with the parity compliance analysis conducted by either DHCS or Contractor.

1) If Contractor provides Members with mental health or Substance Use Disorder (SUD) services in any classification of benefits as described in 42 CFR section 438.910(b)(2), then Contractor must provide to Members those services in every classification that is listed therein and is covered by Contractor. In determining the classification in which a particular benefit belongs, Contractor must apply the same reasonable standards for medical/surgical benefits to mental health or SUD benefits.

2) Contractor must provide referrals and Care Coordination for all non-covered mental health and SUD services, as required in Exhibit A, Attachment III, Subsections 4.3.13 (*Mental Health Services*) and 4.3.14 (*Alcohol and SUD Treatment Services*).

E. Covered Services may be provided to Members through Telehealth, as defined in W&I Code section 14132.72, APL 19-009.

5.3.2 Medically Necessary Services

Contractor must apply the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) standard of Medical Necessity for Members less than 21 years of age, as set forth in 42 USC section 1396d(r)(5). The terms Medically Necessary, or Medical Necessity, are defined in Exhibit A, Attachment I, Article 1.0 (*Definitions*), based upon whether a Member is less than 21 years of age, or ages 21 and over.

5.3.3 Initial Health Appointment

Contractor must ensure provision of an initial health appointment in accordance with California Code of Regulations, Title 22, Sections 53851(b)(1), and 53910.5(a)(1). An initial health appointment at a minimum must include, a history of the Member's physical and mental health, an identification of risks, an assessment of need for preventive screens or services and health education, a physical examination, and the diagnosis and plan for treatment of any diseases, unless the Member's Primary Care Provider (PCP) determines that the Member's medical record contains complete information, updated within the previous 12 months, consistent with the assessment requirements.

A. Contractor must cover and ensure the provision of an initial health appointment for each new Member within timelines stipulated in Subsections 5.3.4 and 5.3.5 below.

B. Contractor must ensure that a Member's completed initial health appointment is documented in their Medical Record and that appropriate assessments from the initial health appointment are available during subsequent health visits.

C. Contractor must make reasonable attempts to contact a Member to schedule an initial health appointment. Contractor must document all attempts to contact a Member. Documented attempts that demonstrate Contractor's efforts to unsuccessfully contact a Member and schedule an initial health appointment shall be considered evidence in meeting this requirement. Contractor may delegate these activities, but Contractor remains ultimately responsible for all delegated functions, as outlined in Exhibit A, Attachment 3.1.1 (*Overview of Contractor's Duties and Obligations*).

5.3.4 Services for Members less than 21 Years of Age

Contractor must cover and ensure the provision of all screening, preventive and Medically Necessary diagnostic and treatment services for Members less than 21 years of age required under the EPSDT benefit described in 42 USC section 1396d(r) and W&I Code section 14132(v). The EPSDT benefit includes all Medically Necessary health care, diagnostic services, treatments, and other services listed in 42 USC section 1396d(a), whether or not covered under the State Plan. All EPSDT services are Covered Services unless expressly excluded under this Contract.

A. Provision of Initial Health Appointment for Members less than 21 Years of Age

1) For Members less than 18 months of age, Contractor must ensure the provision of an initial health appointment within 120 calendar days following the date of Enrollment or within periodicity timelines established by the American Academy of Pediatrics (AAP) Bright Futures for ages two and younger, whichever is sooner.

2) For Members ages 18 months and older, Contractor must ensure an initial health appointment is performed within 120 calendar days of Enrollment.

3) The initial health appointment must provide, or arrange for provision of, all immunizations necessary to ensure that the Member is up-to-date for their age, Adverse Childhood Experiences (ACEs) screening, and any required age-specific screenings including developmental screenings.

4) If the provisions of the initial health appointment are not met, then the contractor must ensure case management and care coordination are working directly with member to receive appropriate services to include but not limited to health screenings, immunizations, and risk assessments.

B. Children's Preventive Services

1) Contractor must provide preventive health visits for all Members less than 21 years of age at times specified by the most recent AAP Bright Futures periodicity schedule and anticipatory guidance as outlined in the AAP Bright Futures periodicity schedule. Contractor must provide, as part of the periodic preventive visit, all age-specific assessments and services required by AAP Bright Futures.

2) Where a request is made for Children's preventive services by the Member, the Member's parent(s) or guardian, or through a referral from the local Child Health and Disability Prevention (CHDP) program, an appointment must be made for the Member to have a visit within ten Working Days of the request, unless Member declines a visit within ten Working Days of the request and another appointment date is chosen by the Member.

3) At each non-emergency Primary Care visit with a Member less than 21 years of age, the Member (if an emancipated minor), or the parent(s) or guardian of the Member, must be advised of the Children's preventive services due and available from Contractor. Documentation must be entered in the Member's Medical Record which shall indicate the receipt of Children's preventive services in accordance with the AAP Bright Futures standards. If the services are refused, documentation must be entered in the Member's Medical Record which shall indicate the services were advised, and the Member's (if an emancipated minor), or the parent(s) or guardian of the Member's voluntary refusal of these services.

4) All Children's preventive services must be reported as part of the Encounter Data submittal required in Exhibit A, Attachment III, Subsection 2.1.2 (*Encounter Data Reporting*). Contractor shall ensure appropriate acquisition for missed reporting of Children's preventive services.

C. Immunizations

Contractor must cover vaccinations, except for vaccinations expressly excluded in DHCS guidance to Medi-Cal Managed Care Health Plans, at the time of any health care visit and ensure the timely provision of

vaccines in accordance with the most recent childhood immunization schedule and recommendations published by Advisory Committee on Immunization Practices (ACIP). Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the vaccination shall be considered sufficient in meeting this requirement. When practical, reasons for failed attempts should be medically coded.

At each non-emergency Primary Care visit with Members less than 21 years of age, the Member (if an emancipated minor), or the parent(s) or guardian of the Member, must be advised of the vaccinations due and available from Contractor immediately, if the Member has not received vaccinations in accordance with ACIP standards. Documentation must be entered in the Member's Medical Record which shall indicate the receipt of vaccinations or proof of prior vaccination in accordance with ACIP standards. If vaccinations that could be given at the time of the visit are refused, documentation must be entered in the Member's Medical Record which shall indicate the vaccinations were advised, and the Member's (if an emancipated minor), or the parent(s) or guardian of the Member's voluntary refusal of these vaccinations. If vaccinations cannot be given at the time of the visit, then it is required that the Medical Record must demonstrate that the Member was informed how to obtain necessary vaccinations or scheduled for a future appointment for vaccinations.

Contractor must ensure that Member-specific vaccination information is reported to immunization registries established in Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports must be made following the Member's initial health appointment and all other health care visits that result in an administered vaccine within 14 calendar days. Reporting must be in accordance with all applicable State and federal laws.

Within 30 calendar days of Federal Food and Drug Administration (FDA) approval of any vaccine for childhood immunization purposes, Contractor must develop policies and procedures for the provision and administration of the vaccine. Contractor must cover and ensure the provision of the vaccine from the date of its approval regardless of whether or not the vaccine has been incorporated into the Vaccines for Children (VFC) Program. Policies and procedures must be in accordance with Medi-Cal guidelines issued prior to final ACIP recommendations.

Contractor must provide information to all Network Providers regarding the VFC Program and is encouraged to promote and support enrollment of applicable Network Providers in the VFC program as see appropriate.

D. Blood Lead Screens

Contractor must cover and ensure the provision of a blood lead screening test to Members at ages one and two in accordance with 17 CCR sections 37000 - 37100, and in accordance with APL 20-016. Contractor must ensure its Network Providers follow the Childhood Lead Poisoning Prevention Branch (CLPPB) guidelines when interpreting blood lead levels and determining appropriate follow-up activities, including, without limitation, appropriate referrals to the local public health department. Contractor must identify, at least quarterly, all Members less than six years of age with no record of receiving a required lead test, and remind the responsible Provider of the requirement to test Children.

If the Member refuses the blood lead screen test, Contractor must ensure a signed statement of voluntary refusal by the Member (if an emancipated minor) or the parent(s) or guardian of the Member is documented in the Member's Medical Record. If the Member (if an emancipated minor) or the parent(s) or guardian of the Member refuses to sign the statement, the refusal must be noted in the Member's Medical Record. Documented unsuccessful attempts to provide the lead screen test shall be considered evidence of Contractor meeting this requirement.

E. EPSDT Services

1) For Members less than 21 years of age, Contractor must comply with all requirements identified in APL 19-010. Contractor must provide, or arrange and pay for, all Medically Necessary EPSDT services, including all Medicaid services listed in 42 USC section 1396d(a), whether or not included in the State Plan, unless expressly excluded in this Contract. Covered Services shall include, without limitation, in-home nursing provided by home health agencies or individual nurse Providers, as required by APL 20-012, Care Coordination, case management, and Targeted Case Management (TCM) services. If Members less than 21 years of age are not eligible or accepted for Medically Necessary TCM services by a RC or local government health program, per requirements in Exhibit A, Attachment III, Section 5.6 (*MOUs with Third Parties*), Contractor must arrange for comparable services for the Member under the EPSDT benefit in accordance with APL 19-010.

2) Contractor must arrange for all Medically Necessary services identified at a preventive screening or other visit identifying the need for treatment, either directly or through referral to appropriate agencies, organizations, or individuals, as required by 42 USC section 1396a(a)(43)(C). Contractor must ensure that all Medically Necessary services are provided in a timely manner, as soon as possible but no later than 60 calendar days following the preventive screening or other visit identifying a need for treatment, whether or not the services are Covered Services under this Contract.

3) Without limitation, Contractor must identify available Providers, including if necessary Out-of-Network Providers and Providers eligible to enroll in the Medi-Cal program, to ensure the timely provision of Medically Necessary services. Contractor must provide appointment scheduling assistance and necessary transportation, including Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT), to and from medical appointments for Medically Necessary services, including all services available through the Medi-Cal program, whether or not they are Covered Services under this Contract.

4) Covered Services do not include California Children's Services (CCS), pursuant to Exhibit A, Attachment III, Section 4.3.15 (*California Children's Services (CCS)*), or Specialty Mental Health Services (SMHS), pursuant to Exhibit A, Attachment III Section 4.3.13 (*Mental Health Services*). Contractor must ensure that the case management for Medically Necessary services authorized by CCS, county mental health plans, Drug Medi-Cal or Drug Medi-Cal Organized Delivery System Plans under this Paragraph is equivalent to that provided by Contractor for Covered Services for Members less than 21 years of age under this Contract and must, if indicated or upon the Member's request, provide additional Care Coordination and case management services as necessary to meet the Member's medical and behavioral health needs.

F. Behavioral Health Treatment (BHT) Services

For Members less than 21 years of age, Contractor must cover Medically Necessary BHT services regardless of diagnosis in compliance with APL 21-XXX.

1) Contractor must provide Medically Necessary BHT services in accordance with a recommendation from a licensed Physician, surgeon, or a licensed psychologist and must provide continuation of BHT services under continuity of care.

2) The Member's treatment plan must be reviewed, revised, and/or modified no less than every six months by a BHT service provider. The Member's behavioral treatment plan may be modified or discontinued only if it is determined that the services are no longer Medically Necessary under the EPSDT Medical Necessity standard.

3) Contractor has primary responsibility for the provision of Medically Necessary BHT services and must coordinate with LEAs, RCs, and other entities that provide BHT services to ensure that Members timely receive all Medically Necessary BHT services, consistent with the EPSDT benefit. Contractor must provide Medically Necessary BHT services across settings, including home, school, and in the community, that are not duplicative of BHT services actively provided by another entity. Contractor must make good faith attempts to enter into MOUs with RCs and LEAs, and Contractor must enter into MOUs with County Mental Health Plans (MHPs) in accordance with Exhibit A, Attachment III, Section 5.6.1 (*MOUs with Third-Party Entities and County Programs*), to facilitate the coordination of services for Members with developmental disabilities, including Autism Spectrum Disorder (ASD), as permitted by federal and State law, and specified by DHCS in APL 18-009 and APL 21-XXX. If Contractor is unable to enter into a MOU or a one-time case agreement with a RC, as required by APL 18-009, Contractor must inform DHCS why it could not reach an agreement with the RC and must demonstrate, by providing all evidence of contracting efforts, a good faith effort to enter into an agreement with the RC.

G. Local Education Agency (LEA) Services

Contractor must reimburse LEAs, as appropriate, for the provision of school-linked EPSDT services including but not limited to BHT as specified in Exhibit A, Attachment III, Subsection 4.3.4.17 (*School-Based Services).*

5.3.5 Services for Adults

A. Initial Health Appointment for Adults Ages 21 and over

1) Contractor must cover and ensure that initial health appointments for adult Members are performed within 120 calendar days of Enrollment.