AMENDMENT TO AGREEMENT BETWEEN THE COUNTY OF SAN MATEO AND THE LATINO COMMISSION

THIS AMENDMENT TO THE AGREEMENT, entered into this _____ day of _____, 20_____, by and between the COUNTY OF SAN MATEO, hereinafter called "County," and THE LATINO COMMISSION, hereinafter called "Contractor";

W I T N E S S E T H:

WHEREAS, pursuant to Government Code, Section 31000, County may contract with independent contractors for the furnishing of such services to or for County or any Department thereof;

WHEREAS, the parties entered into an Agreement on June 25, 2019 for substance use disorder treatment services, for the term July 1, 2019 through June 30, 2021, in an amount not to exceed $2,077,450; and

WHEREAS, the parties wish to amend the Agreement for a 4% cost of living adjustment, increasing the amount of the agreement by $122,661 to $2,200,111, with no change to the term of the agreement.

NOW, THEREFORE, IT IS HEREBY AGREED BY THE PARTIES HERETO AS FOLLOWS:

1. Section 3. Payments of the agreement is amended to read as follows:

   In consideration of the services provided by Contractor in accordance with all terms, conditions and specifications set forth herein and in Exhibit "A1," County shall make payment to Contractor based on the rates and in the manner specified in Exhibit "B1." The County reserves the right to withhold payment if the County determines that the quantity or quality of the work performed is unacceptable. In no event shall the County's total fiscal obligation under this Agreement exceed TWO MILLION TWO HUNDRED THOUSAND ONE HUNDRED ELEVEN DOLLARS ($2,200,111).

2. Exhibit A is hereby deleted and replaced with Exhibit A1 attached hereto.

3. Exhibit B is hereby deleted and replaced with Exhibit B1 attached hereto.

4. All other terms and conditions of the agreement dated June 25, 2019, between

the County and Contractor shall remain in full force and effect.

*** SIGNATURE PAGE FOLLOWS ***

IN WITNESS WHEREOF, the parties hereto, by their duly authorized representatives, have affixed their hands.

COUNTY OF SAN MATEO

By:_____
President, Board of Supervisors
San Mateo County

Date:_____

ATTEST:

By:_____
Clerk of Said Board

THE LATINO COMMISSION

_____
Contractor's Signature

Date: 11/7/2019

EXHIBIT A1 – SCOPE OF WORK
THE LATINO COMMISSION
FY 2019 – 2021

Behavioral Health and Recovery Services (BHRS) provides a continuum of comprehensive services to meet the complex needs of our clients and is designed to promote healthy behavior and lifestyles (a primary driver of positive health outcomes). A full range of high quality services is necessary to meet the various needs of the diverse population residing in San Mateo County (SMC). As financing, program structure and redesign changes occur, the services within this agreement may fluctuate, be further clarified, or discontinued.

In consideration of the payments set forth in Exhibit B1, Contractor shall provide the following services:

I. DESCRIPTION OF SERVICES TO BE PERFORMED BY CONTRACTOR

In providing its services and operations, Contractor shall maintain compliance with requirements listed in the Alcohol and Other Drug (AOD) Policy and Procedure Manual including additions and revisions, incorporated by reference herein. As referenced in the Department of Health Care Services (DHCS) Intergovernmental Agreement for substance use disorder (SUD) services, General Definitions and Definitions specific to Drug Medi-Cal may be found in the AOD Policy and Procedure Manual located at http://smchealth.org/bhrs/aod/handbook. Documentation standards and requirements for all services may also be found in the AOD Policy and Procedure Manual located at http://smchealth.org/bhrs/aod/handbook. Reimbursement is contingent upon client eligibility, compliance with referral and authorization process and procedures, and documentation requirements as outlined in the AOD Policy and Procedure Manual located at: http://smchealth.org/bhrs/aod/policy.

A. Drug Medi-Cal Organized Delivery System SUD Treatment Services

Contractor shall provide treatment services described herein as part of the SMC Drug Medi-Cal Organized Delivery System (DMC-ODS). Contractor shall work with other ODS providers to ensure a seamless service delivery system to clients needing levels of care not provided by the Contractor. The description of all levels of care and Evidence-based Practices (EBPs) provided by SMC DMC-ODS are contained in the AOD Policy and Procedure Manual.

All program staff providing services to San Mateo County residents shall be certified or registered as defined in Title 9, CCR, Division 4, Chapter 8. SUD programs and facilities shall be licensed and/or certified by the DHCS Licensing and Certification Division. Contractors not in compliance with these requirements shall be subject to corrective action, up to and including fees, withheld payments, or termination of this Agreement.

Services will include the following:

1. Outpatient Services – ASAM 1.0

   a. Outpatient services shall be up to nine (9) hours a week for adults, and less than six (6) hours a week for adolescents as determined to be medically necessary by the Medical Director or LPHA.

      i. Outpatient treatment services for adolescents shall comply with Federal, State and Local regulations and with the Youth Treatment Guidelines set forth and as amended by the DHCS located at: http://www.dhcs.ca.gov/individuals/Documents/Youth_Treatment_Guidelines.pdf

   b. Outpatient services shall have of a minimum of two (2) group counseling sessions per month, and at least one (1) hour of individual counseling sessions per month.

   c. Outpatient services shall include intake, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, treatment planning, case management, physician consultation, and discharge planning and care coordination. Avatar service codes for each outpatient service are:

Service Description	Service Code(s)
Intake	AD101ODS
	AD101ODSPERI
Individual Counseling	AD102ODS
	AD102ODSPERI
Group Counseling	AD103ODS
	AD103ODSPERI
Individual Patient Education	AD104ODS
	AD104ODSPERI
Group Patient Education	AD105ODS
	AD105ODSPERI
Crisis Intervention	AD107ODS
	AD107ODSPERI
Treatment Planning	AD109ODS
	AD109ODSPERI
Discharge Planning	AD109ODS
	AD109ODSPERI
Family Counseling	AD110ODS
	AD110ODSPERI

Collateral Service	AD111ODS
	AD111ODSPERI
Case Management	AD61
	AD61PERI
Physician Consultation	AD97ODS
	AD97ODSPERI
Urinalysis Testing	AD75
Non-NTP Medication Assisted Treatment	AD601ODSMAT
	AD601ODSPERIMAT

d. Services may be provided in-person, by telephone, or telehealth, in any appropriate setting in the community. Contractor shall ensure confidentiality of all services provided via telehealth and/or in the community.

e. Contractor shall ensure that all clients enrolled in outpatient services receive medically necessary, individualized and trauma-informed treatment services, based upon the client's ASAM needs assessment, DSM-V diagnosis, and individual clinical needs.

2. Intensive Outpatient Services – ASAM 2.1

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

b. Intensive outpatient services shall have a minimum of one (1) hour of individual counseling session per week.

c. Intensive outpatient services shall include: intake, individual and/or group counseling, patient education, family therapy, medication services, collateral services, crisis intervention services, treatment planning, case management, physician consultation, and discharge planning and care coordination. Avatar service codes for each intensive outpatient service are:

Service Description	Service Code(s)
Intake	AD201ODS
	AD201PERI
Individual Counseling	AD202ODS
	AD202ODSPERI
Group Counseling	AD203ODS

	AD203ODSPERI
Individual Patient Education	AD204ODS
	AD204ODSPERI
Group Patient Education	AD205ODS
	AD205ODSPERI
Crisis Intervention	AD207ODS
	AD207ODSPERI
Treatment Planning	AD208ODS
	AD208ODSPERI
Discharge Planning	AD209ODS
	AD209ODSPERI
Family Counseling	AD210ODS
	AD210ODSPERI
Collateral Service	AD211ODS
	AD211ODSPERI
Case Management	AD61
	AD61PERI
Physician Consultation	AD97ODS
	AD97ODSPERI
Urinalysis Testing	AD75
Non-NTP Medication Assisted Treatment	AD601ODSMAT
	AD601ODSPERIMAT

d. Services may be provided in-person, by telephone, or telehealth, in any appropriate setting in the community. Contractor shall ensure confidentiality of all services provided via telehealth and/or in the community.

e. Contractor shall ensure that all clients enrolled in intensive outpatient services receive medically necessary, individualized and trauma-informed treatment services, based upon the client's ASAM needs assessment, DSM-V diagnosis, and individual clinical needs.

3. Residential Treatment Services

a. ASAM 3.1

Residential Treatment Services shall be provided in a DHCS licensed residential facility that is also DMC certified and designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.

Residential treatment services shall be authorized in advance in accordance with section P of this Agreement. Any service provided without prior authorization shall not be reimbursed.

i. Lengths of stay, treatment plans, and services offered shall be medically necessary, trauma-informed, and individualized according to the client's ASAM needs assessment, DSM-V diagnosis, and individual clinical needs.

ii. Contractor shall provide a minimum of twenty (20) hours per week of structured activities in accordance with the client's treatment plan. At least five (5) of these twenty (20) structured hours shall be clinical in nature.

iii. Residential treatment services shall be co-occurring capable and complexity capable.

iv. In addition to daily room and board, Contractor shall provide at least one (1) of the following treatment services daily: intake, individual counseling, group counseling, patient education, family therapy, collateral services, crisis intervention services, treatment planning, transportation services or discharge services. Contractor shall document the service provided in the client's chart. Avatar service codes for each ASAM 3.1 residential treatment service are:

ASAM 3.1 Service	Service Code(s)
Residential service day less than or equal to 30 days	AD311ODS AD311ODSPERI
Residential service day greater than or equal to 31 days	AD312ODS AD312ODSPERI
Non-NTP Medication Assisted Treatment	AD601ODSMAT31 AD601ODSPERIMAT31

v. Contractor shall not claim a DMC billable treatment service on a day that the above stated services is/are not provided. Avatar service codes for days upon which a treatment service is not provided are:

ASAM 3.1 Service	Service Code
Non-Billable Residential Day	AD98
Client Absent from Residential program	AD999

vi. All clients admitted to ASAM 3.1 Residential Treatment services shall be concurrently admitted to ASAM 3.1 Residential Enhanced Services in Avatar. As part of the Residential Enhanced Services, the Contractor shall provide Case Management and Physician Consultation services to all admitted clients. Avatar service codes for ASAM 3.1 Residential Enhanced Services are:

ASAM 3.1 Service	Service Code(s)
Case Management service, Residential Enhanced services	AD313ODSCM AD313ODSCMPERI
Physician Consultation service, Enhanced services	AD314ODSPC AD314ODSPCPERI

b. ASAM 3.5

Residential services shall be provided in a DHCS or DSS licensed residential facility that is also DMC certified and designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.

Residential services shall be authorized in advance in accordance with section P of this Agreement. Any services provided without prior authorization shall not be reimbursed.

i. Lengths of stay, Treatment Plans, and services offered shall be individualized according to the client's DSM-V diagnosis, medical necessity, and individual needs.

ii. Residential services shall be co-occurring capable OR co-occurring enhanced, and complexity capable.

iii. Residential services shall provide services twenty-four (24) hours/seven (7) days per week in a structured treatment support setting to clients, with clinical care and trained counselors, available to clients twenty-four (24) hours a day.

iv. Residential services shall be provided to adults eighteen (18) and over who are at imminent risk as defined by the ASAM criteria.

v. Contractor shall provide at least one (1) of the following treatment services daily: intake, individual counseling, group counseling, patient education, family therapy, collateral services, crisis intervention services, treatment planning, transportation services or discharge services. Contractor shall document the service provided in the client's chart. Avatar service codes for each ASAM 3.5 residential service are:

ASAM 3.5 Service	Service Code(s)
Residential service day less than or equal to 30 days	AD351ODS AD351ODSPERI
Residential service day greater than or equal to 31 days	AD352ODS AD352ODSPERI
Case Management service, Residential Enhanced services	AD353ODSCM AD353ODSCMPERI
Physician Consultation service, Enhanced services	AD354ODSPC AD354ODSPCPERI
Non-NTP Medication Assisted Treatment	AD601ODSMAT35 AD601ODSPERIMAT35

vi. Contractor shall not claim a DMC billable treatment service on a day that the above stated services is/are not provided. The Avatar service codes for days upon which a treatment service is not provided are:

ASAM 3.5 Service	Service Code
Non-Billable Residential Day	AD99
Client Absent from Residential program	AD998

vii. Contractor shall consult with the client's assigned RTX case manager to complete the course of treatment prior to discharge.

1) The consultation request shall be made through Avatar and by telephone.

2) The consultation request shall occur immediately upon the Contractor's knowledge of the client's potential for early discharge or AWOL.

3) Contractor and the RTX case manager will make every effort to maintain the client in treatment and not discharge the client unsuccessfully prior to completion of treatment.

4) Contractor may bypass the consultation request and discharge a client that is an imminent threat to the safety of staff or other clients. Contractor shall notify the RTX case manager immediately upon the discharge of a client due to imminent threat.

c. Authorization of Residential Services

i. Contractor shall obtain authorization from the BHRS Residential Authorization Team (RTX) for client admission to a residential treatment program, pursuant to 42 CFR 438.210(b).

ii. Contractor shall establish and follow written policies and procedures that comply with BHRS RTX requirements for initial and continuing authorization requests, including but not limited to the Residential Denial Protocol, Waitlist Management Protocol, and submission of timely 60-Day Plans and One-Time Extension requests, in accordance with the Documentation Manual.

iii. Failure to comply with the BHRS RTX requirements for initial and continuing authorization requests will result in an authorization denial, and Contractor shall be financially responsible for the unauthorized treatment service. Contractor shall not penalize the client in any way for unauthorized requests due to Contractor's failure to adhere to the BHRS RTX requirements for initial and continuing authorization requests.

d. Episode Limits and Lengths of Stay for Residential Treatment Services

i. Contractor shall comply with the following time restrictions.

1) Adults twenty-two (22) and over may receive up to two (2) residential episodes per three hundred sixty-five (365) day period. A

residential episode is defined as one (1) stay in a DHCS licensed residential treatment facility for a maximum of ninety (90) days. Adults may receive up to one (1) stay extension, for up to thirty (30) days, provided the extension is medically necessary and is authorized by the RTX team, per three hundred sixty-five (365) day period.

2) Adolescents and young adults twenty-one (21) or younger may receive as many residential episodes per calendar year as is medically necessary. Each residential episode shall be initially authorized by the RTX team for a maximum of thirty (30) days. The length of stay may be re-authorized for an additional thirty (30) days, provided the extension is medically necessary. Adolescents receiving residential treatment services shall be stabilized as soon as possible and moved to a less restrictive level of treatment.

    a) The DMC-ODS shall not override any EPSDT requirements.

3) DMC Perinatal clients may receive a longer length of stay than those described above. If medically necessary and authorized by the RTX team, DMC Perinatal clients may receive a length of stay up to the length of their pregnancy and postpartum period.

4) Adult clients involved in the criminal justice system may receive a longer length of stay than those described above. If medically necessary and authorized by the RTX team or Service Connect, clients involved in the criminal justice system may receive up to six (6) months of residential treatment services, plus a one-time extension of up to thirty (30) days.

    a) Up to ninety (90) days of the six (6) month stay may be funded by DMC, if medically necessary. Additional lengths of stay may be funded by alternative sources, if medically necessary and authorized by the RTX team or Service Connect.

b) The Period of Engagement (POE) is a term reserved for clients involved in the criminal justice system, including Criminal Justice Realignment, Unified Re-Entry, Pathways, and Drug Court. During the POE, the client shall decide if they are ready and willing to fully engage and participate in residential treatment. The POE shall not exceed fourteen (14) consecutive days. Should the criminal justice-involved client discharge from residential treatment prior to the POE, Contractor shall notify the client's Probation Officer and Case Manager within twenty-four (24) hours following discharge. BHRS may use funds other than DMC to pay for residential treatment episodes where the POE was not met, and the episodes may not count toward the client's two (2) episode per three hundred sixty-five (365) day limit.

4. Unplanned or Early Terminations from All Levels of Care

For all unplanned or early terminations from treatment, Contractor shall notify Medi-Cal beneficiaries of Contractors intent to terminate service at least ten (10) days prior to end date or termination date, by providing the beneficiary with a Notice of Adverse Benefit Determination (NOABD). The NOABD shall clearly state the reason for early termination, and document previous attempts to communicate the possibility of discharge directly to the beneficiary and the treatment team when applicable. If the beneficiary is an imminent danger to themselves or others, or is gravely disabled, then Contractor may terminate services immediately and shall provide the beneficiary with a NOABD.

a. Contractor shall notify beneficiary's San Mateo County Case Manager immediately upon Contractor's knowledge of beneficiary's potential for early termination or AWOL, and no later than the same day the NOABD is issued.

b. Contractor shall notify the San Mateo County Case Manager via telephone and Avatar Consultation Request Form.

c. Should the beneficiary not be assigned to a San Mateo County Case Manager or should Contractor not know who the

beneficiary's assigned Case Manager is, Contractor shall notify the San Mateo County RTX Team via telephone and Avatar Consultation Request Form.

d. Contractor shall consult and/or meet with the San Mateo County Case Manager and other individuals involved in the beneficiary's care prior to terminating the beneficiary from treatment and develop a mutually agreeable written plan to keep the beneficiary in treatment and not terminate from care prior to the planned discharge date.

e. If Contractor and the San Mateo County Case Manager determine the beneficiary needs a higher Level of Care or may be best served by a different provider, then Contractor shall work with the Case Manager and the receiving provider to ensure transition of care without any gaps in treatment.

f. Contractor and the San Mateo County Case Manager will make every effort to maintain the beneficiary in treatment and not terminate from care prior to the planned discharge date. If Contractor has issued the beneficiary a NOABD, they may rescind it if they are successful in maintaining the beneficiary in care.

g. The NOABD outlines the beneficiary's rights to appeal early terminations from care. San Mateo County will review beneficiary appeals and may mandate the provider to re-admit the beneficiary into treatment should the appeal be found in the beneficiary's favor.

5. Case Management

Case management services complement treatment services to address areas in the client's life that may negatively impact treatment success and overall quality of life. Case management services connect clients to outside systems of care, such as mental health services and primary care services. Case management also helps clients transition through different levels of care in the SUD treatment continuum. Case management services shall be provided and documented in accordance with the procedures outlined in the Documentation Manual.

a. Case management services are available to all clients who enter SUD treatment.

i. Case management services shall be provided face-to-face, by telephone, or telehealth and may be provided in any appropriate setting in the community. If services are provided in the community, Contractor shall maintain confidentiality requirements/guidelines and document how confidentiality was maintained.

ii. Case management services shall include, but are not limited to the following:

1) Comprehensive assessment and reassessment to determine medical necessity of continuation of case management services;

2) Monitor client's progress and transition coordination to a higher or lower level of SUD care, as medically necessary;

3) Facilitate warm hand-off transition in SUD level of care, including into Recovery Services, and coordinating with and forwarding necessary documentation to the receiving provider.

4) Develop and revise treatment or recovery services plan as medically necessary;

5) Communicate, coordinate, refer and any related activities;

6) Monitor service delivery to ensure client access to service;

7) Patient advocacy, linkages to physical and mental health care, transportation to and retention in primary care services; and

8) Coordinate care and communicate with primary care, MAT or NRT provider, community health clinic and mental health provider to ensure a coordinated approach to client's treatment, and monitoring and follow up with other agencies regarding appointments or other services received by the client.

9) Coordinate care and communicate with County and State entities (Probation, Parole, Child Welfare, Courts, Housing providers, RTX, Pathways, IMAT, Service Connect, Drug Court, DUI Court, etc.) to align objectives and priorities and to ensure the social aspects of health and well-being are coordinated with health services.

10) Advocate for the client with health/social providers, County or community partners, the Courts, and others in the best interest of the client.

11) Help client apply for, keep, or transfer (as needed) benefits such as Medi-Cal, General Assistance, SSI/SSDI, CalWORKs, or housing subsidies.

12) Link clients to community resources or services that maximize independence and support recovery goals, including food banks or churches for groceries or meals, clothing assistance, transportation services, vocational services, and support for employment or education.

13) Case management shall be consistent with and shall not violate the confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California law.

6. Physician Consultation

Physician Consultation Services include consultations between provider physicians and addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are designed to assist provider physicians, allowing them to seek expert advice regarding the design of treatment plans for individual DMC beneficiaries. Physician consultation services may address medication selection, dosing, side effect management, adherence to treatment regiment, drug-drug interactions, or level of care considerations.

7. Recovery Services

Recovery Services shall be provided to clients following completion of treatment, when medically necessary. Recovery services may be

provided face-to-face or by telephone with the client, in any appropriate setting in the community. Recovery services shall include:

a. Periodic outpatient counseling services in the form of individual or group counseling as needed to stabilize the client and reassess if client is in need of further care;

b. Recovery coaching, monitoring via telephone and internet;

c. Peer-to-peer services and relapse prevention;

d. Linkages to life skills, employment services, job training, and education services;

e. Linkages to childcare, parent education, child development support services, family/marriage education;

f. Linkages to self-help and support, spiritual and faith-based support; and

g. Linkages to housing assistance, transportation, case management, individual services coordination.

h. Avatar service codes for Recovery Services are:

Service Description	Service Code
Individual Counseling	AD501ODSRSI
Group Counseling	AD502ODSRSG
Case Management	AD503ODSRSCM
Recovery Monitoring	AD504ODSRSRM

8. Withdrawal Management

Contractor is encouraged to obtain withdrawal management (WM) certification. Once certified, Contractor shall provide WM services according to the ASAM Criteria, when medically necessary, in accordance with the client's individualized treatment plan. Avatar service codes for withdrawal management will be created upon Contractor certification.

Contractor shall ensure that clients receiving both residential services and WM services are monitored during the detoxification process. Withdrawal management services include the following:

a. ASAM 1.0-WM

Ambulatory withdrawal management without extended on-site monitoring. For clients in mild withdrawal who require daily or less than daily outpatient supervision.

b. ASAM 2.0-WM

Ambulatory withdrawal management with extended on-site monitoring. For clients in moderate withdrawal who require all day withdrawal management and support and supervision; at night, the client has a supportive family or living situation.

9. Community-Based Services

Contractors may provide outpatient or intensive outpatient services in any appropriate community setting based on client need.

a. All service locations shall comply with 42 CFR Part 2, and client confidentiality shall be maintained.

b. Contractor may provide services in multiple community settings. However, Contractor's staff may not be assigned a primary worksite that is not DMC certified without informing BHRS QM and BHRS AOD Administration. Contractor may be required to apply for DMC certification and SUDS licensure for that setting.

10. Telehealth

Contractor may utilize telehealth when providing treatment services only when the following criteria are met:

a. The professional determining medical necessity is located onsite, and the client receiving the services is located remotely.

b. All telehealth equipment and service locations comply with 42 CFR Part 2, and client confidentiality is maintained.

11. Additional DMC-ODS Services Required

The following services are also included in the DMC-ODS continuum of care, although they are not reimbursable by DMC. Contractor may provide the following services; however, Contractor shall refer clients to these services based upon client need, medical necessity, and client eligibility. Avatar service codes for additional DMC-ODS required services are:

Service Description	Service Code
Sober Living Environment	AD95

12. Contractor Requirements

a. Licensure/Agency

Contractor shall be licensed, registered, and DMC certified in accordance with applicable laws and regulations. Contractor shall comply with the following regulations and guidelines. In the event of a conflict between regulatory requirements, the more stringent provisions shall prevail.

i. Title 21, CFR Part 1300, et seq.,

ii. Title 42, CFR, Part 8;

iii. Drug Medi-Cal Organized Delivery System Special Terms and Conditions

iv. Title 22, CCR, Sections 51341.1, 51490.1, and 51516.1;

v. DHCS Alcohol and/or Other Drug Program Certification Standards;

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

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

b. Staffing Requirements

Contractor shall employ licensed or certified/registered counselors in accordance with Title 9, CCR, Division 4, Chapter 8 to provide covered services.

i. Professional staff must be licensed, registered, certified or recognized under California scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of

practice laws. A Licensed Practitioner of the Healing Arts (LPHA) includes the following:

1) Physician

2) Nurse Practitioners

3) Physician Assistants

4) Registered Nurses

5) Registered Pharmacists

6) Licensed Clinical Psychologists

7) Licensed Clinical Social Worker

8) Licensed Professional Clinical Counselor

9) Licensed Marriage and Family Therapists

10) License 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. Non-professional staff shall be supervised by professional and/or administrative staff.

Contractor shall comply with HSC Section 11833(b)(1): Any individual who provides counseling services in a licensed or certified alcohol and other drug (AOD) program, except for licensed professionals, must be registered or certified with a DHCS approved certifying organization prior to providing counseling services.

In Fiscal Year 2019-2020, San Mateo County BHRS will establish a minimum expectation that a set percentage of Contractor's AOD counselors will be certified with a DHCC approved certifying organization. A Contractor not in compliance with the minimum expectation will be required to submit a request for a temporary exemption. The request will include justification for the exemption, and a plan with a timeline to meet the minimum expectation.

iii. Professional and Non-Professional staff shall have appropriate experience and all necessary training at the time of hiring.

iv. Registered and certified SUD counselors providing treatment services shall adhere to all certification requirements in the CCR Title 9, Division 4, Chapter 8 and HSC Section 11833 (b)(1).

v. Prior to delivery of services under this Agreement, Contractor shall employ a Medical Director enrolled with DHCS under applicable state regulations, screened as a limited categorical risk within one (1) year prior to serving as Medical Director in accordance with 42CFR455.50(a), and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107.

vi. All staff of Contractor shall undergo fingerprint background checks prior to hiring or service delivery, whichever comes first in accordance with CFR 455.34.

vii. Prior to the delivery of services, all treatment staff shall be trained in ASAM criteria, which consists of two e-training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care".

c. Other Requirements

Contractor shall comply with all DHCS DMC-ODS mandated reporting requirements, and is required to inform BHRS QM and BHRS Program Analyst within forty-eight (48) hours after an occurrence, of the following:

i. Leadership or staffing changes.

ii. Organizational and/or corporate structure changes (example: conversion to non-profit status).

iii. Changes in the type of services being provided at that location; day treatment or medication support services when medications are administered or dispensed from the provider site.

iv. Significant changes in the physical plant of the provider site (some physical plant changes could require a new fire or zoning clearance).

v. Change of ownership or location.

vi. Complaints regarding the provider

13. Client Eligibility

a. Clients are eligible to receive DMC-ODS services if they: (a) are receiving San Mateo County Medi-Cal benefits or are eligible to receive San Mateo County Medi-Cal benefits; (b) are not currently institutionalized; (c) have a substance use disorder per the most current published edition of the Diagnostic and Statistical Manual (DSM-V) and meet ASAM medical necessity criteria; and (d) are a San Mateo County resident.

b. Clients may also be eligible to receive treatment and recovery services under San Mateo County's DMC-ODS network of care using non-Medi-Cal funding if they: (a) do not have health care coverage; (b) are not currently institutionalized; (c) have a substance use disorder per the most current published edition of the Diagnostic and Statistical Manual (DSM-V) and meet ASAM medical necessity criteria; and (d) are a San Mateo County resident.

c. Contractor Responsibilities:

i. Contractor shall verify the client's residency status to ensure they are a San Mateo County resident. Homeless or transient clients shall be homeless or transient in San Mateo County. A statement of verification shall be kept in the client's file.

ii. Contractor shall verify the client's Medi-Cal eligibility status on a monthly basis. Verification of Medi-Cal eligibility shall be kept in the client's file.

d. Medical Necessity

i. Medical necessity shall be determined by the Medical Director, licensed physician, or LPHA. After establishing a DSM-V diagnosis, the diagnosing professional shall apply ASAM criteria to determine the appropriate level of care for placement.

ii. Medical necessity for adults age twenty-one (21) and over is determined by the following:

1) The individual has at least one (1) substance-related diagnosis from the DSM-V, excluding tobacco-related disorders.

2) The individual meets the ASAM Criteria definition of medical necessity to receive services.

iii. Medical necessity for youth and adults under the age of twenty-one (21) is determined by the following:

1) The individual is assessed to be at risk for developing a substance use disorder, and

2) The individual meets the ASAM Criteria definition of medical necessity for adolescent services.

iv. Medical necessity shall be re-evaluated and re-determined at each Treatment Plan update, each Level of Care change, and at least once every six (6) months for the duration of treatment services.

1) Narcotic Treatment Programs/Opioid Treatment Programs shall re-evaluate and re-determine medical necessity at least annually for the duration of treatment services.

14. Timely Access to Service

a. Contractor shall deliver the client's first appointment for outpatient or intensive outpatient services within ten (10) calendar days of the initial request.

b. Contractor shall deliver the client's first appointment for residential services within three (3) calendar days of the initial request.

i. Interim services shall be provided to injection drug using and perinatal services-eligible clients when residential services are not immediately available.

c. Contractor shall ensure that a client experiencing a medical or psychiatric emergency will be transported to the nearest hospital for treatment.

d. Contractor shall advise clients in the program of the County's twenty-four (24) hour on-call Access Call Center. Contractor shall advise clients how to receive treatment or other covered services after hours, weekends and holidays.

e. Contractor's hours of operation shall be no less than the hours of operation to non-Medi-Cal clients.

15. Coordination of Care

Contractor shall provide coordination of client care. Initial care coordination may be provided by the BHRS Residential Treatment Authorization Team (RTX), Whole Person Care (WPC) or Integrated Medication Assisted Treatment Team (IMAT). Once a client is enrolled in and connected to the SUD treatment program, care coordination will be transferred to Contractor. Care coordination responsibilities will comply with those identified in the BHRS DMC-ODS Implementation Plan.

a. Contractor shall ensure coordination and continuity of care within the standards in accordance with 42 CFR 438.208.

b. Contractor shall ensure that through the course of coordinating care, the client's privacy is protected in accordance with all Federal and State privacy laws, including but not limited to 45 CFR 160 and 164, to the extent that such provisions are applicable.

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

d. Contractor shall provide treatment services to clients receiving Medication Assisted Treatment. Contractor shall communicate regularly with the prescribing physician(s) of client prescribed medications unless the client refuses to consent to sign a 42 CFR part 2 compliant Release of Information for this purpose.

16. Sharing Information with Clients

Contractor shall not prohibit or restrict any licensed, registered or certified professional staff, acting within their scope of practice, from advising or advocating on behalf of the client, for whom Contractor is providing SUD treatment from any of the following:

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

b. Any information the client needs in order to decide among all relevant treatment options,

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

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

17. Laboratory Requirements

Contractor shall use testing services of certified laboratories that are in good standing to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) unless exempt from CLIA or are SAMHSA certified.

B. Non-Drug MediCal Organized Delivery System Services

Contractor shall provide substance use disorder (SUD) treatment and recovery services, with structure and supervision, to further a participant's ability to improve his/her level of functioning. Any program staff providing services to San Mateo County residents shall be certified or registered as defined in Title 9, CCR, Division 4, Chapter 8. SUD programs and facilities shall be licensed and/or certified by the DHCS Licensing and Certification Division.

1. Sober Living Environments

Sober Living Environments (SLEs), are also known as Transitional Housing Units, Transitional Living Centers or Alcohol/Drug Free Housing. SLE services are provided for clients involved in Drug Court, Unified Re-Entry, Criminal Justice Realignment, and Pathways Court. SLEs do not provide SUD services or require licensure by DHCS. All SLE residents must be actively engaged in

a DHCS certified Outpatient or Intensive Outpatient Treatment program and all SUD treatment services are to be provided off-site.

a. Contractor shall provide monthly updates regarding client participation to their Case Manager and/or Probation Officer.

b. The SLE home shall be recovery conducive and space should be adequate to accommodate each individual comfortably and with dignity and respect.

c. Contractor shall establish and maintain a culture and environment that is welcoming and understanding to those they serve.

d. Sleeping rooms shall be adequate to provide a bed and private space for each resident. These areas shall not be used for any other purpose. The SLE shall comply with applicable guidelines of required square footage per resident and number of residents per room.

e. All residents shall have access to the: kitchen, refrigerator, stove, dining room, laundry facilities, restrooms, and showers to ensure basic needs are met.

f. The SLE shall post a written description of the procedural process regarding chores, assignment of roommates, and primary house rules in a space that is accessible to all residents.

g. Staffing is not required. At a minimum, Contractor shall have an individual be responsible for the safety of the facility, be available to maintain records, to collect rent (if applicable), to register and check-out residents, and to maintain rules of the house.

h. Contractor shall provide residents with copies of all policies, procedures, house rules and expectations during the interview process or at the time of admission. One policy shall address the use and possession of alcohol, marijuana, illegal substances and non-prescribed medications (excluding OTC). Contractor shall have written policies on sexual harassment and verbal abuse, weapons, filing a grievance and incident reporting.

i. Contractor shall have a written admission and discharge procedure at each SLE facility.

j. Admission and SLE residency documents shall be kept in a resident's file on the premises at all times.

k. Contractor shall have a written policy regarding the use and storage of residents' prescribed medications. Medications shall be properly secured. The SLE shall not dispense medication but shall ensure that it is stored securely by the resident.

l. Contractor shall comply with the provision of 42 C.F.R. Part 2.

m. Contractor shall permit and cooperate with BHRS performance monitoring and contract compliance.

2. Urinalysis Testing

Urinalysis (UA) Testing is a therapeutic intervention when deemed medically appropriate and is used to determine appropriate levels of client care. A positive UA test result may indicate a client's current level of care is not adequate and/or that the client treatment plan should be adjusted.

Contractor shall establish procedures which protect against falsification and/or contamination of any urine sample, and must document urinalysis results in the client's file.

C. Priority Populations

Through the Substance Abuse Prevention and Treatment (SAPT) Block Grant, BHRS is required to serve priority population clients. Contractor shall establish partnerships for the provision of referral to interim or treatment services when capacity is not available, as described in the AOD Policy and Procedure Manual. Contractor shall give priority admission to the following populations, provided they are residents of San Mateo County and do not have health care coverage:

1. Pregnant females who use drugs by injection;

2. Pregnant females who use substances;

3. Other persons who use drugs by injection; and

4. As Funding is Available – all other clients with a SUD, regardless of gender or route of use, without insurance or for whom coverage is terminated for short periods of time.

II. ADMINISTRATIVE REQUIREMENTS

In providing its services and operations, Contractor shall maintain compliance with requirements of the AOD Policy and Procedure Manual, including additions and revisions, which are incorporated by reference herein.

A. System-Wide Improvements

The County has identified issues which require a collaborative and comprehensive approach in order to enhance the system-wide effectiveness and efficiency. Contractor shall implement the following:

1. Community Service Areas

Contractor shall participate in activities to improve the partnership and service delivery within the CSA location. Contractor shall report on participation in CSA activities and accomplishments through the quarterly narrative.

2. External Quality Reviews

DHCS has contracted with an External Quality Review (EQR) organization to conduct a review of the overall quality of services, service accessibility, and availability provided under the ODS. The EQR also requires annual Performance Improvement Projects (PIP) that improve both clinical and administrative performance of the ODS.

a. Contractor shall participate in EQR focus groups, surveys, and other performance measurement and data collection activities.

b. Contractor shall participate in all PIPs implemented by BHRS as part of the EQR process.

3. Direct Service Time

Contractor shall report the time spent providing direct services to clients. Contractors shall develop and implement a weekly direct service time target of fifty-five percent (55%) for staff who provide direct clinical, counseling, and/or treatment services to clients. Contractors may request assistance from BHRS in meeting this requirement.

a. A Contractor providing outpatient and intensive outpatient treatment services shall report the number of minutes spent providing intake, individual counseling, group counseling,

individual patient education, group patient education, crisis intervention, treatment planning, case management, physician consultation, discharge services, and documentation of these services in Avatar.

b. A Contractor providing residential treatment services and enhanced services shall report the number of minutes spent providing intake, individual counseling, group counseling, individual patient education, group patient education, crisis intervention, treatment planning, case management, physician consultation, discharge services, and documentation of these services to the AOD program analyst on a quarterly basis.

B. Qualified Service Organization

As a qualified service organization, BHRS agrees to provide the following services to Contractor:

1. Centralized screening, assessment, and treatment referrals;

2. Billing supports and services;

3. Data gathering and submission in compliance with Federal, State, and local requirements;

4. Policies and procedures related to the service provision, documentation, and billing;

5. Quality Management and utilization review, including problem resolution;

6. Education, training and technical assistance as needed.

C. No Unlawful Use or Unlawful Use Messages Regarding Drugs

Contractor agrees that no aspect of its substance use treatment program services shall include any messaging in the responsible use, if the use is unlawful, of drugs or alcohol. This is including but not limited to: program standards, curricula, materials, and teachings. These materials and programs may include information on the health hazards of use of illegal drugs and alcohol, concepts promoting the well-being of the whole person, risk reduction, the addictive personality, development of positive self-esteem, productive decision-making skills, and other preventive concepts consistent with the "no unlawful use" of drugs and alcohol message. This does not apply to any program receiving state SAPT/NRC funding that provides education and prevention outreach to intravenous drug users with

AIDS or AIDS-related conditions, or persons at risk of HIV-infection through intravenous drug use. (Health and Safety Code Sections 11999-11999.3).

D. Restriction on Distribution of Sterile Needles

Contractor shall not use any SAPT Block Grant/NRC funds made available through this agreement to carry out any program that includes the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug.

E. AVATAR Electronic Health Record

1. Contractor shall enter client data into Avatar for services provided that includes: date of service, service type, service units and service duration.

2. Contractor shall maintain compliance with all documentation, reporting, billing and all other data requirements as required in the BHRS Documentation Manual, Title 22, DMC-ODS STCs, the DHCS AOD Program Certification Standards, CalOMS Tx Data Collection Guide, DMC Billing Manual, and the AOD Policy and Procedure Manual, including additions and revisions.

3. Contractor shall submit electronically treatment capacity and waitlist data to DHCS via DATAR. Contractor shall comply with all BHRS tracking methods for client waitlist times and capacity. This information shall be used to determine unmet treatment needs and wait times to enter treatment.

4. Contractor shall participate in Avatar trainings and monthly Avatar User Group (AUG) meetings to ensure data quality and integrity, and provide input into system improvements to enhance the system.

F. Quality Management and Compliance

1. Clinical Standards of Care and Evidenced-Based Practices

All services provided under this agreement shall be safe, effective, patient centered, timely, culturally competent, efficient and equitable, as defined by the Institute of Medicine.

a. In providing its services and operations, Contractor shall maintain full compliance with the San Mateo County BHRS Standards of Care, Best Practice Guidelines for Working with Limited English Proficiency and LGBTQ Clients, Federal Cultural and Linguistic Access Standards (CLAS) requirements. Contractor shall comply with at least two (2) of

the five (5) DMC-ODS Evidenced-Based Practices. Annually, Contractor shall provide a written report on the status of compliance with, and annual staff training on, the following:

i. Standards of Care

ii. Best Practice Guidelines for Working with Limited English Proficiency and LGBTQ Clients

iii. At least two (2) of the DMC-ODS Evidenced-Based Practices. The DMC-ODS Evidenced-Based Practices include: Motivational Interviewing, Cognitive-Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psycho-Education

iv. Federal CLAS requirements

2. Complex Clients and Co-occurring Disorders

a. Contractor shall implement co-occurring capable policies, procedures, assessments, treatment planning, program content, and discharge planning. Contractor shall coordinate and collaborate with behavioral and physical health services, and: initiate and coordinate with mental health services when appropriate, provide medication monitoring, coordinate with primary health services, and addiction and psychological assessment and consultation.

b. Contractor shall not exclude from treatment, persons who require high risk, specialized services or special health needs. Contractor shall work with the health care providers of clients with special health care needs. Contractor shall collaborate with BHRS and other service providers to meet the identified needs of such clients. Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of services solely because of the client's diagnosis, type of illness, or condition of the client. Contractor shall provide Medi-Cal beneficiaries with a NOABD each time Contractor denies or reduces the amount, duration, or scope of services the beneficiary is receiving.

i. Contractor shall seek ongoing training and support for staff to stay current with best practices for serving individuals with co-occurring disorders.

ii. A Contractor that provides SAPT Block Grant Perinatal services to pregnant and postpartum individuals shall

comply with the requirements contained in Title 22, Section 51341.1, Services for Pregnant and Postpartum Women, and with the DHCS Perinatal Practice Guidelines.

iii. Women, transgender men, and gender nonconforming Medi-Cal beneficiaries who are pregnant or up to sixty (60) days postpartum are eligible to receive DMC-ODS Perinatal services.

iv. A Contractor that provides adolescent treatment services shall comply with the Youth Treatment Services Guidelines. Assessments and services for adolescents shall follow the ASAM Adolescent Treatment Criteria.

3. Quality Management Program and Quality Improvement Plan

Contractor must have a Quality Management Program and submit a Quality Improvement Plan to Behavioral Health and Recovery Services (BHRS) Quality Management (QM) annually by June 30. The Quality Improvement Plan should address 1) how the Contractor will comply with all elements of this Agreement, 2) the Contractor will maintain an audit disallowance rate of less than five percent (5%), and 3) first appointment will be within ten (10) days of referral or request of service for outpatient services; twenty-four (24) hours for residential treatment; and three (3) calendar days for NRT.

BHRS QM will provide feedback if the plan submitted is missing critical components related to San Mateo County requirements. Additional feedback may be available if requested prior to the submission date.

a. Contractor shall have an established Quality Improvement (QI) plan and committee.

b. The QI committee shall include staff from all levels of the Agency and will guide the development and implementation of the annual QI plan. The QI committee shall review quarterly utilization and service quality, performance data, compliance with BHRS SOC, co-occurring and complex client capability, and client feedback.

c. Contractor shall establish and/or maintain mechanisms whereby processes and practices at the organizational level; which create inefficiencies and/or present barriers to client engagement, enrollment and retention in treatment, will be

identified and addressed. An analysis of policies and practices which create barriers for complex clients shall be included.

4. Grievance Process

Contractor shall notify beneficiaries of their right to the following:

a. a state fair hearing, how to obtain a hearing and representation rules at the hearing;

b. file grievances and appeals, and the requirements and timeframes for filing;

i. Beneficiaries may file a grievance, either orally or in writing, either with DHCS, the County, or the Contractor
ii. Beneficiaries may request assistance with filing grievances and appeals

i. If the beneficiary is grieving or appealing the termination, denial, or a change in type or frequency of services, the beneficiary may request services be continued during the appeal or state fair hearing filing although the beneficiary may be liable for the cost of any continued benefits if the action is upheld.

c. give written consent to allow a provider, acting on behalf of the beneficiary, to file an appeal.

5. Referring Individuals to Psychiatrist

Contractor shall have written procedures for referring individuals to a psychiatrist or physician when necessary, if a psychiatrist is not available.

6. Medication Storage and Monitoring

For Contractors that provide or store medications: Contractor shall store and monitor medications in compliance with all pertinent state and federal standards. Policies and procedures must be in place for monitoring, and storing medications consistent with BHRS Policy 99-03, Medication Room Management and BHRS Policy 04-08 Medication Monitoring located at www.smchealth.org/bhrs-documents. In particular:

a. Medications are logged in, verified, counted and added to inventory sheets.

b. All medications obtained by prescription are labeled in compliance with federal and state laws. Prescription labels are altered only by persons legally authorized to do so.

c. Medications intended for external use only are stored separately from medications intended for internal use; food and blood samples are stored in separate refrigerators.

d. All medications are stored at proper temperatures: room temperature drugs at 59-86 degrees Fahrenheit and refrigerated drugs at 36-46 degrees Fahrenheit.

e. Medications are stored in a locked area with access limited to staff authorized to monitor medication.

f. Medications are disposed of after the expiration date and recorded.

g. Injectable multi-dose vials are dated and initialed when opened.

h. A medications log is maintained to ensure that expired, contaminated, deteriorated and abandoned medications are disposed in a manner consistent with state and federal laws.

i. Over the counter medications that are not prescribed by the client's physician may not be used (for example, Tylenol).

7. Record Retention

Paragraph 15 of the Agreement notwithstanding, Contractor shall maintain medical records required by the California Code of Regulations. Notwithstanding the foregoing, Contractor shall maintain beneficiary medical and/or clinical records for a period of ten (10) years, except the records of persons under age eighteen (18) at the time of treatment shall be maintained: a) until ten (10) years beyond the person's eighteenth (18th) birthday or b) for a period of ten (10) years beyond the date of discharge, whichever is later. This rule does not supersede professional standards. Contractor may maintain records for a longer period of time if required by other regulations or licenses.

8. Documentation of Services

Contractor shall provide all pertinent documentation required for state and federal reimbursement including but not limited to Consent Forms, assessments, treatment plans, and progress notes. Contractor agencies must submit, via fax to Quality Management at 650-525-1762, their version of these forms for approval before the forms are to be used. Special attention must be paid to documentation requirements for residential treatment facilities. Documentation shall be completed in compliance with the BHRS Policies & Documentation Manuals. Contractor agencies are required to provide and maintain record of regular documentation training to staff providing direct services. Proof of trainings including attendance by staff may be requested at any time during the term of this Agreement.

Substance Use provider services shall be in compliance with the Alcohol and Other Drug Services Provider Handbook which is located online at http://www.smchealth.org/bhrs/aod/handbook.

9. Audits

Behavioral Health and Recovery Services QM and/or BHRS analyst will conduct regular chart audits of Contractors. Contractor is required to provide either the original or copies of charts, including all documentation upon request. The DHCS and other regulatory agencies conduct regular audits of the clinical services provided by BHRS and Contractors requiring submission of charts as requested. Contractor is required to provide all necessary documentation for external audits and reviews within the stated timeline.

Contractor shall accommodate and cooperate with unannounced chart audits, chart reviews, site visits, and grievance/complaint investigations by BHRS staff with or without advance notice. BHRS has the right to audit, evaluate, inspect any books, records, charts, contracts, computer or other electronic systems of the Contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under this Agreement at any time. Contractor shall make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, charts, contracts, computer or other electronic systems related to DMC, SAPT, or any service funded by this contract.

If deficiencies are found during an audit or utilization review of Contractor's services, Contractor shall develop a Corrective Action Plan (CAP) to include the following:

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

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

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

d. Identify who will be responsible for ongoing compliance.

BHRS will review and approve or require additional changes to the CAP. Contractor failure to submit a CAP within the required timeframe and failure to complete, fully implement, or sustain a CAP over time may result in withheld or denied payments, penalty fees, or termination of this agreement.

10. Client Rights and Satisfaction Surveys

a. Administering Satisfaction Surveys

i. Contractor agrees to administer/utilize any and all survey instruments as directed by BHRS, including outcomes and satisfaction measurement instruments.

ii. Contractor shall participate in Treatment Perception Survey collection processes. Treatment Perception Surveys collect client satisfaction data. Contractor may solicit additional feedback from service recipients and family members. All feedback surveys shall be incorporated into Contractor quality improvement processes and plans.

iii. Contractor shall develop and administer client and family satisfaction surveys on an annual basis for quality improvement and quality assurance purposes.

b. Client/Patient's Rights

Contractor will comply with County policies and procedures relating to beneficiary/patient's rights and responsibilities as referenced in the Agreement.

c. Advance Directives

Contractor will comply with County policies and procedures relating to advance directives.

11. Beneficiary Brochure and Provider Lists

Contractor shall provide Medi-Cal beneficiaries new to BHRS with a Member Handbook at the time of their first service from Contractor. The Member Handbook may be downloaded using this link: https://www.smchealth.org/sites/main/files/file-attachments/dmc-ods_member_handbook_072018.pdf.

Contractor is required to be aware of and make available to BHRS Medi-Cal clients all mandatory postings listed at this website http://www.smchealth.org/bhrs/providers/mandpost.

12. Notice of Adverse Benefit Determination

a. Contractor shall issue Medi-Cal beneficiaries a written Notice of Adverse Benefit Determination (NOABD) each time the beneficiary's service is denied, delayed, terminated, or there is a change in the amount, scope, or duration of the treatment service from what was requested by the beneficiary. Contractor shall use the appropriate BHRS provided templates when issuing a NOABD. The NOABD shall meet the requirements of 42 CFR 438.404.

b. BHRS will conduct random reviews of Contractor to ensure compliance with NOABD requirements.

13. Certification and Licensing

a. SUD Treatment Services

i. Contractors providing SUD treatment services to San Mateo County residents shall be certified and/or licensed by DHCS Licensing and Certification Division. Contractor shall maintain all applicable certifications through San Mateo County and/or DHCS to provide any of the following reimbursable services: Substance Abuse and Treatment Services, and Drug Medi-Cal reimbursed services.

ii. Contractor shall submit a copy of any licensing complaint, deficiency findings, or corrective action report issued by a licensing agency to BHRS QM and the AOD Administrator or their designee, within two (2) business days of Contractor's receipt of any such licensing report.

iii. Should Contractor cease to offer a DMC-ODS service, Contractor will work with BHRS to ensure participating

clients are successfully transferred to another DMC-ODS provider.

iv. Contractor shall provide written notification to the AOD Administrator of any changes in DMC-ODS offered services at least ninety (90) days prior to implementing the changes in services.

b. DMC-ODS SUD Treatment Services

i. If at any time, Contractor's license, registration, certification, or approval to operate a substance use disorder program or provide a DMC-ODS covered service is revoked, suspended, modified, or not renewed outside of DHCS, the Contractor shall notify DHCS Fiscal Management & Accountability Branch by e-mail at DHCSMPF@dhcs.ca.gov and the BHRS Program Analyst within two (2) business days of knowledge of such change.

ii. Contractor's certification to participate in the DMC program shall automatically terminate in the event the Contractor 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.

iii. If Contractor is under investigation by DHCS or any other state, local or federal law enforcement agency for fraud or abuse, DHCS may temporarily suspend the Contractor from the DMC program, pursuant to W&I Code, Section 14043.36(a). Information about Contractor's administrative sanction status is confidential until such time as the action is either completed or resolved. The DHCS may also issue a Payment Suspension to Contractor pursuant to W&I Code, Section 14107.11 and Code of Federal Regulations, Title 42, section 455.23. DHCS will authorize BHRS to withhold payments from the DMC Contractor during the time a Payment Suspension is in effect.

14. Licensing Reports

Contractor shall submit a copy of any licensing complaint or corrective report issued by a licensing agency to BHRS Quality Management and Manager of SUD Services or their designee, within

ten (10) business days of Contractor's receipt of any such licensing report.

15. Compliance with HIPAA, Confidentiality Laws, and PHI Security

a. Contractor must implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Protected Health Information (PHI), including electronic PHI that it creates, receives, maintains, uses or transmits, in compliance with 45 C.F.R and to prevent use or disclosure of PHI other than as provided for by this Agreement. Contractor shall implement reasonable and appropriate policies and procedures to comply with the standards. Contractor is required to report any security incident or breach of confidential PHI to BHRS Quality Management within twenty–four (24) hours.

b. Contractor will develop and maintain a written Privacy and Security Program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities.

i. On an annual basis, Contractor shall require all staff accessing client PHI or PI to sign a confidentiality statement that includes, as a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies.

c. Contractor shall install and actively use comprehensive antivirus software on all workstations, laptops and other systems that process and/or store PHI or PI. The antivirus software solution must have automatic updates scheduled at least daily.

d. All workstations, laptops and other systems that process and/or store PHI or PI shall have critical security patches applied, with system reboot if necessary. Contractor shall document the patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within thirty (30) days of vendor release. Applications and systems that cannot be patched within this timeframe due to significant operational reasons must have compensatory controls implemented to minimize risk until the patches can be installed. Applications and systems that

cannot be patched must have compensatory controls implemented to minimize risk, where possible.

e. Contractor agrees to comply with the provisions of 42 C.F.R. Part 2 as described below if records contain or contract possesses any PHI covered under 42 C.F.R Part 2:

i. Acknowledge that in receiving, storing, processing, or otherwise using any information from BHRS about the clients in the program, it is fully bound by the provisions of the federal regulations governing Confidentiality of Behavioral Health and Recovery Services Patient Records, 42 C.F.R. Part 2;

ii. Undertake to resist in judicial proceedings any effort to obtain access to information pertaining to clients otherwise than as expressly provided for in the federal confidentiality regulations, 42 C.F.R. Part 2; and

iii. Agree to use appropriate safeguards to prevent the unauthorized use or disclosure of the protected information.

f. Confidentiality Training

Contractor is required to conduct, complete and maintain record of annual confidentiality training by all staff serving or accessing PHI of BHRS clients. Contractor may utilize BHRS Confidentiality trainings located at http://smchealth.org/bhrs/providers/ontrain.

16. Critical Incident Reporting

Contractor is required to submit Critical Incident reports to BHRS Quality Management (via fax # 650-525-1762) and the BHRS analyst (via fax # 650-802-6440) when there are unusual events including but not limited to: an accident, medication error, violence or significant injury requiring medical treatment of client, staff or member of the community, death of a client, police activity, 9-1-1 call, suicide attempt, or threat to the health or safety of client, staff or member of the community. (Policy #93-11 and 45 C.F.R. § 164, subpart C, in compliance with 45 C.F.R. § 164.316.)

Incident reports are confidential however discussion may occur with Contractor regarding future prevention efforts to reduce the likelihood of recurrence. Contractor is required to participate in all activities related to the resolution of critical incidents.

a. Contractor shall submit the written Critical Incident report via fax on the same day the incident occurred, or within twenty-four (24) hours.

b. Contractor shall not file or reference a Critical Incident report in the client's chart. However, Contractor shall document the circumstances of the event and services provided.

c. Contractor shall not collect and submit Critical Incident reports in batches.

d. Contractor shall not permit hard copies or electronic copies of the Critical Incident report to be kept by the person reporting the incident. Internal copies may only be maintained by the Contractor's compliance officer/quality management as part of quality oversight. These shall be stored in a secure location without general access. All other copies shall then be shredded or deleted.

e. Contractor shall also comply with DHCS Licensing and Certification Branch Unusual Incident reporting guidelines. The Contractor shall make a telephonic report to the DHCS Complaints and Counselor Certification Division within one (1) working day for any of the following events: client deaths from any cause, any client injury requiring medical treatment, all cases of communicable disease reportable under HSC Section 3125 or California Administrative Code Title 17 Sections 2500, 2502, or 2503, poisonings, natural disasters, and fires or explosions that occur on the premises. The telephonic report shall be followed by a written report to DHCS within seven (7) days of the event using form DHCS 5079: https://www.dhcs.ca.gov/formsandpubs/forms/forms/sudcd/dhcs_5079.pdf

17. Ineligible Employees

Behavioral Health and Recovery Services (BHRS) requires that contractors comply with Federal requirements as outlined in 42 CFR (438.608) Managed Care Regulations. Contractors must identify the eligibility of employees, interns, or volunteers prior to hiring and on a monthly basis thereafter. Results of the eligibility screenings are to be maintained in the employee files. This process is meant to ensure that any person delivering services to clients of BHRS are not currently excluded, suspended, debarred or have been convicted of a criminal offense as described below. The Contractor must notify BHRS Quality Management (by completing the BHRS Critical

Incident Reporting Form, Policy#93-11) should a current employee, intern, or volunteer be identified as ineligible. Contractors are required to screen for ineligible employees, interns, and volunteers by following procedures included in BHRS Policy # 04-01, which can be found online at: http://www.smchealth.org/bhrs-policies/compliance-policy-funded-services-provided-contracted-organizational-providers-04-01. BHRS Quality Management must be notified within twenty-four (24) hours of any violations. Contractor must notify BHRS Quality Management if an employee's license is not current or is not in good standing and must submit a plan to correct to address the matter.

a. Credentialing Check – Initial

During the initial contract process, BHRS will send a packet of contract documents that are to be completed by the Contractor and returned to BHRS. Attachment F – Agency/Group Credentialing Information will be included in the contract packet. Contractor must complete Attachment F and return it along with all other contract forms.

b. Credentialing Check – Monthly

Contractor will complete Attachment F – Agency/Group Credentialing Information each month and submit the completed form to BHRS Quality Management via email at: HS_BHRS_QM@smcgov.org or via a secure electronic format.

18. Compliance Plan and Code of Conduct

Contractor will annually read and be knowledgeable of the compliance principles contained in the BHRS Compliance Plan and Code of Conduct located at http://smchealth.org/bhrs-documents. In addition, Contractor will assure that Contractor's workforce is aware of compliance mandates and informed of the existence and use of the BHRS Compliance Improvement Hotline (650) 573-2695.

Contractor is required to conduct, complete and maintain record of annual compliance training by all staff serving or accessing PHI of BHRS clients. Contractor may utilize BHRS Confidentiality trainings located at http://smchealth.org/bhrs/providers/ontrain.

19. Fingerprint Compliance

Contractor certifies that its employees, trainees, and/or its subcontractors, assignees, volunteers, and any other persons who

provide services under this agreement, who have direct contact with any client will be fingerprinted in order to determine whether they have a criminal history which would compromise the safety of individuals with whom the Contractor's employees, trainees and/or its subcontractors, assignees, or volunteers have contact. Contractor shall have a screening process in place to ensure that employees who have positive fingerprints shall:

a. Adhere to CCR Title 9 Section 13060 (Code of Conduct) when providing services to individuals with whom they have contact as a part of their employment with the contractor; OR

b. Obtain an exemption from Community Care Licensing allowing the employee to provide services to individuals with whom they have contact as a part of their employment with the contractor.

A certificate of fingerprinting certification is attached hereto and incorporated by reference herein as Attachment E.

20. Staff Termination

Contractor shall inform BHRS, within two (2) business days, when staff have been terminated. BHRS Quality Management requires prompt notification to be able to terminate computer access and to safeguard access to electronic medical records by completing the BHRS Credentialing form.

21. Minimum Staffing Requirements

Contractor shall have on file job descriptions (including minimum qualifications for employment and duties performed) for all personnel whose salaries, wages, and benefits are reimbursable in whole or in part under this Agreement. Contractor agrees to submit any material changes in such duties or minimum qualifications to County prior to implementing such changes or employing persons who do not meet the minimum qualifications currently on file. Contractor service personnel shall be direct employees, contractors, volunteers, or training status persons.

G. Cultural Competency

Implementations of these guidelines are based on the National Culturally and Linguistically Accessible Services (CLAS) Standards issued by the Department of Health and Human Services. For more information about these standards, please contact the Health Equity Initiatives Manager

(HEIM) at ode@smcgov.org.

1. Contractor will submit an annual cultural competence plan that details on-going and future efforts to address the diverse needs of clients, families and the workforce. This plan will be submitted to the BHRS Analyst/Program Manager and the Health Equity Initiatives Manager (HEIM) by September 30th of the fiscal year.

   The annual cultural competence plan will include, but is not limited to the following:

   a. Implementation of policies and practices that are related to promoting diversity and cultural competence, such as ongoing organizational assessments on disparities and needs, client's rights to receive language assistance.

   b. Contractor forum for discussing relevant and appropriate cultural competence-related issues (such as a cultural competence committee, grievance, or conflict resolution committee).

   c. Ongoing collection of client cultural demographic information, including race, ethnicity, primary language, gender and sexual orientation in health records to improve service provision and help in planning and implementing CLAS standards.

   d. Staffing objectives that reflect the cultural and linguistic diversity of the clients. (Contractor will recruit, hire and retain clinical staff members who can provide services in a culturally and linguistically appropriate manner.)

   e. Contractor will ensure that all program staff receive at least 8 hours of external training per year (i.e. sponsored by BHRS or other agencies) on how to provide culturally and linguistically appropriate services including the CLAS and use of interpreters.

2. Contractor will actively participate in at least one cultural competence effort within BHRS and/or to send a representative to attend the Cultural Competence Council (CCC) for the term of the Agreement. Participation in the CCC allows for the dissemination of CLAS as well as ongoing collaborations with diverse stakeholders. Contractor shall submit to BHRS Office of Diversity and Equity (ODE) by March 31st, a list of staff who have participated in these efforts. For more information about the CCC, and other cultural competence efforts within BHRS, contact HEIM.

3. Contractor will establish the appropriate infrastructure to provide services in County identified threshold languages. Currently the threshold languages are: Spanish, Tagalog and Chinese (Mandarin and Cantonese). If Contractor is unable to provide services in those languages, Contractor is expected to contact Access Call Center or their BHRS Analyst/Program Manager for consultation. If additional language resources are needed, please contact HEIM.

4. Contractor will translate relevant and appropriate behavioral health-related materials (such as forms, signage, etc.) in County identified threshold languages in a culturally and linguistically appropriate manner. BHRS strongly encourages its contractors to use BHRS-sponsored forms in an effort to create uniformity within the system of care. Contractor shall submit to HEIM by March 31st, copies of Contractor's health-related materials in English and as translated.

5. Should Contractor be unable to comply with the cultural competence requirements, Contractor will meet with the BHRS Analyst/Program Manager at ode@smcgov.org to plan for appropriate technical assistance.

H. Physician Incentive Plans

Contractor shall obtain approval from County prior to implementing a Physician Incentive Plan as described by Title 42, CFR, Section 438.6(h) and Section 422.208. The County will submit the Physician Incentive Plan to the State for approval. The State shall approve the Contractor's request for a Physician Incentive Plan only if the proposed Physician Plan complies with all applicable federal and state regulations.

I. Availability and Accessibility of Service

Contractor shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees, if the Contractor also serves enrollees of a commercial plan, or that are comparable to the hours the Contractor makes available for Medi-Cal services that are not covered by the County or another Mental Health Plan, if the Contractor serves only Medi-Cal clients.

J. Surety Bond

Contractor shall retain and show proof of a bond issued by a surety company in accordance with Community Care Licensing's regulations for a licensee who may be entrusted with care and/or control of client's cash resources.

K. Control Requirements

Contractor shall be familiar and implement the laws, regulations, codes and guidelines listed in Attachment L. Contractor shall assure that its Subcontractors are also familiar with such requirements.

Contractor shall establish written policies and procedures consistent with the requirements identified in Attachment L. Contractor shall be held accountable for audit exceptions taken by the State for any failure to comply with these requirements.

DMC Contractor will fulfill the requirements of 42 CFR Part 438 et seq (managed care) that are appropriate to the service or activity covered under this contract.

Attachment L is subject to modifications by federal, state and local regulations that are applicable to the Intergovernmental Agreement.

L. Trafficking Victims Protection Act of 2000

Contractor shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 as amended (22 U.S.C. 7104(g)) as amended by section 1702: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title22-section7104d&num=0&edition=prelim.

III. PERFORMANCE STANDARDS, GOAL AND OBJECTIVE

Contractor shall ensure that the following outcome objectives are pursued throughout the term of this Agreement:

PERFORMANCE STANDARDS:

A. Timely Access to Care: Contractor shall track and document timely access data, including the date of initial contact, the date of first offered appointment, and the date of first actual appointment, using the UCLA ASAM Level of Care spreadsheet.

1. For Outpatient and Intensive Outpatient Treatment Services, the first appointment shall occur no later than ten (10) days after the initial request for services.
2. For Residential Treatment Services, the first appointment shall occur no later than three (3) days after the referral was received, if the Contractor has capacity to admit the client.
3. For Urgent Treatment Services (Residential Withdrawal Management), the first appointment shall occur within twenty-four (24) hours of the initial request for services, if the Contractor has capacity to admit the client.

B. Transitions Between Levels of Care: Both the admitting and discharging Contractors shall be responsible for facilitating the client's transition between levels of care, including assisting the client in scheduling their first appointment and ensuring a minimal delay between discharge and admission at the next level of care, providing or arranging for transportation as appropriate, and documenting the transition in the client's chart.

1. Transitions between levels of care shall occur within ten (10) business days from the time of the ASAM LOC Re-Assessment indicating the need for a different level of care.

2. At least seventy-five percent (75%) of clients discharged from Residential Treatment are subsequently admitted to another level of care (IOP, OP or Recovery Services) within ten (10) business days from the date of discharge.

3. At least seventy-five percent (75%) of clients discharged from Residential Withdrawal Management care are subsequently admitted to another level of care within ten (10) business days from the date of discharge.

4. At least fifty percent (50%) of clients discharged from Intensive Outpatient or Outpatient Treatment are subsequently admitted to another level of care (including Recovery Services) within ten (10) business days from the date of discharge.

C. Care Coordination: Contractors shall ensure 42 CFR compliant releases are in place for all clients in order to coordinate care. The Contractor shall screen for and link clients with mental health and primary care, as indicated.

1. One hundred percent (100%) of clients are screened for mental health and primary health care needs.

2. At least seventy percent (70%) of clients who screen positive for mental health disorders have documentation of referrals to and coordination with mental health providers.
3. At least eighty percent (80%) of clients who screen positive for primary health care needs have documentation of referrals to and/or coordination with primary care providers.

D. Medication Assisted Treatment: Contractors shall have procedures for referrals to and integration of medication assisted treatment for substance use disorders. Contractor staff shall regularly communicate with physicians of clients prescribed these medications unless the client refuses to sign a Release of Information.

1. At least eighty percent (80%) of clients with a primary opioid or alcohol use disorder will be referred for a MAT assessment and/or MAT services.

E. Culturally Competent Services: Contractors shall be responsible for providing culturally competent and linguistically appropriate services. Translation and interpretation services shall be available to all clients, as needed and at no cost to the client.

1. One hundred percent (100%) of clients who speak a threshold language are provided services in their preferred language.

2. One hundred percent (100%) of clients who read a threshold language are provided written treatment materials in their preferred language.

GOAL AND OBJECTIVE

GOAL: Program participants will achieve a successful treatment discharge.

OBJECTIVE: No less than sixty percent (60%) of participants will have a successful treatment discharge. Successful treatment discharge occurs when a program participant completes his/her treatment/recovery plan or is transferred for continued treatment.

*** END OF EXHIBIT A1 ***

EXHIBIT B1 – PAYMENTS AND RATES
THE LATINO COMMISSION
FY 2019 – 2021

In consideration of the services provided by Contractor in Exhibit A1, County shall pay Contractor based on the following fee schedule:

I. PAYMENTS

In full consideration of the services provided by Contractor under this Agreement and subject to the provisions of Paragraph 3 of this Agreement, County shall pay Contractor in the manner described below:

A. Maximum Obligation

The maximum amount that County shall be obligated to pay for all services provided under this Agreement shall not exceed the amount stated in Paragraph 3 of this Agreement. Furthermore, County shall not pay or be obligated to pay more than the amounts listed below for each component of service required under this Agreement. Contractor shall receive monthly payments as outlined below, upon timely submission of reports as outlined in the AOD Policy and Procedure Manual located at: http://www.smhealth.org/bhrs/aod/reqs.

In any event, the maximum amount County shall be obligated to pay for all services rendered under this contract shall not exceed TWO MILLION TWO HUNDRED THOUSAND ONE HUNDRED ELEVEN DOLLARS ($2,200,111).

B. Drug MediCal Organized Delivery System SUD Treatment Services

The maximum amount County shall be obligated to pay for DMC-ODS services shall not exceed TWO MILLION ONE HUNDRED FORTY THOUSAND ONE HUNDRED ELEVEN DOLLARS ($2,140,111) for the term of the agreement.

1. FY 2019 – 2020

Contractor shall be paid a maximum of ONE MILLION FORTY-NINE THOUSAND SEVENTY-FOUR DOLLARS ($1,049,074). Contractor shall submit monthly invoices for payment. Invoice amounts shall be for the Contractor actual monthly costs, or an advance payment in the amount of EIGHTY-SEVEN THOUSAND FOUR HUNDRED TWENTY-THREE DOLLARS ($87,423), whichever is less. Contractor will submit invoices on forms and in manner prescribed by the County

2. FY 2020 – 2021

Contractor shall be paid a maximum of ONE MILLION NINETY-ONE THOUSAND THIRTY-SEVEN DOLLARS ($1,091,037). Contractor shall submit monthly invoices for payment. Invoice amounts shall be for the Contractor actual monthly costs, or an advance payment in the amount of NINETY THOUSAND NINE HUNDRED TWENTY DOLLARS ($90,920), whichever is less. Contractor will submit invoices on forms and in manner prescribed by the County.

3. Where Contractor requires payment advances, Contractor assures the County that an advance is necessary in order to maintain program integrity. Contractor will not use County funds to provide working capital for non-County programs. Where possible, advances will be deposited in interest-bearing accounts, with said interest being used to reduce program costs.

4. County shall make monthly payments to Contractor for invoiced amounts within thirty (30) days of receipt of invoices.

5. Costs for room and board services must be claimed as a separate line item in invoices and reported in cost reports separately and distinctly from residential treatment services using the methodology for claiming and reporting for room and board services as approved by the County.

6. Billing for DMC Services

   a. Contractor shall bill BHRS for services provided to Medi-Cal clients, covered under the DMC-ODS.

   b. Contractor must follow the process established under DHCS ADP Bulletin 11-01, for clients that have other healthcare coverage (OHC) in addition to Medi-Cal including future DHCS process updates for DMC claims for clients with OHC: http://www.dhcs.ca.gov/services/MH/MHSUD/Documents/ADP_Bulletins/ADP_11-01.pdf.

   c. Services covered through another healthcare provider shall not be reimbursed through the County. Contractor shall bill the other healthcare coverage for which the client is a beneficiary. If Contractor is not a member of the provider network for that healthcare coverage, Contractor shall then refer client to the healthcare provider network

7. DMC-ODS Administrative Requirements

a. Contractor may not use allocated DMC State General Funds to pay for any non-DMC services. In accordance with W&IC Sections 14132.44 and 14132.47, funds allocated to the Contractor for DMC services, including funding for alcohol and other drug services for pregnant and postpartum women pursuant to Title 22, Section 51341.1(c), may not be used as match for targeted case management services or for MediCal Administrative Activities (MAA).

b. DMC rates are contingent upon legislative action of the annual State Budget and/or the approval of the DMC-ODS plan. All claims must be documented in accordance with DHCS DMC Provider Billing Manual, DMC rules, guidelines, timelines, and must be provided by staff who are lawfully authorized to provide, prescribe and/or order these services within the scope of their practice and/or licensure.

c. Contractor shall prepare and retain for DHCS review as needed the following forms: a) multiple billing overrider certification (MC 6700), document 2K; b) Good Cause Certification (6065A) document 2L(a); and Good Cause Certification (6065B) Document 2LB. In the absence of good cause documented on the GCC 6065 a or b form, claims that are not submitted within thirty (30) days of the end of the month of service will be denied.

d. The existence of good cause shall be determined by DHCS in accordance with Title 22, CCR, Sections 51008 and 51008.5.

e. DMC services are jointly funded by Federal Financial Participation (FFP) and matching State and local dollars. FFP is the Federal share of reimbursement for eligible services delivered to MediCal clients as define by CCR Title 9, Section 1840.1000. Contractor will meet the FFP eligibility criteria.

8. Cost Report / Unspent Funds

a. Contractor shall complete and certify State DMC year-end cost report forms. Contractor shall submit completed forms and certification to County no later than August 30th after the end of the fiscal year.

With the cost report, Contractor shall submit a written reconciliation of the total units of services delivered under this agreement with the total number of units reported by Contractor to the County data system. The County reserves the right to withhold payment due to Contractor under this

Agreement or subsequent year's Agreement until such time as Contractor submits the required cost report and reconciliation report to the County.

b. If the annual cost report provided to County shows that total payment to Contractor exceeds the total actual costs for all of the services rendered by Contractor to eligible patients during the reporting period, a single payment in the total amount of the unearned funds shall be made by Contractor to County, unless otherwise authorized by the BHRS Director. This payment shall be submitted with the cost report.

c. If the annual cost report provided to County shows that Contractor had costs that were higher than the payments received (and less than the Agreement maximum), Contractor may submit an invoice to the County for any additional amount owed up to the balance of the Agreement maximum. County will make payment for approved costs within forty-five (45) days of receipt of such invoice.

d. Contractor may request that contract savings or "unspent funds" within the Agreement maximum are expended by Contractor in the following year, provided that these funds are expended for SUD services approved by County in accordance with the following procedures. County reserves the right to deny the request and is under no obligation to approve unspent funds from the previous year (no multiple year roll over.)

    i. Contractor shall submit a detailed budget and summary calculation of any savings ninety (90) days after end of the fiscal year. The detailed budget and summary calculation will be a separate report from the year-end cost report.

    ii. At the time of the submission of the detailed budget and summary calculation Contractor may request to rollover some or all of any savings. The request must be made in writing to the BHRS Director or the Director's designee. The request shall identify specifically how the rollover funds will be spent, including a detailed budget by expenditure line items. Approved rollover funds shall be spent only for the succeeding fiscal year and only for the specific purpose(s) requested and approved. If approved, the Agreement for the succeeding fiscal year will be

amended as necessary to include the approved rollover amount.

iii. Unspent funds may only be used for one-time expenses and not for ongoing costs. Unspent funds will be reimbursed based on actual expenditures incurred and submitted as a separate line item in invoices.

9. Additional forms and/or information may be required in support of Cost Report data at discretion of the County.

C. Non-Drug MediCal SUD Treatment Services

1. Cost Reimbursement with Maximum Allocation

Health Plan of San Mateo (HPSM) funded Contractors shall receive a fixed advance monthly payment in the initial phases of the program up to a maximum allocation. Total payments made by the County shall be reconciled to Contractor actual costs at the end of each fiscal year. Unearned funding shall be returned to the County within 45 days of fiscal year end, unless otherwise authorized by the BHRS Director. Once service data and rates are established, the HPSM Agreement shall be amended and Contractor shall be paid on a fee for services basis with a maximum allocation.

3. Sober Living Environment

The maximum amount County shall be obligated to pay for a Sober Living Environment shall not exceed SIXTY THOUSAND DOLLARS ($60,000) for the term of the agreement.

a. FY 2019 – 2020

County shall pay contractor at a rate of TWENTY-EIGHT DOLLARS ($28.00) per client, per day, on a fee-for-service basis, not to exceed THIRTY THOUSAND DOLLARS ($30,000).

b. FY 2020 – 2021

County shall pay contractor at a rate of TWENTY-EIGHT DOLLARS ($28.00) per client, per day, on a fee-for-service basis, not to exceed THIRTY THOUSAND DOLLARS ($30,000).

D. All Services

1. Cost Settlement

Settlements of total amount due to Contractor for services provided will be made at the following times:

a. Filing of monthly Revenues and Expenditures Reports. Contractor shall submit a monthly Revenues and Expenditure Report to the BHRS Program Analyst.

b. Filing of quarterly Budget Monitoring Reports. Contractor shall submit a quarterly Budget Monitoring Report using the BHRS provided template.

c. Filing of Cost Report. At the time that the Contractor submits the DHCS Cost Report to the County, Contractor shall reconcile all actual costs with payments received. Contractor shall submit an invoice to the County for any balance due, or shall submit a check to the County for any unearned amount. Any balances due or unearned amounts will have been adjusted to account for any subsequent known disallowances for DMC services.

   DMC Cost Report requirements are described in section V.

d. Subsequent to the filing of the County DMC Cost Report to the State DHCS, there may be a secondary settlement required if it is determined that units and/or costs previously submitted by the Contractor are eligible or ineligible for reimbursement. Notice for any settlement under this provision will be sent by the County to the Contractor within 60 (sixty) days of the time in which the County files the DMC Cost Report.

e. It is anticipated that DHCS will make payment to the County of any outstanding claims approximately eighteen (18) months following the close of the fiscal year. At that time there may be reconciliation with DHCS of outstanding County claims that may result in disallowed units or costs previously submitted for payment. Notices for any settlement under this provision will be sent by County to Contractor within sixty (60) days of receipt from DCHS of the total reconciliation of units of service. The County may choose to appeal any such disallowances, and therefore reserves the right to defer any reconciliation with Contractor until the resolution of any such appeal.

f. A final reconciliation and settlement is anticipated subsequent to the audit of the County's DMC Cost Report by DHCS. Notices for any settlement under this provision will be sent by County to Contractor within sixty (60) days of receipt from DCHS of the final audit determination. The County may choose to appeal any audit disallowances, and therefore reserves the right to defer final reconciliation of payments to Contractor until resolution of any such appeal.

g. If the Contractor has acted in good faith to ensure staff and programs completely comply with County's direction and requirements, to the extent that Contractor audit findings are the result of County's directions and requirements and not from Contractor's errors or omissions, Contractor shall not be held responsible for such audit findings. If the Contractor disagrees with a negative audit finding, Contractor may appeal that decision to the BHRS Director, who shall have final authority to determine Contractor's responsibility for the audit finding.

2. Contractor will be responsible for all expenses incurred during the performance of services rendered under this Agreement.

3. Modifications to the allocations in Paragraph A of this Exhibit B1 may be approved by the Chief of San Mateo County Health or designee, subject to the maximum amount set forth in Paragraph 3 of this Agreement.

4. The Chief of San Mateo County Health or designee is authorized to execute contract amendments which modify the County's maximum fiscal obligation by no more than $25,000 (in aggregate), and/or modify the contract term and/or services so long as the modified term or services is/are within the current or revised fiscal provisions.

5. In the event that funds provided under this Agreement are expended prior to the end of the contract period, Contractor shall provide ongoing services under the terms of this Agreement through the end of the contract period without further payment from County.

6. In the event this Agreement is terminated prior to June 30, 2021, Contractor shall be paid on a prorated basis for only that portion of the contract term during which Contractor provided services pursuant to this Agreement. Such billing shall be subject to the approval of the Chief of San Mateo County Health or designee.

7. Disallowances that are attributable to an error or omission on the part of County shall be the responsibility of County. This shall include but not be limited to quality assurance (QA) audit disallowances as a result of QA Plan error or format problems with County-designed service documents.

8. The contracting parties shall be subject to the examination and audit of the Department of Auditor General for a period of three years after final payment under contract (Government Code, Section 8546.7).

9. At any point during the Agreement term, Contractor shall comply with all reasonable requests by County to provide a report accounting for the Grant Funds distributed by the County to the Contractor to-date.

10. Monthly Invoice and Payment

Contractor shall bill County on or before the tenth (10th) working day of each month following the provision of services for the prior month. Payment by County to Contractor shall be monthly. Claims that are received after the tenth (10th) working day of the month are considered to be late submissions and may be subject to a delay in payment. Claims that are received one hundred eighty (180) days or more after the date of service are considered to be late claims. County reserves the right to deny invoices with late claims or claims for which completed service reporting forms or electronic service files are not received. Claims and reports are to be sent to:

County of San Mateo
Behavioral Health and Recovery Services
BHRS Program Analyst
310 Harbor Blvd., Bldg. E
Belmont, CA 94002

Contractor shall set and collect client fees from non Medi-Cal beneficiaries based on the client's ability to pay. The fee requirement shall not apply to prevention and early intervention services. Contractor shall identify in its annual cost report the types and amounts of revenues collected.

11. County anticipates revenues from various sources to be used to fund services provided by Contractor through this Agreement. Should actual revenues be less than the amounts anticipated for any period of this Agreement, the maximum payment obligation and/or payment obligations for specific services may be reduced at the discretion of the Chief of San Mateo County Health or designee.

12. Adjustments may be made to the total of the Agreement and amounts may be withheld from payments otherwise due to the Contractor for nonperformance to the extent that nonperformance involves fraud, abuse, or failure to achieve the objectives of the provisions of Exhibit A1.

13. In the event Contractor claims or receives payment from County for a service, reimbursement for which is later disallowed by County or the State of California or the United States Government, then Contractor shall promptly refund the disallowed amount to County upon request, or, at its option, County may offset the amount disallowed from any payment due or become due to Contractor under this Agreement or any other agreement.

14. Contractor shall provide all pertinent documentation required for Medi-Cal, Medicare, and any other federal and state regulation applicable to reimbursement including assessment and service plans, and progress notes. The County may withhold payment for any and all services for which the required documentation is not provided, or if the documentation provided does not meet professional standards as determined by the San Mateo County BHRS Quality Improvement Manager.

    Contractor shall maintain for review and audit and supply to County and/or DHCS upon request, adequate documentation of all expenses claimed pursuant to this Intergovernmental Agreement to permit a determination of expense allowability.

    If the allowability or appropriateness of an expense cannot be determined by County or DHCS because invoice detail, fiscal records, or backup documentation is nonexistent or inadequate according to generally accepted accounting principles and generally accepted governmental audit standards, all questionable costs may be disallowed by County or DHCS. Upon receipt of adequate documentation supporting a disallowed or questionable expense, reimbursement may be made for the amount substantiated and deemed allowable. Invoices, received from a Contractor and accepted and/or submitted for payment by County, shall not be deemed evidence of allowable Intergovernmental Agreement costs.

    It is understood and agreed that failure by the County or Contractor to comply with applicable federal and state requirements in rendering covered services shall be sufficient cause for the State to deny payments to and/or recover payments from the County and/or terminate the Contractor from DMC program participation. If the State or the Department of Health Care Services (DHCS) disallows or denies payments for any claim, County shall repay to the State the

federal Medicaid funds and/or State General Funds it received for all claims so disallowed or denied. The overpayment shall be recovered by any of the methods allowed in Title 22, CCR, Sections 51047(a) and (b).

Before such denial, recoupment, or disallowances are made, State shall provide the Contractor with written notice of its proposed action. Such notice shall include the reason for the proposed action and shall allow the Contractor sixty (60) days to submit additional information before the proposed action is taken, as required in Title 22, CCR, Section 51047(a).

Reimbursement for covered services, other than NTP services, shall be limited to the lower of:

a. Contractor's usual and customary charges to the general public for the same or similar services;

b. Contractor's actual allowable costs.

15. Substance Abuse Prevention and Treatment Funding

Contractor shall comply with the SAPT Block Grant financial management standards contained in Title 45, CFR, Part 74, Sections 74.21(b)(1) through (4) and (b)(7), and Part 96, Section 96.30.

Pursuant to 42 U.S.C. 300x-31, Contractor shall not use SAPT Block Grant funds provided by the Intergovernmental Agreement on the following activities:

a. Provide inpatient services;

b. Make cash payment to intended recipients of health services;

c. Purchase or improve land, purchase, construct or permanently improve (other than minor remodeling) any building or other facility or purchase major medical equipment;

d. Satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;

e. Provide financial assistance to any entity other than a public or nonprofit private entity;

f. Pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of level I of the Executive Salary Schedule for the award year: see

http://grants.nih.gov/grants/policy/salcap_summary.htm;

g. Purchase treatment services in penal or correctional institutions of this State of California; and

h. Supplant state funding of programs to prevent and treat substance abuse and related activities.

16. County May Withhold Payment

Contractor shall provide all pertinent documentation required for Medi-Cal, Medicare, and any other federal and state regulation applicable to reimbursement including assessment and service plans, and progress notes. The County may withhold payment for any and all services for which the required documentation is not provided, or if the documentation provided does not meet professional standards as determined by the BHRS Quality Improvement Manager. Contractor shall meet quarterly with County contract monitor, as designated by the BHRS Deputy Director, Adult and Older Adults, to review documentation and billing reports, and to take appropriate corrective action, as needed, to resolve any identified discrepancies.

17. Inadequate Performance

If County or Contractor finds that performance is inadequate, at the County's discretion, a meeting may be called to discuss the causes for the performance problem, to review documentation, billing and/or other reports, and to take appropriate corrective action, as needed, to resolve any identified discrepancies. This Agreement may be renegotiated, allowed to continue to end of term, or terminated pursuant to Paragraph 5 of this Agreement. Any unspent monies due to performance failure may reduce the following year's agreement, if any.

18. Election of Third Party Billing Process

Contractor shall select an option for participating in serial billing of third-party payors for services provided through this Agreement through the completion of Attachment C – Election of Third Party Billing Process. The completed Attachment C shall be returned to the County with the signed Agreement. Based upon the option selected by the Contractor the appropriate following language shall be in effect for this Agreement.

a. Option One

i. Contractor shall bill all eligible third-party payors financially responsible for a beneficiary's health care services that Contractor provides through this Agreement. Within ten (10) days of the end of each month, Contractor shall provide to County copies of the Explanation of Benefits or other remittance advice for every third-party payment and/or denial of such third-party payments for services provided by Contractor during such month. The amount of any such third-party payment shall be deducted from the total actual costs for all services rendered by Contractor as reflected on the Cost Report as defined in Paragraph R of this Exhibit B1. County accepts no financial responsibility for services provided to beneficiaries where there is a responsible third-party payor, and to the extent that County inadvertently makes payments to Contractor for such services rendered, County shall be entitled to recoup such reimbursement, through the Cost Report reconciliation.

ii. Contractor shall provide a copy of each completed Payor Financial Form (Attachment D) and subsequent annual updates for all clients who receive services through this Agreement. For clients who begin to receive services during the term of this Agreement, completed Payor Financial Forms shall be provided to the County with client registration forms. For clients who were receiving services prior to the start date of this Agreement and who continue to receive services through this Agreement, completed Payor Financial Forms are due within ten (10) days of the end of the first month of the Agreement.

a. Option Two

i. Contractor shall provide information to County so that County may bill applicable other third-parties before billing Medi-Cal for services provided by Contractor through this Agreement. The amount of any such third-party payment shall be deducted from the total actual costs for all services rendered by Contractor as reflected on the Cost Report as defined in Paragraph R of this Exhibit B1. County accepts no financial responsibility for services provided to beneficiaries where there is a responsible third-party payor, and to the extent that County inadvertently makes payments to Contractor for such services rendered, County shall

be entitled to recoup such reimbursement through the Cost Report reconciliation.

ii. Contractor shall provide a copy of the completed Payor Financial Form (Attachment D) and subsequent annual updates for all clients who receive services through this agreement. For clients who begin to receive services during the term of this Agreement, completed Payor Financial Forms shall be provided to the County with client registration forms. For clients who were receiving services prior to the start date of this Agreement and who continue to receive services through this Agreement, completed Payor Financial Forms are due within ten (10) days of the end of the first month of the Agreement.

19. Beneficiary Billing

Contractor shall not submit a claim to, demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any specialty mental health or related administrative services provided under this contract except to collect other health insurance coverage, share of cost and co-payments. The Contractor shall not hold beneficiaries liable for debts in the event that the County becomes insolvent, for costs of covered services for which the State does not pay the County, for costs of covered services for which the State or the County does not pay the Contractor, for costs of covered services provided under this or other contracts, referral or other arrangement rather than from the County, or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a beneficiary with an emergency psychiatric condition.

20. Claims Certification and Program Integrity

a. Contractor shall comply with all state and federal statutory and regulatory requirements for certification of claims, including Title 42, Code of Federal Regulations (CFR) Part 438, Sections 438.604, 438.606, and, as effective August 13, 2003, Section 438.608, as published in the June 14, 2002 Federal Register (Vol. 67, No. 115, Page 41112), which are hereby incorporated by reference.

b. Anytime Contractor submits a claim to the County for reimbursement for services provided under Exhibit A1 of this Agreement, Contractor shall certify by signature that the claim

is true and accurate by stating the claim is submitted under the penalty of perjury under the laws of the State of California.

The claim must include the following language and signature line at the bottom of the form(s) and/or cover letter used to report the claim.

"Under the penalty of perjury under the laws of the State of California, I hereby certify that this claim for services complies with all terms and conditions referenced in the Agreement with San Mateo County.

Executed at San Bruno California, on November 7 2019

Signed _____ Title Executive Director

Agency The Latino Commission"

c. The certification shall attest to the following for each beneficiary with services included in the claim:

i. An assessment of the beneficiary was conducted in compliance with the requirements established in this agreement.

ii. The beneficiary was eligible to receive services described in Exhibit A1 of this Agreement at the time the services were provided to the beneficiary.

iii. The services included in the claim were actually provided to the beneficiary.

iv. Medical necessity was established for the beneficiary as defined under California Code of Regulations, Title 9, Division 1, Chapter 11, for the service or services provided, for the timeframe in which the services were provided.

v. A client plan was developed and maintained for the beneficiary that met all client plan requirements established in this agreement.

vi. For each beneficiary with specialty mental health services included in the claim, all requirements for Contractor payment authorization for specialty mental health services were met, and any reviews for such service or services were conducted prior to the initial

authorization and any re-authorization periods as established in this agreement.

vii. Services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

d. Except as provided in Paragraph II.F.7. of Exhibit A1 relative to medical records, Contractor agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. Contractor agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Mental Health; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, Managed Risk Medical Insurance Board or their duly authorized representatives, and/or the County.

21. Audit Requirements

All expenditures of County realignment funds, state and federal funds furnished to the Contractor are subject to audit by the State. Such audits shall consider and build upon external independent audits performed pursuant to audit requirements of the Office of Management and Budget (OMB) 2 CFR 200 and/or any independent Contractor audits or reviews.

In addition to requirements below, Contractor shall be in compliance with federal Single Audit requirements as a designated sub-recipient of federal funding. Contractor agrees to amend this agreement during the contract term to add federal Uniform Guidance compliance requirements.

Objectives of audits may include, but not limited to, the following:

a. To determine whether units of service claimed/reported are properly documented by service records and accurately accumulated for claiming/reporting;

b. To validate data reported by the Contractor for prospective Intergovernmental Agreement negotiations;

c. To provide technical assistance in addressing current year activities and providing recommendation on internal controls, accounting procedures, financial records, and compliance with laws and regulations;

d. To determine the cost of services, net of related patient and participant fees, third- party payments, and other related revenues and funds;

e. To determine that expenditures are made in accordance with applicable state and federal laws and regulations and State Agreement with the State requirements, and/or;

f. To determine the facts in relation to analysis of data, complaints, or allegations, which may be indicative of fraud, abuse, willful misrepresentation.

Unannounced visits may be made at the discretion of the State and/or County.

The refusal of the Contractor to permit access to and inspection of electronic or print books and records, physical facilities, and/or refusal to permit interviews with employees, as described in this part constitutes an express and immediate material breach of this Agreement and will be sufficient basis to terminate the Agreement for cause or default.

County shall monitor the activities of Contractor to ensure that:

a. Contractor is complying with program requirements and achieving performance goals; and

b. Contractor is complying with fiscal requirements, such as having appropriate fiscal controls in place, and using awards for authorized purposes.

Contractor shall be responsible for any disallowance taken by the Federal Government, the State, or the California State Auditor, as a result of any audit exception that is related to the Contractor's responsibilities herein.

Pursuant to OMB Circular A-133, State may impose sanctions against the Contractor for not submitting single or program-specific audit reports, or failure to comply with all other audit requirements. Should such sanctions be due to noncompliance by the Contractor, such sanctions will be passed on to the Contractor by the County. The sanctions may include:

a. Withholding a percentage of federal awards until the audit is completed satisfactorily;

b. Withhold or disallowing overhead costs;

c. Suspending federal awards until the audit is conducted; or

d. Terminating the federal award.

22. Drug Medi-Cal Financial Audit Requirements

In addition to the audit requirements, the State may also conduct financial audits of DMC programs, exclusive of NTP services, to accomplish any of, but not limited to, the following audit objectives:

a. To review reported costs for validity, appropriate allocation methodology, and compliance with Medicaid laws and regulations;

b. To ensure that only the cost of allowable DMC activities are included in reported costs;

c. To determine the provider's usual and customary charge to the general public in accordance with CMS (The Medicare Provider Reimbursement Manual) (CMS- Pub.15), which can be obtained from the Centers for Medicare & Medicaid Services, Baltimore, Maryland, or www.cms.hhs.gov for comparison to the DMC cost per unit;

d. To review documentation of units of service and determine the final number of approved units of service;

e. To determine the amount of clients' third-party revenue and MediCal share of cost to offset allowable DMC reimbursement; and

f. To compute final settlement based on the lower of actual allowable cost, the usual and customary charge, or the maximum allowance, in accordance with Title 22, Section 51516.1.

23. Contractor shall be responsible for any disallowances taken by the Federal Government, the State, or the Bureau of State Audits as a result of any audit exception that is related to its responsibilities. Contractor shall not use funds administered by the State to repay one federal funding source with funds provided by another federal funding

source, or to repay federal funds with state funds, or to repay state funds with federal funds.

Contractor agrees to promptly develop and implement any corrective action plans in a manner acceptable to the State in order to comply with recommendations contained in any audit report. Such corrective action plans shall include time-specific objectives to allow for measurement of progress and are subject to verification by the State within six (6) months from the date of the plan.

24. DMC Record Keeping

Contractor shall maintain sufficient books, records, documents, and other evidence necessary for the State to audit Intergovernmental Agreement performance and Intergovernmental Agreement compliance. Contractor shall make these records available to the State, upon request, to evaluate the quality and quantity of services, accessibility and appropriateness of services, and to ensure fiscal accountability. Regardless of the location or ownership of such records, they shall be sufficient to determine if costs incurred by Contractor are reasonable, allowable and allocated appropriately. All records must be capable of verification by qualified auditors.

a. Contractor shall include in any Agreement with an audit firm a clause to permit access by the State to the working papers of the external independent auditor, and require that copies of the working papers shall be made for the State at its request.

b. Contractor shall keep adequate and sufficient financial records and statistical data to support the year-end documents filed with the State. All records must be capable of verification by qualified auditors.

c. Accounting records and supporting documents shall be retained for a ten (10) year period from the date the year-end cost settlement report was approved by the State for interim settlement. When an audit by the Federal Government, the State, or the California State Auditor has been started before the expiration of the ten (10) year period, the records shall be retained until completion of the audit and final resolution of all issues that arise in the audit. Final settlement shall be made at the end of the audit and appeal process. If an audit has not been completed within three years, the interim settlement shall be considered as the final settlement.

d. Financial records shall be kept so that they clearly reflect the source of funding for each type of service for which

reimbursement is claimed. These documents include, but are not limited to, all ledgers, books, vouchers, time sheets, payrolls, appointment schedules, client data cards, and schedules for allocating costs. All records must be capable of verification by qualified auditors.

e. Should Contractor discontinue its contractual agreement with the County, or cease to conduct business in its entirety, Contractor shall provide fiscal and program records for the Agreement period to the County. Records shall be provided in compliance with the State Administrative Manual (SAM), located at http://sam.dgs.ca.gov/TOC/1600.aspx.

The Contractor shall retain all records required by Welfare and Institutions Code section 14124.1, 42 CFR 433.32, and California Code of Regulations, Title 22, Section 51341.1 et seq. for reimbursement of services and financial audit purposes.

f. In the expenditure of funds hereunder, and as required by 45 CFR Part 96, Contractor shall comply with the requirements of SAM and the laws and procedures applicable to the obligation and expenditure of federal and state funds.

g. Contractor shall retain records of utilization review activities required for a minimum of ten (10) years.

In addition, Contractor shall, upon request, make available to the County and/or the State their fiscal and other records to assure that Contractor has adequate recordkeeping capability and to assure that reimbursement for covered DMC services is made in accordance with Title 22, CCR, Section 51516.1. These records include, but are not limited to, matters pertaining to:

- Provider ownership, organization, and operation;
- Fiscal, medical, and other recordkeeping systems;
- Federal income tax status;
- Asset acquisition, lease, sale, or other action;
- Franchise or management arrangements;
- Patient service charge schedules;
- Costs of operation;
- Cost allocation methodology;
- Amounts of income received by source and purpose; and
- Flow of funds and working capital.

25. Dispute Resolution Process

a. When a financial audit is conducted by the Federal Government, the State, or the California State Auditor directly with Contractor, and if the Contractor disagrees with audit disallowances related to its programs, claims or services, County shall, at the Contractor's request, request an appeal to the State. Contractor must file such an appeal of State audit findings with the County. The appeal must be in writing and sent to the County AOD Administrator within thirty (30) days of receipt of the audit findings.

b. When a financial audit is conducted by the County with Contractor, and if the Contractor disagrees with audit disallowances related to its programs, claims or services, the Contractor may file a written appeal by email or facsimile with the Director of Behavioral Health and Recovery Services. The appeal must be sent within thirty (30) days of receipt of the audit findings from the County.

The County will respond to an appeal within ten (10) business days of receiving it, and the County may, at its election, set up a meeting with the Contractor to discuss the concerns raised by the appeal. The decision of the County will be final. The appeal letter must be sent as follows:

Director, Behavioral Health and Recovery Services
c/o Ritu Modha
rmodha@smcgov.org
Facsimile: 650-573-2110

*** END OF EXHIBIT B1 ***