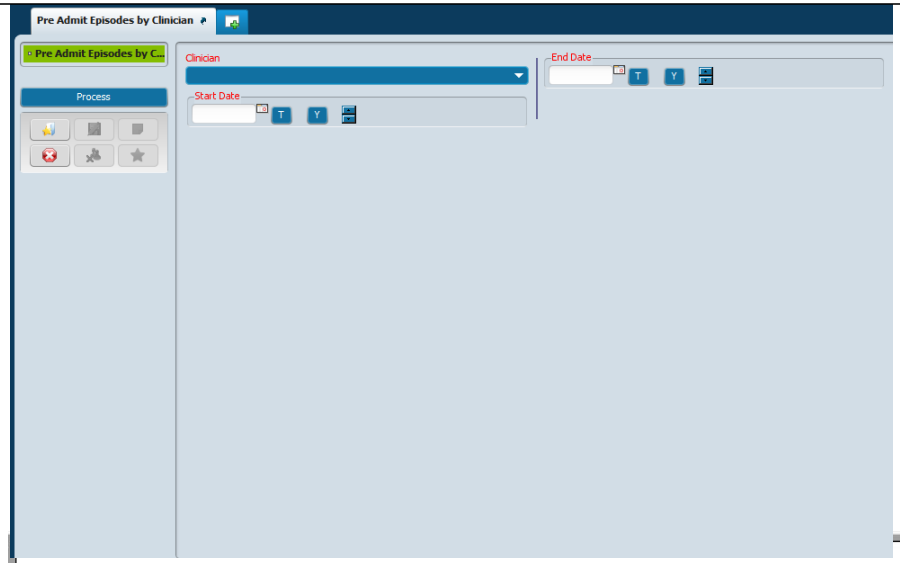
Report Output

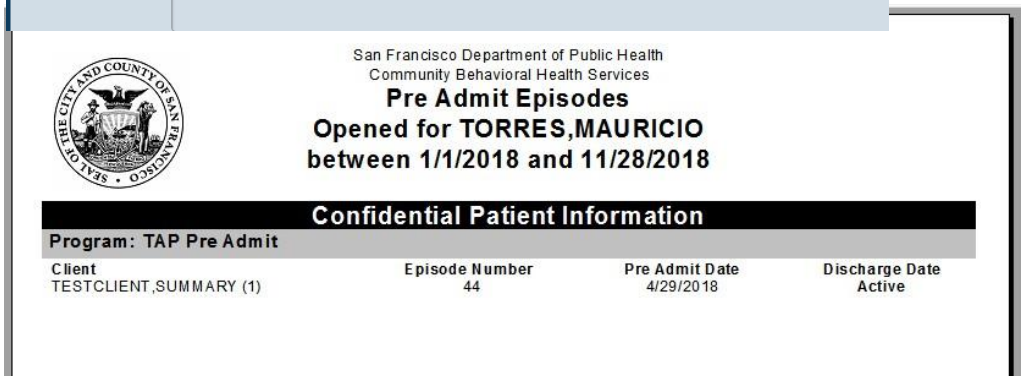
Program Name

Client Name/BIS Number
Episode Number

Pre Admit Date

Discharge Date of the Pre Admit Episode*





San Francisco Department of Public Health
Community Behavioral Health Services

Pre Admit Episodes
Opened for TORRES,MAURICIO
between 1/1/2018 and 11/28/2018

Confidential Patient Information

Program: TAP Pre Admit

Client	Episode Number	Pre Admit Date	Discharge Date
TESTCLIENT,SUMMARY (1)	44	4/29/2018	Active

Pre Admit Episodes by Program Report

This report is to be used by pre admit programs to determine the number of active clients (within the

specified date range) that are open in pre admit episodes.

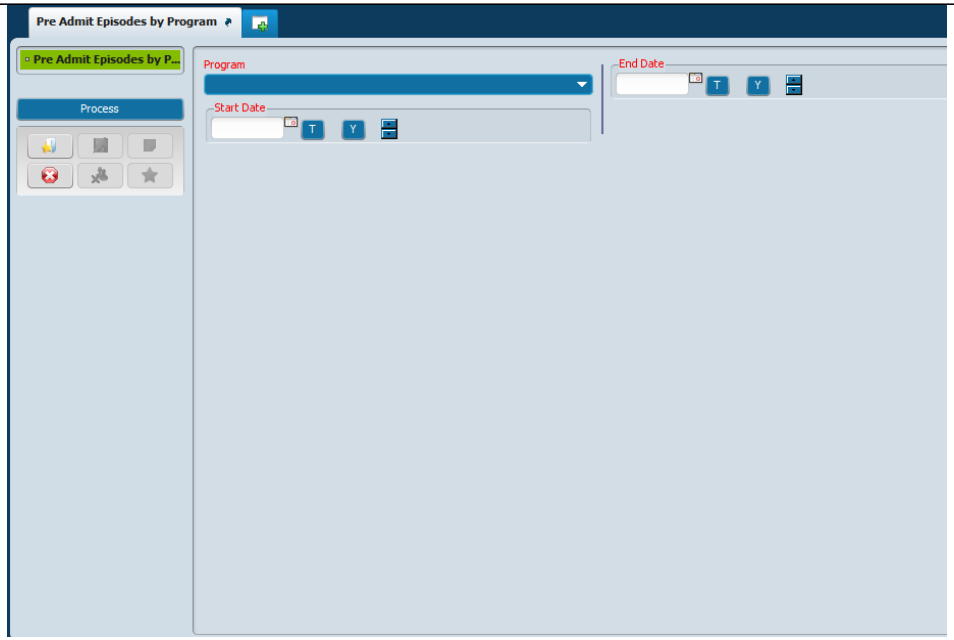
Report Criteria
Program Name
Start Date

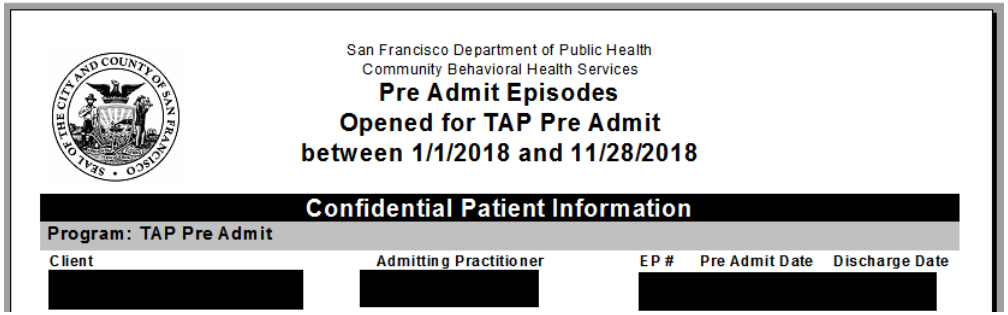
End Date

Report Output
Program Name

Client Name (BIS Number)
Admitting Practitioner
Episode Number

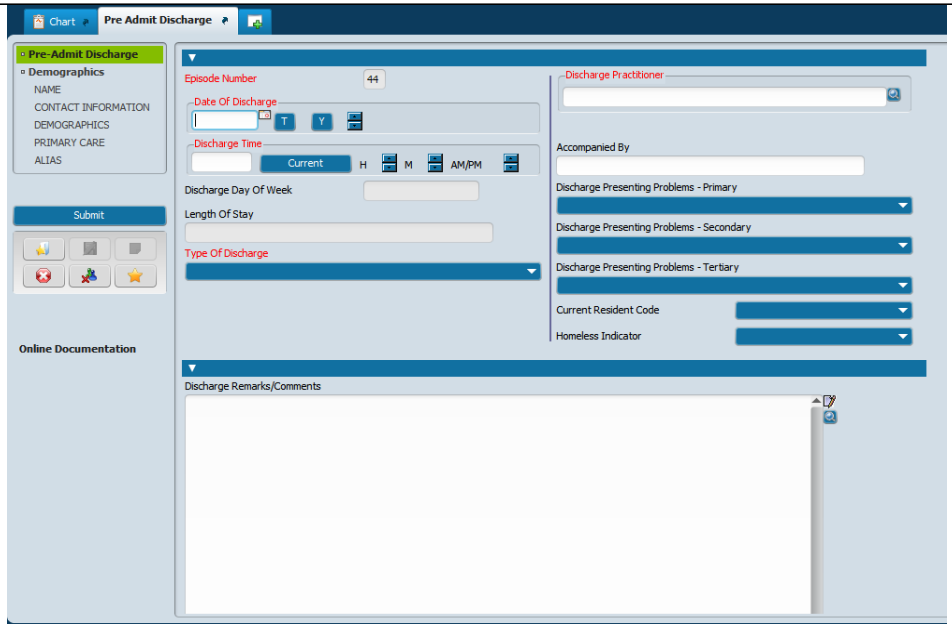
Pre Admit Date
Discharge Date





Pre Admit Discharge Form

This form is used to discharge a Pre Admit client. The client may have not met medical eligibility or was not able to be reachable while still open in a Pre Admit episode. This form will closed the Pre Admit Episode.



Missing DSM5 Diagnosis By Clinician Report

This report can be run by clinical staff to determine which clients on their caseload are missing a diagnosis.

Report Criteria

Clinician Name/Staff ID

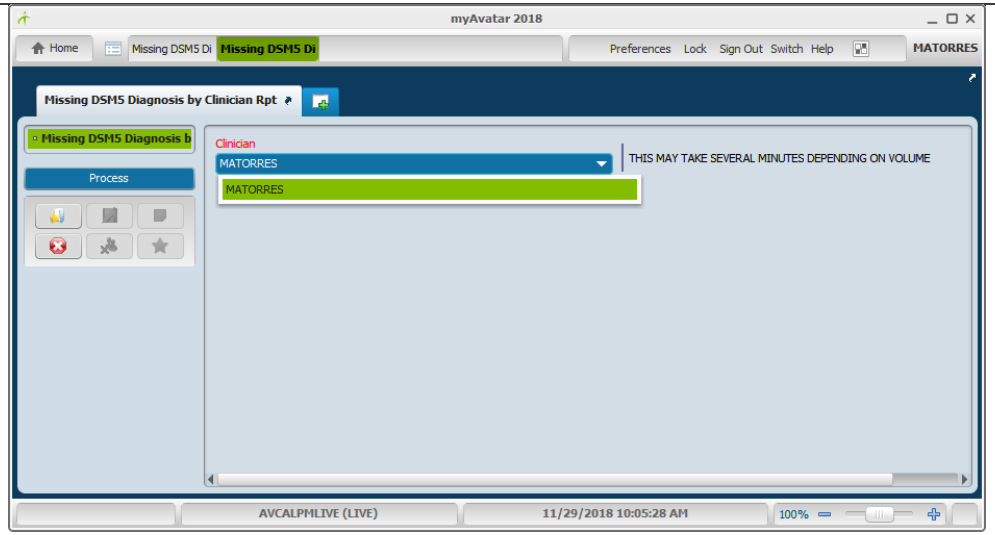
Report Output

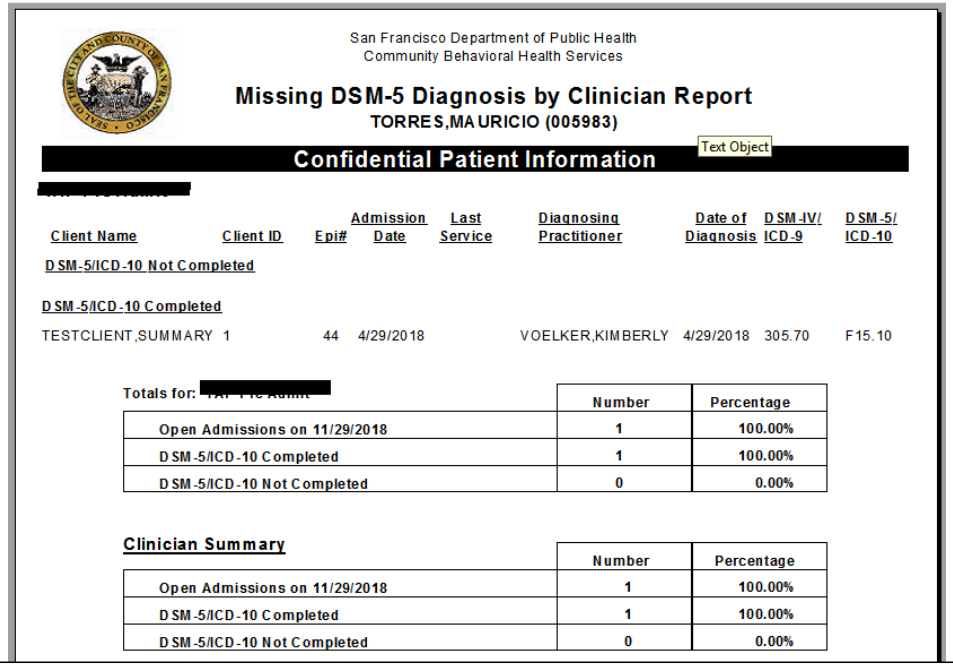
Program Name

Client Name (BIS Number)
Episode Number
Admission Date

Last Service
Diagnosing Practitioner
Date of Diagnosis
DSMIV Code

DSM5 Code
Stats by Program
Stats by Clinician





San Francisco Department of Public Health
Community Behavioral Health Services

Missing DSM-5 Diagnosis by Clinician Report

TORRES,MAURICIO (005983)

Confidential Patient Information

Text Object

[redacted]

Client Name	Client ID	Epi#	Admission Date	Last Service	Diagnosing Practitioner	Date of Diagnosis	DSM-IV/ ICD-9	DSM-5/ ICD-10
DSM-5/ICD-10 Not Completed								
DSM-5/ICD-10 Completed								
TESTCLIENT,SUMMARY	1	44	4/29/2018		VOELKER,KIMBERLY	4/29/2018	305.70	F15.10

Totals for: [redacted]

	Number	Percentage
Open Admissions on 11/29/2018	1	100.00%
DSM-5/ICD-10 Completed	1	100.00%
DSM-5/ICD-10 Not Completed	0	0.00%

Clinician Summary

	Number	Percentage
Open Admissions on 11/29/2018	1	100.00%
DSM-5/ICD-10 Completed	1	100.00%
DSM-5/ICD-10 Not Completed	0	0.00%

Missing DSM5 Diagnosis By Prog Staff Rpt

This report is a program level report that captures which clients in a program are missing a diagnosis.

Report Criteria

Program

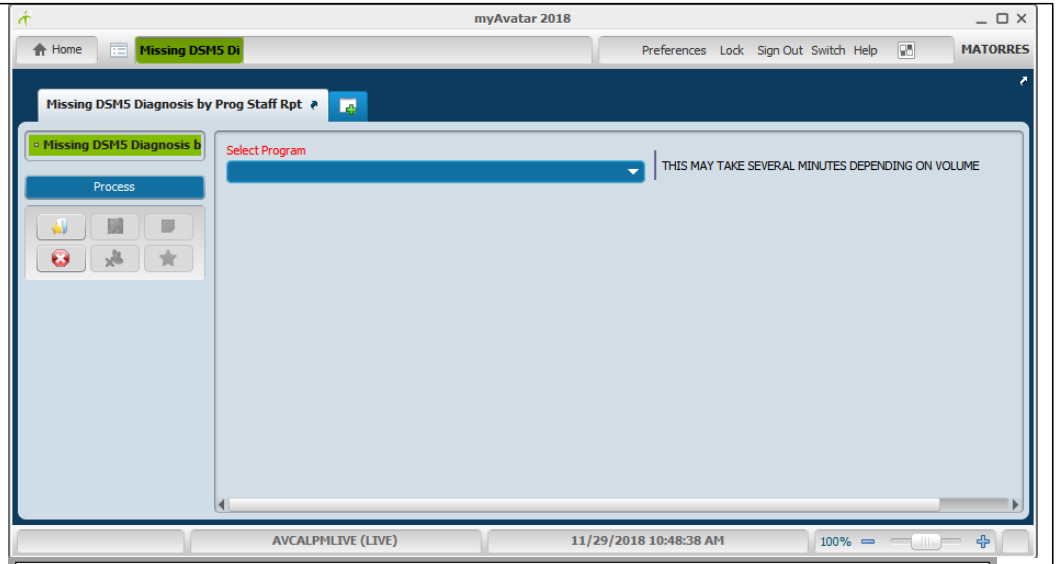
Report Output

Program Name

Client Name (BIS Number)
Episode Number
Admission Date

Last Service
Diagnosing Practitioner
Date of Diagnosis
DSMIV Code

DSM5 Code
Stats by Clinician
Stats by Program



San Francisco Department of Public Health
Community Behavioral Health Services

Missing DSM-5 Diagnosis by Program/Staff Report

[redacted]

Confidential Patient Information

Admitting/Primary Clinician: [redacted]

Client Name	Client ID	Epi#	Admission Date	Last Service	Diagnosing Practitioner	Date of Diagnosis	DSM-IV/ ICD-9	DSM-5/ ICD-10
DSM-5/ICD-10 Not Completed								
DSM-5/ICD-10 Completed								
[redacted]		13	10/24/2018		[redacted]	10/26/2018	[redacted]	

Totals for: [redacted]

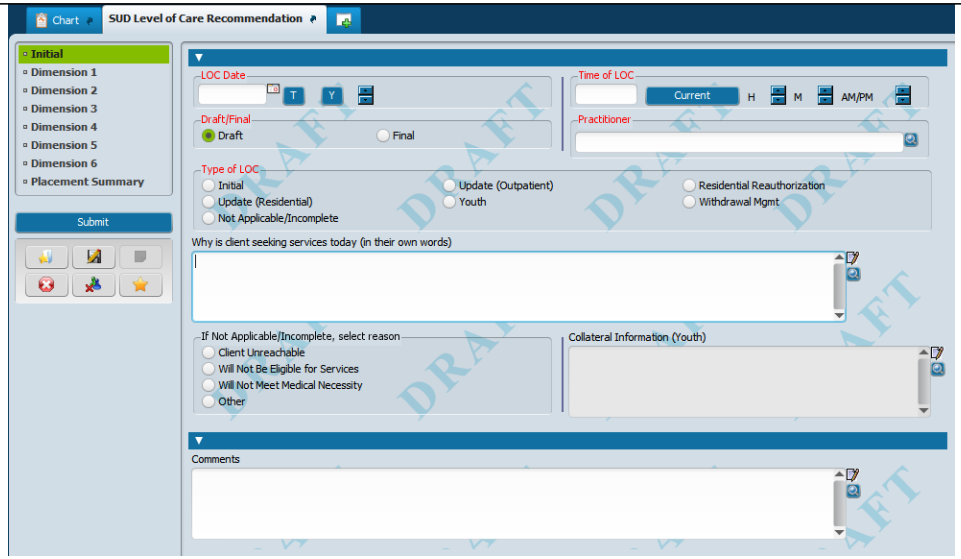
	Number	Percentage
Open Admissions on 11/29/2018	1	100.00%
DSM-5/ICD-10 Completed	1	100.00%
DSM-5/ICD-10 Not Completed	0	0.00%

Program Summary

	Number	Percentage
Open Admissions on 11/29/2018	399	100.00%
DSM-5/ICD-10 Completed	56	14.04%
DSM-5/ICD-10 Not Completed	343	85.96%

SUD Level of Care Recommendation Form

This form is utilized by staff to determine client severity and helps to match the client to the appropriate level of service. There are multiple dimensions of care that are examined with this form.



SUD Level of Care Recommendation Rpt

This report is used to printout and review the SUD Level of Care Recommendation form.

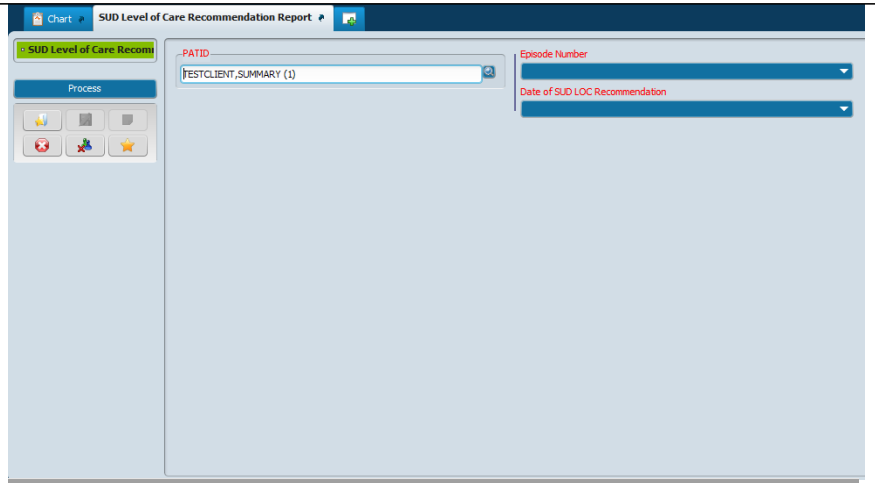
Report Criteria

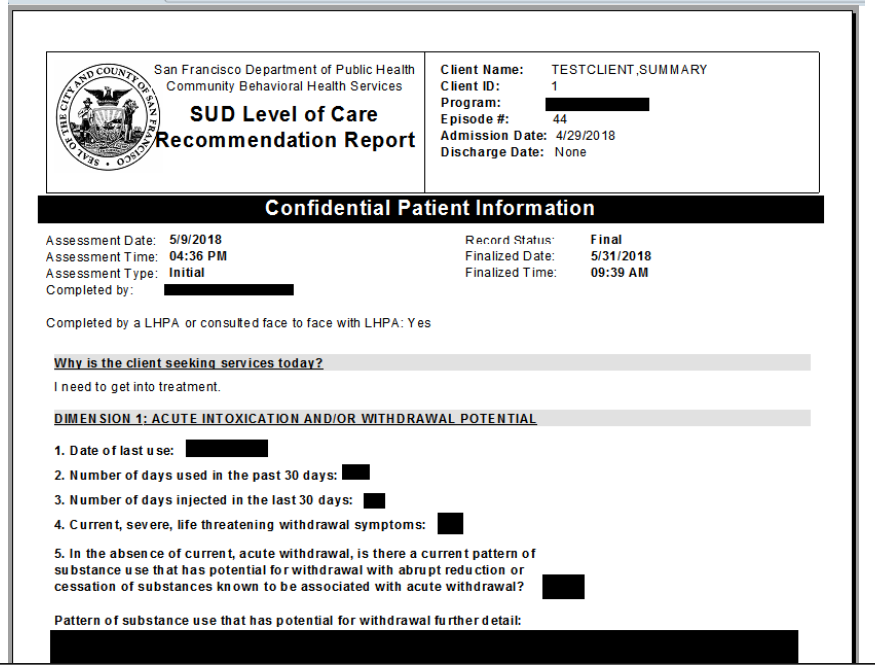
Client Name/BIS Number
Episode Number

Date of SUD LOC Recommendation

Report Output

A detailed report will include all the collected data from the client for all 6 dimensions of care and the "Placement of Summary" section.





San Francisco Department of Public Health
Community Behavioral Health Services

SUD Level of Care Recommendation Report

Client Name: TESTCLIENT,SUMMARY
Client ID: 1
Program: [redacted]
Episode #: 44
Admission Date: 4/29/2018
Discharge Date: None

Confidential Patient Information

Assessment Date: **5/9/2018**
Assessment Time: **04:36 PM**
Assessment Type: **Initial**
Completed by: [redacted]

Record Status: **Final**
Finalized Date: **5/31/2018**
Finalized Time: **09:39 AM**

Completed by a LHPA or consulted face to face with LHPA: Yes

Why is the client seeking services today?

I need to get into treatment.

DIMENSION 1: ACUTE INTOXICATION AND/OR WITHDRAWAL POTENTIAL

1. Date of last use: [redacted]
2. Number of days used in the past 30 days: [redacted]
3. Number of days injected in the last 30 days: [redacted]
4. Current, severe, life threatening withdrawal symptoms: [redacted]
5. In the absence of current, acute withdrawal, is there a current pattern of substance use that has potential for withdrawal with abrupt reduction or cessation of substances known to be associated with acute withdrawal? [redacted]

Pattern of substance use that has potential for withdrawal further detail:

[redacted]

SUD LOC in Draft by Program

This report is utilized by the program to determine Level of Care Recommendation forms left in draft status.

Report Criteria

Program

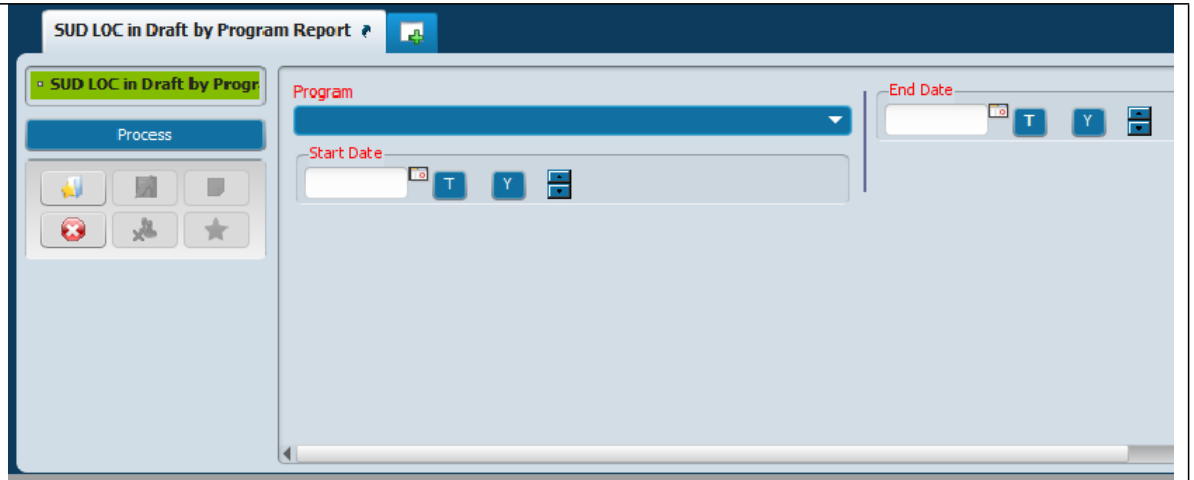
Start Date
End Date

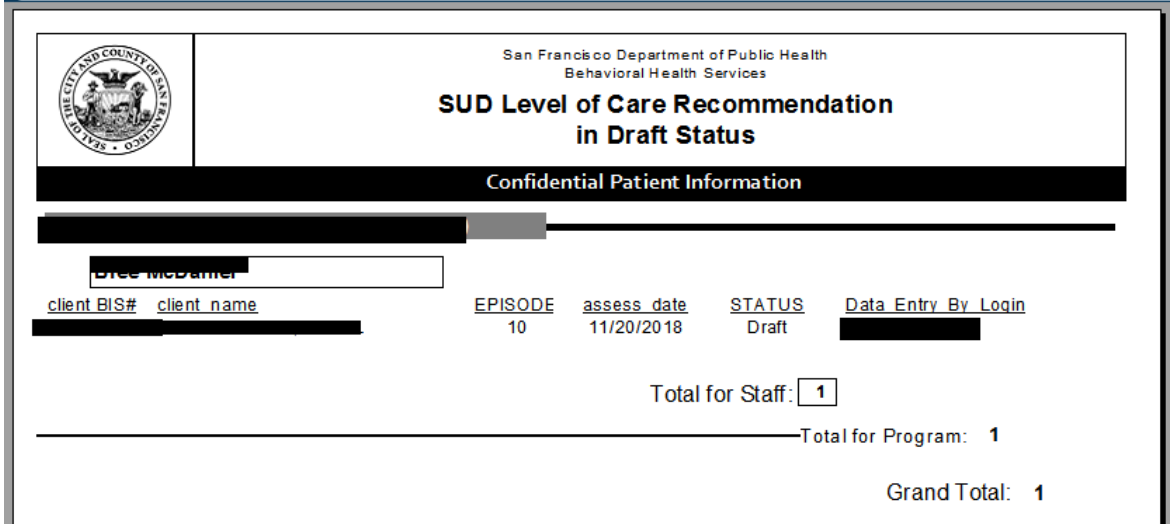
Report Output

Program Name
Clinician Name
Client BIS/Name
Episode Number

LOC Assessment Date
Form Status

Date Entry Login ID





San Francisco Department of Public Health
Behavioral Health Services

SUD Level of Care Recommendation in Draft Status

Confidential Patient Information

[redacted]

[redacted]

client BIS#	client_name	EPISODE	assess_date	STATUS	Data_Entry_By_Login
[redacted]		10	11/20/2018	Draft	[redacted]

Total for Staff: 1

Total for Program: 1

Grand Total: 1

SUD LOC Status Report

This report can be utilized by any program to identify if the submitted SUD LOC for the client has been approved or denied.

Report Criteria

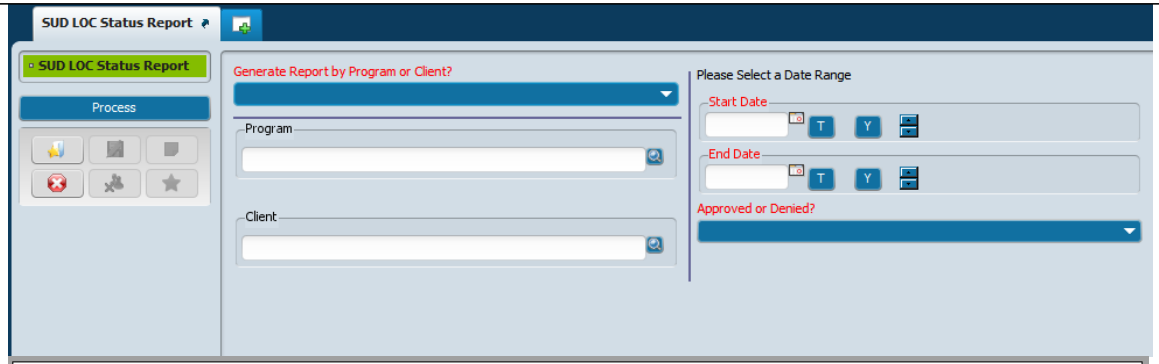
Select Program or Client
Program Name or Client BIS
Start Date

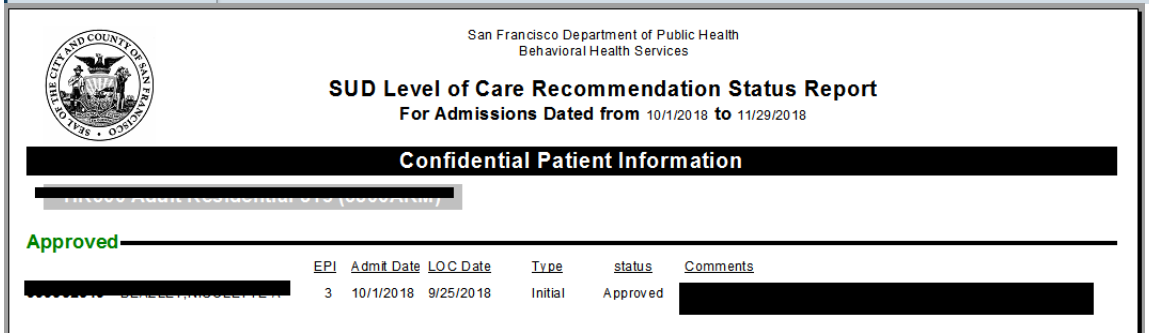
End Date

Select Approved or Denied

Report Output

Program Name
Client BIS/Name
Episode Number




San Francisco Department of Public Health
Behavioral Health Services

SUD Level of Care Recommendation Status Report
For Admissions Dated from 10/1/2018 **to** 11/29/2018

Confidential Patient Information

[redacted]

Approved

EPI	Admit Date	LOC Date	Type	status	Comments
[redacted]	3	10/1/2018	9/25/2018	Initial	Approved	[redacted]

Residential Preauth Status Report

This report is used to identify the status of the SUD Level of Care Recommendation submitted to provide preauthorization for residential services.

Report Criteria

Select Program or Client

Enter Program or Client Identifier
Start Date

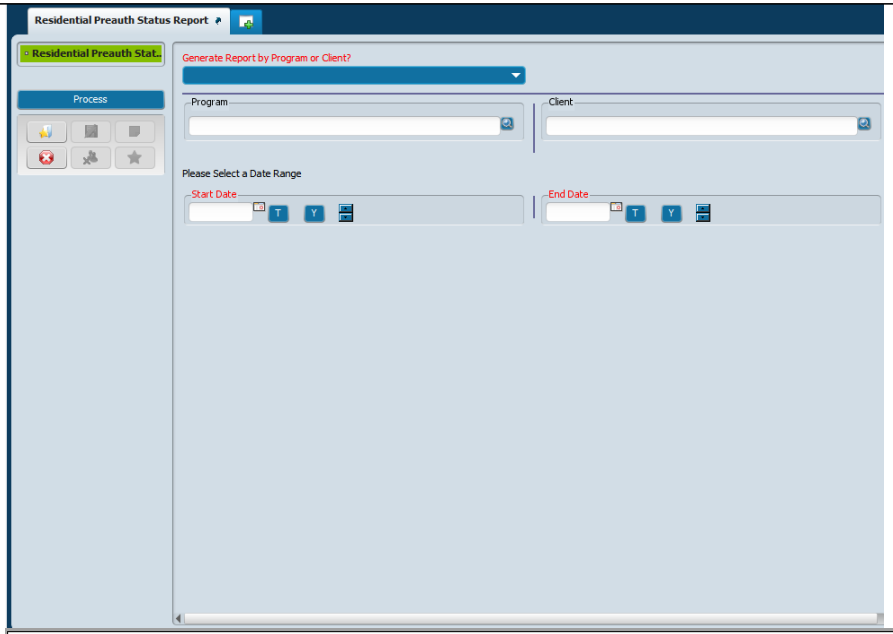
End Date

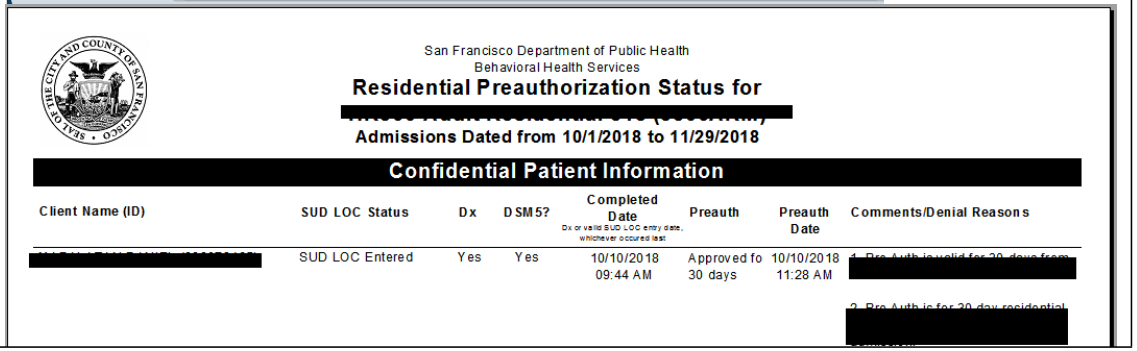
Report Output

Program Name

Client Name/BIS Number
LOC Status

DX entered?
DSM5?





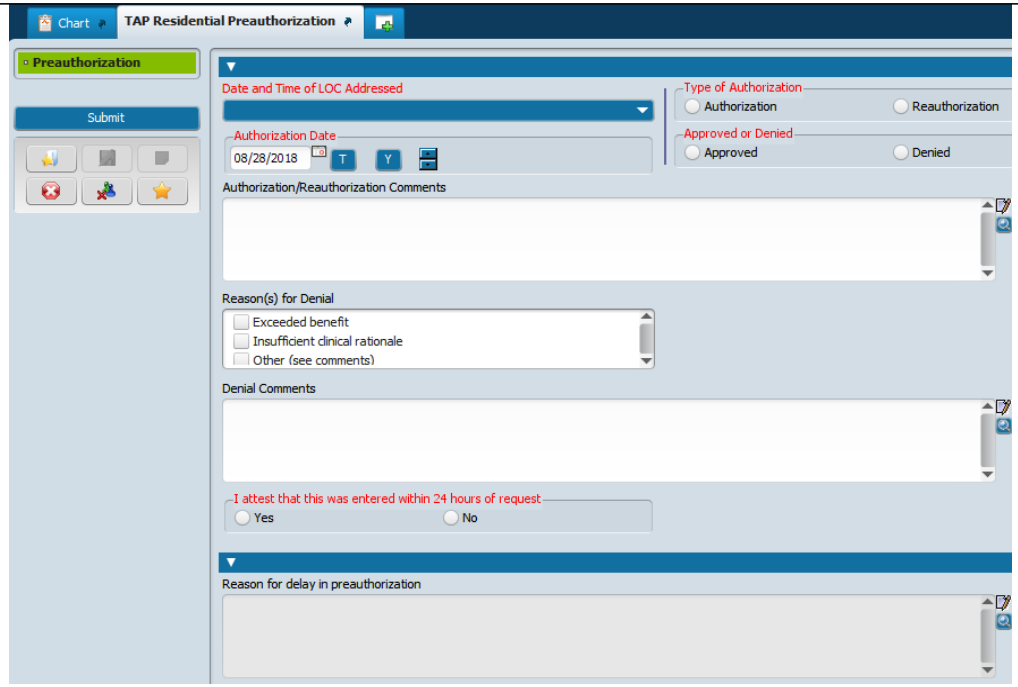
San Francisco Department of Public Health
Behavioral Health Services

Residential Preauthorization Status for

Admissions Dated from 10/1/2018 to 11/29/2018

Confidential Patient Information

Client Name (ID)	SUD LOC Status	Dx	DSM5?	Completed Date (Dx or valid SUD LOC entry date, whichever occured last)	Preauth	Preauth Date	Comments/Denial Reasons
[redacted]	SUD LOC Entered	Yes	Yes	10/10/2018 09:44 AM	Approved fo 30 days	10/10/2018 11:28 AM	1. Pre-Auth is valid for 30 days from [redacted] 2. Pre-Auth is for 30 day residential [redacted]

<u>TAP Residential Preauthorization Form</u> This form is used to approve or deny residential preauthorization and reauthorization requests. A SUD Level of Care Recommendation is be submitted in order to use this form to authorize services or continued services.	

TAP RES Authorization Requests

This report is used to review authorization requests for residential services for the client. This report is exclusively accessed by TAP.

Report Criteria

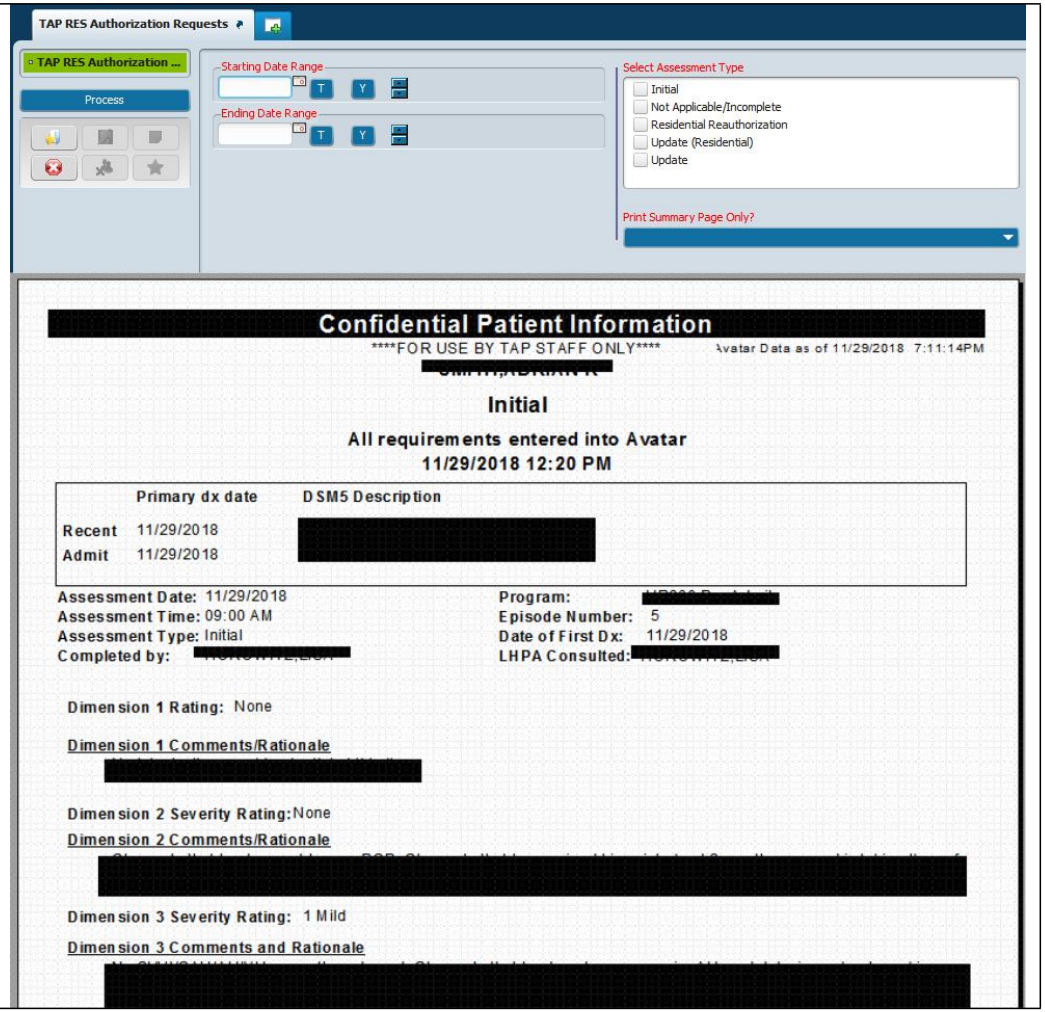
Start Date
End Date

Select an LOC Type

Print Summary Page only (Y/N)?

Report Output

This detailed report will display all the SUD LOC information collected for the client(s) based on the report selection criteria. Because of the quantity of data that is pulled into the report, this report is best utilized for small date ranges.



TAP Pre Admit to Residential

This report identifies those clients that have been converted from a Pre Admit Episode to a Residential Admission Episode during the specified date range.

Report Criteria

Start Date
End Date

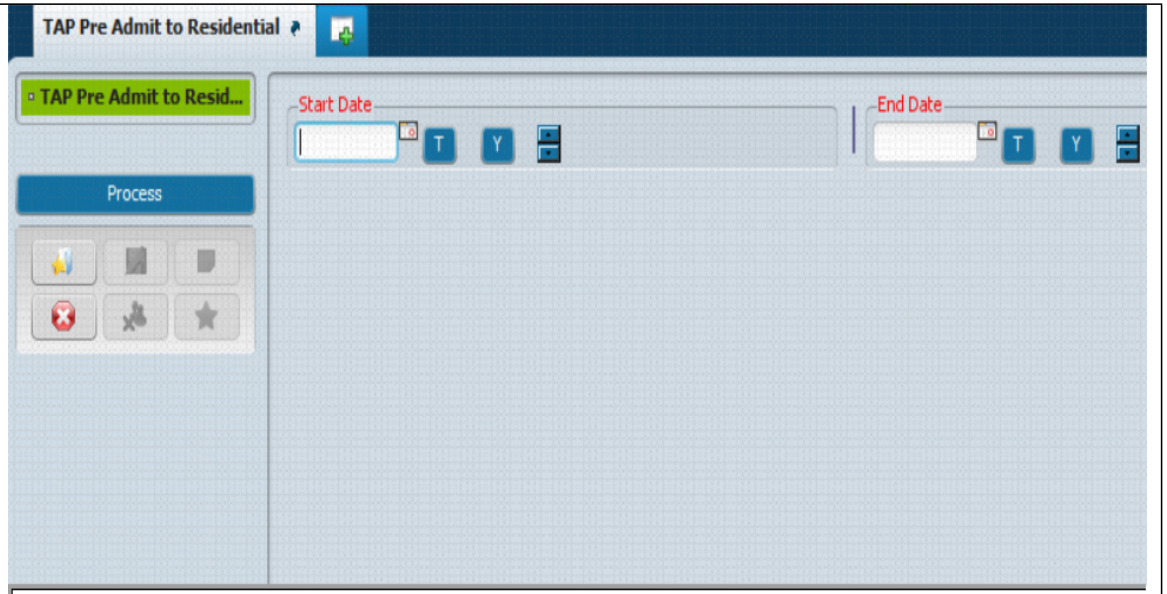
Report Output

Program

Client Name/BIS Number
Episode Number
Admission Date

Data Entry Date

Whether Authorization Start Date Exists for residential episode



Pre Admit to Residential Program Transfers
Entered from 11/1/2018 to 11/29/2018

Client	EP	Program	Admission Date	Date Entered	Authorization Start Date
[redacted]	3	[redacted]	10/31/2018	11/2/2018	10/31/2018
	4		11/5/2018	11/5/2018	11/5/2018
	4		11/2/2018	11/5/2018	11/2/2018
	2		11/5/2018	11/6/2018	11/5/2018
	91		11/6/2018	11/7/2018	11/6/2018
	9		11/6/2018	11/7/2018	11/6/2018
	9		11/5/2018	11/8/2018	11/5/2018

(Residential Program Comprehensive

This report is utilized by the residential program to determine client's current Financial Eligibility Status, Manage Care Authorizations and Level of Care Recommendation. This report includes Admission Date, Length of Stay and Diagnosis. The report provides a snapshot of all the active clients within the selected program.

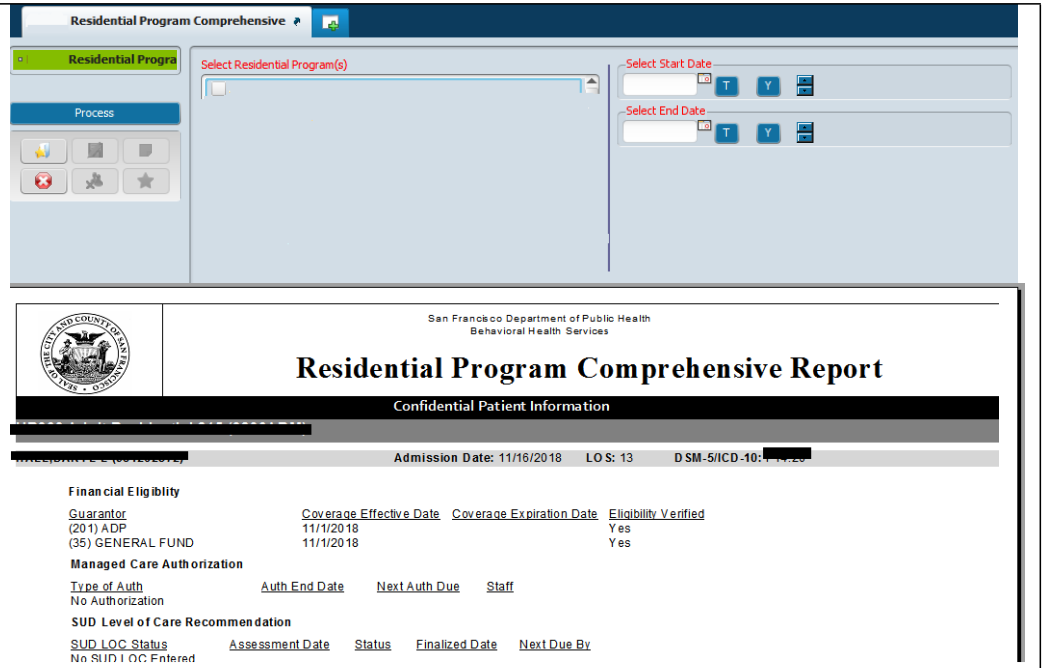
Report Criteria

Select one or several programs
Start Date

End Date

Report Output

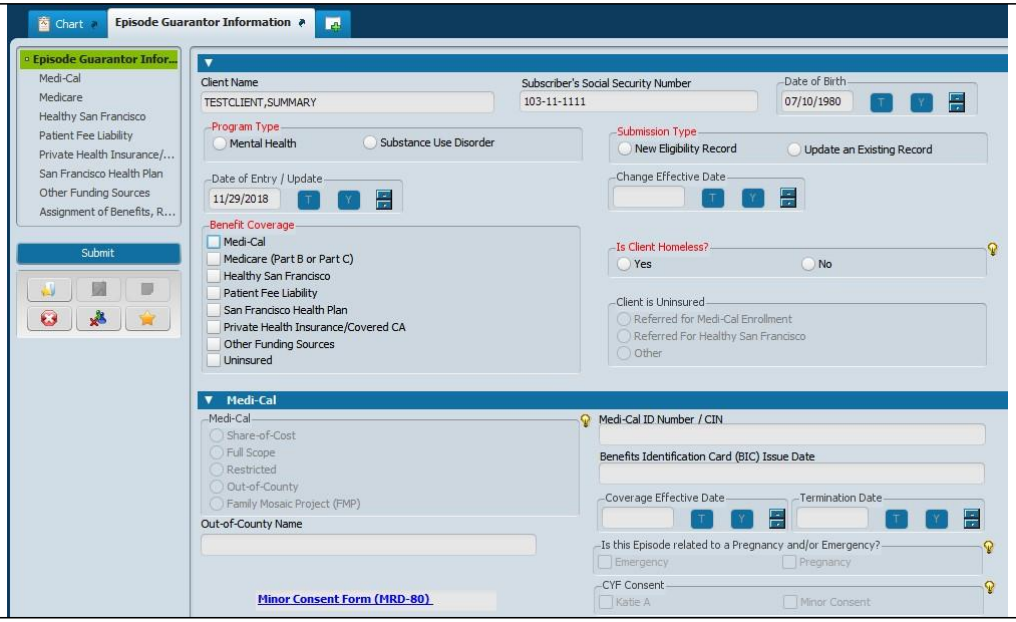
Program



SA Admission RES CalOMS Program Bundle The bundle is used to simplify the process of opening a Residential episode and assists with capturing all the required information. As one form is completed, the next form in the bundle will open.	Contains several forms, • Admissions • CalOMS Admission • Episode Guarantor Information • Admission Referral Information • Contact Information • Forms (Consent) • Diagnosis

Episode Guarantor Information Form

This form collects guarantor information for the client. This information is required prior to obtaining reauthorization for residential services.



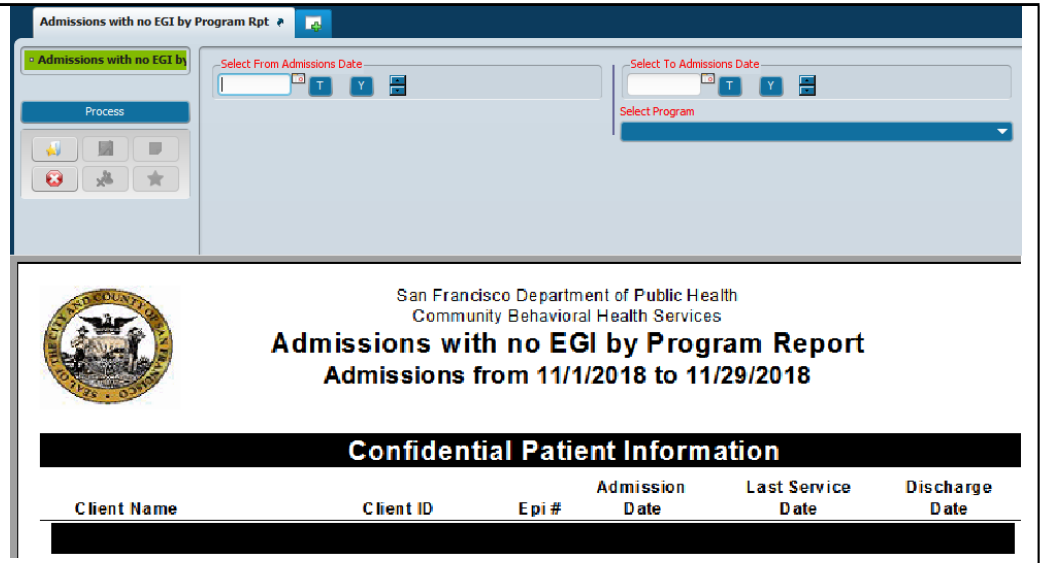
Admission with no EGI by Program Rpt

This report is used to determine if there are any clients with missing Episode Guarantor Information for a specified date range.

Report Criteria

From (Admission Date)
To (Admission Date)
Program

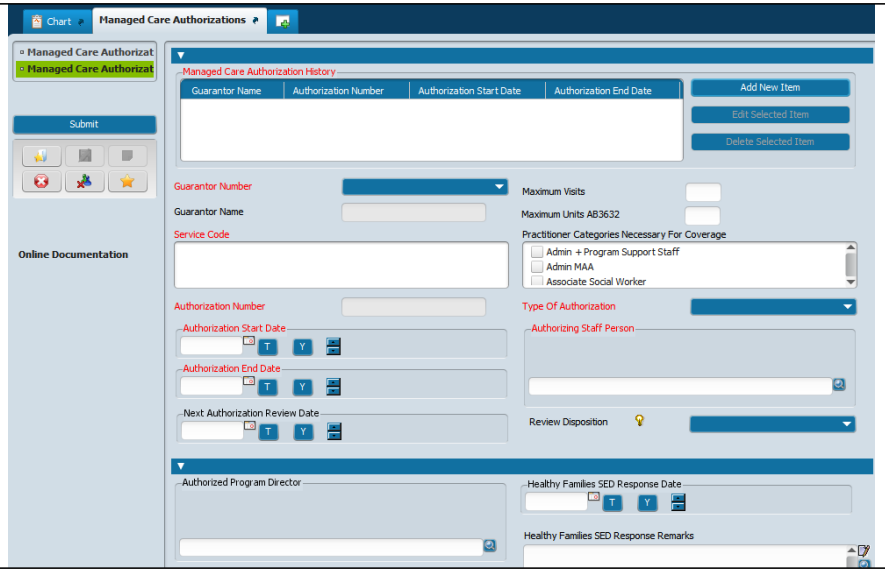
Report Output



Managed Care Authorizations Form

This form is used to document the approved authorizations for residential services for a specific start/end date range.

Note, the Episode Guarantor Information form and the Financial Eligibility form need to be completed with guarantor(s) assigned to the client prior to utilizing this form



ODS Managed Care Authorization Requests Rpt

This report can be utilized to determine when the next authorization is due for clients in the selected program for the specified date range. The report can be processed by client or by program.

Report Criteria

Select to run the report by Client or Program
Start Date

End Date

Report Output

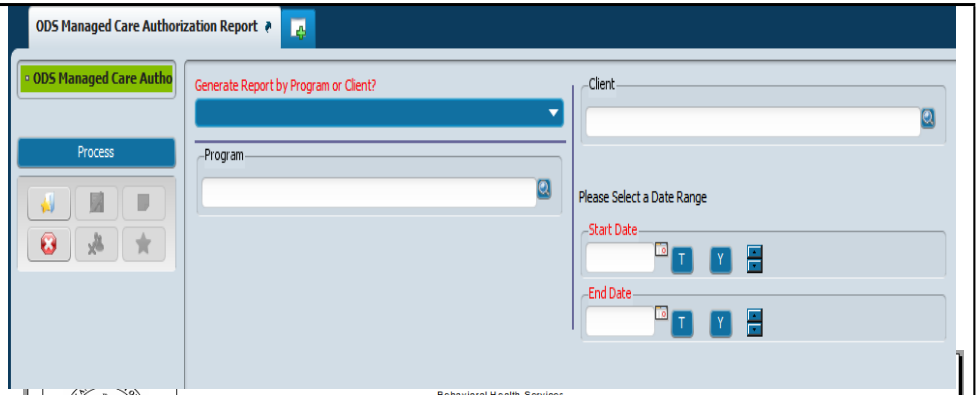
Program

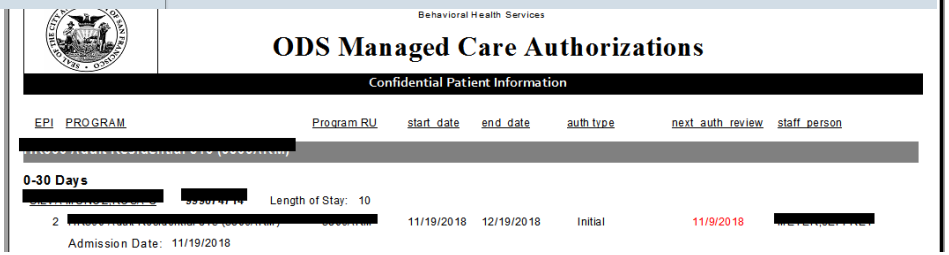
Client Name/BIS Number
Length of Stay

Start Date of Authorization
End Date of Authorization
Type of Authorization

When Next Authorization is Due
Staff Person

Admission Date





Residential Reauthorization Requests Report

This report is be used by TAP to monitor the reauthorizations requests for a specified date range that have been submitted for their review.

Report Criteria

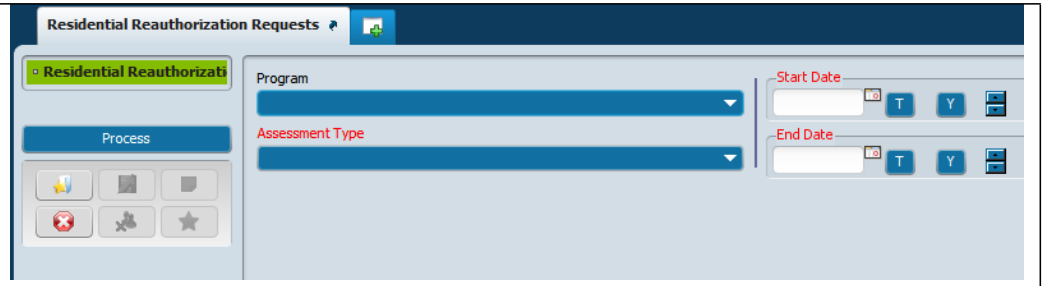
Select Program

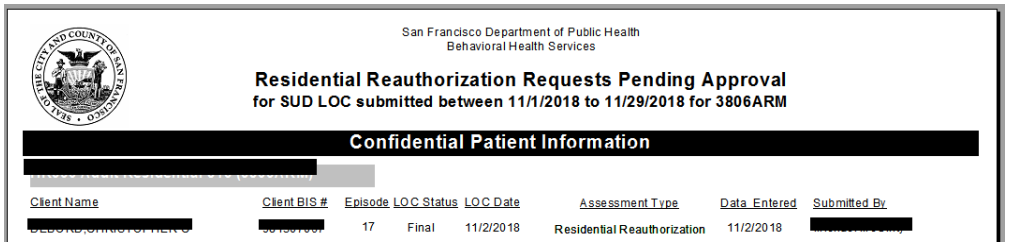
Select Assessment Type
Start Date

End Date

Report Output

Program





San Francisco Department of Public Health
Behavioral Health Services

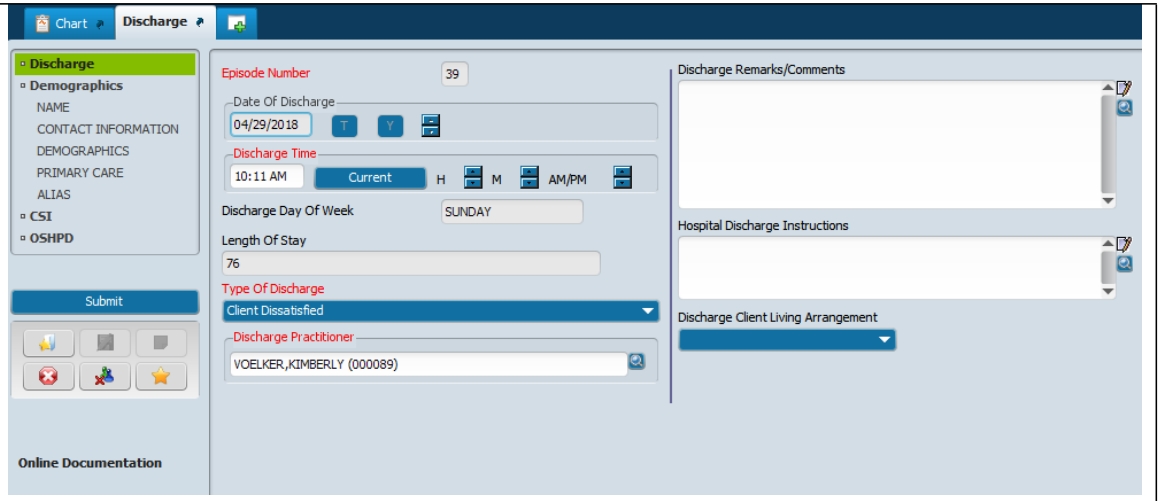
Residential Reauthorization Requests Pending Approval
for SUD LOC submitted between 11/1/2018 to 11/29/2018 for 3806ARM

Confidential Patient Information

Client Name	Client BIS #	Episode	LOC Status	LOC Date	Assessment Type	Data Entered	Submitted By
[redacted]	[redacted]	17	Final	11/2/2018	Residential Reauthorization	11/2/2018	[redacted]

Discharge Form

This form is used to discharge the client and close the episode.



Residential Console/Widgets

The Residential Console is a type of dashboard that alerts the clinician in real time the status of various forms. The client is information displayed is by the caseload of the clinician.

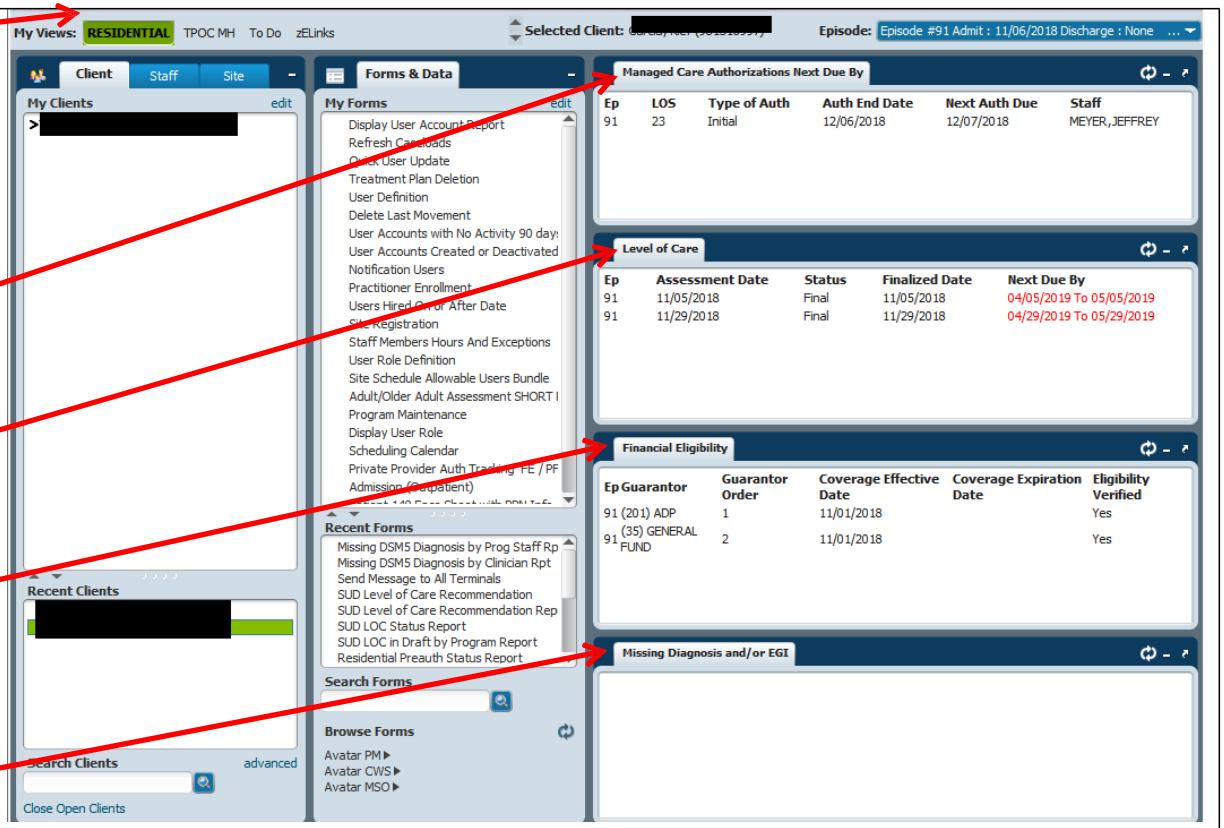
Managed Care Authorizations Next Due By Widget

This widget provides information on client's authorizations.

Level of Care Widget

This widget provides information on the status of their LOC.

Financial Eligibility



Note: A caseload is defined in Avatar as clients that appear in your "My Clients" list.

Section 13: Withdrawal Management

Withdrawal Management Overview

Each county participating under the DMC-ODS pilot program must assess clients for the need for and provide withdrawal management (WM) or detox services.

WM services are provided as part of a continuum of five ASAM WM levels when determined medically necessary by a Medical Director or LPHA acting within his/her professional scope of practice, and in accordance with an individualized client plan. Medically necessary habilitative and rehabilitative services are provided in accordance with the individualized treatment plan prescribed by a licensed physician or licensed prescriber (Intergovernmental Agreement: Exhibit A, Attachment 1 A2: 1.12.). In San Francisco, ASAM Level 1-WM and Level-3.2 WM services are provided. See chart at the end of this section for descriptions of the ASAM WM levels of care.

Each client must reside at the facility if receiving a residential service and must be medically monitored during the detoxification process (Intergovernmental Agreement: Exhibit A, Attachment 1 A2: 1.12.). WM services delivered in a residential setting can be provided in facilities with no bed capacity limit under the DMC-ODS (Intergovernmental Agreement: Exhibit A, Attachment 1 A2: I.8.).

WM Client Consent

Each client must attest to voluntary participation in a program by providing written documentation of his/her informed consent (9 CCR § 10290). The program must ensure that the client reads and understands the consent form, explain program rules, and supply the client with copies of the consent form and program rules.

If a client is admitted to a new treatment episode after a previous episode of treatment was terminated by the program physician and the discharge was noted in the client's record, the program client reissue rules and instructions to the client and require that the client resign the consent form.

WM Client Orientation Requirements

Programs must advise clients of the nature and purpose of treatment which must include, but not be limited to, the following information (9 CCR §10280):

1. The addicting nature of medications used in replacement narcotic therapy.
2. The hazards and risks involved in replacement narcotic therapy.
3. The client's responsibility to the program.
4. The program's responsibility to the client.
5. The client's participation in the program is wholly voluntary and the client may terminate his/her participation in the program at any time without penalty.
6. The client will be tested for evidence of use of opiates and other illicit drugs.
7. The client's medically determined dosage level may be adjusted without the client's knowledge, and at some later point the client's dose may contain no medications used in replacement narcotic therapy.
8. Take-home medication which may be dispensed to the client is only for the client's personal use.

9. Misuse of medications will result in specified penalties within the program and may also result in criminal prosecution.
10. The client has a right to a humane procedure of withdrawal from medications used in replacement narcotic therapy and a procedure for gradual withdrawal is available.
11. Possible adverse effects of abrupt withdrawal from medications used in replacement narcotic therapy.
12. Protection under the confidentiality requirements.

Client acknowledgement of orientation must be documented in the client record.

WM Perinatal Orientation Requirements
Each program shall provide the following orientation to female clients of childbearing age **(**9 CCR §10285):

1. Knowledge of the effects of medications used in replacement narcotic therapy on pregnant women and their unborn children is presently inadequate to guarantee that these medications may not produce significant or serious side effects.
2. These medications are transmitted to the unborn child and may cause physical dependence.
3. Abrupt withdrawal from these medications may adversely affect the unborn child.
4. The use of other medications or illicit drugs in addition to medications used in replacement narcotic therapy may harm the client and/or unborn child.
5. The client should consult with a physician before nursing.
6. The child may show irritability or other ill effects from the client's use of these medications for a brief period following birth.

Client acknowledgement of orientation must be documented in the client record.

WM Medical Evaluation
Before admitting an individual to WM treatment, the medical director must either conduct a medical evaluation or document his or her review and concurrence of a medical evaluation conducted by a LPHA acting within their scope of professional practice. At a minimum, documentation of **all** the following must be in the client record:

1. A medical history which includes the individual's history of illicit drug use;
2. Laboratory tests for determination of narcotic drug use, tuberculosis, and syphilis (unless the medical director has determined the individual's subcutaneous veins are severely damaged to the extent that a blood specimen cannot be obtained); and
3. A physical examination which includes:
    a. An evaluation of the individual's organ systems for possibility of infectious diseases; pulmonary, liver, or cardiac abnormalities; and dermatologic sequelae of addiction;
    b. A record of the individual's vital signs (temperature, pulse, blood pressure, and respiratory rate);

c. An examination of the individual's head, ears, eyes, nose, throat (thyroid), chest (including heart, lungs, and breasts), abdomen, extremities, skin, and general appearance;
d. An assessment of the individual's neurological system; and
e. A record of an overall impression which identifies any medical condition or health problem for which treatment is warranted.

Before admitting an individual to either detoxification treatment, the medical director must:

1. Document the evidence, or review and concur with the LPHA's documentation of evidence, used from the medical evaluation to determine physical dependence and addiction to opiates; and
2. Document his or her final determination concerning physical dependence and addiction to opiates.

WM Intake Screening Criteria

The program must determine which clients with an addiction to opiates are accepted as clients for detoxification treatment, subject to the following minimum criteria which must be documented in each client's record:

1. Certification of fitness for replacement narcotic therapy by a physician.
2. Determination by a program physician that the client is currently physically dependent on opiates. Evidence of current physical dependence in the client record must include:
   a. Observed signs of physical dependence, which must be clearly and specifically noted in the client's record.
   b. Results of an initial test or analysis for illicit drug use must be used to aid in determining current physical dependence, and must be noted in the client's record. Results of the initial test or analysis may be obtained after commencement of detoxification treatment.
3. Clients under the age of 18 years must have the written consent of their parent(s) or guardian prior to the administration of the first medication dose.
4. At least seven days must have elapsed since termination of the immediately preceding episode of detoxification treatment. A program may not knowingly admit a client who does not satisfy this requirement.
5. The client's signed statement that at least seven days have elapsed since termination of the immediately preceding episode of detoxification treatment may, if reliable, be acceptable evidence of compliance with the requirements of subsection (c)(4) above.
6. The client is not in the last trimester of pregnancy.

WM Client Treatment Plans
The primary counselor shall enter in the client's record his or her name and the date the client was assigned to the counselor.

Programs shall develop an individualized treatment plan for each client which shall include:

1. Provisions to assist the client to understand illicit drug addictions and how to deal with them.
2. Provisions for furnishing services to the client as needed when the period of detoxification treatment is completed.
3. The treatment services required and a description of the role they play in achieving the stated goals.
4. The type and frequency of scheduled counseling services.

WM Client Record Documentation Requirements
Each program shall document the following information in the individual client's record:

1. The client's birth date.
2. Physical examination data, including laboratory results for required tests and analyses.
3. Evidence of current use of heroin or other opiates.
4. Date of admission to the program, plan of treatment, and medication orders signed by the physician.
5. The program's response to a test or analysis for illicit drug use which discloses the absence of both methadone and its primary metabolite (when prescribed by the medical director and program physician), the presence of any illicit drugs, or abuse of other substances, including alcohol.
6. Incidence of arrest and conviction or any other signs of retrogression.
7. Any other client information which the program finds useful in treating the client.

In addition to the requirements set forth above, records for clients in detoxification shall contain the following:

1. Documentation of services and treatment provided, as well as progress notes signed by the physician, nurse, or counselor, test or analysis results for illicit drug use; and periodic review or evaluation by the medical director.
2. For clients who have completed the program, a discharge summary and follow-up notations to allow determination of success or failure of treatment and follow-up.

Medication Documentation
The medical director or program physician shall individually determine each client's medication schedule based on the following criteria (9 CCR § 10355):

1. Medications shall be administered daily under observation;
2. Dosage levels shall not exceed that which is necessary to suppress withdrawal symptoms; and
3. Schedules shall include initial, stabilizing, and reducing dosage amounts for a period of not more than 21 days.

The medical director or program physician must record, date, and sign in the client's record each change in the dosage schedule with reasons for such deviations.

Detoxification Dosage Levels Specific to Methadone
The first-day dose of methadone shall not exceed 30 milligrams unless:

1. The dose is divided and the initial portion of the dose is not above 30 milligrams; and
2. The subsequent portion is administered to the patient separately after the observation period prescribed by the medical director or program physician.

The total dose of methadone for the first day shall not exceed 40 milligrams unless the medical director or program physician determines that 40 milligrams is not sufficient to suppress the client's opiate abstinence symptoms, and documents in the client's record the basis for his/her determination.

WM Client Test or Analysis for Illicit Drug Use Documentation
Each program shall maintain test or analysis records for illicit drug use which contain the following information for each client (9 CCR § 10330):

1. The date the client body specimen was collected;
2. The test or analysis results; and
3. The date the program received the results of the test or analysis.

When a client fails to provide a body specimen when required, the program must proceed as though the client's sample from his or her body specimen disclosed the presence of an illicit drug(s). Such failures must be noted in the client's records (9 CCR § 10335).

WM Client Attendance Documentation
A client must report to the same program to which he or she was admitted unless prior approval is obtained from the client's medical director or program physician to receive services on a temporary basis from another narcotic treatment program (9 CCR Section 10295 The approval shall be noted in the client's record and must include the following documentation:

1. The client's signed and dated consent for disclosing identifying information to the program which will provide services on a temporary basis;
2. A medication change order by the referring medical director or program physician permitting the client to receive services on a temporary basis from the other program for a length of time not to exceed 30 days; and
3. Evidence that the medical director or program physician for the program contacted to provide services on a temporary basis has accepted responsibility to treat the visiting client, concurs with his or her dosage schedule, and supervises the administration of the medication, subject to Section 10210(d).

WM Client Absence Documentation
If a client in detoxification treatment misses appointments for three consecutive days or more without notifying the program, the client's episode of treatment may be terminated by the medical director or program physician and the discharge must be noted in the client record (9 CCR § 10300).

A client in detoxification treatment that is discharged may be continued in treatment by the program physician if medically indicated, based upon establishment of a legitimate reason for absence. The reasons for continuation of treatment must be documented in the client's record (9 CCR § 10300).

Voluntary and Involuntary Client Participation & Discharge Summary Documentation

A client may voluntarily terminate participation in a program even though termination may be against the advice of the medical director or program physician (9 CCR § 10415). If the medical director or program director determines that the client's continued participation in the program creates a physically threatening situation for staff or other clients, the client's participation may be terminated immediately.

A client's participation in a program may be involuntarily terminated by the medical director or program physician for cause. If a program utilizes disciplinary proceedings which include involuntary termination for cause, the program shall include in its protocol reasons and procedures for involuntarily terminating a client's participation in the program. The procedures shall provide for:

1. Explanation to the client of when participation may be terminated for cause.
2. Client notification of termination.
3. Client's right to hearing.
4. Client's right to representation.

Either voluntary or involuntary termination shall be individualized, under the direction of the medical director or program physician, and take place over a period of time not less than 15 days, unless:

1. The medical director or program physician deems it clinically necessary to terminate participation sooner and documents why in the client's record;
2. The client requests in writing a shorter termination period; or
3. The client is currently within a 21-day detoxification treatment episode.

Discharge Summary Documentation

The program must complete a discharge summary for each client who is terminated from treatment, either voluntarily or involuntarily. The discharge summary must include at least the following:

1. The client's name and date of discharge;
2. The reason for the discharge; and
3. A summary of the client's progress during treatment.

San Francisco Health Network

SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

Monitored 3.2 Residential Withdrawal Management Protocol
(Rev. 3.04.19)

Admissions and Intake

Admission to program is open to all adult San Francisco residents needing Withdrawal Management services from alcohol and/or other drugs that meet medical necessity according to ASAM criteria.

Timely Access

Beneficiaries who are seeking Withdrawal Management Services shall be entered into the Timely Access Log in Avatar when they initially request services to facilitate collection and reporting of the required information.

For Withdrawal Management Services that may be urgently needed as defined by the ASAM Criteria dimension(s) 1, 2 and/or 3 severity ratings and is considered a “crisis”, referral to WM services should be available to anyone who needs these services, and qualifies based on medical necessity, including individuals who may not be San Francisco residents.

Beneficiaries can access the WM service modality by coming to the intake department at HR360, 1563 Mission Street, in person Monday through Friday 8:45 a.m. - 5:00 p.m. Beneficiaries should arrive early as these beds are limited and are filled on a first come first serve basis daily. Referrals from San Francisco Treatment Access Program (TAP) are also accepted in addition to other community organizations and hospitals.

During the admission process each beneficiary receives a brief screening for substance use, mental health, and physical health problems.

Withdrawal Management Screening

Screening shall include:

- Basic Demographics
- Recent Drug Use
- Medications
- Withdrawal Symptoms
- ASAM Dimension 1: Acute Intoxication and/or Withdrawal Potential
- ASAM Dimension 2: Medical Conditions and Complications
- ASAM Dimension 3: Emotional Behavioral or Cognitive Conditions & Complications

Beneficiaries are also assessed through a more structured interview process to collect additional information related to behavioral risks, treatment history and housing status.

Depending upon the type of information gathered, beneficiaries may be referred for further evaluation to ensure safety of placement in the Withdrawal Management facility.

In instances where substance use withdrawal or mental health symptoms indicate possible inappropriateness for admission, a complete and thorough evaluation will be performed by a Health Coordinator or Licensed Clinician LPHA will evaluate persons seeking services who present with unstable or decompensating biomedical or psychiatric conditions or symptoms.

In instances where emergency services are indicated staff will contact 911 to ensure the most appropriate care possible.

Staffing

1. For every 15 clients receiving Withdrawal Management services there shall always be a least one awake staff member on duty with a current cardiopulmonary resuscitation certificate and current first aid training.

2. A LPHA and/or the Medical Director will also support or have oversight of Withdrawal Management services.

Practices

1. A Level of Care (LOC) Assessment will be performed for each client upon admission to Withdrawal Management services.

2. Staff will perform a face to face observation of each client receiving Withdrawal Management services at least every 30 minutes during the first 72 hours following admission.

    a) Documentation of observations and physical checks shall be recorded on the designated log and signed by the program staff.

    b) Only staff that has been trained in the provisions of Withdrawal Management services may conduct and record observations and physical checks. Training shall include information on Withdrawal Management medications, signs and symptoms that require referral to a higher level of care. Copies of training records shall be kept in staff training files.

3. At least one staff member trained to provide Withdrawal Management services shall be assigned to the observation of Withdrawal Management clients at all times.

4. After 24 hours, close observations and physical checks may be discontinued or reduced based upon a determination by the LPHA or Medical Director. Documentation of the information that supports a decrease in close observation and physical checks shall be recorded in the beneficiary's file.

Documentation

1. The observation log will be completed by staff and entered in to the client record.

2. Documentation of justification for reduction of observations can be determined by the LPHA or Medical Director. Documentation will be completed by the LPHA or Medical Director who makes the determination.

3. At minimum the following will be documented:
    a. Beneficiary's name
    b. Purpose of service (as it related to LOC)
    c. Description of how service relates to the beneficiary's treatment plan- per a treatment plan progress note.
    d. Date, start and end time of services.
    e. Printed or typed and signed name of Medical Director or LPHA

Discharge Planning and Referrals

Discharge planning, referral to another level of care and linkage to community service providers begins during stabilization and is based upon the need of each beneficiary. All beneficiaries interested in participating in ongoing treatment services and meet medical necessity should be referred to another level of care whenever is possible, based upon need and preference. Referrals should be made as appropriate.

ASAM Withdrawal Management Level of Care Descriptions

San Francisco offers 1-WM Ambulatory Withdrawal Management without extended on-site monitoring and 3.2 – WM Residential/Inpatient Withdrawal Management. See descriptions below.

ASAM Level	Description	Provider	Certification/License Required
1 – WM Ambulatory Withdrawal Management without extended on-site monitoring	Mild withdrawal with daily or less than daily outpatient supervision.	DHCS Certified Outpatient Facility	• AOD Certification with a non-residential detox service authorization • DMC Outpatient Certification
2 – WM Ambulatory Withdrawal Management with extended on-site monitoring	Moderate withdrawal with all day withdrawal management and support and supervision; at night has supportive family or living situation.	DHCS Certified Outpatient Facility	• AOD Certification with a non-residential detox service authorization • DMC Outpatient Certification
3.2 – WM Residential/Inpatient Withdrawal Management	Moderate withdrawal, but needs 24-hour support to complete withdrawal management and increase likelihood of continuing treatment or recovery.	DHCS Licensed Residential Facility	• DHCS Residential License with detox service authorization • DMC Residential Certification
3.7 – WM Medically Monitored Inpatient Withdrawal Management	Severe withdrawal, needs 24-hour nursing care & physician visits; unlikely to complete withdrawal management without medical monitoring.	Chemical Dependency Recovery Hospital or Free Standing Psychiatric Hospital	• Licensure by Department of Public Health
4 – WM Medically Managed Intensive Inpatient Withdrawal Management	Severe, unstable withdrawal and needs 24-hour nursing care and daily physician visits to modify withdrawal management regimen and manage medical instability.	Chemical Dependency Recovery Hospital or Free Standing Psychiatric Hospital	• Licensure by Department of Public Health

Section 14: Recovery Services

Recovery Services Overview

Recovery services are important to clients in the recovery and wellness process. As part of the assessment and treatment needs of Dimension 6, Recovery Environment of the ASAM Criteria, and during the transfer/transition planning process, clients must be linked to applicable recovery services. Treatment is designed to emphasize the client's central role in managing their health, promote the use of effective self-management support strategies, and provide internal and community resources to support ongoing self-management (Intergovernmental Agreement, Exhibit A, Attachment I A2: IV.A.100).

Community-Based Recovery and Wellness Services must be provided face-to-face, by telephone or via telehealth to support transfers and transitions for clients that are provided whether a client has been triggered, relapsed, or as a preventative measure to prevent relapse (Intergovernmental Agreement, Exhibit A, Attachment I A2: V.M).

Required Components of Recovery Services

The required components of recovery services include all of the following (Intergovernmental Agreement, Exhibit A, Attachment I A2: V.M):

1. Individual and Group Outpatient Counseling to stabilize the beneficiary and reassess if further care is needed;
2. Recovery Monitoring: recovery coaching and monitoring via telephone/ telehealth;
3. Substance Abuse Assistance: peer-to-peer services and relapse prevention;
4. Support for Education and Job Skills: linkages to life skills, employment services, job training, and education services;
5. Family Support: linkages to childcare, parent education, child development support services, and family/marriage education;
6. Support Groups: linkages to self-help and faith-based support; and
7. Ancillary Services: linkages to housing assistance, transportation, case management, and individual services coordination.

In San Francisco, recovery care management will be utilized though primary care and behavioral health homes to manage client maintenance of well-being and recovery (Intergovernmental Agreement: Exhibit A, Attachment 1, Section D). Documentation of client linkage to primary care and behavioral health homes must be included in the client record.

A Recovery Plan must be completed for each client and documented in the client record.

Authorized Providers of Recovery Services

Recovery services may be provided by a LPHA, certified/registered counselor, or peers when provided as substance abuse assistance services as a component of recovery services. Any site offering recovery services must be certified as a DMC provider. This does not mean that services must be provided at the certified site; services may be provided in the community.

Client Access to Recovery Services & Recovery Plan
Clients may access medically necessary recovery services after completing their course of treatment. Services are available to clients whether they are triggered, have relapsed, or as a measure to prevent relapse. Services must be provided in the context of an individualized recovery plan that includes specific goals. This may include the plan for ongoing recovery and relapse prevention that was developed during discharge planning when treatment was completed. Medical necessity criteria for recovery services must be appropriately documented in the client record.

If a client is receiving medication assisted treatment services through a Narcotic Treatment Program (NTP), the client must access any related counseling services through the NTP provider since counseling and other supports are included as part of the NTP program. For clients receiving medication assisted treatment in non-NTP-settings, such as primary care settings, the clients may access recovery services as necessary through certified DMC providers after their course of treatment (other than ongoing medication support) has been completed (DHCS Recovery Services FAQs, Revised November 2018).

Delivery Modes of Recovery Services
Recovery services can be provided to a client to support client transfers and transitions: a) face-to-face; b) by telephone; c) via telehealth; or d) in the community. If provided in the community, the provider delivering the service must be linked with a physical site/facility that is DMC-certified and ensure that client confidentiality is protected (DHCS Recovery Services FAQs, Revised November 2018).

Residential Step-Down (RSD) Recovery Services
RSD Overview
Residential Step-Down (RSD) is a service component of the San Francisco Health Network- Behavioral Health Services (SFHN-BHS) substance use disorder (SUD) continuum of care which promotes the wellness and recovery of individuals with substance use and related disorders. Residential step-down programs are sub-acute, short-term, residential services that provide support and access to outpatient treatment in a 24-hour staffed, open home-like environment.

RSD services are available to clients who are stepping down from inpatient/ residential substance use disorder treatment. Clients must be concurrently in treatment, specifically in outpatient (OP), intensive outpatient (IOP), Opioid Treatment Program (OTP), or Outpatient (aka: Ambulatory) Withdrawal Management (OP-WM) settings. RSD provides temporary, drug and alcohol-free environment to residents that are actively engaged in outpatient treatment for medically necessary SUD provided to the client off-site.

The core goal of RSD is to provide a safe living space that is supportive of recovery for clients who are transitioning to longer term treatment in the community, often after more restrictive residential treatment, and are receiving OP/IOP/OTP/OP-WM treatment for their SUD.

RSD Treatment Population
RSD is available for young adults (ages 18-20) and adults (ages 21+) who are:

1. In need of a stable, safe environment in order to best support their recovery from a SUD; and
2. Concurrently enrolled in OP/IOP/OTP/OP-WM treatment settings.

RSD services for families with children must ensure childcare is provided by licensed professionals, and recovery, case management, family/child, and parenting ancillary services are accessible. For perinatal clients, the DHCS Perinatal Treatment Guidelines FY 2018-19 must be followed. For adolescent clients, the ASAM Criteria for adolescent treatment must be followed.

Eligible clients are medically and psychiatrically stable enough to benefit from RSD and outpatient treatment. Program participation is self-initiated for clients choosing abstinence-focused RSD.

Client Priorities for Admission
The following high-risk client populations need to be prioritized for RSD at the SUD treatment provider level according to the following ranking:

1. Perinatal clients;
2. People who injected drugs;
3. People defined as 'high utilizers';
4. Chronically homeless;
5. Certain non-AB 109 criminal justice clients without alternative criminal justice funding for recovery housing;
6. Young Adults (aged 18 to 20);
7. People with HIV/AIDS;
8. Residential step down (homeless clients stepping down from residential treatment into RSD); and
9. Lesbian, gay, bisexual, transgender, questioning, queer, intersex, pansexual, two-spirit, androgynous, and asexual (LGBTQQIP2SAA) populations.

Undocumented homeless adults who meet the prioritization criteria listed above are eligible for placement in RSD. Clients who fall outside of the prioritized list will be authorized for RSD if sufficient capacity is available to accommodate prioritized populations.

Programs emphasize the personal recovery goals of participants and long-term housing stability so as to minimize the likelihood of homelessness. Program design establishes minimal barriers for entry into programs.

RSD Service Components
Clients are continually assessed for beneficial ancillary services such as linkages to primary care, government benefits, family reunification, legal, mental health, and other services based on needs. Holistic services and peer-based supports are available to all clients in addition to other recovery services.

Relapse is not treated as an automatic cause for eviction from housing or termination from the program. Clients who determine they are no longer interested in RSD or who are discharged from the program are offered assistance in accessing other service options.

RSD Length of Stay
Length of stays are limited to short-term episodes, up to 24 months.

RSD Staffing Levels and Responsibilities
At a minimum, staff must be responsible for the safety of the building, available to maintain records, to admit and discharge residents, and to maintain rules of the house. Programs may choose to have other staff available such as cooks, groundskeepers, and licensed child care except where perinatal clients are served, child care must be provided while pregnant and parenting women are receiving recovery services. Staff shall not provide any direction to clients but shall be available for appropriate management of the physical plant.

RSD Required Documentation
The following documentation must be included in the client record in addition to a weekly progress note and other documentation requirements found in this manual:

1. Admission
2. Intake Assessment
3. Program Consent Form including 42CFR release;
4. Consent to Treatment Form
5. Complaint/Grievance/HIPAA Form; and
6. Client Rights Form.

Section 15: Additional Medication Assisted Treatment

Medication Assisted Treatment (MAT) is the use of prescription medications, in combination with counseling and behavioral therapies, to provide a whole-person approach to the treatment of specific substance use disorders. Care coordination and linkage to other services and supports are critical services provided to clients receiving MAT, including regular communication with the physicians of the clients who are prescribed these medications, unless the client chooses not to consent to signing a 42 CFR Part 2-compliant release of information for this purpose.

Additional MAT Services Covered under DMC-ODS

Medication Assisted Treatment is the use of prescription medications, in combination with counseling and behavioral therapies, to provide a whole-person approach to the treatment of specific substance use disorders. Research shows that a combination of MAT and behavioral therapies is a successful method to treat SUD. In particular, opioid and alcohol dependence have well-established medication options.

Counties contracting to participate in DMC-ODS may choose to offer additional MAT beyond the required NTP services. Additional MAT includes the ordering, prescribing, administering, and monitoring of all medications for SUDs. These are medically necessary services that are provided in accordance with an individualized treatment plan determined by a licensed physician or licensed prescriber.

The S.F. Department of Public Health has elected to provide: 1) Alcohol MAT (naltrexone – also available for opioid use disorder, acamprosate, and disulfiram); 2) Buprenorphine MAT within primary care and behavioral health clinics, for OBIC patients during stabilization, and residential care and residential detoxification; and Naltrexone MAT injected for alcohol and either oral or injected for alcohol or opioid use disorder.

MAT Care Coordination and Service Linkage Documentation

Additional MAT Providers are required to assure care coordination and linkage to other services and supports for clients receiving MAT. Provider staff must maintain regular communication with the physicians of clients who are prescribed these medications, unless the client chooses not to consent to signing a 42 CFR Part 2-compliant release of information for this purpose. Residential and outpatient facilities cannot deny a client utilizing or needing MAT from program participation.

Although DHCS has not indicated specific documentation requirements for Additional MAT Services, DPH believes it is prudent to document communication with physicians and other providers, as well as service referral linkages, in the client record.

In addition, the *January 2018 DPH CBHS Pharmacy Services Manual* includes the "Approaches to Opioid Use Disorder Medication-Assisted Treatment Guideline (CBHS Pharmacy Services Manual)" which offers insights on client record documentation. At a minimum, the following should be documented in the client record:

1. Identification of any urgent or emergent medical or psychiatric crises that required immediate attention and/or a transfer to a higher level of care;
2. Components of a comprehensive assessment including, at a minimum:
    a. Client Medical History including
        i. Review of systems, past diagnoses, pregnancy status, chronic conditions (HIV, viral or alcoholic hepatitis, diabetes, chronic pain conditions, thyroid, etc.), current medications and adherence, relevant family history, and allergies;
        ii. Sexual transmitted infections or diseases (STI/STD) risks/exposure (e.g., sharing needles, sex work, unprotected sex); and
        iii. Treatment history and pharmacotherapy history.
    b. Physical Examination including:
        i. Signs of intoxication and withdrawal; and
        ii. Findings of Opioid Use Disorder or other substance use disorder(s);
    c. Diagnostics including:
        i. Labs: Hepatitis serologies, HIV, STIs, tuberculosis, pregnancy, complete blood count and liver function tests
        ii. Urine drug screen
        iii. Breathalyzer (as appropriate)
        iv. Prescription Drug Monitoring Program (CURES in California)
    3. MAT pharmacotherapy provided to the client;
    4. Client co-occurring mental health disorders;
    5. Client co-occurring chronic pain;
    6. Client co-occurring HIV; and
    7. Documentation of counseling provided to pregnant/lactating client on the risks and benefits of MAT treatment;
    8. Documentation of providing a “Take-Home Naloxone Kit” to a client, including documentation of education provided to the client and the client’s family and friends on how to identify and respond to an opioid overdose.

A copy of the “Approaches to Opioid Use Disorder Medication-Assisted Treatment Guideline” follows.

Approaches to Opioid Use Disorder Medication-Assisted Treatment Guideline

SCOPE: This Approaches to Opioid Use Disorder Medication-Assisted Treatment (OUD MAT) Guideline is intended to offer prescribing assistance for providers, clients and the interested general public to increase the effectiveness and safety of OUD MAT use in the ambulatory care setting. It is not intended to be comprehensive in scope. These recommendations are not a substitute for clinical judgment, and decisions about care must carefully consider and incorporate the clinical characteristics and circumstances of each individual patient.

INTRODUCTION: The American Society of Addiction Medicine (ASAM) defines opioid use disorder (OUD), also known as opioid addiction, as a "primary, chronic disease of brain reward, motivation, memory, and related circuitry." OUD requires ongoing attention to the affected physical, psychological, social and spiritual areas of an individual's life. Opioids are a group of drugs that include heroin and prescription pain relievers including morphine, hydrocodone, oxycodone, hydromorphone, methadone, fentanyl and others. In 2015, heroin use disorder affected 0.2% and pain reliever use disorder affected 0.7% of people 12 years and older in the US. Locally in San Francisco, 5% of persons over the age 12 reported non-prescribed use of pain relievers between 2012 and 2014. In San Francisco public high- school students, 13% reported use of prescription drugs in 2015.

Opioids are associated with increased risk of death. In 2014, unintentional drug overdose was the leading cause of unintentional death in the United States at 14.7 per 100,000. The majority of the overdoses involved opioids at 9.0 per 100,000. This is a 200% increase in overdoses from 2000. In addition, opioid use is associated with increased risk of death due to injury from motor vehicle accidents and homicide.

Opioids are also associated with increased risk of multiple medical conditions. Opioids can lead to decreased gut motility and constipation. Taking opioids use can lead to sexual dysfunction including erectile dysfunction in men and changes in menstruation in women. Syringe and paraphernalia sharing or high risk behaviors such as unprotected sex can lead to multiple additional medical conditions. This includes viral infections, such as HIV, hepatitis C, hepatitis B, tetanus, botulism, and tuberculosis. Injecting contaminated drugs and/or non-sterile injection techniques can lead to infections of the skin, heart and bones. Injecting drugs can cause scarring on veins and, if severe enough, result in swelling in the legs.

A range of interventions should be considered for all people with OUD, including assessment of withdrawal, management of detoxification, and long-term strategies to reduce the medical and psychosocial harms of OUD. Retention in treatment is an important goal in order to address the OUD as well as any co-occurring conditions that resulted from injecting opioids or jeopardize a person's treatment success.

Medication-Assisted Treatment (MAT) refers to the combination of medication therapy with counseling or behavioral interventions. MAT for OUD is recommended for those with moderate to severe OUD who are unsuccessful at ceasing opioid use without the assistance of medication or at risk for relapse.

While medication remains the cornerstone for treating the physiology of opioid dependence, withdrawal and cravings, non-medication supports and services are necessary components in the comprehensive treatment of OUD. A range of treatment modalities should be considered, including, but not limited to, cognitive behavioral therapy, intensive outpatient programs and residential treatment.

OPIOID WITHDRAWAL: The neurobiology of opioid withdrawal typically does not include the serious and life-threatening symptoms that may be common with prolonged and heavy alcohol or benzodiazepine use. However, it is crucial that patients are provided with a humane and tolerable withdrawal experience that preserves their dignity and safety. Failure to do so may lead to patient relapse, overdose or abandonment of treatment, and may be experienced as a lack of empathy or concern for their well-being.

The symptoms of opioid withdrawal are experienced as the opposite of this class's pharmacologic effect (See Appendix 2 for review of opioid withdrawal symptoms). However, the onset, duration and intensity of the withdrawal is variable and dependent upon the particular agent used, the duration of use, and the degree of neuroadaptation. The severity of withdrawal experienced may also be influenced by numerous other factors, including conditions such as mood, anxiety, trauma, stress and tolerance.

EVALUATION: ASAM describes the comprehensive assessment and diagnosis of OUD that occurs during the initial phase of treatment as "a crucial aspect of patient engagement and treatment planning." The initial task should include the identification of urgent or emergent medical or psychiatric crises that may require immediate attention and/or a transfer to a higher level of care. The components of a comprehensive assessment are detailed below.

Medical History

- Review of systems, past diagnoses, pregnancy status, chronic conditions (HIV, viral or alcoholic hepatitis, diabetes, chronic pain conditions, thyroid, etc.), current medications and adherence, relevant family history and allergies
- Sexual transmitted infections or diseases (STI/STD) risks/exposure (e.g., sharing needles, sex work, unprotected sex)
- Treatment history, pharmacotherapy history

Physical Examination

- Include signs of intoxication & withdrawal
- Include findings common with OUD or other substance use disorder

Diagnostics

- Labs: Hepatitis serologies, HIV, STIs, tuberculosis, pregnancy, complete blood count and liver function tests
- Urine drug screen
- Breathalyzer (as appropriate)
- Prescription Drug Monitoring Program (CURES in California)

OPIOID WITHDRAWAL MANAGEMENT: In general, opioid withdrawal management alone is not recommended due to significant relapse rates, especially in those with moderate and severe OUD. However, monitored inpatient or residential opioid withdrawal management may be necessary to ensure safety for individuals with severe or poorly managed co-occurring medical, psychiatric or cognitive conditions, and/or for individuals concurrently using other central nervous system (CNS) depressants. Facilitating linkage to appropriate long-term recovery support should occur as a treatment plan component. While opioid withdrawal management alone should not be considered adequate treatment, it may be included as the first of a series of step-wise interventions that include evaluation, stabilization and fostering readiness for and entry into treatment, as is the ASAM recommendation for all addictions.

LEVEL OF CARE SELECTION: Several factors should be considered when selecting level of care. This includes functional status indicators such as mental health conditions, co-occurring use disorders, housing and employment status, and community and family supports.

Opiate Treatment Program (OTP): In the OTP, patients remain under daily management for MAT until such time as they earn take-home doses. In addition, there is required counseling and urine drug screening. While the OTP has become synonymous with methadone, recent expansion of buprenorphine to the OTP setting expands medication options for treatment at this level of care. OTP-based buprenorphine or methadone is considered a higher level of care than office-based treatment (OBOT) by providing more structure and oversight. Buprenorphine and methadone provided in an OTP will not appear on CURES due to privacy requirements for substance abuse treatment programs. A benefit of OTP is that these clinics are generally open at earlier hours than primary care clinics and community pharmacies, therefore patients who require OUD MAT before work or during their lunch break may best be served by an OTP. Some OTPs offer directly observed therapy (DOT) of medications other than OUD MAT including alcohol use disorder MAT, psychiatric medications, HIV treatment medications, hepatitis C treatment medications and others. DOT may benefit patients who have difficulty with medication adherence.

Office-Based Opioid Treatment (OBOT): Buprenorphine's originally intended use under Drug Addiction Treatment Act (DATA) 2000 was office-based opioid treatment (OBOT) rather than in the OTP setting. When considering buprenorphine for an office-based patient, an assessment of psychosocial functioning is crucial and should include the patient's capacity and ability to safely store medication, adhere with dosing instructions and an exploration of prior MAT treatment history, if any. Patients well-suited for OBOT buprenorphine typically are psychiatrically stable and show no evidence of concurrent

substance use patterns that negatively impact their ability to engage in treatment. Patients with moderate to severe ETOH and/or sedative use disorders may benefit from the higher level of care found in OTP. Housing, employment and social and/or family support are important factors in recovery and be indicators of psychosocial stability. Alternatively, loss of dispensed buprenorphine may indicate diversion or the presence of functional impairments that preclude participation in office-based treatment.

OUD MAT PHARMACOTHERAPY SELECTION: Three medications, methadone, buprenorphine and naltrexone, are approved by the US Food and Drug Administration. Buprenorphine and methadone are indicated for the treatment of OUD and naltrexone is indicated for relapse prevention of OUD. (See Appendix 1). The effect of each medication is through effects on the mu opioid receptor and each agent has demonstrated decreased time to relapse to non-prescribed opioids. Beyond this, the agents differ in their mechanism of action and respective treatment outcomes.

The two major medications available for the treatment of OUD are buprenorphine and methadone. Choice between these agents is based on availability in the chosen level of care. Methadone, and possibly buprenorphine, are available in OTPs, while buprenorphine is available for OBOT. Additional considerations include patient preference, past treatment experience with OUD MAT, level of motivation, their medical status and contraindications for each medication. For example, in a patient with underlying QTc prolongation, buprenorphine is a safer option. For a list of contraindications and cautions for each agent, see Appendix 1.

For relapse prevention in a patient who has successfully completed opioid detoxification, naltrexone has been shown to be an effective choice for the highly motivated, high functioning individual willing to engage in the requirements of therapy. Barriers to effective treatment with naltrexone include continued opioid use vis a vis an inability to abstain long enough to achieve the required full two-week post-detoxification period necessary to initiate the medication. Failure of the medication to reduce opioid cravings may be related to treatment efficacy outcome or poor medication adherence.

CO-OCCURRING MENTAL ILLNESS: As complex brain diseases, substance use and psychiatric disorders share common genetic and environmental risk factors and brain pathways, contributing to the challenge of accurate assessment of either. However, the identification of co-occurring OUD and psychiatric conditions is crucial to developing appropriate interventions to address the complex interaction between both conditions. Inadequate or absence of treatment of the brain based diseases affecting the patient will negatively impact the course and prognosis of recovery. Accordingly, a fundamental principle of effective OUD emphasizes the need for comprehensive treatment of both conditions in this patient, who is likely to exhibit more severe, persistent and treatment resistant symptoms of their disorders.

In particular, ASAM recommends evaluating for co-occurring depression, anxiety, personality disorders and trauma in patients presenting with possible OUD. A barrier to comprehensive and integrated treatment is the 42 Code of Federal Regulations (CFR) Part 2 confidentiality regulations that protect and limit the disclosure of substance use-related health information by a substance use disorder program to a mental health program without the explicit and signed consent by the patient for each

disclosure made. Therefore, it is strongly recommended that providers of both substance use and mental health programs review and obtain the necessary consents for release of information between programs in order to ensure appropriate and timely coordination and access to necessary treatment.

Included in the initial comprehensive evaluation, immediate risks, such as suicidal or homicidal thoughts or behavior and/or acute psychosis or mania should be identified and managed appropriately. Patients should be assessed for psychiatric disorders, including a detailed mental status examination prior to beginning OUD pharmacotherapy, and treated accordingly. Likewise, reassessment should occur after stabilization of OUD MAT to identify previously undiagnosed psychiatric disorders. It is also prudent clinical practice to consider the existence of undiagnosed psychiatric conditions in the patient who repeatedly is unable to adhere with the established OUD management plan.

While there is no absolute contraindication to concurrent pharmacotherapy in patients with co-occurring psychiatric and OUD, prescribers should remain aware of potential interactions between these medications. ASAM recommends the concurrent initiation of antidepressant and OUD MAT in patients that present with symptoms of depression, and the concurrent initiation of antipsychotics and OUD MAT in patients with a psychotic disorder, including the use of depot formulations as a strategy for increasing adherence. Patients with more severe psychiatric impairments may benefit from greater coordination between involved providers, or a referral for intensive case management. Patients with co-occurring OUD and psychiatric disorders should always be offered psychosocial support as a component of their long-term recovery.

CO-OCCURRING OTHER DRUGS AND ALCOHOL: OUD frequently co-occurs with alcohol and other substance use disorders. Taking other substances during OUD treatment is associated with poorer treatment outcomes. Treatment recommendations for patients who drink alcohol and/or take other drugs depends on the substance used and the presence and severity of a use disorder.

OUD MAT can be initiated and should not be withheld when the substance used does not interact with opioids and should not be discontinued when benefit has been shown. This includes marijuana, tobacco, cocaine, methamphetamine or other non-CNS depressant substances.

Alcohol, benzodiazepines or other CNS depressants use should be considered when selecting OUD MAT. Combining CNS depressants with buprenorphine or methadone can have additive CNS depressant effects and increase a patient's risk for accidental overdose. Patients with co-occurring alcohol use disorder or other CNS depressant use disorders may require detoxification prior to initiating OUD MAT. If naltrexone is chosen for relapse prevention, it may also help with treating co-occurring alcohol use disorder.

CO-OCCURRING CHRONIC PAIN: Among people with chronic pain, approximately 10-20% of people have a co-occurring opioid use disorder. General approaches to the management of co-occurring chronic pain include using nonpharmacological treatments and non-opioid treatments as first-line treatments. In patients where opioid-

based treatments are used, both buprenorphine and methadone can be used for analgesic effects. The analgesic effects are shorter for both agents, therefore divided dosing should be used.

CO-OCCURRING HIV: Injection drug use (IDU) of heroin and stimulants is the second most common mode of HIV transmission in the United States. Maintaining adherence with antiretroviral therapy (ART) can be particularly challenging among active drug users as a consequence of the depression, anxiety and general life instability commonly associated with repeated use and/or withdrawal. Engagement and offering OUD MAT to opioid users is crucial to decreasing the harms associated with both untreated HIV and continued illicit opioid use. Directly observed therapy (DOT) can be a useful strategy for successful management of both HIV and opioid use disorder.

*Methadone***:** Opioid-induced decreased gastric emptying may decrease the absorption of ARTs. The CYP450 2B6, 3A4 and 2D6 metabolism of methadone may interact with ARTs in any or all of the following ways: opioid withdrawal, methadone toxicity (including overdose) and decreased ART efficacy. Initial and first-line ARTs for the management of HIV include integrase strand transfer inhibitor (INSTI) based regimens, and include raltegravir, dolutegravir, and elvitegravir. There is no methadone dose adjustment recommendation for patients on concurrent INSTIs. While non-first-line agents, OUD MAT prescribers may encounter patients prescribed the non-nucleoside reverse transcriptase inhibitors (NNRTIs) efavirenz (EFV) and nevirapine (NVP), or the protease inhibitor (PI) agent lopinavir/ritonavir (LPV/r), all known to significantly decrease methadone levels. The clinical effects of decreased methadone levels are typically seen after seven days of the coadministration of EFV, NVP or LPVr and methadone. See “References and Further Readings” section for a link to a comprehensive list of methadone and ART interactions.

*Buprenorphine/naloxone***:** Buprenorphine is metabolized by CYP450 3A4, therefore there is a theoretical risk of buprenorphine toxicity with CYP450 3A4 inhibitors. However, there is little evidence that clinically significant interactions occur with the exception of the non-first-line agent PIs atazanavir (ATV) and ritonavir-boosted atazanavir (ATV/r). A small study and case reports showed increased sedation and buprenorphine concentration levels in the groups receiving co-administered ATV and ATV/r compared with buprenorphine alone. However, compared with methadone, buprenorphine has a much lower risk of respiratory depression. A significant advantage of buprenorphine is that primary care providers may prescribe buprenorphine in their clinic setting, enabling one provider to manage both primary care/HIV and OUD MAT in one visit.

*Naltrexone***:** Naltrexone is not metabolized via the CYP450 enzyme system and is not expected to interact with PIs or NNRTIs.

SPECIAL POPULATIONS:

Older Adults: Older adults are more susceptible to over sedation with buprenorphine and methadone. Therefore, doses may need to be titrated slower in order to prevent adverse effects. In addition, older adults may be taking more medications than the general population and the potential for drug interactions should be considered.

Adolescents: The ASAM consensus opinion is adolescents can be considered for treatment with OUD MAT. However, there are few studies in this patient population. There are no studies comparing the effects of the agents in adolescents. There are no methadone or naltrexone placebo controlled trials in patients under the age of 18. Buprenorphine is indicated for patients 16 years and older. Psychosocial treatment is recommended for all adolescents with OUD. This includes family intervention approaches, vocational support and behavioral interventions to reduce opioid use.

Pregnancy/Lactation: The decision to treat OUD with an opioid agonist should include a discussion of the risks and benefits of treatment. Drug use during pregnancy is associated with increased risk of preeclampsia, miscarriage, premature delivery, fetal growth restriction and fetal death. Treatment with an opioid agonist during pregnancy is not associated with long-term effects on children. Neonatal abstinence syndrome (NAS), where the infant experiences withdrawal if not treated, can occur with opioid agonist treatment during pregnancy. However, the risks of NAS are much less substantial than untreated OUD. Therefore, the ASAM consensus opinion is opioid agonist treatment should be offered if opioid use is likely during pregnancy. In addition, treatment should begin early in pregnancy to avoid the harms of illicit drug use. Women currently taking opioid agonist treatment who become pregnant should be encouraged to continue treatment during pregnancy.

Both methadone and buprenorphine can be used during pregnancy. Methadone has generally been the standard treatment in pregnancy. However, buprenorphine is associated with a shorter duration of NAS and is an appropriate alternative to methadone. When using buprenorphine in pregnancy, the mono- product should be used to decrease exposure to the small amount of naloxone absorbed. When using methadone, a higher dose and/or split dosing may be needed in the second and third trimester.

Women can breastfeed when taking methadone or the buprenorphine mono-product and should be encouraged. Breastfeeding with both agents is associated with decreased NAS.

See Local Resources for local resources for pregnant women.

Liver impairment: The manufacturer of methadone does not provide guidance on dose adjustment in liver impairment. However, because methadone is metabolized by the liver, the half-life may be prolonged in moderate to severe liver impairment and dose reductions may be required.
Buprenorphine and naloxone can be used in mild liver impairment without dose adjustment. However, the half-life of buprenorphine and naloxone are prolonged in moderate and severe liver impairment. If the combination product is used, the prolongation is greater for naloxone than buprenorphine, potentially resulting in naloxone accumulation and precipitated withdrawal. Combination products with naloxone are contraindicated in severe liver impairment and should be used cautiously in moderate liver impairment. Instead, patients should be treated cautiously with mono-buprenorphine products.

Naltrexone can be used in mild to moderate liver impairment without dose adjustment. Naltrexone has not been studied in patients with severe liver impairment. Due to hepatotoxicity in studies with higher than recommended doses of naltrexone, it is recommended that naltrexone be avoided in severe liver impairment until studies have been completed in this population. One SAMSHA expert panel recommends avoiding naltrexone in patients with liver function tests greater than five times the upper limit of normal.

Kidney impairment: Buprenorphine and methadone doses do not need to be adjusted in kidney impairment or dialysis. Naltrexone doses do not need to be adjusted in mild kidney impairment. Oral naltrexone has not been studied in moderate to severe kidney impairment. Naltrexone long-acting injectable has not been studied in CrCl <50mL/min. Due to hepatotoxicity in studies with higher than recommended doses of naltrexone, it is recommended that naltrexone be avoided in moderate to severe kidney impairment.

OPIOID OVERDOSE TREATMENT AND PREVENTION*:* Death from unintentional opioid overdose is a growing epidemic. Unintentional poisonings have surpassed motor vehicles accidents as the number one cause of unintentional death in the United States. Naloxone is a mu opioid receptor antagonist that reverses the effects of opioids. In California, anyone who is at risk for experiencing or witnessing an opioid overdose can be furnished take-home naloxone for bystander administration. People with OUD, both not in treatment and in treatment, should be offered a take-home naloxone kit and provided education on reducing their risk of opioid overdose. Non-prescribed and street drugs can be contaminated with opioids. Therefore, anyone that takes these should be offered a take-home naloxone kit. The person's family and friends should be included in the education in order for them to be trained to identify and respond to an opioid overdose. For details on take-home naloxone, see the BHS Overdose Prevention and Naloxone guideline.

Section 16: Discharge Plan & Discharge Summary

Discharge from treatment may occur on a voluntary or involuntary basis. Below are discharge planning requirements for Outpatient Services, Intensive Outpatient Services, and Residential Services (Intergovernmental Agreement, Exhibit A, Attachment 1 A2: III.PP.16). Discharge requirements for Narcotic Treatment Programs and Withdrawal Management services can be found under Section 9: Narcotic Treatment Programs and Section 12: Withdrawal Management in this manual.

Discharge Plan: Client No Longer Meets Medical Necessity

An LPHA or counselor is required to complete a discharge plan for each client, except for a client for whom a provider loses contact (Intergovernmental Agreement, Exhibit A, Attachment 1 A2: III.PP.16). When the Medical Director or LPHA determines that a client no longer meets medical necessity for treatment services, a discharge plan must be completed by a LPHA or counselor within 30 calendar days prior to the scheduled date of the last face-to-face treatment with the client. A discharge plan must include, but is not limited to, all of the following:

1. A list and description of each of the client's relapse triggers;
2. A plan to assist the client to avoid relapse when confronted with each trigger; and
3. A support plan.

During the LPHA's or counselor's last face-to-face treatment with the client, the LPHA or counselor and the client shall type or legibly print their names, sign (or electronic equivalent for LPHA/counselor) and date the discharge plan. The signatures must be adjacent to the typed or legibly printed name (Intergovernmental Agreement, Exhibit A, Attachment 1 A2: III.PP.16.ii.c.). A copy of the discharge plan must be provided to the client and documented in the client record.

Timely and Adequate Client Notice of Adverse Benefit Requirements

Where a client is being involuntarily discharged from outpatient services, intensive outpatient services and residential services, the client must be given timely and adequate notice in writing (42 CFR §438.404). This written notice must explain all of the following in the language and/or alternative format preferred by the client (42 CFR §438.10):

1. A statement that the client is being discharged from treatment services;
2. The reasons for discharge, including the right of the client to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the decision to discharge the client from treatment. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
3. The client's right to request an appeal of the decision to discharge client from treatment, including information on exhausting the provider's one level of appeal described at 42 CFR §438.402(b) and the right to request a state fair hearing consistent with 42 CFR §438.402(c).
4. The procedures for exercising the client's appeal rights.

5. The circumstances under which an appeal process can be expedited and how to request it.
6. The client's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the client may be required to pay the costs of these services.

The provider is required to mail the written notice of discharge from treatment services to the client at least 10 days before the date of the treatment discharge.

Circumstance Where Client Discharge Is Not Required
If a client is transferred to a higher or lower level of care based on ASAM criteria offered by the same DMC-certified provider, a client is not required to be discharged unless there has been more than a 30-calendar day lapse in treatment services.

Discharge Summary
The S.F. Department of Public Health requires that a LPHA or counselor must prepare a discharge summary for all clients in the client record within 30 calendar days of the last face-to-face treatment contact with the client that includes all of the following:

1. The duration of the client's treatment as determined by the dates of admission to and discharge from treatment;
2. The reason for discharge;
3. A narrative summary of the treatment episode; **and**
4. The client's prognosis.

Section 17: Case Management Services

Case Management Services Overview

Case management is a service to assist clients in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Each client must have an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the client (Intergovernmental Agreement, Exhibit A, Attachment 1 A2: II.E.3 and 42 CFR Section 438.208). The client must be provided information on how to contact their designated person or entity (Intergovernmental Agreement, Exhibit A, Attachment I A2: II.E.3. and 42 CFR Section 438.208).

The focus of case management services is coordinating care. Care coordination, as a subset of case management, is as any activity performed to facilitate the entry of a client into services at the appropriate ASAM level of care. This includes the transition of a client from one ASAM level of care to another, the coordination of services for a very complex case, and the discharge of a client from treatment to recovery services (DHCS MHSUDS Information Notice No.: 18-005).

Providers are required to make the best effort to conduct an initial screening of each client's care coordination needs within 90 calendar days of the effective date of enrollment for all new clients including subsequent attempts if the initial attempt to contact the client is unsuccessful (Intergovernmental Agreement, Exhibit A, Attachment I A2: II.E.3).

Time spent in face-to-face consultation between a counselor and Medical Director/LPHA may be billed as case management when making a medical necessity determination (Source: DHCS DMS ODS Waiver Mailbox Answer to J.Gorndt, DPH, 8/15/18).

Care coordination needs may be (Intergovernmental Agreement, Exhibit A, Attachment I 02: II.E.3.):

1. Between settings of care including appropriate discharge planning for short-term and long-term hospital and institutional stays;
2. With the services a client receives from any other managed care organization;
3. With the services a client receives through FFS Medi-Cal primary care; and
4. With the services a client received from community and social support providers.

The LPHA or counselor who provided the treatment service must record a progress note **for each client** provided case management services in the client record (see Progress Notes section under this manual).

Required Components of Case Management

Case management services include all of the following:

1. Comprehensive assessment and periodic reassessment of individual needs to determine the need for the continuation of case management services;

2. Transition to a higher or lower level of substance use disorder (SUD) care;
3. Development and periodic revision of a client plan that includes service activities;
4. Communication, coordination, referral, and related activities;
5. Monitoring service delivery to ensure client access to service and the service delivery system;
6. Monitoring the client's progress; and
7. Client advocacy, linkages to physical and mental health care, transportation, and retention in primary care services.

Case management services must be consistent with and must not violate confidentiality of treatment clients as set forth in federal regulations (42 CFR Part 2), and California law which protect information that would identify a client, either directly or indirectly, as having or having had a substance use disorder, or being or having been a client in a federally-assisted program.

Authorized Providers of Case Management Services
A LPHA working within the scope of his/her professional practice or certified/registered counselor may provide case management services. The individual providing case management services must be linked, at a minimum, to a DMC certified site/facility.

Service Locations for Case Management Services
Case management services can be provided in the following settings as long as the services are affiliated with a DMC certified location: a) DMC provider sites; b) county locations; c) regional centers; or d) face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.

Delivery of Case Management Services
Case management services can be provided to a client in the following ways:
a) face-to-face; b) by telephone; c) via telehealth; or d) in the community. If case management services are provided in the community, the provider delivering the service must be linked with a physical site/facility that is DMC certified, and there must be documentation in the client record that a service was delivered in the community and how client confidentiality was protected.

Client Eligibility Requirements for Reimbursement of Case Management Services
Clients receiving case management services must meet all of the following eligibility requirements in order to be reimbursable:

1. The client is Medi-Cal eligible;
2. The client is a San Francisco resident;
3. The client meets established medical necessity criteria;
4. The initial medical necessity determination is performed by a medical director, licensed physician, or LPHA; and
5. Services are delivered by a qualified provider and linked to a DMC-certified site/facility.

Section 18: Other DMC-ODS Documentation Requirements

0.5 Early Intervention Services

ASAM 0.5 Early Intervention is a service for adults and youth who, for a known reason, are at risk of developing substance-related problems, or a service for those for whom there is not yet sufficient information to document a diagnosable substance use disorder**.**

Primary care physicians are required to administer the Screening, Brief Intervention, and Referral to Treatment (SBIRT) screening tool, brief behavioral health interventions, and referrals to behavioral health treatment for individuals at risk of a substance use disorder, aged 18 and older (Intergovernmental Agreement, Exhibit A, Attachment I A2: V.G).

Physician Consultation Services

Physician Consultation Services include DMC physicians consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are designed to assist DMC physicians by allowing them to seek expert advice when developing treatment plans for specific DMC-ODS clients.

Physician consultation services must be able to address all of the following:

1. Medication selection;
2. Dosing;
3. Side effect management;
4. Adherence;
5. Drug-drug interactions; and
6. Level of care considerations.

The physician-to-specialist consultation will be provided by network physicians, with addiction medicine physicians, addiction psychiatrists, addiction specialist Nurse Practitioners or specialist clinical pharmacists to support SUD treatment plans for clients with complex needs.

DMC physician consultation with the DPH SFHN Medical Director is available by phone and email:

- **Judith Martin, MD, Deputy Medical Director, Behavioral Health Services**
  Medical Director, Substance Use Services
  County Alcohol and Drug Administrator
  Email: judith.martin@sfdph.org
  Phone: 415-255-3601

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Billing/Units of Services by Services Provided by Modality
Below is a chart that shows DMC-ODS billing units of services by ASAM Level of Care and DMC-ODS service.

Services Provided by Modality (funded by DMC-ODS)	**Billing/Unit of Service (minutes, day, hour)**
Outpatient Services	**15-minute increments entered fractionally or in 1-minute increments**
Intensive Outpatient Services	**15-minute increments entered fractionally or in 1-minute increments**
Recovery Services	**15-minute increments entered fractionally or in 1-minute increments**
Case Management	**15-minute increments entered fractionally or in 1-minute increments**
Physician Consultation	**15-minute increments entered fractionally or in 1-minute increments**
Level 1-WM	**Per Day**
Level 2-WM	**Per Day**
Level 3.2-WM	**Per Day**
Level 3.1- Residential	**Per Day**
Level 3.3 - Residential	**Per Day**
Level 3.5 - Residential	**Per Day**
Additional Medication Assisted Treatment	**15-minute increments entered fractionally or in 1-minute increments**
Partial Hospitalization	**15-minute increments**
NTP - Methadone Dosing	**Daily**
NTP - Individual Counseling	**One 10-minute increment**
NTP - Group Counseling	**One 10-minute increment**
NTP - Buprenorphine	**Daily**
NTP - Disulfiram	**Daily**
NTP - Naloxone (2-pack Nasal Spray)	**Dispensed as needed**

Note: 15-minute increments entered fractionally (e.g., 0.25 = 15 minutes; 0.50 = 30 minutes; 0.75 = 45 minutes; 1.0 = 60 minutes) or **in 1-minute increments** (e.g., 37 minutes of service provided).

Working Draft 11.4.19

DMC-ODS SUD Privileging Chart

The DPH Office of Compliance and Privacy Affairs has developed a staff billing privilege matrix for DMC-ODS SUD treatment services. See below.

SUD Privileging Chart

Name of Service	LPHA Physician	LPHA Non-Physician										SUD Counselors		Med Support
	MD	NP, PA	LCSW	LMFT	LPCC	Licensed Clinical Psychologist	ASW	MFTI	PCCI	Waivered Clinical Psychologist	Registered Pharmacist	RN (AA, BA)**	Certified	Registered	LVN, Psych Tech
Intake	X	X	X	X	X	X	X	X	X	X		Reviewed & approved by a LPHA other than an RN	Reviewed & approved by a LPHA other than an RN	Reviewed & approved by a LPHA other than an RN	
Intake - Physical Exam/Lab	X	X													
Individual Counseling	X	X	X	X	X	X	X	X	X	X		X	X	X	
Group Counseling	X	X	X	X	X	X	X	X	X	X		X	X	X	
Family Therapy	X	X	X	X	X	X	X	X	X	X					
Patient Education	X	X	X	X	X	X	X	X	X	X		X	X	X	
Collateral Services	X	X	X	X	X	X	X	X	X	X		X	X	X	
Case Management	X	X	X	X	X	X	X	X	X	X		X	X	X	
Crisis Intervention	X	X	X	X	X	X	X	X	X	X		X	X	X	
Treatment Planning	X	X	X	X	X	X	X	X	X	X		Reviewed & approved by a LPHA other than an RN	Reviewed & approved by a LPHA other than an RN	Reviewed & approved by a LPHA other than an RN	
Discharge Services	X	X	X	X	X	X	X	X	X	X		X	X	X	
Recovery Services	X	X	X	X	X	X	X	X	X	X		X	X	X	
Withdrawal Management - Intake	X	X	X	X	X	X	X	X	X	X		Reviewed & approved by a LPHA other than an RN	Reviewed & approved by a LPHA other than an RN	Reviewed & approved by a LPHA other than an RN	
Withdrawal Management - Discharge	X	X	X	X	X	X	X	X	X	X		X	X	X	
Withdrawal Management - Observation *	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Withdrawal Management - Medication Services -Prescribing, Ordering	X	X													
Withdrawal Management - Medication Services - Administering/Dispensing, Monitoring, Assessment	X	X									X	X			X
Medication Services - Prescibing, Ordering	X	X													
Medication Services - Administering/Dispensing, Monitoring	X	X									X	X			X
Physician Consultation	X														
NTP Medication Psychotherapy	X														

*Only program staff that have been trained in the provisions of detoxifications services may conduct observations and physical checks [2017 AOD Cert. Standards, 11030 (a) & (c)].

** Only when working within scope of practice. RN (BA) and RN (AA) are not permitted to diagnose, provide therapy, or approve counselor documentation.

Service Descriptions

- ***Intake*** means the process of determining a beneficiary meets the medical necessity criteria and a beneficiary is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for substance use disorder treatment and evaluation.
- ***Individual Counseling*** means contact between a beneficiary and a therapist or counselor. Services provided in-person, by telephone or by telehealth qualify as Medi-Cal reimbursable units of service, and are reimbursed without distinction.
- ***Group Counseling*** means contacts in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served. A beneficiary that is 17 years of age or younger shall not participate in-group counseling with any participants who are 18 years of age or older. However, a beneficiary who is 17 years of age or younger may participate in group counseling with participants who are 18 years of age or older when the counseling is at a provider's certified school site.
- ***Family Therapy*** means including a beneficiary's family members and loved ones in the treatment process, and education about factors that are important to the beneficiary's recovery as well as their own recovery can be conveyed. Family members may provide social support to beneficiaries, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.
- ***Patient Education*** means providing research based education on addiction, treatment, recovery and associated health risks.
- ***Collateral Services*** means sessions with therapists or counselors and significant persons in the life of a beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.
- ***Case Management*** means a service to assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.
- ***Crisis Intervention*** means a contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance, which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the beneficiary's emergency situation.
- **Treatment planning** means the collaboration of the client and primary counselor to develop a plan that resolves problems identified on the assessment.
- ***Discharge services*** means the process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.
- ***Recovery Services*** are available after the beneficiary has completed a course of treatment. Recovery services emphasize the patient's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to patients.
- ***Withdrawal Management"*** means detoxification services provided in either an ambulatory or non-ambulatory setting consistent with the ASAM level of care criteria to DMC ODS beneficiaries.
- ***Medication Services*** means the prescription or administration of medication related to substance use disorder treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services.
- ***Physician Consultation"*** services are to support DMC physicians with complex cases, which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.
- **NTP Medication Psychotherapy** session means a face-to-face discussion conducted by the medical director on a one-on-one basis with the patient, on issues identified in the patient's treatment plan.

Rev. 8/14/2018

Select DMC-ODS Service Definitions

(from County Interagency Agreement found under Appendix)

Below is a list and description for select authorized DMC-ODS services. Not all services are authorized for each ASAM Level of Care. Please consult specific ASAM Level of Care treatment sections for specific services authorized.

Service	Description
Case Management	A service to assist a client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.
Client Education	Provide research-based education on addiction, treatment, recovery, and associated health risks.
Collateral Services	Sessions with therapists or counselors and significant persons in the life of the client, focused on the treatment needs of the client in terms of supporting the achievement of the client's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the client.
Crisis Intervention	A contact between a therapist or counselor and a client in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the client an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the client's emergency situation.
Discharge Services	The process to prepare the client for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.
Education and Job Skills	Linkages to life skills, employment services, job training, and education services.
Face-to-Face	A service occurring in person.
Family Support	Linkages to childcare, parent education, child development support services, and family and marriage education.

Service	Description
Family Therapy	Including a client's family members and loved one in the treatment process, and education about factors that are important to the client's recovery as well as their own recovery can be conveyed. Family members may provide social support to clients, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.
Group Counseling	Face-to-face contacts in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 12 clients in the group, focusing on the needs of the clients served. Services must be provided face-to-face to qualify as Drug Medi-Cal reimbursable units of service.
Individual Counseling	Contact between a client and a therapist or counselor. Services provided in-person, by telephone or by telehealth qualify as Medi-Cal reimbursable units of services, and are reimbursed without distinction.
Intake (includes Assessment)	The process of determining a client meets medical necessity criteria and a client is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral and substance use disorders, and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment and evaluation.
Medication Services	The prescription or administration of medication related to substance use disorder treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice or licensure.
Recovery Monitoring	Recovery coaching, monitoring via telephone and internet; recovery monitoring is only available in Recovery services.
Recovery Services	Available after the client has completed a course of treatment; recovery services emphasize the client's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to patients.

Service	Description
Rehabilitation Services	Any medical or remedial services recommended by a physician or other licensed practitioner of the health arts, within the scope of his/her practice under state law, for maximum reduction of physical or mental disability and restoration of a client to his best possible functional level.
Relapse	A single instance of a client's substance use or a client's return to a pattern of substance abuse.
Relapse Trigger	An event, circumstance, place or person that puts a client at risk of relapse.
Safeguarding Medications	Facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.
Support Groups	Linkages to self-help and support, spiritual and faith-based support.
Support Plan	List of individuals and/or organizations that can provide support and assistance to a client to maintain sobriety.
Telehealth Between Provider and Client	Office or outpatient visits via interactive audio and video telecommunication systems.
Telehealth Between Providers	Communication between two providers for purposes of consultation, performed via interactive audio and video telecommunication systems.
Transportation Services	Provision of or arrangement for transportation to and from a medically necessary treatment.

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Section 19: Client Record & Information Services Requirements

General Client Record Requirements

Client records must be kept and maintained for **10 years.** In addition to treatment episode and other related documentation requirements included in this manual, the client record must include all of the following information and documents:

1. Identifier (i.e., name, number);
2. Birth date;
3. Gender;
4. Race and/or Ethnic Background;
5. Address;
6. Telephone number;
7. Next of Kin or Emergency Contact;
8. Consent to Treatment Form including 42 CFR Release
9. Complaint/Grievance/HIPAA Form
10. Client Rights Form
11. Client Medication Consent Forms
12. Note: for adolescents under age 18, parental/guardian consent required for medical treatment prior to first dose of medication;
13. Copies of Referrals to Services; and
14. Client receipt of notification that DMC substance use disorder services are paid in full (no cost to client).

Information Services Requirements

(42 CFR §438.10, 42 CFR §438.100; also see DPH BHS Cultural and Linguistic Competency Requirement for BHS Services, Policy #3.02-15)
All clients must be offered free of charge oral interpreter services, alternative format materials, and the use of auxiliary aids including TTY/TDY and American Sign Language during all phases of treatment from admission through discharge (Interagency Agreement, Exhibit A, Attachment 1 A2, II.B.):

Clients whose primary language is not English must be made aware of the availability of and offered or linked to oral language interpreter services in their primary language and provided service-related personal correspondence in their preferred language (42 CFR §438.10(d)(2), (4)-(5) 42 CFR § 100(b)(2)(i) and (Interagency Agreement, Exhibit A, Attachment 1, A2, II.B.):
Clients who are hearing impaired must be made aware of the availability of and offered American Sign Language interpreter services, or linked to auxiliary aids and services such as TTY/TDY ((Interagency Agreement, Exhibit A, Attachment 1, A2, II.B.).

Clients who are visually impaired must be provided client protection materials and treatment specific information in alternative formats (e.g. braille, audio, or large print formats) (42 CFR §438.100 and (Interagency Agreement, Exhibit A, Attachment 1 A2, II.B.):

Where the need for oral interpreter or auxiliary services is identified, it is best practice to document in the client record that the services were provided, or offered, along with the client's response.

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Section 20: DHCS Common Compliance Issues

The Department of Health Care Services monitors county compliance with DMC-ODS requirements. The most common compliance deficiencies at the provider level cited by DHCS in September 2018 included (DHCS DMC-ODS Common Compliance Issues and Relevant Resources, Technical Assistance Webinar for Counties, September 2018):

- Providers do not have Medical Director policies and procedures developed;
- Verification of required 5 Continuing Medical Education credits (CMEs) for the medical director not found;
- Beneficiary not placed in level of care according to ASAM or ASAM appears inaccurate; and
- Counselors determining the diagnosis.

Below is a list of DHCS compliance questions and answers (DHCS DMC-ODS Common Compliance Issues and Relevant Resources, Webinar Q&A, September 2018).

Drug Medi-Cal Organized Delivery System: Common Compliance Issues and Relevant Resources

Technical Assistance Webinar for Counties
September 6, 2018

Q&A from 9/6/18 DMC-ODS TA Webinar – Common Compliance Issues & Resources

1. **In regard to an assessment progress note where there is 45 minutes of f2f time, 13 minutes of non-f2f time involved in completing the assessment form (reflecting the clinical content of that f2f session) and then 7 minutes to write the progress note: Is the expectation that we document the start time and end time for each of those activities?**
   Yes
2. **According to the CA RN Scope of Practice, RNs are allowed to diagnose or practice other delegated tasks under a standard operating procedure agreed upon by the organization. Has this been considered?**
   No

3. **Can you speak to what you have seen regarding recovery services?**
   Recovery Services is still quite new. At this point in time, there seems to be confusion regarding how to document. DHCS encourages counties to set guidelines for providers that allows for clear verification that billed services were rendered and supports program integrity.

4. **Can the counselors or RNs enter a deferred Dx?**
   It is recommended that the diagnosis not be entered into the EHR until after it has been documented by the LPHA. Documentation of a diagnosis by a registered or certified counselor or RN would be out of the scope of practice for those professionals. Billing for ODS services is not required for six months after service delivery, therefore the EHR may be updated following the diagnosis by the LPHA.

5. **Also to confirm RN's cannot diagnose even though they are classified as an LPHA. Same as pharmacist.**
   Correct. Scope of Practice is the key. Pharmacists are listed as well but they cannot diagnose as it is not in their Scope of Practice.

6. **Will discrepancies in ASAM level of care documentation (and actual level of care) lead to disallowances?**
   Not necessarily. It would depend on several factors including the reason for the difference.

7. **Any guidance on documentation standards for Recovery Services?**
   The IA is silent on documentation standards for Recovery Services. In this case it is the County's responsibility to determine requirements. Counties should consider how any service billed for can be verified through documentation requirements.

8. **Any guidance on documentation standards for WM?**
   The IA is silent on documentation requirements for WM. The County in collaboration with a physician trained in addiction withdrawal should develop these requirements.

9. **We are a DMC-ODS county. What do you think is the best way to document the start and stop times for documentation and travel if the documentation occurs on a different day than the service?**
   Documentation does not have to be completed the same day the service is rendered. The service/documentation time/and travel time must be clearly described including date and start and end times. Beyond these requirements we encourage counties to set guidelines for providers that support program integrity.

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Working Draft v.3-2019

City and County of San Francisco Interagency Agreement

I. Preamble

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

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

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

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

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

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

II. Federal Requirements

A. Waived and Inapplicable Federal Requirements

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

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

B. General Provisions

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

i. CMS shall review and approve this Agreement.

ii. Enrollment discrimination is prohibited.

a. The Contractor shall accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under this Agreement.

b. Enrollment is mandatory.

c. The Contractor shall not, based on health status or need for health care services, discriminate against individuals eligible to enroll.

d. The Contractor shall not discriminate against individuals eligible to enroll based on race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. (WIC 14029.91 (e)(3))

e. The Contractor will not use any policy or practice that has the effect of discriminating on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

f. The Contractor shall provide information on how to file a discrimination complaint with the United States Department of Health and Human Services Office of Civil Rights if there is a concern of discrimination based on race, color, national origin, age, disability, or sex. (WIC 14029.91(e)(5))

iii. Services that may be covered by the Contractor.

a. The Contractor may cover, for beneficiaries, services that are in addition to those covered under the State Plan as follows:

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

ii. Any services necessary for compliance by the Contractor with the parity requirements set

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

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

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

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

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

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

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

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

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

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

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

vi. Subcontracts.

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

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

vii. Choice of network provider.

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

viii. Audited financial reports.

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

ix. Recordkeeping requirements.

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

2. Information Requirements (42 CFR §438.10).

i. Basic Rules

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

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

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

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

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

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

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

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

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

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

vi. Language and format:

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

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

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

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

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

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

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

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

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

xii. The Contractor shall notify its beneficiaries:

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

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

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

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

xv. Information for potential beneficiaries.

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

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

xvi. Information for all beneficiaries of the Contractor.

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

xvii. Beneficiary handbook.

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

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

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

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

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

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

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

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

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

ix. Beneficiary rights and responsibilities, including:

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

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

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

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

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

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

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

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

xviii. Provider Directory.

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

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

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

xix. Formulary.

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

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

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

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

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

iv. This section may not be construed to:

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

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

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

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

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

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

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

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

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

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

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

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

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

v. Payment requirements.

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

C. State Responsibilities

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

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

2. Prohibition of Additional Payments (42 CFR §438.60).

i. The Department shall ensure that no payment is made to a network provider other than by the Contractor for services covered under this Agreement, except when these payments are specifically required to be made by the Department in Title XIX of the Act, in 42 CFR chapter IV.

3. Continued Services to Beneficiaries (42 CFR §438.62).

i. The Department shall arrange for Medicaid services to be provided without delay to any Medicaid beneficiary of the Contractor if this Agreement is terminated.

ii. The Department shall have in effect a transition of care policy to ensure continued access to services during a transition from fee-for-service (FFS) to the Contractor or transition from one Contractor to another when a beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

iii. The Contractor shall implement a transition of care policy consistent with the requirements of the Department's transition of care policy.

iv. The Department shall make its transition of care policy publicly available and provide instructions on how beneficiaries and potential beneficiaries access continued services upon transition. At a minimum, the Contractor shall provide the transition of care policy to beneficiaries and potential beneficiaries in the beneficiary handbook and notices.

4. **State Monitoring Requirements (42 CFR §438.66).**
   - **i.** The Department shall have in effect a monitoring system for the Contractor.
   - **ii.** The Department's monitoring system is outlined in Article III.DD of this Agreement.
   - **iii.** The Department shall use data collected from its monitoring activities to improve the performance of the Contractor. That data shall include, at minimum:
     a. Beneficiary grievance and appeal logs
     b. Provider complaint and appeal logs
     c. Findings from the State's External Quality Review process
     d. Results from any beneficiary or provider satisfaction survey conducted by the State or the Contractor
     e. Performance on required quality measures
     f. Medical management committee reports and minutes
     g. The annual quality improvement plan for the Contractor
     h. Customer service performance data submitted by the Contractor and performance data submitted by the beneficiary support system
5. **Network Adequacy Standards (42 CFR §438.68).**
   - **i.** Beginning on July 1, 2018, the Contractor shall comply with the Department's network adequacy standards.
   - **ii.** The Department's network adequacy standards are as follows:
     a. Pursuant to WIC Section 14197(c)(4), the Contractor shall maintain a network of outpatient and intensive outpatient (non-OTP) providers that are located within the following applicable time and distance standards:
        i. Up to 15 miles or 30 minutes from the beneficiary's place of residence for Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara counties.
        ii. Up to 30 miles or 60 minutes from the beneficiary's place of residence for Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura counties.

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

b. Pursuant to WIC Section 14197(d)(3), the Contractor's shall ensure that all beneficiaries seeking non-OTP services be provided with an appointment within 10 business days of a non-OTP service request.
c. Pursuant to WIC Section 14197(c)(4), the Contractor shall maintain a network of OTP providers that are located within the following applicable time and distance standards:
    i. Up to 15 miles or 30 minutes from the beneficiary's place of residence for Alameda, Contra Costa, Los Angeles, Orange, Sacramento, San Diego, San Francisco, San Mateo, and Santa Clara counties.
    ii. Up to 30 miles or 60 minutes from the beneficiary's place of residence for Marin, Placer, Riverside, San Joaquin, Santa Cruz, Solano, Sonoma, Stanislaus, and Ventura counties.
    iii. Up to 45 miles or 75 minutes from the beneficiary's place of residence for Amador, Butte, El Dorado, Fresno, Kern, Kings, Lake, Madera, Merced, Monterey, Napa, Nevada, San Bernardino, San Luis Obispo, Santa Barbara, Sutter, Tulare, Yolo, and Yuba counties.
    iv. Up to 60 miles or 90 minutes from the beneficiary's place of residence for Alpine, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Imperial, Inyo, Lassen, Mariposa,

Mendocino, Modoc, Mono, Plumas, San Benito, Shasta, Sierra, Siskiyou, Tehama, Trinity, and Tuolumne counties.

d. Pursuant to WIC Section 14197(d)(1)(A), the Contractor shall ensure that all beneficiaries seeking OTP services are provided with an appointment within three business days of an OTP service request.
e. If the Contractor cannot meet the time and distance standards set forth in this section, the Contractor shall submit a request for alternative access standards to the department.
f. Pursuant to WIC 14197(e), DHCS may grant requests for alternative access standards if the Contractor has exhausted all other reasonable options to obtain providers to meet the applicable standard or if DHCS determines that the Contractor has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.
    i. The Contractor shall include a description of the reasons justifying the alternative access standards.
        1. Requests for alternative access standards shall be approved or denied on a zip code and service type basis.
        2. Requests for alternative access standards may include seasonal considerations (e.g. winter road conditions), when appropriate. Furthermore, the Contractor shall include an explanation about gaps in the county's geographic service area, including information about uninhabitable terrain within the county (e.g., desert, forestland), as appropriate. The use of clinically appropriate telecommunications technology may be considered in determining compliance with the applicable standards established in the DHCS Information Notice 18-011 and/or for the purpose of approving an alternative access request.

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

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

D. Beneficiary Rights and Protections

1. Beneficiary Rights (42 CFR §438.100).

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

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

iii. Specific rights.

a. The Contractor shall ensure that its beneficiaries have the right to:
    i. Receive information regarding the Contractor's PIHP and plan in accordance with 42 CFR §438.10.

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

b. The Contractor shall ensure that its beneficiaries have the right to be furnished health care services in accordance with 42 CFR §§438.206 through 438.210.

iv. Free exercise of rights.

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

v. Compliance with other Federal and state laws.

a. The Contractor shall comply with any other applicable Federal and state laws, including, but not limited to:
i. Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80.

ii. The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91.
iii. The Rehabilitation Act of 1973.
iv. Title IX of the Education Amendments of 1972 (regarding education programs and activities).
v. Titles II and III of the Americans with Disabilities Act.
vi. Section 1557 of the Patient Protection and Affordable Care Act.

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

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

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

iii. Information requirements.
a. If the Contractor elects to not provide a counseling or referral service based on moral or religious grounds, then the Contractor shall furnish information about the services it does not cover as follows:
i. To the Department:

1. With its application for a Medicaid contract.
2. Whenever the Contractor adopts the policy during the term of the contract.

ii. Consistent with the provisions of 42 CFR §438.10, to beneficiaries, within 90 days after adopting the policy for any particular service.

iii. The Contractor shall furnish the information to the beneficiary at least 30 days before the effective date of the policy for any particular service.

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

v. Information requirements: state responsibility.

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

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

i. The Contractor shall ensure that its beneficiaries are not held liable for any of the following:

a. The Contractor's debts, in the event of the entity's insolvency.

b. Covered services provided to the beneficiary, for which:

i. The state does not pay the Contractor.

ii. The Contractor or the Department does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.

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

4. Cost Sharing (42 CFR §438.108).

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

E. Contractor Standards as a PIHP

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

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

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

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

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

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

d. Require out-of-network subcontractors and providers to coordinate with the Contractor for payment and ensures the cost to the beneficiary is no greater than it would be if the services were furnished within the network.

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

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

a. Meet and require its network providers to meet Department standards for timely access to care and services, taking into account the urgency of the need for services.
b. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid FFS, if the provider serves only Medicaid beneficiaries.
c. Make services included in this Agreement available 24 hours a day, 7 days a week, when medically necessary.
d. Establish mechanisms to ensure compliance by network providers.
e. Monitor network providers regularly to determine compliance.
f. Take corrective action if there is a failure to comply by a network provider.

iv. Access and cultural considerations (WIC 14029.91).

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

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

a. The Contractor shall ensure that their health programs or activities provided through electronic and information technology are accessible to individuals with disabilities, unless doing so would result in undue financial and administrative burdens or a fundamental alteration in the nature of the health programs or activities. When undue financial and administrative burdens or a fundamental alteration exist, the covered entity shall provide information in a format other than an electronic format that would not result in such undue financial and administrative burdens or a

fundamental alteration but would ensure, to the maximum extent possible, that individuals with disabilities receive the benefits or services of the health program or activity that are provided through electronic and information technology

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

2. Assurances of Adequate Capacity and Services (42 CFR §438.207).

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

ii. The Contractor shall submit documentation to the Department to demonstrate that it complies with the following requirements:

a. Offers an appropriate range of specialty services that are adequate for the anticipated number of beneficiaries for the service area.

b. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the

needs of the anticipated number of beneficiaries in the service area.

iii. The Contractor shall submit network adequacy documentation to the SUD Program, Policy and Fiscal Division (PPFD) via email to ODSSubmissions@dhcs.ca.gov:

a. Upon entering into this Agreement with the Department.
b. On an annual basis, on or before April 1.
c. Within 10 business days of a significant change in the Contractor's operations that would affect the adequacy and capacity of services, including composition of the Contractor's provider network.
d. As requested by the Department.

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

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

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

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

viii. If the Department determines that the Contractor does not comply with the applicable standards at any time, the Department may require a CAP, impose fines, or penalties, withhold payments, or any other actions deemed necessary

by the Department to ensure compliance with network adequacy standards (WIC 14712(e)).

a. Fines and penalties imposed by the Department for late submissions shall be in the amounts specified below:
    i. First violation: $500, plus $25 per day for each day that the item to be submitted is late.
    ii. Second and subsequent violation: $500, plus $25 per day for each day that the item to be submitted is late.

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

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

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

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

a. Ensure that each beneficiary has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary. The beneficiary shall be provided information on how to contact their designated person or entity.
b. Coordinate the services the Contractor furnishes to the beneficiary:
    i. Between settings of care, including appropriate discharge planning for short-term and long- term hospital and institutional stays.
    ii. With the services the beneficiary receives from any other managed care organization.
    iii. With the services the beneficiary receives in FFS Medicaid.

iv. With the services the beneficiary receives from community and social support providers.

c. Make a best effort to conduct an initial screening of each beneficiary's needs, within 90 calendar days of the effective date of enrollment for all new beneficiaries, including subsequent attempts if the initial attempt to contact the beneficiary is unsuccessful.

d. Share with the Department or other managed care organizations serving the beneficiary, the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities.

e. Ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards.

f. Ensure that in the process of coordinating care, each beneficiary's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E and 42 CFR Part 2, to the extent that they are applicable.

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

v. The Contractor shall produce a treatment or service plan meeting the criteria below for beneficiaries with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan shall be:

a. Developed with beneficiary participation, and in consultation with any providers caring for the beneficiary.

b. Developed by a person trained in person-centered planning using a person-centered process and plan, as defined in 42 CFR §441.301(c)(1).
c. Approved by the Contractor in a timely manner, if this approval is required by the Contractor.
d. In accordance with any applicable Department quality assurance and utilization review standards.
e. Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the beneficiary's circumstances or needs change significantly, or at the request of the beneficiary per 42 CFR §441.301(c)(3).

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

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

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

ii. The Contractor:
a. Shall ensure that the medically necessary services provided are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
b. Shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of diagnosis, type of illness, or condition of the beneficiary.

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

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

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

v. Authorization of services.

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

vi. Standard authorization decisions.

a. For standard authorization decisions, the Contractor shall provide notice as expeditiously as the beneficiary's condition requires, not to exceed 14 calendar days following receipt of the request for

service, with a possible extension of up to 14 additional calendar days when:

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

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

vii. Expedited authorization decisions.

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

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

viii. Compensation for utilization management activities.

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

5. Provider Selection (42 CFR §438.214).

i. The Contractor shall implement written policies and procedures for selection and retention of network providers and -the implemented policies and procedures, at a minimum, meet the following requirements:

a. Credentialing and re-credentialing requirements.

i. The Contractor shall follow the state's established uniform credentialing and re-credentialing policy that addresses behavioral and substance use disorders, outlined in DHCS Information Notice 18-019.
ii. The Contractor shall follow a documented process for credentialing and re-credentialing of network providers.

b. Nondiscrimination.
i. The Contractor's network provider selection policies and procedures, consistent with 42 CFR §438.12, shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

c. Excluded providers.
i. The Contractor shall not employ or subcontract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.

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

6. Confidentiality (42 CFR §438.224).

i. For medical records and any other health and enrollment information that identifies a particular beneficiary, the Contractor shall use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E and 42 CFR Part 2, to the extent that these requirements are applicable.

7. Grievance and Appeal Systems (42 CFR §438.228).

i. The Contractor shall have in effect, a grievance and appeal system that meets the requirements outlined in Article II.G of this Agreement.

ii. The Contractor shall be responsible for issuing any Notice of Adverse Benefit Determination (NOABD) under 42 CFR Part 431, subpart E. The Department shall conduct random

reviews of the Contractor and its providers and subcontractors to ensure that they are notifying beneficiaries in a timely manner.

8. **Subcontractual Relationships and Delegation (42 CFR §438.230).**

   i. The requirements of this section apply to any contract or written arrangement that the Contractor has with any subcontractor.

   ii. Notwithstanding any relationship(s) that Contractor may have with any subcontractor, the Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Agreement.

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

      a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.
      b. The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the Contractor's contract obligations.
      c. The contract or written arrangement shall either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the Department or the Contractor determine that the subcontractor has not performed satisfactorily.
      d. The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.
      e. The subcontractor agrees that—
         i. The Department, CMS, the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's Contractor, that pertain to

any aspect of services and activities performed, or determination of amounts payable under this Agreement at any time.

ii. The subcontractor will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid beneficiaries.

iii. The Department, CMS, the HHS Inspector General, the Comptroller General, or their designees' right to audit the subcontractor will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

iv. If the Department, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the Department, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

9. Practice Guidelines (42 CFR §438.236).

i. The Contractor shall adopt practice guidelines that meet the following requirements:

a. Are based on valid and reliable clinical evidence or a consensus of providers in the particular field.
b. Consider the needs of the Contractor's beneficiaries.
c. Are adopted in consultation with contracting health care professionals.
d. Are reviewed and updated periodically as appropriate.

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

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

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

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

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

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

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

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

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

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

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

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

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

F. Quality Measurement and Improvement External Quality Review

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

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

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

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

a. Performance improvement projects.
b. Collection and submission of performance measurement.
c. Mechanisms to detect both underutilization and overutilization of services.
d. Mechanisms to assess the quality and appropriateness of care furnished to beneficiaries with special health care needs, as defined by the Department in the quality strategy under 42 CFR §438.340.

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

v. Annually, the Contractor shall:

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

vi. Performance improvement projects.

a. The Contractor shall conduct performance improvement projects, including any performance improvement projects required by CMS that focus on both clinical and nonclinical areas.
b. Each performance improvement project shall be designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction, and shall include the following elements:
    i. Measurement of performance using required quality indicators.
    ii. Implementation of interventions to achieve improvement in the access to and quality of care.
    iii. Evaluation of the effectiveness of the interventions based on the performance measures.
    iv. Planning and initiation of activities for increasing or sustaining improvement.
c. The Contractor shall report the status and results of each project conducted to the Department as requested, but not less than once per year.

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

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

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

a. Accreditation status, survey type, and level (as applicable).
b. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings.
c. Expiration date of the accreditation.

iii. The Department shall:

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

G. Grievance and Appeal System

1. General Requirements (42 CFR §438.402).

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

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

iii. Filing requirements:

a. Authority to file.

i. A beneficiary may file a grievance and request an appeal with the Contractor. A beneficiary may request a state fair hearing after receiving notice under 42 CFR §438.408 that the adverse benefit determination is upheld.

1. In the case that the Contractor fails to adhere to the notice and timing requirements in 42 CFR §438.408, the beneficiary is deemed to have exhausted the Contractor's appeals

process. The beneficiary may initiate a state fair hearing.

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

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

b. Timing:

i. Grievance:

1. The beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, may file a grievance with the Contractor at any time.

ii. Appeal:

1. The Contractor shall allow the beneficiary, an authorized provider, or

an authorized representative acting on behalf of the beneficiary, as state law permits, to file a request for an appeal to the Contractor within 60 calendar days from the date on the adverse benefit determination notice.

c. Procedures:

i. Grievance:

1. The beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, may file a grievance either orally or in writing and, as determined by the Department, either with the Department or with the Contractor.

ii. Appeal:

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

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

i. Notice.

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

ii. Content of notice.

a. The notice shall explain the following:

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

ii. The reasons for the adverse benefit determination, including the right of the beneficiary to be provided upon request and

free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.

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

iv. The procedures for exercising these appeal rights.

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

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

iii. Timing of notice.

a. The Contractor shall mail the notice within the following timeframes:

i. At least 10 days before the date of the adverse benefit determination, when the adverse benefit determination is a termination, suspension, or reduction of previously authorized Medicaid-covered services.

ii. For denial of payment, at the time of any adverse benefit determination affecting the claim.

iii. As expeditiously, as the beneficiary's condition requires within state-established timeframes

that shall not exceed 14 calendar days following receipt of the request for service, for standard authorization decisions that deny or limit services.

1. The Contractor shall be allowed to extend the 14 calendar day NOABD timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the beneficiary or the provider requests an extension.
2. The Contractor shall be allowed to extend the 14 calendar day NOABD timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the Contractor justifies a need (to the Department, upon request) for additional information and shows how the extension is in the beneficiary's best interest. Consistent with 42 CFR §438.210(d)(1)(ii), the Contractor shall:
    a. Give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he or she disagrees with that decision.
    b. Issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

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

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

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

c. The Contractor shall mail the NOABD by the date of the action when any of the following occur:
   i. The recipient has died.
   ii. The beneficiary submits a signed written statement requesting service termination.
   iii. The beneficiary submits a signed written statement including information that requires service termination or reduction and indicates that he understands that service termination or reduction will result.
   iv. The beneficiary has been admitted to an institution where he or she is ineligible under the plan for further services.
   v. The beneficiary's address is determined unknown based on returned mail with no forwarding address.
   vi. The beneficiary is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
   vii. A change in the level of medical care is prescribed by the beneficiary's physician.
   viii. The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act.
   ix. The transfer or discharge from a facility will occur in an expedited fashion.

3. Handling of Grievances and Appeals (42 CFR §438.406).

i. In handling grievances and appeals, the Contractor shall give beneficiaries any reasonable assistance in completing

forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

ii. The Contractor's process for handling beneficiary grievances and appeals of adverse benefit determinations shall:

a. Acknowledge receipt of each grievance and appeal within five calendar days.

b. Ensure that the individuals who make decisions on grievances and appeals are individuals—

i. Who, were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

ii. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the Department, in treating the beneficiary's condition or disease.

1. An appeal of a denial that is based on lack of medical necessity.
2. A grievance regarding denial of expedited resolution of an appeal.
3. A grievance or appeal that involves clinical issues.

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

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

d. Provide the beneficiary a reasonable opportunity, in person and in writing, to present evidence and

testimony and make legal and factual arguments. The Contractor shall inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution.

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

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

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

i. The Contractor shall resolve each grievance and appeal, and provide notice, as expeditiously as the beneficiary's health condition requires, within the following timeframes:

a. Standard resolution of grievances: 90 calendar days from the day the Contractor receives the grievance.

b. Standard resolution of appeals: 30 calendar days from the day the Contractor receives the appeal. This timeframe may be extended in the manner described below.

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

ii. Extension of timeframes.

a. The Contractor may extend the timeframes for standard and expedited resolution of grievances and appeals by up to 14 calendar days if:

i. The beneficiary requests the extension.
ii. The Contractor shows (to the satisfaction of the Department, upon its request) that there is need for additional information and how the delay is in the beneficiary's interest.

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

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

v. Format of notice:
a. Grievances.
i. The Contractor shall notify the beneficiary of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR §438.10.
b. Appeals.
i. For all appeals, the Contractor shall provide written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR §438.10.
ii. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice.

vi. The written notice of the resolution shall include the following:
a. The results of the resolution process and the date it was completed.

b. For appeals not resolved wholly in favor of the beneficiaries—
    i. The right to request a state fair hearing.
    ii. How to make the request a state fair hearing.
    iii. The right to request and receive benefits, while the hearing is pending and how to make the request.
    iv. That the beneficiary may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the Contractor's adverse benefit determination.

vii. Requirements for state fair hearings—

a. A beneficiary may request a state fair hearing only after receiving notice that the Contractor is upholding the adverse benefit determination.
b. If the Contractor fails to adhere to the notice and timing requirements in 42 CFR §438.408, then the beneficiary is deemed to have exhausted the Contractor's appeals process. The beneficiary may initiate a state fair hearing.
c. The Department shall offer and arrange for an external medical review when the following conditions are met:
    i. The review shall be at the beneficiary's request and shall not be required before, or used as a deterrent to, proceeding to the state fair hearing
    ii. The review shall be independent of both the Department and the Contractor.
    iii. The review shall be offered without any cost to the beneficiary.
    iv. The review shall not extend any of the timeframes specified in 42 CFR §438.408 and shall not disrupt the continuation of benefits in 42 CFR §438.420.
d. State fair hearing.
    i. The beneficiary shall request a state fair hearing no later than 120 calendar days from

the date of the Contractor's Notice of Appeal Resolution.

ii. The parties to the state fair hearing include the Contractor, as well as the beneficiary and his or her representative or the representative of a deceased beneficiary's estate.

5. **Expedited Resolution of Appeals (42 CFR §438.410).**
   - **i.** The Contractor shall establish and maintain an expedited review process for appeals when the Contractor determines (for a request from the beneficiary) or the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
   - **ii.** The Contractor shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's appeal.
   - **iii.** If the Contractor denies a request for expedited resolution of an appeal, it shall:
     a. Transfer the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2).
     b. Follow the requirements in 42 CFR §438.408(c)(2).
6. **Information About the Grievance and Appeal System to Providers and Subcontractors (42 CFR §438.414).**
   - **i.** The Contractor shall provide the information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.
7. **Recordkeeping Requirements (42 CFR §438.416).**[i]
   - **i.** The Contractor shall maintain records of grievances and appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the Department quality strategy.
   - **ii.** The record of each grievance or appeal shall contain, at a minimum, all of the following information:
     a. A general description of the reason for the appeal or grievance.

b. The date received.
c. The date of each review or, if applicable, review meeting.
d. Resolution at each level of the appeal or grievance, if applicable.
e. Date of resolution at each level, if applicable.
f. Name of the covered person for whom the appeal or grievance was filed.

iii. The record shall be accurately maintained in a manner accessible to the Department and available upon request to CMS.

8. Continuation of Benefits While the Contractor's Appeal and the State Fair Hearing Are Pending (42 CFR §438.420).

i. Timely files mean files for continuation of benefits on or before the later of the following:
a. Within 10 calendar days of Contractor sending the NOABD.
b. The intended effective date of the Contractor's proposed adverse benefit determination.

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

iii. At the beneficiary's request, the Contractor shall continue or reinstate the beneficiary's benefits while the appeal or state fair hearing is pending, the benefits shall be continued until one of following occurs:
a. The beneficiary withdraws the appeal or request for state fair hearing.

b. The beneficiary fails to request a state fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the beneficiary's appeal under 42 CFR §438.408(d)(2).
c. A state fair hearing officer issues a hearing decision adverse to the beneficiary.

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

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

i. The Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires (but no later than 72 hours from the date it receives notice reversing the determination) if the services were not furnished while the appeal was pending and if the Contractor or state fair hearing officer reverses a decision to deny, limit, or delay services.

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

H. Additional Program Integrity Safeguards

1. Basic Rule (42 CFR §438.600).

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

2. **State Responsibilities (42 CFR §438.602).**
    i. **Monitoring Contractor compliance.**
        a. Consistent with 42 CFR §438.66, the Department shall monitor the Contractor's compliance, as applicable, with 42 CFR §§438.604, 438.606, 438.608, 438.610, 438.230, 438.808, 438.900 et seq.
    ii. **Screening, enrollment, and revalidation of providers.**
        a. The Department shall screen and enroll, and revalidate every five years, all of the Contactor's network providers, in accordance with the requirements of 42 CFR, Part 455, Subparts B and E. This provision does not require the network provider to render services to FFS beneficiaries.
    iii. **Ownership and control information.**
        a. The Department shall review the ownership and control disclosures submitted by the Contractor, and any subcontractors as required in 42 CFR §438.608(c).
    iv. **Federal database checks.**
        a. Consistent with the requirements in 42 CFR §455.436, the Department shall confirm the identity and determine the exclusion status of the Contractor, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the Contractor through routine checks of Federal databases. This includes the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases as the state or Secretary may prescribe. These databases shall be consulted upon contracting and no less frequently than monthly thereafter. If the Department finds a party that is excluded, it shall promptly notify the Contractor and take action consistent with 42 CFR §438.610(c).
    v. **Periodic audits.**
        a. The Department shall periodically, but no less frequently than once every three years, conduct, or

contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, the Contractor.

vi. **Whistleblowers.**

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

vii. **Transparency.**

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

viii. **Contracting integrity.**

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

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

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

3. **Data, Information, and Documentation that shall be submitted (42 CFR §438.604).**
    - **i.** The Contractor shall submit to the Department the following data:
        a. Encounter data in the form and manner described in 42 CFR §438.818.
        b. Documentation described in 42 CFR §438.207(b) on which the Department bases its certification that the Contractor has complied with the Department's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR §438.206.
        c. Information on ownership and control described in 42 CFR §455.104 from the Contractor's subcontractors as governed by 42 CFR §438.230.
        d. The annual report of overpayment recoveries as required in 42 CFR §438.608(d)(3).
    - **ii.** In addition to the data, documentation, or information above, the Contractor shall submit any other data, documentation, or information relating to the performance of the Contractor's program integrity safeguard obligations required by the Department or the Secretary.
4. **Source, Content, and Timing of Certification (42 CFR §438.606).**
    - **i.** The data, documentation, or information specified in 42 CFR §438.604, shall be certified by either the Contractor's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.
    - **ii.** The certification shall attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR §438.604 is accurate, complete, and truthful.
    - **iii.** The Contractor shall submit the certification concurrently with the submission of the data, documentation, or information required in 42 CFR §438.604(a) and (b)

5. **Program Integrity Requirements (42 CFR §438.608).**
    - **i.** The Contractor, and its subcontractors to the extent that the subcontractors are delegated responsibility by the Contractor for coverage of services and payment of claims under this Agreement, shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse.
    - **ii.** The arrangements or procedures shall include the following:
        a. A compliance program that includes, at a minimum, all of the following elements:
            i. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements.
            ii. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Agreement and who reports directly to the Behavioral Health Director and the Board of Supervisors.
            iii. The establishment of a Regulatory Compliance Committee on the Board of Supervisors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under this Contract.
            iv. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and state standards and requirements under this Contract.
            v. Effective lines of communication between the compliance officer and the organization's employees.
            vi. Enforcement of standards through well- publicized disciplinary guidelines.

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

b. Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the Department.
c. Provision for prompt notification to the Department when it receives information about changes in a beneficiary's circumstances that may affect the beneficiary's eligibility including all of the following:
    i. Changes in the beneficiary's residence.
    ii. The death of a beneficiary.
d. Provision for notification to the Department when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor.
e. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by beneficiaries and the application of such verification processes on a regular basis.
f. If the Contractor makes or receives annual payments under this Agreement of at least $5,000,000, provision for written policies for all employees of the entity, and of any subcontractor or agent, that provide

detailed information about the False Claims Act and other Federal and state laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers

g. Provision for the prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the Department Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.
h. Provision for the Contractor's suspension of payments to a network provider for which the Department determines there is a credible allegation of fraud in accordance with 42 CFR §455.23.

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

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

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

a. The Contractor shall specify in accordance with this Exhibit A, Attachment I and Exhibit B of this Agreement:
    i. The retention policies for the treatment of recoveries of all overpayments from the Contractor to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.
    ii. The process, timeframes, and documentation required for reporting the recovery of all overpayments.

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

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

6. Prohibited Affiliations (42 CFR §438.610).

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

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

iii. The relationships described in paragraph (i) of this section, are as follows:

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

iv. If the Department finds that the Contractor is not in compliance, the Department:
a. Shall notify the Secretary of the noncompliance.
b. May continue an existing agreement with the Contractor unless the Secretary directs otherwise.
c. May not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary provides to the state and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement despite the prohibited affiliations.
d. Nothing in this section shall be construed to limit or otherwise affect any remedies available to the U.S. under sections 1128, 1128A or 1128B of the Act.

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

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

i. The Contractor and its subcontractors shall provide the following disclosures through the DMC certification process described in Article III.J:
a. The name and address of any person (individual or corporation) with an ownership or control interest in the Contractor. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

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

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

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

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

v. For the purposes of this section "person with an ownership or control interest" means a person or corporation that -

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

I. Conditions for Federal Financial Participation (FFP)

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

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

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

1. General Parity Requirement

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

drugs) other than those limitations permitted and outlined in this Agreement.

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

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

2. Quantitative Limitations

i. The Contractor shall not apply any cumulative financial requirement for substance use disorder services in a classification that accumulates separately from any established for medical/surgical services in the same classification. (42 CFR 438.910(c)(3))

3. Non-Quantitative Limitations

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

ii. The Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for substance use disorder services that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors

in determining access to out-of-network providers for medical/surgical benefits. (42 CFR §438.910(d)(3))

III. Program Specifications

A. Provision of Services

1. Provider Specifications

i. The following requirements shall apply to the Contractor, the provider, and the provider staff:

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

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

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

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

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

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

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

2. Services for Adolescents and Youth

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

B. Organized Delivery System (ODS) Timely Coverage

1. Non-Discrimination - Member Discrimination Prohibition

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

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

2. DMC-ODS services shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in this opt-in County. Determination of who may receive the DMC-ODS benefits shall be performed in accordance with DMC-ODS Special Terms and Conditions (STC) 132(d), Article II.E.4 of this Agreement, and as follows:

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

shall be conducted as set forth in the Tribal Delivery System - Attachment BB to the STCs.

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

a. The individual shall have received a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders or be assessed to be at risk for developing substance use disorder (for youth under 21).

b. The individual shall meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.

c. For beneficiaries in treatment prior to implementation of the DMC-ODS, the provider must conduct an ASAM assessment by the due date of the next updated treatment plan or continuing services justification, whichever occurs first.

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

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

iv. In addition to Article III.B.2.ii, the initial medical necessity determination, for an individual to receive a DMC-ODS benefit, shall be performed by a Medical Director or an LPHA. The Medical Director or LPHA shall evaluate each beneficiary's assessment and intake information if completed by a counselor through a face-to-face review or telehealth with the counselor to establish a beneficiary meets medical

necessity criteria. After establishing a diagnosis and documenting the basis for diagnosis, the ASAM Criteria shall be applied to determine placement into the level of assessed services.

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

C. Covered Services

1. In addition to the coverage and authorization of services requirements set forth in Article II.E.4 of this Agreement, the Contractor shall:

i. Identify, define, and specify the amount, duration, and scope of each medically necessary service that the Contractor is required to offer.

ii. Require that the medically necessary services identified be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in 42 CFR 440.230.

iii. Specify the extent to which the Contractor is responsible for covering medically necessary services related to the following:

a. The prevention, diagnosis, and treatment of health impairments.
b. The ability to achieve age-appropriate growth and development.
c. The ability to attain, maintain, or regain functional capacity.

2. The Contractor shall deliver the DMC-ODS Covered Services within a continuum of care as defined in the ASAM criteria.
3. Mandatory DMC-ODS Covered Services include:
    i. Withdrawal Management (minimum one level)
    ii. Intensive Outpatient
    iii. Outpatient
    iv. Opioid (Narcotic) Treatment Programs
    v. Recovery Services
    vi. Case Management
    vii. Physician Consultation
    viii. Perinatal Residential Treatment Services (excluding room and board)
        a. Room and board shall not be a covered expenditure under the DMC-ODS. Room and board may be paid with funding sources unrelated to the DMC-ODS.
    ix. Non-perinatal Residential Treatment Services (excluding room and board)
        a. Room and board shall not be a covered expenditure under the DMC-ODS. Room and board may be paid with funding sources unrelated to DMC-ODS.
4. Contractor, to the extent applicable, shall comply with "Sobky v. Smoley" (Document 2A), 855 F. Supp. 1123 (E.D. Cal 1994), incorporated by this reference.
5. Contractor shall comply with federal and state mandates to provide SUD treatment services deemed medically necessary for Medi-Cal eligible: (1) pregnant and postpartum women, and (2) adolescents under age 21 who are eligible under the EPSDT Program.

D. Financing

1. **Payment for Services**
    i. For claiming Federal Financial Participation (FFP), the Contractor shall certify the total allowable expenditures incurred in providing the DMC-ODS services provided either through Contractor operated providers, contracted fee-for-service providers or contracted managed care plans.
    ii. DHCS shall establish a Center for Medicare and Medicaid Services (CMS) approved Certified Public Expenditure (CPE) protocol before FFP associated with DMC-ODS

services, is made available to DHCS. This DHCS approved CPE protocol (Attachment AA of the STCs) shall explain the process DHCS shall use to determine costs incurred by the counties under this demonstration.

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

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

a. The recipient's OHC coverage has been exhausted, or
b. The specific service is not a benefit of the OHC.

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

2. Rate Setting

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

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

ii. The DHCS Rate Setting Work Group pursuant to the process set forth in WIC 14021.51 shall set the OTP/NTP

reimbursement rate. The Contractor shall reimburse all OTP/NTP providers at this rate.

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

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

E. Availability of Services

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

i. Consider the number and types (in terms of training, experience, and specialization) of providers required to ensure the availability and accessibility of medically necessary services.

ii. Maintain and monitor a network of appropriate providers that is supported by written agreements for subcontractors, and that is sufficient to provide its beneficiaries with adequate access to all services covered under this Agreement.

iii. In establishing and monitoring the network, document the following:

a. The anticipated number of Medi-Cal eligible beneficiaries.
b. The expected utilization of services, taking into account the characteristics and SUD treatment needs of beneficiaries.
c. The expected number and types of providers in terms of training and experience needed to meet expected utilization.
d. The number of network providers who are not accepting new beneficiaries.

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

F. Access to Services

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

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

3. In addition to the coverage and authorization of service requirements set forth in Article II.E.4 of this Agreement, the Contractor shall:

i. Authorize DMC-ODS services in accordance with the medical necessity requirements specified in Title 22, Section 51303 and the coverage provisions of the approved State Medi-Cal Plan.

ii. If services are denied, inform the beneficiary in accordance with Article II.G.2 of this Agreement.

iii. Provide prior authorization for residential services within 24 hours of the prior authorization request being submitted by the provider.

a. Prior authorization is prohibited for non-residential DMC-ODS services.

b. The Contractor's prior authorization process shall comply with the parity requirements set forth in 42 CFR §438.910(d).

iv. Review the DSM and ASAM Criteria documentation to ensure that the beneficiary meets the requirements for the service.

v. Have written policies and procedures for processing requests for initial and continuing authorization of services.

vi. Have a mechanism in place to ensure that there is consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate.

vii. Track the number, percentage of denied, and timeliness of requests for authorization for all DMC-ODS services that are submitted, processed, approved, and denied.

viii. Pursuant to 42 CFR 438.3(l), allow each beneficiary to choose his or her health professional to the extent possible and appropriate.

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

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

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

i. DMC-ODS services approved through the Special Terms and Conditions shall be available to all beneficiaries that reside in the ODS County and enrolled in the ODS Plan.

ii. Access to State Plan services shall remain at the current, pre-implementation level or expand upon implementation.

G. Coordination of Care

1. In addition to meeting the coordination and continuity of care requirements set forth in Article II.E.3, the Contractor shall develop a care coordination plan that provides for seamless transitions of care for beneficiaries with the DMC-ODS system of care. Contractor is responsible for developing a structured approach to care coordination to ensure that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient) without disruptions to services.

2. In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, the Contractor shall ensure that beneficiaries have access to recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.
3. Contractor shall enter into a Memorandum of Understanding (MOU) with any Medi-Cal managed care plan that enrolls beneficiaries served by the DMC-ODS. This requirement may be met through an amendment to the Specialty Mental Health Managed Care Plan MOU.
    i. The following elements in the MOU should be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers:
        a. Comprehensive substance use, physical, and mental health screening.
        b. Beneficiary engagement and participation in an integrated care program as needed.
        c. Shared development of care plans by the beneficiary, caregivers, and all providers.
        d. Collaborative treatment planning with managed care.
        e. Delineation of case management responsibilities.
        f. A process for resolving disputes between the Contractor and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved.
        g. Availability of clinical consultation, including consultation on medications.
        h. Care coordination and effective communication among providers including procedures for exchanges of medical information.
        i. Navigation support for patients and caregivers.
        j. Facilitation and tracking of referrals between systems including bidirectional referral protocol.

H. Authorization of Services – Residential Programs

1. The Contractor shall implement residential treatment program standards that comply with the authorization of services requirements set forth in Article II.E.4 and shall:
   - **i.** Establish, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services for residential programs.
   - **ii.** Ensure that residential services are provided in DHCS or Department of Social Services (DSS) licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.
   - **iii.** Ensure that residential services may be provided in facilities with no bed capacity limit.
   - **iv.** Ensure that the length of residential services comply with the following time restrictions:
     a. Adults, ages 21 and over, may receive up to two non-continuous short-term residential regimens per 365-day period. A short-term residential regimen is defined as one residential stay in a DHCS licensed facility for a maximum of 90 days per 365-day period.
        i. An adult beneficiary may receive one 30-day extension, if that extension is medically necessary, per 365-day period.
     b. Adolescents, under the age of 21, may receive up to two 30-day non-continuous regimens per 365-day period. Adolescent beneficiaries receiving residential treatment shall be stabilized as soon as possible and moved down to a less intensive level of treatment.
        i. Adolescent beneficiaries may receive a 30-day extension if that extension is determined to be medically necessary. Adolescent beneficiaries are limited to one extension per 365-day period.
     c. Nothing in the DMC-ODS overrides any EPSDT requirements. EPSDT beneficiaries may receive a longer length of stay based on medical necessity.

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

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

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

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

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

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

I. Provider Selection and Certification

1. In addition to complying with the provider selection requirements set forth in Article II.E.5 and the provider discrimination prohibitions in Article II.B.3, the Contractor:

i. Shall have written policies and procedures for selection and retention of providers that are in compliance with the terms and conditions of this Agreement and applicable federal laws and regulations.

ii. Shall apply those policies and procedures equally to all providers regardless of public, private, for-profit or non-profit status, and without regard to whether a provider treats persons who require high-risk or specialized services.

iii. Shall not discriminate against persons who require high-risk or specialized services.

iv. Shall subcontract with providers in another state where out-of-state care or treatment is rendered on an emergency basis or is otherwise in the best interests of the person under the circumstances.

v. Shall select only providers that have a license and/or certification issued by the state that is in good standing.

vi. Shall select only providers that, prior to the furnishing of services under this Agreement, have enrolled with, or revalidated their current enrollment with, DHCS as a DMC provider under applicable federal and state regulations.

vii. Shall select only providers that have been screened in accordance with 42 CFR 455.450(c) as a "high" categorical risk prior to furnishing services under this Agreement, have signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107, and have complied with the ownership and control disclosure requirements of 42 CFR 455.104. DHCS shall deny enrollment and DMC certification to any provider (as defined in Welfare & Institutions Code section 14043.1), or a person with ownership or control interest in the provider (as defined in 42 CFR 455.101), that, at the time of application, is under investigation for fraud or abuse pursuant to Part 455 of Title 42 of the Code of Federal Regulations, unless DHCS determines that there is good cause not to deny enrollment upon the same bases enumerated in 42 CFR 455.23(e). If a provider is under investigation for fraud or abuse, that provider shall be subject to temporary suspension pursuant to Welfare & Institutions Code section 14043.36. Upon receipt of a credible allegation of fraud, a provider shall be subject to a payment suspension pursuant to Welfare & Institutions Code section 14107.11 and DHCS may thereafter collect any overpayment identified through an audit or examination. During the time a provider is subject to a temporary suspension pursuant to Welfare & Institutions Code section 14043.36, the provider, or a person with ownership or control interest in the provider (as defined in 42 CFR 455.101), may not receive reimbursement for services provided to a DMC- ODS beneficiary. A provider shall be subject to suspension

pursuant to WIC 14043.61 if claims for payment are submitted for services provided to a Medi-Cal beneficiary by an individual or entity that is ineligible to participate in the Medi-Cal program. A provider will be subject to termination of provisional provider status pursuant to WIC 14043.27 if the provider has a debt due and owing to any government entity that relates to any federal or state health care program, and has not been excused by legal process from fulfilling the obligation. Only providers newly enrolling or revalidating their current enrollment on or after January 1, 2015 would be required to undergo fingerprint- based background checks required under 42 CFR 455.434.

2. **Disclosures that shall be provided.**
   - **i.** A disclosure from any provider or disclosing entity is due at any of the following times:
     a. Upon the provider or disclosing entity submitting the provider application.
     b. Upon the provider or disclosing entity executing the provider agreement.
     c. Upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414.
     d. Within 35 days after any change in ownership of the disclosing entity.
   - **ii.** All disclosures shall be provided to the Medicaid agency.
   - **iii.** Consequences for failure to provide required disclosures.
     a. Federal Financial Participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.
3. The Contractor shall only select providers that have a Medical Director who, prior to the delivery of services under this Agreement, has enrolled with DHCS under applicable state regulations, has been screened in accordance with 42 CFR 455.450(a) as a “limited” categorical risk within a year prior to serving as a Medical Director under this Agreement, and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107.

4. The Contractor may contract individually with LPHAs to provide DMC-ODS services in the network.
5. The Contractor shall have a protest procedure for providers that are not awarded a subcontract. The Contractor's protest procedure shall ensure that:
    i. Providers that submit a bid to be a subcontracted provider, but are not selected, shall exhaust the Contractor's protest procedure if a provider wishes to challenge the denial to DHCS.
    ii. If the Contractor does not render a decision within 30 calendar days after the protest was filed with the Contractor, then the protest shall be deemed denied and the provider may appeal the failure to DHCS.

J. DMC Certification and Enrollment

1. DHCS shall certify eligible providers to participate in the DMC program.
2. The DHCS shall certify any Contractor-operated or non-governmental providers. This certification shall be performed prior to the date on which the Contractor begins to deliver services under this Agreement at these sites.
3. Contractor shall require that providers of perinatal DMC services are properly certified to provide these services and comply with the applicable requirements contained in Article III.PP of this Exhibit A, Attachment I.
4. Contractor shall require all the subcontracted providers of services to be licensed, registered, DMC certified and/or approved in accordance with applicable laws and regulations. Contractor's subcontracts shall require that providers comply with the following regulations and guidelines:
    i. Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8
    ii. Title 22, Sections 51490.1(a)
    iii. Exhibit A, Attachment I, Article III.PP – Requirements for Services
    iv. Title 9, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq
    v. Title 22, Division 3, Chapter 3, sections 51000 et. seq
5. In the event of conflicts, the provisions of Title 22 shall control if they are more stringent.

6. The Contractor shall notify Provider Enrollment Division (PED) of an addition or change of information in a providers pending DMC certification application within 35 days of receiving notification from the provider. The Contractor shall ensure that a new DMC certification application is submitted to PED reflecting the change.
7. The Contractor shall be responsible for ensuring that any reduction of covered services or relocations by providers are not implemented until the approval is issued by DHCS. Within 35 days of receiving notification of a provider's intent to reduce covered services or relocate, the Contractor shall submit, or require the provider to submit, a DMC certification application to PED. The DMC certification application shall be submitted to PED 60 days prior to the desired effective date of the reduction of covered services or relocation.
8. The Contractor shall notify DHCS PED by e-mail at DHCSDMCRecert@dhcs.ca.gov within two business days of learning that a subcontractor's license, registration, certification, or approval to operate an SUD program or provide a covered service is revoked, suspended, modified, or not renewed by entities other than DHCS.
    i. A provider's certification to participate in the DMC program shall automatically terminate in the event that the provider, or its owners, officers or directors are convicted of Medi-Cal fraud, abuse, or malfeasance. For purposes of this section, a conviction shall include a plea of guilty or nolo contendere.

K. Continued Certification

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

L. Laboratory Testing Requirements

1. This part sets forth the conditions that all laboratories shall meet to be certified to perform testing on human specimens under the

Clinical Laboratory Improvement Amendments of 1988 (CLIA). Except as specified in paragraph (2) of this section, a laboratory will be cited as out of compliance with section 353 of the Public Health Service Act unless it:

i. Has a current, unrevoked or unsuspended certificate of waiver, registration certificate, certificate of compliance, certificate for PPM procedures, or certificate of accreditation issued by HHS applicable to the category of examinations or procedures performed by the laboratory.

ii. Is CLIA-exempt.

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

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

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

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

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

M. Recovery from Other Sources or Providers

1. The Contractor shall recover the value of covered services rendered to beneficiaries whenever the beneficiaries are covered for the same services, either fully or partially, under any other state or federal medical care program or under other contractual or legal entitlement including, but not limited to, a private group or indemnification program, but excluding instances of the tort liability of a third party or casualty liability insurance.
2. The monies recovered are retained by the Contractor. However, Contractor's claims for FFP for services provided to beneficiaries under this Agreement shall be reduced by the amount recovered.

3. The Contractor shall maintain accurate records of monies recovered from other sources.
4. Nothing in this section supersedes the Contractor's obligation to follow federal requirements for claiming FFP for services provided to beneficiaries with other coverage under this Agreement.

N. Early Intervention (ASAM Level 0.5)

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

O. Outpatient Services (ASAM Level 1.0)

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

P. Intensive Outpatient Services (ASAM Level 2.1)

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

Q. Residential Treatment Services

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

R. Case Management

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

S. Physician Consultation Services

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

T. Recovery Services

1. Recovery Services shall include:
   - **i.** Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care.
   - **ii.** Recovery Monitoring: Recovery coaching, monitoring via telephone and internet.
   - **iii.** Substance Abuse Assistance: Peer-to-peer services and relapse prevention.
   - **iv.** Education and Job Skills: Linkages to life skills, employment services, job training, and education services.
   - **v.** Family Support: Linkages to childcare, parent education, child development support services, and family/marriage education.
   - **vi.** Support Groups: Linkages to self-help and support, spiritual and faith-based support.
   - **vii.** Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.
2. Recovery services shall be utilized when the beneficiary is triggered, when the beneficiary has relapsed, or simply as a preventative measure to prevent relapse. As part of the assessment and treatment needs of Dimension 6, Recovery Environment of the ASAM Criteria and during the

transfer/transition planning process, the Contractor shall provide beneficiaries with recovery services.

3. Additionally, the Contractor shall:
   - **i.** Provide recovery services to beneficiaries as medically necessary.
   - **ii.** Provide beneficiaries with access to recovery services after completing their course of treatment.
   - **iii.** Provide recovery services either face-to-face, by telephone, or by telehealth, and in any appropriate setting in the community with the beneficiary.

U. Withdrawal Management

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

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

1. Pursuant to WIC 14124.22, an OTP/NTP provider who is also enrolled as a Medi-Cal provider may provide medically necessary treatment of concurrent health conditions to Medi-Cal beneficiaries who are not enrolled in managed care plans as long as those services are within the scope of the provider's practice. OTP/NTP providers shall refer all Medi-Cal beneficiaries that are enrolled in managed care plans to their respective managed care plan to receive medically necessary medical treatment of their concurrent health conditions.
2. The diagnosis and treatment of concurrent health conditions of Medi-Cal beneficiaries that are not enrolled in managed care plans by an OTP/NTP provider may be provided within the Medi-Cal coverage limits. When the services are not part of the SUD treatment reimbursed pursuant to WIC 14021.51, the services

rendered shall be reimbursed in accordance with the Medi-Cal program. Services reimbursable under this section shall include all of the following:

i. Medical treatment visits
ii. Diagnostic blood, urine, and X-rays
iii. Psychological and psychiatric tests and services
iv. Quantitative blood and urine toxicology assays
v. Medical supplies

3. An OTP/NTP provider who is enrolled as a Medi-Cal fee-for-service provider shall not seek reimbursement from a beneficiary for SUD treatment services, if the OTP/NTP provider bills the services for treatment of concurrent health conditions to the Medi-Cal fee-for-service program.
4. The Contractor shall subcontract with licensed NTPs to offer services to beneficiaries who meet medical necessity criteria requirements.
5. Services shall be provided in accordance with an individualized beneficiary plan determined by a licensed prescriber.
6. Offer and prescribe medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone, and disulfiram.
7. Services provided as part of an OTP/NTP shall include: assessment, treatment planning, individual and group counseling, patient education, medication services, collateral services, crisis intervention services, treatment planning, medical psychotherapy, and discharge services.
    i. Beneficiaries shall receive between 50 and 200 minutes of counseling per calendar month with a therapist or counselor, and, when medically necessary, additional counseling services may be provided.
8. **Courtesy Dosing**
    i. An OTP/NTP provider may provide replacement narcotic therapy to visiting beneficiaries approved to receive services on a temporary basis (less than 30 days) in accordance with Title 9, Section 10295. Prior to providing replacement narcotic therapy to a visiting beneficiary, an OTP/NTP provider must comply with Title 9, Section 10210(d).

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

W. Cultural Competence Plan

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

X. Implementation Plan

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

Y. Additional Provisions

1. **Additional Intergovernmental Agreement Restrictions**
   - **i.** This Agreement is subject to any additional restrictions, limitations, conditions, or statutes enacted or amended by the federal or state governments, which may affect the provisions, terms, or funding of this Agreement in any manner.
2. **Voluntary Termination of DMC-ODS Services**
   - **i.** The Contractor may terminate this Agreement at any time, for any reason, by giving 60 days written notice to DHCS. The Contractor shall be paid for DMC-ODS services provided to beneficiaries up to the date of termination. Upon termination, the Contractor shall immediately begin providing DMC services to beneficiaries in accordance with the State Plan.

3. **Nullification of DMC-ODS Services**
    i. The parties agree that failure of the Contractor, or its subcontractors, to comply with W&I section 14124.24, the Special Terms and Conditions, and this Agreement, shall be deemed a breach that results in the termination of this Agreement for cause.
    ii. In the event of a breach, DMC-ODS services shall terminate. The Contractor shall immediately begin providing DMC services to the beneficiaries in accordance with the State Plan.
4. **Hatch Act**
    i. Contractor agrees to comply with the provisions of the Hatch Act (Title 5 USC, Sections 1501-1508), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.
5. **No Unlawful Use or Unlawful Use Messages Regarding Drugs**
    i. Contractor agrees that information produced through these funds, and which pertains to drug and alcohol related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug or alcohol related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (HSC Section 11999-11999.3). By signing this Agreement, Contractor agrees that it shall enforce, and shall require its subcontractors to enforce, these requirements.
6. **Noncompliance with Reporting Requirements**
    i. Contractor agrees that DHCS has the right to withhold payments until Contractor has submitted any required data and reports to DHCS, as identified in this Exhibit A, Attachment I or as identified in Document 1F(a), Reporting Requirement Matrix for Counties.
7. **Limitation on Use of Funds for Promotion of Legalization of Controlled Substances**
    i. None of the funds made available through this Agreement may be used for any activity that promotes the legalization of any drug or other substance included in Schedule I of Section 202 of the Controlled Substances Act (21 USC 812).

8. **Health Insurance Portability and Accountability Act (HIPAA) of 1996**
   i. If any of the work performed under this Agreement is subject to the HIPAA, Contractor shall perform the work in compliance with all applicable provisions of HIPAA. As identified in Exhibit F, DHCS and the Contractor shall cooperate to ensure mutual agreement as to those transactions between them, to which this Provision applies. Refer to Exhibit F for additional information.
   ii. **Trading Partner Requirements**
      a. No Changes. Contractor hereby agrees that for the personal health information (Information), it shall not change any definition, data condition or use of a data element or segment as proscribed in the federal HHS Transaction Standard Regulation. (45 CFR Part 162.915 (a))
      b. No Additions. Contractor hereby agrees that for the Information, it shall not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation. (45 CFR Part 162.915 (b))
      c. No Unauthorized Uses. Contractor hereby agrees that for the Information, it shall not use any code or data elements that either are marked "not used" in the HHS Transaction's Implementation specification or are not in the HHS Transaction Standard's implementation specifications. (45 CFR Part 162.915 (c))
      d. No Changes to Meaning or Intent. Contractor hereby agrees that for the Information, it shall not change the meaning or intent of any of the HHS Transaction Standard's implementation specification. (45 CFR Part 162.915 (d))
   iii. **Concurrence for Test Modifications to HHS Transaction Standards**
      a. Contractor agrees and understands that there exists the possibility that DHCS or others may request an extension from the uses of a standard in the HHS

Transaction Standards. If this occurs, Contractor agrees that it shall participate in such test modifications.

iv. Adequate Testing

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

v. Deficiencies

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

vi. Code Set Retention

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

vii. Data Transmission Log

a. Both Parties shall establish and maintain a Data Transmission Log, which shall record any and all data transmissions taking place between the Parties during the term of this Agreement. Each Party shall take necessary and reasonable steps to ensure that such Data Transmission Logs constitute a current, accurate, complete, and unaltered record of any and all Data Transmissions between the Parties, and shall be retained by each Party for no less than 24 months following the date of the Data Transmission. The

Data Transmission Log may be maintained on computer media or other suitable means provided that, if necessary to do so, the information contained in the Data Transmission Log may be retrieved in a timely manner and presented in readable form.

9. **Counselor Certification**
   - **i.** Any counselor or registrant providing intake, assessment of need for services, treatment or recovery planning, individual or group counseling to participants, patients, or residents in a DHCS licensed or certified program is required to be certified as defined in Title 9, Division 4, Chapter 8. (Document 3H)
10. **Cultural and Linguistic Proficiency**
   - **i.** To ensure equal access to quality care by diverse populations, each service provider receiving funds from this Agreement shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards (Document 3V) and comply with 42 CFR 438.206(c)(2).
11. **Trafficking Victims Protection Act of 2000**
   - **i.** Contractor and its subcontractors that provide services covered by this Agreement shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(g)) as amended by section 1702. For full text of the award term, go to: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title22-section7104d&num=0&edition=prelim
12. **Participation in the County Behavioral Health Director's Association of California.**
   - **i.** The Contractor's County AOD Program Administrator shall participate and represent the county in meetings of the County Behavioral Health Director's Association of California for the purposes of representing the counties in their relationship with DHCS with respect to policies, standards, and administration for SUD services.
   - **ii.** The Contractor's County AOD Program Administrator shall attend any special meetings called by the Director of DHCS.

13. Youth Treatment Guidelines

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

14. Nondiscrimination in Employment and Services

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

15. Federal Law Requirements:

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

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

iii. Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.

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

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

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

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

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

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

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

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

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

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

16. State Law Requirements:

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

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

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

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

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

17. Investigations and Confidentiality of Administrative Actions

i. Contractor acknowledges that if a DMC provider is under investigation by DHCS or any other state, local or federal law enforcement agency for fraud or abuse, DHCS may temporarily suspend the provider from the DMC program, pursuant to WIC 14043.36(a). Information about a provider's administrative sanction status is confidential until such time

as the action is either completed or resolved. DHCS may also issue a Payment Suspension to a provider pursuant to WIC 14107.11 and Code of Federal Regulations, Title 42, section 455.23. The Contractor is to withhold payments from a DMC provider during the time a Payment Suspension is in effect.

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

18. Subcontract Provisions

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

Z. Beneficiary Problem Resolution Process

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

2. Contractor shall inform subcontractors and providers at the time they enter into a subcontract about:

i. The beneficiary's right to a state fair hearing, how to obtain a hearing and the representation rules at the hearing.

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

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

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

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

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

vii. The beneficiary's right to request continuation of benefits during an appeal or state fair hearing filing although the

beneficiary may be liable for the cost of any continued benefits if the action is upheld.

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

3. The Contractor shall represent the Contractor's position in fair hearings, as defined in 42 CFR 438.408 dealing with beneficiaries' appeals of denials, modifications, deferrals or terminations of covered services. The Contractor shall carry out the final decisions of the fair hearing process with respect to issues within the scope of the Contractor's responsibilities under this Agreement. Nothing in this section is intended to prevent the Contractor from pursuing any options available for appealing a fair hearing decision.

i. Pursuant to 42 CFR 438.228, the Contractor shall develop problem resolution processes that enable beneficiary to request and receive review of a problem or concern he or she has about any issue related to the Contractor's performance of its duties, including the delivery of SUD treatment services.

4. The Contractor's beneficiary problem resolution processes shall include:

i. A grievance process

ii. An appeal process

iii. An expedited appeal process

AA. Subcontracts

1. In addition to complying with the subcontractual relationship requirements set forth in Article II.E.8 of this Agreement, the Contractor shall ensure that all subcontracts require that the Contractor oversee and is held accountable for any functions and responsibilities that the Contractor delegates to any subcontractor.

2. Each subcontract shall:

i. Fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract.

ii. Ensure that the Contractor evaluates the prospective subcontractor's ability to perform the activities to be delegated.

iii. Require a written agreement between the Contractor and the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor, and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

iv. Ensure the Contractor monitors the subcontractor's performance on an ongoing basis and subject it to an annual onsite review, consistent with statutes, regulations, and Article III.PP.

v. Ensure the Contractor identifies deficiencies or areas for improvement, the subcontractor shall take corrective actions and the Contractor shall ensure that the subcontractor implements these corrective actions.

3. The Contractor shall include the following provider requirements in all subcontracts with providers:

i. Culturally Competent Services: Providers are responsible to provide culturally competent services. Providers shall ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations. Translation services shall be available for beneficiaries, as needed.

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

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

a. Motivational Interviewing: A beneficiary-centered, empathic, but directive counseling strategy designed

to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on beneficiaries' past successes.

b. Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
c. Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.
d. Trauma-Informed Treatment: Services shall take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.
e. Psycho-Education: Psycho-educational groups are designed to educate beneficiaries about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries' lives, to instill self- awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

BB. Program Integrity Requirements

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

2. DMC Claims and Reports

i. Contractor or providers that bill DHCS or the Contractor for DMC-ODS services shall submit claims in accordance with

Department of Health Care Service's DMC Provider Billing Manual.

ii. Contractor and subcontractors that provide DMC services shall be responsible for verifying the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for DMC services to that beneficiary for that month. Medi-Cal eligibility verification should be performed prior to rendering service, in accordance with and as described in the DHCS DMC Provider Billing Manual. Options for verifying the eligibility of a Medi-Cal beneficiary are described in the Department of Health Care Services DMC Provider Billing Manual.

iii. Claims for DMC reimbursement shall include DMC-ODS services covered under the Special Terms and Conditions of this Agreement, and any State Plan services covered under Title 22, Section 51341.1(c-d) and administrative charges that are allowed under WIC, Sections 14132.44 and 14132.47.

a. Contractor shall submit to DHCS the "Certified Expenditure" form reflecting either: 1) the approved amount of the 837P claim file, after the claims have been adjudicated, or 2) the claimed amount identified on the 837P claim file, which could account for both approved and denied claims. Contractor shall submit to DHCS the Drug Medi-Cal Certification Form DHCS 100224A (Document 4D) for each 837P transaction approved for reimbursement of the federal Medicaid funds.

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

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

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

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

3. **Certified Public Expenditure - County Administration**
   i. Separate from direct service claims as identified above, the Contractor may submit an invoice for administrative costs for administering the DMC-ODS program on a quarterly basis. The form requesting reimbursement shall be submitted to DHCS.
      a. **Mail Form MC 5312 to:**
         Department of Health Care Services
         Fiscal Management & Accountability Section
         1500 Capitol Avenue, MS 2629
         P.O. Box 997413, Sacramento, CA 95899-7413

         Alternatively, scan signed Form MC 5312 and email to:

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

CC. Quality Management (QM) Program

1. The Contractor's QM Program shall improve Contractor's established treatment outcomes through structural and

operational processes and activities that are consistent with current standards of practice.

2. The Contractor shall have a written description of the QM Program, which clearly defines the QM Program's structure and elements, assigns responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement.
3. Annually, each Contractor shall:
   i. Measure and report to DHCS its performance using standard measures required by DHCS including those that incorporate the requirements set forth in Article II.F.1 of this Agreement.
   ii. Submit to DHCS data specified by DHCS that enables DHCS to measure the Contractor's performance.
   iii. Perform a combination of the activities described above.
   iv. The QM Program shall be evaluated annually and updated by the Contractor as necessary as set forth in Article II.F.1 of this Agreement.
4. During the Triennial Reviews, DHCS shall review the status of the Quality Improvement Plan and the Contractor's monitoring activities.
   i. This review shall include the counties service delivery system, beneficiary protections, access to services, authorization for services, compliance with regulatory and contractual requirements of the waiver, and a beneficiary records review.
   ii. This triennial review shall provide DHCS with information as to whether the counties are complying with their responsibility to monitor their service delivery capacity.
   iii. The counties shall receive a final report summarizing the findings of the triennial review, and if out of compliance, the Contractor shall submit a corrective action plan (CAP) within 60 days of receipt of the final report. DHCS shall follow-up with the CAP to ensure compliance.
5. The QM Program shall conduct performance-monitoring activities throughout the Contractor's operations. These activities shall include, but not be limited to, beneficiary and system outcomes, utilization management, utilization review, provider appeals,

credentialing and monitoring, and resolution of beneficiary grievances.

6. The Contractor shall ensure continuity and coordination of care with physical health care providers. The Contractor shall coordinate with other human services agencies used by its beneficiaries. The Contractor shall assess the effectiveness of any MOU with a physical health care plan.
7. The Contractor shall have mechanisms to detect both underutilization of services and overutilization of services, as required by Article II.F.1 of this Agreement.
8. The Contractor shall implement mechanisms to assess beneficiary/family satisfaction. The Contractor shall assess beneficiary/family satisfaction by:
    a. Surveying beneficiary/family satisfaction with the Contractor's services at least annually.
    b. Evaluating beneficiary grievances, appeals and fair hearings at least annually.
    c. Evaluating requests to change persons providing services at least annually.
    d. The Contractor shall inform providers of the results of beneficiary/family satisfaction activities.
9. The Contractor shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. Monitoring shall occur at least annually.
10. The Contractor shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The Contractor shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the Contractor at least annually.
11. The Contractor shall have a QM Work Plan covering the current Agreement cycle with documented annual evaluations and documented revisions as needed. The Contractor's QM Work Plan shall evaluate the impact and effectiveness of its quality assessment and performance improvement program. The QM Work Plan shall include:

i. Evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Article II.F.1 and Article II.G.7 of this Agreement.

ii. Evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service.

iii. A description of completed and in-process QM activities, including performance improvement projects. The description shall include:
   a. Monitoring efforts for previously identified issues, including tracking issues over time.
   b. Objectives, scope, and planned QM activities for each year.
   c. Targeted areas of improvement or change in service delivery or program design.

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

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

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

1. DHCS shall conduct Postservice Postpayment and Postservice Prepayment (PSPP) Utilization Reviews of the contracted DMC providers to determine whether the DMC services were provided in accordance with Article III.PP of this exhibit. DHCS shall issue the PSPP report to the Contractor with a copy to subcontracted DMC provider. The Contractor shall be responsible for their subcontracted providers and their Contractor run programs to ensure any deficiencies are remediated pursuant to Article III.DD.2. The Contractor shall attest the deficiencies have been

remediated and are complete, pursuant to Article III.EE.5 of this Agreement.

2. The Department shall recover payments made if subsequent investigation uncovers evidence that the claim(s) should not have been paid, DMC-ODS services have been improperly utilized, and requirements of Article III.PP were not met.

i. All deficiencies identified by PSPP reports, whether or not a recovery of funds results, shall be corrected and the Contractor shall submit a Contractor-approved CAP. The CAP shall be submitted to the DHCS Analyst that conducted the review, within 60 days of the date of the PSPP report.

a. The CAP shall:

i. Be documented on the DHCS CAP template.

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

iii. Identify the title of the individual(s) responsible for:

1. Correcting the deficiency
2. Ensuring on-going compliance

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

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

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

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

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

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

         i. The provider and/or Contractor shall submit the letter on the official stationery of the provider and/or Contractor and it shall be signed by an authorized representative of the provider and/or Contractor.
         ii. The letter shall identify the specific claim(s) involved and describe the disputed (in)action regarding the claim.
      b. The letter shall be submitted to the address listed in Subsection (a) above within 90 calendar days from the date the provider and/or Contractor received written notification of the decision to disallow claims.
      c. The SUD-PPFD shall acknowledge provider and/or Contractor letter within 15 calendar days of receipt.
      d. The SUD-PPFD shall inform the provider and/or Contractor of SUD–PPFD's decision and the basis for the decision within 15 calendar days after the SUD-PPFD's acknowledgement notification. The SUD-PPFD shall have the option of extending the decision response time if additional information is required from the provider and/or Contractor. The provider and/or Contractor will be notified if the SUD-PPFD extends the response time limit.
4. A provider and/or Contractor may initiate a second level appeal to the Office of Administrative Hearings and Appeals (OAHA).
   i. The second level process may be pursued only after complying with first-level procedures and only when:

a. The SUD-PPFD has failed to acknowledge the grievance or complaint within 15 calendar days of its receipt, or
b. The provider and/or Contractor is dissatisfied with the action taken by the SUD-PPFD where the conclusion is based on the SUD-PPFD's evaluation of the merits.

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

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

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

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

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

5. The appeal process listed here shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of DHCS pursuant to Exhibit B of this Agreement.

6. State shall monitor the subcontractor's compliance with Contractor utilization review requirements, as specified in Article III.EE. Counties are also required to monitor the subcontractor's compliance pursuant to Article III.AA of this Agreement. The federal government may also review the existence and effectiveness of DHCS' utilization review system.

7. Contractor shall, at a minimum, implement and maintain compliance with the requirements described in Article III.PP for the purposes of reviewing the utilization, quality, and

appropriateness of covered services and ensuring that all applicable Medi-Cal requirements are met.

8. Contractor shall ensure that subcontractor sites shall keep a record of the beneficiaries/patients being treated at that location. Contractor shall retain beneficiary records for a minimum of 10 years, in accordance with 438.3(h), from the finalized cost settlement process with the Department. When an audit by the Federal Government or DHCS has been started before the expiration of the 10-year period, the beneficiary records shall be maintained until completion of the audit and the final resolution of all issues.

EE. Contractor Monitoring

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

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

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

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

   Technical assistance is available to counties from SUD-PPFD.

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

3. If the Contractor is removed from participating in the Waiver, the county shall provide DMC services in accordance with the California Medi-Cal State Plan.
4. Contractor shall ensure that DATAR submissions, detailed in Article III.FF of this Exhibit, are complied with by all treatment providers and subcontracted treatment providers. Contractor shall attest that each subcontracted provider is enrolled in DATAR at the time of execution of the subcontract.
5. The Contractor shall monitor and attest compliance and/or completion by providers with CAP requirements (detailed in Article III.DD) of this Exhibit as required by any PSPP review. The Contractor shall attest to DHCS, using the form developed by DHCS that the requirements in the CAP have been completed by the Contractor and/or the provider. Submission of DHCS Form 8049 by Contractor shall be accomplished within the timeline specified in the approved CAP, as noticed by DHCS.
6. Contractor shall attest that DMC claims submitted to DHCS have been subject to review and verification process for accuracy and legitimacy. (45 CFR 430.30, 433.32, 433.51). Contractor shall not knowingly submit claims for services rendered to any beneficiary after the beneficiary's date of death, or from uncertified or decertified providers.

FF. Reporting Requirements

1. Contractor agrees that DHCS has the right to withhold payments until Contractor has submitted any required data and reports to DHCS, as identified in this Exhibit A, Attachment I or as identified in Document 1F(a), Reporting Requirement Matrix for Counties.
2. Contractor shall submit documentation to DHCS in a format specified by DHCS that complies with the following requirements:
    i. Offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service area,
    ii. Maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of beneficiaries in the area, and
    iii. Demonstrates the Contractor's compliance with the parity requirements set forth in 42 CFR §438.900 et seq.

3. The Contractor shall submit the documentation described in paragraph (2) of this section as specified by DHCS, but no less frequently than the following:
    i. At the time it enters into this Agreement with DHCS.
    ii. At any time there has been a significant change in the Contractor's operations that would affect adequate capacity, services, and parity, including:
        i. Changes in Contractor services, benefits, geographic service area or payments.
        ii. Enrollment of a new population in the Contractor.
        iii. Changes in a quantitative limitation or non-quantitative limitation on a substance use disorder benefit.
    iii. After DHCS reviews the documentation submitted by the Contractor, DHCS shall certify to CMS that the Contractor has complied with the state's requirements for availability of services, as set forth in §438.206, and parity requirements, as set forth in 42 CFR §438.900 et seq.
    iv. CMS' right to inspect documentation. DHCS shall make available to CMS, upon request, all documentation collected by DHCS from the Contractor.
4. **California Outcomes Measurement System (CalOMS) for Treatment (CalOMS-Tx)**
    i. The CalOMS-Tx business rules and requirements are:
        a. Contractor shall contract with a software vendor that complies with the CalOMS-Tx data collection system requirements for submission of CalOMS-Tx data. A Business Associate Agreement (BAA) shall be established between the Contractor and the software vendor. The BAA shall state that DHCS is allowed to return the processed CalOMS-Tx data to the vendor that supplied the data to DHCS.
        b. Contractor shall conduct information technology (IT) systems testing and pass state certification testing before commencing submission of CalOMS-Tx data. If the Contractor subcontracts with vendor for IT services, Contractor is responsible for ensuring that the subcontracted IT system is tested and certified by

the DHCS prior to submitting CalOMS-Tx data. If Contractor changes or modifies the CalOMS-Tx IT system, then Contractor shall re-test and pass state re-certification prior to submitting data from new or modified system.

c. Electronic submission of CalOMS-Tx data shall be submitted by Contractor within 45 days from the end of the last day of the report month.
d. Contractor shall comply with data collection and reporting requirements established by the DHCS CalOMS-Tx Data Collection Guide (Document 3J) and all former Department of Alcohol and Drug Programs Bulletins and DHCS Information Notices relevant to CalOMS-Tx data collection and reporting requirements.
e. Contractor shall submit CalOMS-Tx admission, discharge, annual update, resubmissions of records containing errors or in need of correction, and "provider no activity" report records in an electronic format approved by DHCS.
f. Contractor shall comply with the CalOMS-Tx Data Compliance Standards established by DHCS identified in (Document 3S) for reporting data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method.
g. Contractor shall participate in CalOMS-Tx informational meetings, trainings, and conference calls.
h. Contractor shall implement and maintain a system for collecting and electronically submitting CalOMS-Tx data.
i. Contractor shall meet the requirements as identified in Exhibit F, Privacy and Information Security Provisions.

5. CalOMS-Tx General Information

i. If the Contractor experiences system or service failure or other extraordinary circumstances that affect its ability to timely submit CalOMS-Tx data, and or meet other CalOMS-

Tx compliance requirements, Contractor shall report the problem in writing by secure, encrypted e-mail to DHCS at: ITServiceDesk@dhcs.ca.gov, before the established data submission deadlines. The written notice shall include a remediation plan that is subject to review and approval by DHCS. A grace period of up to 60 days may be granted, at DHCS' sole discretion, for the Contractor to resolve the problem before non-DMC payments are withheld.

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

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

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

6. Drug and Alcohol Treatment Access Report (DATAR)

i. The DATAR business rules and requirements:

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

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

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

d. The Contractor shall ensure that all applicable providers are enrolled in DHCS' web-based DATAR program for submission of data, accessible on the DHCS website when executing the subcontract.
e. If the Contractor or its subcontractor experiences system or service failure or other extraordinary circumstances that affect its ability to timely submit a monthly DATAR report, and/or to meet data compliance requirements, the Contractor shall report the problem in writing before the established data submission deadlines. The written notice shall include a CAP that is subject to review and approval by DHCS. A grace period of up to 60 days may be granted, at DHCS' sole discretion, for the Contractor to resolve the problem before non-DMC payments are withheld (See Exhibit B, Part II, Section 2).
f. If DHCS experiences system or service failure, no penalties shall be assessed to Contractor for late data submission.
g. The Contractor shall be considered compliant if a minimum of 95% of required DATAR reports from the Contractor's treatment providers are received by the due date.

7. Year-End Cost Settlement Reports

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

a. County Certification form (MC 6229): Submit via regular mail or overnight services. DHCS needs original signatures, not a copy.
b. Drug Medi-Cal (DMC) data: Submit the data via the Substance Use Disorder Cost Report System (SUDCRS) and submit the individual provider Excel files via email, regular mail, or overnight services.
c. DMC Provider Certification forms: Submit via regular mail or overnight services. DHCS needs original signatures, not a copy.

8. **Failure to Meet Reporting Requirements**
    i. Failure to meet required reporting requirements shall result in:
        a. DHCS shall issue a Notice of Deficiency (Deficiencies) to Contractor regarding specified providers with a deadline to submit the required data and a request for a CAP to ensure timely reporting in the future. DHCS shall approve or reject the CAP or request revisions to the CAP, which shall be resubmitted to DHCS within 30 days.
        b. If the Contractor has not ensured compliance with the data submission or CAP request within the designated timeline, then DHCS may withhold funds until all data is submitted. DHCS shall inform the Contractor when funds shall be withheld.

GG. Training

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

b. The Contractor shall ensure that all residential service providers meet the established ASAM criteria for each level of residential care they provide and receive an ASAM Designation prior to providing DMC-ODS services.

HH. Program Complaints

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

   SUD Compliance Division:

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

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

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

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

II. Record Retention

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

JJ. Subcontract Termination

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

KK. Corrective Action Plan

1. If the Contractor fails to ensure any of the foregoing oversight through an adequate system of monitoring, utilization review, and fiscal and programmatic controls, DHCS may request a CAP from the Contractor to address these deficiencies and a timeline for implementation. Failure to submit a CAP or adhere to the provisions in the CAP can result in a withholding of funds allocated to Contractor for the provision of services, and/or termination of this Agreement for cause.
2. Failure to comply with Monitoring requirements shall result in:
   - **i.** DHCS shall issue a report to Contractor after conducting monitoring or utilization reviews of the Contractor. When the DHCS report identifies non-compliant services or processes, it shall require a CAP. The Contractor shall submit a CAP to DHCS within the timeframes required by DHCS.
     a. The CAP shall:
        i. Be documented on the DHCS CAP template.
        ii. Provide a specific description of how the deficiency shall be corrected.
        iii. Identify the title of the individual(s) responsible for:
           1. Correcting the deficiency
           2. Ensuring on-going compliance
        iv. Provide a specific description of how the provider will ensure on-going compliance.
        v. Specify the target date of implementation of the corrective action.
   - **ii.** DHCS shall provide written approval of the CAP to the Contractor. If DHCS does not approve the CAP submitted by the Contractor, DHCS shall provide guidance on the deficient areas and request an updated CAP from the Contractor with a new deadline for submission.
   - **iii.** If a CAP is not submitted, or, the Contractor does not implement the approved CAP provisions within the designated timeline, then DHCS may withhold funds until the Contractor is in compliance. DHCS shall inform the Contractor when funds shall be withheld.

LL. Quality Improvement (QI) Program

1. Contractor shall establish an ongoing quality assessment and performance improvement program consistent with Article II.F.1 of this Agreement.
2. CMS, in consultation with DHCS and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by DHCS in this Agreement.
3. Performance improvement projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and beneficiary satisfaction.
4. The monitoring of accessibility of services outlined in the Quality Improvement (QI) Plan will at a minimum include:
   - **i.** Timeliness of first initial contact to face-to-face appointment.
   - **ii.** Frequency of follow-up appointments in accordance with individualized treatment plans.
   - **iii.** Timeliness of services of the first dose of OTP/NTP services.
   - **iv.** Access to after-hours care.
   - **v.** Responsiveness of the beneficiary access line.
   - **vi.** Strategies to reduce avoidable hospitalizations.
   - **vii.** Coordination of physical and mental health services with waiver services at the provider level.
   - **viii.** Assessment of the beneficiaries' experiences.
   - **ix.** Telephone access line and services in the prevalent non-English languages.
5. The Contractor's QI program shall monitor the Contractor's service delivery system with the aim of improving the processes of providing care and better meeting the needs of its beneficiaries. The QI Program shall be accountable to the Contractor's Director.
6. The Contractor shall establish a QI Committee to review the quality of SUD treatment services provided to beneficiaries. The QI Committee shall recommend policy decisions; review and evaluate the results of QI activities, including performance improvement projects; institute needed QI actions; ensure follow- up of QI processes; and document QI Committee meeting minutes regarding decisions and actions taken. The QI committee shall recommend policy decisions; review and evaluate the results of QI activities; institute needed QI actions, ensure follow-up of QI

process and document QI committee minutes regarding decisions and actions taken.

7. Each Contractor's QI Committee shall review the following data at a minimum on a quarterly basis since external quality review (EQR) site reviews will begin after county implementation. The External Quality Review Organization (EQRO) shall measure defined data elements to assess the quality of service provided by the Contractor. These data elements shall be incorporated into the EQRO protocol:
   i. Number of days to first DMC-ODS service at appropriate level of care after referral.
   ii. Existence of a 24/7 telephone access line with prevalent non-English language(s).
   iii. Access to DMC-ODS services with translation services in the prevalent non-English language(s).
8. Operation of the QI program shall include substantial involvement by a licensed SUD staff person.
9. The QI Program shall include active participation by the Contractor's practitioners and providers, as well as beneficiaries and family members, in the planning, design and execution of the QI Program.
10. The Contractor shall maintain a minimum of two active Performance Improvement Projects (PIPs) that meet the criteria in 42 CFR 438.240(b)(1) and (d). Performance improvement projects shall focus on a clinical area, as well as one non-clinical area.
11. PIPs shall:
   i. Measure performance using required quality indicators.
   ii. Implement system interventions to achieve improvement in quality.
   iii. Evaluate the effectiveness of interventions.
   iv. Plan and initiate activities for increasing or sustaining improvement.
12. The Contractor shall report the status and results of each PIP to DHCS, as requested.
13. Each PIP shall be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care annually.

MM. Utilization Management (UM) Program

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

NN. Formation and Purpose

1. **Authority**
   - **i.** The state and the Contractor enter into this Agreement, by authority of Chapter 3 of Part 1, Division 10.5 of the Health and Safety Code (HSC) and with approval of Contractor's County Board of Supervisors (or designee) for the purpose of providing alcohol and drug services, which shall be reimbursed pursuant to Exhibit B. The state and the Contractor identified in the State Standard (STD) Form 213 are the only parties to this Intergovernmental Agreement. This Agreement is not intended, nor shall it be construed, to confer rights on any third party.
2. **Control Requirements**
   - **i.** Performance under the terms of this Exhibit A, Attachment I, is subject to all applicable federal and state laws, regulations, and standards. The Contractor shall:
     a. Require its subcontractors to establish written policies and procedures consistent with the requirements listed in 2(c).
     b. Monitor for compliance with the written procedures.
     c. Be held accountable for audit exceptions taken by DHCS against the Contractor and its subcontractors for any failure to comply with these requirements:
        i. HSC, Division 10.5, commencing with Section 11760
        ii. Title 9, Division 4, Chapter 8, commencing with Section 13000

iii. Government Code Section 16367.8
iv. Title 42, CFR, Sections 8.1 through 8.6
v. Title 21, CFR, Sections 1301.01 through 1301.93, Department of Justice, Controlled Substances
vi. State Administrative Manual (SAM), Chapter 7200 (General Outline of Procedures)

3. Contractor shall be familiar with the above laws, regulations, and guidelines and shall ensure that its subcontractors are also familiar with such requirements.

4. The provisions of this Exhibit A, Attachment I are not intended to abrogate any provisions of law or regulation, or any standards existing or enacted during the term of this Agreement.

OO. Performance Provisions

1. Monitoring

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

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

SUDCountyReports@dhcs.ca.gov Alternatively, mail to:

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

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

2. Performance Requirements

i. Contractor shall provide services based on funding set forth in Exhibit B, Attachment I, and under the terms of this Agreement.

ii. Contractor shall provide services to all eligible persons in accordance with federal and state statutes and regulations.

iii. Contractor shall ensure that in planning for the provision of services, the following barriers to services are considered and addressed:

a. Lack of educational materials or other resources for the provision of services.
b. Geographic isolation and transportation needs of persons seeking services or remoteness of services.
c. Institutional, cultural, and/or ethnicity barriers.
d. Language differences.
e. Lack of service advocates.
f. Failure to survey or otherwise identify the barriers to service accessibility.
g. Needs of persons with a disability.

3. Contractor shall comply with any additional requirements of the documents that have been incorporated by reference, including, but not limited to, those in the Exhibit A – Statement of Work.

4. Amounts awarded pursuant to Exhibit B, Attachment I shall be used exclusively for providing DMC-ODS services consistent with the purpose of the funding.

5. DHCS shall issue a report to Contractor after conducting monitoring or utilization reviews of county or county subcontracted providers. When the DHCS report identifies non-compliant services or processes, it shall require a CAP. The Contractor, or in coordination with its subcontracted provider, shall submit a CAP to the DHCS Analyst that conducted the review, within 60 calendar days from the date of the report. The CAP shall be

electronically submitted, directly to the DHCS analyst who conducted the review.

6. The CAP shall follow the requirements in Article III.KK.2.

PP. Requirements for Services

1. **Confidentiality.**
   i. All SUD treatment services shall be provided in a confidential setting in compliance with 42 CFR, Part 2 requirements.
2. **Perinatal Services.**
   i. Perinatal services shall address treatment and recovery issues specific to pregnant and postpartum women, such as relationships, sexual and physical abuse, and development of parenting skills.
   ii. Perinatal services shall include:
      a. Mother/child habilitative and rehabilitative services (i.e., development of parenting skills, training in child development, which may include the provision of cooperative child care pursuant to Health and Safety Code Section 1596.792).
      b. Service access (i.e., provision of or arrangement for transportation to and from medically necessary treatment).
      c. Education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant.
      d. Coordination of ancillary services (i.e., assistance in accessing and completing dental services, social services, community services, educational/vocational training and other services which are medically necessary to prevent risk to fetus or infant).
   iii. Medical documentation that substantiates the beneficiary's pregnancy and the last day of pregnancy shall be maintained in the beneficiary record.
   iv. Contractor shall comply with the perinatal program requirements as outlined in the Perinatal Practice Guidelines. The Perinatal Practice Guidelines are attached to this Agreement as Document 1G, incorporated by reference. The Contractor shall comply with the current version of these guidelines until new Perinatal Practice Guidelines are established and adopted. The incorporation of any new Perinatal Practice Guidelines into this Agreement shall not require a formal amendment.

3. **Narcotic Treatment Programs.**
    i. OTP/NTP services and regulatory requirements shall be provided in accordance with Title 9, Chapter 4.
4. **OTP/NTP Courtesy Dosing Documentation Requirements**
    i. The Contractor shall require the referring OTP/NTP to maintain documentation of the referral, and treatment by a Dosing OTP/NTP, in the beneficiary medical record for each day of courtesy dosing. The Contractor shall also require the Referring OTP/NTP to maintain a record of the invoice and payment for the courtesy dosing for each claim submitted for reimbursement. The invoice shall include all information needed to complete a claim, including dates of service, type of service, and units of service.
    ii. If applicable, the Contractor shall require an OTP/NTP provider include entries on a cost report to capture the revenue and expenses related to courtesy dosing for the purpose of cost settlement.
5. **Naltrexone Treatment Services.**
    i. For each beneficiary, all of the following shall apply:
        a. The provider shall confirm and document that the beneficiary meets all of the following conditions:
    ii. Has a documented history of opiate addiction.
    iii. Is at least 18 years of age.
    iv. Has been opiate free for a period of time to be determined by a physician based on the physician's clinical judgment. The provider shall administer a body specimen test to confirm the opiate free status of the beneficiary.
    v. Is not pregnant and is discharged from the treatment if she becomes pregnant.
    vi. The physician shall certify the beneficiary's fitness for treatment based upon the beneficiary's physical examination, medical history, and laboratory results.
    vii. The physician shall advise the beneficiary of the overdose risk should the beneficiary return to opiate use while taking Naltrexone and the ineffectiveness of opiate pain relievers while on Naltrexone.
6. **Substance Use Disorder Medical Director.**
    i. The SUD Medical Director's responsibilities shall, at a minimum, include all of the following:
        a. Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.

b. Ensure that physicians do not delegate their duties to non-physician personnel.
c. Develop and implement written medical policies and standards for the provider.
d. Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
e. Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
f. Ensure that provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries, and determine the medical necessity of treatment for beneficiaries.
g. Ensure that provider's physicians are adequately trained to perform other physician duties, as outlined in this section.

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

7. Provider Personnel.

i. Personnel files shall be maintained on all employees and volunteers/interns and shall contain the following:
a. Application for employment and/or resume
b. Signed employment confirmation statement/duty statement
c. Job description
d. Performance evaluations
e. Health records/status as required by the provider, AOD Certification or Title 9
f. Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries)
g. Training documentation relative to substance use disorders and treatment
h. Current registration, certification, intern status, or licensure
i. Proof of continuing education required by licensing or certifying agency and program

j. Provider's Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying/licensing body's code of conduct as well

ii. Job descriptions shall be developed, revised as needed, and approved by the provider's governing body. The job descriptions shall include:
    a. Position title and classification
    b. Duties and responsibilities
    c. Lines of supervision
    d. Education, training, work experience, and other qualifications for the position

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

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

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

8. Beneficiary Admission.

i. Each provider shall include in its policies, procedures, and

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

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

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

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

v. All referrals made by the provider staff shall be documented in the beneficiary record.

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

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

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

9. Assessment.

i. The provider shall ensure a counselor or LPHA completes a personal, medical, and substance use history for each beneficiary upon admission to treatment.
    a. Assessment for all beneficiaries shall include at a minimum:
        i. Drug/Alcohol use history
        ii. Medical history
        iii. Family history

iv. Psychiatric/psychological history
v. Social/recreational history
vi. Financial status/history
vii. Educational history
viii. Employment history
ix. Criminal history
x. Legal status
xi. Previous SUD treatment history

b. The Medical Director or LPHA shall review each beneficiary's personal, medical, and substance use history if completed by a counselor within 30 calendar days of each beneficiary's admission to treatment date.

10. Beneficiary Record.

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

ii. Documentation of treatment episode information shall include documentation of all activities, services, sessions, and assessments, including, but not limited to all of the following:
   a. Intake and admission data including, a physical examination, if applicable.
   b. Treatment plans.
   c. Progress notes.
   d. Continuing services justifications.
   e. Laboratory test orders and results.
   f. Referrals.
   g. Discharge plan.

h. Discharge summary.
i. Contractor authorizations for Residential Services.
j. Any other information relating to the treatment services rendered to the beneficiary.

10. Diagnosis Requirements.

i. The Medical Director or LPHA shall evaluate each beneficiary's assessment and intake information if completed by a counselor through a face-to-face review or telehealth with the counselor to establish a beneficiary meets the medical necessity criteria in Article III.B.2.ii.
   a. The Medical Director or LPHA shall document separately from the treatment plan the basis for the diagnosis in the beneficiary's record within 30 calendar days of each beneficiary's admission to treatment date.
      i. The basis for the diagnosis shall be a narrative summary based on DSM-5 criteria, demonstrating the Medical Director or LPHA evaluated each beneficiary's assessment and intake information, including their personal, medical, and substance use history.
      ii. The Medical Director or LPHA shall type or legibly print their name, and sign and date the diagnosis narrative documentation. The signature shall be adjacent to the typed or legibly printed name.

11. Physical Examination Requirements.

i. If a beneficiary had a physical examination within the twelve-month period prior to the beneficiary's admission to treatment date, the physician or registered nurse practitioner or physician's assistant (physician extenders) shall review documentation of the beneficiary's most recent physical examination within 30 calendar days of the beneficiary's admission to treatment date.
   a. If a provider is unable to obtain documentation of a beneficiary's most recent physical examination, the provider shall describe the efforts made to obtain this documentation in the beneficiary's individual patient record.

ii. As an alternative to complying with paragraph (i) above or in addition to complying with paragraph (i) above, the physician or physician extender may perform a physical examination of

the beneficiary within 30 calendar days of the beneficiary's admission to treatment date.

iii. If the physician or a physician extender, has not reviewed the documentation of the beneficiary's physical examination as provided for in paragraph (i), or the provider does not perform a physical examination of the beneficiary as provided for in paragraph (ii), then the LPHA or counselor shall include in the beneficiary's initial and updated treatment plans the goal of obtaining a physical examination, until this goal has been met and the physician has reviewed the physical examination results. The physician shall type or legibly print their name, sign, and date documentation to support they have reviewed the physical examination results. The signature shall be adjacent to the typed or legibly printed name.

12. Treatment Plan.

i. For each beneficiary admitted to treatment services, the LPHA or counselor shall prepare an individualized written initial treatment plan, based upon the information obtained in the intake and assessment process.

a. The LPHA or counselor shall attempt to engage the beneficiary to meaningfully participate in the preparation of the initial treatment plan and updated treatment plans.

i. The initial treatment plan and updated treatment plans shall include all of the following:

1. A statement of problems identified through the ASAM, other assessment tool(s) or intake documentation.
2. Goals to be reached which address each problem.
3. Action steps that will be taken by the provider and/or beneficiary to accomplish identified goals.
4. Target dates for the accomplishment of action steps and goals.
5. A description of the services, including the type of counseling, to be provided and the frequency thereof.
6. The assignment of a primary therapist or counselor.

7. The beneficiary's diagnosis as documented by the Medical Director or LPHA.
8. If a beneficiary has not had a physical examination within the 12-month period prior to the beneficiary's admission to treatment date, a goal that the beneficiary have a physical examination.
9. If documentation of a beneficiary's physical examination, which was performed during the prior 12 months, indicates a beneficiary has a significant medical illness, a goal that the beneficiary obtain appropriate treatment for the illness.

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

treatment plan are medically necessary, the Medical Director or LPHA shall type or legibly print their name, and sign and date the treatment plan within 15 calendar days of signature by the counselor. The signature shall be adjacent to the typed or legibly printed name.

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

13. **Sign-in Sheet.**
    i. Establish and maintain a sign-in sheet for every group counseling session, which shall include all of the following:
        a. The LPHA(s) and/or counselor(s) conducting the counseling session shall type or legibly print their name(s), sign, and date the sign-in sheet on the same day of the session. The signature(s) must be adjacent to the typed or legibly printed name(s). By signing the sign-in sheet, the LPHA(s) and/or counselor(s) attest that the sign-in sheet is accurate and complete.
        b. The date of the counseling session.
        c. The topic of the counseling session.
        d. The start and end time of the counseling session.
        e. A typed or legibly printed list of the participants' names and the signature of each participant that attended the counseling session. The participants shall sign the sign-in sheet at the start of or during the counseling session.
14. **Progress Notes.**
    i. Progress notes shall be legible and completed as follows:
        a. For outpatient services, Naltrexone treatment services, and recovery services, each individual and group session, the LPHA or counselor who conducted the counseling session or provided the service shall record a progress note for each beneficiary who participated in the counseling session or treatment service.
            i. The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven calendar days of the counseling session. The signature shall be adjacent to the typed or legibly printed name.
            ii. Progress notes are individual narrative summaries and shall include all of the following:
                1. The topic of the session or purpose of the service.
                2. A description of the beneficiary's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals.
                3. Information on the beneficiary's attendance, including the date, start and

end times of each individual and group counseling session or treatment service.
4. Identify if services were provided in-person, by telephone, or by telehealth.
5. If services were provided in the community, identify the location and how the provider ensured confidentiality.

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

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

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

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

15. Continuing Services.

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

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

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

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

16. **Discharge.**

i. Discharge of a beneficiary from treatment may occur on a voluntary or involuntary basis. For outpatient services, intensive outpatient services and residential services, in addition to the requirements of this subsection, an

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

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

iii. The LPHA or counselor shall complete a discharge summary, for any beneficiary with whom the provider lost contact, in accordance with all of the following requirements:
    a. The LPHA or counselor shall complete the discharge summary within 30 calendar days of the date of the last face-to-face treatment contact with the beneficiary.
    b. The discharge summary shall include all of the following:
        i. The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment.
        ii. The reason for discharge.

iii. A narrative summary of the treatment episode.
iv. The beneficiary's prognosis.

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

IV. Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7. ***"ASAM Criteria-Medical Necessity"*** pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. It should not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs (as in Dimension 2); or Dimension 3 psychiatric issues (such as imminent suicidality). Rather, "medical necessity" encompasses all six assessment dimensions so that a more holistic concept would be "Clinical

Necessity," "necessity of care," or "clinical appropriateness."

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

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

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

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

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

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

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

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

16. ***"Collateral Services"*** means sessions with therapists or counselors and significant persons in the life of a beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.

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

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

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

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

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

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

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

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

25. ***"Delivery System"*** DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program. DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a county that opts into the Pilot program. Upon approval of an implementation plan, the state shall contract with the county to provide DMC-ODS services. The county shall, in turn, contract with DMC certified providers or provide county-operated services to provide all services outlined in the DMC-ODS. Counties may also contract with a managed care plan to provide services. Participating counties with the approval from the state may develop

regional delivery systems for one or more of the required modalities or request flexibility in delivery system design or comparability of services. Counties may act jointly in order to deliver these services.

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

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

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

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

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

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

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

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

(2) Serious impairment to bodily functions.

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

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

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

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

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

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

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

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

38. ***"Fair Hearing"*** means the state hearing provided to beneficiaries upon denial of appeal pursuant to 22 CCR 50951 and 50953 and 9 CCR 1810.216.6. Fair hearings shall comply with 42 CFR 431.220(a)(5), 438.408(f), 438.414, and 438.10(g)(1).

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

40. ***"Final Settlement"*** means permanent settlement of the Contractor's actual allowable costs or expenditures as determined

at the time of audit, which shall be completed within three years of the date the year-end cost settlement report was accepted for interim settlement by the state. If the audit is not completed within three years, the interim settlement shall be considered as the final settlement.

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

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

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

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

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

46. ***"Individual Counseling"*** means contact between a beneficiary and a therapist or counselor. Services provided in-person, by

telephone or by telehealth qualify as Medi-Cal reimbursable units of service, and are reimbursed without distinction.

47. ***"Intake"*** means the process of determining a beneficiary meets the medical necessity criteria and a beneficiary is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for substance use disorder treatment and evaluation.
48. ***"Intensive Outpatient Services"*** means (ASAM Level 2.1) structured programming services consisting primarily of counseling and education about addiction-related problems a minimum of nine (9) hours with a maximum of 19 hours per week for adults, and a minimum of six (6) hours with a maximum of 19 hours per week for adolescents. Services may be provided in any appropriate setting in the community. Services may be provided in-person, by telephone or by telehealth. Also known as Intensive Outpatient Treatment.
49. ***"Interim Settlement"*** means temporary settlement of actual allowable costs or expenditures reflected in the Contractor's year-end cost settlement report.
50. ***"Key Points of Contact"*** means common points of access to substance use treatment services from the county, including but not limited to the county's beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the county.
51. ***"Long-Term Services and Supports (LTSS)"*** means services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.
52. ***"Licensed Practitioners of the Healing Arts (LPHA)"*** includes: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical

Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

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

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

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

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

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

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

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

56. ***"Medical Necessity" and "Medically Necessary Services"*** means those SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of a disease, illness, or injury consistent with 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.

57. ***"Medical Necessity Criteria"*** means adult beneficiaries must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, and must meet the ASAM Criteria definition of medical necessity for services based on the

ASAM Criteria. Adults shall meet the ASAM Adult Dimensional Admission Criteria. Youth under 21 may be assessed to be at risk for developing a substance use disorder, and if applicable, must meet the ASAM adolescent diagnostic admission criteria. Beneficiaries under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

77. "***Perinatal DMC Services"*** means covered services as well as

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

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

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

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

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

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

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

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

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

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

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

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

(3) Does not have a comprehensive risk contract.

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

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

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

(3) Does not have a comprehensive risk contract.

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

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

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

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

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

furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

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

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

(2) Development of enrollee care plans.

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

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

(5) Provision of enrollee outreach and education activities.

(6) Operation of a customer service call center.

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

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

(9) Coordination with behavioral health systems/providers.

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

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

(1) A physician assistant

(2) A nurse practitioner

(3) A certified nurse-midwife

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

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

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

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

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

(1) Is identified in the State Plan.

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

(3) Has a negative consequence for the beneficiary.

(4) Is auditable.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

112. ***"Subcontractor"*** means an individual or entity that is DMC certified and has entered into an agreement with the Contractor to be a provider of covered services. It may also mean a vendor who has entered into a procurement agreement with the Contractor to provide any of the administrative functions related to fulfilling the Contractor's obligations under the terms of this Exhibit A, Attachment I.

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

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

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

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

117. ***"Support Plan"*** means a list of individuals and/or organizations

that can provide support and assistance to a beneficiary to maintain sobriety.

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

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

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

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

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

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

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

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

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

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

(E) For residential services, providing 24-hour daily service, per

beneficiary, per bed rate.

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

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

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

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

V. Contractor Specific Requirements

Beginning June 15, 2017 and ending June 30, 2019, in addition to the general requirements outlined in Exhibit A, Attachment I, the Contractor agrees to the following Contractor specific requirements:

A. Covered Services

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

1) The Contractor shall deliver the Contractor Specific Covered Services within a continuum of care as defined in the ASAM criteria.
2) Contractor Specific Covered Services include:
   a) Additional Medication Assisted Treatment (MAT).

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) Referrals

a) The main designated point of access for treatment services shall be the Howard Street Program Treatment Access Program (TAP), at the Behavioral Health Access Center.

i. The Treatment Access Program (TAP) shall support walk-in, centralized intake, assessment, referral/placement services, central authorization of residential treatment services, and the 24/7 toll-free behavioral health access line.

b) Beneficiaries may also self-refer to treatment providers or be referred through other community access points such as behavioral health or primary care clinics.

2) Comprehensive Beneficiary Assessments

a) Howard Street TAP shall be staffed by LPHAs and Certified Drug Counselors.

b) Howard Street TAP staff shall conduct the assessment of a beneficiary presenting for treatment.

c) This assessment shall include screening/triage assessment and documenting the diagnosis and need for care in particular dimension.

d) If care is immediately available, referral for care shall be prioritized. Once referred the program site shall conduct an ASAM criteria assessment as part of intake within 72 hours of admission and shall communicate the results to TAP electronically.

e) If treatment is not immediately available, or if further assessment is required, the full ASAM assessment shall be carried out at TAP within 72 hours.

f) If beneficiaries present to treatment sites directly, requesting residential treatment, the ASAM Assessment shall be carried out by trained staff, either LPHAs or under LPHA supervision and then be communicated to TAP at Howard Street for authorization.

i. This assessment shall consider the immediate needs of beneficiaries due to imminent risk for any of the six ASAM

Multidimensional Assessment dimensions.

ii. Howard Street TAP shall manage supervised withdrawal beds and initiates medication for alcohol withdrawal treatment by prescriptions filled at the BHS pharmacy on site.

iii. Beneficiaries with opioid use disorders shall be either referred to the Office-based Buprenorphine Induction Clinic onsite or referred to one of the methadone clinics for same-day admission to MAT.

g) Methadone maintenance for MAT beneficiaries:

i. SUD treatment provider medical staff shall conduct assessment according to federal and state regulations, which includes: 1) a medical history, including the individual's history of substance use; 2) laboratory tests for determination of narcotic drug use, tuberculosis and syphilis; and 3) physical examination.

ii. Transition to levels of care within methadone maintenance shall follow federal and state regulations and include frequency of counseling as well as need for supervised dosing.

iii. Physicians, social workers, clinical pharmacists and nurse practitioners shall determine when office-based MAT can replace Opioid Treatment Program (OTP) MAT as they work with each patient.

iv. ASAM assessment shall be provided as part of OTP treatment planning, within 30 days of admission, and will aid in determining further or higher levels of care that might be needed.

v. For patients on buprenorphine who stabilize, transfer criteria shall be used to decide to move to primary care/Office Based Opioid Treatment (OBOT) setting.

vi. Administration of the ASAM assessment shall not delay treatment.

h) Non-residential assessments:

i. At the end of residential treatment, the ASAM assessment shall be used to guide outpatient placement in level 1 or 2.1 as part

of ongoing treatment and transition to community.

ii. All other non-residential treatment beneficiaries shall be assessed by SUD treatment providers in compliance with pertinent state and federal regulations.

3) Level of Care Placement and Reassessments

a) Using information from the comprehensive assessment conducted with beneficiaries, beneficiaries shall be placed in the appropriate level of care at intake, taking into account beneficiary preferences and needs including the intensity of withdrawal services needed.

C. Timely Access

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

1) The Contractor's Quality Management Program (QMP) shall monitor the timeliness of services on a quarterly basis, including time from request for service to first offered appointment, to first face to face appointment, and to first OTP service.

2) The QMP shall also monitor the timeliness of urgent services.

3) Each provider shall document any request for service in the electronic Timely Access Log, which includes a checkbox for whether the service request is for an urgent need. The first offered appointment shall be documented in the Timely Access Log. Once the beneficiary completes the initial visit, time from initial contact to first face-to-face service, including first OTP service, is calculated.

4) A dashboard report shall monitor the completion of the Timely Access Log, both at the system and program level, with the indicator being that the number of entries on the Timely Access Log should be greater than or equal to the number of service episodes open.

5) Timeliness of afterhours care shall be monitored by obtaining the call logs of the crisis services (Comprehensive Crisis Services).

6) The timeliness requirement from any contact marked 'urgent' shall be 24 hours to first or follow-up service.

7) For non-urgent, there shall be same day engagement/orientation on weekdays for outpatient, with assessment to follow.

8) The timeliness standard for outpatient care shall be a maximum of 10 days from initial request to face to face visit, and 30 days from initial face to face visit to full assessment.

9) For OTP, standard shall be same day admission and same day first methadone dosing on weekdays, with next workday admission on weekends and holidays.

10) Timeliness standard for residential treatment shall be 15 days from referral to intake.

D. Coordination and Continuity of Care

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

1) The Contractor shall require that its providers utilize of the Screening, Brief Intervention and Referral to Treatment (SBIRT) screening tool in primary care settings (ASAM level 0.5). (SBIRT services shall not be paid for under the DMC-ODS system.)

   a) SBIRT shall be provided in primary care.

2) The Contractor shall develop strategies to improve care transitions among levels of care including “warm hand-offs”.

   a) Once the client is admitted, transitions of care throughout the treatment continuum are routine and handled by case management and care coordination at each program.

   b) The Treatment Access Program (TAP) will manage requests for transitions of care to level three, residential by reviewing ASAM assessment and authorizing referrals.

   c) The Contractor’s Alcohol and Drug (AOD) Administrator shall be the primary entity responsible for the coordination and continuity of care. The AOD Administrator shall manage LOC authorizations along with the health program administrators and the Director of TAP.

3) The Contractor shall utilize recovery care management through primary care and behavioral health homes to manage beneficiary maintenance of well-being and recovery.

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

5) When a beneficiary requires inpatient substance use disorder (SUD) services (ASAM level 3.7 and 4.0 services) in an acute care hospital, or another Fee for Service (FFS) facility, the Contractor shall manage the needed transition of care up to the medically necessary LOC. If the Contractor has subcontracted with either a Chemical Dependency Recovery Hospital (CDRH) or Acute Freestanding Psychiatric hospital for inpatient SUD services using other county funds, the same transition of care coordination is required.

E. Memorandum of Understanding

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

1) The Contractor shall enter into MOUs with medical health plan provider or providers. The MOUs shall outline mechanisms for sharing information and coordination of service delivery.

F. Authorization of Services – Residential Programs

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

1) All residential treatment placements shall be authorized centrally through the Howard Street Services TAP staff which maintain up-to-

date residential treatment slot capacity for the Contractor's SUD treatment system.

2) Prior authorizations for residential treatment shall be processed within 24 hours of a beneficiary presenting for treatment.

3) Residential treatment shall be reassessed and re-authorized at 30 days as required under the DMC-ODS Pilot.

G. Early Intervention (ASAM Level 0.5)

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

1) The Contractor shall require the utilization of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) by primary care physicians, brief behavioral counseling interventions, and referrals to behavioral health treatment services to beneficiaries at risk of SUD, aged 18 and older. (SBIRT services not paid for under the DMC-ODS system.)

   a) SBIRT services shall be delivered by the primary care health plans.

H. Outpatient Services (ASAM Level 1)

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

1) Outpatient Drug Free services are recovery or motivational enhancement therapies/strategies provided to adults for less than 9 hours a week and provided to adolescents less than 6 hours a week.

2) <u>Outpatient Drug Free Service Components shall include</u>:

   a) Intake;

   b) Individual & Group Counseling;

   c) Patient Education;

   d) Family Therapy;

e) Medication Services;

f) Collateral Services;

g) Crisis Intervention Services;

h) Treatment Planning; and

i) Discharge Services.

3) The Contractor shall provide outpatient services to adolescents through mental health civil service clinics that serve teenagers and young adults and school-based mental health partnerships.

4) The Contractor shall develop, implement, and evaluate strategies to address identified challenges to service access (neighborhood clinic locations, cultural specificity of programs).

I. Intensive Outpatient Services (ASAM Level 2.1)

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

1) Intensive Outpatient services are structured programming services to treat multidimensional instability care for a minimum of 9 or more hours with a maximum of 19 hours a week for adults and 6 hours or more with a maximum of 19 hours for adolescents.

2) Intensive Outpatient Treatment Service Components shall include*:*

a) Intake;

b) Individual & Group Counseling;

c) Patient Education;

d) Family Therapy;

e) Medication Services;

f) Collateral Services;

g) Crisis Intervention Services;

h) Treatment Planning; and

i) Discharge Services.

3) The Contractor shall provide intensive outpatient services to adolescents through mental health civil service clinics that serve teenagers and young adults and school-based mental health partnerships.

4) The Contractor shall develop, implement, and evaluate strategies to address identified challenges to service access (neighborhood clinic locations, cultural specificity of programs).

J. Residential Treatment Services

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

1) The Contractor shall provide Levels 3.1, 3.3, and 3.5 of Residential Services as part of the ODS implementation in the first-year of this Intergovernmental Agreement.

2) ASAM Level 3.1

a) ASAM Level 3.1 Residential Services shall include a 24-hour structure with available trained personnel, at least 5 hours of clinical services per week, and prepare beneficiaries for outpatient treatment.

b) Service Components:

i. Intake;

ii. Individual & Group Counseling;

iii. Patient Education;

iv. Family Therapy;

v. Safeguarding Medications;

vi. Collateral Services;

vii. Crisis Intervention Services;

viii. Treatment Planning;

ix. Transportation Services (to/from medically necessary treatment); and

x. Discharge Services.

3) ASAM Level 3.3

a) ASAM Level 3.3. Residential Services shall include 24-hour care with trained counselors to stabilize multidimensional imminent danger and less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.

b) Service Components:

i. Intake;

ii. Individual & Group Counseling;

iii. Patient Education;

iv. Family Therapy;

v. Safeguarding Medications;

vi. Collateral Services;

vii. Crisis Intervention Services;

viii. Treatment Planning;

ix. Transportation Services (to/from medically necessary treatment); and

x. Discharge Services.

4) ASAM Level 3.5

a) ASAM Level 3.5 Residential Services shall include 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment and be able to tolerate and use full milieu or therapeutic community.

b) Service Components:

i. Intake;

ii. Individual & Group Counseling;

iii. Patient Education;

iv. Family Therapy;

v. Safeguarding Medications;

vi. Collateral Services;

vii. Crisis Intervention Services;

viii. Treatment Planning;

ix. Transportation Services (to/from medically necessary treatment); and

x. Discharge Services.

5) ASAM Levels 3.7 and 4.0

a) ASAM Level 3.7 residential treatment services are clinically managed medium-intensity residential services for adolescents and clinically managed high-intensity residential services for adults. This level of care shall provide 24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment.

b) ASAM Level 4.0 residential treatment services are medically managed intensive inpatient services for adolescents and adults, this level of care shall include 24-hour nursing care and daily physician care for severe, unstable problems.

c) When a beneficiary receives ASAM Level 3.7 or 4.0 residential treatment services in an acute care hospital, or other Fee-for-Service (FFS) facility, the Contractor shall manage the beneficiary's transition to a lower level of care by referring that beneficiary to a DMC-ODS provider.

d) When a beneficiary receives ASAM Level 3.7 or 4.0 residential treatment services in a subcontracted Chemical Dependency Recovery Hospital (CDRH) or Acute Freestanding Psychiatric Hospital using other county funds, the Contractor shall manage the beneficiary's transition to a lower level of care by referring that beneficiary to a DMC-ODS provider.

e) The transition of care from an ASAM Level 3.7 or 4.0 residential treatment provider to a lower level of care with a DMC-ODS provider shall be reimbursable under the DMC-ODS Waiver as case management services.

K. Case Management

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

1) Case management services shall assist a beneficiary in accessing needed medical, educational, social, prevocational, rehabilitative, or other community services and shall focus on the coordination of SUD care, integration around primary care and interaction with the criminal justice system if needed. Case management services will be monitored by the Behavioral Health Services compliance monitoring staff.

2) Service Components:

a) Comprehensive assessment and periodic reassessment of individual needs for continuation of case management;

b) Transition to a higher or lower level of SUD care;

c) Development and periodic revision of a beneficiary's plan that includes service activities;

d) Communication, coordination, referral and related activities;

e) Monitoring service delivery to ensure beneficiary's access to service and service delivery system;

f) Monitoring beneficiary's progress; and

g) Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services.

3) OTP primary counselors shall also provide case management services.

4) The Contractor's case management model shall reflect a collaborative team-based approach to assessment, planning, facilitation, care coordination, evaluation and advocacy for options and services to meet a beneficiary's comprehensive health and behavioral health needs. This case management model shall conclude regular team communication, trust and respect among team members for the role each is trained to play in beneficiary wellness and recovery, including peer support staff, and access to resources and supports needed to promote positive beneficiary outcomes and high quality, cost effective services. This shall include access to needed medical, educational, social, prevocational, vocational, rehabilitative, and other community services.

5) The Contractor's case management model shall tailor case management services to the beneficiary's needs.

6) Case management services shall be undertaken by the certified drug counselor or LPHA in cooperation with the treatment team.

7) Case management services shall be provided in full compliance with all beneficiary confidentiality requirements under federal and state law.

L. Physician Consultation

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

1) The DMC physician-to-specialist consultation shall be provided by network physicians, with addiction medicine physicians, addiction psychiatrists, addiction specialist Nurse Practitioners (NPs), or specialist clinical pharmacists to support SUD treatment plans for

beneficiaries with complex needs.

2) The DMC physician consultation services shall include:

   a) medication selection;

   b) dosing;

   c) side effect management;

   d) adherence;

   e) drug-drug interactions; and

   f) level of care considerations.

3) The DMC physician consultation with the Medical Director shall be available by phone and email.

4) The Contractor shall make a pharmacy 'drug information line' available by phone at the Howard Street BHS pharmacy, and this line shall be staffed by clinical pharmacists with a SUD specialization.

M. Recovery Services

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

1) Community-based recovery and wellness services shall be provided face-to-face, by telephone or by telehealth with the beneficiary to support transfers/transitions. The recovery services shall be provided to beneficiaries whether they are triggered, have relapsed, or as a preventative measure to prevent relapse.

2) <u>Service Components</u>:

   a) Individual and Group Outpatient Counseling to stabilize beneficiaries and reassess if further care is needed;

   b) Recovery Monitoring: recovery coaching, monitoring via telephone or internet;

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

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

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

f) Support Groups: linkages to self-help and support, spiritual and faith-based support; and

g) Ancillary Services: linkages to housing assistance, transportation, case management, individual services coordination.

3) The Contractor shall make relapse prevention counseling available to all beneficiaries through SUD treatment providers.

4) The Contractor shall provide system-wide training on Wellness & Recovery Model including appropriate recovery monitoring in primary care and provide consultation services to SUD providers through the Wellness and Recovery Coordinator's Office.

5) Coordination and expansion of peer services and training is being developed as part of the workforce development during the DMC-ODS expansion.

N. Withdrawal Management

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

1) The Contractor shall provide ASAM Level 1-WM detoxification/withdrawal management services with daily or less than daily outpatient supervision.

a) The Contractor shall make opioid withdrawal management services available through methadone clinics as methadone detox and Buprenorphine tapers available as needed.

b) The Contractor shall provide medically supervised outpatient alcohol withdrawal available for safely housed beneficiaries.

c) The contractor shall provide level 3.2 residential supervised withdrawal services for beneficiaries who need residential care.

O. Opioid (Narcotic) Treatment Program Services

In addition to the general Opioid (Narcotic) Treatment Program (OTP) services requirements outlined in Article III.V of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific opioid (narcotic) treatment program services requirements:

1) Opioid (Narcotic) Treatment Program services shall include daily or several times weekly opioid agonist medication and counseling available for those with severe opioid disorder.

2) Service Components shall include:

   a) Intake;

   b) Individual and Group Counseling;

   c) Patient Education;

   d) Medication Services;

   e) Collateral Services;

   f) Crisis Intervention Services;

   g) Treatment Planning;

   h) Medical Psychotherapy: one-on-one counseling conducted by the Medical Director with the beneficiary; and

   i) Discharge Services.

P. Additional Medication Assisted Treatment (MAT)

As stated in Article V.A of Exhibit A, Attachment I, the Contractor has elected to provide MAT services as a Contractor specific service. Therefore, the Contractor shall comply with the following Contractor specific MAT requirements:

1) Alcohol MAT:

   a) The Contractor shall provide alcohol medications including naltrexone, acamprosate, and disulfiram. The Contractor shall also

make naltrexone available for opioid use disorder.

2) Buprenorphine MAT services shall include:

   a) Integrated buprenorphine model into primary care and mental health clinics;

   b) Support for buprenorphine induction at Howard Street Program;

   c) Contractor's pharmacy shall provide observed dosing and medication advice by specialized clinical pharmacists;

   d) Contractor's pharmacy shall provide medication for OBIC patients during stabilization; and

   e) Buprenorphine integrated into residential care and residential detoxification.

3) Naltrexone MAT shall include:

   a) Injected naltrexone for alcohol; and

   b) Naltrexone MAT, either oral or injected, shall be offered for alcohol or opioid use disorder.

For more information about DMC-ODS documentation requirements, please contact:

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Visit the DPH website for additional DMC-ODS pilot program resources at:

https://www.sfdph.org/dph/comupg/oservices/mentalHlth/SubstanceAbuse/SF-DMC-ODS-Health-Plan.asp