

## Contract Definitions

### 1. General Definitions.

The words and terms of this Intergovernmental Agreement are intended to have their usual meanings unless a particular or more limited meaning is associated with their usage pursuant to Division 10.5 of HSC, Section 11750 et seq., and Title 9, CCR, Section 9000 et seq.

- A. **"Available Capacity"** means the total number of units of service (bed days, hours, slots, etc.) that a Contractor actually makes available in the current fiscal year.
- B. **"Contractor"** means the county identified in the Standard Agreement or DHCS authorized by the County Board of Supervisors to administer substance use disorder programs.
- C. **"Corrective Action Plan" (CAP)** means the written plan of action document which the Contractor or its subcontracted service provider develops and submits to DHCS to address or correct a deficiency or process that is non-compliant with laws, regulations or standards.
- D. **"County"** means the county in which the Contractor physically provides covered substance use treatment services.
- E. **"County Realignment Funds"** means Behavioral Health Subaccount funds received by the County as per California Code Section 30025.
- F. **"Days"** means calendar days, unless otherwise specified.
- G. **"Dedicated Capacity"** means the historically calculated service capacity, by modality, adjusted for the projected expansion or reduction in services, which the Contractor agrees to make available to provide non-DMC substance use disorder services to persons eligible for Contractor services.
- H. **"Final Allocation"** means the amount of funds identified in the last allocation letter issued by the State for the current fiscal year.
- I. **"Final Settlement"** means permanent settlement of the Contractor's actual allowable costs or expenditures as determined at the time of audit, which shall be completed within three years of the date the year-end cost settlement report was accepted for interim settlement by the State. If the audit is not completed within three years, the interim settlement shall be considered as the final settlement.
- J. **"Interim Settlement"** means temporary settlement of actual allowable costs or expenditures reflected in the Contractor's year-end cost settlement report.
- K. **"Maximum Payable"** means the encumbered amount reflected on the Standard Agreement of this Intergovernmental Agreement and supported by Exhibit B, Attachment I.
- L. **"Modality"** means those necessary overall general service activities to provide substance use disorder services as described in Division 10.5 of the HSC.

- M. **“Non-Drug Medi-Cal Amount”** means the contracted amount of SAPT Block Grant funds for services agreed to by the State and the Contractor.
- N. **“Performance”** means providing the dedicated capacity in accordance with Exhibit B, Attachment I, and abiding by the terms of this Exhibit A, including all applicable state and federal statutes, regulations, and standards, including Alcohol and/or Other Drug Certification Standards (Document 1P), in expending funds for the provision of substance use services hereunder.
- O. **“Preliminary Settlement”** means the settlement of only SAPT funding for counties that do include DMC funding.
- P. **“Revenue”** means Contractor’s income from sources other than the State allocation.
- Q. **“Service Area”** means the geographical area under Contractor’s jurisdiction.
- R. **“Service Authorization Request”** means a beneficiary’s request for the provision of a service.
- S. **“Service Element”** is the specific type of service performed within the more general service modalities. A list of the service modalities and service elements and service elements codes is incorporated into this Intergovernmental Agreement as Document 1H(a) “Service Code Descriptions”.
- T. **“State”** means the Department of Health Care Services or DHCS.
- U. **“Threshold Language”** means a language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.
- V. **“Utilization”** means the total actual units of service used by beneficiaries and participants.

## 2 Definitions Specific to Drug Medi-Cal

The words and terms of this Intergovernmental Agreement are intended to have their usual meaning unless a specific or more limited meaning is associated with their usage pursuant to the HSC, Title 6, and/or Title 22. Definitions of covered treatment modalities and services are found in Title 22 (Document 2C) and are incorporated by this reference.

- A. **“Action”** - (1) The denial or limited authorization of a requested service, including the type or level of service; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service; (4) The failure to provide services in a timely manner, as defined by the State; or (5) The failure of a Contractor to act within the timeframes provided in §438.408(b).
- B. **“Administrative Costs”** means the Contractor's actual direct costs, as recorded in the Contractor’s financial records and supported by source documentation, to administer the program or an activity to provide service to the DMC program. Administrative costs do not include the cost of treatment or other direct services to the beneficiary. Administrative costs may include, but are not limited to, the cost of training, programmatic and financial audit reviews, and activities related to billing. Administrative costs may include Contractor’s overhead per the approved indirect cost rate proposal

pursuant to OMB Circular A-87 and the State Controller's Office Handbook of Cost Plan Procedures.

- C. **"Appeal"** is the request for review of an "action".
- D. **"Authorization"** is the approval process for DMC Services prior to the submission of a DMC claim.
- E. **"Beneficiary"** means a person who: (a) has been determined eligible for Medi-Cal; (b) is not institutionalized; (c) has a substance-related disorder per the current "Diagnostic and Statistical Manual of Mental Disorders (DSM)" criteria; and (d) meets the admission criteria to receive DMC covered services.
- F. **"Case Management"** means a service to assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.
- G. **"Certified Provider"** means a substance use disorder clinic and/or satellite clinic location that has received certification to be reimbursed as a DMC clinic by the State to provide services as described in Title 22, California Code of Regulations, Section 51341.1.
- H. **"Covered Services"** means those DMC services authorized by Title XIX or Title XXI of the Social Security Act; Title 22 Section 51341.1; W&I Code, Section 14124.24; and California's Medicaid State Plan, including the DMC ODS 1115 Demonstration Waiver standard terms and conditions.
- I. **"Delivery System"** DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program. DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a county that opts into the Pilot program. Upon approval of an implementation plan, the State shall contract with the county to provide DMC-ODS services. The county shall, in turn, contract with DMC certified providers or provide county-operated services to provide all services outlined in the DMC-ODS. Counties may also contract with a managed care plan to provide services. Participating counties with the approval from the State may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design or comparability of services. Counties may act jointly in order to deliver these services.
- J. **"Drug Medi-Cal Program"** means the state system wherein beneficiaries receive covered services from DMC-certified substance use disorder treatment providers.
- K. **"Drug Medi-Cal Termination of Certification"** means the provider is no longer certified to participate in the Drug Medi-Cal program upon the State's issuance of a Drug Medi-Cal certification termination notice.
- L. **"Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)"** means the federally mandated Medicaid benefit that entitles full-scope Medi-Cal-covered beneficiaries less than 21 years of age to receive any Medicaid service necessary to correct or ameliorate a defect, mental illness, or other condition, such as a substance-related disorder, that is discovered during a health screening.
- M. **"Fair Hearing"** means the State hearing provided to beneficiaries upon denial of appeal pursuant to 22 CCR 50951 and 50953 and 9 CCR 1810.216.6. Fair hearings

must comply with 42 CFR 431.220(a)(5), 438.408(f), 438.414, and 438.10(g)(1).

- N. **“Federal Financial Participation (FFP)”** means the share of federal Medicaid funds for reimbursement of DMC services.
- O. **“Grievance”** means an expression of dissatisfaction about any matter other than an “action”.
- P. **“Key Points of Contact”** means common points of access to substance use treatment services from the county, including but not limited to the county’s beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the county.
- Q. **“Medical Necessity”** means those substance use treatment services that are reasonable and necessary to protect life, prevent significant illness or disability, or alleviate severe pain through the diagnosis and treatment of a disease, illness or injury consistent with and 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.
- R. **“Minor Consent DMC Services”** are those covered services that, pursuant to Family Code Section 6929, may be provided to persons 12-20 years old without parental consent.
- S. **“Narcotic Treatment Program”** means an outpatient clinic licensed by the State to provide narcotic **replacement** therapy directed at stabilization and rehabilitation of persons who are opiate-addicted and have a substance use diagnosis.
- T. **“Non-Perinatal Residential Program”** services are provided in DHCS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria. These residential services are provided to the non-perinatal population and do not require the enhanced services found in the perinatal residential programs.
- U. **“Notice of Action”** means a formal communication of any action, as defined above and consistent with 42 CFR 438.404 and 438.10.
- V. **“Payment Suspension”** means the Drug Medi-Cal certified provider has been issued a notice **pursuant** to W&I Code, Section 14107.11 and is not authorized to receive payments after the payment suspension date for DMC services, regardless of when the service was provided.
- W. **“Perinatal DMC Services”** means covered services as well as mother/child habilitative and **rehabilitative** services; services access (i.e., provision or arrangement of transportation to and from medically necessary treatment); education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant; and coordination of ancillary services (Title 22, Section 51341.1(c) 4).
- X. **“Postpartum”**, as defined for DMC purposes, means the 60-day period beginning on the last day of **pregnancy**, regardless of whether other conditions of eligibility are met. Eligibility shall end on the last day of the calendar month in which the 60<sup>th</sup> day occurs.
- Y. **“Post Service Post Payment (PSP) Utilization Review”** means the review for program compliance and medical necessity conducted by the State after service was rendered and paid. State may recover prior payments of Federal and State funds if

such review determines that the services did not comply with the applicable statutes, regulations, or standards (Cal. Code Regs. CCR, Title 22, Section 51341.1 (k)).

- Z. **“Physician Consultation”** services are to support DMC physicians with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.
- AA. **“Projected Units of Service”** means the number of reimbursable DMC units of service, based on historical data and current capacity, the Contractor expects to provide on an annual basis.
- BB. **“Provider Certification”** means the provider must be certified in order to participate in the Medi-Cal program.
- CC. **“Provider of DMC Services”** means any person or entity that provides direct substance use treatment services and has been certified by the State as meeting the standards for participation in the DMC program set forth in the “DMC Certification Standards for Substance Abuse Clinics”, Document 2E and “Standards for Drug Treatment Programs (October 21, 1981)”, Document 2F.
- DD. **“Re-certification”** means the process by which the DMC certified clinic and/or satellite program is required to submit an application and specified documentation, as determined by DHCS, to remain eligible to participate in and be reimbursed in through the DMC program. Re-certification shall occur no less than every five years from the date of previous DMC certification or re-certification.
- EE. **“Recovery Services”** are available after the beneficiary has completed a course of treatment. Recovery services emphasize the patient’s central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to patients.
- FF. **“Short-Term Resident”** means any beneficiary receiving residential services pursuant to DMC-ODS, regardless of the length of stay, is a “short-term resident” of the residential facility in which they are receiving the services.
- GG. **“Subcontract”** means an agreement between the Contractor and its subcontractors. A subcontractor shall not delegate its obligation to provide covered services or otherwise subcontract for the provision of direct patient/beneficiary services.
- HH. **“Subcontractor”** means an individual or entity that is DMC certified and has entered into an agreement with the Contractor to be a provider of covered services. It may also mean a vendor who has entered into a procurement agreement with the Contractor to provide any of the administrative functions related to fulfilling the Contractor’s obligations under the terms of this Exhibit A, Attachment I.
- II. **“Temporary Suspension”** means the provider is temporarily suspended from participating in the DMC program as authorized by W&I Code, Section 14043.36(a). The provider cannot bill for DMC services from the effective date of the temporary suspension.
- JJ. **“Withdrawal Management”** means detoxification services provided in either an ambulatory or non-ambulatory setting consistent with the ASAM level of care criteria to DMC ODS beneficiaries.