STATE OF CALIFORNIA

STANDARD AGREEMENT

STD 213_DHCS (Rev. 06/16)

REGISTRATION NUMBER	AGREEMENT NUMBER
	16-93234

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

STATE AGENCY'S NAME (Also known as DHCS, CDHS, DHS or the State)

Department of Health Care Services

CONTRACTOR'S NAME (Also referred to as Contractor)

County of San Mateo

2. The term of this Agreement is: October 18, 2016 through June 30, 2019

3. The maximum amount of this Agreement is: **$** 19,269,141
Nineteen Million, Two Hundred Sixty Nine Thousand, One Hundred Forty One Dollars

4. The parties agree to comply with the terms and conditions of the following exhibits, which are by this reference made a part of this Agreement.

Exhibit A – Scope of Work	5 pages
Exhibit A, Attachment I – Program Specifications	107 pages
Exhibit B – Budget Detail and Payment Provisions	20 pages
Exhibit B, Attachment I – Funding Amounts	1 page
Exhibit C * – General Terms and Conditions	GTC 610
Exhibit D (F) – Special Terms and Conditions	26 pages
Exhibit E – Additional Provisions	4 pages
Exhibit G – Privacy and Information Security Provisions	31 pages
Exhibit G, Attachment I – Social Security Administration Agreement	70 Pages

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

IN WITNESS WHEREOF, this Agreement has been executed by the parties hereto.

CONTRACTOR

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

County of San Mateo

BY *(Authorized Signature)* — DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING

Louise Rogers, Chief, Health System

ADDRESS

225 37th Avenue
San Mateo, CA 94403

STATE OF CALIFORNIA

AGENCY NAME

Department of Health Care Services

BY *(Authorized Signature)* — DATE SIGNED *(Do not type)*

PRINTED NAME AND TITLE OF PERSON SIGNING

Don Rodriguez, Chief, Contract Management Unit

ADDRESS

1501 Capitol Avenue, Suite 71.2048, MS 1400, P.O. Box 997413, Sacramento, CA 95899-7413

California Department of General Services Use Only

[X] Exempt per: DGS memo dated 07/10/96 and Welfare and Institutions Code 14087.4

CCC-307

CERTIFICATION

I, the official named below, CERTIFY UNDER PENALTY OF PERJURY that I am duly authorized to legally bind the prospective Contractor to the clause(s) listed below. This certification is made under the laws of the State of California.

Contractor/Bidder Firm Name (Printed) *County of San Mateo*	*Federal ID Number* *94-6000532*
By (Authorized Signature)	
Printed Name and Title of Person Signing	
Date Executed	*Executed in the County of* *San Mateo*

CONTRACTOR CERTIFICATION CLAUSES

1. STATEMENT OF COMPLIANCE: Contractor has, unless exempted, complied with the nondiscrimination program requirements. (Gov. Code §12990 (a-f) and CCR, Title 2, Section 8103) (Not applicable to public entities.)

2. DRUG-FREE WORKPLACE REQUIREMENTS: Contractor will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:

a. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.

b. Establish a Drug-Free Awareness Program to inform employees about:

1) the dangers of drug abuse in the workplace;
2) the person's or organization's policy of maintaining a drug-free workplace;
3) any available counseling, rehabilitation and employee assistance programs; and,
4) penalties that may be imposed upon employees for drug abuse violations.

c. Every employee who works on the proposed Agreement will:

1) receive a copy of the company's drug-free workplace policy statement; and,
2) agree to abide by the terms of the company's statement as a condition of employment on the Agreement.

Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both and Contractor may be ineligible for award of any future State agreements if the department determines that any of the following has occurred: the Contractor has made false certification, or violated the

certification by failing to carry out the requirements as noted above. (Gov. Code §8350 et seq.)

3. NATIONAL LABOR RELATIONS BOARD CERTIFICATION: Contractor certifies that no more than one (1) final unappealable finding of contempt of court by a Federal court has been issued against Contractor within the immediately preceding two-year period because of Contractor's failure to comply with an order of a Federal court, which orders Contractor to comply with an order of the National Labor Relations Board. (Pub. Contract Code §10296) (Not applicable to public entities.)

4. CONTRACTS FOR LEGAL SERVICES $50,000 OR MORE- PRO BONO REQUIREMENT: Contractor hereby certifies that contractor will comply with the requirements of Section 6072 of the Business and Professions Code, effective January 1, 2003.

Contractor agrees to make a good faith effort to provide a minimum number of hours of pro bono legal services during each year of the contract equal to the lessor of 30 multiplied by the number of full time attorneys in the firm's offices in the State, with the number of hours prorated on an actual day basis for any contract period of less than a full year or 10% of its contract with the State.

Failure to make a good faith effort may be cause for non-renewal of a state contract for legal services, and may be taken into account when determining the award of future contracts with the State for legal services.

5. EXPATRIATE CORPORATIONS: Contractor hereby declares that it is not an expatriate corporation or subsidiary of an expatriate corporation within the meaning of Public Contract Code Section 10286 and 10286.1, and is eligible to contract with the State of California.

6. SWEATFREE CODE OF CONDUCT:

a. All Contractors contracting for the procurement or laundering of apparel, garments or corresponding accessories, or the procurement of equipment, materials, or supplies, other than procurement related to a public works contract, declare under penalty of perjury that no apparel, garments or corresponding accessories, equipment, materials, or supplies furnished to the state pursuant to the contract have been laundered or produced in whole or in part by sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor, or with the benefit of sweatshop labor, forced labor, convict labor, indentured labor under penal sanction, abusive forms of child labor or exploitation of children in sweatshop labor. The contractor further declares under penalty of perjury that they adhere to the Sweatfree Code of Conduct as set forth on the California Department of Industrial Relations website located at www.dir.ca.gov, and Public Contract Code Section 6108.

b. The contractor agrees to cooperate fully in providing reasonable access to the contractor's records, documents, agents or employees, or premises if reasonably required by authorized officials of the contracting agency, the Department of Industrial Relations,

or the Department of Justice to determine the contractor's compliance with the requirements under paragraph (a).

7. DOMESTIC PARTNERS: For contracts over $100,000 executed or amended after January 1, 2007, the contractor certifies that contractor is in compliance with Public Contract Code section 10295.3.

DOING BUSINESS WITH THE STATE OF CALIFORNIA

The following laws apply to persons or entities doing business with the State of California.

1. CONFLICT OF INTEREST: Contractor needs to be aware of the following provisions regarding current or former state employees. If Contractor has any questions on the status of any person rendering services or involved with the Agreement, the awarding agency must be contacted immediately for clarification.

Current State Employees (Pub. Contract Code §10410):

1). No officer or employee shall engage in any employment, activity or enterprise from which the officer or employee receives compensation or has a financial interest and which is sponsored or funded by any state agency, unless the employment, activity or enterprise is required as a condition of regular state employment.

2). No officer or employee shall contract on his or her own behalf as an independent contractor with any state agency to provide goods or services.

Former State Employees (Pub. Contract Code §10411):

1). For the two-year period from the date he or she left state employment, no former state officer or employee may enter into a contract in which he or she engaged in any of the negotiations, transactions, planning, arrangements or any part of the decision-making process relevant to the contract while employed in any capacity by any state agency.

2). For the twelve-month period from the date he or she left state employment, no former state officer or employee may enter into a contract with any state agency if he or she was employed by that state agency in a policy-making position in the same general subject area as the proposed contract within the 12-month period prior to his or her leaving state service.

If Contractor violates any provisions of above paragraphs, such action by Contractor shall render this Agreement void. (Pub. Contract Code §10420)

Members of boards and commissions are exempt from this section if they do not receive payment other than payment of each meeting of the board or commission, payment for preparatory time and payment for per diem. (Pub. Contract Code §10430 (e))

2. LABOR CODE/WORKERS' COMPENSATION: Contractor needs to be aware of the provisions which require every employer to be insured against liability for Worker's Compensation or to undertake self-insurance in accordance with the provisions, and Contractor affirms to comply with such provisions before commencing the performance of the work of this Agreement. (Labor Code Section 3700)

3. AMERICANS WITH DISABILITIES ACT: Contractor assures the State that it complies with the Americans with Disabilities Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA. (42 U.S.C. 12101 et seq.)

4. CONTRACTOR NAME CHANGE: An amendment is required to change the Contractor's name as listed on this Agreement. Upon receipt of legal documentation of the name change the State will process the amendment. Payment of invoices presented with a new name cannot be paid prior to approval of said amendment.

5. CORPORATE QUALIFICATIONS TO DO BUSINESS IN CALIFORNIA:

a. When agreements are to be performed in the state by corporations, the contracting agencies will be verifying that the contractor is currently qualified to do business in California in order to ensure that all obligations due to the state are fulfilled.

b. "Doing business" is defined in R&TC Section 23101 as actively engaging in any transaction for the purpose of financial or pecuniary gain or profit. Although there are some statutory exceptions to taxation, rarely will a corporate contractor performing within the state not be subject to the franchise tax.

c. Both domestic and foreign corporations (those incorporated outside of California) must be in good standing in order to be qualified to do business in California. Agencies will determine whether a corporation is in good standing by calling the Office of the Secretary of State.

6. RESOLUTION: A county, city, district, or other local public body must provide the State with a copy of a resolution, order, motion, or ordinance of the local governing body which by law has authority to enter into an agreement, authorizing execution of the agreement.

7. AIR OR WATER POLLUTION VIOLATION: Under the State laws, the Contractor shall not be: (1) in violation of any order or resolution not subject to review promulgated by the State Air Resources Board or an air pollution control district; (2) subject to cease and desist order not subject to review issued pursuant to Section 13301 of the Water Code for violation of waste discharge requirements or discharge prohibitions; or (3) finally determined to be in violation of provisions of federal law relating to air or water pollution.

8. PAYEE DATA RECORD FORM STD. 204: This form must be completed by all contractors that are not another state agency or other governmental entity.

S:\ADMIN\HOMEPAGE\CCC\CCC-307.doc

Exhibit A
Scope of Work

1. Service Overview

Contractor agrees to provide to the California Department of Health Care Services (DHCS) the services described herein.

The term “contract” or “agreement” shall also mean, “Intergovernmental Agreement”.

State and the Contractor enter into this Intergovernmental Agreement by authority of Chapter 3 of Part 1, Division 10.5 of the Health and Safety Code (HSC) and with approval of Contractor’s County Board of Supervisors (or designee) for the purpose of providing alcohol and drug services. State and the Contractor identified in the Standard Agreement are the only parties to this Intergovernmental Agreement. This Intergovernmental Agreement is not intended, nor shall it be construed, to confer rights on any third party.

State and the Contractor enter into this Intergovernmental Agreement for the purpose of identifying and providing for covered Drug Medi-Cal (DMC) services for substance use treatment in the Contractor’s service area pursuant to Sections 11848.5(a) and (b) of the Health and Safety Code (hereinafter referred to as HSC), Sections 14021.51 – 14021.53, and 14124.20 – 14124.25 of the Welfare and Institutions Code (hereinafter referred to as W&IC), and Title 22 of the California Code of Regulations (hereinafter referred to as Title 22), Sections 51341.1, 51490.1, and 51516.1, and Part 438 of the Code of Federal Regulations, hereinafter referred to as 42 CFR 438.

State and the Contractor enter into this Intergovernmental Agreement by authority of Title 45 of the Code of Federal Regulations Part 96 (45 CFR Part 96), Substance Abuse Prevention and Treatment Block Grants (SAPT Block Grant) for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse. SAPT Block Grant recipients must adhere to Substance Abuse and Mental Health Administration’s (SAMHSA) National Outcome Measures (NOMs).

The objective is to make substance use treatment services available to Medi-Cal and other non-DMC beneficiaries through utilization of federal and state funds available pursuant to Title XIX and Title XXI of the Social Security Act and the SAPT Block Grant for reimbursable covered services rendered by certified DMC providers.

2. Service Location

The services shall be performed at applicable facilities in the County of San Mateo.

3. Service Hours

The services shall be provided during the working hours and days as defined by the Contractor.

4. Project Representatives

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

Department of Health Care Services	**Contractor's/Grantee's Name**
Contract/Grant Manager: Mike Reeves Telephone: (916) 327-2696 Fax: (916) 322-1176 Email: Michael.reeves@dhcs.ca.gov	County Administrator: Steve Kaplan Telephone: (650) 573-3609 Fax: (650) 573-2841

B. Direct all inquiries to:

Department of Health Care Services	**Contractor's/Grantee's Name**
Department of Health Care Services SUD PPFD - PSGMB Attention: Robert Strom Mail Station Code 2624 P.O. Box 997413 Sacramento, CA, 95899-7413 Telephone: (916) 327-2701 Fax: (916) 322-1176 Email: Robert.Strom@dhcs.ca.gov	San Mateo County Behavioral Health and Recovery Services Attention: County AOD Program Administrator 225 37th Avenue San Mateo, CA 94403 Telephone: (650) 573-3609 Fax: (650) 573-2841

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

5. See Exhibit A, Attachment I, for a detailed description of the services to be performed.

6. Reference Documents

The following documents are hereby incorporated by reference into the ODS Waiver contract though they may not be physically attached to the contract but will be issued in a CD under separate cover:

Document 1A: Title 45, Code of Federal Regulations 96, Subparts C and L, Substance Abuse Prevention and Treatment Block Grant Requirements

https://www.gpo.gov/fdsys/granule/CFR-2005-title45-vol1/CFR-2005-title45-vol1-part96

Document 1B: Title 42, Code of Federal Regulations, Charitable Choice Regulations

https://www.law.cornell.edu/cfr/text/42/part-54

Document 1C: Driving-Under-the-Influence Program Requirements

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

Document 1G: Perinatal Services Network Guidelines 2016

Document 1H(a): Service Code Descriptions

Document 1J(a): Non-Drug Medi-Cal Audit Appeals Process

Document 1J(b): DMC Audit Appeals Process

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

http://www.dhcs.ca.gov/provgovpart/Pages/DATAR.aspx

Document 1P: Alcohol and/or Other Drug Program Certification Standards (March 15, 2004)

http://www.dhcs.ca.gov/provgovpart/Pages/Facility_Certification.aspx

Document 1T: CalOMS Prevention Data Quality Standards

Document 1V: Youth Treatment Guidelines

http://www.dhcs.ca.gov/individuals/Documents/Youth_Treatment_Guidelines.pdf

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

Document 2C: Title 22, California Code of Regulations

http://ccr.oal.ca.gov

Document 2E: Drug Medi-Cal Certification Standards for Substance Abuse Clinics (Updated July 1, 2004)

http://www.dhcs.ca.gov/services/adp/Documents/DMCA_Drug_Medi-Cal_Certification_Standards.pdf

Document 2F: Standards for Drug Treatment Programs (October 21, 1981)

http://www.dhcs.ca.gov/services/adp/Documents/DMCA_Standards_for_Drug_Treatment_Programs.pdf

Document 2G Drug Medi-Cal Billing Manual

http://www.dhcs.ca.gov/formsandpubs/Documents/Info%20Notice%202015/DMC_Billing_Manual%20FINAL.pdf

Document 2K: Multiple Billing Override Certification (MC 6700)

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

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

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

Document 2P(a): Drug Medi-Cal Cost Report Forms – Intensive Outpatient Treatment – Non-Perinatal (form and instructions)

Document 2P(b): Drug Medi-Cal Cost Report Forms – Intensive Outpatient Treatment – Perinatal (form and instructions)

Document 2P(c): Drug Medi-Cal Cost Report Forms – Outpatient Drug Free Individual Counseling – Non-Perinatal (form and instructions)

Document 2P(d): Drug Medi-Cal Cost Report Forms – Outpatient Drug Free Individual Counseling – Perinatal (form and instructions)

Document 2P(e): Drug Medi-Cal Cost Report Forms – Outpatient Drug Free Group Counseling – Non-Perinatal (form and instructions)

Document 2P(f): Drug Medi-Cal Cost Report Forms – Outpatient Drug Free Group Counseling – Perinatal (form and instructions)

Document 2P(g): Drug Medi-Cal Cost Report Forms – Residential – Perinatal (form and instructions)

Document 2P(h): Drug Medi-Cal Cost Report Forms – Narcotic Treatment Program – County – Non-Perinatal (form and instructions)

Document 2P(i): Drug Medi-Cal Cost Report Forms – Narcotic Treatment Program – County – Perinatal (form and instructions)

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

http://www.calregs.com

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

http://www.calregs.com

Document 3J: CalOMS Treatment Data Collection Guide

http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf

Document 3O: Quarterly Federal Financial Management Report (QFFMR) 2014-15

http://www.dhcs.ca.gov/provgovpart/Pages/SUD_Forms.aspx

Document 3S CalOMS Treatment Data Compliance Standards

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

http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15

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

Document 5A : Confidentiality Agreement

Exhibit A Attachment I
Program Specifications

1. Provision of Services

This Intergovernmental Agreement is entered into by and between the Department of Health Care Services (DHCS) and the Contractor for the purpose of identifying and providing for covered Drug Medi-Cal (DMC) services for substance use disorder (SUD) treatment in the Contractor's service area pursuant to Sections 11848.5(a) and (b) of the Health and Safety Code (hereinafter referred to as HSC), Sections, 14021.51 – 14021.53, and 14124.20 – 14124.25 of the W&I Code, Sections and Title 22 of the California Code of Regulations (hereinafter referred to as Title 22), Sections 51341.1, 51490.1, and 51516.1, and Part 438 of the Code of Federal Regulations (hereinafter referred to as 42 CFR 438).

A. It is further agreed this Intergovernmental Agreement is controlled by applicable provisions of: (a) the W&I Code, Chapter 7, Sections 14000, et seq., in particular, but not limited to, Sections 14100.2, 14021, 14021.5, 14021.6, 14043, et seq., (b) Title 22, including but not limited to Sections 51490.1, 51341.1 and 51516.1; and (c) Division 4 of Title 9 of the California Code of Regulations (hereinafter referred to as Title 9).

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

C. The objective of this Intergovernmental Agreement is to make SUD treatment services available to Medi-Cal beneficiaries through utilization of federal and state funds available pursuant to Title XIX or Title XXI of the Social Security Act for reimbursable covered services rendered by certified DMC providers. These services shall be provided through a Prepaid Inpatient Hospital Plan (PIHP) as defined in 42 CFR 438.2.

D. Awards under the Medical Assistance Program (CFDA 93.778) are no longer excluded from coverage under the Health and Human Services (HHS) implementation of the A-102 Common Rule, 45 CFR part 92 (*Federal Register*, September 8, 2003, 68 FR 52843-52844). This change is effective for any grant award under this program made after issuance of the initial awards for the second quarter of Federal Fiscal Year 2004. This program also is subject to the requirements of 45 CFR part 95 and the cost principles under Office of Management and Budget Circular A-87 (as provided in *Cost Principles and Procedures for Developing Cost Allocation Plans and Indirect Cost Rates for Agreements with the Federal Government*, HHS Publication ASMB C-10, available on the Internet at http://www.dol.gov/oasam/boc/ASMB C-10.pdf.

E. The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a Medi-Cal benefit provided by, and within, this county (Contractor) through a county operated PIHP as defined in 42 CFR 438.2. The Medi-Cal DMC-ODS waiver program covers only drug Medi-Cal services and is limited to the coverage of DMC-ODS services. Accordingly, the following provisions of 42 CFR 438 are not applicable to the DMC-ODS waiver: 1) obtaining information regarding advanced directives (42 CFR 438.6(i), 2) marketing activities (42 CFR 438.104), 3) providing emergency post-stabilization services (42 CFR 438.114), 4) solvency standards (42 CFR 438.116), 5) women's health services (42

CFR 438.206(b)(2) and 6) identification of individuals with special health care needs (42 CFR 438.208(c)(1) (there is no difference in the provision of services for special needs populations and any other covered population under the DMC-ODS waiver program). In addition, no family planning services, including abortion procedures, are provided through the DMC-ODS waiver; therefore 42 CFR 431.51(b)(2) and 441.202 are not applicable. Finally, the disclosure requirements set forth in 42 CFR 455.100-104 are not applicable to the DMC-ODS waiver given that each PIHP is county owned and operated.

Under this DMC-ODS waiver program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive DMC-ODS services through a single county operated PIHP. Based on this service delivery model, DHCS has requested, and CMS has granted approval to waive the following provisions for the DMC-ODS delivery model: 1) choice of PIHP (42 CFR 438.52), 2) allowance of disenrollment (42 CFR 438.56) (beneficiaries shall be provided with a choice of providers within the PIHP and an opportunity to change providers whenever feasible), and 3) notice required by 42 CFR 438.10(f)(3).

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

This Agreement requires Contractor to provide all information that meets the content requirements of 42 CFR 438.10. This Agreement also requires Contractor to provide this information to all potential and actual beneficiaries upon their request, when they first access services under the DMC-ODS waiver and, within 30 days of any change. Any additional information distribution requirements are not required under this Agreement.

Pursuant to 42 CFR 438.100, the Contractor shall comply with any applicable Federal and State laws that pertain to beneficiary rights and shall ensure that its staff and affiliated providers take those rights into account when furnishing services under this Agreement to beneficiaries. Contractor shall provide information regarding these rights to potential and current beneficiaries as specified in Section 14 of this Agreement since the notice required by 42 CFR 438.10(f)(3) has been waived.

DHCS shall have in effect safeguards against conflicts of interest on the part of State and local officers and employees and agents of the State who have responsibilities relating to this Agreement or the default enrollment process as described by 42 CFR 438.58.

F. Contractor shall not receive payment for services not available under this Agreement in accordance with 42 CFR 438.60:

1) DHCS must ensure that no payment is made to a provider other than the Contractor for services available under the Intergovernmental Agreement between the DHCS and the Contractor, except when these payments are provided for in Title XIX of the Act, in 42 CFR, or when DHCS has adjusted the capitation rates paid under the Intergovernmental Agreement, in accordance with §438.6(c)(5)(v), to make payments for graduate medical education.

G. Provider Specifications

The following requirements shall apply to Contractor and subcontractor staff:

1) 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. Licensed Practitioner of the Healing Arts (LPHA):

a) Physician
b) Nurse Practitioners
c) Physician Assistants
d) Registered Nurses
e) Registered Pharmacists
f) Licensed Clinical Psychologists
g) Licensed Clinical Social Worker
h) Licensed Professional Clinical Counselor
i) Licensed Marriage and Family Therapists
j) License Eligible Practitioners working under the supervision of Licensed Clinicians

2) 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.

3) Professional and Non-Professional staff are required to have appropriate experience and any necessary training at the time of hiring.

4) Registered and certified SUD counselors shall adhere to all requirements in the California Code of Regulations, Title 9, Chapter 8.

H. Services for Adolescents and Youth

At a minimum, assessment and services for adolescents will follow the American Society of Addiction Medicine (ASAM) adolescent treatment criteria.

1.1 Organized Delivery System (ODS) Timely Coverage

A. Non-Discrimination

Member Discrimination Prohibition

Contractor shall accept individuals eligible for enrollment in the order in which they apply without restriction in accordance with this Agreement. Contractor shall take affirmative action to ensure that beneficiaries are provided covered services and will not discriminate against individuals eligible to enroll under the laws of the United States and the State of California. Contractor shall not unlawfully discriminate against any person pursuant to:

1) Title VI of the Civil Rights Act of 1964

2) Title IX of the Education Amendments of 1972 (regarding education and programs and activities)

3) The Age Discrimination Act of 1975

4) The Rehabilitation Act of 1973

5) The Americans with Disabilities Act

6) Enrollment discrimination prohibited. Intergovernmental Agreements with Managed Care Organizations (MCOs), PIHPs, Prepaid Ambulatory Health Plans (PAHPs), and Primary Care Case Managers (PCCMs) must provide as follows:

   (a) The Contractor accepts individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by the Regional Administrator), up to the limits set under the Intergovernmental Agreement.

   (b) Enrollment is voluntary, except in the case of mandatory enrollment programs that meet the conditions set forth in §438.50(a).

   (c) The Contractor will not, on the basis of health status or need for health care services, discriminate against individuals eligible to enroll.

   (d) The Contractor will not discriminate against individuals eligible to enroll under the laws of the United States and the State of California, and will not use any policy or practice that has the effect of discriminating on the basis of this section.

B. DMC-ODS services shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in this opt in County. Determination of who may receive the DMC-ODS benefit shall be performed as follows (ODS Standard Terms and Conditions (STC) 128(e) pursuant to 42 CFR 438.210: (STC's found at: http://www.dhcs.ca.gov/provgovpart/Documents/MC2020_FINAL_STC_12-30-15.pdf)

1) The Contractor or its subcontracted provider must verify the Medicaid eligibility determination of an individual. When the subcontracted provider conducts the initial eligibility verification, that verification shall be reviewed and approved by the Contractor prior to payment for services, unless the individual is eligible to receive services from tribal health programs operating under the Indian Self Determination and Education Assistance Act (ISDEAA – Pub.L 93-638, as amended) and urban

Indian organizations operating under Title V of the IHCIA. If the individual is eligible to receive services from tribal health programs operating under the ISDEAA, then the determination shall be conducted as set forth in the Tribal Delivery System - Attachment BB to the STCs.

2) The initial medical necessity determination for an individual to receive a DMC-ODS benefit must be performed through a face-to-face review or telehealth by a Medical Director, licensed physician, or Licensed Practitioner of the Healing Arts (LPHA) as defined in Section 142(a) of the STCs. After establishing a diagnosis, the American Society of Addiction Medicine (ASAM) Criteria shall be applied by the diagnosing individual to determine placement into the level of assessed services.

   a) Medical necessity for an adult (an individual age 21 and over) is determined using the following criteria:

      i. The individual must have received at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders;

      ii. The individual must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.

   b) Individuals under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under the age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Nothing in the DMC-ODS Pilot overrides any EPSDT requirements.

      Medical necessity for an adolescent individual (an individual under the age of 21) is determined using the following criteria:

      i. The adolescent individual must be assessed to be at risk for developing a SUD; and

      ii. The adolescent individual must meet the ASAM adolescent treatment criteria.

3) For an individual to receive ongoing DMC-ODS services, the Medical Director, licensed physician, or LPHA shall reevaluate that individual's medical necessity qualification at least every six months through the reauthorization process and determine that those services are still clinically appropriate for that individual. For an individual to receive ongoing Opioid Treatment Program/Narcotic Treatment Program (OTP/NTP) services, the Medical Director, licensed physician, or LPHA must reevaluate that individual's medical necessity qualification at least annually through the reauthorization process and determine that those services are still clinically appropriate for that individual.

C. Beneficiaries shall be mandatorily enrolled in the Contractor's PIHP and the Contractor's enrollment process shall be consistent with 42 CFR 438.6(d); 42 CFR 438.50(a).

D. Contractor shall notify all beneficiaries of their disenrollment rights annually in accordance with 42 CFR 438.10(f)(1).

1.2 Covered Services

A. The Contractor shall provide the Covered Services as a Prepaid Inpatient Hospital Plan (PIHP) pursuant to 42 CFR 438.210(a)(1) and (2), and 42 CFR 438.210(a)(3)(i), (ii), and (iii). Additionally, the Contractor shall:

1) Identify, define, and specify the amount, duration, and scope of each service that the Contractor is required to offer.

2) Require that the services identified in paragraph (1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in 42 CFR 440.230.

3) Provide that the Contractor:

a) Shall ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.

b) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary;

c) May place appropriate limits on a service

i. On the basis of criteria applied under the State plan, such as medical necessity; or

ii. For the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose, as required in paragraph (A)(3)(a) of this section.

4) Specify what constitutes "medically necessary services" in a manner that:

a) Is no more restrictive than that used in the State Medicaid program as indicated in California State statutes and regulations, the California State Plan, and other California State policy and procedures; and

b) Addresses the extent to which the Contractor is responsible for covering services related to the following:

i. The prevention, diagnosis, and treatment of health impairments.

ii. The ability to achieve age-appropriate growth and development.

iii. The ability to attain, maintain, or regain functional capacity.

B. Contractor shall establish assessment and referral procedures and shall arrange, provide, or subcontract for medically necessary Mandatory Covered Services in the Contractor's service area in compliance with 42 CFR 438.210(a)(1), 438.210(a)(2), and 438.210(a)(3). The Contractor shall deliver the Covered Services within a continuum of care as defined in the ASAM criteria. Mandatory Covered Services include:

1) Withdrawal Management (minimum one level);

2) Intensive Outpatient;

3) Outpatient;

4) Opioid (Narcotic) Treatment Programs;

5) Recovery Services;

6) Case Management;

7) Physician Consultation;

8) Perinatal Residential Substance Abuse Services (excluding room and board); and

a) Room and board shall be reimbursable through the Substance Abuse Prevention and Treatment Block Grant (SAPT BG) treatment funding allocated to the Contractor.

9) Nonperinatal Residential Substance Abuse Services (excluding room and board);

a) Room and board shall be reimbursable through the SAPT BG treatment funding allocated to the Contractor.

C. In the event of a conflict between the definition of services contained in this Section of the Intergovernmental Agreement, and the definition of services in Title 22, Sections 51341.1, 51490.1, and 51516.1, the provisions of Title 22 shall govern.

D. Contractor, to the extent applicable, shall comply with "Sobky v. Smoley" (Document 2A), 855 F. Supp. 1123 (E.D. Cal 1994), incorporated by this reference.

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

1) If DMC services are provided to Minor Consent beneficiaries, Contractor shall comply with California Family Code Section 6929, and California Code of

Regulations, Title 22, Sections 50147.1, 50030, 50063.5, 50157(f)(3), 50167(a)(6)(D), and 50195(d).

1.3 Financing

A. Payment for Services

1) For claiming Federal Financial Participation (FFP), the Contractor shall certify the total allowable expenditures incurred in providing the DMC-ODS Pilot program services provided either through Contractor-operated providers, contracted fee-for-service providers or contracted managed care plans.

2) DHCS shall establish a Center for Medicare and Medicaid Services (CMS) approved Certified Public Expenditure (CPE) protocol before FFP associated with Pilot program services is made available to DHCS. This DHCS approved CPE protocol (Attachment AA of the STCs) must explain the process DHCS shall use to determine costs incurred by the counties under this demonstration.

3) The Contractor shall only provide state plan DMC services until DHCS and CMS approve of this Intergovernmental Agreement and the approved Intergovernmental Agreement is executed by the Contractor's County Board of Supervisors. During this time, state plan DMC services shall be reimbursed pursuant to the state plan reimbursement methodologies.

4) Pursuant to Title 42 CFR 433.138 and 22 CCR 51005(a), if a beneficiary has Other Heath Coverage (OHC), then the Contractor shall bill that OHC prior to billing DMC to receive either payment from the OHC, or a notice of denial from the OHC indicating that:

   a) The recipient's OHC coverage has been exhausted, or

   b) The specific service is not a benefit of the OHC.

   If the Contractor submits a claim to an OHC and receives partial payment of the claim, the Contractor may submit the claim to DMC and is eligible to receive payment up to the maximum DMC rate for the service, less the amount of the payment made by the OHC.

B. Rate Setting

1) The Contractor shall propose county-specific fee-for-service (FFS) provider rates for all modalities except the OTP/NTP modality. DHCS shall approve or deny those proposed rates to determine if the rates are sufficient to ensure access to available DMC-ODS Pilot program services.

   a) If DHCS denies the Contractor's proposed rates, the Contractor shall have an opportunity to adjust the rates and resubmit them to DHCS to determine if the adjusted rates are sufficient to ensure access to available DMC-ODS Pilot program services. The Contractor must receive DHCS approval of its rates prior

to providing any covered DMC-ODS Pilot program services.

2) OTP/NTP reimbursement rate shall be set by the DHCS Rate Setting Work Group pursuant to the process set forth in W&I Code, Section 14021.51. The Contractor shall reimburse all OTP/NTP providers at this rate.

   a) The Contractor shall ensure that all of its contracted OTP/NTP providers provide it with financial data on an annual basis. The Contractor shall collect and submit this data to the DHCS Rates Setting Work Group upon its request for the purpose of setting the OTP/NTP rates after the expiration of the DMC-ODS Pilot program.

      i. The DHCS Rates Setting Workgroup shall propose a recommended format for this annual financial data and DHCS shall approve a final format.

3) Pursuant to W&I Code, Section 14124.24(h), the Contractor shall not require OTP/NTP providers to submit cost reports to the Contractor for the purpose of cost settlement.

2. Availability and Accessibility of Service

2.1 Availability of Services

A. Pursuant to 42 CFR 438.206(a) and (b), the Contractor shall consider the numbers and types (in terms of training, experience and specialization) of providers required to ensure the availability and accessibility of medically necessary services. At a minimum, the Contractor shall meet the following requirements:

1) The Contractor shall maintain and monitor a network of appropriate providers that is supported by written agreements for subcontractors and that is sufficient to provide its beneficiaries with adequate access to all services covered under this Intergovernmental Agreement. In establishing and monitoring the network, the Contractor must document the following:

   a) The anticipated number of Medi-Cal eligible beneficiaries;

   b) The expected utilization of services, taking into account the characteristics and SUD treatment needs of beneficiaries;

   c) The expected number and types of providers in terms of training and experience needed to meet expected utilization;

   d) The numbers of network providers who are not accepting new beneficiaries;

   e) The geographic location of providers and their accessibility to beneficiaries, considering distance, travel time, means of transportation ordinarily used by Medi-Cal beneficiaries, and physical access for disabled beneficiaries;

f) To the extent required by 42 CFR 438.206(b)(4), if the Contractor is unable to provide necessary medical services covered under the Intergovernmental Agreement to a particular beneficiary, the Contractor must adequately and timely cover these services out of network for the beneficiary, for as long as the Contractor is unable to provide them;

g) Pursuant to 42 CFR 438.206(b)(5) the Contractor shall require that out-of-network providers coordinate authorization and payment with the Contractor. As is consistent with 42 CFR 438.106, the Contractor must ensure that the cost to the beneficiary for services provided out of network pursuant to an authorization is no greater than it would be if the services were furnished within the Contractor's network; and

h) The Contractor shall demonstrate that its providers are credentialed according to Section 1(G) of this Agreement and pursuant to 42 CFR 438.214.

2.2 Access to Services

A. Subject to DHCS provider enrollment certification requirements, Contractor shall maintain continuous availability and accessibility of covered services and facilities, service sites, and personnel to provide the covered services through use of DMC certified providers. Such services shall not be limited due to budgetary constraints.

1) When a request for covered services is made by a beneficiary, Contractor shall require services to be initiated with reasonable promptness. Contractor shall have a documented system for monitoring and evaluating the quality, appropriateness and accessibility of care, including a system for addressing problems that develop regarding waiting times and appointments.

2) The contractor shall authorize DMC-ODS services in accordance with the medical necessity criteria specified in Title 22, Section 51303 and the coverage provisions of the approved state Medi-Cal Plan. For residential services, room and board are not reimbursable DMC services. If services are denied, the provider shall inform the beneficiary in accordance with Title 22, Section 51341.1 (p) and 42 CFR 438.404.

a) The Contractor must provide prior authorization for residential services within 24 hours of the prior authorization request being submitted by the provider,

i. Prior authorization is not required for non-residential DMC-ODS services.

b) The Contractor shall review the DSM and ASAM Criteria to ensure that the beneficiary meets the requirements for the service.

c) The Contractor shall have written policies and procedures for processing requests for initial and continuing authorization of services.

d) The Contractor shall have a mechanism in place to ensure that there is consistent application of review criteria for authorization decisions and shall

consult with the requesting provider when appropriate.

e) The Contractor shall meet the following timelines for decisions for service authorization.

i. Contractor must provide for the following decisions and notices:

a. For standard authorization decisions, Contractor shall provide notice as expeditiously as the beneficiary's health condition requires, not to exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if:

(i) The beneficiary, or the provider, requests extension; or

(ii) The Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the beneficiary's best interest.

b. Expedited authorization decisions.

(i) For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the Contractor must make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires and no later than 3 working days after receipt of the request for service.

(ii) The Contractor may extend the 3 working days time period by up to 14 calendar days if the beneficiary requests an extension, or if the Contractor justifies (to the State agency upon request) a need for additional information and how the extension is in the beneficiary's best interest.

f) The Contractor shall track the number, percentage of denied requests, and timeliness of requests for authorization for all DMC-ODS services that are submitted, processed, approved and denied.

3) Contractor shall provide notice to the beneficiary that the timeframe was not met, as required above, on the date that the timeline was not met.

4) Pursuant to 42 CFR 438.6(m), the Contractor shall allow each beneficiary to choose his or her health professional to the extent possible and appropriate.

5) The Contractor shall require that treatment programs are accessible to people with disabilities in accordance with Title 45, Code of Federal Regulations (hereinafter referred to as CFR), Part 84 and the Americans with Disabilities Act.

6) Pursuant to 42 CFR 438.206(b)(3), when requested by the beneficiary, the Contractor must provide for a second opinion from a qualified health care professional within the network, or arrange for the ability of the beneficiary to obtain one outside the network, at no cost to the beneficiary.

7) The Contractor shall have a 24/7 toll free number for prospective beneficiaries to call to access DMC-ODS services. The Contractor shall make oral interpretation services available for beneficiaries, as needed.

8) Covered services, whether provided directly by the Contractor or through subcontractor with DMC certified and enrolled programs, shall be provided to beneficiaries in the following manner:

   a) Standard DMC services approved through the State Plan Benefit shall be available to all beneficiaries regardless of county of residence.

   b) Access to State Plan services must remain at the current, pre-implementation level or expand upon implementation of the Pilot.

9) The failure of the Contractor or its subcontractor to comply with Section 2.2 shall be deemed a breach of this Intergovernmental Agreement resulting in the termination of this Intergovernmental Agreement for cause. In the event the Intergovernmental Agreement is terminated, the provision of this Exhibit, Attachment I, Section 17(B), shall apply.

2.3 Timely Access

A. In accordance with 42 CFR 438.206(c)(1), the Contractor shall comply with the following requirements:

1) Meet and require its providers to meet DHCS standards for timely access to care and services, taking into account the urgency of need for services;

2) Require subcontracted providers to have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries. If the provider only serves Medi-Cal beneficiaries, the Contractor shall require that hours of operation are comparable to the hours the provider makes available for Medi-Cal services that are not covered by the Contractor;

3) Make services available to beneficiaries 24 hours a day, 7 days a week, when medically necessary;

4) Establish mechanisms to ensure that network providers comply with the timely access requirements;

5) Monitor network providers regularly to determine compliance with timely access requirements; and

6) Take corrective action if there is a failure to comply with timely access requirements.

2.4 Adequate Capacity and Standards

A. The Contractor shall assure adequate network capacity within the standards prescribed by 42 CFR 438.207.

1) Pursuant to 42 CFR 438.207(b), the Contractor shall, when requested by the DHCS, submit documentation to the DHCS, in a format specified by the DHCS, and after receiving reasonable advance notice of its obligation, to demonstrate that the Contractor:

a) Offers an appropriate range of SUD treatment services that is adequate for the anticipated number of beneficiaries for the service area;

b) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area; and

c) Consistent with 42 CFR 438.207(c)(2), whenever there is a change in the Contractor's operation that would cause a decrease of 2 or more in services or providers available to beneficiaries, the Contractor shall report this to the DHCS-SUD-PPFD (DHCSMPF@DHCS.CA.GOV), including details regarding the change and plans to maintain adequate services and providers available to beneficiaries within 24 hours.

2.5 Coordination and Continuity of Care

A. The Contractor shall assure coordination and continuity of care within the standards prescribed by 42 CFR 438.208.

1) The Contractor shall coordinate the services that the Contractor either furnishes or arranges to be furnished to the beneficiary with services that the beneficiary receives from any other Medi-Cal managed care plan or subcontractor in accordance with 42 CFR 438.208(b)(2).

2) The Contractor shall ensure that, in the course of coordinating care, each beneficiary'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.

3) The Contractor shall enter into a Memorandum of Understanding (MOU) with any Medi-Cal managed care plan serving the Contractor's beneficiaries in accordance with 42 CFR 438.208.

a) The Contractor shall notify the DHCS in writing if the Contractor is unable to enter into an MOU or if an MOU is terminated, providing a description of the Contractor's good faith efforts to enter into or maintain the MOU. The contractor shall monitor the effectiveness of its MOU with Physical Health Care Plans.

4) Pursuant to 42 CFR 438.208(b)(1), (2), and (3), the Contractor must implement procedures to:

a) Ensure that each beneficiary has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the beneficiary;

b) Coordinate the services the Contractor furnishes to the beneficiary with the services the beneficiary receives from any other health plan;

c) Share with other health plans serving the beneficiary the results of its identification and assessment of any beneficiary with special health care needs (as defined by DHCS) so that those activities need not be duplicated; and

d) At State discretion, exceptions may exist for health plans that serve dually eligible beneficiaries.

5) Beneficiaries with special health care needs:

a) For beneficiaries determined to need a course of treatment or regular care monitoring, the Contractor shall have a mechanism in place to allow beneficiaries to directly access a specialist, as appropriate, for the beneficiary's condition and identified needs.

b) The Contractor shall implement mechanisms to assess each Medicaid beneficiary identified as having special health care needs in order to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring. The assessment mechanisms must:

i. Use appropriate health care professionals;

ii. Assess the quality and appropriateness of care furnished to beneficiaries with special health care needs.

c) The Contractor shall produce a treatment plan for beneficiaries determined to need a course of treatment or regular care monitoring, the treatment plan must be:

i. Developed by the beneficiary's primary care provider with beneficiary participation, and in consultation with any specialists caring for the beneficiary;

ii. Approved by the entity in a timely manner, if this approval is required; and

iii. In accordance with any applicable State quality assurance and utilization review standards.

d) Pursuant to 42 CFR 438.206(b)(2), the Contractor shall ensure that female

beneficiaries have direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the beneficiaries designated source of primary care if that source is not a women's health specialist.

B. Care Coordination within DMC-ODS levels of care

1) Contractor shall develop a care coordination plan that provides for seamless transitions of care for beneficiaries with the DMC-ODS system of care. Contractor is responsible for developing a structured approach to care coordination to ensure that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient) without disruptions to services.

2) In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, the Contractor shall ensure that beneficiaries have access to recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.

C. Contractor shall enter into a Memorandum Of Understanding (MOU) with any Medi-Cal managed care plan that enrolls beneficiaries served by the DMC-ODS. This requirement can be met through an amendment to the Specialty Mental Health Managed Care Plan MOU.

1) The following elements in the MOU should be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers:

a) Comprehensive substance use, physical, and mental health screening, including ASAM Level 0.5 SBIRT services;

b) Beneficiary engagement and participation in an integrated care program as needed;

c) Shared development of care plans by the beneficiary, caregivers and all providers;

d) Collaborative treatment planning with managed care;

e) Delineation of case management responsibilities;

f) A process for resolving disputes between the county and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved;

g) Availability of clinical consultation, including consultation on medications;

h) Care coordination and effective communication among providers including procedures for exchanges of medical information;

i) Navigation support for patients and caregivers; and

j) Facilitation and tracking of referrals between systems including bidirectional referral protocol.

2.6 Authorization of Services – Residential Programs

A. Pursuant to 42 CFR 438.210(b), the Contractor shall implement mechanisms to assure residential treatment program authorization decision standards are met.

B. The Contractor's residential treatment program standards shall:

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

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

b) Ensure that residential services may be provided in facilities with no bed capacity limit;

c) Ensure that the length of residential services comply with the following time restrictions:

i. Adults, ages 21 and over, may receive up to two (2) continuous short-term residential regimens per 365 day period. A short-term residential regimen is defined as one (1) residential stay in a DHCS licensed facility for a maximum of ninety (90) days per 365 day period.

An adult beneficiary may receive one thirty (30) day extension, if that extension is medically necessary, per 365 day period.

ii. Adolescents, under the age of 21, shall receive continuous residential services for a maximum of 30 days. Adolescent beneficiaries may receive a 30 day extension if that extension is determined to be medically necessary. Adolescent beneficiaries are limited to one extension per year. Adolescent beneficiaries receiving residential treatment shall be stabilized as soon as possible and moved down to a less intensive level of treatment. Nothing in the DMC-ODS Pilot or in this paragraph overrides any EPSDT requirements.

iii. If determined to be medically necessary, perinatal beneficiaries may receive a longer length of stay than those described above.

d) Ensure that at least one ASAM level of Residential Treatment Services is available to beneficiaries in the first year of implementation; and

e) Demonstrate ASAM levels of Residential Treatment Services (Levels 3.1-3.5) within three years of CMS approval of the county implementation plan and state-

county Intergovernmental Agreement and describe coordination for ASAM Levels 3.7 and 4.0.

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

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

4) Have decisions made within the timeframes outlined for service authorizations in 42 CFR 438.210(d), and notices of action related to such decisions provided within the timeframes set forth in 42 CFR 438.404(c).

C. Pursuant to 42 CFR 431.201, the Contractor shall define service authorization request in a manner that at least includes a beneficiary's request for the provision of a service. See General Definitions in Exhibit A, Attachment I for the definition of "Service Authorization Request".

3. Provider Selection and Certification

A. Pursuant to 42 CFR 438.12(a)(2), all Contractor contracts with providers shall comply with the requirements set forth in 42 CFR 438.214.

B. The Contractor shall ensure that its providers are credentialed as required by 42 CFR 438.214.

C. Consistent with 42 CFR 438.214, the contractor shall have written policies and procedures for selection, retention, credentialing and re-credentialing of providers; the provider selection policies and procedures shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

D. Selection Criteria and Provider Contracting Requirements: In selecting providers to furnish services under DMC-ODS, Contractor must:

1) Have written policies and procedures for selection and retention of providers that are in compliance with the terms and conditions of this amendment and applicable federal laws and regulations.

2) Apply those policies and procedures equally to all providers regardless of public, private, for-profit or non-profit status, and without regard to whether a provider treats persons who require high-risk or specialized services.

3) Must not discriminate against persons who require high-risk or specialized services.

4) May contract with providers in another state where out-of-state care or treatment is rendered on an emergency basis or is otherwise in the best interests of the person

under the circumstances.

5) Select only providers that have a license and/or certification issued by the state that is in good standing.

E. Select only providers that, prior to the furnishing of services under this pilot, have enrolled with, or revalidated their current enrollment with, DHCS as a DMC provider under applicable federal and state regulations, have been screened in accordance with 42 CFR 455.450(c) as a "high" categorical risk prior to furnishing services under this pilot, have signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107, and have complied with the ownership and control disclosure requirements of 42 CFR 455.104. DHCS shall deny enrollment and DMC certification to any provider (as defined in Welfare & Institutions Code section 14043.1), or a person with ownership or control interest in the provider (as defined in 42 CFR 455.101), that, at the time of application, is under investigation for fraud or abuse pursuant to Part 455 of Title 42 of the Code of Federal Regulations, unless DHCS determines that there is good cause not to deny enrollment upon the same bases enumerated in 42 CFR 455.23(e). If a provider is under investigation for fraud or abuse, that provider shall be subject to temporary suspension pursuant to Welfare & Institutions Code section 14043.36. Upon receipt of a credible allegation of fraud, a provider shall be subject to a payment suspension pursuant to Welfare & Institutions Code section 14107.11 and DHCS may thereafter collect any overpayment identified through an audit or examination. During the time a provider is subject to a temporary suspension pursuant to Welfare & Institutions Code section 14043.36, the provider, or a person with ownership or control interest in the provider (as defined in 42 CFR 455.101), may not receive reimbursement for services provided to a DMC-ODS beneficiary. A provider shall be subject to suspension pursuant to Welfare and Institutions Code section 14043.61 if claims for payment are submitted for services provided to a Medi-Cal beneficiary by an individual or entity that is ineligible to participate in the Medi-Cal program. A provider will be subject to termination of provisional provider status pursuant to Welfare and Institutions Code section 14043.27 if the provider has a debt due and owing to any government entity that relates to any federal or state health care program, and has not been excused by legal process from fulfilling the obligation. Only providers newly enrolling or revalidating their current enrollment on or after January 1, 2015 would be required to undergo fingerprint-based background checks required under 42 CFR 455.434.

1) When the disclosures must be provided.

a) Disclosures from providers or disclosing entities. Disclosure from any provider or disclosing entity is due at any of the following times:

i. Upon the provider or disclosing entity submitting the provider application.

ii. Upon the provider or disclosing entity executing the provider agreement.

iii. Upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414.

iv. Within 35 days after any change in ownership of the disclosing entity.

b) All disclosures must be provided to the Medicaid agency.

c) Consequences for failure to provide required disclosures. Federal financial participation (FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.

F. The Contractor shall only select providers that have a Medical Director who, prior to the delivery of services under this pilot, has enrolled with DHCS under applicable state regulations, has been screened in accordance with 42 CFR 455.450(a) as a "limited" categorical risk within a year prior to serving as a Medical Director under this pilot, and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107.

G. The Contractor may contract individually with licensed LPHAs to provide DMC-ODS services in the network.

H. Pursuant to 42 CFR 438.12(a)(1), the Contractor shall not discriminate in the selection, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

I. Consistent with 42 CFR 438.12(a)(1) and (b)(1), if the Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This section shall not be construed to:

1) Require the Contractor to contract with providers beyond the number necessary to meet the needs of its beneficiary.

2) Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

3) Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to beneficiary.

J. The Contractor shall have a protest procedure for providers that are not awarded an Intergovernmental Agreement. The Contractor's protest procedure shall ensure that:

1) Providers that submit a bid to be a contract provider, but are not selected, must exhaust the Contractor's protest procedure if a provider wishes to challenge the denial to DHCS; and

2) If the Contractor does not render a decision within 30 calendar days after the protest was filed with the Contractor, then the protest shall be deemed denied and the provider may appeal the failure to DHCS.

3.1 DMC Certification and Enrollment

A. DHCS shall certify eligible providers to participate in the DMC program.

B. The DHCS shall certify any Contractor operated or non-governmental providers. This certification shall be performed prior to the date on which the Contractor begins to deliver services under this Intergovernmental Agreement at these sites.

C. Contractor shall require that providers of perinatal DMC services are properly certified to provide these services and comply with the requirements contained in Title 22, Section 51341.1, Services for Pregnant and Postpartum Women.

D. Contractor shall require all the subcontracted providers of services to be licensed, registered, DMC certified and/or approved in accordance with applicable laws and regulations. Contractor's subcontracts shall require that providers comply with the following regulations and guidelines:

1) Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8;

2) Drug Medi-Cal Certification Standards for Substance Abuse Clinics (Document 2E);

3) Title 22, CCR, Sections 51341.1, 51490.1, and 51516.1, (Document 2C);

4) Standards for Drug Treatment Programs (October 21, 1981) (Document 2F);

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

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

In the event of conflicts, the provisions of Title 22 shall control if they are more stringent.

E. The Contractor shall notify Provider Enrollment Division (PED) of an addition or change of information in a provider's pending DMC certification application within 35 days of receiving notification from the provider. The Contractor must ensure that a new DMC certification application is submitted to PED reflecting the change.

F. The Contractor is responsible for ensuring that any reduction of covered services or relocations by providers are not implemented until approval is issued by DHCS. Within 35 days of receiving notification of a provider's intent to reduce covered services or relocate, the Contractor shall submit, or require the provider to submit, a DMC certification application to PED. The DMC certification application must be submitted to PED 60 days prior to the desired effective date of the reduction of covered services or relocation.

G. If, at any time, a subcontractor's license, registration, certification, or approval to operate a substance use disorder program or provide a covered service is revoked, suspended, modified, or not renewed outside of DHCS, the Contractor must notify DHCS Fiscal Management & Accountability Branch by e-mail at DHCSMPF@dhcs.ca.gov within two business days of knowledge of Section 3.1(G).

1) A provider's certification to participate in the DMC program shall automatically terminate in the event that the provider or its owners, officers or directors are convicted of Medi-Cal fraud, abuse or malfeasance. For purposes of this section, a

conviction shall include a plea of guilty or nolo contendere.

3.2 Continued Certification

A. All DMC certified providers shall be subject to continuing certification requirements at least once every five years. DHCS may allow the Contractor to continue delivering covered services to beneficiaries at a site subject to on-site review by DHCS as part of the recertification process prior to the date of the on-site review, provided the site is operational, the certification remains valid, and has all required fire clearances.

B. DHCS shall conduct recertification on-site visits at clinics for circumstances identified in the “Drug Medi-Cal Certification Standards for Substance Abuse Clinics” (Document 2E). Document 2E contains the appeal process in the event DHCS disapproves a provider's request for certification or recertification and shall be included in the Contractor's subcontracts.

3.3 Laboratory Testing Requirements

A. This part sets forth the conditions that all laboratories must meet to be certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Except as specified in paragraph (B) of this section, a laboratory will be cited as out of compliance with section 353 of the Public Health Service Act unless it:

1) Has a current, unrevoked or unsuspended certificate of waiver, registration certificate, certificate of compliance, certificate for Provider Performed Microscopy (PPM) procedures, or certificate of accreditation issued by HHS applicable to the category of examinations or procedures performed by the laboratory; or

2) Is CLIA-exempt.

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

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

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

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

C. Federal laboratories. Laboratories under the jurisdiction of an agency of the Federal Government are subject to the rules of this part, except that the Secretary may modify the application of such requirements as appropriate.

4. Recovery from Other Sources or Providers

A. The Contractor shall recover the value of covered services rendered to beneficiaries whenever the beneficiaries are covered for the same services, either fully or partially, under any other state or federal medical care program or under other contractual or legal entitlement including, but not limited to, a private group or indemnification program, but excluding instances of the tort liability of a third party or casualty liability insurance.

B. The monies recovered are retained by the Contractor. However, Contractor's claims for FFP for services provided to beneficiaries under this Intergovernmental Agreement shall be reduced by the amount recovered.

C. The Contractor shall maintain accurate records of monies recovered from other sources.

D. Nothing in this section supersedes the Contractor's obligation to follow federal requirements for claiming FFP for services provided to beneficiaries with other coverage under this Intergovernmental Agreement.

4.1 Beneficiary Liability for Payment

A. Pursuant to 42 CFR 438.106, the Contractor or an affiliate, vendor, contractor, or sub-subcontractor of the Contractor shall not submit a claim to, or demand or otherwise collect reimbursement from, the beneficiary or persons acting on behalf of the beneficiary for any SUD or related administrative services provided under this Intergovernmental Agreement, except to collect other health insurance coverage, share of cost, and co-payments. Consistent with 42 CFR 438.106, the Contractor or an affiliate, vendor, contractor, or sub-subcontractor of the Contractor shall not hold beneficiaries liable for debts in the event that the Contractor becomes insolvent, for costs of covered services for which DHCS does not pay the Contractor, for costs of covered services for which DHCS or the Contractor does not pay the Contractor's providers, for costs of covered services provided under an Intergovernmental Agreement, referral or other arrangement rather than from the Contractor, or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a beneficiary with an emergency condition.

B. Pursuant to 42 CFR 438.6(l) and 438.230 the Contractor and subcontractor shall not bill beneficiaries for covered services, any amount greater than would be owed if the Contractor provided the services directly.

C. Pursuant to 438.108, Contractor shall provide that any cost sharing imposed on beneficiaries is in accordance with Medicaid fee for service requirements (Section 447.50 – 447.60)

5. Early Intervention (ASAM Level 0.5)

A. Contractor's staff shall provide Screening, Brief Intervention, and Referral to Treatment (SBIRT) for all substance use conditions.

B. Contractor shall identify beneficiaries at risk of developing a SUD or those with an existing SUD and offer those beneficiaries: screening for adults and youth, brief treatment as medically necessary, and, when indicated, a referral to treatment with a formal linkage.

6. Outpatient Services (ASAM Level 1.0)

A. Outpatient services consist of up to nine (9) hours per week of medically necessary services for adults and less than six (6) hours per week of services for adolescents.

B. Contractor shall ensure that its providers will offer ASAM Level 1 services including: assessment, treatment planning; individual and group counseling; family therapy; patient education; medication services; collateral services; crisis intervention services; and discharge planning and coordination.

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

7. Intensive Outpatient Services (ASAM Level 2.1)

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

B. Intensive outpatient services shall include: assessment, treatment planning, individual and/or group counseling, patient education, family therapy, medication services, collateral services, crisis intervention services, treatment planning, and discharge planning and coordination.

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

8. Residential Treatment Services

A. Residential services are provided in DHCS or DSS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.

1) Residential services can be provided in facilities with no bed capacity limit.

2) The length of residential services range from 1 to 90 days with a 90-day maximum for adults and 30-day maximum for adolescents per 365 days period; unless medical necessity authorizes a one-time extension of up to 30 days per 365 day period.

a) Only two non-continuous 90-day regimens may be authorized in a one-year period (365 days.) The average length of stay for residential services is 30 days.

b) Perinatal beneficiaries may receive a longer length of stay based on medical necessity.

c) Adolescents require shorter lengths of stay and should be stabilized and then moved down to a less intensive level of treatment.

9. Case Management

A. Case management services are defined as a service that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

B. The Contractor shall:

1) Ensure that case management services focus on coordination of SUD care, integration around primary care especially for beneficiaries with a chronic SUD, and interaction with the criminal justice system, if needed.

2) The Contractor shall be responsible for determining which entity monitors the case management activities.

3) Case management services may be provided by a Licensed Practitioner of the Healing Arts or certified counselor.

4) The Contractor shall coordinate a system of case management services with physical and/or mental health in order to ensure appropriate level of care.

5) Case management services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.

10. Physician Consultation

A. Physician Consultation Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are designed to assist DMC physicians by allowing them to seek expert advice with regards to designing treatment plans for specific DMC-ODS beneficiaries. Physician consultation services may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

B. Contractor may contract with one or more physicians or pharmacists in order to provide consultation services.

C. The Contractor shall only allow DMC providers to bill for physician consultation services.

11. Recovery Services

A. Recovery Services shall

1) Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care;

2) Recovery Monitoring: Recovery coaching, monitoring via telephone and internet;

3) Substance Abuse Assistance: Peer-to-peer services and relapse prevention;

4) Education and Job Skills: Linkages to life skills, employment services, job training, and education services;

5) Family Support: Linkages to childcare, parent education, child development support services, family/marriage education;

6) Support Groups: Linkages to self-help and support, spiritual and faith-based support; and

7) Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

B. Recovery services can be utilized when the beneficiary is triggered, when the beneficiary has relapsed, or simply as a preventative measure to prevent relapse. As part of the assessment and treatment needs of Dimension 6, Recovery Environment of the ASAM Criteria and during the transfer/transition planning process, the Contractor shall provide beneficiaries with recovery services.

C. Additionally, the Contractor shall:

1) Provide recovery services to beneficiaries as medically necessary.

2) Provide beneficiaries with access to recovery services after completing their course of treatment.

3) Provide recovery services either face-to-face, by telephone, or by telehealth with the beneficiary.

12. Withdrawal Management

A. The Contractor shall provide at least one of the five levels of withdrawal management (WM) services according to the ASAM Criteria, when determined by a Medical Director or Licensed Practitioner of the Healing Arts as medically necessary, and in accordance with the beneficiary's individualized beneficiary plan.

B. The Contractor shall ensure that all beneficiaries that are receiving both residential services and WM services are monitored during the detoxification process.

C. The Contractor shall provide medically necessary habilitative and rehabilitative services in accordance with an individualized treatment plan prescribed by a licensed physician or licensed prescriber.

13. Opioid (Narcotic) Treatment Program Services (NTP)

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

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

1) Medical treatment visits;

2) Diagnostic blood, urine, and X-rays;

3) Psychological and psychiatric tests and services;

4) Quantitative blood and urine toxicology assays; and

5) Medical supplies.

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

D. The Contractor shall contract with licensed NTP to offer services to beneficiaries who meet medical necessity criteria requirements.

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

F. Offer and prescribe medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone, and disulfiram.

G. Services provided as part of an NTP shall include: assessment, treatment planning, individual and group counseling, patient education; medication services; collateral services; crisis intervention services; treatment planning; medical psychotherapy; and discharge services.

1) Beneficiaries shall receive between 50 and 200 minutes of counseling per calendar month with a therapist or counselor, and, when medically necessary, additional counseling services may be provided.

14. Beneficiary Brochure and Provider List

The Contractor shall be responsible for ensuring that the following requirements are met and notice thereof is provided in the beneficiary brochure upon automatic mandatory enrollment of the beneficiaries. The production and update of its booklet section(s) and provider list in accordance with 42 CFR 438.10. The Contractor shall establish criteria to update its booklet and provider list.

A. Contractor shall provide all enrollment notices, informational materials and instructional materials in a manner and format that may be easily understood in language and format. Contractor shall provide notice to all potential beneficiaries and beneficiaries regarding the availability of materials in alternative formats to ensure comprehension and understanding of the requirements and benefits of the plan. Contractor shall provide instructions on how to access those alternative format materials.

    1) Contractor shall make oral interpretation services available and provide those services free of charge to each potential beneficiary and beneficiary.

    2) Contractor shall ensure written materials:

        a. Use easily understood language and format; and

        b. Be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency.

    3) All enrollees and potential enrollees shall be informed by the Contractor that information is available in alternative formats and how to access those formats.

B. Pursuant to 42 CFR 438.10(e)(2)(i), upon automatic mandatory enrollment, the Contractor shall provide the following information to potential beneficiaries:

    1) The basic features of managed care;

    2) Which populations are excluded from enrollment, subject to mandatory enrollment, or free to enroll voluntarily in the program; and

    3) The Contractor's responsibility for coordination of the beneficiary's care.

C. Pursuant to 42 CFR 438.10(e)(2)(ii), upon automatic mandatory enrollment, the Contractor shall provide potential beneficiaries with a summary of the following information:

    1) Benefits covered;

    2) Cost sharing, if any;

    3) Service area;

    4) Names, locations, telephone numbers of, and non-English language spoken by current contracted providers, and including identification of providers that are not

accepting new patients. For MCOs, PIHPs, and PAHPs this includes at a minimum information on primary care physicians, specialists and hospitals;

5) Benefits that are available under the state plan but are not covered under the Intergovernmental Agreement, including how and where the enrollee may obtain those benefits, any cost sharing, and how transportation is provided; and

6) Counseling and referral services that are not covered under the Intergovernmental Agreement because of moral or religious objections.

D. Pursuant to 42 CFR 438.10(f)(2) and (6), upon automatic mandatory enrollment, and/or upon request, the Contractor shall provide the following information to beneficiaries:

1) Their right to change providers;

2) Their right to request and receive a copy of his or her medical records, and to request that they be amended or corrected;

3) Their right to obtain the following information:

a) Names, locations, telephone numbers of, and non-English languages spoken by current contracted providers in the beneficiary's service area, including identification of providers that are not accepting new patients.

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

c) Beneficiary rights and protections, as specified in 42 CFR 438.100, as follow:

i. To receive information in accordance with 42 CFR 438.10.

ii. To be treated with respect and with due consideration for his/her dignity and privacy.

iii. To receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's conditions and ability to understand.

iv. To participate in decisions regarding his or health care, including the right to refuse treatment.

v. To be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.

vi. To request and receive a copy of his/her medical records, and request that they be amended or corrected, as specified in 45 CFR 164.524 and 164.526.

vii. To exercise his/her rights, and that the exercised of those rights will not

adversely affect the way the Contractor and its providers treat the beneficiary.

d) Information on grievance and State level fair hearing procedures in accordance with Title 22, California Code of Regulations 50951 and 50953.

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

f) Procedures for obtaining benefits, including authorization requirements.

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

h) The extent to which, and how, after-hours and emergency coverage are provided, including:

   i. What constitutes an emergency medical condition, emergency services, and post-stabilization services, with reference to the definitions in 42 CFR 438.114(a).

   ii. The fact that prior authorization is not required for emergency services.

   iii. The process and procedures for obtaining emergency services, including use of the 911-telephone system or its local equivalent.

   iv. The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered under the Intergovernmental Agreement.

   v. The fact that, subject to the provisions of 42 CFR 438.10(f)(6), the beneficiary has a right to use any hospital or other setting for emergency care.

   vi. The post-stabilization care services rules set forth in 42 CFR 422.113(c).

   vii. Policy on referrals for specialty care and for other benefits not furnished by the beneficiary's primary care provider (42 CFR 438.10(f)(6)(x)).

i) Cost sharing, if any.

   i. How and where to access any benefits that are available under the State Plan but are not covered under this Intergovernmental Agreement, including any cost sharing, and how any necessary transportation is provided.

   ii. Pursuant to 42 CFR 438.102(a)(2), for a counseling or referral service that the Contractor does not cover because of moral or religious

objections, the Contractor need not furnish information on how and where to obtain the service; however, Pursuant to 42 CFR 438.102(b)(1), the Contractor must provide notice to DHCS and beneficiaries about counseling and/or referral services it will not continue to provide on moral or religious grounds: 1) upon initial application to provide services under this Agreement and, 2) in the event of any discontinuation.

a. DHCS shall provide beneficiaries information on how and where to obtain services not provided by Contractor based on moral or religious grounds.

E. The Contractor shall ensure that the general program literature it uses to assist beneficiaries in accessing services including, but not limited to, the booklet required by 42 CFR 438.10, materials explaining the beneficiary problem resolution and fair hearing processes, and SUD education materials used by the Contractor, are available in the threshold languages of the Contractor's county in compliance with 42 CFR 438.10(c)(3).

F. Pursuant to 42 CFR 438.10(c)(1), the State shall identify the threshold non-English languages spoken by beneficiaries and potential beneficiaries and provides that information to the Contractor in the manner and format that may be easily understood as described in the Threshold Language Translation Requirements:

1) Pursuant to Government Code Section 7290-7299.8, Contractor shall comply with the linguistic requirements included in this Section. Contractor shall have:

a) A methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the County. "Prevalent" means a non-English language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

b) Oral interpreter services in threshold languages at key points of contact available to assist beneficiaries whose primary language is a threshold language to access the substance use treatment services or related services through that key point of contact. The threshold languages shall be determined on a countywide basis. Counties may limit the key points of contact at which interpreter services in a threshold language are available to a specific geographic area within the county when:

i. The County has determined, for a language that is a threshold language on a countywide basis, that there are geographic areas of the county where that language is a threshold language, and other areas where it is not; and

ii. The Contractor provides referrals for beneficiaries who prefer to receive services in that threshold language, but who initially access services outside the specified geographic area, to a key point of contact that does have interpreter services in that threshold language.

c) Policies and procedures in place to assist beneficiaries who need oral interpreter services in languages other than threshold languages to access the substance use treatment services or related services available at the key points of contact.

d) General program literature used by the Contractor to assist beneficiaries in accessing services available in threshold languages, based on the threshold languages in the county as a whole.

G. Pursuant to 42 CFR 438.10(c)(4) and (5), the Contractor must make oral interpretation and sign language services available free of charge to each beneficiary. This applies to all non-English languages and not just those identified as prevalent. The Contractor must notify beneficiaries that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services.

H. Pursuant to 42 CFR 438.10(g), the booklet shall include grievance, appeal and fair hearing procedures and timeframes, as provided in 42 CFR 438.400 through 438.424, using a DHCS-developed or DHCS-approved description that must include the following:

1) For State Fair Hearing

a) The right to hearing;

b) The method for obtaining a hearing; and

c) The rules that govern representation at the hearing.

2) The right to file grievances and appeals.

3) The requirements and timeframes for filing a grievance or appeal

4) The availability of assistance in the filing process.

5) The toll-free numbers that the beneficiary can use to file a grievance or an appeal by phone.

6) The fact that, when requested by the beneficiary:

a) Benefits shall continue if the beneficiary files an appeal or a request for State Fair Hearing within the timeframes specified for filing.

7) The appeal rights that the DHCS has chosen to make available to providers consistent with in 42 CFR 438.10 (g)(1)(vii), to challenge the Contractor's failure to cover a service.

8) Additional information that is available upon request, includes the following:

a) Information on the structure and operation of the Contractor.

b) Physician incentive plans as set forth in 42 CFR 438.6(h).

I. The Contractor shall provide beneficiaries with a copy of the booklet and provider list upon automatic mandatory enrollment and shall notify beneficiaries of their right to request and obtain this information at least once a year and thereafter upon request in accordance with 42 CFR 438.10.

J. The Contractor shall ensure that the booklet above includes the current toll-free telephone number(s) that provides information in threshold languages and is available twenty-four hours a day, seven days a week.

K. The Contractor shall ensure that provider directories:

1) Include information on the category or categories of services available from each provider;

2) Contain the names, locations, and telephone numbers of current contracted providers by category;

3) Identify options for services in languages other than English and services that are designed to address cultural differences and;

4) Provide a means by which a beneficiary can identify which providers are not accepting new beneficiaries.

L. As required by 42 CFR 438.10(f)(4), when there is a change that DHCS defines as significant in the scope of SUD treatment services covered by the Contractor, the update, in the form of a booklet insert, shall be provided to beneficiaries at least 30 days prior to the change.

M. Consistent with 42 CFR 438.10(f)(5), the Contractor must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each beneficiary who was seen on a regular basis by the terminated provider.

15. Cultural Competence Plan

A. The Contractor shall develop a cultural competency plan and subsequent plan updates.

B. Contractor shall promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

16. Implementation Plan

A. The Contractor shall comply with the provisions of the Contractor's Implementation Plan as approved by DHCS, including the administration of beneficiary problem resolution processes as required by 42 CFR 438.10.

B. The Contractor shall not provide DMC-ODS services without: 1) an approved

Implementation Plan approved by DHCS and CMS; and 2) a CMS approved State/County Intergovernmental Agreement executed by DHCS and the Contractor's Board of Supervisors.

C. The Contractor shall obtain written approval by DHCS prior to making any changes to the Implementation Plan.

17. Additional Provisions

A. Additional Intergovernmental Agreement Restrictions

This Intergovernmental Agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress, or any statute enacted by the Congress, which may affect the provisions, terms, or funding of this Intergovernmental Agreement in any manner including, but not limited to, 42 CFR 438.610(c)(3).

B. Nullification of DMC Treatment Program SUD services (if applicable)

The parties agree that if the Contractor fails to comply with the provisions of W&I Code, Section 14124.24, all areas related to the DMC Treatment Program SUD services shall be null and void and severed from the remainder of this Intergovernmental Agreement.

In the event the DMC Treatment Program Services component of this Intergovernmental Agreement becomes null and void, an updated Exhibit B, Attachment I shall take effect reflecting the removal of federal Medicaid funds and DMC State General Funds from this Intergovernmental Agreement. All other requirements and conditions of this Intergovernmental Agreement shall remain in effect until amended or terminated.

C. Hatch Act

Contractor agrees to comply with the provisions of the Hatch Act (Title 5 USC, Sections 1501-1508), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.

D. No Unlawful Use or Unlawful Use Messages Regarding Drugs

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

E. Noncompliance with Reporting Requirements

Contractor agrees that DHCS has the right to withhold payments until Contractor has submitted any required data and reports to DHCS, as identified in this Exhibit A, Attachment I or as identified in Document 1F(a), Reporting Requirement Matrix for

Counties.

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

None of the funds made available through this Intergovernmental Agreement may be used for any activity that promotes the legalization of any drug or other substance included in Schedule I of Section 202 of the Controlled Substances Act (21 USC 812).

G. Restriction on Distribution of Sterile Needles

No Substance Abuse Prevention and Treatment (SAPT) Block Grant funds made available through this Intergovernmental Agreement shall be used to carry out any program that includes the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug unless DHCS chooses to implement a demonstration syringe services program for injecting drug users.

H. Health Insurance Portability and Accountability Act (HIPAA) of 1996

If any of the work performed under this Intergovernmental Agreement is subject to the HIPAA, Contractor shall perform the work in compliance with all applicable provisions of HIPAA. As identified in Exhibit G, DHCS and Contractor shall cooperate to assure mutual agreement as to those transactions between them, to which this Provision applies. Refer to Exhibit G for additional information.

1) Trading Partner Requirements

a) No Changes. Contractor hereby agrees that for the personal health information (Information), it shall not change any definition, data condition or use of a data element or segment as proscribed in the federal HHS Transaction Standard Regulation. (45 CFR Part 162.915 (a))

b) No Additions. Contractor hereby agrees that for the Information, it shall not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation. (45 CFR Part 162.915 (b))

c) No Unauthorized Uses. Contractor hereby agrees that for the Information, it shall not use any code or data elements that either are marked “not used” in the HHS Transaction’s Implementation specification or are not in the HHS Transaction Standard’s implementation specifications. (45 CFR Part 162.915 (c))

d) No Changes to Meaning or Intent. Contractor hereby agrees that for the Information, it shall not change the meaning or intent of any of the HHS Transaction Standard’s implementation specification. (45 CFR Part 162.915 (d))

2) Concurrence for Test Modifications to HHS Transaction Standards

Contractor agrees and understands that there exists the possibility that DHCS or others may request an extension from the uses of a standard in the HHS Transaction Standards. If this occurs, Contractor agrees that it shall participate in

such test modifications.

3) Adequate Testing

Contractor is responsible to adequately test all business rules appropriate to their types and specialties. If the Contractor is acting as a clearinghouse for enrolled providers, Contractor has obligations to adequately test all business rules appropriate to each and every provider type and specialty for which they provide clearinghouse services.

4) Deficiencies

The Contractor agrees to cure transactions errors or deficiencies identified by DHCS, and transactions errors or deficiencies identified by an enrolled provider if the Contractor is acting as a clearinghouse for that provider. If the Contractor is a clearinghouse, the Contractor agrees to properly communicate deficiencies and other pertinent information regarding electronic transactions to enrolled providers for which they provide clearinghouse services.

5) Code Set Retention

Both Parties understand and agree to keep open code sets being processed or used in this Intergovernmental Agreement for at least the current billing period or any appeal period, whichever is longer.

6) Data Transmission Log

Both Parties shall establish and maintain a Data Transmission Log, which shall record any and all Data Transmission taking place between the Parties during the term of this Intergovernmental Agreement. Each Party shall take necessary and reasonable steps to ensure that such Data Transmission Logs constitute a current, accurate, complete, and unaltered record of any and all Data Transmissions between the Parties, and shall be retained by each Party for no less than twenty-four (24) months following the date of the Data Transmission. The Data Transmission Log may be maintained on computer media or other suitable means provided that, if it is necessary to do so, the information contained in the Data Transmission Log may be retrieved in a timely manner and presented in readable form.

I. Nondiscrimination and Institutional Safeguards for Religious Providers

Contractor shall establish such processes and procedures as necessary to comply with the provisions of Title 42, USC, Section 300x-65 and Title 42, CFR, Part 54, (Reference Document 1B).

J. Counselor Certification

Any counselor or registrant providing intake, assessment of need for services, treatment or recovery planning, individual or group counseling to participants, patients, or residents in a DHCS licensed or certified program is required to be certified as defined

in Title 9, CCR, Division 4, Chapter 8. (Document 3H)

K. Cultural and Linguistic Proficiency

To ensure equal access to quality care by diverse populations, each service provider receiving funds from this Intergovernmental Agreement shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards (Document 3V) and comply with 42 CFR 438.206(c)(2).

L. Intravenous Drug Use (IVDU) Treatment

Contractor shall ensure that individuals in need of IVDU treatment shall be encouraged to undergo SUD treatment (42 USC 300x-23 and 45 CFR 96.126(e)).

M. Tuberculosis Treatment

Contractor shall ensure the following related to Tuberculosis (TB):

1) Routinely make available TB services to each individual receiving treatment for SUD use and/or abuse;

2) Reduce barriers to patients' accepting TB treatment; and,

3) Develop strategies to improve follow-up monitoring, particularly after patients leave treatment, by disseminating information through educational bulletins and technical assistance.

N. Trafficking Victims Protection Act of 2000

Contractor and its subcontractors that provide services covered by this Intergovernmental Agreement shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(g)) as amended by section 1702. For full text of the award term, go to:

http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title22-section7104d&num=0&edition=prelim

O. Tribal Communities and Organizations

Contractor shall regularly assess (e.g. review population information available through Census, compare to information obtained in CalOMS Treatment to determine whether population is being reached, survey Tribal representatives for insight in potential barriers) the substance use service needs of the American Indian/Alaskan Native (AI/AN) population within the Contractor's geographic area and shall engage in regular and meaningful consultation and collaboration with elected officials of the tribe, Rancheria, or their designee for the purpose of identifying issues/barriers to service delivery and improvement of the quality, effectiveness and accessibility of services available to AI/NA communities within the Contractor's county.

P. Participation of County Alcohol and Drug Program Administrators Association of

California and California Behavioral Health Director's Association of California.

1) Pursuant to HSC Section 11801(g), the Contractor's County AOD Program Administrator shall participate and represent the County in meetings of the County Alcohol and Drug Program Administrators Association of California for the purposes of representing the counties in their relationship with DHCS with respect to policies, standards, and administration for SUD abuse services. Participation and representation shall also be provided by the County Behavioral Health Director's Association of California.

2) Pursuant to HSC Section 11811.5(c), the Contractor's County AOD Program Administrator shall attend any special meetings called by the Director of DHCS. Participation and representation shall also be provided by the County Behavioral Health Director's Association of California.

Q. Youth Treatment Guidelines

Contractor shall follow the guidelines in Document 1V, incorporated by this reference, "Youth Treatment Guidelines," in developing and implementing adolescent treatment programs funded under this Exhibit, until such time new Youth Treatment Guidelines are established and adopted. No formal amendment of this Intergovernmental Agreement is required for new guidelines to be incorporated into this Intergovernmental Agreement.

R. Restrictions on Grantee Lobbying – Appropriations Act Section 503

1) No part of any appropriation contained in this Act shall be used, other than for formal and recognized executive-legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, radio, television, or video presentation designed to support or defeat legislation pending before the Congress, except in presentation to the Congress or any State legislative body itself.

2) No part of any appropriation contained in this Act shall be used to pay the salary or expenses of any Intergovernmental Agreement recipient, or agent acting for such recipient, related to any activity designed to influence legislation or appropriations pending before the Congress or any State legislature.

S. Nondiscrimination in Employment and Services

By signing this Intergovernmental Agreement, Contractor certifies that under the laws of the United States and the State of California, incorporated into this Intergovernmental Agreement by reference and made a part hereof as if set forth in full, Contractor shall not unlawfully discriminate against any person.

T. Federal Law Requirements:

1) Title VI of the Civil Rights Act of 1964, Section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in federally funded programs.

2) Title IX of the education amendments of 1972 (regarding education and programs and activities), if applicable.

3) Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.

4) Age Discrimination Act of 1975 (45 CFR Part 90), as amended (42 USC Sections 6101 – 6107), which prohibits discrimination on the basis of age.

5) Age Discrimination in Employment Act (29 CFR Part 1625).

6) Title I of the Americans with Disabilities Act (29 CFR Part 1630) prohibiting discrimination against the disabled in employment.

7) Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities.

8) Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.

9) Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.

10) Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than $10,000 funded by federal financial assistance.

11) Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.

12) The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.

13) The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism.

U. State Law Requirements:

1) Fair Employment and Housing Act (Government Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (California Administrative Code, Title 2, Section 7285.0 et seq.).

2) Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135.

3) Title 9, Division 4, Chapter 8 of the CCR, commencing with Section 10800.

4) No state or federal funds shall be used by the Contractor or its subcontractors for sectarian worship, instruction, or proselytization. No state funds shall be used by

the Contractor or its subcontractors to provide direct, immediate, or substantial support to any religious activity.

5) Noncompliance with the requirements of nondiscrimination in services shall constitute grounds for state to withhold payments under this Intergovernmental Agreement or terminate all, or any type, of funding provided hereunder.

V. Investigations and Confidentiality of Administrative Actions

1) Contractor acknowledges that if a DMC provider is under investigation by DHCS or any other state, local or federal law enforcement agency for fraud or abuse, DHCS may temporarily suspend the provider from the DMC program, pursuant to W&I Code, Section 14043.36(a). Information about a provider'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 a provider pursuant to W&I Code, Section 14107.11 and Code of Federal Regulations, Title 42, section 455.23. The Contractor is to withhold payments from a DMC provider during the time a Payment Suspension is in effect.

2) Contractor shall execute the Confidentiality Agreement, attached as Document 5A. The Confidentiality Agreement permits DHCS to communicate with Contractor concerning subcontracted providers that are subject to administrative sanctions.

W. This Intergovernmental Agreement is subject to any additional restrictions, limitations, or conditions enacted by the federal or state governments that affect the provisions, terms, or funding of this Intergovernmental Agreement in any manner.

X. Subcontract Provisions

Contractor shall include all of the foregoing provisions in all of its subcontracts.

Y. Conditions for Federal Financial Participation

1) Contractor shall meet all conditions for Federal Financial Participation, consistent with 42 CFR 438.802, 42 CFR 438.804, 42 CFR 438.806, 42 CFR 438.808, 42 CFR 438.810, 42 CFR 438.812.

2) Pursuant to 42 CFR 438.808, Federal Financial Participation (FFP) is not available to the Contractor if the Contractor:

a) Is an entity that could be excluded under section 1128(b)(8) as being controlled by a sanctioned individual;

b) Is an entity that has a substantial contractual relationship as defined in section 431.55(h)(3), either directly or indirectly, with an individual convicted of certain crimes described in section 1128(8)(B); or

c) Is an entity that employs or contracts, directly or indirectly, for the furnishing of health care utilization review, medical social work, or administrative services, with one of the following:

i. Any individual or entity excluded from participation in federal health care programs under section 1128 or section 1126A; or

ii. An entity that would provide those services through an excluded individual or entity.

18. Beneficiary Problem Resolution Processes

The Contractor shall establish and comply with a beneficiary problem resolution process.

A. General Provisions

Contractor shall inform subcontractors and providers at the time they enter into a contract about:

1) The beneficiary's right to a State fair hearing, how to obtain a hearing and the representation rules at the hearing.

2) The beneficiary's right to file grievances and appeals and the requirements and timeframes for filing.

3) The beneficiary's right to give written consent to allow a provider, acting on behalf of the beneficiary, to file an appeal. A provider may file a grievance or request a State fair hearing on behalf of a beneficiary, if the State permits the provider to act as the enrollee's authorized representative in doing so.

4) The beneficiary may file a grievance either orally or in writing and, as determined by DHCS, either with the DHCS or with the Contractor.

5) The availability of assistance with filing grievances and appeals.

6) The toll-free number to file oral grievances and appeals.

7) The beneficiary's right to request continuation of benefits during an appeal or State fair hearing filing although the beneficiary may be liable for the cost of any continued benefits if the action is upheld.

8) Any State determined provider's appeal rights to challenge the failure of the Contractor to cover a service.

B. The Contractor shall represent the Contractor's position in fair hearings, as defined in 42 CFR 438.408 dealing with beneficiaries' appeals of denials, modifications, deferrals or terminations of covered services. The Contractor shall carry out the final decisions of the fair hearing process with respect to issues within the scope of the Contractor's responsibilities under this Intergovernmental Agreement. Nothing in this section is intended to prevent the Contractor from pursuing any options available for appealing a fair hearing decision.

1) Pursuant to 42 CFR 438.228, the Contractor shall develop problem resolution

processes that enable beneficiary to request and receive review of a problem or concern he or she has about any issue related to the Contractor's performance of its duties, including the delivery of SUD treatment services.

2) The Contractor's beneficiary problem resolution processes shall include:

   a) A grievance process;

   b) An appeal process; and

   c) An expedited appeal process.

3) For the grievance, appeal, and expedited appeal processes, described in 42 CFR. 438 Subpart F, the Contractor shall comply with all of the following requirements:

   a) Dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the beneficiary's health condition requires, within the DHCS established timeframes;

   b) Assure that each beneficiary has adequate information about the Contractor's problem resolution processes by taking at least the following actions;

      i. Including information describing the grievance, appeal, and expedited appeal processes in the Contractor's beneficiary booklet and providing the beneficiary booklet to beneficiaries as described in Section 14 of this Intergovernmental Agreement;

      ii. Posting notices explaining grievance, appeal, and expedited appeal process procedures in locations at all Contractor provider sites. Notices shall be sufficient to ensure that the information is readily available to both beneficiaries and provider staff. The posted notice shall also explain the availability of fair hearings or expedited appeal process, including information that a fair hearing may be requested whether or not the beneficiary has received a notice of action pursuant to 42 CFR 438.404. For the purposes of this Section, a Contractor provider site means any office or facility owned or operated by the Contractor or a provider contracting with the Contractor at which beneficiaries may obtain SUD treatment services; and

      iii. Pursuant to 42 CFR 438.10, making available forms that may be used to file grievances, appeals, and expedited appeals and self-addressed envelopes that beneficiaries can access at all Contractor provider sites without having to make a verbal or written request to anyone.

   c) Pursuant to 42 CFR 438.406(a)(1), giving beneficiaries any reasonable assistance in completing the forms and other procedural steps not limited to providing interpreter services and toll-free numbers with TTY/TDD and interpreter capability;

   d) Pursuant to 42 CFR 438.406(a)(2), the Contractor shall acknowledge receipt of

each grievance, appeal, and request for expedited appeal to the beneficiary in writing regardless of whether the appeal was received in writing or orally;

e) Consistent with 42 CFR 438.402(b)(1)(ii), a beneficiary may authorize, in writing, another person to act on the beneficiary's behalf. The beneficiary may select a provider as his or her representative in the appeal or expedited appeal process, if the provider consents;

f) Consistent with 42 CFR 438.402(b)(2), 42 CFR 438.408(f)(1), California Welfare and Institutions Code section 10951, the beneficiary, or provider acting on behalf of the beneficiary, may file an appeal within 90 days of the date on the notice of action was taken;

g) A beneficiary's legal representative may use the grievance, appeal, or expedited appeal processes on the beneficiary's behalf.

h) At the beneficiary's request, the Contractor shall identify staff or another individual, such as a legal guardian, to be responsible for assisting a beneficiary with these processes, including providing assistance in writing the grievance, appeal, or expedited appeal. If the individual identified by the Contractor is the person providing SUD treatment services to the beneficiary requesting assistance, the Contractor shall identify another individual to assist that beneficiary;

i) A beneficiary shall not be subject to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal;

j) Procedures for these beneficiary problem resolution processes shall maintain the confidentiality of each beneficiary's information;

k) A procedure shall be included by which issues identified as a result of the grievance, appeal or expedited appeal processes are transmitted to the Contractor's Quality Improvement Committee, the Contractor's administration or another appropriate body within the Contractor's operations. These issues shall be considered in the Contractor's Quality Improvement Program, as required by 42 CFR 438.240;

l) Individuals involved in any previous review or decision-making on the issue(s) presented in a problem resolution process shall not participate in making the decision on the grievance, appeal, or expedited appeal pursuant to 42 CFR 438.406(a)(3)(i); and

m) The individual making the decision on the grievance, appeal, or expedited appeal shall have the appropriate clinical expertise, as determined by the Contractor, required to treat the beneficiary's condition, if the grievance concerns the denial of a request for an expedited appeal or if the grievance, appeal, or expedited appeal addresses any clinical issue, including a lack of medical necessity pursuant to Title per 42, CFR 438.406(a)(3)(ii) or Title 22, Sections 51303 and 51340.1.

4) Pursuant to record keeping and review requirements in 42 CFR 438.416, and to facilitate monitoring consistent with 42 CFR 438.240 the Contractor shall:

   a) Maintain a grievance and appeal log and record grievances, appeals, and expedited appeals in the log within one working day of the date of receipt of the grievance or appeal. The log entry shall include, but not be limited to, the name of the beneficiary, the date of receipt of the grievance, appeal, or expedited appeal, and the nature of the problem;

   b) Record in the grievance and appeal log or another central location determined by the Contractor, the final dispositions of grievances, appeals, and expedited appeals, including the date the decision is sent to the beneficiary. If there has not been final disposition of the grievance, appeal, or expedited appeal, the reason(s) shall be included in the log;

   c) Provide a staff person or other individual with responsibility to provide information requested by the beneficiary or the beneficiary's representative regarding the status of the beneficiary's grievance, appeal, or expedited appeal;

   d) Acknowledge the receipt of each grievance, appeal, and expedited appeal to the beneficiary in writing;

   e) Identify in its grievance, appeal, and expedited appeal documentation, the roles and responsibilities of the Contractor, the provider, and the beneficiary;

   f) Notify the beneficiary, in writing, of the final disposition of the problem resolution process including the reasons for the disposition; and

   g) Notify, in writing, any provider identified by the beneficiary or involved in the grievance, appeal, or expedited appeal of the final disposition of the beneficiary's grievance, appeal, or expedited appeal.

C. Notice to Beneficiaries

Notice to beneficiaries shall be in writing and shall explain the following:

1) The action that the Contractor or its subcontractor has taken or intends to take;

2) The reasons for the action;

3) The beneficiary's or the provider's right to file a PIHP appeal;

4) The beneficiary's right to request a State fair hearing;

5) The procedures for exercising a grievance and/or appeal;

6) The circumstances under which expedited resolution is available and how to request it; and

7) The beneficiary's right to have benefits continue pending resolution of the appeal,

how to request that benefits be continued, and the circumstances under which the beneficiary may be required of these services.

Notices shall be available in the State-established prevalent non-English language in Contractor's service area and be available in alternative formats for persons with special needs, and use easily understood language and format.

D. Grievance Process

Consistent with 42 CFR §§ 438.400, 438.402, 438.406, the Contractor shall ensure that its grievance process contains provisions that, at a minimum:

1) Allow beneficiaries or Contractor to present their grievance orally, or in writing;

2) Provide for a decision on the grievance, as expeditiously as the enrollee's health condition requires, and notify the affected parties within 60 calendar days of receipt of the grievance. This timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or if the Contractor determines that there is a need for additional information and that the delay is in the beneficiary's interest. If the Contractor extends the timeframe, the Contractor shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in 42 CFR 438.210; and

3) Provide for notification of the beneficiary or the appropriate representative in writing of the grievance decision and documentation of the notification or efforts to notify the beneficiary, if he or she could not be contacted.

E. Appeal Process

1) Consistent with 42 CFR 438.408, the Contractor shall ensure that its appeal process, at a minimum:

a) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the enrollee or the provider requests expedited resolution pursuant to 42 CFR 438.406(b)(1);
.

b) Allow a beneficiary to file an appeal orally or in writing pursuant to 42 CFR 438.402(b)(3)(ii);

c) Pursuant to 42 CFR 438.402(b)(3)(ii), require a beneficiary who makes an oral appeal, that is not an expedited appeal, to subsequently submit the appeal in writing. The date the Contractor receives the oral appeal shall be considered the filing date for the purpose of applying the appeal timeframes;

d) Pursuant to 42 CFR 438.408(b) and (c), provide for a decision on the appeal and notify the affected parties within 45 calendar days of receipt of the appeal, or as expeditiously as the enrollee's health condition requires. This timeframe may be extended by up to 14 calendar days, if the beneficiary requests an

extension or the Contractor determines that there is a need for additional information and that the delay is in the beneficiary's interest. If the Contractor extends the timeframes, the Contractor shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in 42 CFR 438.210;

e) Consistent with 42 CFR 438.408(f), inform the beneficiary of his or her right to request a fair hearing;

f) Allow the beneficiary to have a reasonable opportunity to present evidence and arguments of fact or law, in person and/or in writing, in accordance with the beneficiary's election;

g) Allow the beneficiary and/or his or her representative to examine the beneficiary's case file, including medical records, and any other documents or records considered before and during the appeal process, provided that there is no disclosure of the protected health information of any individual other than the beneficiary; and

h) Allow the beneficiary and/or his or her representative, or the legal representative of a deceased beneficiary's estate, to be included as parties to the appeal.

2) Pursuant to 42 CFR 438.420(a) and (b), the Contractor shall continue the beneficiary's benefits while an appeal is in process if all of the following conditions are met:

a) The appeal was filed on or before the later of the following: within 10 days of the Contractor mailing the notice of action; or the intended effective date of the Contractor's proposed action;

b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

c) The services were ordered by an authorized provider;

d) The authorization period has not expired; and

e) The beneficiary requests an extension of benefits.

3) Pursuant to 42 CFR 438.420(c), the Contractor shall continue the beneficiary's benefits while an appeal is pending until one of the following occurs:

a) The beneficiary withdraws the appeal;

b) The beneficiary does not request a State Fair Hearing with continuation of benefits within 10 days from the date the Contractor mails an adverse appeal decision;

c) A State Fair Hearing decision adverse to the beneficiary is made; or

d) The service authorization expires or authorization limits are met.

4) Pursuant to 42 CFR 438.408(e), the Contractor shall notify the beneficiary, and/or his or her representative, of the resolution of the appeal in writing. The notice shall contain:

a) The results of the appeal resolution process;

b) The date that the appeal decision was made;

c) If the appeal is not resolved wholly in favor of the beneficiary, the notice shall also contain:

i. Information regarding the beneficiary's right to a fair hearing and the procedure for filing for a fair hearing, if the beneficiary has not already requested a fair hearing on the issue involved in the appeal; and

ii. Information on the beneficiary's right to continue to receive benefits while the fair hearing is pending and how to request the continuation of benefits.

5) If the decision of the appeal resolution process reverses a decision to deny, limit or delay services, the Contractor shall promptly provide or arrange and pay for the services at issue in the appeal.

6) Pursuant to 42 CFR 438.420(d), the Contractor may recover the cost of the continued services furnished to the beneficiary while the appeal was pending if the final resolution of the appeal upholds the Contractor's action.

F. Expedited Appeal Process

As defined in 42 CFR 438.400, to the expedited appeal process shall be used when the Contractor determines or the beneficiary and/or the beneficiary's provider certifies that following the timeframe for an appeal as established in 42 CFR 438.408, would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

In addition to meeting the requirements of 42 CFR 438.410(a), 42 CFR 438.406(b), the Contractor shall ensure that its expedited appeal process, at a minimum:

1) Be used when the Contractor determines or the beneficiary and/or the beneficiary's provider certifies that taking the time for a standard appeal resolution could seriously jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function.

2) Pursuant to 42 CFR 438.402(b)(3), allow the beneficiary to file the request for an expedited appeal orally without requiring that the request be followed by a written appeal.

3) Pursuant to 42 CFR 438.410(b), ensure that punitive action is not taken against a beneficiary or a provider because they request an expedited appeal or support a beneficiary's request for an expedited appeal.

4) Pursuant to 42 CFR 438.406(b)(4), provide the beneficiary a reasonable opportunity to present evidence, allegations of fact or law, in person as well as in writing and inform the beneficiary of the limited time available for the presentation of evidence.

5) Pursuant to 42 CFR 438.408(b)(3), resolve an expedited appeal, and notify, as expeditiously as the enrollee's health condition requires, the affected parties in writing, no later than three working days after the Contractor receives the appeal. Pursuant to 42 CFR 438.408(c) this timeframe may be extended by up to 14 calendar days if the beneficiary requests an extension, or the Contractor determines that there is need for additional information and that the delay is in the beneficiary's interest. If the Contractor extends the timeframes, the Contractor shall, for any extension not requested by the beneficiary, notify the beneficiary of the extension and the reasons for the extension in writing. The written notice of the extension is not a Notice of Action as defined in 42 CFR 438.210.

6) Pursuant to 42 CFR 438.408(d)(2), provide a beneficiary with a written notice of the expedited appeal disposition and make reasonable efforts to provide oral notice to the beneficiary and/or his or her representative.

7) Pursuant to 42 CFR 438.410(c), if the Contractor denies a request for expedited appeal resolution:

   a) Transfer the expedited appeal request to the timeframe for appeal resolution Pursuant to 42 CFR 438.408(b)(2), that timeframe shall not be longer than 45 days from the day the Contractor receives the appeal with a possible 14 day extension under the circumstances outlined in 42 CFR 438.408(c).

   b) Make reasonable efforts to give the beneficiary and his or her representative prompt oral notice of the denial of the request for an expedited appeal and provide written notice within two calendar days of the date of the denial. The written notice of the denial of the request for an expedited appeal is not a Notice of Action as defined in 42 CFR 438.210.

   c) Pursuant to 42 CFR 438.408(a)-(b), the Contactor shall dispose of each grievance and resolve each appeal, and provide notice, as expeditiously as the beneficiary’s health condition requires, within DHCS established timeframes that shall not exceed 3 working days after the Contractor receives the appeal request.

G. Beneficiary Problem Resolution Processes Established by Providers

Nothing in 42 CFR 438.10, 438.400, 438.402, 438.406, and 438.408 precludes a provider other than the Contractor from establishing beneficiary problem resolution processes for beneficiaries receiving services from that provider. When such processes exist, the Contractor shall not require that beneficiaries use or exhaust the provider's

processes prior to using the Contractor's beneficiary problem resolution process, unless the following conditions have been met:

1) The Contractor delegates the responsibility for the beneficiary problem resolution process to the provider in writing, specifically outlining the provider's responsibility under the delegation;

2) The provider's beneficiary problem resolution process fully complies with this Section of the Intergovernmental Agreement, the relevant provisions of 42 CFR Subpart F, 438.400, and depending on processes delegated, 42 CFR 438.406, 42 CFR 438.408, and/or 42 CFR 438.410; and

3) No beneficiary is prevented from accessing the grievance, appeal or expedited appeal processes solely on the grounds that the grievance, appeal or expedited appeal was incorrectly filed with either the Contractor or the provider.

H. Fair Hearing

"Fair Hearing" means the State hearing provided to beneficiaries pursuant to Title 22, CCR, Sections 50951 and 50953. All fair hearings requested by beneficiaries shall comply with 42 CFR §§ 431.220(a)(5), 438.408(f), 438.414, and 438.10(g)(1).

1) If a beneficiary requests a State Fair Hearing, DHCS (not the Contractor) shall grant the request. The right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the beneficiary and provider by Contractor in its notice of decision or notice of action. Beneficiaries and providers shall also be informed of the following:

   a) A beneficiary may request a State Fair Hearing.

   b) The provider may request a State Fair Hearing only if DHCS permits the provider to act as the beneficiary's authorized representative.

   c) DHCS must permit the beneficiary to request a State Fair Hearing within a reasonable time period specified by DHCS, but not less than 20 or in excess of 90 days, from whichever of the following dates applies:

      i. From the date indicated on the Contractor's notice of action, if the beneficiary appeals directly to DHCS for a fair hearing.

      ii. From the date indicated on the Contractor's notice of resolution, if the beneficiary exhausts the Contractor-level appeals.

2) DHCS must reach its decisions within the specified timeframes:

   a) Standard resolution: within 90 days of the date the beneficiary filed the appeal with the Contractor, if the beneficiary filed initially with the Contractor (excluding the days the beneficiary took to subsequently file for a State Fair Hearing), or the date the beneficiary filed for direct access to a State Fair Hearing.

b) Expedited resolution:

i. If the appeal was heard first through the Contractor appeal process DHCS shall reach a decision within 3 working days from agency receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process but was not resolved using the Contractor's expedited appeal timeframes, or

ii. Was resolved wholly or partially adversely to the beneficiary using the Contractor's expedited appeal timeframes.

iii. If the appeal was made directly to the State Fair Hearing process without accessing the Contractor's appeal process, DHCS shall reach a decision as expeditiously as the beneficiary's health condition requires, but no later than 3 working days from state receipt of a hearing request for a denial of a service that meets the criteria for an expedited resolution.

3) Pursuant to 42 CFR 438.408(f)(2), the parties to the State Fair Hearing include the Contractor as well as the beneficiary and his or her representative or the representative of a deceased beneficiary's estate.

I. Expedited Fair Hearing

As described in 42 CFR 438.410(a), an expedited fair hearing shall be used when the Contractor determines, or the beneficiary and/or the beneficiary's provider certifies, that the following the timeframe for a fair hearing as established in 42 CFR 431.244(f)(1) would seriously jeopardize the beneficiary's life, health, or ability to attain, maintain, or regain maximum function.

J. Continuation of Services Pending Fair Hearing Decision

1) A beneficiary receiving SUD treatment services shall have a right to file for continuation of SUD treatment services pending the outcome of a fair hearing pursuant to 42 CFR 438.420, and Cal. Code Regs., Title 22., § 51014.2.

2) The Contractor shall continue to provide SUD treatment services pending the outcome of a fair hearing in accordance with 42 CFR 438.420(c) and Cal. Code Regs., Title 22, § 51014.2. If the Contractor allows providers to deliver SUD treatment services for a set number of visits or a set duration of time without prior authorization, the Contractor shall continue to provide SUD treatment services pending the outcome of a fair hearing when the Contractor denies a payment authorization request from a provider requesting continuation of services beyond the number or duration permitted without prior authorization and the beneficiary files a timely request for fair hearing.

3) If the beneficiary utilizes the Contractor's problem resolution processes, that process shall be conducted as described in this Exhibit A, Attachment I (18)(B)(C), and (D), and in 42 CFR 438.400.

K. Provision of Notice of Action

1) Consistent with 42 CFR 438.400(b), 42 CFR 438.52, and 42 CFR 438.56 “Action,” in the case of a contractor, means:

   a) A denial, modification, reduction or termination of a provider's request for contractor payment authorization of a SUD treatment service covered by the contractor;

   b) A determination by the contractor or its providers that the medical necessity criteria in 42 CFR 438.210(a)(4), or for EPSDT, Title 22, Sections 51303 and51340.1 have not been met and the beneficiary is not entitled to any SUD treatment services from the Contractor;

   c) A failure by the Contractor to provide a SUD treatment service covered by the Contractor within the timeframe for delivery of the service established by the Contractor; or

   d) A failure by the Contractor to act within the timeframes for resolution of grievances, appeals, or the expedited appeals.

2) Pursuant to 42 CFR 438.404(a), the Notice of Action (NOA) shall be in writing and shall meet the language and format requirements of 42 CFR 438.10(c) and (d) as specified in Section 14 paragraphs (A) and (F) to ensure ease of understanding. The NOA shall contain the items specified in 42 CFR 438.404 (b).

3) The Contractor shall provide a beneficiary with an NOA when the Contractor denies or modifies a Contractor payment authorization request from a provider for a SUD treatment service to the beneficiary.

4) When the denial or modification involves a request from a provider for continued Contractor payment authorization of a SUD treatment service or when the Contractor reduces or terminates a previously approved Contractor payment authorization, notice shall be provided in accordance with Cal. Code. Regs., Title 22, § 51014.1.

5) A NOA is not required when a denial is a non-binding verbal description to a provider of the SUD treatment services that may be approved by the Contractor.

6) A NOA is not required when the Contractor modifies the duration of any approved substance use disorder treatment services as long as the Contractor provides an opportunity for the provider to request Contractor payment authorization of additional SUD treatment services before the end of the approved duration of services.

7) Except as provided in subsection 6 below, a NOA is not required when the denial or modification is a denial or modification of a request for Contractor payment authorization for a SUD treatment service that has already been provided to the beneficiary.

8) A NOA is required when the Contractor denies or modifies a payment authorization request from a provider for a SUD treatment service that has already been provided to the beneficiary when the denial or modification is a result of post-service, prepayment determination by the Contractor that the service was not medically necessary or otherwise was not a service covered by the Contractor.

9) The Contractor shall deny the Contractor payment authorization request and provide the beneficiary with a NOA when the Contractor does not have sufficient information to approve or modify, or deny on the merits, a Contractor payment authorization request from a provider within the timeframes required by 42 CFR 438.404(c)(5).

10) The Contractor shall provide the beneficiary with a NOA if the Contractor fails to notify the affected parties of a grievance decision within 60 calendar days, of an appeal decision within 45 days, or of an expedited appeal decision within three working days. If the timeframe for a grievance, appeal or expedited appeal decision is extended pursuant to 42 CFR 438.408, 42 CFR 438.410(a), or 42 CFR 438.406(b)(2) and the Contractor failed to notify the affected parties of its decision within the extension period; the Contractor shall provide the beneficiary with a NOA.

11) The Contractor shall provide a beneficiary with a NOA if the Contractor fails to provide a SUD treatment service covered by the Contractor within the timeframe for delivery of the service established by the Contractor.

12) The Contractor shall comply with the requirements of 42 CFR 438.404(b), regarding the content of NOAs and with the following timeframes for mailing of NOAs:

    a) The written NOA issued pursuant to (1) or (6) above shall be deposited with the United States Postal Service in time for pick-up no later than the third working day after the action. A Notice of Action issued pursuant to (2) above shall be provided in accordance with the applicable timelines set forth in Cal. Code Regs., Title 22, § 51014.1.

    b) The written NOA issued pursuant to (7) or (8) above shall be deposited with the United States Postal Service in time for pick-up on the date that the applicable timeframe expires.

    c) The written NOA issued pursuant to subsection (9) above shall be deposited with the United States Postal Service in time for pick up on the date that the timeframe for delivery of the service established by the Contractor expires.

13) When a NOA would not be required as described in (3)-(5) above, the Contractor shall provide a beneficiary with a NOA when the Contractor or its providers determine that the medical necessity criteria in 42 CFR 438.210(a)(4) or in Title 22, Sections 51303 and 51340.1 have not been met and that the beneficiary is not entitled to any SUD treatment services from the Contractor. A NOA is not required when a provider, including the Contractor acting as a provider, determines that a beneficiary does not qualify for a specific service covered by the Contractor, including but not limited to: crisis intervention, crisis stabilization, crisis residential treatment services, or any SUD treatment service to treat a beneficiary's urgent condition, provided that the determination does not apply to any other SUD

treatment service covered by the Contractor. The NOA shall, at the election of the Contractor, be hand-delivered to the beneficiary on the date of the action or mailed to the beneficiary in accordance with 42 CFR 438.404.

14) For the purpose of this Section, each reference to a Medi-Cal managed care plan in Cal. Code Regs., Title 22, § 51014.1, shall mean the Contractor.

15) For the purposes of this Section, “medical service”, as used in Cal. Code Regs., Title 22, § 51014.1, shall mean SUD residential treatment services that are subject to prior authorization by a Contractor pursuant to 42 CFR 438.210.

16) The Contractor shall retain copies of all Notices of Action issued to beneficiaries under this Section in a centralized file accessible to DHCS.

L. Contents of a NOA

1) The NOA issued in writing pursuant to Section I of this Intergovernmental Agreement and 42 CFR 438.404(b), shall contain the following information:

a) The action taken or intends to take by the Contractor;

b) The reason for the action taken;

c) Citations to the regulations or Contractor payment authorization procedures supporting the action;

d) The beneficiary's or the provider's right to file an appeal or expedited appeal with the Contractor;

e) The procedures for exercising the rights specified in this paragraph;

f) Beneficiary’s rights to continue benefits are pursuant to subsection C, paragraph 7 of this section;

g) The circumstances under which an expedited resolution is available, and how to request it; and,

h) Information about the beneficiary's right to request a state fair hearing or an expedited fair hearing, including:

i. The method by which a hearing may be obtained;

ii. A statement that the beneficiary may be either self-represented, or represented by an authorized third party such as legal counsel, a relative, friend or any other person;

iii. An explanation of the circumstances under which a SUD treatment service shall be continued if a fair hearing is requested; and,

iv. The time limits for requesting a fair hearing or an expedited fair hearing.

2) A NOA issued pursuant to 42 CFR 438.404, relating to denials for lack of medical necessity, shall specify the following:

   a) The reason that the medical necessity criteria were not met, including a citation to the applicable regulation;

   b) The beneficiary's options for obtaining care from sources other than the Contractor, if applicable;

   c) The beneficiary's right to request a second opinion on the determination;

   d) The beneficiary's right to file an appeal or expedited appeal with the Contractor; and,

   e) The beneficiary's right to request a fair hearing or an expedited fair hearing, including:

      i. The method by which a hearing may be obtained;

      ii. The time period in which the request for a fair hearing or expedited fair hearing must be filed; and,

      iii. That the beneficiary may be either self–represented, or represented by an authorized third party such as legal counsel, a relative, friend or any other person;

M. Consistent with 42 CFR 438.404(c), the Contractor shall give notice at least 10 days before the effective date of action when the action is a termination, suspension, or reduction of previously authorized Medi-Cal-covered services, except:

   1) The period of advanced notice is shortened to 5 days if:

      a. The agency has facts indicating that action should be taken because of probable fraud by the beneficiary.

   2) The Contractor shall give notice of adverse action by the date of the action when any of the following occur:

      a) The death of a beneficiary;

      b) Receipt of a signed written beneficiary statement requesting service termination or giving information requiring termination or reduction of services (provided the beneficiary understands that this shall be the result of supplying that information);

      c) The beneficiary's admission to an institution where he or she is ineligible for further services;

      d) The beneficiary's whereabouts are unknown and mail directed to him or her has

no forwarding address;

e) Notice that the beneficiary has been accepted for Medicaid services by another local jurisdiction;

f) A change in the beneficiary's physician's prescription for the level of medical care; or

g) Endangerment of the safety or health of individuals in the facility; improvement in the resident's health sufficient to allow a more immediate transfer or discharge; urgent medical needs that require a resident's immediate transfer or discharge; or notice that a resident has not resided in the nursing facility (NF) for 30 days (but only in adverse actions based on NF transfers).

3) If payment is denied, the Contractor shall give notice to the beneficiary on the date of the action.

N. Pursuant to 42 CFR 438.416, the Contractor is required to submit to DHCS a report that summarizes beneficiary grievances, appeals and expedited appeals filed from July 1 of the previous year through June 30 of that year by October 1 of each year. The report shall include the total number of grievances, appeals and expedited appeals by type, by subject areas established by DHCS, and by disposition.

O. Effectuation of reversed appeal resolutions.

1) If the Contractor or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires (42 CFR 438.424(a)).

2) If the Contractor or the State fair hearing officer reverses a decision to deny authorization of services, and the beneficiary received the disputed services while the appeal was pending, the Contractor shall pay for those services, in accordance with State policy and regulations (42 CFR 438.424(b)).

19. Subcontracts

A. The Contractor shall ensure that all of its subcontract requires that the Contractor oversees and is held accountable for any functions and responsibilities that it delegates to any subcontractor consistent with 42 CFR 438.6(l); 42 CFR 438.230(a); 42 CFR 438.230(b)(1), (2), (3), including:

1) All subcontracts must fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract.

2) Each Intergovernmental Agreement must ensure that the Contractor evaluates the prospective subcontractor's ability to perform the activities to be delegated.

3) The Intergovernmental Agreement must require a written agreement between the Contractor and the subcontractor that specifies the activities and report

responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.

4) Each Intergovernmental Agreement must ensure that the Contractor monitor the subcontractor's performance on an ongoing basis and subject it to an annual onsite review, consistent with statutes and regulations.

5) Each Intergovernmental Agreement must ensure that the Contractor identifies deficiencies or areas for improvement, the subcontractor must take corrective actions and the Contractor shall ensure that the subcontractor implements these corrective actions.

B. Contractor shall include the following provider requirements in their subcontracts with providers:

1) Culturally Competent Services: Providers are responsible to provide culturally competent services. Providers must ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to- day operations. Translation services must be available for beneficiaries, as needed.

2) Medication Assisted Treatment: Providers will have procedures for linkage/integration for beneficiaries requiring medication assisted treatment. Provider staff will regularly communicate with physicians of beneficiaries who are prescribed these medications unless the beneficiary refuses to consent to sign a 42 CFR part 2 compliant release of information for this purpose.

3) Evidenced Based Practices: Providers will implement at least two of the following evidenced based treatment practices (EBPs) based on the timeline established in the county implementation plan. The two EBPs are per provider per service modality. Counties will ensure the providers have implemented EBPs. The State will monitor the implementation of EBP's during reviews. The required EBP include:

a) Motivational Interviewing: A beneficiary-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on beneficiaries' past successes.

b) Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.

c) Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.

d) Trauma-Informed Treatment: Services must take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.

e) Psycho-Education: Psycho-educational groups are designed to educate beneficiaries about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries' lives; to instill self- awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

C. Subcontractor Documentation

The Contractor shall require its subcontractors that are not licensed or certified by DHCS to submit organizational documents to DHCS within thirty (30) days of execution of an initial subcontract, within ninety (90) days of the renewal or continuation of an existing subcontract or when there has been a change in subcontractor name or ownership. Organizational documents shall include the subcontractor's Articles of Incorporation or Partnership Agreements (as applicable), and business licenses, fictitious name permits, and such other information and documentation as may be requested by DHCS.

20. Program Integrity Requirements

A. The Contractor shall comply with state and federal law and regulations, including, but not limited to, 42 CFR 433.32, 42 CFR 433.51, 42 CFR 431.800 et. seq., 42 CFR 440.230, 42 CFR 440.260, 42 CFR 455 et. seq., 42 CFR 456 et. seq., 42 CFR 456.23, 22 CCR 51490, 22 CCR 51490.1, 22 CCR 51341.1, 22 CCR 51159, WIC 14124.1, and WIC 14124.2; 42 CFR 438.600, 42 CFR 438.602, 42 CFR 438.608.

B. The Contractor shall comply with the provisions of 42 CFR 438.600(a), (b), and (c), 438.604, 438.606 and 438.608, regarding the certification of accurate data submitted by the Contractor to DHCS and which require the Contractor to have administrative or management arrangements or procedures and a mandatory compliance plan designed to guard against fraud and abuse.

1) The management arrangements or procedures shall include:

a) Written policies and procedures and standards of conduct that articulate the Contractor's commitment to comply with all applicable federal and State standards;

b) The designation of a compliance officer and a compliance committee that are accountable to senior management;

c) Effective training and education for the compliance officer, the Contractor's employees and all subcontractor;

d) Effective lines of communication between the compliance officer and the Contractor's employees and subcontractor;

e) Enforcement of standards through well publicized disciplinary guidelines;

f) Provision for internal and subcontractor monitoring and auditing; and

g) Provision for prompt response to detected offenses and for development of corrective action initiatives relating to this Agreement and any subcontracts relating to this Agreement,

i. The Contractor's shall provide the following data certified by the Contractor's Chief Executive Officer, Chief Financial Officer or an individual who has delegated authority to sign for and reports directly to the CEO or CFO:

a. Enrollment information;

b. Encounter data;

c. Other information required by DHCS and contained in Intergovernmental Agreements, proposals and related documents for purposes of developing MCE payments; and

d. The certification of this information must attest, based on best knowledge, information and belief as follows:

(i) To the accuracy, completeness and truthfulness of the data;

(ii) To the accuracy, completeness and truthfulness of the documents specified by DHCS; and

(iii) The certification must be submitted concurrently with the certified data.

C. The Contractor shall comply with the provisions of 42 CFR 438.610:

1) The Contractor may not knowingly have a relationship of the type described in paragraph (2)(i) of this section with the following:

i. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

ii. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described in paragraph (1)(i) of this section.

2) Specific requirements. The relationships described in this paragraph are as follow:

i. A director, officer, or partner of the Contractor.

ii. A person with beneficial ownership of five percent or more of the Contractor's equity.

iii. A person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under its Intergovernmental Agreement with the State.

3) Effect of Noncompliance. If a DHCS finds that a Contractor is not in compliance with paragraphs (1) and (2) of this section, DHCS:

i. Must notify the Secretary of the noncompliance.

ii. May continue an existing agreement with the Contractor unless the Secretary directs otherwise.

iii. May not renew or otherwise extend the duration of an existing agreement with the Contractor unless the Secretary provides to DHCS and to Congress a written statement describing compelling reasons that exist for renewing or extending the agreement.

4) Consultation with the Inspector General. Any action by the Secretary described in paragraphs (3)(ii) or (3)(iii) of this section is taken in consultation with the Inspector General.

D. Pursuant to 42 CFR 438.214(d), the Contractor shall not employ or contract with providers or other individuals and entities excluded from participation in federal health care programs (as defined in section 1128B(f) of the Social Security Act) under either Section 1128, 1128A, or 1156 of the Social Security Act. FFP is not available for amounts expended for providers excluded by Medicare, Medicaid, or the State Children's Health Insurance Program, except for emergency services. DHCS shall submit, as part of its waiver request, assurance that the entities described in paragraph (D)(2) of this section will be excluded from participation under an approved waiver.

1) FFP is available in payments to an entity that furnishes services under a section 1915(b)(1) waiver only if the agency excludes from participation any entity described in paragraph (D)(2) of this section.

2) Entities that must be excluded. DHCS shall exclude an entity that meets any of the following conditions:

a) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual.

b) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes, as described in section 1128(b)(8)(B) of the Act.

c) Employs or contracts directly or indirectly with one of the following:

i. Any individual or entity that, under section 1128 or section 1128A of the Act, is precluded from furnishing health care, utilization review, medical

social services, or administrative services.

ii. Any entity described in paragraph (D)(2)(a) of this section.

E. The Contractor shall periodically check the Office of the Inspector General's List of Excluded Individuals/Entities and the Medi-Cal Suspended and Ineligible Provider List (S & I List) to prevent employment of, or payments to, any individuals or entities on those lists, this must be satisfied prior to Medi-Cal certification of any individual or organizational provider. If the provider is listed on either the Office of the Inspector General's List of Excluded Individuals/Entities or the Medi-Cal S & I List, the Contractor shall not certify or pay any provider with Medi-Cal funds, and any such inappropriate payments or overpayments may be subject to recovery and/or be the basis for other sanctions by the appropriate authority.

F. Report. Pursuant to 42 CFR 455.1(a)(1), the Contractor must report fraud and abuse information to DHCS.

1) If the Contractor identifies an issue or receives notification of a complaint concerning an incident of possible potential fraud or abuse, the Contractor shall conduct an internal investigation to determine the validity of the issue/complaint, regarding potential fraud and/or abuse, and develop and implement corrective action, if needed. The majority of potential fraud or abuse issues are expected to be resolved at the Contractor level.

2) If the Contractor's internal investigation concludes that fraud or abuse has occurred or is suspected, the issue is egregious, or beyond the scope of the Contractor's ability to pursue, the Contractor shall report the issue to DHCS for review and disposition.

3) DHCS is to be notified if the Contractor discontinues a provider contract or disciplines a provider due to a fraud or abuse issue.

G. Service Verification. To assist DHCS in meeting its obligation under 42 CFR 455.1(a)(2), the Contractor shall have a way to verify whether services were actually furnished to beneficiaries.

H. DMC Claims and Reports

Contractor or providers that bill DHCS or the Contractor for services identified in Section 51516.1 of Title 22 shall submit claims in accordance with DHCS's DMC Provider Billing Manual.

Contractor and subcontractors that provide DMC services shall be responsible for verifying the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for DMC services to that beneficiary for that month. Medi-Cal eligibility verification should be performed prior to rendering service, in accordance with and as described in the DHCS's DMC Provider Billing Manual. Options for verifying the eligibility of a Medi-Cal beneficiary are described in the DHCS's DMC Provider Billing Manual.

Claims for DMC reimbursement shall include DMC-ODS services covered under the 1115 terms and conditions, and any State Plan services covered under Title 22, Section 51341.1(c-d) and administrative charges that are allowed under W&I Code, Sections 14132.44 and 14132.47.

1) Contractor shall submit to DHCS the "Certified Expenditure" form reflecting either: 1) the approved amount of the 837P claim file, after the claims have been adjudicated; or 2) the claimed amount identified on the 837P claim file, which could account for both approved and denied claims. Contractor shall submit to DHCS the Drug Medi-Cal Certification Form DHCS 100224A (Document 4D) for each 837P transaction approved for reimbursement of the federal Medicaid funds.

2) DMC service claims shall be submitted electronically in a Health Insurance Portability and Accountability Act (HIPAA) compliant format (837P). All adjudicated claim information must be retrieved by the Contractor via an 835 HIPAA compliant format (Health Care Claim Payment/Advice).

3) The following forms shall be prepared as needed and retained by the provider for review by State staff:

   a) Good Cause Certification (6065A), Document 2L(a)

   b) Good Cause Certification (6065B), Document 2L(b)

   In the absence of good cause documented on the Good Cause Certification (6065A or 6065B) form, claims that are not submitted within 30 days of the end of the month of service shall be denied. The existence of good cause shall be determined by DHCS in accordance with Title 22, CCR, Sections 51008 and 51008.5.

4) Certified Public Expenditure County Administration

   Separate from direct service claims as identified in #2 above, the Contractor may submit an invoice for administrative costs for administering the DMC program on a quarterly basis. The form requesting reimbursement shall be submitted to DHCS.

5) Utilization Review and Quality Assurance

   If while completing the Utilization Review and Quality Assurance requirements of this Exhibit A, Attachment I, any of the Contractor's skilled professional medical and personnel directly supporting staff meet the criteria set forth in 42 CFR 432.50(d)(1), then the Contractor shall submit a written request that specifically demonstrates how the skilled professional medical personnel and directly supporting staff meet all of the applicable criteria set forth in 42 CFR 432.50(d)(1) and outlines the duties they shall perform to assist DHCS, or DHCS's skilled professional medical personnel, in activities that are directly related to the administration of the DMC Program. DHCS shall respond to the Contractor's written request within 20 days with either a written agreement pursuant to 42 CFR 432.50(d)(2) approving the request or a written explanation as to why DHCS does not agree that the Contractor's skilled professional medical personnel and directly supporting staff do not meet the criteria set forth in 42 CFR 432.50(d)(1).

21. Additional Requirements

A. Confidentiality Requirements

1) The Contractor shall ensure that each beneficiary's privacy is protected in accordance with all federal and state privacy laws, including but not limited to 45 CFR 160 and 164, 42 CFR 438.208(b)(4), and 42 CFR 438.224, to the extent that such provisions are applicable.

B. Sharing of Information with Beneficiaries

1) Sharing of Information with Beneficiaries. The Contractor shall not prohibit nor otherwise restrict, a licensed, or registered professional, who is acting within the lawful scope of practice (pursuant to 42 CFR. 438.102(a)(1) and Title 9, Section 13015), from advising or advocating on behalf of a beneficiary for whom the provider is providing SUD treatment services for any of the following:

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

b) Any information the beneficiary needs in order to decide among all relevant treatment options,

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

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

2) Pursuant to 42 CFR 438.102(a)(2), for a counseling or referral service that the Contractor does not cover because of moral or religious objections, the Contractor need not furnish information on how and where to obtain the service. Pursuant to 42 CFR 438.102(b)(1), the Contractor must provide information about the services it does not cover on moral or religious grounds. A Contractor that elects the option provided in paragraph (A)(2) of this section must furnish information about the services it does not cover as follows:

a) To DHCS:

i. With its application for a Medicaid Intergovernmental Agreement; and

ii. Whenever it adopts the policy during the term of the Intergovernmental Agreement.

b) Consistent with the provisions of §438.10:

i. To potential enrollees, before and during enrollment; and

ii. To enrollees, within 90 days after adopting the policy with respect to any particular service. (Although this timeframe would be sufficient to entitle the Contractor to the option provided in paragraph (A)(2) of this section, the overriding rule in §438.10(f)(4) requires DHCS, its contracted representative, or the Contractor to furnish the information at least 30 days before the effective date of the policy.)

3) Information requirements: State responsibility. For each service excluded by the Contractor under paragraph (a)(2) of this section, DHCS must provide information on how and where to obtain the service, as specified in 438.10, paragraphs (e)(2)(ii)(E) and (f)(6)(xii).

4) Notice of provider termination. Pursuant to 42 CFR 438.10(f)(5) the Contractor must make a good faith effort to give written notice of termination of a contracted provider, within 15 days after receipt or issuance of the termination notice, to each beneficiary who received his or her SUD treatment services from, or was seen on a regular basis by, the terminated provider.

   a) When one of the Contractor's subcontracted SUD service providers is terminated, the Contractor shall transfer all of its beneficiaries to another SUD service provider.

5) Pursuant to 42 CFR 438.100, the Contractor shall have written policies and procedures in place for beneficiaries to request and receive copies of their medical records, and to request that they be amended or corrected.

C. Health Information System

Pursuant to 42 CFR 438.242, the Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas including, but not limited to, utilization, grievances, disenrollments, and appeals.

1) The Contractor's health information system shall, at a minimum:

   a) Collect data on beneficiary and provider characteristics as specified by DHCS, and on services furnished to beneficiaries as specified by DHCS in the Cal OMS Data Collection Guide (attached as Document 3J); http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf

   b) Ensure that data received from providers is accurate and complete by:

      i. Verifying the accuracy and timeliness of reported data;

      ii. Screening the data for completeness, logic, and consistency; and

      iii. Collecting service information in standardized formats to the extent feasible and appropriate.

c) Make all collected data available to DHCS and, upon request, to CMS.

D. Share of Cost

1) Share of Cost. Pursuant to 42 CFR 438.108, any sharing of cost imposed on DMC beneficiaries shall be in accordance with 42 CFR 447.50 through 447.60.

E. Physician Incentive Plans

1) The Contractor shall obtain approval from DHCS prior to implementing a Physician Incentive Plan. A Physician Incentive Plan is any compensation arrangement to pay a physician or physician group that may directly or indirectly have the effect of reducing or limiting the services provided to any beneficiary. For purposes of this definition, the words shall have the meanings set forth in 42 CFR 422.208(a). DHCS shall approve the Contractor's request only if the proposed Physician Incentive Plan complies with all applicable federal and state regulations.

a) Pursuant to 42 CFR 438.6(h), the Contractor shall comply with the requirements set forth in 42 CFR §§ 422.208 and 422.210.

b) The Contractor may operate a Physician Incentive Plan only if no specific payment can be made directly or indirectly under a Physician Incentive Plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

c) When seeking approval from DHCS for its Physician Incentive Plan, the Contractor shall disclose the following:

i. Whether services not furnished by physician/group are covered by incentive plan. No further disclosure required if the Physician Incentive Plan does not cover services not furnished by physician/group;

ii. The type of incentive arrangement, e.g. withhold, bonus, capitation;

iii. The percentage of funds withheld or bonus provided (if applicable);

iv. The size of the panel, and, if patients are pooled, the approved method used for pooling; and

v. If the physician/group is at substantial financial risk, proof that the physician/group has adequate stop loss coverage, including amount and type of stop-loss.

d) If a physician or physician group is put at substantial financial risk for services not provided by the physician/group, the Contractor shall ensure adequate stop-loss protection to individual physicians and conduct annual beneficiary surveys.

e) The Contractor shall provide information on its Physician Incentive Plan to any Medicaid beneficiary upon request (this includes the right to adequate and timely information on a Physician Incentive Plan).

f) If required to conduct beneficiary survey, survey results shall be disclosed to DHCS and, upon request, to beneficiaries, per the Social Security Act (SSA) 1903(m)(2)(A)(x); 42 CFR §§ 422.208; 422.210;438.6(h); and SSA 1876(i)(8)(A)(ii)(II).

22. Quality Management (QM) Program

A. The Contractor's QM Program shall improve Contractor's established treatment outcomes through structural and operational processes and activities that are consistent with current standards of practice.

B. The Contractor shall have a written description of the QM Program which clearly defines the QM Program's structure and elements, assigns responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement.

C. Annually, each Contractor must:

1) Measure and report to DHCS its performance using standard measures required by DHCS including those that incorporate the requirements of section 438.204(c) and 438.240(a)(2);

2) Submit to DHCS data specified by DHCS that enables DHCS to measure the Contractor's performance; or

3) Perform a combination of the activities described above.

D. The QM Program shall be evaluated annually and updated by the Contractor as necessary per 42 CFR 438.240(e).

E. Triennial Review

1) During the triennial reviews, DHCS shall review the status of the Quality Improvement Plan and the Contractor's monitoring activities.

a) This review shall include the counties service delivery system, beneficiary protections, access to services, authorization for services, compliance with regulatory and contractual requirements of the waiver, and a beneficiary records review.

b) This triennial review shall provide DHCS with information as to whether the counties are complying with their responsibility to monitor their service delivery capacity.

c) The counties shall receive a final report summarizing the findings of the triennial review and if out of compliance, the Contractor must submit a plan of correction (POC) within 60 days of receipt of the final report. DHCS shall follow-up with the POC to ensure compliance.

F. The QM Program shall conduct performance monitoring activities throughout the Contractor's operations. These activities shall include, but not be limited to, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, and resolution of beneficiary grievances.

G. The Contractor shall ensure continuity and coordination of care with physical health care providers. The Contractor shall coordinate with other human services agencies used by its beneficiaries. The Contractor shall assess the effectiveness of any MOU with a physical health care plan.

H. The Contractor shall have mechanisms to detect both underutilization of services and overutilization of services, as required by 42 CFR 438.240(b)(3).

I. The Contractor shall implement mechanisms to assess beneficiary/family satisfaction. The Contractor shall assess beneficiary/family satisfaction by:

1) Surveying beneficiary/family satisfaction with the Contractor's services at least annually;

2) Evaluating beneficiary grievances, appeals and fair hearings at least annually;

3) Evaluating requests to change persons providing services at least annually; and

4) The Contractor shall inform providers of the results of beneficiary/family satisfaction activities.

J. The Contractor shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. Monitoring shall occur at least annually.

K. The Contractor shall implement mechanisms to address meaningful clinical issues affecting beneficiaries system-wide.

L. The Contractor shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The Contractor shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the Contractor at least annually.

M. The Contractor shall have a QM Work Plan covering the current Intergovernmental Agreement cycle with documented annual evaluations and documented revisions as needed. The Contractor's QM Work Plan shall evaluate the impact and effectiveness of its quality assessment and performance improvement program. The QM Work Plan shall include:

1) Evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by 42 CFR 438.240 and 42 CFR 438.416;

2) Evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service;

3) A description of completed and in-process QM activities, including performance improvement projects. The description shall include:

   a) Monitoring efforts for previously identified issues, including tracking issues over time;

   b) Objectives, scope, and planned QM activities for each year; and

   c) Targeted areas of improvement or change in service delivery or program design.

4) A description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area. This shall include goals for responsiveness for the Contractor's 24-hour toll-free telephone number, timeliness for scheduling of routine appointments, timeliness of services for urgent conditions, and access to after-hours care; and

5) Evidence of compliance with the requirements for cultural competence and linguistic competence specified in 42 CFR 438.10 and 42 CFR 438.206.

23. State Monitoring

A. DHCS Monitoring Reviews and Financial Audits of Contractor

DHCS shall monitor the Contractor's operations for compliance with the provisions of this Intergovernmental Agreement and applicable federal and state law and regulations, including 42 CFR 438.66, 42 CFR 438.200, 42 CFR 438.202, 42 CFR 438.204, and 42 CFR 438.6(g). Such monitoring activities shall include, but not be limited to, inspection and auditing of Contractor services, management systems and procedures, and books and records, as DHCS deems appropriate, at any time during the Contractor's or facility's normal business hours. When monitoring activities identify areas of non-compliance, DHCS shall issue reports to the Contractor detailing findings, recommendations, and corrective action. DHCS shall specifically monitor the following in accordance with 42 CFR 438.66:

1) Beneficiary enrollment and disenrollment

2) Processing of grievances and appeals

3) Violations subject to intermediate sanctions

4) Violations of the conditions for FFP

5) All other provisions of the Agreement, as appropriate.

B. DHCS Imposition of Sanctions Upon the Contractor

1) Pursuant to 42 CFR 438.700, DHCS may impose sanctions upon the Contractor if

DCHS makes any of the following determinations:

a) The Contractor acted or failed to act as follows:

i. Fails substantially to provide medically necessary services that the Contractor is required to provide, under law or under its Intergovernmental Agreement with DHCS, to a beneficiary covered under the Intergovernmental Agreement.

ii. Imposes on beneficiaries premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.

iii. Acts to discriminate among beneficiaries on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.

iv. Misrepresents or falsifies information that it furnishes to CMS or to DHCS.

v. Misrepresents or falsifies information that it furnishes to a beneficiary, potential beneficiary, or health care provider.

2) DHCS may base its determinations of violations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

3) The types of intermediate sanctions that DHCS may impose upon the Contractor the above listed violations include the following:

a) Civil money penalties in the amounts specified in 42 CFR §438.704.

b) Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until CMS or DHCS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

4) DHCS retains authority to impose additional sanctions under State statutes or State regulations that address areas of noncompliance specified in 42 CFR §438.700, as well as additional areas of noncompliance. Nothing in this subsection prevents DHCS from exercising that authority.

C. Postservice Postpayment Utilization Reviews

1) After the DMC services have been rendered and paid, DHCS shall conduct Postservice Postpayment (PSPP) Utilization Reviews of the subcontracted DMC providers to determine whether the DMC services were provided in accordance with Title 22, Section 51341.1. DHCS shall issue the PSPP report to the Contractor with a copy to subcontracted DMC provider. The Contractor shall be responsible for their subcontracted providers and their Contractor-run programs to ensure any deficiencies are remediated pursuant to Sections 1 and 2 herein. The Contractor

shall attest the deficiencies have been remediated and are complete, pursuant to Section 23.1 (E).

2) State shall take appropriate steps in accordance with Title 22, CCR, Section 51341.1 to recover payments made if subsequent investigation uncovers evidence that the claim(s) should not have been paid or that DMC services have been improperly utilized, and/or shall take the corrective action as appropriate. If programmatic or fiscal deficiencies are identified, the Provider shall be required to submit a Corrective Action Plan (CAP) to the Contractor for review and approval prior to submission to DHCS for final approval.

   a) Pursuant to CCR, Title 22, Section 51341.1(o), all deficiencies identified by the PSPP-review, whether or not a recovery of funds results, must be corrected and the entity that provided the services must submit a Contractor-approved CAP to the PSPP Unit within 60 days of the date of the PSPP report.

      i. The plan shall:

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

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

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

         d. Identify who will be responsible for correction and who will be responsible for on-going compliance.

      ii. DHCS shall provide written approval of the CAP to the Contractor with a copy to the Provider. If DHCS does not approve the CAP, DHCS shall provide guidance on the deficient areas and request an updated CAP from the Contractor with a copy to the Provider. The entity that provided the services must submit an updated CAP to the DMC PSPP Unit within 30 days of notification.

      iii. If the entity that provided the services, does not submit a CAP, or, does not implement the approved CAP provisions within the designated timeline, then DHCS may withhold funds from the Contractor until the entity that provided the services is in compliance with Exhibit A, Attachment I, Section 23.1 (E). DHCS shall inform the Contractor when funds shall be withheld.

3) Contractor and/or subcontractor may appeal DMC dispositions concerning demands for recovery of payment and/or programmatic deficiencies of specific claims. Such appeals shall be handled pursuant to Title 22, CCR, Section 51341.1(q). This section shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of DHCS pursuant to Exhibit B, Part II, Section 3, of this Contract.

4) State shall monitor the subcontractor's compliance with PSPP utilization review requirements in accordance with Title 22. Counties are also required to monitor of the subcontractor's compliance pursuant to Section 23 (C), of this Intergovernmental Agreement. The federal government may also review the existence and effectiveness of DHCS's utilization review system.

5) Contractor shall implement and maintain compliance with the system of review described in Title 22, Section 51341.1, for the purposes of reviewing the utilization, quality, and appropriateness of covered services and ensuring that all applicable Medi-Cal requirements are met.

6) Contractor shall assure that subcontractor sites must keep a record of the beneficiaries/patients being treated at that location. Contractor shall retain beneficiary records for a minimum of three (3) years from the date of the last face-to-face contact. When an audit by the Federal Government or DHCS has been started before the expiration of the three-year period, the beneficiary records shall be maintained until completion of the audit and the final resolution of all issues as a result of the audit.

23.1 Contractor Monitoring

A. EQRO Monitoring Plan: Beginning in Intergovernmental Agreement year two, DHCS shall monitor the counties at least once per year through the External Quality Review Organizations (EQRO) pursuant to 42 CFR 438.350:

1) Except as provided in §438.362, a qualified EQRO performs an annual EQR for each contracting MCO or PIHP;

2) The EQRO has sufficient information to use in performing the review;

a) The contractor shall make the following data elements available, including but not limited to;

i. Number of days to first DMC-ODS service at appropriate level of care after referral;

ii. Existence of a 24/7 telephone access line with prevalent non-English language(s);

iii. Access to DMC-ODS services with translation services in the prevalent non-English language(s); and

iv. Number, percentage of denied and time period of authorization requests approved or denied.

3) The information used to carry out the review must be obtained from the EQR-related activities described in §438.358.

a) A detailed technical report that describes the manner in which the data from all activities conducted in accordance with § 438.358 were aggregated and

analyzed, and conclusions were drawn as to the quality, timeliness, and access to the care furnished by the MCO or PIHP. The report must also include the following for each activity conducted in accordance with § 438.358:

i. Objectives.

ii. Technical methods of data collection and analysis.

iii. Description of data obtained.

iv. Conclusions drawn from the data.

b) An assessment of each PIHP's strengths and weaknesses with respect to the quality, timeliness, and access to health care services furnished to Medicaid beneficiaries.

c) Recommendations for improving the quality of health care services furnished by each PIHP.

d) As the State determines, methodologically appropriate, comparative information about all PIHPs.

e) An assessment of the degree to which each PIHP has addressed effectively the recommendations for quality improvement made by the EQRO during the previous year's EQR.

4) The information provided to the EQRO in accordance with paragraph (c) of this section is obtained through methods consistent with the protocols established under §438.352; and

5) The results of the reviews are made available as specified in §438.364(a)(1)(i) through (a)(1)(iv).

B. Contractor shall conduct, at least annually, a utilization review of DMC providers to assure covered services are being appropriately rendered. The annual review must include an on-site visit of the service provider. Reports of the annual review shall be provided to DHCS's Performance Management Branch at:

Substance Use Disorder – Program, Policy, and Fiscal Division
Performance Management Branch
Department of Health Care Services
PO Box 997413, MS-2621
Sacramento, CA 95899-7413;

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

Review reports shall be provided to DHCS within 2 weeks of completion by the Contractor.

Technical assistance is available to counties from DHCS SUD PPFD.

C. If significant deficiencies or significant evidence of noncompliance with the terms of the DMC-ODS waiver, or this Agreement are found in a county, DHCS shall engage the Contractor to determine if their challenges that can be addressed with facilitation and technical assistance. If the Contractor remains noncompliant, the Contractor shall submit a corrective action plan (CAP) to DHCS. The CAP must detail how and when the Contractor shall remedy the issue(s). DHCS may remove the Contractor from participating in the Waiver if the CAP is not promptly implemented.

   If the Contractor is removed from participating in the Waiver, the county must provide DMC services in accordance with the California Medi-Cal State Plan.

D. Contractor shall ensure that DATAR submissions, detailed in Section 23.2 (E) of this Intergovernmental Agreement are complied with by all treatment providers and subcontracted treatment providers. Contractor shall attest that each subcontracted provider is enrolled in DATAR at the time of execution of the subcontract.

E. Contractor must monitor and attest compliance and/or completion by Providers with CAP requirements (detailed in Section 23 (C)(2)(a)(i)) of this Exhibit as required by any PSPP review. Contractor shall attest to DHCS, using the form developed by DHCS that the requirements in the CAP have been completed by the Contractor and/or the Provider. Submission of DHCS Form 8049 by Contractor must be accomplished within the timeline specified in the approved CAP, as noticed by DHCS.

F. Contractor shall attest that DMC claims submitted to DHCS have been subject to review and verification process for accuracy and legitimacy. (45 CFR 430.30, 433.32, 433.51). Contractor shall not knowingly submit claims for services rendered to any beneficiary after the beneficiary's date of death, or from uncertified or decertified providers.

G. Contractor shall comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions as set forth in 42 CFR 434.6(a)(12) and 42 CFR 447.26.

   1) Contractor shall report all identified provider preventable conditions that are associated with claims for Medicaid payment or with courses of treatment furnished to Medicaid patients for which Medicaid payment would otherwise be available as specified by DHCS in accordance with 42 CFR 438.6(f)(2)(ii). The contractor must use and submit the report using the DHCS Drug Medi-Cal Organized Delivery System Provider Preventable Conditions (PPC) Reporting Form at the time of discovery of any provider preventable conditions that are covered under this provision to:

      Substance Use Disorder – Program, Policy, and Fiscal Division, Performance Management Branch
      Department of Health Care Services
      PO Box 997413, MS-2621
      Sacramento, CA 95899-7413;

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

23.2 Reporting Requirements

Contractor agrees that DHCS has the right to withhold payments until Contractor has submitted any required data and reports to DHCS, as identified in this Exhibit A, Attachment I or as identified in Document 1F(a), Reporting Requirement Matrix for Counties.

A. Contractor shall submit documentation to DHCS in a format specified by DHCS that complies with the following requirements:

1) Offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service area,

2) Maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of beneficiaries in the area,

3) Submits the documentation described in paragraph (B) of this section as specified by DHCS, but no less frequently than the following:

a) At the time it enters into an Intergovernmental Agreement with DHCS.

b) At any time there has been a significant change (as in the Contractor's operations that would affect adequate capacity and services, including:

i. Changes in Contractor services, benefits, geographic service area or payments; or

ii. Enrollment of a new population in the Contractor.

4) DHCS review and certification to CMS. After DHCS reviews the documentation submitted by the Contractor, DHCS must certify to CMS that the Contractor has complied with the State's requirements for availability of services, as set forth in §438.206.

5) CMS' right to inspect documentation. DHCS must make available to CMS, upon request, all documentation collected by DHCS from the Contractor.

B. California Outcomes Measurement for Prevention (CalOMS-Pv)

The CalOMS-Pv Business Rules and Requirements are:

1) Contractor and/or subcontractors receiving Substance Abuse Prevention and Treatment (SAPT) Primary Prevention Set-Aside funding shall input planning, service/activity and evaluation data into CalOMS Pv. When submitting data, Contractor shall comply with the CalOMS Pv Data Quality Standards (Document 1T).

2) Contractor shall report services/activities by the date of occurrence on an ongoing basis throughout each month. All data for each month must be input no later than the 10th day of the following month.

3) Contractor shall review all data input into CalOMS Pv on a quarterly basis. Contractor shall verify that the data meets the CalOMS Pv Data Quality Standards by reviewing and releasing the data. Certification is due by the last day of the month following the end of the quarter.

4) Contractor shall report progress to DHCS via CalOMS Pv for the goals and objectives in the County Strategic Prevention Plan (as described in Exhibit A, Attachment I, Section 27(B)(2) on an annual basis by September 30th of each fiscal year.

5) If Contractor cannot meet the established due dates, a written request for an extension shall be submitted to DHCS 10-days prior to the due date.

6) In order to ensure that all persons responsible for CalOMS Pv data entry have sufficient knowledge of the CalOMS Pv Data Quality Standards, all new CalOMS Pv users, whether employed by the Contractor or its subcontractors, shall participate in CalOMS Pv trainings prior to inputting data into the system.

C. California Outcomes Measurement System (CalOMS) for Treatment (CalOMS-Tx)

The CalOMS-Tx business rules and requirements are:

1) Contractor shall contract with a software vendor that complies with the CalOMS-Tx data collection system requirements for submission of CalOMS-Tx data. A Business Associate Agreement (BAA) shall be established between the Contractor and the software vendor. The BAA shall state that DHCS is allowed to return the processed CalOMS-Tx data to the vendor that supplied the data to DHCS.

2) Contractor shall conduct information technology (IT) systems testing and pass State certification testing before commencing submission of CalOMS-Tx data. If the Contractor subcontracts with vendor for IT services, Contractor is responsible for ensuring that the subcontracted IT system is tested and certified by the DHCS prior to submitting CalOMS-Tx data. If Contractor changes or modifies the CalOMS-Tx IT system, then Contractor shall re-test and pass state re-certification prior to submitting data from new or modified system.

3) Electronic submission of CalOMS-Tx data shall be submitted by Contractor within 45 days from the end of the last day of the report month.

4) Contractor shall comply with data collection and reporting requirements established by the DHCS CalOMS-Tx Data Collection Guide (Document 3J) and all former Department of Alcohol and Drug Programs Bulletins and DHCS Information Notices relevant to CalOMS-Tx data collection and reporting requirements.

5) Contractor shall submit CalOMS-Tx admission, discharge, annual update, resubmissions of records containing errors or in need of correction, and “provider no activity” report records in an electronic format approved by DHCS.

6) Contractor shall comply with the CalOMS-Tx Data Compliance Standards

established by DHCS identified in (Document 3S) for reporting data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method.

7) Contractor shall participate in CalOMS-Tx informational meetings, trainings, and conference calls.

8) Contractor shall implement and maintain a system for collecting and electronically submitting CalOMS-Tx data.

9) Contractor shall meet the requirements as identified in Exhibit G, Privacy and Information Security Provisions and Exhibit G, Attachment I – SSA Agreement.

D. CalOMS-Tx and CalOMS-Pv General Information

1) If the Contractor experiences system or service failure or other extraordinary circumstances that affect its ability to timely submit CalOMS-Tx and/or CalOMS-Pv data, and or meet other CalOMS-Tx and/or CalOMS-Pv compliance requirements, Contractor shall report the problem in writing before the established data submission deadlines. The written notice shall include a remediation plan that is subject to review and approval by DHCS. A grace period of up to sixty (60) days may be granted, at DHCS's sole discretion, for the Contractor to resolve the problem before non-DMC payments are withheld.

2) If DHCS experiences system or service failure, no penalties shall be assessed to the Contractor for late data submission.

3) Contractor shall comply with the treatment and prevention data quality standards established by DHCS. Failure to meet these standards on an ongoing basis may result in withholding non-DMC funds.

4) If the Contractor submits data after the established deadlines, due to a delay or problem, Contractor is still responsible for collecting and reporting data from time of delay or problem.

E. Drug and Alcohol Treatment Access Report (DATAR)

The DATAR business rules and requirements are:

1) The Contractor shall be responsible for ensuring that the Contractor-operated treatment services and all treatment providers with whom Contractor makes an Intergovernmental Agreement or otherwise pays for the services, submit a monthly DATAR report in an electronic copy format as provided by DHCS.

In those instances where the Contractor maintains, either directly or indirectly, a central intake unit or equivalent which provides intake services including a waiting list, the Contractor shall identify and begin submitting monthly DATAR reports for the central intake unit by a date to be specified by DHCS.

2) The Contractor shall ensure that all DATAR reports are submitted by either Contractor-operated treatment services and by each subcontracted treatment provider to DHCS by the 10th of the month following the report activity month.

3) The Contractor shall ensure that all applicable providers are enrolled in DHCS's web-based DATAR Web program for submission of data, accessible on the DHCS website when executing the subcontract.

4) If the Contractor or its subcontractor experiences system or service failure or other extraordinary circumstances that affect its ability to timely submit a monthly DATAR report, and/or to meet data compliance requirements, the Contractor shall report the problem in writing before the established data submission deadlines. The written notice shall include a corrective action plan that is subject to review and approval by DHCS. A grace period of up to sixty (60) days may be granted, at DHCS's sole discretion, for the Contractor to resolve the problem before non-DMC payments are withheld (See Exhibit B, Part II, Section 2).

5) If DHCS experiences system or service failure, no penalties shall be assessed to Contractor for late data submission.

6) The Contractor shall be considered compliant if a minimum of 95% of required DATAR reports from the Contractor's treatment providers are received by the due date.

F. Charitable Choice

Contractor shall document the total number of referrals necessitated by religious objection to other alternative substance abuse providers. The contractor shall annually submit this information to DHCS by October 1st. The annual submission shall contain all substantive information required by DHCS and be formatted in a manner prescribed by DHCS,

G. Quarterly Federal Financial Management Report (QFFMR)

The QFFMR must be submitted to reflect quarterly SAPTBG expenditures.

For the beginning of each federal award year, the due dates are:

March 1 for the period October through December
June 1 for the period January through March
September 1 for the period April through June
December 1 for the period July through September

H. Year-End Cost Settlement Reports

Pursuant to W&I Code, Section 14124.24 (g(1)) Contractor shall submit to DHCS, on November 1 of each year, the following year-end cost settlement documents by paper or electronic format submission as prescribed by DHCS for the previous fiscal year:

1) Document 2P, County Certification Year-End Claim for Reimbursement

2) Document 2P(a) and 2P(b), Drug Medi-Cal Cost Report Forms for Intensive Outpatient Treatment for Non-Perinatal or Perinatal (if applicable)

3) Document 2P(c) and 2P(d), Drug Medi-Cal Cost Report Forms for Outpatient Drug Free Individual Counseling for Non-Perinatal or Perinatal (if applicable)

4) Document 2P(e) and 2P(f), Drug Medi-Cal Cost Report Forms for Outpatient Drug Free Group Counseling for Non-Perinatal or Perinatal (if applicable)

5) Document 2P(g), Drug Medi-Cal Cost Report Forms for Residential for Perinatal (if applicable)

6) Document 2P(h) and 2P(i), Drug Medi-Cal Expenditure Forms for Narcotic Treatment Programs, Non-Perinatal or Perinatal (if applicable)

I. Failure to meet required reporting requirements shall result in:

1) The DHCS shall issue a Notice of Deficiency (Deficiencies) to Contractor regarding specified providers with a deadline to submit the required data and a request for a Corrective Action Plan (CAP) to ensure timely reporting in the future. DHCS shall approve or reject the CAP or request revisions to the CAP which shall be resubmitted to DHCS within thirty (30) days.

2) If the Contractor has not ensured compliance with the data submission or CAP request within the designated timeline, then DHCS may withhold funds until all data is submitted. DHCS shall inform the Contractor when funds shall be withheld.

23.3 Training

A. DHCS SUD - Program, Policy, and Fiscal Division (SUD PPFD) shall provide mandatory annual training to the Contractor on the requirements of Title 22 and the DMC program requirements.

B. Contractor may request additional Technical Assistance or training from SUD-PPFD on an ad hoc basis.

C. Training to DMC Subcontractors

1) Contractor shall ensure that all subcontractors receive training on the requirements of Title 22 regulations and DMC requirements at least annually. Documented attendance of any subcontracted provider at the annual trainings offered by DHCS (specified in Section 23.3, of this Intergovernmental Agreement) shall suffice to meet the requirements of this provision. Contractor shall report compliance with this section to DHCS annually as part of the DHCS County monitoring process.

2) The Contractor shall require subcontractors to be trained in the ASAM Criteria prior to providing services.

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

b) The Contractor shall ensure that all residential service providers meet the established ASAM criteria for each level of residential care they provide and receive an ASAM Designation prior to providing Pilot program services.

23.4 Monthly Monitoring

A. Contractor shall check the status of all providers monthly to ensure that they are continuing active participation in the DMC program. Any subcontracted provider who surrenders their certification or closes their facility must be reported by the Contractor to DHCS's County Monitoring Unit within two (2) business days of notification or discovery.

B. During the monthly status check, the Contractor shall monitor for a triggering recertification event (change in ownership, change in scope of services, remodeling of facility, or change in location) and report any triggering events to DHCS's County Monitoring Unit within two (2) business days of notification or discovery.

23.5 Program Complaints

A. All complaints received by Contractor regarding a DMC certified facility shall be forwarded to:

Drug Medi-Cal Complaints are to be submitted to:

Department of Health Care Services
P.O. Box 997413
Sacramento, CA 95899-7413
Call the Hotline
Phone Toll-Free: (800) 822-6222

Complaints for Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities may also be made by telephoning the appropriate licensing branch listed below:

SUD Compliance Division:

Public Number: (916) 322-2911
Toll Free Number: (877) 685-8333

The Complaint Form is available and can also be submitted online at:
http://www.dhcs.ca.gov/individuals/Pages/Sud-Complaints.aspx

B. Counties shall be responsible for investigating complaints and providing the results of all investigations to DHCS's e-mail address by secure, encrypted e-mail to: SUDCountyReports@dhcs.ca.gov within two (2) business days of completion;

23.6 Record Retention

A. Contractor shall include instructions on record retention and include in any subcontract with providers the mandate to keep and maintain records for each service rendered, to whom it was rendered, and the date of service, pursuant to W&I Code, Section 14214.1 and 42 CFR 433.32; and 22 CCR section 51341.1.

1) Subcontract Termination

a) The Contractor must notify DHCS' County Monitoring Unit of the termination of any Intergovernmental Agreement with a certified subcontracted provider, and the basis for termination of the Intergovernmental Agreement, within two (2) business days.

2) Corrective Action Plan

a) If the Contractor fails to ensure any of the foregoing oversight through an adequate system of monitoring, utilization review, and fiscal and programmatic controls, DHCS may request a CAP from the Contractor to address these deficiencies and a timeline for implementation. Failure to submit a CAP or adhere to the provisions in the CAP can result in a withhold of funds allocated to Contractor for the provision of services, and/or termination of this Intergovernmental Agreement for cause

b) Failure to comply with Monitoring requirements shall result in:

i. DHCS shall issue a report to Contractor after conducting monitoring, utilization, or fiscal auditing reviews of the Contractor. When the DHCS report identifies non-compliant services or processes, it shall require a CAP. The Contractor shall submit a CAP to DHCS within the timeframes required by DHCS.

a. The CAP shall include:

(i) A statement of the deficiency;

(ii) A list of action steps to be taken to correct the deficiency;

(iii) Date of completion of each deficiency corrected; and

(iv) Who will be responsible for correction and ongoing compliance.

ii. DHCS shall provide written approval of the CAP to the Contractor. If DHCS does not approve the CAP submitted by the Contractor, DHCS shall provide guidance on the deficient areas and request an updated

CAP from the Contractor with a new deadline for submission.

iii. If the Contractor does not submit a CAP, or, does not implement the approved CAP provisions within the designated timeline, then DHCS may withhold funds until the Contractor is in compliance. DHCS shall inform the Contractor when funds shall be withheld.

24. Quality Improvement (QI) Program

Contractor shall establish an ongoing quality assessment and performance improvement program consistent with 42 CFR 438.240.

CMS, in consultation with DHCS and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by DHCS in this Agreement.

Performance improvement projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and beneficiary satisfaction.

A. The monitoring of accessibility of services outlined in the Quality Improvement Plan will at a minimum include:

1) Timeliness of first initial contact to face-to-face appointment “frequency of follow-up appointments in accordance with individualized treatment plans”

2) Timeliness of services of the first dose of NTP services

3) Access to after-hours care

4) Responsiveness of the beneficiary access line
5) Strategies to reduce avoidable hospitalizations

6) Coordination of physical and mental health services with waiver services at the provider level

7) Assessment of the beneficiaries’ experiences

8) Telephone access line and services in the prevalent non-English languages.

B. The Contractor’s QI program shall monitor the Contractor’s service delivery system with the aim of improving the processes of providing care and better meeting the needs of its beneficiaries. The QI Program shall be accountable to the Contractor’s Director.

C. The Contractor shall establish a QI Committee to review the quality of SUD treatment services provided to beneficiaries. The QI Committee shall recommend policy decisions; review and evaluate the results of QI activities, including performance improvement projects; institute needed QI actions; ensure follow-up of QI processes; and document QI Committee meeting minutes regarding decisions and actions taken.

The QI committee shall recommend policy decisions; review and evaluate the results of QI activities; institute needed QI actions, ensure follow-up of QI process and document QI committee minutes regarding decisions and actions taken.

D. Each Contractor' s QI Committee shall review the following data at a minimum on a quarterly basis since external quality review (EQR) site reviews will begin after county implementation. These data elements shall be incorporated into the EQRO protocol:

1) Number of days to first DMC-ODS service at appropriate level of care after referral

2) Existence of a 24/7 telephone access line with prevalent non-English language(s)

3) Access to DMC-ODS services with translation services in the prevalent

E. Operation of the QI program shall include substantial involvement by a licensed SUD staff person.

F. The QI Program shall include active participation by the Contractor's practitioners and providers, as well as beneficiaries and family members, in the planning, design and execution of the QI Program.

G. The Contractor shall maintain a minimum of two active Performance Improvement Projects (PIPs) that meet the criteria in 42 CFR 438.240(b)(1) and (d). Performance improvement projects shall focus on a clinical area, as well as one non-clinical area.

H. PIPs shall:

1) measure performance using objective quality indicators;

2) implement system interventions to achieve improvement in quality;

3) evaluate the effectiveness of interventions;

4) plan and initiate activities for increasing or sustaining improvement;

I. The Contractor shall report the status and results of each PIP to DHCS as requested

J. Each PIP must be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care annually.

25. Utilization Management (UM) Program

A. The Contractor shall have a Utilization Management (UM) Program assuring that beneficiaries have appropriate access to SUD services; medical necessity has been established, the beneficiary is at the appropriate ASAM level of care, and that the interventions are appropriate for the diagnosis and level of care. The Contractor shall have a documented system for collecting, maintaining and evaluating accessibility to care and waiting list information, including tracking the number of days to first DMC-ODS service at an appropriate level of care following initial request or referral for all

DMC-ODS services.

B. Pursuant to 42 CFR 438.210(e) the Contractor shall ensure that, consistent with 42 CFR 438.6(h), and 42 CFR 422.208, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

26. Practice Guidelines

The Contractor shall comply with 42 CFR 438.236(b) which requires the adoption of practice guidelines.

The Contractor shall comply with the practice guidelines established in Exhibit A, Attachment I Section 1.2(B).

A. The Contractor's practice guidelines shall:

1) be based on valid and reliable clinical evidence or a consensus of health care professionals in the applicable field;

2) consider the needs of the beneficiaries;

3) be adopted in consultation with contracting health care professionals; and

4) be reviewed and updated periodically as appropriate.

B. The Contractor shall disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.

C. The Contractor shall take steps to assure that decisions for utilization management, beneficiary education, coverage of services, and any other areas to which the guidelines apply shall be consistent with the guidelines.

27. Non-DMC/SAPT

A. Restrictions on Salaries

The Contractor agrees that no part of any federal funds provided under this Intergovernmental Agreement shall be used by the Contractor or its subcontractors to pay the salary and wages of an individual at a rate in excess of Level I of the Executive Schedule. Salary and wages schedules may be found at http://www.opm.gov/oca. SAPT Block Grant funds used to pay a salary in excess of the rate of basic pay for Level I of the Executive Schedule shall be subject to disallowance. The amount disallowed shall be determined by subtracting the individual's actual salary from the Level I rate of basic pay and multiplying the result by the percentage of the individual's salary that was paid with SAPT Block Grant funds (Reference: Terms and Conditions of the SAPT Block Grant award.)

B. Primary Prevention

1) The SAPT Block Grant regulation defines "Primary Prevention Programs" as those programs directed at "individuals who have not been determined to require treatment for substance abuse" (45 CFR 96.121). Primary Prevention includes strategies, programs and initiatives which reduce both direct and indirect adverse personal, social, health, and economic consequences resulting from problematic AOD availability, manufacture, distribution, promotion, sales, and use. The desired result of primary prevention is to promote safe and healthy behaviors and environments for individuals, families and communities. The Contractor shall expend not less than its allocated amount of the Substance Abuse Prevention and Treatment (SAPT) Block Grant on primary prevention as described in the SAPT Block Grant requirements (45 CFR 96.125).

2) The Contractor is required to have a current and DHCS approved County Strategic Prevention Plan (SPP) County Prevention Plan. The SPP must demonstrate use of the Substance Abuse and Mental Health Services Administration's Strategic Prevention Framework (SPF) in developing the plan as described at http://www.dhcs.ca.gov/provgovpart/Pages/Strategic-Prevention-Framework-State-Incentive-Grant-GPAC-Workgroup.aspx. DHCS shall only approve SPP's that demonstrate that the Contractor utilized the SPF. Contractor must:

    a) Follow the DHCS guidelines provided in the Strategic Prevention Framework Plan Resource Document located in the CalOMS Pv Library at https://caprev.onmosaix.com/caprevent2016/pLibDialog.aspx.

    b) Begin preparing a new SPP at least 9-months prior to the expiration date of the current SPP.

    c) Submit a timeline to DHCS for completion of the SPP that includes proposed dates for submitting each section of the SPP. The sections are outlined in the Strategic Prevention Framework Plan Resource Document.

    d) Submit a draft to DHCS, based on the timeline, for each section of the SPP for review and approval.

    e) Submit to DHCS the final draft of the SPP no later than 30-days prior to the start date of the new SPP.

    f) Upload an electronic copy of the approved SPP into CalOMS Pv within 10-days of approval.

    g) Input the Problem Statements, Goals and Objectives from the SPP into CalOMS Pv no later than 10-days after the start date of the SPP.

3) The Contractor shall submit a Prevention Mid-Year Budget to DHCS by January 31 of each fiscal year. The budget shall indicate how the SAPT Block Grant Primary Prevention Set-Aside shall be expended for the fiscal year.

4) Friday Night Live

The Contractor and any subcontractors receiving SAPT Friday Night Live funding must meet the following:

a) Engage in programming that meets the FNL Youth Development Standards of Practice, Operating Principles and Core Components outlined at http://fridaynightlive.org/about-us/cfnlp-overview/;

b) Use CalOMS Pv for all reporting including Chapter Profiles, FNL County Profiles and chapter activity;

c) Follow the FNL Data Entry Instructions for CalOMS Pv as provided by DHCS in the CalOMS Pv Library;

d) Meet the Member in Good Standing (MIGS) requirements, as determined by DHCS in conjunction with the California Friday Night Live Partnership. If the Contractor does not meet the MIGS requirements, then the Contractor shall submit counties fail to a technical assistance plan detailing how the Contractor intends to ensure satisfaction of the MIGS requirements to DHCS for approval.

C. Perinatal Services Network Guidelines 2016

Pursuant to 45 CFR 96.124 ((c)(1-3)) the Contractor shall expend the specified percentage of SAPT Block Grant funds, as calculated by said regulations, on perinatal services, pregnant women, and women with dependent children each state fiscal year (SFY). The Contractor shall expend these funds either by establishing new programs or expanding the capacity of existing programs. The Contractor shall calculate the appropriate expenditure amount by using Generally Accepted Accounting Principles and the composition of the base shall be applied consistently from year to year. (See the County Share of SAPT Block Grant Women Services Expenditure Requirement: http://www.dhcs.ca.gov/formsandpubs/Pages/Information_Notices_2016.aspx)

Contractor shall comply with the perinatal programs requirements as outlined in the Perinatal Services Network Guidelines, promulgated to 45 CFR 96.137. The “Perinatal Services Network Guidelines 2016” are attached to this Intergovernmental Agreement as Document 1G, incorporated by reference. The Contractor shall comply with the "Perinatal Services Network Guidelines 2016" until new Perinatal Services Network Guidelines are established and adopted. The incorporation of any new Perinatal Service Network Guidelines into this Intergovernmental Agreement shall not require a formal amendment.

All SAPT BG-funded programs providing treatment services designed for pregnant women and women with dependent children will treat the family as a unit and therefore will admit both women and their children into treatment services, if appropriate.

The Contractor must directly provide, or provide a referral for, the following services:

1) Primary medical care for women, including referral for prenatal care and, while the women are receiving such services, child care;

2) Primary pediatric care, including immunization, for their children;

3) Gender specific substance abuse treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse and parenting, and child care while the women are receiving these services;

4) Therapeutic interventions for children in custody of women in treatment which may, among other things, address their developmental needs, their issues of sexual and physical abuse, and neglect; and

5) Sufficient case management and transportation to ensure that women and their children have access to services.

D. Recovery Services shall include:

1) Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care;

2) Recovery Monitoring: Recovery coaching, monitoring via telephone and internet;

3) Substance Abuse Assistance: Peer-to-peer services and relapse prevention;

4) Education and Job Skills: Linkages to life skills, employment services, job training, and education services;

5) Family Support: Linkages to childcare, parent education, child development support services, family/marriage education;

6) Support Groups: Linkages to self-help and support, spiritual and faith-based support;

7) Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

8) Recovery Residences

E. Funds identified in this Intergovernmental Agreement shall be used exclusively for county alcohol and drug abuse services to the extent activities meet the requirements for receipt of federal block grant funds for prevention and treatment of substance abuse described I subchapter XVII of Chapter 6A of Title 42 of the United State Code.

28. Formation and Purpose

A. Authority

State and the Contractor enter into this Exhibit A, Attachment I, by authority of Chapter 3 of Part 1, Division 10.5 of the Health and Safety Code (HSC) and with approval of Contractor's County Board of Supervisors (or designee) for the purpose of providing alcohol and drug services, which shall be reimbursed pursuant to Exhibit A, Attachment I. State and the Contractor identified in the Standard Agreement are the only parties to this Intergovernmental Agreement. This Intergovernmental Agreement is not intended,

nor shall it be construed, to confer rights on any third party.

B. Control Requirements

1) Performance under the terms of this Exhibit A, Attachment I, is subject to all applicable federal and state laws, regulations, and standards. In accepting DHCS drug and alcohol combined program allocation pursuant to HSC Sections 11814(a) and (b), Contractor shall: (i) establish, and shall require its subcontractors to establish, written policies and procedures consistent with the following requirements; (ii) monitor for compliance with the written procedures; and (iii) be held accountable for audit exceptions taken by DHCS against the Contractor and its subcontractors for any failure to comply with these requirements:

   a) HSC, Division 10.5, commencing with Section 11760;

   b) Title 9, California Code of Regulations (CCR) (herein referred to as Title 9), Division 4, commencing with Section 9000;

   c) Government Code Section 16367.8;

   d) Government Code, Article 7, Federally Mandated Audits of Block Grant Funds Allocated to Local Agencies, Chapter 1, Part 1, Division 2, Title 5, commencing at Section 53130;

   e) Title 42 United State Code (USC), Sections 300x-21 through 300x-31, 300x-34, 300x-53, 300x-57, and 330x-65 and 66;

   f) The Single Audit Act Amendments of 1996 (Title 31, USC Sections 7501-7507) and the Office of Management and Budget (OMB) Circular A-133 revised June 27, 2003 and June 26, 2007.

   g) Title 45, Code of Federal Regulations (CFR), Sections 96.30 through 96.33 and Sections 96.120 through 96.137;

   h) Title 42, CFR, Sections 8.1 through 8.6;

   i) Title 21, CFR, Sections 1301.01 through 1301.93, Department of Justice, Controlled Substances; and,

   j) State Administrative Manual (SAM), Chapter 7200 (General Outline of Procedures).

   Contractor shall be familiar with the above laws, regulations, and guidelines and shall assure that its subcontractors are also familiar with such requirements.

2) The provisions of this Exhibit A, Attachment I are not intended to abrogate any provisions of law or regulation, or any standards existing or enacted during the term

of this Intergovernmental Agreement.

3) Contractor shall adhere to the applicable provisions of Title 45, CFR, Part 96, Subparts C and L, as applicable, in the expenditure of the SAPTBG funds. Document 1A, 45 CFR 96, Subparts C and L, is incorporated by reference.

4) Documents 1C incorporated by this reference, contains additional requirements that shall be adhered to by those Contractors that receive Document 1C. This document is:

   a) Document 1C, Driving-Under-the-Influence Program Requirements;

C. In accordance with the Fiscal Year 2011-12 State Budget Act and accompanying law (Chapter 40, Statues of 2011 and Chapter 13, Statues of 2011, First Extraordinary Session), contractors that provide Women and Children's Residential Treatment Services shall comply with the program requirements (Section 2.5, Required Supplemental/Recovery Support Services) of the Substance Abuse and Mental Health Services Administration's Grant Program for Residential Treatment for Pregnant and Postpartum Women, RFA found at http://www.samhsa.gov/grants/grant-announcements/ti-14-005.

28.1 Performance Provisions

A. Monitoring

1) Contractor's performance under this Exhibit A, Attachment I, shall be monitored by DHCS during the term of this Intergovernmental Agreement. Monitoring criteria shall include, but not be limited to:

   a) Whether the quantity of work or services being performed conforms to Exhibit B;

   b) Whether the Contractor has established and is monitoring appropriate quality standards;

   c) Whether the Contractor is abiding by all the terms and requirements of this Intergovernmental Agreement;

   d) Whether the Contractor is abiding by the terms of the Perinatal Services Network Guidelines 2016 (Document 1G); and

   e) Contractor shall conduct annual onsite monitoring reviews of services and subcontracted services for programmatic and fiscal requirements. Contractor shall submit copy of their monitoring and audit reports to DHCS within two weeks of issuance. Reports should be sent by secure, encrypted e-mail to:

      SUDCountyReports@dhcs.ca.gov

      or

      Substance Use Disorder - Prevention, Treatment and Recovery Services

Division, Performance Management Branch
Department of Health Care Services
PO Box 997413, MS-2627
Sacramento, CA 95899-7413;

2) Failure to comply with the above provisions shall constitute grounds for DHCS to suspend or recover payments, subject to the Contractor's right of appeal, or may result in termination of the Intergovernmental Agreement or both.

B. Performance Requirements

1) Contractor shall provide services based on funding set forth in Exhibit B, Attachment I, and under the terms of this Intergovernmental Agreement.

2) Contractor shall provide services to all eligible persons in accordance with federal and state statutes and regulations. Contractor shall assure that in planning for the provision of services, the following barriers to services are considered and addressed:

a) Lack of educational materials or other resources for the provision of services;

b) Geographic isolation and transportation needs of persons seeking services or remoteness of services;

c) Institutional, cultural, and/or ethnicity barriers;

d) Language differences;

e) Lack of service advocates;

f) Failure to survey or otherwise identify the barriers to service accessibility; and,

g) Needs of persons with a disability.

3) Contractor shall comply with any additional requirements of the documents that have been incorporated herein by reference, including, but not limited to, those in the Exhibit A – Scope of Work, Provision 6.

4) Amounts awarded pursuant to Exhibit A, Attachment I shall be used exclusively for providing alcohol and/or drug program services consistent with the purpose of the funding.

5) DHCS shall issue a report to Contractor after conducting monitoring, utilization, or auditing reviews of county or county subcontracted providers. When the DHCS report identifies non-compliant services or processes, it shall require a CAP. The Contractor, or in coordination with its subcontracted provider, shall submit a CAP to DHCS within 60 calendar days from the date of the report to:

Substance Use Disorder – Program, Policy and Fiscal Division, Performance Management Branch

Department of Health Care Services
PO Box 997413, MS-2621
Sacramento, CA 95899-7413;

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

6) The CAP shall include a statement of the problem and the goal of the actions the Contractor and or its sub-contracted provider shall take to correct the deficiency or non-compliance. The CAP shall:

   a) Address the specific actions to correct deficiency or non-compliance

   b) Identify who/which unit(s) shall act; who/which unit(s) are accountable for acting; and

   c) Provide a timeline to complete the actions.

29. Definitions

29.1 General Definitions.

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

A. **"Available Capacity"** means the total number of units of service (bed days, hours, slots, etc.) that a Contractor actually makes available in the current fiscal year.

B. **"Contractor"** means the county identified in the Standard Agreement or DHCS authorized by the County Board of Supervisors to administer substance use disorder programs.

C. **"Corrective Action Plan" (CAP)** means the written plan of action document which the Contractor or its subcontracted service provider develops and submits to DHCS to address or correct a deficiency or process that is non-compliant with laws, regulations or standards.

D. **"County"** means the county in which the Contractor physically provides covered substance use treatment services.

E. **"County Realignment Funds"** means Behavioral Health Subaccount funds received by the County as per California Code Section 30025.

F. **"Days"** means calendar days, unless otherwise specified.

G. **"Dedicated Capacity"** means the historically calculated service capacity, by modality, adjusted for the projected expansion or reduction in services, which the Contractor agrees to make available to provide non-DMC substance use disorder services to persons eligible for Contractor services.

H. **"Final Allocation"** means the amount of funds identified in the last allocation letter issued by the State for the current fiscal year.

I. **"Final Settlement"** means permanent settlement of the Contractor's actual allowable costs or expenditures as determined at the time of audit, which shall be completed within three years of the date the year-end cost settlement report was accepted for interim settlement by the State. If the audit is not completed within three years, the interim settlement shall be considered as the final settlement.

J. **"Interim Settlement"** means temporary settlement of actual allowable costs or expenditures reflected in the Contractor's year-end cost settlement report.

K. **"Maximum Payable"** means the encumbered amount reflected on the Standard Agreement of this Intergovernmental Agreement and supported by Exhibit B, Attachment I.

L. **"Modality"** means those necessary overall general service activities to provide substance use disorder services as described in Division 10.5 of the HSC.

M. **"Non-Drug Medi-Cal Amount"** means the contracted amount of SAPT Block Grant funds for services agreed to by the State and the Contractor.

N. **"Performance"** means providing the dedicated capacity in accordance with Exhibit B, Attachment I, and abiding by the terms of this Exhibit A, including all applicable state and federal statutes, regulations, and standards, including Alcohol and/or Other Drug Certification Standards (Document 1P), in expending funds for the provision of substance use services hereunder.

O. **"Preliminary Settlement"** means the settlement of only SAPT funding for counties that do include DMC funding.

P. **"Revenue"** means Contractor's income from sources other than the State allocation.

Q. **"Service Area"** means the geographical area under Contractor's jurisdiction.

R. **"Service Authorization Request"** means a beneficiary's request for the provision of a service.

S. **"Service Element"** is the specific type of service performed within the more general service modalities. A list of the service modalities and service elements and service elements codes is incorporated into this Intergovernmental Agreement as Document 1H(a) "Service Code Descriptions".

T. **"State"** means the Department of Health Care Services or DHCS.

U. **"Threshold Language"** means a language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

V. **"Utilization"** means the total actual units of service used by beneficiaries and participants.

29.2 Definitions Specific to Drug Medi-Cal

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

A. **"Action**" - (1) The denial or limited authorization of a requested service, including the type or level of service; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service; (4) The failure to provide services in a timely manner, as defined by the State; or (5) The failure of a Contractor to act within the timeframes provided in §438.408(b).

B. **"Administrative Costs"** means the Contractor's actual direct costs, as recorded in the Contractor's financial records and supported by source documentation, to administer the program or an activity to provide service to the DMC program. Administrative costs do not include the cost of treatment or other direct services to the beneficiary. Administrative costs may include, but are not limited to, the cost of training, programmatic and financial audit reviews, and activities related to billing. Administrative costs may include Contractor's overhead per the approved indirect cost rate proposal pursuant to OMB Circular A-87 and the State Controller's Office Handbook of Cost Plan Procedures.

C. "**Appeal**" is the request for review of an "action".

D. **"Authorization"** is the approval process for DMC Services prior to the submission of a DMC claim.

E. **"Beneficiary"** means a person who: (a) has been determined eligible for Medi-Cal; (b) is not institutionalized; (c) has a substance-related disorder per the current "Diagnostic and Statistical Manual of Mental Disorders (DSM)" criteria; and (d) meets the admission criteria to receive DMC covered services.

F. **"Case Management"** means a service to assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

G. **"Certified Provider"** means a substance use disorder clinic and/or satellite clinic location that has received certification to be reimbursed as a DMC clinic by the State to provide services as described in Title 22, California Code of Regulations, Section 51341.1.

H. **"Covered Services"** means those DMC services authorized by Title XIX or Title XXI of the Social Security Act; Title 22 Section 51341.1; W&I Code, Section 14124.24; and California's Medicaid State Plan, including the DMC ODS 1115 Demonstration Waiver standard terms and conditions.

I. **“Delivery System”** DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program. DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a county that opts into the Pilot program. Upon approval of an implementation plan, the State shall contract with the county to provide DMC-ODS services. The county shall, in turn, contract with DMC certified providers or provide county-operated services to provide all services outlined in the DMC-ODS. Counties may also contract with a managed care plan to provide services. Participating counties with the approval from the State may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design or comparability of services. Counties may act jointly in order to deliver these services.

J. **"Drug Medi-Cal Program"** means the state system wherein beneficiaries receive covered services from DMC-certified substance use disorder treatment providers.

K. **“Drug Medi-Cal Termination of Certification”** means the provider is no longer certified to participate in the Drug Medi-Cal program upon the State’s issuance of a Drug Medi-Cal certification termination notice.

L. **"Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)"** means the federally mandated Medicaid benefit that entitles full-scope Medi-Cal-covered beneficiaries less than 21 years of age to receive any Medicaid service necessary to correct or ameliorate a defect, mental illness, or other condition, such as a substance-related disorder, that is discovered during a health screening.

M. **“Fair Hearing”** means the State hearing provided to beneficiaries upon denial of appeal pursuant to 22 CCR 50951 and 50953 and 9 CCR 1810.216.6. Fair hearings must comply with 42 CFR 431.220(a)(5), 438.408(f), 438.414, and 438.10(g)(1).

N. **“Federal Financial Participation (FFP)”** means the share of federal Medicaid funds for reimbursement of DMC services.

O. **“Grievance”** means an expression of dissatisfaction about any matter other than an “action”.

P. **“Key Points of Contact”** means common points of access to substance use treatment services from the county, including but not limited to the county’s beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the county.

Q. **"Medical Necessity"** means those substance use treatment services that are reasonable and necessary to protect life, prevent significant illness or disability, or alleviate severe pain through the diagnosis and treatment of a disease, illness or injury consistent with and 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.

R. **"Minor Consent DMC Services"** are those covered services that, pursuant to Family Code Section 6929, may be provided to persons 12-20 years old without parental consent.

S. **"Narcotic Treatment Program"** means an outpatient clinic licensed by the State to provide narcotic **replacement** therapy directed at stabilization and rehabilitation of persons who are opiate-addicted and have a substance use diagnosis.

T. **"Non-Perinatal Residential Program"** services are provided in DHCS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria. These residential services are provided to the non-perinatal population and do not require the enhanced services found in the perinatal residential programs.

U. **"Notice of Action"** means a formal communication of any action, as defined above and consistent with 42 CFR 438.404 and 438.10.

V. **"Payment Suspension"** means the Drug Medi-Cal certified provider has been issued a notice **pursuant** to W&I Code, Section 14107.11 and is not authorized to receive payments after the payment suspension date for DMC services, regardless of when the service was provided.

W. **"Perinatal DMC Services"** means covered services as well as mother/child habilitative and **rehabilitative** services; services access (i.e., provision or arrangement of transportation to and from medically necessary treatment); education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant; and coordination of ancillary services (Title 22, Section 51341.1(c) 4).

X. **"Postpartum",** as defined for DMC purposes, means the 60-day period beginning on the last day of **pregnancy**, regardless of whether other conditions of eligibility are met. Eligibility shall end on the last day of the calendar month in which the 60th day occurs.

Y. **"Post Service Post Payment (PSPP) Utilization Review"** means the review for program compliance and medical necessity conducted by the State after service was rendered and paid. State may recover prior payments of Federal and State funds if such review determines that the services did not comply with the applicable statutes, regulations, or standards (Cal. Code Regs. CCR, Title 22, Section 51341.1 (k)).

Z. **"Physician Consultation"** services are to support DMC physicians with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

AA. **"Projected Units of Service"** means the number of reimbursable DMC units of service, based on historical data and current capacity, the Contractor expects to provide on an annual basis.

BB. **"Provider Certification"** means the provider must be certified in order to participate in the Medi-Cal program.

CC. **"Provider of DMC Services"** means any person or entity that provides direct substance use treatment services and has been certified by the State as meeting the standards for participation in the DMC program set forth in the "DMC Certification Standards for Substance Abuse Clinics", Document 2E and "Standards for Drug

Treatment Programs (October 21, 1981)", Document 2F.

DD. **"Re-certification"** means the process by which the DMC certified clinic and/or satellite program is required to submit an application and specified documentation, as determined by DHCS, to remain eligible to participate in and be reimbursed in through the DMC program. Re-certification shall occur no less than every five years from the date of previous DMC certification or re-certification.

EE. **"Recovery Services"** are available after the beneficiary has completed a course of treatment. Recovery services emphasize the patient's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to patients.

FF. **"Short-Term Resident"** means any beneficiary receiving residential services pursuant to DMC-ODS, regardless of the length of stay, is a "short-term resident" of the residential facility in which they are receiving the services.

GG. **"Subcontract"** means an agreement between the Contractor and its subcontractors. A subcontractor shall not delegate its obligation to provide covered services or otherwise subcontract for the provision of direct patient/beneficiary services.

HH. **"Subcontractor"** means an individual or entity that is DMC certified and has entered into an agreement with the Contractor to be a provider of covered services. It may also mean a vendor who has entered into a procurement agreement with the Contractor to provide any of the administrative functions related to fulfilling the Contractor's obligations under the terms of this Exhibit A, Attachment I.

II. **"Temporary Suspension"** means the provider is temporarily suspended from participating in the DMC program as authorized by W&I Code, Section 14043.36(a). The provider cannot bill for DMC services from the effective date of the temporary suspension.

JJ. **"Withdrawal Management"** means detoxification services provided in either an ambulatory or non-ambulatory setting consistent with the ASAM level of care criteria to DMC ODS beneficiaries.

30. Contractor Specific Requirements

Beginning October 18, 2016 and ending June, 30, 2019, in addition to the general requirements outlined in Exhibit A, Attachment I, the Contractor agrees to the following Contractor specific requirements:

A. Covered Services

In addition to the Mandatory Covered Services outlined in Section 1.2(B) of Exhibit A, Attachment I, the Contractor shall establish assessment and referral procedures and shall arrange, provide, or subcontract for medically necessary Contractor Specific

Covered Services in the Contractor's service area in compliance with 42 CFR 438.210(a)(1), 438.210(a)(2), and 438.210(a)(3).

1) The Contractor shall deliver the Contractor Specific Covered Services within a continuum of care as defined in the ASAM criteria.

2) Contractor Specific Covered Services include:

   a) Additional Medication Assisted Treatment (MAT);

   b) Recovery Residences; and

   c) Telehealth for addiction medicine.

B. Access to Services

In addition to the general access to services requirements outlined in Section 2.2 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific access to services requirements:

1) There are typically three pathways of system entry: 1) calls or walk-ins to a SUD network provider, 2) calls to the Behavioral Health Referral System (BHRS) Access Call Center (ACC), 3) walk-ins or direct referrals to the BHRS County Care Coordination Team (CCCT). Regardless of the entry point, the Contractor shall ensure that each individual is registered and screened following the same process and tools described below.

2) Initial Service Screening

   a) The Contractor shall ensure that all individuals are triaged for risk (suicidality, homelessness, emergent physical health needs), insurance coverage/eligibility verification, and are advised of the benefits to which they are entitled under the DMC-ODS.

   b) A uniform SUD screening tool and decision tree based on the American Society of Addiction Medicine (ASAM) dimensions shall be developed and implemented by the Access Call Center staff, the Contractor's Care Coordinators, and network SUD providers.

   c) The Contractor shall ensure that all screenings include beneficiary eligibility and demographics and preliminary SUD level of care (LOC) determination.

   d) Contractor shall ensure that all screenings shall be completed by clinicians or certified SUD counselors.

3) Once screened, the Contractor shall ensure that the beneficiary is referred/linked to the appropriate ASAM level of care. Placement considerations include: findings from the screening, geographic accessibility, threshold language needs, and beneficiary preference.

4) The Contractor shall publish uniform referral procedures for all entry pathways established.

5) Beneficiaries may be referred directly to any SUD network provider for an intake appointment for the following services:

   a) Outpatient and Intensive Outpatient Services;

   b) Narcotic Treatment Program Services;

   c) Withdrawal Management Services (Outpatient);

   d) Medication Assisted Treatment Services;

   e) Recovery Services; and

   f) Case Management Services.

6) Contractor shall ensure that individuals with an initial screening suggestive of a residential placement shall be provided a residential evaluation prior to scheduling the intake appointment.

7) Re-Assessment

   a) Re-assessments allow the treatment team to review beneficiary progress, comparing the most recent beneficiary functioning and severity to the initial assessment and to evaluate the beneficiary's response to care or treatment services. Each ASAM dimension is reviewed to determine the current level of functioning and severity. The Contractor shall ensure that all providers demonstrate that their beneficiaries continue to meet current level of care criteria or determine that an alternative is most appropriate.

   b) The Contractor shall ensure that all beneficiaries shall be reassessed any time there is a significant change in his/her status, diagnosis, a revision to the beneficiary's individualized treatment plan, and as requested by the beneficiary.

   c) The Contractor shall ensure that providers reassess beneficiaries for medical necessity and appropriate level of care within the following maximum timeframes:

      i. Residential Detoxification, Level 3.2: 5 days;

      ii. Residential Treatment, Levels 3.1, 3.3, 3.5: 30 days;

      iii. Intensive Outpatient, Level 2.1: 60 days;

      iv. Outpatient Treatment, Level 1: 90 days;

      v. Narcotic Treatment Programs: 1 year;

vi. Medication Assisted Treatment: 1 year;

vii. Recovery Services: 6 months; and

viii. Case Management: Evaluate as part of above service modalities.

C. Timely Access

In addition to the general timely access requirements outlined in Section 2.3 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific timely access requirements:

1) Timeliness of First Visit

a) The Contractor shall ensure that each beneficiary be offered a first appointment within 15 days of referral or request for service for non-urgent services.

b) To improve timely access to services for all beneficiaries, the Contractor shall collect baseline data implementation year 1 to identify problem areas and solutions, with the goal of all beneficiaries being offered an appointment within 10 days of a request for non-urgent services by implementation year 3. A first appointment may be provided in any appropriate community setting, in-person, by telephone, or by telehealth.

c) Urgent conditions require immediate attention but do not require inpatient hospitalization. At the time of first contact, the Contractor shall ensure that each beneficiary will be triaged to identify the presence of an urgent condition or emergent condition. Once the Contractor or one of its network providers is made aware of the beneficiary's urgent condition, the urgent condition shall be addressed (or the timeframe in which a beneficiary with an urgent condition must be seen) within 24 hours.

d) The Contractor shall offer beneficiaries access to screening and assessment as part of "Same Day Assistance". The Contractor shall ensure that beneficiaries can walk into a clinic or be referred to a clinic for a same day appointment by the Contractor's Access Call Center.

e) The Contractor shall ensure that all beneficiaries experiencing a medical or psychiatric emergency will be directed to the nearest hospital for services.

f) The Contractor shall ensure that beneficiaries can access after-hours care by calling the 24-hour BHRS ACC, where callers are screened and triaged for risk and appropriate referrals are made. In addition, Contractor shall ensure that network providers maintain a system of 24-hour on-call services for beneficiaries in their programs and shall ensure that beneficiaries are aware of how to contact the treating or covering provider after-hours, and during weekends and holidays. Contractor shall also ensure the call center services will be available in all threshold languages. Contractor shall ensure that all provider contracts will

include performance standards that will be measured monthly and reported to assure transparency.

g) Upon request from the beneficiary, the Contractor shall provide for a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee.

2) Access for Persons with Disabilities

a) The Contractor shall require all of its network providers to serve persons with disabilities in compliance with SAPT BG and DHCS requirements and the following policies and regulations:

i. Americans with Disabilities Act of 1990;

ii. Section 540 of Rehabilitation Act of 1973;

iii. 45 Code of Federal Regulations (CFR), Part 84, Non-discrimination on the Basis of Handicap in programs or Activities Receiving Federal Financial Assistance;

iv. Title 24, California Code of Regulations (CCR), Part 2, Activities Receiving Federal Financial Assistance;

v. Unruh Civil Rights Act California Civil Code (CCC) Sections 51 through 51.3 and all applicable laws related to services and access to services for persons with disabilities; and

vi. 42 CFR 438.6(d).

3) The Contractor shall require that providers make accommodations to serve persons with physical disabilities, including vision and hearing impairments. In addition, services must be made available to all individuals with mobility, communication or cognitive impairments as required by federal and state laws and regulations.

4) The Contractor shall maintain a reference list of SUD network treatment providers able to accommodate persons in wheelchairs. If a provider is unable to meet the needs of a person with a specific physical disability, the Contractor shall ensure that they must use the aforementioned list to refer the person to a provider who can meet the needs of the individual.

5) The Contractor shall require that the referring provider contact the new provider to expedite the person's transition to ensure the individual is successful in accessing needed support and services.

6) The Contractor shall ensure that its providers use the DHCS checklist for accessibility and BHRS staff monitors compliance with regulations through a biennial desk audit. The Contractor shall ensure that beneficiaries are advised of their right to receive services and any complaints and grievances are investigated and appropriate and timely action is taken to ensure access.

D. Coordination and Continuity of Care

In addition to the general coordination and continuity of care requirements outlined in Section 2.5 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor coordination and continuity of care requirements:

1) The Contractor's County Care Coordination Team (CCCT) shall connect individuals to the appropriate SUD service provider. Once connected and the transition has been completed, the CCCT no longer provides services. All case management and care coordination services and supports shall be provided by Contractor staff.

2) Contractor's CCCT shall facilitate connections to ancillary services and supports that are identified in the beneficiary's treatment and recovery plan.

3) Contractor's CCCT shall turn over case management responsibilities to the provider once the beneficiary is enrolled in the new program.

4) Below are responsibilities that are provided by either or both CCCT and Case Manager (CM):

   a) Assesses beneficiary needs, motivation, and barriers to care (CCCT, CM);

   b) Provides patient education and engagement (CCCT, CM);

   c) Coordinates quality referrals to improve transitions into SUD and other needed services (CCCT, CM);

   d) Provide SBIRT services, including comprehensive substance use, physical and mental health screening (CCCT) (SBIRT services are not paid for under the DMC-ODS system);

   e) Engage beneficiaries and support their participation in integrated health programs (CCCT, CM);

   f) Evaluate beneficiaries with SUD to determine residential treatment need (authorization and reauthorizations) and to identify the most appropriate service provider(s) for the beneficiary (CCCT);

   g) Provide logistical support for beneficiaries to ensure seamless and timely entry or transitions between levels of care (CCCT, CM);

   h) Provide services to high risk and high utilizers of emergency services with an emphasis on outreach, engagement, systems navigation, and collaborative care planning across SUD services, mental and physical health services, and other social and community based service providers (CCCT);

i) Initiate complex case conferences and physician consultation (CCCT, CM); and

j) Receive referrals for individuals who are at-risk of or have histories of unsuccessful treatment engagements. Deliver engagement strategies including motivational interventions (CCCT).

5) CCCT and CM services may be provided to a beneficiary face-to-face, by telephone, or by telehealth and may be provided anywhere in the community and are provided in compliance with confidentiality of alcohol or drug patients as established by 42 CFR Part 2 and California law.

E. Memorandum of Understanding

In addition to the general memorandum of understanding requirements outlined in Section 2.5(C) of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor memorandum of understanding requirements:

1) The Contractor is a “one plan county” for Medi-Cal managed care and the plan is administered by the Health Plan of San Mateo (HPSM).

2) The Contractor and HPSM shall finalize details to amend the existing agreement to address the coordination of service delivery specific to the implementation of the DMC-ODS by September 30, 2016. A copy of the agreement shall be sent to DHCS when approved and will become an addendum to the Implementation Plan.

F. Authorization of Services – Residential Programs

In addition to the general authorization of residential services requirements outlined in Section 2.6 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific authorization of residential services requirements:

1) The Contractor shall ensure that all of its providers obtain authorization for residential services prior to admitting a beneficiary. Residential authorization processes shall be completed to assure beneficiaries access medically necessary services in a timely manner. The Contractor shall track all authorization and reauthorization through the Contractor’s electronic health record. The Contractor shall utilize four primary pathways that will support beneficiaries in accessing and receiving timely authorization for residential services.

2) Path 1: Access Call Center - BHRS Care Coordination Team Authorizations:

a) Beneficiaries are advised to contact the Access Call Center (ACC) to inquire about services. When the ACC screening yields a residential withdrawal management need, an authorization and referral for Level 3.2 Withdrawal Management is created. When the ACC screenings yields a residential treatment need, an appointment shall be made by the ACC with the BHRS Care Coordination Team, provided the caller is open to exploring a residential placement. A beneficiary shall be offered an evaluation appointment within 24 hours of the initial call with a BHRS care coordinator staff. Evaluation

appointments may be provided face-to-face, by telephone, or by telehealth, and may be provided anywhere in the community.

b) The BHRS County Care Coordination Team (CCCT) shall be staffed by certified AOD counselors and case managers who work under the directions of an LPHA. County Care Coordinators shall evaluate beneficiaries using ASAM and will authorize individuals for residential withdrawal management or residential treatment, or refer the beneficiary to a non-residential network provider. Time-limited case management services shall be provided by the CCCT to ensure smooth and timely admissions to care including referrals to other needed services such as mental health, housing, employment, psychiatric or medical services. If ongoing care coordination of the beneficiary is required outside of the direct treatment provider, it shall be provided by the CCCT.

c) In the event that an evaluation appointment cannot be made within 24 hours, such as on weekends or holidays, the ACC after-hours provider shall complete an additional residential evaluation with the beneficiary, and when indicated, shall provide the beneficiary with a preliminary 7-day authorization for residential treatment. Once admitted to care, the network provider must request a re-authorization (see below) for treatment for continued care at a residential level.

3) Path 2: Residential Detox/Withdrawal Management Authorizations

a) Beneficiaries authorized and receiving 3.2-WM services from a stand-alone provider shall be assessed for further care needs and the 3.2-WM provider may provide an initial authorization for beneficiaries to a residential treatment facility, when medically necessary. The beneficiary shall be referred to a network provider offering the needed ASAM level of care and case management provided to ensure smooth and timely admission to the next appropriate level of care. The 3.2 WM provider and beneficiary shall consult with the BHRS Care Coordination Team regarding bed availability as needed.

4) Path 3: Residential Provider Initiated Authorization

a) Prospective beneficiaries often are referred directly to residential treatment providers by family members, friends, clergy, social service and health providers. In order to ensure timely authorizations and admissions, the Contractor shall ensure that the provider conducts an initial ASAM screening. If the results from the screening indicate the likely need for residential treatment the provider shall enroll the beneficiary and within 24 hours inform the BHRS Care Coordination Team who will provide an ASAM evaluation to validate and authorize services. If the beneficiary is not eligible for that level of care the CCCT staff will facilitate a “warm hand off” to the provider that best matches the beneficiary’s needs. If housing is an issue the CCCT staff will work to ensure the beneficiary is not discharged into homelessness working with Shelter Care providers, family and friends or other temporary housing options.

5) Path 4: Outpatient Provider Initiated Authorization

a) Outpatient provider initiated residential authorization requests shall be made to the ACC including those made on weekends or holidays or after-hours for evaluation and authorization. When indicated, the beneficiary shall be granted a preliminary 7-day authorization for residential treatment. Once admitted to care, the residential provider shall request a re-authorization for treatment for continued care at a residential level.

6) Residential Treatment Re-Authorizations

a) Contractor shall ensure that residential providers request a re-authorization, based on the results of the ASAM assessments, from the BHRS via the Avatar (electronic health record) system, at least 7 calendar days from the initial authorization expiration date. This will allow time for the provider to transition the beneficiary if the request is denied.

G. Early Intervention (ASAM Level 0.5)

In addition to the general early intervention services requirements outlined in Section 5 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific residential treatment services requirements:

1) The Contractor shall provide SBIRT for all substance use conditions in collaboration with the San Mateo Medical Center (SMMC) within primary care clinics, specialty care clinics, Emergency Department and Psychiatric Emergency Services Department.

H. Residential Treatment Services

In addition to the general residential treatment services requirements outlined in Section 8 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific residential treatment services requirements:

1) Residential services shall be provided in facilities designated by DHCS as capable of delivering care consistent with ASAM Level 3.1: Clinically-Managed Low-Intensity Residential, ASAM Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Services (Adult only), and ASAM Level 3.5: Clinically-Managed High-Intensity Residential.

2) Beneficiaries shall be approved for residential treatment through a prior authorization process based on the results identified by the residential evaluation and ASAM assessment.

3) Residential treatment services shall include assessment, treatment planning, individual and group counseling, beneficiary education, family therapy, collateral services, crisis intervention services, treatment planning, transportation to medically necessary treatments, and discharge planning and coordination. The

Contractor shall ensure that all of its providers accept and support patients who are receiving medication-assisted treatments.

4) Contractor shall make available ASAM residential levels 3.1 and 3.5 in implementation year 1. The Contractor shall ensure that ASAM level 3.3 is available within 3 years of final approval of the County's implementation plan and will follow the Contractor's policy and process for selecting new providers.

5) For beneficiaries in any residential treatment program, case management services shall be provided to facilitate "step down" to lower levels of care and support.

I. Case Management

In addition to the general case management requirements outlined in Section 9 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific case management requirements:

1) Case management services support beneficiaries as they move through the DMC-ODS continuum of care from initial engagement and early intervention, through treatment, to recovery supports. The Contractor shall ensure that case management services are provided to beneficiaries who may be pre-contemplative and challenging to engage, and/or those needing assistance connecting to treatment services, and/or those beneficiaries stepping down to lower levels of care and support.

2) The Contractor shall use a comprehensive case management model based on the ASAM bio-psychosocial assessment to identify needs and develop a case plan and follow the SAMHSA/CSAT TIP 27 (Treatment Improvement Protocol) Comprehensive Case Management for Substance Abuse Treatment.

3) Case management services include: comprehensive assessment; level of care identification; beneficiary plan development; coordination of care with mental health and physical health; beneficiary advocacy and linkages to other supports including but not limited to mental health, housing, transportation, food, and benefits enrollment.

4) The Contractor shall ensure that case managers are trained and utilize Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET), harm reduction, and strength based approaches. The Contractor shall ensure that all case management services are provided by contract providers and Contractor staff.

5) The Contractor shall ensure that high utilizers and complex beneficiaries have an assigned lead case manager from the BHRS CCCT to oversee SUD care and coordinate with other treatment services and systems. The CCCT shall communicate with the treatment provider to reduce risk of duplicated case management efforts and shall lead complex care coordination when the beneficiary needs services from multiple county systems.

6) The Contractor shall ensure that all other beneficiaries receive case management services exclusively from the provider agency where the beneficiary is admitted and receiving treatment services.

7) All case management services shall be consistent with confidentiality requirements identified in 42 CFR, Part 2, and California law, and the Health Insurance Portability and Accountability Act (HIPAA).

J. Physician Consultation

In addition to the general physician consultation requirements outlined in Section 10 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific physician consultation requirements:

1) Physician consultation services shall assist physicians and nurse practitioners seeking expert advice on complex beneficiary cases and designing the treatment plan in such areas as: medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

2) The Contractor shall train psychiatrists and psychiatric nurse practitioners in integrated settings on medication guidelines and offer the opportunity for them to consult one-on-one with a psychiatrist who has an addiction medicine background. The Contractor shall make physician consultations to primary care and behavioral health providers for the use of Vivitrol, buprenorphine, other medications, and pain management available in an effort to build the capacity of the entire health system to treat beneficiaries with substance use disorders.

3) The Contractor may use existing staff, or contract with addiction medicine physicians, addiction psychiatrists, or clinical pharmacists to provide consultation services.

K. Recovery Services

In addition to the general recovery services requirements outlined in Section 11 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific recovery services requirements:

1) The Contractor shall make recovery services available to a beneficiary once he/she has completed the primary course of treatment and during the transition process. The Contractor shall ensure that beneficiaries accessing recovery services are supported to manage their own health and health care, use effective self-management support strategies, and use community resources to provide ongoing support.

2) Recovery services may be provided face-to-face, by telehealth/telephone, via the internet, or elsewhere in the community.

3) Recovery services include: outpatient individual or group counseling to support the stabilization of the beneficiary or reassess the need for further care; recovery monitoring/recovering coaching; peer-to-peer services and relapse prevention,

WRAP development, education and job skills; family support; support groups and linkages to various ancillary services.

4) Any eligible DMC provider within the network may provide medically necessary recovery services to beneficiaries.

L. Withdrawal Management

In addition to the general withdrawal management requirements outlined in Section 12 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific recovery services requirements:

1) Withdrawal Management services shall be provided as medically necessary to beneficiaries and include: assessment, observation, medication services, and discharge planning and coordination.

2) Beneficiaries receiving a residential withdrawal management shall reside at the facility for monitoring during the detoxification process.

3) The Contractor shall offer ASAM Levels 1-WM: Ambulatory Withdrawal Management without Extended On-Site Monitoring by the end of Implementation Year 1. BHRS will release a Request for Proposal (RFP) to identify qualified DMC-ODS providers for ASAM Level 3.2-WM: Clinically-Management Residential Withdrawal Management. The Contractor will not offer ASAM Level 2-WM. However, the Contractor shall review utilization and ASAM data and make a determination by the end of implementation year 2 whether there is a demonstrated need for this level of care within the Contractor's continuum. Should a need be substantiated an RFP would be released for ASAM L 2-WM.

4) The Contractor shall work with Sutter Health's Mills Peninsula Hospital and other area service providers to assist beneficiaries to access ASAM Levels 3.7-WM (Medically- Monitored Inpatient Withdrawal Management) and 4.0-WM (Medically-Managed Inpatient Withdrawal Management) when medically necessary. The Contractor shall coordinate with these providers to smoothly transition and support beneficiaries to less intensive levels of care available within the DMC-ODS.

M. Opioid (Narcotic) Treatment Program Services

In addition to the general opioid (narcotic) treatment program services requirements outlined in Section 13 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific opioid (narcotic) treatment program services requirements:

1) The Contractor shall contract with licensed Narcotic Treatment Programs to offer services to beneficiaries who meet medical necessity criteria requirements.

2) Services shall be provided in accordance with an individualized beneficiary plan determined by a licensed prescriber.

3) Prescribed medications offered include medications covered under the DMC-ODS formulary.

4) Services provided as part of an OTP shall include: assessment, treatment planning, individual and group counseling, patient education; medication services; collateral services; crisis intervention services; treatment planning; medical psychotherapy; and discharge services.

5) Beneficiaries shall receive between 50 and 200 minutes of counseling per calendar month with a therapist or counselor, and, when medically necessary, additional services may be provided.

N. Additional Medication Assisted Treatment (MAT)

As stated in Section 30(A) of Exhibit A, Attachment I, the Contractor has elected to provide MAT services as a Contractor specific service. Therefore, the Contractor shall comply with the following Contractor specific MAT requirements:

1) BHRS shall offer medically necessary MAT services through Contractor staff and contracted providers, an NTP program and a provider licensed as a primary care clinic.

2) MAT services shall include: assessment, treatment planning, treatment, case management, ordering, prescribing, administering, and monitoring of medication for substance use disorders.

3) The Contractor shall make available the following medications to beneficiaries:

   a) For reduction of alcohol craving: naltrexone, both oral (ReVia) and extended release injectable (Vivitrol), topiramate (Topamax), gabapentin (Neurontin), acamprosate (Campral), and disulfiram (Antabuse);

   b) For opiate overdose prevention: naloxone (Narcan); and

   c) For opiate use treatment: buprenorphine-naloxone (Suboxone) and naltrexone (oral and extended release) (Note: Methadone will continue to be available through the licensed narcotic treatment program).

4) Additionally, the Contractor shall coordinate care and expand the availability of MAT outside the DMC-ODS by building the capacity of the entire health system to use these treatments for beneficiaries with a substance use disorder. The Contractor shall train physicians, nurse practitioners, and psychiatrists in primary care and specialty mental health clinics on the efficacy of using MAT, practice guidelines, and medication administration. Physician consultation shall support implementation in areas such as: medication selection, dosing, side effect management, adherence, and drug-drug interactions.

O. Telehealth

As stated in Section 30(A) of Exhibit A, Attachment I, the Contractor has elected to provide Telehealth services as a Contractor specific service. Therefore, the Contractor shall comply with the following Contractor specific Telehealth requirements:

1) The Contractor shall implement a telehealth pilot project based out of the BHRS Coastside Clinic in Half Moon Bay. This shall provide behavioral health services for the rural and hard to reach populations along the coast. Services include consultative and "direct" care including medication evaluation and management.

2) The Contractor shall expand the services throughout the County including consultation to substance use treatment providers on issues such as co-occurring mental health concerns, medication assisted treatment, physical health co-morbidities, and other categories.

3) The Contractor shall utilize the following applications of telehealth:

   a) Consultation to evaluate clients in SUD treatment programs. In lieu of a client coming to a site or a psychiatrist providing on-site services at multiple locations telehealth shall be used to centralize the services thus improving client access, minimizing travel time, and maximizing the use of the psychiatrists' time. The psychiatrist shall operate out of one central site; meet with clients or staff over the telehealth network providing direct care and consultation to the providers.

   b) Advanced service delivery using innovative technology. The Contractor shall utilize telehealth services through mobile devices (tablets, mobile phones, and laptops) that will allow provision of services regardless of the location of the client. Staff can then have complex case discussions while each member of the team is in a different location and view presentations together. The Contractor shall equip clients with self-care applications that connect them with their case managers beyond "office hours" and locations.

4) The Contractor shall monitor telehealth equipment and service locations to ensure 42 CFR part 2 and confidentiality are strictly protected.

P. Recovery Residences

As stated in Section 30(A) of Exhibit A, Attachment I, the Contractor has elected to provide Recovery Residence services as a Contractor specific service. Therefore, the Contractor shall comply with the following Contractor specific Recovery Residence requirements:

1) The Contractor shall make Recovery Residences (RR) available to beneficiaries who require housing assistance in order to support their health, wellness and recovery.

2) There is no formal treatment provided at these facilities; however, residents are required to actively participate in outpatient treatment and/or recovery supports during their stay.

3) There is no predetermined maximum length of stay. On a case by case basis the Contractor shall determine the length of stay.

4) The Contractor shall develop standards for contracted RR providers and shall monitor to these standards.

5) RRs are not reimbursable through Medi-Cal.

Exhibit B
Budget Detail and Payment Provisions

Part I – General Fiscal Provisions

Section 1 – General Fiscal Provisions

A. Fiscal Provisions

For services satisfactorily rendered, and upon receipt and approval of documentation as identified in Exhibit A, Attachment I, Section 23.2, DHCS agrees to compensate the Contractor for actual expenditures incurred in accordance with the rates and/or allowable costs specified herein.

B. Use of State General Funds

Contractor may not use allocated Drug Medi-Cal State General Funds to pay for any non-Drug Medi-Cal services.

C. Funding Authorization

Contractor shall bear the financial risk in providing any substance use disorder services covered by this Intergovernmental Agreement.

D. Availability of Funds

It is understood that, for the mutual benefit of both parties, this Intergovernmental Agreement may have been written before ascertaining the availability of congressional appropriation of funds in order to avoid program and fiscal delays that would occur if this Intergovernmental Agreement were not executed until after that determination. If so, State may amend the amount of funding provided for in this Intergovernmental Agreement based on the actual congressional appropriation.

E. Subcontractor Funding Limitations

Pursuant to HSC Section 11818 (b)(2)(A), Contractor shall reimburse its Subcontractors that receive a combination of Drug Medi-Cal funding and other federal or county realignment funding for the same service element and location based on the Subcontractor's actual costs in accordance with Medicaid reimbursement requirements as specified in Title XIX or Title XXI of the Social Security Act; Title 22, and the State's Medicaid Plan. Payments at negotiated rates shall be settled to actual cost at year-end.

F. Budget Contingency Clause

It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this Intergovernmental Agreement does not appropriate sufficient funds for the program, this Intergovernmental Agreement shall be of no further force and effect. In this event, DHCS shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Intergovernmental Agreement and Contractor shall not be obligated to perform any provisions of this Intergovernmental Agreement.

If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, DHCS shall have the option to either cancel this Intergovernmental Agreement with no liability occurring to DHCS, or offer an amended Intergovernmental Agreement to Contractor to reflect the reduced amount.

G. Expense Allowability / Fiscal Documentation

1. Invoices, received from a Contractor and accepted and/or submitted for payment by DHCS, shall not be deemed evidence of allowable Intergovernmental Agreement costs.

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

3. If the allowability or appropriateness of an expense cannot be determined by 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 and payment may be withheld by DHCS. Upon receipt of adequate documentation supporting a disallowed or questionable expense, reimbursement may resume for the amount substantiated and deemed allowable.

4. Costs and/or expenses deemed unallowable are subject to recovery by DHCS.

H. Maintenance of Effort for SAPT Block Grant

1. Notwithstanding any other provision in this Intergovernmental Agreement, the Director may reduce federal funding allocations, on a dollar-for-dollar basis, to a county that has a reduced or anticipates reduced expenditures in a way that would result in a decrease in California's receipt of federal Substance Abuse Prevention and Treatment Block Grant funds (42 U.S.C. Sect 300x-30).

2. Prior to making any reductions pursuant to this subdivision, the Director shall notify all counties that county underspending will reduce the federal Substance Abuse Prevention and Treatment Block Grant maintenance of effort (MOE). Upon receipt of notification, a county may submit a revision to the county budget initially submitted pursuant to subdivision (a) of Section 11798 in an effort to maintain the statewide SAPT Block Grant MOE.

3. Pursuant to 45 CFR 96.124 C 1-3 the Contractor shall expend a specified percentage of SAPT Block Grant funds for perinatal services, pregnant women, and women with dependent children each state fiscal year (SFY). The Contractor shall expend that percentage of SAPT Block Grant funds by, either establishing new programs or expanding the capacity of existing programs. In accordance with 45 CFR 96.124 (c)(1-3), the Contractor shall calculate the percentage of funds to be expended for perinatal services, pregnant women, and women with dependent children in the manner described in Exhibit G: County Share of SAPT Block Grant Women Services Expenditure Requirement.

4. Pursuant to subdivision (b) of Section 11798.1, a county shall notify the Department in writing of proposed local changes to the county's expenditure of funds. The Department shall review and may approve the proposed local changes depending on the level of expenditures needed to maintain the statewide SAPT Block Grant MOE.

Section 2 – General Fiscal Provisions – Non-Drug Medi-Cal

A. Revenue Collection

Contractor shall conform to revenue collection requirements in Division 10.5 of the HSC, Sections 11841, by raising revenues in addition to the funds allocated by the State. These revenues include, but are not limited to, fees for services, private contributions, grants, or other governmental funds. These revenues shall be used in support of additional alcohol and other drug services or facilities. Each alcohol and drug program shall set and collect client fees 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.

B. Cost Efficiencies

It is intended that the cost to the Contractor in maintaining the dedicated capacity and units of service shall be met by the non-DMC funds allocated to the Contractor and other Contractor or Subcontractor revenues. Amounts awarded pursuant to Exhibit A, Attachment I, Section 27, shall not be used for services where payment has been made, or can reasonably be expected to be made under any other state or federal compensation or benefits program, or where services can be paid for from revenues.

Section 3 – General Fiscal Provisions – Drug Medi-Cal

A. Return of Unexpended Funds

Contractor assumes the total cost of providing covered services on the basis of the payments delineated in this Exhibit B, Part II. Any State General Funds or federal Medicaid funds paid to the Contractor, but not expended for DMC services shall be returned to the State.

B. Amendment or Cancellation Due to Insufficient Appropriation

This Intergovernmental Agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the purpose of the DMC program. It is mutually agreed that if the Congress does not appropriate sufficient funds for this program, State has the option to void this Intergovernmental Agreement or to amend the Intergovernmental Agreement to reflect any reduction of funds.

C. Exemptions

Exemptions to the provisions of Item B above, of this Exhibit, may be granted by the California Department of Finance provided that the Director of DHCS certifies in writing that federal funds are available for the term of the Intergovernmental Agreement.

D. Allowable costs

Allowable costs, as used in Section 51516.1 of Title 22 shall be determined in accordance with Title 42, CFR Parts 405 and 413, CMS-Pub 15-1 and 15-2, 2 CFR Part 200 Subpart E, CMS non-institutional reimbursement policy, and Centers for Medicare and Medicaid Services (CMS), "Medicare Provider Reimbursement Manual (Publication Number 15)," which can be obtained from the Centers for Medicare & Medicaid Services, or www.cms.hhs.gov." 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 Medi-Cal administrative activities.

Exhibit B
Budget Detail and Payment Provisions

Part II – Reimbursements

Section 1. General Reimbursement

A. Prompt Payment Clause

Payment will be made in accordance with, and within the time specified in, Government Code Chapter 4.5, commencing with Section 927.

B. Amounts Payable

1. The amount payable under this Intergovernmental Agreement shall not exceed the amount identified on the Standard Intergovernmental Agreement.

2. Reimbursement shall be made for allowable expenses up to the amount annually encumbered commensurate with the state fiscal year in which services are performed and/or goods are received.

3. The funds identified for the fiscal years covered by under this Section, within this Exhibit, are subject to change depending on the availability and amount of funds appropriated by the Legislature and the Federal Government. The amount of funds available for expenditure by the Contractor shall be limited to the amount identified in the final allocations issued by the State for that fiscal year or the non-DMC amount, whichever is less. Changes to allocated funds will require written amendment to the Intergovernmental Agreement.

4. For each fiscal year, the State may settle costs for services based on each fiscal year year-end cost settlement report as the final amendment for the specific fiscal year cost settlement report to the approved single state/county Intergovernmental Agreement.

Section 2. Non-Drug Medi-Cal

A. Amounts Payable for Non-Drug Medi-Cal

1. State shall reimburse the Contractor monthly in arrears an amount equal to one-twelfth of the maximum amount allowed pursuant to Exhibit B of the Intergovernmental Agreement or the most recent allocation based on the Budget Act Allocation, whichever is less. Final allocations will reflect any increases or reductions in the appropriations as reflected in the State Budget Act allocation and any subsequent allocation revisions.

2. Monthly disbursement to the Intergovernmental Agreement at the beginning of each fiscal year of the Intergovernmental Agreement shall be based on the preliminary allocation of funds, as detailed in this Exhibit.

3. However, based on the expenditure information submitted by the counties in the Quarterly Federal Financial Management Report (QFFMR) (Document 3O), State may adjust monthly payments of encumbered block grant federal funds to extend the length of time (not to exceed 21 months) over which payments of federal funds will be made.

4. Monthly disbursements to the Contractor at the beginning of each fiscal year of the Intergovernmental Agreement shall be based on the preliminary allocation of funds, as detailed in Exhibit B.

5. State may withhold monthly non-DMC payments if the Contractor fails to:

   (a) submit timely reports and data required by the State, including but not limited to, reports required pursuant to Exhibit A, Attachment I, Section 23.2.

   (b) submit the Intergovernmental Agreement amendment within 90 days from issuance from the State to the Contractor.

   (c) submit and attest the completion of Corrective Action Plans for services provided pursuant to this Intergovernmental Agreement.

6. Upon the State's receipt of the complete and accurate reports, data, or signed Intergovernmental Agreement, the Contractor's monthly payment shall commence with the next scheduled monthly payment, and shall include any funds withheld due to late submission of reports, data and/or signed Intergovernmental Agreement.

7. Adjustments may be made to the total of the Intergovernmental Agreement and amounts may be withheld from payments otherwise due to the Contractor hereunder, for nonperformance to the extent that nonperformance involves fraud, abuse, or failure to achieve the objectives of the provisions of Exhibit A, Attachment I, Section 27.

B. Payment Provisions

For each fiscal year, the total amount payable by the State to the Contractor for services provided under Exhibit A, Attachment I, Section 27, shall not exceed the encumbered amount. The funds identified for the fiscal years covered by Exhibit A, Attachment I, Section 27, are subject to change depending on the availability and amount of funds appropriated by the Legislature and the Federal Government. Changes to encumbered funds will require written amendment to the Intergovernmental Agreement. State may settle costs for non-DMC services based on the year-end cost settlement report as the final amendment to the approved single state/county Intergovernmental Agreement.

C. In the event of an Intergovernmental Agreement amendment, as required by the preceding paragraph, Contactor shall submit to the State information as identified in Exhibit E, Section 1.D. To the extent the Contractor is notified of the State Budget Act allocation prior to the execution of the Intergovernmental Agreement, the State and the Contractor may agree to amend the Intergovernmental Agreement after the issuance of the first Budget Act allocation.

D. Accrual of Interest

Any interest accrued from State-allocated funds and retained by the Contractor must be used for the same purpose as the State allocated funds from which the interest was accrued.

E. Expenditure Period

Substance Abuse Prevention and Treatment (SAPT) Block Grant funds are allocated based upon the Federal Grant award period. These funds must be expended for activities authorized pursuant to 42 USC Sections 300x-21(b) through 300x-66; and Title 45, CFR, Subpart L, within the availability period of the grant award. Any SAPT Block Grant funds that have not been expended by a Contractor at the end of the expenditure period identified below shall be returned to the State for subsequent return to the Federal government.

1. The expenditure period of the FFY 2016 award is October 1, 2015 through June 30, 2017.

2. The expenditure period of the FFY 2017 award is October 1, 2016 through June 30, 2018.

3. The expenditure period of the FFY 2018 award is October 1, 2017 through June 30, 2019.

F. Contractors receiving SAPT Block Grant funds shall comply with the financial management standards contained in Title 45, CFR, Part 92, Sections 92.20(b)(1) through (6), and Title 45, CFR, Part 96, Section 96.30.

G. Non-profit Subcontractors receiving SAPT Block Grant funds shall comply with the 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.

H. Contractors receiving SAPT Block Grant funds shall track obligations and expenditures by individual SAPT Block Grant award, including, but not limited to, obligations and expenditures for primary prevention, services to pregnant women and women with dependent children. “Obligation” shall have the same meaning as used in Title 45, CFR, Part 92, Section 92.3.”

I. Restrictions on the Use of SAPT Block Grant Funds

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:

1. Provide inpatient services;

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

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

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

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

6. 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;

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

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

Section 3. Drug Medi-Cal

A. To the extent that the Contractor provides the covered services in a satisfactory manner and in accordance with the terms and conditions of this Intergovernmental Agreement, the State agrees to pay the Contractor federal Medicaid funds according to Exhibit A, Attachment I, Section 28.1. Subject to the availability of such funds, Contractor shall receive federal Medicaid funds and/or State General Funds for allowable expenditures as established by the federal government and approved by the State, for the cost of services rendered to beneficiaries.

B. Any payment for covered services rendered pursuant to Exhibit A, Attachment I, shall only be made pursuant to applicable provisions of Title XIX or Title XXI of the Social Security Act; the W&IC; the HSC; California's Medicaid State Plan; and Sections 51341.1, 51490.1, 51516.1, and 51532 of Title 22.

C. It is understood and agreed that failure by the Contractor or its Subcontractors 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 Contractor and/or terminate the Contractor or its Subcontractor from DMC program participation. If the State or the Department of Health and Human Services (DHHS) disallows or denies payments for any claim, Contractor 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).

D. 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). This requirement does not apply to the DMC Post Service Post Payment Utilization Reviews.

E. The State shall refund to the Contractor any recovered Federal Drug Medi-Cal overpayment that is subsequently determined to have been erroneously collected, together with interest, in accordance with Title 22, CCR, Section 51047(e).

F. Contractor shall be reimbursed by the State on the basis of its actual net reimbursable cost, not to exceed the unit of service maximum rate.

G. Claims submitted to the contractor by a sub-contracted provider that is not certified or whose certification has been suspended pursuant to the Welfare and Institutions Code section 14107.11, and Code of Federal Regulations, Title 42, section 455.23 shall not be certified or processed for federal or state reimbursement by the contractor. Payments for any DMC services shall be held by the Contractor until the payment suspension is resolved.

H. In the event an Intergovernmental Agreement amendment is required pursuant to the preceding paragraph, Contractor shall submit to the State information as identified in Exhibit E, Section 1.D. To the extent the Contractor is notified of the State Budget Act allocation prior to the execution of the Intergovernmental Agreement, the State and the Contractor may agree to amend the Intergovernmental Agreement after the issuance of the first revised allocation.

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

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

2. the provider's actual allowable costs.

J. Reimbursement to NTP's shall be limited to the lower of either the USDR rate, pursuant to W&IC Section 14021.51(h), or the provider's usual and customary charge to the general public for the same or similar service. However, reimbursement paid by a county to an NTP provider for services provided to any person subject to Penal Code Sections 1210.1 or 3063.1 and for which the individual client is not liable to pay, does not constitute a usual or customary charge to the general public. (W&IC Section 14021.51(h)(2)(A)).

K. State shall reimburse the Contractor the State General Funds and/or federal Medicaid amount of the approved DMC claims and documents submitted in accordance with Exhibit A, Attachment I, Section 23.2.

L. State will adjust subsequent reimbursements to the Contractor to actual allowable costs. Actual allowable costs are defined in 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.

M. Contractors and Subcontractors must accept, as payment in full, the amounts paid by the State in accordance with Title 22, CCR, Section 51516.1, plus any cost sharing charges (deductible, coinsurance, or copayment) required to be paid by the client. However, Contractors and Subcontractors may not deny services to any client eligible for DMC services on account of the client's inability to pay or location of eligibility. Contractors and Subcontractors may not demand any additional payment from the State, client, or other third party payers.

Exhibit B
Budget Detail and Payment Provisions

Part III - Financial Audit Requirements

Section 1. General Fiscal Audit Requirements

A. In addition to the requirements identified below, the Contractor and its Subcontracts are required to meet the audit requirements as delineated in Exhibit C, General Terms and Conditions, and Exhibit D(F), Special Terms and Conditions, of this Intergovernmental Agreement.

B. All expenditures of county realignment funds, state and federal funds furnished to the Contractor and its Subcontractors pursuant to this Intergovernmental Agreement 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) Circular A-133 (Revised December 2013) and/or any independent Contractor audits or reviews. Objectives of such audits may include, but not limited to, the following:

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

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

3. 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;

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

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

6. To determine the facts in relation to analysis of data, complaints, or allegations, which may be indicative of fraud, abuse, willful misrepresentation, or failure to achieve the Intergovernmental Agreement objectives of Exhibit C and D(F).

C. Unannounced visits may be made at the discretion of the State.

D. The refusal of the Contractor or its Subcontractors 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 Intergovernmental Agreement and will be sufficient basis to terminate the Intergovernmental Agreement for cause or default.

E. Reports of audits conducted by the State shall reflect all findings, recommendations, adjustments and corrective action as a result of it's finding in any areas.

Section 2. Non-Drug Medi-Cal Financial Audits

A. Pursuant to OMB Circular A-133 §.400(d)(3), Contractor shall monitor the activities of all of its Subcontractors to ensure that:

1. Subcontractors are complying with program requirements and achieving performance goals

2. Subcontractors are complying with fiscal requirements, such as having appropriate fiscal controls in place, and are using awards for authorized purposes.

B. Contractor can use a variety of monitoring mechanism, including limited scope audits, on-site visits, progress reports, financial reports, and review of documentation support requests for reimbursement, to meet the Contractor's monitoring objectives. The Contractor may charge federal awards for the cost of these monitoring procedures as outlined in OMB Circular A-133.

C. The Contractor shall submit to the State a copy of the procedures and any other monitoring mechanism used to monitor non-profit Subcontracts at the time of the County's annual site visit or within 60 days thereafter. Contractor shall state the frequency that non-profit Subcontracts are monitored.

D. Limited scope audits, as defined in the OMB Circular A-133, only include agreed-upon engagements that are (1) conducted in accordance with either the American Institute of Certified Public Accountants generally accepted auditing standards or attestation standards; (2) paid for and arranged by pass-through entities (counties); and (3) address one or more of the following types of compliance requirements: (i) activities allowed or unallowed; (ii) allowable costs/cost principals; (iii) eligibility; (9v) matching, level of effort and earmarking; and (v) reporting.

E. On-site visits focus on compliance and controls over compliance areas. The reviewer must make site visits to the subcontractor locations(s), and can use a variety of monitoring mechanism to document compliance requirements. The finding and the corrective action will require follow-up by the Contractor.

F. 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. Contractor shall not use funds administered by the State to repay one federal funding source with funds provided by another federal funding source, to repay federal funds with state funds, or to repay state funds with federal funds. State shall invoice Contractor 60 days after issuing the final audit report or upon resolution of an audit appeal. Contractor agrees to 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 one year from the date of the plan.

If differences cannot be resolved between the State and Contractor regarding the terms of the financial audit settlements for funds expended under Exhibit A, Attachment I, Section 27, Contractor may request an appeal in accordance with the appeal process described in Document 1J(a), "Non-DMC Audit Appeal Process," incorporated by this reference. When a financial audit is conducted by the Federal Government, the State, or the California State Auditor directly with a Subcontractor of the Contractor, and if the Subcontractor disagrees with audit disallowances related to its programs, claims or services, Contractor shall, at the Subcontractor's request, request an appeal to the State in accordance with Document 1J(a). Contractor shall include a provision in its subcontracts regarding the process by which its Subcontractors may file an appeal via the Contractors.

G. Contractors that conduct financial audits of Subcontractors, other than a Subcontractor whose funding consists entirely of non-Department funds, shall develop a process to resolve disputed financial findings and notify Subcontractors of their appeal rights pursuant to that process. This section shall not apply to those grievances or compliances arising from the financial findings of an audit or examination made by or on behalf of the State.

H. 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. The sanctions shall include:

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

2. Withhold or disallowing overhead costs

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

4. Terminating the federal award

Section 3. Drug Medi-Cal Financial Audits

A. In addition to the audit requirements set forth in Exhibit D(F), 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:

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

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

3. 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;

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

5. To determine the amount of clients' third-party revenue and Medi-Cal share of cost to offset allowable DMC reimbursement; and,

6. 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.

B. In addition to the audit requirements set forth in Exhibit D(F), State may conduct financial audits of NTP programs. For NTP services, the audits will address items A(3) through A(5) above, except that the comparison of the provider's usual and customary charge in A(3) will be to the DMC USDR rate in lieu of DMC cost per unit. In addition, these audits will include, but not be limited to:

1. For those NTP providers required to submit a cost report pursuant to W&IC Section 14124.24, a review of cost allocation methodology between NTP and other service modalities, and between DMC and other funding sources;

2. A review of actual costs incurred for comparison to services claimed;

3. A review of counseling claims to ensure that the appropriate group or individual counseling rate has been used and that counseling sessions have been billed appropriately;

4. A review of the number of clients in group sessions to ensure that sessions include no less than two and no more than twelve clients at the same time, with at least one Medi-Cal client in attendance;

5. Computation of final settlement based on the lower of USDR rate or the provider's usual and customary charge to the general public; and,

6. A review of supporting service, time, financial, and patient records to verify the validity of counseling claims.

C. 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

D. 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 months from the date of the plan.

E. Contractor, in coordination with the State, must provide follow-up on all significant findings in the audit report, including findings relating to a Subcontractor, and submit the results to the State.

If differences cannot be resolved between the State and the Contractor regarding the terms of the final financial audit settlements for funds expended under Exhibit B, Contractor may request an appeal in accordance with the appeal process described in the "DMC Audit Appeal Process," Document 1J(b), incorporated by this reference. When a financial audit is conducted by the Federal Government, the State, or the Bureau of State Audits directly with a Subcontractor of the Contractor, and if the Subcontractor disagrees with audit disallowances related to its programs, claims or services, Contractor shall, at the Subcontractor's request, request an appeal to the State in accordance with Document 1J(b). Contractor shall include a provision in its subcontracts regarding the process by which a Subcontractor may file an audit appeal via the Contractor.

F. Providers of DMC services shall, upon request, make available to the State their fiscal and other records to assure that such provider have adequate recordkeeping capability and to assure that reimbursement for covered DMC services are made in accordance with Title 22, CCR, Section 51516.1. These records include, but are not limited to, matters pertaining to:

1. Provider ownership, organization, and operation;

2. Fiscal, medical, and other recordkeeping systems;

3. Federal income tax status;

4. Asset acquisition, lease, sale, or other action;

5. Franchise or management arrangements;

6. Patient service charge schedules;

7. Costs of operation;

8. Cost allocation methodology;

9. Amounts of income received by source and purpose; and,

10. Flow of funds and working capital.

G. Contractor shall retain records of utilization review activities required for a minimum of three (3) years.

Exhibit B
Budget Detail and Payment Provisions

Part IV – Records

Section 1. General Provisions

A. Maintenance of Records

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.

1. Contractor shall include in any Intergovernmental 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.

2. 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.

3. Accounting records and supporting documents shall be retained for a three-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 three-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.

4. 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.

5. Contractor's subcontracts shall require that all Subcontractors comply with the requirements of Exhibit A, Attachment I, Section 19.

6. Should a Subcontractor discontinue its contractual agreement with the Contractor, or cease to conduct business in its entirety, Contractor shall be responsible for retaining the Subcontractor's fiscal and program records for the required retention period. The State Administrative Manual (SAM) contains statutory requirements governing the retention, storage, and disposal of records pertaining to state funds. Contractor shall follow SAM requirements 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.

7. 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.

B. Dispute Resolution Process

1. In the event of a dispute, other than an audit dispute, Contractor shall provide written notice of the particulars of the dispute to the State before exercising any other available remedy. Written notice shall include the Intergovernmental Agreement number. The Director (or designee) of the State and the County Drug or Alcohol Program Administrator (or designee) shall meet to discuss the means by which they can effect an equitable resolution to the dispute. Contractor shall receive a written response from the State within sixty (60) days of the notice of dispute. The written response shall reflect the issues discussed at the meeting and state how the dispute will be resolved.

2. In the event of a dispute over financial audit findings between the State and the Contractor, Contractor may appeal the audit in accordance with the "non- DMC Audit Appeal Process" (Document 1J(a)). When a financial audit by the Federal Government, the State, or the California State Auditor is conducted directly with a Subcontractor of the Contractor, and if the Subcontractor disagrees with audit disallowances related to its programs, claims or services, Contractor shall, at the Subcontractor's request, request an appeal to the State in accordance with Document 1J(a). Contractor shall include a provision in its subcontracts regarding the process by which a Subcontractor may file an audit appeal via the Contractor.

3. As stated in Part III, Section 3, of this Exhibit, in the event of a dispute over financial audit findings between the State and the Contractor, Contractor may appeal the audit in accordance with DMC Audit Appeal Process" (Document 1J(b)). When a financial audit by the Federal Government, the State, or the California State Auditor is conducted directly with a Subcontractor of the Contractor, and if the Subcontractor disagrees with audit disallowances related to its programs, claims or services, Contractor shall, at the Subcontractor's request, request an appeal to the State in accordance with DMC Audit Appeal Process" (Document 1J(b)). Contractor shall include a provision in its subcontracts regarding the process by which a Subcontractor may file an audit appeal via the Contractor.

4. Contractors that conduct financial audits of Subcontractors, other than a Subcontractor whose funding consists entirely of non-Department funds, shall develop a process to resolve disputed financial findings and notify Subcontractors of their appeal rights pursuant to that process. This section shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of the State pursuant to Part II of this Exhibit.

5. To ensure that necessary corrective actions are taken, financial audit findings are either uncontested or upheld after appeal may be used by the State during prospective Intergovernmental Agreement negotiations.

Exhibit B
Budget Detail and Payment Provisions

Part V. Drug Medi-Cal Reimbursement Rates

A. **"Uniform Statewide Daily Reimbursement (USDR) Rate"** means the rate for NTP services based on a unit of service that is a daily treatment service provided pursuant to Title 22, Sections 51341.1 and 51516.1 and Title 9, commencing with Section 10000 (Document 3G), or the rate for individual or group counseling. The following table shows USDR rates.

Service	Type of Unit of Service (UOS)	Non-Perinatal (Regular) Rate Per UOS	Perinatal Rate Per UOS
NTP-Methadone Dosing	Daily	$11.95	$13.80
NTP-Individual Counseling (*)	One 10-minute increment	$13.90	$18.43
NTP Group Counseling (*)	One 10-minute increment	$3.05	$6.07

(*) The NTP contractors may be reimbursed for up to 200 minutes (20-10 minute increments) of individual and/or group counseling per calendar month. If medical necessity is met that requires additional NTP counseling beyond 200 minutes per calendar month, NTP contractors may bill and be reimbursed for additional counseling (in 10 minute increments). Medical justification for the additional counseling must be clearly documented in the patient record.

Reimbursement for covered NTP services shall be limited to the lower of the NTP's usual and customary charge to the general public for the same or similar services or the USDR rate.

B. **"Unit of Service"** means a face-to-face contact on a calendar day for outpatient drug free, intensive outpatient treatment, partial hospitalization, and residential treatment services. Units of service are identified in the following table:

Service Modality (funded by DMS)	Billing/Unit of Service	Revised Interim Rate per Unit of Service*
Encounter Rates		
Outpatient	15 minute increments	**$ 31.00**
Recovery Services	15 minute increments	**$ 19.80**
Case Management	15 minute increments	**$ 36.29**
Physician Consultation	15 minute increments	**$ 154.84**
Intensive Outpatient	15 minute increments	**$ 29.18**
Daily Rates		
Level 1-WM	Per Day	**$ 154.84**
Level 2-WM	Per Day	**N/A**
Level 3.2-WM	Per Day	**$ 207.22**
Level 3.1 - Residential	Per Day	**$ 111.95**
Level 3.3 - Residential	Per Day	**$ 268.29**
Level 3.5 - Residential	Per Day	**$ 188.63**
Optional		
Additional Medication Assisted Treatment	15 minute increments	**$ 154.84**
Partial Hospitalization	N/A	**N/A**

Exhibit B, Attachment I - Funding for Fiscal Year 2016-17 through FY 2018-19

Version:	Original
Date:	10/18/2016

County: San Mateo

Contract Number: 16-93234

Fiscal Year 2016-17	2016-17 Funding Amount
State General Funds (7/1/16 to 6/30/17)	
Drug Medi-Cal SGF	23,317
ODS Waiver SGF	148,368
TOTAL	**171,685**
SAPT Block Grant - FFY 2017 Award (10/1/16 to 6/30/18)	
- Discretionary	3,390,718
- Prevention Set-Aside	955,792
- Friday Night Live/Club Live	30,000
- Perintal	222,167
- Adolescent/Youth	56,352
TOTAL	**4,655,029**
Drug Medi-Cal Federal Share (7/1/16 to 6/30/17)	
- Non Perinatal Federal Share	1,596,333
- Perinatal Federal Share	0
TOTAL	**1,596,333**
GRAND TOTAL	**6,423,047**

Fiscal Year 2017-18	2017-18 Funding Amount
State General Funds (7/1/17 to 6/30/18)	
Drug Medi-Cal SGF	23,317
ODS Waiver SGF	148,368
TOTAL	**171,685**
SAPT Block Grant - FFY 2018 Award (10/1/17 to 6/30/19)	
- Discretionary	3,390,718
- Prevention Set-Aside	955,792
- Friday Night Live/Club Live	30,000
- Perintal	222,167
- Adolescent/Youth	56,352
TOTAL	**4,655,029**
Drug Medi-Cal Federal Share (7/1/17 to 6/30/18)	
- Non Perinatal Federal Share	1,596,333
- Perinatal Federal Share	0
TOTAL	**1,596,333**
GRAND TOTAL	**6,423,047**

Fiscal Year 2018-19	2018-19 Funding Amount
State General Funds (7/1/18 to 6/30/19)	
Drug Medi-Cal SGF	23,317
ODS Waiver SGF	148,368
TOTAL	**171,685**
SAPT Block Grant - FFY 2019 Award (10/1/18 to 6/30/20)	
- Discretionary	3,390,718
- Prevention Set-Aside	955,792
- Friday Night Live/Club Live	30,000
- Perintal	222,167
- Adolescent/Youth	56,352
TOTAL	**4,655,029**
Drug Medi-Cal Federal Share (7/1/18 to 6/30/19)	
- Non Perinatal Federal Share	1,596,333
- Perinatal Federal Share	0
TOTAL	**1,596,333**
GRAND TOTAL	**6,423,047**

THREE-YEAR TOTAL	**19,269,141**

Special Terms and Conditions

(For federally funded service contracts or agreements and grant agreements)

The use of headings or titles throughout this exhibit is for convenience only and shall not be used to interpret or to govern the meaning of any specific term or condition.

The terms "contract", "Contractor" and "Subcontractor" shall also mean, “agreement”, "grant", “grant agreement”, "Grantee" and "Subgrantee" respectively.

The terms “California Department of Health Care Services”, “California Department of Health Services”, ‘Department of Health Care Services”, “Department of Health Services”, “CDHCS”, “DHCS”, “CDHS”, and “DHS” shall all have the same meaning and refer to the California State agency that is a party to this Agreement.

This exhibit contains provisions that require strict adherence to various contracting laws and policies. Some provisions herein are conditional and only apply if specified conditions exist (i.e., agreement total exceeds a certain amount; agreement is federally funded, etc.). The provisions herein apply to this Agreement unless the provisions are removed by reference on the face of this Agreement, the provisions are superseded by an alternate provision appearing elsewhere in this Agreement, or the applicable conditions do not exist.

Index of Special Terms and Conditions

1. Federal Equal Employment Opportunity Requirements
2. Travel and Per Diem Reimbursement (Revised 6/2014)
3. Procurement Rules
4. Equipment Ownership / Inventory / Disposition
5. Subcontract Requirements
6. Income Restrictions
7. Audit and Record Retention
8. Site Inspection
9. Federal Contract Funds
10. Intellectual Property Rights
11. Air or Water Pollution Requirements
12. Prior Approval of Training Seminars, Workshops or Conferences
13. Confidentiality of Information
14. Documents, Publications, and Written Reports
15. Dispute Resolution Process (Revised 2/2012)
16. Financial and Compliance Audit Requirements
17. Human Subjects Use Requirements
18. Novation Requirements
19. Debarment and Suspension Certification
20. Smoke-Free Workplace Certification
21. Covenant Against Contingent Fees
22. Payment Withholds
23. Performance Evaluation
24. Officials Not to Benefit
25. Four-Digit Date Compliance
26. Prohibited Use of State Funds for Software
27. Use of Small, Minority Owned and Women's Businesses
28. Alien Ineligibility Certification
29. Union Organizing
30. Contract Uniformity (Fringe Benefit Allowability)
31. Suspension or Stop Work Notification
32. Lobbying Restrictions and Disclosure Certification

1. Federal Equal Opportunity Requirements

(Applicable to all federally funded agreements entered into by the Department of Health Care Services)

a. The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. The Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

b. The Contractor will, in all solicitations or advancements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

c. The Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Contractor's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

d. The Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,‘ and as supplemented by regulation at 41 CFR part 60, “Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” and of the rules, regulations, and relevant orders of the Secretary of Labor.

e. The Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,‘ and as supplemented by regulation at 41 CFR part 60, “Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

f. In the event of the Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, ‘Amending Executive Order 11246 Relating to Equal Employment Opportunity,‘ and as supplemented by regulation at 41 CFR part 60, “Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor,” or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

g. The Contractor will include the provisions of Paragraphs a through g in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event the Contractor becomes involved in, or is threatened with litigation by a subcontractor or vendor as a result of such direction by DHCS, the Contractor may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2. Travel and Per Diem Reimbursement

(Applicable if travel and/or per diem expenses are reimbursed with agreement funds.)

Reimbursement for travel and per diem expenses from DHCS under this Agreement shall, unless otherwise specified in this Agreement, be at the rates currently in effect, as established by the California Department of Human Resources (CalHR), for nonrepresented state employees as stipulated in DHCS' Travel Reimbursement Information Exhibit. If the CalHR rates change during the term of the Agreement, the new rates shall apply upon their effective date and no amendment to this Agreement shall be necessary. Exceptions to CalHR rates may be approved by DHCS upon the submission of a statement by the Contractor indicating that such rates are not available to the Contractor. No travel outside the State of California shall be reimbursed without prior authorization from DHCS. Verbal authorization should be confirmed in writing. Written authorization may be in a form including fax or email confirmation.

3. Procurement Rules

(Applicable to agreements in which equipment/property, commodities and/or supplies are furnished by DHCS or expenses for said items are reimbursed by DHCS with state or federal funds provided under the Agreement.)

a. **Equipment/Property definitions**

Wherever the term equipment and/or property is used, the following definitions shall apply:

(1) **Major equipment/property**: A tangible or intangible item having a base unit cost of **$5,000 or more** with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement. Software and videos are examples of intangible items that meet this definition.

(2) **Minor equipment/property**: A tangible item having a base unit cost of **less than $5,000** with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement.

b. **Government and public entities** (including state colleges/universities and auxiliary organizations), whether acting as a contractor and/or subcontractor, may secure all commodities, supplies, equipment and services related to such purchases that are required in performance of this Agreement. Said procurements are subject to Paragraphs d through h of Provision 3. Paragraph c of Provision 3 shall also apply, if equipment/property purchases are delegated to subcontractors that are nonprofit organizations or commercial businesses.

c. **Nonprofit organizations and commercial businesses**, whether acting as a contractor and/or subcontractor, may secure commodities, supplies, equipment/property and services related to such purchases for performance under this Agreement.

(1) Equipment/property purchases shall not exceed $50,000 annually.

To secure equipment/property above the annual maximum limit of $50,000, the Contractor shall

make arrangements through the appropriate DHCS Program Contract Manager, to have all remaining equipment/property purchased through DHCS' Purchasing Unit. The cost of equipment/property purchased by or through DHCS shall be deducted from the funds available in this Agreement. Contractor shall submit to the DHCS Program Contract Manager a list of equipment/property specifications for those items that the State must procure. DHCS may pay the vendor directly for such arranged equipment/property purchases and title to the equipment/property will remain with DHCS. The equipment/property will be delivered to the Contractor's address, as stated on the face of the Agreement, unless the Contractor notifies the DHCS Program Contract Manager, in writing, of an alternate delivery address.

(2) All equipment/property purchases are subject to Paragraphs d through h of Provision 3. Paragraph b of Provision 3 shall also apply, if equipment/property purchases are delegated to subcontractors that are either a government or public entity.

(3) Nonprofit organizations and commercial businesses shall use a procurement system that meets the following standards:

(a) Maintain a code or standard of conduct that shall govern the performance of its officers, employees, or agents engaged in awarding procurement contracts. No employee, officer, or agent shall participate in the selection, award, or administration of a procurement, or bid contract in which, to his or her knowledge, he or she has a financial interest.

(b) Procurements shall be conducted in a manner that provides, to the maximum extent practical, open, and free competition.

(c) Procurements shall be conducted in a manner that provides for all of the following:

[1] Avoid purchasing unnecessary or duplicate items.

[2] Equipment/property solicitations shall be based upon a clear and accurate description of the technical requirements of the goods to be procured.

[3] Take positive steps to utilize small and veteran owned businesses.

d. Unless waived or otherwise stipulated in writing by DHCS, prior written authorization from the appropriate DHCS Program Contract Manager will be required before the Contractor will be reimbursed for any purchase of $5,000 or more for commodities, supplies, equipment/property, and services related to such purchases. The Contractor must provide in its request for authorization all particulars necessary, as specified by DHCS, for evaluating the necessity or desirability of incurring such costs. The term "purchase" excludes the purchase of services from a subcontractor and public utility services at rates established for uniform applicability to the general public.

e. In special circumstances, determined by DHCS (e.g., when DHCS has a need to monitor certain purchases, etc.), DHCS may require prior written authorization and/or the submission of paid vendor receipts for any purchase, regardless of dollar amount. DHCS reserves the right to either deny claims for reimbursement or to request repayment for any Contractor and/or subcontractor purchase that DHCS determines to be unnecessary in carrying out performance under this Agreement.

f. The Contractor and/or subcontractor must maintain a copy or narrative description of the procurement system, guidelines, rules, or regulations that will be used to make purchases under this Agreement. The State reserves the right to request a copy of these documents and to inspect the purchasing practices of the Contractor and/or subcontractor at any time.

g. For all purchases, the Contractor and/or subcontractor must maintain copies of all paid vendor invoices, documents, bids and other information used in vendor selection, for inspection or audit. Justifications supporting the absence of bidding (i.e., sole source purchases) shall also be maintained on file by the Contractor and/or subcontractor for inspection or audit.

h. DHCS may, with cause (e.g., with reasonable suspicion of unnecessary purchases or use of inappropriate purchase practices, etc.), withhold, cancel, modify, or retract the delegated purchase authority granted under Paragraphs b and/or c of Provision 3 by giving the Contractor no less than 30 calendar days written notice.

4. Equipment/Property Ownership / Inventory / Disposition

(Applicable to agreements in which equipment/property is furnished by DHCS and/or when said items are purchased or reimbursed by DHCS with state or federal funds provided under the Agreement.)

a. Wherever the term equipment and/or property is used in Provision 4, the definitions in Paragraph a of Provision 3 shall apply.

Unless otherwise stipulated in this Agreement, all equipment and/or property that is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement shall be considered state equipment and the property of DHCS.

(1) **Reporting of Equipment/Property Receipt -** DHCS requires the reporting, tagging and annual inventorying of all equipment and/or property that is furnished by DHCS or purchased/reimbursed with funds provided through this Agreement.

Upon receipt of equipment and/or property, the Contractor shall report the receipt to the DHCS Program Contract Manager. To report the receipt of said items and to receive property tags, Contractor shall use a form or format designated by DHCS' Asset Management Unit. If the appropriate form (i.e., Contractor Equipment Purchased with DHCS Funds) does not accompany this Agreement, Contractor shall request a copy from the DHCS Program Contract Manager.

(2) **Annual Equipment/Property Inventory -** If the Contractor enters into an agreement with a term of more than twelve months, the Contractor shall submit an annual inventory of state equipment and/or property to the DHCS Program Contract Manager using a form or format designated by DHCS' Asset Management Unit. If an inventory report form (i.e., Inventory/Disposition of DHCS-Funded Equipment) does not accompany this Agreement, Contractor shall request a copy from the DHCS Program Contract Manager. Contractor shall:

(a) Include in the inventory report, equipment and/or property in the Contractor's possession and/or in the possession of a subcontractor (including independent consultants).

(b) Submit the inventory report to DHCS according to the instructions appearing on the inventory form or issued by the DHCS Program Contract Manager.

(c) Contact the DHCS Program Contract Manager to learn how to remove, trade-in, sell, transfer or survey off, from the inventory report, expired equipment and/or property that is no longer wanted, usable or has passed its life expectancy. Instructions will be supplied by either the DHCS Program Contract Manager or DHCS' Asset Management Unit.

b. Title to state equipment and/or property shall not be affected by its incorporation or attachment to any property not owned by the State.

c. Unless otherwise stipulated, DHCS shall be under no obligation to pay the cost of restoration, or rehabilitation of the Contractor's and/or Subcontractor's facility which may be affected by the removal of any state equipment and/or property.

d. The Contractor and/or Subcontractor shall maintain and administer a sound business program for ensuring the proper use, maintenance, repair, protection, insurance and preservation of state equipment and/or property.

(1) In administering this provision, DHCS may require the Contractor and/or Subcontractor to repair or replace, to DHCS' satisfaction, any damaged, lost or stolen state equipment and/or property. In the event of state equipment and/or miscellaneous property theft, Contractor and/or Subcontractor shall immediately file a theft report with the appropriate police agency or the California Highway Patrol and Contractor shall promptly submit one copy of the theft report to the DHCS Program Contract Manager.

e. Unless otherwise stipulated by the Program funding this Agreement, equipment and/or property purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, shall only be used for performance of this Agreement or another DHCS agreement.

f. Within sixty (60) calendar days prior to the termination or end of this Agreement, the Contractor shall provide a final inventory report of equipment and/or property to the DHCS Program Contract Manager and shall, at that time, query DHCS as to the requirements, including the manner and method, of returning state equipment and/or property to DHCS. Final disposition of equipment and/or property shall be at DHCS expense and according to DHCS instructions. Equipment and/or property disposition instructions shall be issued by DHCS immediately after receipt of the final inventory report. At the termination or conclusion of this Agreement, DHCS may at its discretion, authorize the continued use of state equipment and/or property for performance of work under a different DHCS agreement.

g. **Motor Vehicles**

(Applicable only if motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under this Agreement.)

(1) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, within thirty (30) calendar days prior to the termination or end of this Agreement, the Contractor and/or Subcontractor shall return such vehicles to DHCS and shall deliver all necessary documents of title or registration to enable the proper transfer of a marketable title to DHCS.

(2) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the State of California shall be the legal owner of said motor vehicles and the Contractor shall be the registered owner. The Contractor and/or a subcontractor may only use said vehicles for performance and under the terms of this Agreement.

(3) The Contractor and/or Subcontractor agree that all operators of motor vehicles, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, shall hold a valid State of California driver's license. In the event that ten or more passengers are to be transported in any one vehicle, the operator shall also hold a State of California Class B driver's license.

(4) If any motor vehicle is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the Contractor and/or Subcontractor, as applicable, shall provide, maintain, and certify that, at a minimum, the following type and amount of automobile liability insurance is in effect during the term of this Agreement or any extension period during which any vehicle remains in the Contractor's and/or Subcontractor's possession:

Automobile Liability Insurance

(a) The Contractor, by signing this Agreement, hereby certifies that it possesses or will obtain automobile liability insurance in the amount of $1,000,000 per occurrence for bodily injury and property damage combined. Said insurance must be obtained and made effective upon the delivery date of any motor vehicle, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, to the Contractor and/or Subcontractor.

(b) The Contractor and/or Subcontractor shall, as soon as practical, furnish a copy of the certificate of insurance to the DHCS Program Contract Manager. The certificate of insurance shall identify the DHCS contract or agreement number for which the insurance applies.

(c) The Contractor and/or Subcontractor agree that bodily injury and property damage liability insurance, as required herein, shall remain in effect at all times during the term of this Agreement or until such time as the motor vehicle is returned to DHCS.

(d) The Contractor and/or Subcontractor agree to provide, at least thirty (30) days prior to the expiration date of said insurance coverage, a copy of a new certificate of insurance evidencing continued coverage, as indicated herein, for not less than the remainder of the term of this Agreement, the term of any extension or continuation thereof, or for a period of not less than one (1) year.

(e) The Contractor and/or Subcontractor, if not a self-insured government and/or public entity, must provide evidence, that any required certificates of insurance contain the following provisions:

[1] The insurer will not cancel the insured's coverage without giving thirty (30) calendar days prior written notice to the State (California Department of Health Care Services).

[2] The State of California, its officers, agents, employees, and servants are included as additional insureds, but only with respect to work performed for the State under this Agreement and any extension or continuation of this Agreement.

[3] The insurance carrier shall notify the California Department of Health Care Services (DHCS), in writing, of the Contractor's failure to pay premiums; its cancellation of such policies; or any other substantial change, including, but not limited to, the status, coverage, or scope of the required insurance. Such notices shall contain a reference to each agreement number for which the insurance was obtained.

(f) The Contractor and/or Subcontractor is hereby advised that copies of certificates of insurance may be subject to review and approval by the Department of General Services (DGS), Office of Risk and Insurance Management. The Contractor shall be notified by DHCS, in writing, if this provision is applicable to this Agreement. If DGS approval of the certificate of insurance is required, the Contractor agrees that no work or services shall be performed prior to obtaining said approval.

(g) In the event the Contractor and/or Subcontractor fails to keep insurance coverage, as required herein, in effect at all times during vehicle possession, DHCS may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

5. Subcontract Requirements

(Applicable to agreements under which services are to be performed by subcontractors including independent consultants.)

a. Prior written authorization will be required before the Contractor enters into or is reimbursed for any subcontract for services costing $5,000 or more. Except as indicated in Paragraph a(3) herein, when securing subcontracts for services exceeding $5,000, the Contractor shall obtain at least three bids or justify a sole source award.

(1) The Contractor must provide in its request for authorization, all information necessary for evaluating the necessity or desirability of incurring such cost.

(2) DHCS may identify the information needed to fulfill this requirement.

(3) Subcontracts performed by the following entities or for the service types listed below are exempt from the bidding and sole source justification requirements:

(a) A local governmental entity or the federal government,

(b) A State college or State university from any State,

(c) A Joint Powers Authority,

(d) An auxiliary organization of a California State University or a California community college,

(e) A foundation organized to support the Board of Governors of the California Community Colleges,

(f) An auxiliary organization of the Student Aid Commission established under Education Code § 69522,

(g) Firms or individuals proposed for use and approved by DHCS' funding Program via acceptance of an application or proposal for funding or pre/post contract award negotiations,

(h) Entities and/or service types identified as exempt from advertising and competitive bidding in State Contracting Manual Chapter 5 Section 5.80 Subsection B.3. View this publication at the following Internet address: http://www.dgs.ca.gov/ols/Resources/StateContractManual.aspx.

b. DHCS reserves the right to approve or disapprove the selection of subcontractors and with advance written notice, require the substitution of subcontractors and require the Contractor to terminate subcontracts entered into in support of this Agreement.

(1) Upon receipt of a written notice from DHCS requiring the substitution and/or termination of a subcontract, the Contractor shall take steps to ensure the completion of any work in progress and select a replacement, if applicable, within 30 calendar days, unless a longer period is agreed to by DHCS.

c. Actual subcontracts (i.e., written agreement between the Contractor and a subcontractor) of $5,000 or more are subject to the prior review and written approval of DHCS. DHCS may, at its discretion, elect to waive this right. All such waivers shall be confirmed in writing by DHCS.

d. Contractor shall maintain a copy of each subcontract entered into in support of this Agreement and shall, upon request by DHCS, make copies available for approval, inspection, or audit.

e. DHCS assumes no responsibility for the payment of subcontractors used in the performance of this Agreement. Contractor accepts sole responsibility for the payment of subcontractors used in the performance of this Agreement.

f. The Contractor is responsible for all performance requirements under this Agreement even though performance may be carried out through a subcontract.

g. The Contractor shall ensure that all subcontracts for services include provision(s) requiring compliance with applicable terms and conditions specified in this Agreement.

h. The Contractor agrees to include the following clause, relevant to record retention, in all subcontracts for services:

"(*Subcontractor Name*) agrees to maintain and preserve, until three years after termination of (*Agreement Number*) and final payment from DHCS to the Contractor, to permit DHCS or any duly authorized representative, to have access to, examine or audit any pertinent books, documents, papers and records related to this subcontract and to allow interviews of any employees who might reasonably have information related to such records."

i. Unless otherwise stipulated in writing by DHCS, the Contractor shall be the subcontractor's sole point of contact for all matters related to performance and payment under this Agreement.

j. Contractor shall, as applicable, advise all subcontractors of their obligations pursuant to the following numbered provisions of this Exhibit: 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 17, 19, 20, 24, 32 and/or other numbered provisions herein that are deemed applicable.

6. Income Restrictions

Unless otherwise stipulated in this Agreement, the Contractor agrees that any refunds, rebates, credits, or other amounts (including any interest thereon) accruing to or received by the Contractor under this Agreement shall be paid by the Contractor to DHCS, to the extent that they are properly allocable to costs for which the Contractor has been reimbursed by DHCS under this Agreement.

7. Audit and Record Retention

(Applicable to agreements in excess of $10,000.)

a. The Contractor and/or Subcontractor shall maintain books, records, documents, and other evidence, accounting procedures and practices, sufficient to properly reflect all direct and indirect costs of whatever nature claimed to have been incurred in the performance of this Agreement, including any matching costs and expenses. The foregoing constitutes "records" for the purpose of this provision.

b. The Contractor's and/or subcontractor's facility or office or such part thereof as may be engaged in the performance of this Agreement and his/her records shall be subject at all reasonable times to inspection, audit, and reproduction.

c. Contractor agrees that DHCS, the Department of General Services, the Bureau of State Audits, or their designated representatives including the Comptroller General of the United States shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this

Agreement. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, the Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Agreement. (GC 8546.7, CCR Title 2, Section 1896).

d. The Contractor and/or Subcontractor shall preserve and make available his/her records (1) for a period of three years from the date of final payment under this Agreement, and (2) for such longer period, if any, as is required by applicable statute, by any other provision of this Agreement, or by subparagraphs (1) or (2) below.

   (1) If this Agreement is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of three years from the date of any resulting final settlement.

   (2) If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the three-year period, the records shall be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular three-year period, whichever is later.

e. The Contractor and/or Subcontractor shall comply with the above requirements and be aware of the penalties for violations of fraud and for obstruction of investigation as set forth in Public Contract Code § 10115.10, if applicable.

f. The Contractor and/or Subcontractor may, at its discretion, following receipt of final payment under this Agreement, reduce its accounts, books and records related to this Agreement to microfilm, computer disk, CD ROM, DVD, or other data storage medium. Upon request by an authorized representative to inspect, audit or obtain copies of said records, the Contractor and/or Subcontractor must supply or make available applicable devices, hardware, and/or software necessary to view, copy and/or print said records. Applicable devices may include, but are not limited to, microfilm readers and microfilm printers, etc.

g. The Contractor shall, if applicable, comply with the Single Audit Act and the audit reporting requirements set forth in OMB Circular A-133.

8. Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract supported activities and the premises in which it is being performed. If any inspection or evaluation is made of the premises of the Contractor or Subcontractor, the Contractor shall provide and shall require Subcontractors to provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

9. Federal Contract Funds

(Applicable only to that portion of an agreement funded in part or whole with federal funds.)

a. It is mutually understood between the parties that this Agreement may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the Agreement were executed after that determination was made.

b. This agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the fiscal years covered by the term of this Agreement. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress which may affect the provisions, terms or funding of this Agreement in any manner.

c. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this Agreement shall be amended to reflect any reduction in funds.

d. DHCS has the option to invalidate or cancel the Agreement with 30-days advance written notice or to amend the Agreement to reflect any reduction in funds.

10. Intellectual Property Rights

a. Ownership

(1) Except where DHCS has agreed in a signed writing to accept a license, DHCS shall be and remain, without additional compensation, the sole owner of any and all rights, title and interest in all Intellectual Property, from the moment of creation, whether or not jointly conceived, that are made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.

(2) For the purposes of this Agreement, Intellectual Property means recognized protectable rights and interest such as: patents, (whether or not issued) copyrights, trademarks, service marks, applications for any of the foregoing, inventions, trade secrets, trade dress, logos, insignia, color combinations, slogans, moral rights, right of publicity, author's rights, contract and licensing rights, works, mask works, industrial design rights, rights of priority, know how, design flows, methodologies, devices, business processes, developments, innovations, good will and all other legal rights protecting intangible proprietary information as may exist now and/or here after come into existence, and all renewals and extensions, regardless of whether those rights arise under the laws of the United States, or any other state, country or jurisdiction.

(a) For the purposes of the definition of Intellectual Property, "works" means all literary works, writings and printed matter including the medium by which they are recorded or reproduced, photographs, art work, pictorial and graphic representations and works of a similar nature, film, motion pictures, digital images, animation cells, and other audiovisual works including positives and negatives thereof, sound recordings, tapes, educational materials, interactive videos and any other materials or products created, produced, conceptualized and fixed in a tangible medium of expression. It includes preliminary and final products and any materials and information developed for the purposes of producing those final products. Works does not include articles submitted to peer review or reference journals or independent research projects.

(3) In the performance of this Agreement, Contractor will exercise and utilize certain of its Intellectual Property in existence prior to the effective date of this Agreement. In addition, under this Agreement, Contractor may access and utilize certain of DHCS' Intellectual Property in existence prior to the effective date of this Agreement. Except as otherwise set forth herein, Contractor shall not use any of DHCS' Intellectual Property now existing or hereafter existing for any purposes without the prior written permission of DHCS. **Except as otherwise set forth herein, neither the Contractor nor DHCS shall give any ownership interest in or rights to its Intellectual Property to the other Party.** If during the term of this Agreement, Contractor accesses any third-party Intellectual Property that is licensed to DHCS, Contractor agrees to abide by all license and confidentiality restrictions applicable to DHCS in the third-party's license agreement.

(4) Contractor agrees to cooperate with DHCS in establishing or maintaining DHCS' exclusive rights in the Intellectual Property, and in assuring DHCS' sole rights against third parties with respect to the Intellectual Property. If the Contractor enters into any agreements or subcontracts with other parties in order to perform this Agreement, Contractor shall require the terms of the Agreement(s) to include all Intellectual Property provisions. Such terms must include, but are not limited to, the subcontractor assigning and agreeing to assign to DHCS all rights, title and interest in Intellectual Property made, conceived, derived from, or reduced to practice by the subcontractor, Contractor or DHCS and which result directly or indirectly from this Agreement or any subcontract.

(5) Contractor further agrees to assist and cooperate with DHCS in all reasonable respects, and execute all documents and, subject to reasonable availability, give testimony and take all further acts reasonably necessary to acquire, transfer, maintain, and enforce DHCS' Intellectual Property rights and interests.

b. Retained Rights / License Rights

(1) Except for Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, Contractor shall retain title to all of its Intellectual Property to the extent such Intellectual Property is in existence prior to the effective date of this Agreement. Contractor hereby grants to DHCS, without additional compensation, a permanent, non-exclusive, royalty free, paid-up, worldwide, irrevocable, perpetual, non-terminable license to use, reproduce, manufacture, sell, offer to sell, import, export, modify, publicly and privately display/perform, distribute, and dispose Contractor's Intellectual Property with the right to sublicense through multiple layers, for any purpose whatsoever, to the extent it is incorporated in the Intellectual Property resulting from this Agreement, unless Contractor assigns all rights, title and interest in the Intellectual Property as set forth herein.

(2) Nothing in this provision shall restrict, limit, or otherwise prevent Contractor from using any ideas, concepts, know-how, methodology or techniques related to its performance under this Agreement, provided that Contractor's use does not infringe the patent, copyright, trademark rights, license or other Intellectual Property rights of DHCS or third party, or result in a breach or default of any provisions of this Exhibit or result in a breach of any provisions of law relating to confidentiality.

c. Copyright

(1) Contractor agrees that for purposes of copyright law, all works [as defined in Paragraph a, subparagraph (2)(a) of this provision] of authorship made by or on behalf of Contractor in connection with Contractor's performance of this Agreement shall be deemed "works made for hire". Contractor further agrees that the work of each person utilized by Contractor in connection with the performance of this Agreement will be a "work made for hire," whether that person is an employee of Contractor or that person has entered into an agreement with Contractor to perform the work. Contractor shall enter into a written agreement with any such person that: (i) all work performed for Contractor shall be deemed a "work made for hire" under the Copyright Act and (ii) that person shall assign all right, title, and interest to DHCS to any work product made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.

(2) All materials, including, but not limited to, visual works or text, reproduced or distributed pursuant to this Agreement that include Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, shall include DHCS' notice of copyright, which shall read in 3mm or larger typeface: "© *[Enter Current Year e.g., 2010, etc.]*, California Department of Health Care Services. This material may not be reproduced or disseminated without prior written permission from the California Department of Health Care Services." This notice should be placed prominently on the materials and set apart from other matter on the page where it appears. Audio productions shall contain a similar audio notice of copyright.

d. Patent Rights

With respect to inventions made by Contractor in the performance of this Agreement, which did not result from research and development specifically included in the Agreement's scope of work, Contractor hereby grants to DHCS a license as described under Section b of this provision for devices or material incorporating, or made through the use of such inventions. If such inventions result from research and development work specifically included within the Agreement's scope of work, then Contractor agrees to assign to DHCS, without additional compensation, all its right, title and interest in and to such inventions and to assist DHCS in securing United States and foreign patents with respect thereto.

e. Third-Party Intellectual Property

Except as provided herein, Contractor agrees that its performance of this Agreement shall not be dependent upon or include any Intellectual Property of Contractor or third party without first: (i) obtaining DHCS' prior written approval; and (ii) granting to or obtaining for DHCS, without additional compensation, a license, as described in Section b of this provision, for any of Contractor's or third-party's Intellectual Property in existence prior to the effective date of this Agreement. If such a license upon the these terms is unattainable, and DHCS determines that the Intellectual Property should be included in or is required

for Contractor's performance of this Agreement, Contractor shall obtain a license under terms acceptable to DHCS.

f. Warranties

(1) Contractor represents and warrants that:

(a) It is free to enter into and fully perform this Agreement.

(b) It has secured and will secure all rights and licenses necessary for its performance of this Agreement.

(c) Neither Contractor's performance of this Agreement, nor the exercise by either Party of the rights granted in this Agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any state, the United States, or any foreign country. There is currently no actual or threatened claim by any such third party based on an alleged violation of any such right by Contractor.

(d) Neither Contractor's performance nor any part of its performance will violate the right of privacy of, or constitute a libel or slander against any person or entity.

(e) It has secured and will secure all rights and licenses necessary for Intellectual Property including, but not limited to, consents, waivers or releases from all authors of music or performances used, and talent (radio, television and motion picture talent), owners of any interest in and to real estate, sites, locations, property or props that may be used or shown.

(f) It has not granted and shall not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to DHCS in this Agreement.

(g) It has appropriate systems and controls in place to ensure that state funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

(h) It has no knowledge of any outstanding claims, licenses or other charges, liens, or encumbrances of any kind or nature whatsoever that could affect in any way Contractor's performance of this Agreement.

(2) DHCS MAKES NO WARRANTY THAT THE INTELLECTUAL PROPERTY RESULTING FROM THIS AGREEMENT DOES NOT INFRINGE UPON ANY PATENT, TRADEMARK, COPYRIGHT OR THE LIKE, NOW EXISTING OR SUBSEQUENTLY ISSUED.

g. Intellectual Property Indemnity

(1) Contractor shall indemnify, defend and hold harmless DHCS and its licensees and assignees, and its officers, directors, employees, agents, representatives, successors, and users of its products, ("Indemnitees") from and against all claims, actions, damages, losses, liabilities (or actions or proceedings with respect to any thereof), whether or not rightful, arising from any and all actions or claims by any third party or expenses related thereto (including, but not limited to, all legal expenses, court costs, and attorney's fees incurred in investigating, preparing, serving as a witness in, or defending against, any such claim, action, or proceeding, commenced or threatened) to which any of the Indemnitees may be subject, whether or not Contractor is a party to any pending or threatened litigation, which arise out of or are related to (i) the incorrectness or breach of any of the representations, warranties, covenants or agreements of Contractor pertaining to Intellectual Property; or (ii) any Intellectual Property infringement, or any other type of actual or alleged infringement claim, arising out of DHCS' use, reproduction, manufacture, sale, offer to sell, distribution, import, export, modification, public and private performance/display, license, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by

Contractor or DHCS and which result directly or indirectly from this Agreement. This indemnity obligation shall apply irrespective of whether the infringement claim is based on a patent, trademark or copyright registration that issued after the effective date of this Agreement. DHCS reserves the right to participate in and/or control, at Contractor's expense, any such infringement action brought against DHCS.

(2) Should any Intellectual Property licensed by the Contractor to DHCS under this Agreement become the subject of an Intellectual Property infringement claim, Contractor will exercise its authority reasonably and in good faith to preserve DHCS' right to use the licensed Intellectual Property in accordance with this Agreement at no expense to DHCS. DHCS shall have the right to monitor and appear through its own counsel (at Contractor's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for DHCS to continue using the licensed Intellectual Property; or, replace or modify the licensed Intellectual Property so that the replaced or modified Intellectual Property becomes non-infringing provided that such replacement or modification is functionally equivalent to the original licensed Intellectual Property. If such remedies are not reasonably available, DHCS shall be entitled to a refund of all monies paid under this Agreement, without restriction or limitation of any other rights and remedies available at law or in equity.

(3) Contractor agrees that damages alone would be inadequate to compensate DHCS for breach of any term of this Intellectual Property Exhibit by Contractor. Contractor acknowledges DHCS would suffer irreparable harm in the event of such breach and agrees DHCS shall be entitled to obtain equitable relief, including without limitation an injunction, from a court of competent jurisdiction, without restriction or limitation of any other rights and remedies available at law or in equity.

h. Federal Funding

In any agreement funded in whole or in part by the federal government, DHCS may acquire and maintain the Intellectual Property rights, title, and ownership, which results directly or indirectly from the Agreement; except as provided in 37 Code of Federal Regulations part 401.14; however, the federal government shall have a non-exclusive, nontransferable, irrevocable, paid-up license throughout the world to use, duplicate, or dispose of such Intellectual Property throughout the world in any manner for governmental purposes and to have and permit others to do so.

i. Survival

The provisions set forth herein shall survive any termination or expiration of this Agreement or any project schedule.

11. Air or Water Pollution Requirements

Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt under 40 CFR 15.5.

a. Government contractors agree to comply with all applicable standards, orders, or requirements issued under section 306 of the Clean Air Act [42 U.S.C. 1857(h)], section 508 of the Clean Water Act (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (40 CFR part 15).

b. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 U.S.C. 7401 et seq.), as amended, and the Federal Water Pollution Control Act (33 U.S.C. 1251 et seq.), as amended.

12. Prior Approval of Training Seminars, Workshops or Conferences

Contractor shall obtain prior DHCS approval of the location, costs, dates, agenda, instructors, instructional materials, and attendees at any reimbursable training seminar, workshop, or conference conducted pursuant to this Agreement and of any reimbursable publicity or educational materials to be made available for distribution. The Contractor shall acknowledge the support of the State whenever publicizing the work under this Agreement in any media. This provision does not apply to necessary staff meetings or training sessions held for the staff of the Contractor or Subcontractor to conduct routine business matters.

13. Confidentiality of Information

a. The Contractor and its employees, agents, or subcontractors shall protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to the Contractor, its employees, agents, or subcontractors as a result of services performed under this Agreement, except for statistical information not identifying any such person.

b. The Contractor and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out the Contractor's obligations under this Agreement.

c. The Contractor and its employees, agents, or subcontractors shall promptly transmit to the DHCS Program Contract Manager all requests for disclosure of such identifying information not emanating from the client or person.

d. The Contractor shall not disclose, except as otherwise specifically permitted by this Agreement or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS Program Contract Manager, except if disclosure is required by State or Federal law.

e. For purposes of this provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

f. As deemed applicable by DHCS, this provision may be supplemented by additional terms and conditions covering personal health information (PHI) or personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will either be attached to this Agreement or incorporated into this Agreement by reference.

14. Documents, Publications and Written Reports

(Applicable to agreements over $5,000 under which publications, written reports and documents are developed or produced. Government Code Section 7550.)

Any document, publication or written report (excluding progress reports, financial reports and normal contractual communications) prepared as a requirement of this Agreement shall contain, in a separate section preceding the main body of the document, the number and dollar amounts of all contracts or agreements and subcontracts relating to the preparation of such document or report, if the total cost for work by nonemployees of the State exceeds $5,000.

15. Dispute Resolution Process

a. A Contractor grievance exists whenever there is a dispute arising from DHCS' action in the administration of an agreement. If there is a dispute or grievance between the Contractor and DHCS, the Contractor must seek resolution using the procedure outlined below.

(1) The Contractor should first informally discuss the problem with the DHCS Program Contract Manager. If the problem cannot be resolved informally, the Contractor shall direct its grievance together with any evidence, in writing, to the program Branch Chief. The grievance shall state the issues in dispute, the legal authority or other basis for the Contractor's position and the remedy sought. The Branch Chief shall render a decision within ten (10) working days after receipt of the written grievance from the Contractor. The Branch Chief shall respond in writing to the Contractor indicating the decision and reasons therefore. If the Contractor disagrees with the Branch Chief's decision, the Contractor may appeal to the second level.

(2) When appealing to the second level, the Contractor must prepare an appeal indicating the reasons for disagreement with Branch Chief's decision. The Contractor shall include with the appeal a copy of the Contractor's original statement of dispute along with any supporting evidence and a copy of the Branch Chief's decision. The appeal shall be addressed to the Deputy Director of the division in which the branch is organized within ten (10) working days from receipt of the Branch Chief's

decision. The Deputy Director of the division in which the branch is organized or his/her designee shall meet with the Contractor to review the issues raised. A written decision signed by the Deputy Director of the division in which the branch is organized or his/her designee shall be directed to the Contractor within twenty (20) working days of receipt of the Contractor's second level appeal.

b. If the Contractor wishes to appeal the decision of the Deputy Director of the division in which the branch is organized or his/her designee, the Contractor shall follow the procedures set forth in Health and Safety Code Section 100171.

c. Unless otherwise stipulated in writing by DHCS, all dispute, grievance and/or appeal correspondence shall be directed to the DHCS Program Contract Manager.

d. There are organizational differences within DHCS' funding programs and the management levels identified in this dispute resolution provision may not apply in every contractual situation. When a grievance is received and organizational differences exist, the Contractor shall be notified in writing by the DHCS Program Contract Manager of the level, name, and/or title of the appropriate management official that is responsible for issuing a decision at a given level.

16. Financial and Compliance Audit Requirements

a. The definitions used in this provision are contained in Section 38040 of the Health and Safety Code, which by this reference is made a part hereof.

b. Direct service contract means a contract or agreement for services contained in local assistance or subvention programs or both (see Health and Safety [H&S] Code Section 38020). Direct service contracts shall not include contracts, agreements, grants, or subventions to other governmental agencies or units of government nor contracts or agreements with regional centers or area agencies on aging (H&S Code Section 38030).

c. The Contractor, as indicated below, agrees to obtain one of the following audits:

(1) ***If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040)*** and receives **$25,000 or more** from any State agency under a direct service contract or agreement; the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit. Said audit shall be conducted according to Generally Accepted Auditing Standards. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit shall be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, **and/or**

(2) ***If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040)*** and receives **less than $25,000** per year from any State agency under a direct service contract or agreement, the Contractor agrees to obtain a biennial single, organization wide financial and compliance audit, unless there is evidence of fraud or other violation of state law in connection with this Agreement. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit shall be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, **and/or**

(3) ***If the Contractor is a State or Local Government entity or Nonprofit organization (as defined by the Federal Office of Management and Budget [OMB] Circular A-133)*** and expends $500,000 or more in Federal awards, the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit according to the requirements specified in OMB Circular A-133 entitled "Audits of States, Local Governments, and Non-Profit Organizations". An audit conducted pursuant to this provision will fulfill the audit requirements outlined in Paragraphs c(1) and c(2) above. The audit shall be completed by the end of the ninth month following the end of the audit period. The requirements of this provision apply if:

(a) The Contractor is a recipient expending Federal awards received directly from Federal awarding agencies, or

(b) The Contractor is a subrecipient expending Federal awards received from a pass-through entity such as the State, County or community based organization.

(4) If the Contractor submits to DHCS a report of an audit other than an OMB A-133 audit, the Contractor must also submit a certification indicating the Contractor has not expended $500,000 or more in federal funds for the year covered by the audit report.

d. Two copies of the audit report shall be delivered to the DHCS program funding this Agreement. The audit report must identify the Contractor's legal name and the number assigned to this Agreement. The audit report shall be due within 30 days after the completion of the audit. Upon receipt of said audit report, the DHCS Program Contract Manager shall forward the audit report to DHCS' Audits and Investigations Unit if the audit report was submitted under Section 16.c(3), unless the audit report is from a City, County, or Special District within the State of California whereby the report will be retained by the funding program.

e. The cost of the audits described herein may be included in the funding for this Agreement up to the proportionate amount this Agreement represents of the Contractor's total revenue. The DHCS program funding this Agreement must provide advance written approval of the specific amount allowed for said audit expenses.

f. The State or its authorized designee, including the Bureau of State Audits, is responsible for conducting agreement performance audits which are not financial and compliance audits. Performance audits are defined by Generally Accepted Government Auditing Standards.

g. Nothing in this Agreement limits the State's responsibility or authority to enforce State law or regulations, procedures, or reporting requirements arising thereto.

h. Nothing in this provision limits the authority of the State to make audits of this Agreement, provided however, that if independent audits arranged for by the Contractor meet Generally Accepted Governmental Auditing Standards, the State shall rely on those audits and any additional audit work and shall build upon the work already done.

i. The State may, at its option, direct its own auditors to perform either of the audits described above. The Contractor will be given advance written notification, if the State chooses to exercise its option to perform said audits.

j. The Contractor shall include a clause in any agreement the Contractor enters into with the audit firm doing the single organization wide audit to provide access by the State or Federal Government to the working papers of the independent auditor who prepares the single organization wide audit for the Contractor.

k. Federal or state auditors shall have "expanded scope auditing" authority to conduct specific program audits during the same period in which a single organization wide audit is being performed, but the audit report has not been issued. The federal or state auditors shall review and have access to the current audit work being conducted and will not apply any testing or review procedures which have not been satisfied by previous audit work that has been completed.

The term "expanded scope auditing" is applied and defined in the U.S. General Accounting Office (GAO) issued Standards for *Audit of Government Organizations, Programs, Activities and Functions*, better known as the "yellow book".

17. Human Subjects Use Requirements

(Applicable only to federally funded agreements/grants in which performance, directly or through a subcontract/subaward, includes any tests or examination of materials derived from the human body.)

By signing this Agreement, Contractor agrees that if any performance under this Agreement or any subcontract or subagreement includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 U.S.C. Section 263a (CLIA) and the regulations thereunder.

18. Novation Requirements

If the Contractor proposes any novation agreement, DHCS shall act upon the proposal within 60 days after receipt of the written proposal. DHCS may review and consider the proposal, consult and negotiate with the Contractor, and accept or reject all or part of the proposal. Acceptance or rejection of the proposal may be made orally within the 60-day period and confirmed in writing within five days of said decision. Upon written acceptance of the proposal, DHCS will initiate an amendment to this Agreement to formally implement the approved proposal.

19. Debarment and Suspension Certification

(Applicable to all agreements funded in part or whole with federal funds.)

a. By signing this Agreement, the Contractor/Grantee agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 7 CFR Part 3017, 45 CFR 76, 40 CFR 32 or 34 CFR 85.

b. By signing this Agreement, the Contractor certifies to the best of its knowledge and belief, that it and its principals:

   (1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

   (2) Have not within a three-year period preceding this application/proposal/agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

   (3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph b(2) herein; and

   (4) Have not within a three-year period preceding this application/proposal/agreement had one or more public transactions (Federal, State or local) terminated for cause or default.

   (5) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

   (6) Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

c. If the Contractor is unable to certify to any of the statements in this certification, the Contractor shall submit an explanation to the DHCS Program Contract Manager.

d. The terms and definitions herein have the meanings set out in the Definitions and Coverage sections of the rules implementing Federal Executive Order 12549.

e. If the Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHCS may terminate this Agreement for cause or default.

20. Smoke-Free Workplace Certification

(Applicable to federally funded agreements/grants and subcontracts/subawards, that provide health, day care, early childhood development services, education or library services to children under 18 directly or through local governments.)

a. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed.

b. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.

c. By signing this Agreement, Contractor or Grantee certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.

d. Contractor or Grantee further agrees that it will insert this certification into any subawards (subcontracts or subgrants) entered into that provide for children's services as described in the Act.

21. Covenant Against Contingent Fees

(Applicable only to federally funded agreements.)

The Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this Agreement upon an agreement of understanding for a commission, percentage, brokerage, or contingent fee, except *bona fide* employees or *bona fide* established commercial or selling agencies retained by the Contractor for the purpose of securing business. For breach or violation of this warranty, DHCS shall have the right to annul this Agreement without liability or in its discretion to deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

22. Payment Withholds

(Applicable only if a final report is required by this Agreement. Not applicable to government entities.)

Unless waived or otherwise stipulated in this Agreement, DHCS may, at its discretion, withhold 10 percent (10%) of the face amount of the Agreement, 50 percent (50%) of the final invoice, or $3,000 whichever is greater, until DHCS receives a final report that meets the terms, conditions and/or scope of work requirements of this Agreement.

23. Performance Evaluation

(Not applicable to grant agreements.)

DHCS may, at its discretion, evaluate the performance of the Contractor at the conclusion of this Agreement. If performance is evaluated, the evaluation shall not be a public record and shall remain on file with DHCS. Negative performance evaluations may be considered by DHCS prior to making future contract awards.

24. Officials Not to Benefit

No members of or delegate of Congress or the State Legislature shall be admitted to any share or part of this Agreement, or to any benefit that may arise therefrom. This provision shall not be construed to extend to this Agreement if made with a corporation for its general benefits.

25. Four-Digit Date Compliance

(Applicable to agreements in which Information Technology (IT) services are provided to DHCS or if IT equipment is procured.)

Contractor warrants that it will provide only Four-Digit Date Compliant (as defined below) Deliverables and/or services to the State. "Four Digit Date compliant" Deliverables and services can accurately process, calculate, compare, and sequence date data, including without limitation date data arising out of or relating to leap years and changes in centuries. This warranty and representation is subject to the warranty terms and conditions of this Contract and does not limit the generality of warranty obligations set forth elsewhere herein.

26. Prohibited Use of State Funds for Software

(Applicable to agreements in which computer software is used in performance of the work.)

Contractor certifies that it has appropriate systems and controls in place to ensure that state funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

27. Use of Small, Minority Owned and Women's Businesses

(Applicable to that portion of an agreement that is federally funded and entered into with institutions of higher education, hospitals, nonprofit organizations or commercial businesses.)

Positive efforts shall be made to use small businesses, minority-owned firms and women's business enterprises, whenever possible (i.e., procurement of goods and/or services). Contractors shall take all of the following steps to further this goal.

(1) Ensure that small businesses, minority-owned firms, and women's business enterprises are used to the fullest extent practicable.

(2) Make information on forthcoming purchasing and contracting opportunities available and arrange time frames for purchases and contracts to encourage and facilitate participation by small businesses, minority-owned firms, and women's business enterprises.

(3) Consider in the contract process whether firms competing for larger contracts intend to subcontract with small businesses, minority-owned firms, and women's business enterprises.

(4) Encourage contracting with consortiums of small businesses, minority-owned firms and women's business enterprises when a contract is too large for one of these firms to handle individually.

(5) Use the services and assistance, as appropriate, of such organizations as the Federal Small Business Administration and the U.S. Department of Commerce's Minority Business Development Agency in the solicitation and utilization of small businesses, minority-owned firms and women's business enterprises.

28. Alien Ineligibility Certification

(Applicable to sole proprietors entering federally funded agreements.)

By signing this Agreement, the Contractor certifies that he/she is not an alien that is ineligible for state and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 U.S.C. 1601, et seq.)

29. Union Organizing

(Applicable only to grant agreements.)

Grantee, by signing this Agreement, hereby acknowledges the applicability of Government Code Sections 16645 through 16649 to this Agreement. Furthermore, Grantee, by signing this Agreement, hereby certifies that:

a. No state funds disbursed by this grant will be used to assist, promote or deter union organizing.

b. Grantee shall account for state funds disbursed for a specific expenditure by this grant, to show those funds were allocated to that expenditure.

c. Grantee shall, where state funds are not designated as described in b herein, allocate, on a pro-rata basis, all disbursements that support the grant program.

d. If Grantee makes expenditures to assist, promote or deter union organizing, Grantee will maintain records sufficient to show that no state funds were used for those expenditures, and that Grantee shall provide those records to the Attorney General upon request.

30. Contract Uniformity (Fringe Benefit Allowability)

(Applicable only to nonprofit organizations.)

Pursuant to the provisions of Article 7 (commencing with Section 100525) of Chapter 3 of Part 1 of Division 101 of the Health and Safety Code, DHCS sets forth the following policies, procedures, and guidelines regarding the reimbursement of fringe benefits.

a. As used herein fringe benefits shall mean an employment benefit given by one's employer to an employee in addition to one's regular or normal wages or salary.

b. As used herein, fringe benefits do not include:

(1) Compensation for personal services paid currently or accrued by the Contractor for services of employees rendered during the term of this Agreement, which is identified as regular or normal salaries and wages, annual leave, vacation, sick leave, holidays, jury duty and/or military leave/training.
(2) Director's and executive committee member's fees.
(3) Incentive awards and/or bonus incentive pay.
(4) Allowances for off-site pay.
(5) Location allowances.
(6) Hardship pay.
(7) Cost-of-living differentials

c. Specific allowable fringe benefits include:

(1) Fringe benefits in the form of employer contributions for the employer's portion of payroll taxes (i.e., FICA, SUI, SDI), employee health plans (i.e., health, dental and vision), unemployment insurance, worker's compensation insurance, and the employer's share of pension/retirement plans, provided they are granted in accordance with established written organization policies and meet all legal and Internal Revenue Service requirements.

d. To be an allowable fringe benefit, the cost must meet the following criteria:

(1) Be necessary and reasonable for the performance of the Agreement.
(2) Be determined in accordance with generally accepted accounting principles.
(3) Be consistent with policies that apply uniformly to all activities of the Contractor.

e. Contractor agrees that all <u>fringe benefits</u> shall be at <u>actual cost</u>.

f. Earned/Accrued Compensation

(1) Compensation for vacation, sick leave and holidays is limited to that amount earned/accrued within the agreement term. Unused vacation, sick leave and holidays earned from periods prior to the agreement term cannot be claimed as allowable costs. See Provision f (3)(a) for an example.

(2) For multiple year agreements, vacation and sick leave compensation, which is earned/accrued but not paid, due to employee(s) not taking time off may be carried over and claimed within the overall term of the multiple years of the Agreement. Holidays cannot be carried over from one agreement year to the next. See Provision f (3)(b) for an example.

(3) For single year agreements, vacation, sick leave and holiday compensation that is earned/accrued but not paid, due to employee(s) not taking time off within the term of the Agreement, cannot be claimed as an allowable cost. See Provision f (3)(c) for an example.

(a) **Example No. 1:**

If an employee, John Doe, earns/accrues three weeks of vacation and twelve days of sick leave each year, then that is the maximum amount that may be claimed during a one year agreement. If John Doe has five weeks of vacation and eighteen days of sick leave at the beginning of an agreement, the Contractor during a one-year budget period may only claim up to three weeks of vacation and twelve days of sick leave as actually used by the employee. Amounts earned/accrued in periods prior to the beginning of the Agreement are not an allowable cost.

(b) **Example No. 2:**

If during a three-year (multiple year) agreement, John Doe does not use his three weeks of vacation in year one, or his three weeks in year two, but he does actually use nine weeks in year three; the Contractor would be allowed to claim all nine weeks paid for in year three. The total compensation over the three-year period cannot exceed 156 weeks (3 x 52 weeks).

(c) **Example No. 3:**

If during a single year agreement, John Doe works fifty weeks and used one week of vacation and one week of sick leave and all fifty-two weeks have been billed to DHCS, the remaining unused two weeks of vacation and seven days of sick leave may not be claimed as an allowable cost.

31. Suspension or Stop Work Notification

a. DHCS may, at any time, issue a notice to suspend performance or stop work under this Agreement. The initial notification may be a verbal or written directive issued by the funding Program's Contract Manager. Upon receipt of said notice, the Contractor is to suspend and/or stop all, or any part, of the work called for by this Agreement.

b. Written confirmation of the suspension or stop work notification with directions as to what work (if not all) is to be suspended and how to proceed will be provided within 30 working days of the verbal notification. The suspension or stop work notification shall remain in effect until further written notice is received from DHCS. The resumption of work (in whole or part) will be at DHCS' discretion and upon receipt of written confirmation.

(1) Upon receipt of a suspension or stop work notification, the Contractor shall immediately comply with its terms and take all reasonable steps to minimize or halt the incurrence of costs allocable to the performance covered by the notification during the period of work suspension or stoppage.

(2) Within 90 days of the issuance of a suspension or stop work notification, DHCS shall either:

(a) Cancel, extend, or modify the suspension or stop work notification; or

(b) Terminate the Agreement as provided for in the Cancellation / Termination clause of the Agreement.

c. If a suspension or stop work notification issued under this clause is canceled or the period of suspension or any extension thereof is modified or expires, the Contractor may resume work only upon written concurrence of funding Program's Contract Manager.

d. If the suspension or stop work notification is cancelled and the Agreement resumes, changes to the services, deliverables, performance dates, and/or contract terms resulting from the suspension or stop work notification shall require an amendment to the Agreement.

e. If a suspension or stop work notification is not canceled and the Agreement is cancelled or terminated pursuant to the provision entitled Cancellation / Termination, DHCS shall allow reasonable costs resulting from the suspension or stop work notification in arriving at the settlement costs.

f. DHCS shall not be liable to the Contractor for loss of profits because of any suspension or stop work notification issued under this clause.

32. Lobbying Restrictions and Disclosure Certification

(Applicable to federally funded agreements in excess of $100,000 per Section 1352 of the 31, U.S.C.)

a. Certification and Disclosure Requirements

(1) Each person (or recipient) who requests or receives a contract or agreement, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph b of this provision.

(2) Each recipient shall file a disclosure (in the form set forth in Attachment 2, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action) in connection with a contract, or grant or any extension or amendment of that contract, or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

(3) Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph a(2) herein. An event that materially affects the accuracy of the information reported includes:

(a) A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

(b) A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

(c) A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

(4) Each person (or recipient) who requests or receives from a person referred to in Paragraph a(1) of this provision a contract or agreement, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or agreement, or grant shall file a certification, and a disclosure form, if required, to the next tier above.

(5) All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person shall forward all disclosure forms to DHCS Program Contract Manager.

b. Prohibition

Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract or agreement, grant, loan, or cooperative agreement to pay any person for

influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract or agreement, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract or agreement, grant, loan, or cooperative agreement.

Attachment 1
State of California
Department of Health Care Services

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

California Department of Health Care Services

DHCS reserves the right to notifiy the contractor in writing of an alternate submission address.

Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action: [ ] a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	2. Status of Federal Action: [ ] a. bid/offer/application b. initial award c. post-award	3. Report Type: [ ] a. initial filing b. material change For Material Change Only: Year _____ quarter _____ date of last report _____.
4. Name and Address of Reporting Entity: ☐ Prime ☐ Subawardee Tier ___, if known: Congressional District, If known:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime: Congressional District, If known:	
6. Federal Department/Agency	7. Federal Program Name/Description: CDFA Number, if applicable: _____	
8. Federal Action Number, if known:	9. Award Amount, if known: $	
10.a. Name and Address of Lobbying Registrant *(If individual, last name, first name, MI)*:	b. Individuals Performing Services *(including address if different from 10a.* *(Last name, First name, MI):*	
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person that fails to file the required disclosure shall be subject to a not more than $100,000 for each such failure.	Signature: _____ Print Name: _____ Title: Telephone No.: _____ Date: _____	
Federal Use Only	Authorized for Local Reproduction Standard Form-LLL (Rev. 7-97)	

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriateclassification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if itis, or expects to be,a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizationallevel below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001".

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).

11. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No. 0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

Exhibit E
Additional Provisions

1. Amendment Process

A. Both the Contractor and the State may agree to amend or renegotiate the Intergovernmental Agreement.

B. Should either party, during the term of this Intergovernmental Agreement, desire a change or amendment to the terms of this Intergovernmental Agreement, such changes or amendments shall be proposed in writing to the other party, who will respond in writing as to whether the proposed changes/amendments are accepted or rejected. If accepted and after negotiations are concluded, the agreed upon changes shall be made through the State's official agreement amendment process. No amendment will be considered binding on either party until it is formally approved by the both parties and the Department of General Services (DGS), if DGS approval is required.

C. Intergovernmental Agreement amendments will be required to change encumbered amounts for each year of a multi-year contract period, of which the first amendment will be based on the Governor's Budget Act allocation of that specific fiscal year. The signed Intergovernmental Agreement from the Contractor will be due to the Department of Health Care Services (DHCS) within 90 days from the issuance to the County. If the signed Intergovernmental Agreement from the Contractor is not received within 90 days from the issuance to the County, DHCS may withhold all non-DMC payments under Exhibit B of this Intergovernmental Agreement until the required amendment is received by the State.

D. Intergovernmental Agreement amendments may be requested by the Contractor until May 1 of each of the contract's fiscal years. An amendment proposed by either the Contractor or the State shall be forwarded in writing to the other party.

1) The proposed amendment submitted by Contractor shall include the proposed changes, and a statement of the reason and basis for the proposed change.

2) Amendments shall be duly approved by the County Board of Supervisors or its authorized designee, and signed by a duly authorized representative.

E. Contractor acknowledges that any newly allocated funds that are in excess of the initial amount for each fiscal year may be forfeited if DHCS does not receive a fully executable Intergovernmental Agreement amendment on or before June 30th.

F. State may settle costs for substance use disorder services based on the year-end cost settlement report as the final amendment to the approved Intergovernmental Agreement.

2. Cancellation / Termination

A. This Intergovernmental Agreement may be cancelled by DHCS without cause upon 30 calendar days advance written notice to the Contractor.

B. DHCS reserves the right to cancel or terminate this Intergovernmental Agreement immediately for cause. The Contractor may submit a written request to terminate this Intergovernmental Agreement only if DHCS substantially fails to perform its responsibilities as provided herein.

C. The term "for cause" shall mean that the Contractor fails to meet the terms, conditions, and/or responsibilities of this Intergovernmental Agreement.

D. Intergovernmental Agreement termination or cancellation shall be effective as of the date indicated in DHCS' notification to the Contractor. The notice shall stipulate any final performance, invoicing or payment requirements.

E. Upon receipt of a notice of termination or cancellation, the Contractor shall take immediate steps to stop performance and to cancel or reduce subsequent agreement costs.

F. In the event of early termination or cancellation, the Contractor shall be entitled to payment for all allowable costs authorized under this Intergovernmental Agreement and incurred up to the date of termination or cancellation, including authorized non-cancelable obligations, provided such expenses do not exceed the stated maximum amounts payable.

G. In the event of changes in law that affect provisions of this Intergovernmental Agreement, the parties agree to amend the affected provisions to conform to the changes in law retroactive to the effective date of such changes in law. The parties further agree that the terms of this Intergovernmental Agreement are severable and in the event that changes in law render provisions of the Intergovernmental Agreement void, the unaffected provisions and obligations of this Intergovernmental Agreement will remain in full force and effect.

H. The following additional provisions regarding termination apply only to Exhibit A, Attachment I, of this Intergovernmental Agreement:

1) In the event the federal Department of Health and Human Services (hereinafter referred to as DHHS), or State determines Contractor does not meet the requirements for participation in the DMC-ODS Waiver Program, State will terminate payments for services provided pursuant to Exhibit A, Attachment I, of this Intergovernmental Agreement for cause.

2) All obligations to provide covered services under this Intergovernmental Agreement will automatically terminate on the effective date of any termination of this Intergovernmental Agreement. Contractor will be responsible for providing or arranging for covered services to beneficiaries until the effective date of termination or expiration of the Intergovernmental Agreement.

   Contractor will remain liable for processing and paying invoices and statements for covered services and utilization review requirements prior to the expiration or termination until all obligations have been met.

3) In the event Exhibit A, Attachment I, of this Intergovernmental Agreement is nullified, Contractor shall refer DMC clients to providers who are certified to provide State Plan services.

I. In the event this Intergovernmental Agreement is terminated, Contractor shall deliver its entire fiscal and program records pertaining to the performance of this Intergovernmental Agreement to the State, which will retain the records for the required retention period.

3. Avoidance of Conflicts of Interest by Contractor

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

B. Conflicts of interest include, but are not limited to:

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

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

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

D. Contractor acknowledges that state laws on conflict of interest, found in the Political Reform Act, Public Contract Code Section 10365.5, and Government Code Section 1090, apply to this Intergovernmental Agreement.

4. Freeze Exemptions

(Applicable only to local government agencies.)

A. Contractor agrees that any hiring freeze adopted during the term of this Intergovernmental Agreement shall not be applied to the positions funded, in whole or part, by this Intergovernmental Agreement.

B. Contractor agrees not to implement any personnel policy, which may adversely affect performance or the positions funded, in whole or part, by this Intergovernmental Agreement.

C. Contractor agrees that any travel freeze or travel limitation policy adopted during the term of this Intergovernmental Agreement shall not restrict travel funded, in whole or part, by this Intergovernmental Agreement.

D. Contractor agrees that any purchasing freeze or purchase limitation policy adopted during the term of this Intergovernmental Agreement shall not restrict or limit purchases funded, in whole or part, by this Intergovernmental Agreement.

5. Force Majeure

Neither party shall be responsible for delays or failures in performance resulting from acts beyond the control of the offending party. Such acts shall include but not be limited to acts of God, fire, flood, earthquake, other natural disaster, nuclear accident, strike, lockout, riot, freight-embargo, related-utility, or governmental statutes or regulations super-imposed after the fact. If a delay or failure in performance by the Contractor arises out of a default of its Subcontractor, and if such default of its Subcontractor, arises out of causes beyond the control of both the Contractor and Subcontractor, and without the fault or negligence of either of them, the Contractor shall not be liable for damages of such delay or failure, unless the supplies or services to be furnished by the Subcontractor were obtainable from other sources in sufficient time to permit the Contractor to meet the required performance schedule.

EXHIBIT G

PRIVACY AND INFORMATION SECURITY PROVISIONS

This Exhibit G is intended to protect the privacy and security of specified Department information that Contractor may access, receive, or transmit under this Agreement. The Department information covered under this Exhibit G consists of: (1) Protected Health Information as defined under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA")(PHI): and (2) Personal Information (PI) as defined under the California Information Practices Act (CIPA), at California Civil Code Section 1798.3. Personal Information may include data provided to the Department by the Social Security Administration.

Exhibit G consists of the following parts:

1. Exhibit G-1, HIPAA Business Associate Addendum, which provides for the privacy and security of PHI.

2. Exhibit G-2, which provides for the privacy and security of PI in accordance with specified provisions of the Agreement between the Department and the Social Security Administration, known as the Information Exchange Agreement (IEA) and the Computer Matching and Privacy Protection Act Agreement between the Social Security Administration and the California Health and Human Services Agency (Computer Agreement) to the extent Contractor access, receives, or transmits PI under these Agreements. Exhibit G-2 further provides for the privacy and security of PI under Civil Code Section 1798.3(a) and 1798.29.

3. Exhibit G-3, Miscellaneous Provision, sets forth additional terms and conditions that extend to the provisions of Exhibit G in its entirety.

EXHIBIT G-1

HIPAA Business Associate Addendum

1. Recitals.

A. A business associate relationship under the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), 42 U.S.C. Section 17921 et seq., and their implementing privacy and security regulations at 45 CFR Parts 160 and 164 ("the HIPAA regulations") between Department and Contractor arises only to the extent that Contractor creates, receives, maintains, transmits, uses or discloses PHI or ePHI on the Department's behalf, or provides services, arranges, performs or assists in the performance of functions or activities on behalf of the Department that are included in the definition of "business associate" in 45 C.F.R. 160.103 where the provision of the service involves the disclosure of PHI or ePHI from the Department, including but not limited to, utilization review, quality assurance, or benefit management. To the extent Contractor performs these services, functions, and activities on behalf of Department, Contractor is the Business Associate of the Department, acting on the Department's behalf. The Department and Contractor are each a party to this Agreement and are collectively referred to as the "parties."

B. The Department wishes to disclose to Contractor certain information pursuant to the terms of this Agreement, some of which may constitute Protected Health Information ("PHI"), including protected health information in electronic media ("ePHI"), under federal law, to be used or disclosed in the course of providing services and activities as set forth in Section 1.A. of Exhibit G-1 of this Agreement. This information is hereafter referred to as "Department PHI".

C. The purpose of this Exhibit G-1 is to protect the privacy and security of the PHI and ePHI that may be created, received, maintained, transmitted, used or disclosed pursuant to this Agreement, and to comply with certain standards and requirements of HIPAA, the HITECH Act, and the HIPAA regulations, including, but not limited to, the requirement that the Department must enter into a contract containing specific requirements with Contractor prior to the disclosure of PHI to Contractor, as set forth in 45 CFR Parts 160 and 164 and the HITECH Act. To the extent that data is both PHI or ePHI and Personally Identifying Information, both Exhibit G-2 (including Attachment I, the SSA Agreement between SSA, CHHS and DHCS, referred to in Exhibit G-2) and this Exhibit G-1 shall apply.

D. The terms used in this Exhibit G-1, but not otherwise defined, shall have the same meanings as those terms have in the HIPAA regulations. Any reference

to statutory or regulatory language shall be to such language as in effect or as amended.

2. Definitions.

A. Breach shall have the meaning given to such term under HIPAA, the HITECH Act, and the HIPAA regulations.

B. Business Associate shall have the meaning given to such term under HIPAA, the HITECH Act, and the HIPAA regulations.

C. Covered Entity shall have the meaning given to such term under HIPAA, the HITECH Act, and the HIPAA regulations.

D. Department PHI shall mean Protected Health Information or Electronic Protected Health Information, as defined below, accessed by Contractor in a database maintained by the Department, received by Contractor from the Department or acquired or created by Contractor in connection with performing the functions, activities and services on behalf of the Department as specified in Section 1.A. of Exhibit G-1 of this Agreement. The terms PHI as used in this document shall mean Department PHI.

E. Electronic Health Records shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 U.S.C. Section 17921 and implementing regulations.

F. Electronic Protected Health Information (ePHI) means individually identifiable health information transmitted by electronic media or maintained in electronic media, including but not limited to electronic media as set forth under 45 CFR section 160.103.

G. Individually Identifiable Health Information means health information, including demographic information collected from an individual, that is created or received by a health care provider, health plan, employer or health care clearinghouse, and relates to the past, present or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, that identifies the individual or where there is a reasonable basis to believe the information can be used to identify the individual, as set forth under 45 CFR Section 160.103.

H. Privacy Rule shall mean the HIPAA Regulations that are found at 45 CFR Parts 160 and 164, subparts A and E.

I. Protected Health Information (PHI) means individually identifiable health information that is transmitted by electronic media, maintained in electronic

media, or is transmitted or maintained in any other form or medium, as set forth under 45 CFR Section 160.103 and as defined under HIPAA.

J. Required by law, as set forth under 45 CFR Section 164.103, means a mandate contained in law that compels an entity to make a use or disclosure of PHI that is enforceable in a court of law. This includes, but is not limited to, court orders and court-ordered warrants, subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information, and a civil or an authorized investigative demand. It also includes Medicare conditions of participation with respect to health care providers participating in the program, and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

K. Secretary means the Secretary of the U.S. Department of Health and Human Services ("HHS") or the Secretary's designee.

L. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of Department PHI, or confidential data utilized by Contractor to perform the services, functions and activities on behalf of Department as set forth in Section 1.A. of Exhibit G-1 of this Agreement; or interference with system operations in an information system that processes, maintains or stores Department PHI.

M. Security Rule shall mean the HIPAA regulations that are found at 45 CFR Parts 160 and 164.

N. Unsecured PHI shall have the meaning given to such term under the HITECH Act, 42 U.S.C. Section 17932(h), any guidance issued by the Secretary pursuant to such Act and the HIPAA regulations.

3. Terms of Agreement.

A. **Permitted Uses and Disclosures of Department PHI by Contractor.**

Except as otherwise indicated in this Exhibit G-1, Contractor may use or disclose Department PHI only to perform functions, activities or services specified in Section 1.A of Exhibit G-1 of this Agreement, for, or on behalf of the Department, provided that such use or disclosure would not violate the HIPAA regulations or the limitations set forth in 42 CFR Part 2, or any other applicable law, if done by the Department. Any such use or disclosure, if not for purposes of treatment activities of a health care provider as defined by the Privacy Rule, must, to the extent practicable, be limited to the limited data set, as defined in 45 CFR Section 164.514(e)(2), or, if needed, to the minimum necessary to accomplish the intended purpose of such use or disclosure, in compliance with the HITECH

Act and any guidance issued pursuant to such Act, and the HIPAA regulations.

B. **Specific Use and Disclosure Provisions**. Except as otherwise indicated in this Exhibit G-1, Contractor may:

1) **Use and Disclose for Management and Administration**. Use and disclose Department PHI for the proper management and administration of the Contractor's business, provided that such disclosures are required by law, or the Contractor obtains reasonable assurances from the person to whom the information is disclosed, in accordance with section D(7) of this Exhibit G-1, that it will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Contractor of any instances of which it is aware that the confidentiality of the information has been breached.

2) **Provision of Data Aggregation Services**. Use Department PHI to provide data aggregation services to the Department to the extent requested by the Department and agreed to by Contractor. Data aggregation means the combining of PHI created or received by the Contractor, as the Business Associate, on behalf of the Department with PHI received by the Business Associate in its capacity as the Business Associate of another covered entity, to permit data analyses that relate to the health care operations of the Department

C. **Prohibited Uses and Disclosures**

1) Contractor shall not disclose Department PHI about an individual to a health plan for payment or health care operations purposes if the Department PHI pertains solely to a health care item or service for which the health care provider involved has been paid out of pocket in full and the individual requests such restriction, in accordance with 42 U.S.C. Section 17935(a) and 45 CFR Section 164.522(a).

2) Contractor shall not directly or indirectly receive remuneration in exchange for Department PHI.

D. **Responsibilities of Contractor**

Contractor agrees:

1) **Nondisclosure**. Not to use or disclose Department PHI other than as permitted or required by this Agreement or as required by law, including but not limited to 42 CFR Part 2.

2) **Compliance with the HIPAA Security Rule**. To implement administrative, physical, and technical safeguards that reasonably and appropriately

protect the confidentiality, integrity, and availability of the Department PHI, including electronic PHI, that it creates, receives, maintains, uses or transmits on behalf of the Department, in compliance with 45 CFR Sections 164.308, 164.310 and 164.312, and to prevent use or disclosure of Department PHI other than as provided for by this Agreement. Contractor shall implement reasonable and appropriate policies and procedures to comply with the standards, implementation specifications and other requirements of 45 CFR Section 164, subpart C, in compliance with 45 CFR Section164.316. Contractor shall develop and maintain a written information 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, and which incorporates the requirements of section 3, Security, below. Contractor will provide the Department with its current and updated policies upon request.

3) **Security***.* Contractor shall take any and all steps necessary to ensure the continuous security of all computerized data systems containing PHI and/or PI, and to protect paper documents containing PHI and/or PI. These steps shall include, at a minimum:

   a. Complying with all of the data system security precautions listed in Attachment A, Data Security Requirements;

   b. Achieving and maintaining compliance with the HIPAA Security Rule (45 CFR Parts 160 and 164), as necessary in conducting operations on behalf of DHCS under this Agreement; and

   c. Providing a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III- Security of Federal Automated Information Systems, which sets forth guidelines for automated information systems in Federal agencies.

4) **Security Officer**. Contractor shall designate a Security Officer to oversee its data security program who shall be responsible for carrying out the requirements of this section and for communicating on security matters with the Department.

5) **Mitigation of Harmful Effects**. To mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of Department PHI by Contractor or its subcontractors in violation of the requirements of this Exhibit G.

6) **Reporting Unauthorized Use or Disclosure.** To report to Department any use or disclosure of Department PHI not provided for by this Exhibit G of which it becomes aware.

7) **Contractor's Agents and Subcontractors**.

a. To enter into written agreements with any agents, including subcontractors and vendors to whom Contractor provides Department PHI, that impose the same restrictions and conditions on such agents, subcontractors and vendors that apply to Contractor with respect to such Department PHI under this Exhibit G, and that require compliance with all applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, including the requirement that any agents, subcontractors or vendors implement reasonable and appropriate administrative, physical, and technical safeguards to protect such PHI. As required by HIPAA, the HITECH Act and the HIPAA regulations, including 45 CFR Sections 164.308 and 164.314, Contractor shall incorporate, when applicable, the relevant provisions of this Exhibit G-1 into each subcontract or subaward to such agents, subcontractors and vendors, including the requirement that any security incidents or breaches of unsecured PHI be reported to Contractor.

b. In accordance with 45 CFR Section 164.504(e)(1)(ii), upon Contractor's knowledge of a material breach or violation by its subcontractor of the agreement between Contractor and the subcontractor, Contractor shall:

i) Provide an opportunity for the subcontractor to cure the breach or end the violation and terminate the agreement if the subcontractor does not cure the breach or end the violation within the time specified by the Department; or

ii) Immediately terminate the agreement if the subcontractor has breached a material term of the agreement and cure is not possible.

8) **Availability of Information to the Department and Individuals to Provide Access and Information:**

a. To provide access as the Department may require, and in the time and manner designated by the Department (upon reasonable notice and during Contractor's normal business hours) to Department PHI in a Designated Record Set, to the Department (or, as directed by the Department), to an Individual, in accordance with 45 CFR Section 164.524. Designated Record Set means the group of records maintained for the Department health plan under this Agreement that includes medical, dental and billing records about individuals;

enrollment, payment, claims adjudication, and case or medical management systems maintained for the Department health plan for which Contractor is providing services under this Agreement; or those records used to make decisions about individuals on behalf of the Department. Contractor shall use the forms and processes developed by the Department for this purpose and shall respond to requests for access to records transmitted by the Department within fifteen (15) calendar days of receipt of the request by producing the records or verifying that there are none.

b. If Contractor maintains an Electronic Health Record with PHI, and an individual requests a copy of such information in an electronic format, Contractor shall provide such information in an electronic format to enable the Department to fulfill its obligations under the HITECH Act, including but not limited to, 42 U.S.C. Section 17935(e) and the HIPAA regulations.

9) **Confidentiality of Alcohol and Drug Abuse Patient Records.** Contractor agrees to comply with all confidentiality requirements set forth in Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2. Contractor is aware that criminal penalties may be imposed for a violation of these confidentiality requirements.

10) **Amendment of Department PHI**. To make any amendment(s) to Department PHI that were requested by a patient and that the Department directs or agrees should be made to assure compliance with 45 CFR Section 164.526, in the time and manner designated by the Department, with the Contractor being given a minimum of twenty (20) days within which to make the amendment.

11) **Internal Practices**. To make Contractor's internal practices, books and records relating to the use and disclosure of Department PHI available to the Department or to the Secretary, for purposes of determining the Department's compliance with the HIPAA regulations. If any information needed for this purpose is in the exclusive possession of any other entity or person and the other entity or person fails or refuses to furnish the information to Contractor, Contractor shall provide written notification to the Department and shall set forth the efforts it made to obtain the information.

12) **Documentation of Disclosures**. To document and make available to the Department or (at the direction of the Department) to an individual such disclosures of Department PHI, and information related to such disclosures, necessary to respond to a proper request by the subject Individual for an accounting of disclosures of such PHI, in accordance with the HITECH Act and its implementing regulations, including but not limited to 45 CFR Section

164.528 and 42 U.S.C. Section 17935(c). If Contractor maintains electronic health records for the Department as of January 1, 2009 and later, Contractor must provide an accounting of disclosures, including those disclosures for treatment, payment or health care operations. The electronic accounting of disclosures shall be for disclosures during the three years prior to the request for an accounting.

13) **Breaches and Security Incidents.** During the term of this Agreement, Contractor agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

a. **Initial Notice to the Department.** (1) To notify the Department **immediately by telephone call or email or fax** upon the discovery of a breach of unsecured PHI in electronic media or in any other media if the PHI was, or is reasonably believed to have been, accessed or acquired by an unauthorized person. (2) To notify the Department **within 24 hours (one hour if SSA data) by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement or this ExhibitG-1~~,~~ or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Contractor as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Contractor.

Notice shall be provided to the Information Protection Unit, Office of HIPAA Compliance. If the incident occurs after business hours or on a weekend or holiday and involves electronic PHI, notice shall be provided by calling the Information Protection Unit (916.445.4646, 866-866-0602) or by emailing privacyofficer@dhcs.ca.gov). Notice shall be made using the DHCS "Privacy Incident Report" form, including all information known at the time. Contractor shall use the most current version of this form, which is posted on the DHCS Information Security Officer website (www.dhcs.ca.gov, then select "Privacy" in the left column and then "Business Partner" near the middle of the page) or use this link: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of Department PHI, Contractor shall take:

i) Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment; and

ii) Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

b. **Investigation and Investigation Report***.* To immediately investigate such suspected security incident, security incident, breach, or unauthorized access, use or disclosure of PHI . Within 72 hours of the discovery, Contractor shall submit an updated "Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the Information Protection Unit.

c. **Complete Report***.* To provide a complete report of the investigation to the Department Program Contract Manager and the Information Protection Unit within ten (10) working days of the discovery of the breach or unauthorized use or disclosure. The report shall be submitted on the "Privacy Incident Report" form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred under applicable provisions of HIPAA, the HITECH Act, and the HIPAA regulations. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure. If the Department requests information in addition to that listed on the "Privacy Incident Report" form, Contractor shall make reasonable efforts to provide the Department with such information. If, because of the circumstances of the incident, Contractor needs more than ten (10) working days from the discovery to submit a complete report, the Department may grant a reasonable extension of time, in which case Contractor shall submit periodic updates until the complete report is submitted. If necessary, a Supplemental Report may be used to submit revised or additional information after the completed report is submitted, by submitting the revised or additional information on an updated "Privacy Incident Report" form. The Department will review and approve the determination of whether a breach occurred and whether individual notifications and a corrective action plan are required.

d. **Responsibility for Reporting of Breaches***.* If the cause of a breach of Department PHI is attributable to Contractor or its agents, subcontractors or vendors, Contractor is responsible for all

required reporting of the breach as specified in 42 U.S.C. section 17932 and its implementing regulations, including notification to media outlets and to the Secretary (after obtaining prior written approval of DHCS). If a breach of unsecured Department PHI involves more than 500 residents of the State of California or under its jurisdiction, Contractor shall first notify DHCS, then the Secretary of the breach immediately upon discovery of the breach. If a breach involves more than 500 California residents, Contractor shall also provide, after obtaining written prior approval of DHCS, notice to the Attorney General for the State of California, Privacy Enforcement Section. If Contractor has reason to believe that duplicate reporting of the same breach or incident may occur because its subcontractors, agents or vendors may report the breach or incident to the Department in addition to Contractor, Contractor shall notify the Department, and the Department and Contractor may take appropriate action to prevent duplicate reporting.

e. **Responsibility for Notification of Affected Individuals.** If the cause of a breach of Department PHI is attributable to Contractor or its agents, subcontractors or vendors and notification of the affected individuals is required under state or federal law, Contractor shall bear all costs of such notifications as well as any costs associated with the breach. In addition, the Department reserves the right to require Contractor to notify such affected individuals, which notifications shall comply with the requirements set forth in 42U.S.C. section 17932 and its implementing regulations, including, but not limited to, the requirement that the notifications be made without unreasonable delay and in no event later than 60 calendar days after discovery of the breach. The Department Privacy Officer shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made. The Department will provide its review and approval expeditiously and without unreasonable delay.

f. **Department Contact Information***.* To direct communications to the above referenced Department staff, the Contractor shall initiate contact as indicated herein. The Department reserves the right to make changes to the contact information below by giving written notice to the Contractor. Said changes shall not require an amendment to this Addendum or the Agreement to which it is incorporated.

Department Program Contract Manager	**DHCS Privacy Officer**	**DHCS Information Security Officer**
See the Exhibit A, Scope of Work for Program Contract Manager information	Information Protection Unit c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 (916) 445-4646; (866) 866-0602 Email: privacyofficer@dhcs.ca.gov Fax: (916) 440-7680	Information Security Officer DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: iso@dhcs.ca.gov Telephone: ITSD Service Desk (916) 440-7000; (800) 579-0874 Fax: (916)440-5537

14) **Termination of Agreement.** In accordance with Section 13404(b) of the HITECH Act and to the extent required by the HIPAA regulations, if Contractor knows of a material breach or violation by the Department of this Exhibit G-1, it shall take the following steps:

a. Provide an opportunity for the Department to cure the breach or end the violation and terminate the Agreement if the Department does not cure the breach or end the violation within the time specified by Contractor; or

b. Immediately terminate the Agreement if the Department has breached a material term of the Exhibit G-1 and cure is not possible.

15) **Sanctions and/or Penalties**. Contractor understands that a failure to comply with the provisions of HIPAA, the HITECH Act and the HIPAA regulations that are applicable to Contractors may result in the imposition of sanctions and/or penalties on Contractor under HIPAA, the HITECH Act and the HIPAA regulations.

E. Obligations of the Department.

The Department agrees to:

1) **Permission by Individuals for Use and Disclosure of PHI**. Provide the Contractor with any changes in, or revocation of, permission by an Individual

to use or disclose Department PHI, if such changes affect the Contractor's permitted or required uses and disclosures.

2) **Notification of Restrictions**. Notify the Contractor of any restriction to the use or disclosure of Department PHI that the Department has agreed to in accordance with 45 CFR Section 164.522, to the extent that such restriction may affect the Contractor's use or disclosure of PHI.

3) **Requests Conflicting with HIPAA Rules**. Not request the Contractor to use or disclose Department PHI in any manner that would not be permissible under the HIPAA regulations if done by the Department.

4) **Notice of Privacy Practices**. Provide Contractor with the web link to the Notice of Privacy Practices that DHCS produces in accordance with 45 CFR Section 164.520, as well as any changes to such notice. Visit the DHCS website to view the most current Notice of Privacy Practices at: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/NoticeofPrivacyPractices.aspx or the DHCS website at www.dhcs.ca.gov (select "Privacy in the right column and "Notice of Privacy Practices" on the right side of the page).

F. Audits, Inspection and Enforcement

If Contractor is the subject of an audit, compliance review, or complaint investigation by the Secretary or the Office for Civil Rights, U.S. Department of Health and Human Services, that is related to the performance of its obligations pursuant to this HIPAA Business Associate Exhibit G-1,Contractor shall immediately notify the Department. Upon request from the Department, Contractor shall provide the Department with a copy of any Department PHI that Contractor, as the Business Associate, provides to the Secretary or the Office of Civil Rights concurrently with providing such PHI to the Secretary. Contractor is responsible for any civil penalties assessed due to an audit or investigation of Contractor, in accordance with 42 U.S.C. Section 17934(c).

G. Termination.

1) **Term.** The Term of this Exhibit G-1 shall extend beyond the termination of the Agreement and shall terminate when all Department PHI is destroyed or returned to the Department, in accordance with 45 CFR Section 164.504(e)(2)(ii)(J).

2) **Termination for Cause**. In accordance with 45 CFR Section 164.504(e)(1)(iii), upon the Department's knowledge of a material breach or violation of this Exhibit G-1 by Contractor, the Department shall:

a. Provide an opportunity for Contractor to cure the breach or end the violation and terminate this Agreement if Contractor does not cure the breach or end the violation within the time specified by the Department; or

b. Immediately terminate this Agreement if Contractor has breached a material term of this Exhibit G-1 and cure is not possible.

THE REST OF THIS PAGE IS INTENTIONALLY BLANK

EXHIBIT G-2

Privacy and Security of Personal Information and Personally Identifiable Information Not Subject to HIPAA

1. Recitals.

A. In addition to the Privacy and Security Rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) the Department is subject to various other legal and contractual requirements with respect to the personal information (PI) and personally identifiable information (PII) it maintains. These include:

1) The California Information Practices Act of 1977 (California Civil Code §§1798 et seq.),

2) The Agreement between the Social Security Administration (SSA) and the Department, known as the Information Exchange Agreement (IEA), which incorporates the Computer Matching and Privacy Protection Act Agreement (CMPPA) between the SSA and the California Health and Human Services Agency. The IEA, including the CMPPA is attached to this Exhibit G as Attachment I and is hereby incorporated in this Agreement.

3) Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2.

B. The purpose of this Exhibit G-2 is to set forth Contractor's privacy and security obligations with respect to PI and PII that Contractor may create, receive, maintain, use, or disclose for or on behalf of Department pursuant to this Agreement. Specifically this Exhibit applies to PI and PII which is not Protected Health Information (PHI) as defined by HIPAA and therefore is not addressed in Exhibit G-1 of this Agreement, the HIPAA Business Associate Addendum; however, to the extent that data is both PHI or ePHI and PII, both Exhibit G-1 and this Exhibit G-2 shall apply.

C. The IEA Agreement referenced in A.2) above requires the Department to extend its substantive privacy and security terms to subcontractors who receive data provided to DHCS by the Social Security Administration. If Contractor receives data from DHCS that includes data provided to DHCS by the Social Security Administration, Contractor must comply with the following specific sections of the IEA Agreement: E. Security Procedures, F. Contractor/Agent Responsibilities, and G. Safeguarding and Reporting Responsibilities for Personally Identifiable Information ("PII"), and in Attachment 4 to the IEA, Electronic Information Exchange Security Requirements, Guidelines and Procedures for Federal, State and Local Agencies Exchanging Electronic Information with the Social Security Administration. Contractor must also ensure that any agents, including a

subcontractor, to whom it provides DHCS data that includes data provided by the Social Security Administration, agree to the same requirements for privacy and security safeguards for such confidential data that apply to Contractor with respect to such information.

D. The terms used in this Exhibit G-2, but not otherwise defined, shall have the same meanings as those terms have in the above referenced statute and Agreement. Any reference to statutory, regulatory, or contractual language shall be to such language as in effect or as amended.

2. Definitions.

A. "Breach" shall have the meaning given to such term under the IEA and CMPPA. It shall include a "PII loss" as that term is defined in the CMPPA.

B. "Breach of the security of the system" shall have the meaning given to such term under the California Information Practices Act, Civil Code section 1798.29(f).

C. "CMPPA Agreement" means the Computer Matching and Privacy Protection Act Agreement between the Social Security Administration and the California Health and Human Services Agency (CHHS).

D. "Department PI" shall mean Personal Information, as defined below, accessed in a database maintained by the Department, received by Contractor from the Department or acquired or created by Contractor in connection with performing the functions, activities and services specified in this Agreement on behalf of the Department.

E. "IEA" shall mean the Information Exchange Agreement currently in effect between the Social Security Administration (SSA) and the California Department of Health Care Services (DHCS).

F. "Notice-triggering Personal Information" shall mean the personal information identified in Civil Code section 1798.29 whose unauthorized access may trigger notification requirements under Civil Code section 1798.29. For purposes of this provision, identity shall include, but not be limited to, name, address, email address, identifying number, symbol, or other identifying particular assigned to the individual, such as a finger or voice print, a photograph or a biometric identifier. Notice-triggering Personal Information includes PI in electronic, paper or any other medium.

G. "Personally Identifiable Information" (PII) shall have the meaning given to such term in the IEA and CMPPA.

H. "Personal Information" (PI) shall have the meaning given to such term in California Civil Code Section 1798.3(a).

I. "Required by law" means a mandate contained in law that compels an entity to make a use or disclosure of PI or PII that is enforceable in a court of law. This includes, but is not limited to, court orders and court-ordered warrants, subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information, and a civil or an authorized investigative demand. It also includes Medicare conditions of participation with respect to health care providers participating in the program, and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

J. "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PI, or confidential data utilized in complying with this Agreement; or interference with system operations in an information system that processes, maintains or stores PI.

3. Terms of Agreement

A. **Permitted Uses and Disclosures of Department PI and PII by Contractor**

Except as otherwise indicated in this Exhibit G-2, Contractor may use or disclose Department PI only to perform functions, activities or services for or on behalf of the Department pursuant to the terms of this Agreement provided that such use or disclosure would not violate the California Information Practices Act (CIPA) if done by the Department.

B. **Responsibilities of Contractor**

Contractor agrees:

1) **Nondisclosure.** Not to use or disclose Department PI or PII other than as permitted or required by this Agreement or as required by applicable state and federal law.

2) **Safeguards*.*** To implement appropriate and reasonable administrative, technical, and physical safeguards to protect the security, confidentiality and integrity of Department PI and PII, to protect against anticipated threats or hazards to the security or integrity of Department PI and PII, and to prevent use or disclosure of Department PI or PII other than as provided for by this Agreement. Contractor shall develop and maintain a written information privacy and security program that include administrative, technical and physical safeguards appropriate to the size and complexity of Contractor's operations and the nature and scope of its activities, which incorporate the requirements of section 3, Security, below. Contractor will provide DHCS with its current policies upon request.

3) **Security.** Contractor shall take any and all steps necessary to ensure the continuous security of all computerized data systems containing PHI and/or PI, and to protect paper documents containing PHI and/or PI. These steps shall include, at a minimum:

a. Complying with all of the data system security precautions listed in Attachment A, Business Associate Data Security Requirements;

b. Providing a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III-Security of Federal Automated Information Systems, which sets forth guidelines for automated information systems in Federal agencies; and

c. If the data obtained by Contractor from DHCS includes PII, Contractor shall also comply with the substantive privacy and security requirements in the Computer Matching and Privacy Protection Act Agreement between the SSA and the California Health and Human Services Agency (CHHS) and in the Agreement between the SSA and DHCS, known as the Information Exchange Agreement, which are attached as Attachment I and incorporated into this Agreement. The specific sections of the IEA with substantive privacy and security requirements to be complied with are sections E, F, and G, and in Attachment 4 to the IEA, Electronic Information Exchange Security Requirements, Guidelines and Procedures for Federal, State and Local Agencies Exchanging Electronic Information with the SSA. Contractor also agrees to ensure that any agents, including a subcontractor to whom it provides DHCS PII, agree to the same requirements for privacy and security safeguards for confidential data that apply to Contractor with respect to such information.

4) **Mitigation of Harmful Effects.** To mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of Department PI or PII by Contractor or its subcontractors in violation of this Exhibit G-2.

5) **Contractor's Agents and Subcontractors*.*** To impose the same restrictions and conditions set forth in this Exhibit G-2 on any subcontractors or other agents with whom Contractor subcontracts any activities under this Agreement that involve the disclosure of Department PI or PII to the subcontractor.

6) **Availability of Information to DHCS*.*** To make Department PI and PII available to the Department for purposes of oversight, inspection, amendment, and response to requests for records, injunctions, judgments, and orders for production of Department PI and PII. If

Contractor receives Department PII, upon request by DHCS, Contractor shall provide DHCS with a list of all employees, contractors and agents who have access to Department PII, including employees, contractors and agents of its subcontractors and agents.

7) **Cooperation with DHCS*.*** With respect to Department PI, to cooperate with and assist the Department to the extent necessary to ensure the Department's compliance with the applicable terms of the CIPA including, but not limited to, accounting of disclosures of Department PI, correction of errors in Department PI, production of Department PI, disclosure of a security breach involving Department PI and notice of such breach to the affected individual(s).

8) **Confidentiality of Alcohol and Drug Abuse Patient Records.** Contractor agrees to comply with all confidentiality requirements set forth in Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2. Contractor is aware that criminal penalties may be imposed for a violation of these confidentiality requirements.

9) **Breaches and Security Incidents*.*** During the term of this Agreement, Contractor agrees to implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and to take the following steps:

a. Initial Notice to the Department. (1) To notify the Department **immediately by telephone call or email or fax** upon the discovery of a breach of unsecured Department PI or PII in electronic media or in any other media if the PI or PII was, or is reasonably believed to have been, accessed or acquired by an unauthorized person, or upon discovery of a suspected security incident involving Department PII. (2) To notify the Department **within one (1) hour by email or fax** if the data is data subject to the SSA Agreement; and **within 24 hours by email or fax** of the discovery of any suspected security incident, intrusion or unauthorized access, use or disclosure of Department PI or PII in violation of this Agreement or this Exhibit G-1 or potential loss of confidential data affecting this Agreement. A breach shall be treated as discovered by Contractor as of the first day on which the breach is known, or by exercising reasonable diligence would have been known, to any person (other than the person committing the breach) who is an employee, officer or other agent of Contractor.

b. Notice shall be provided to the Information Protection Unit, Office of HIPAA Compliance. If the incident occurs after business hours or on a weekend or holiday and involves electronic Department PI or PII, notice shall be provided by calling the Department Information Security Officer. Notice shall be made using the DHCS

"Privacy Incident Report" form, including all information known at the time. Contractor shall use the most current version of this form, which is posted on the DHCS Information Security Officer website (www.dhcs.ca.gov, then select "Privacy" in the left column and then "Business Partner" near the middle of the page) or use this link: http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx .

c. Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of Department PI or PII, Contractor shall take:

i. Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment; and

ii. Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

d. **Investigation and Investigation Report**. To immediately investigate such suspected security incident, security incident, breach, or unauthorized access, use or disclosure of PHI. Within 72 hours of the discovery, Contractor shall submit an updated "Privacy Incident Report" containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time, to the Department Information Security Officer.

e. **Complete Report**. To provide a complete report of the investigation to the Department Program Contract Manager and the Information Protection Unit within ten (10) working days of the discovery of the breach or unauthorized use or disclosure. The report shall be submitted on the "Privacy Incident Report" form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure. If the Department requests information in addition to that listed on the "Privacy Incident Report" form, Contractor shall make reasonable efforts to provide the Department with such information. If, because of the circumstances of the incident, Contractor needs more than ten (10) working days from the discovery to submit a complete report, the Department may grant a reasonable extension of time, in which case Contractor shall submit periodic updates until the complete report is submitted. If necessary, a Supplemental Report may be used to submit revised or additional information after the

completed report is submitted, by submitting the revised or additional information on an updated “Privacy Incident Report” form. The Department will review and approve the determination of whether a breach occurred and whether individual notifications and a corrective action plan are required.

f. **Responsibility for Reporting of Breaches*.*** If the cause of a breach of Department PI or PII is attributable to Contractor or its agents, subcontractors or vendors, Contractor is responsible for all required reporting of the breach as specified in CIPA, section 1798.29and as may be required under the IEA. Contractor shall bear all costs of required notifications to individuals as well as any costs associated with the breach. The Privacy Officer shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made. The Department will provide its review and approval expeditiously and without unreasonable delay.

g. If Contractor has reason to believe that duplicate reporting of the same breach or incident may occur because its subcontractors, agents or vendors may report the breach or incident to the Department in addition to Contractor, Contractor shall notify the Department, and the Department and Contractor may take appropriate action to prevent duplicate reporting.

h. **Department Contact Information***.* To direct communications to the above referenced Department staff, the Contractor shall initiate contact as indicated herein. The Department reserves the right to make changes to the contact information below by giving written notice to the Contractor. Said changes shall not require an amendment to this Addendum or the Agreement to which it is incorporated.

Department Program Contract Manager	**DHCS Privacy Officer**	**DHCS Information Security Officer**
See the Exhibit A, Scope of Work for Program Contract Manager information	Information Protection Unit c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 (916) 445-4646 Email: privacyofficer@dhcs.ca.gov Telephone:(916) 445-4646 Fax: (916) 440-7680	Information Security Officer DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: iso@dhcs.ca.gov Telephone: ITSD Service Desk (916) 440-7000 or (800) 579-0874 Fax: (916)440-5537

10) Designation of Individual Responsible for Security

Contractor shall designate an individual, (e.g., Security Officer), to oversee its data security program who shall be responsible for carrying out the requirements of this Exhibit G-2 and for communicating on security matters with the Department.

EXHIBIT G-3

Miscellaneous Terms and Conditions

Applicable to Exhibit G

1) **Confidentiality of Alcohol and Drug Abuse Patient Records.** Contractor agrees to comply with all confidentiality requirements set forth in Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2. Contractor is aware that criminal penalties may be imposed for a violation of these confidentiality requirements.

2) **Disclaimer**. The Department makes no warranty or representation that compliance by Contractor with this Exhibit G, HIPAA or the HIPAA regulations will be adequate or satisfactory for Contractor's own purposes or that any information in Contractor's possession or control, or transmitted or received by Contractor, is or will be secure from unauthorized use or disclosure. Contractor is solely responsible for all decisions made by Contractor regarding the safeguarding of the Department PHI, PI and PII.

3) **Amendment**. The parties acknowledge that federal and state laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Exhibit G may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, and the HIPAA regulations, and other applicable state and federal laws. Upon either party's request, the other party agrees to promptly enter into negotiations concerning an amendment to this Exhibit G embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, and the HIPAA regulations, and other applicable state and federal laws. The Department may terminate this Agreement upon thirty (30) days written notice in the event:

a) Contractor does not promptly enter into negotiations to amend this Exhibit G when requested by the Department pursuant to this section; or

b) Contractor does not enter into an amendment providing assurances regarding the safeguarding of Department PHI that the Department deems is necessary to satisfy the standards and requirements of HIPAA and the HIPAA regulations.

4) **Judicial or Administrative Proceedings**. Contractor will notify the Department if it is named as a defendant in a criminal proceeding for a violation of HIPAA or other security or privacy law. The Department may terminate this Agreement if Contractor is found guilty of a criminal violation of

HIPAA. The Department may terminate this Agreement if a finding or stipulation that the Contractor has violated any standard or requirement of HIPAA, or other security or privacy laws is made in any administrative or civil proceeding in which the Contractor is a party or has been joined. DHCS will consider the nature and seriousness of the violation in deciding whether or not to terminate the Agreement.

5) **Assistance in Litigation or Administrative Proceedings**. Contractor shall make itself and any subcontractors, employees or agents assisting Contractor in the performance of its obligations under this Agreement, available to the Department at no cost to the Department to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Department, its directors, officers or employees based upon claimed violation of HIPAA, or the HIPAA regulations, which involves inactions or actions by the Contractor, except where Contractor or its subcontractor, employee or agent is a named adverse party.

6) **No Third-Party Beneficiaries**. Nothing express or implied in the terms and conditions of this Exhibit G is intended to confer, nor shall anything herein confer, upon any person other than the Department or Contractor and their respective successors or assignees, any rights, remedies, obligations or liabilities whatsoever.

7) **Interpretation**. The terms and conditions in this Exhibit G shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, and the HIPAA regulations. The parties agree that any ambiguity in the terms and conditions of this Exhibit G shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act and the HIPAA regulations, and, if applicable, any other relevant state and federal laws.

8) **Conflict.** In case of a conflict between any applicable privacy or security rules, laws, regulations or standards the most stringent shall apply. The most stringent means that safeguard which provides the highest level of protection to PHI, PI and PII from unauthorized disclosure. Further, Contractor must comply within a reasonable period of time with changes to these standards that occur after the effective date of this Agreement.

9) **Regulatory References**. A reference in the terms and conditions of this Exhibit G to a section in the HIPAA regulations means the section as in effect or as amended.

10) **Survival.** The respective rights and obligations of Contractor under Section 3, Item D of Exhibit G-1, and Section 3, Item B of Exhibit G-2, Responsibilities of Contractor, shall survive the termination or expiration of this Agreement.

11) **No Waiver of Obligations**. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver

of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

12) **Audits, Inspection and Enforcement.** From time to time, and subject to all applicable federal and state privacy and security laws and regulations, the Department may conduct a reasonable inspection of the facilities, systems, books and records of Contractor to monitor compliance with this Exhibit G. Contractor shall promptly remedy any violation of any provision of this Exhibit G. The fact that the Department inspects, or fails to inspect, or has the right to inspect, Contractor's facilities, systems and procedures does not relieve Contractor of its responsibility to comply with this Exhibit G. The Department's failure to detect a non-compliant practice, or a failure to report a detected non-compliant practice to Contractor does not constitute acceptance of such practice or a waiver of the Department's enforcement rights under this Agreement, including this Exhibit G.

13) **Due Diligence.** Contractor shall exercise due diligence and shall take reasonable steps to ensure that it remains in compliance with this Exhibit G and is in compliance with applicable provisions of HIPAA, the HITECH Act and the HIPAA regulations, and other applicable state and federal law, and that its agents, subcontractors and vendors are in compliance with their obligations as required by this Exhibit G.

14) **Term.** The Term of this Exhibit G-1 shall extend beyond the termination of the Agreement and shall terminate when all Department PHI is destroyed or returned to the Department, in accordance with 45 CFR Section 164.504(e)(2)(ii)(I), and when all Department PI and PII is destroyed in accordance with Attachment A.

14) **Effect of Termination**. Upon termination or expiration of this Agreement for any reason, Contractor shall return or destroy all Department PHI, PI and PII that Contractor still maintains in any form, and shall retain no copies of such PHI, PI or PII. If return or destruction is not feasible, Contractor shall notify the Department of the conditions that make the return or destruction infeasible, and the Department and Contractor shall determine the terms and conditions under which Contractor may retain the PHI, PI or PII. Contractor shall continue to extend the protections of this Exhibit G to such Department PHI, PI and PII, and shall limit further use of such data to those purposes that make the return or destruction of such data infeasible. This provision shall apply to Department PHI, PI and PII that is in the possession of subcontractors or agents of Contractor.

Attachment A
Data Security Requirements

1. Personnel Controls

A. **Employee Training**. All workforce members who assist in the performance of functions or activities on behalf of the Department, or access or disclose Department PHI or PI must complete information privacy and security training, at least annually, at Contractor's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member's name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following termination of this Agreement.

B. **Employee Discipline**. Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.

C. **Confidentiality Statement**. All persons that will be working with Department PHI or PI must sign a confidentiality statement that includes, at a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The statement must be signed by the workforce member prior to access to Department PHI or PI. The statement must be renewed annually. The Contractor shall retain each person's written confidentiality statement for Department inspection for a period of six (6) years following termination of this Agreement.

D. **Background Check**. Before a member of the workforce may access Department PHI or PI, a background screening of that worker must be conducted. The screening should be commensurate with the risk and magnitude of harm the employee could cause, with more thorough screening being done for those employees who are authorized to bypass significant technical and operational security controls. The Contractor shall retain each workforce member's background check documentation for a period of three (3) years.

2. Technical Security Controls

A. **Workstation/Laptop encryption**. All workstations and laptops that store Department PHI or PI either directly or temporarily must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by the Department Information Security Office.

B. **Server Security**. Servers containing unencrypted Department PHI or PI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.

C. **Minimum Necessary**. Only the minimum necessary amount of Department PHI or PI required to perform necessary business functions may be copied, downloaded, or exported.

D. **Removable media devices**. All electronic files that contain Department PHI or PI data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, Blackberry, backup tapes etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.

E. **Antivirus software**. All workstations, laptops and other systems that process and/or store Department PHI or PI must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.

F. **Patch Management**. All workstations, laptops and other systems that process and/or store Department PHI or PI must have critical security patches applied, with system reboot if necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within 30 days of vendor release. Applications and systems that cannot be patched within this time frame 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.

G. **User IDs and Password Controls**. All users must be issued a unique user name for accessing Department PHI or PI. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password. Passwords are not to be shared. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed at least every 90 days, preferably every 60 days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:

1) Upper case letters (A-Z)
2) Lower case letters (a-z)
3) Arabic numerals (0-9)
4) Non-alphanumeric characters (punctuation symbols)

H. **Data Destruction**. When no longer needed, all Department PHI or PI must be wiped using the Gutmann or US Department of Defense (DoD) 5220.22-M (7 Pass) standard, or by degaussing. Media may also be physically destroyed in accordance with NIST

Special Publication 800-88. Other methods require prior written permission of the Department Information Security Office.

I. **System Timeout**. The system providing access to Department PHI or PI must provide an automatic timeout, requiring re-authentication of the user session after no more than 20 minutes of inactivity.

J. **Warning Banners**. All systems providing access to Department PHI or PI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.

K. **System Logging**. The system must maintain an automated audit trail which can identify the user or system process which initiates a request for Department PHI or PI, or which alters Department PHI or PI. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If Department PHI or PI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least 3 years after occurrence.

L. **Access Controls**. The system providing access to Department PHI or PI must use role based access controls for all user authentications, enforcing the principle of least privilege.

M. **Transmission encryption**. All data transmissions of Department PHI or PI outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing Department PHI can be encrypted. This requirement pertains to any type of Department PHI or PI in motion such as website access, file transfer, and E-Mail.

N. **Intrusion Detection**. All systems involved in accessing, holding, transporting, and protecting Department PHI or PI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

3. Audit Controls

A. **System Security Review**. Contractor must ensure audit control mechanisms that record and examine system activity are in place. All systems processing and/or storing Department PHI or PI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.

B. **Log Reviews**. All systems processing and/or storing Department PHI or PI must have a routine procedure in place to review system logs for unauthorized access.

C. **Change Control**. All systems processing and/or storing Department PHI or PI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

4. Business Continuity / Disaster Recovery Controls

A. **Emergency Mode Operation Plan**. Contractor must establish a documented plan to enable continuation of critical business processes and protection of the security of Department PHI or PI held in an electronic format in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this Agreement for more than 24 hours.

B. **Data Backup Plan**. Contractor must have established documented procedures to backup Department PHI to maintain retrievable exact copies of Department PHI or PI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore Department PHI or PI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of Department data.

5. Paper Document Controls

A. **Supervision of Data**. Department PHI or PI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. Department PHI or PI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

B. **Escorting Visitors**. Visitors to areas where Department PHI or PI is contained shall be escorted and Department PHI or PI shall be kept out of sight while visitors are in the area.

C. **Confidential Destruction**. Department PHI or PI must be disposed of through confidential means, such as cross cut shredding and pulverizing.

D. **Removal of Data**. Only the minimum necessary Department PHI or PI may be removed from the premises of the Contractor except with express written permission of the Department. Department PHI or PI shall not be considered "removed from the premises" if it is only being transported from one of Contractor's locations to another of Contractors locations.

E. **Faxing**. Faxes containing Department PHI or PI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending the fax.

F. **Mailing**. Mailings containing Department PHI or PI shall be sealed and secured from damage or inappropriate viewing of such PHI or PI to the extent possible. Mailings which include 500 or more individually identifiable records of Department PHI or PI in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of the Department to use another method is obtained.

THE REST OF THIS PAGE IS INTENTIONALLY BLANK

Attachment I

Information Exchange Agreement between the
Social Security Administration (SSA) and the
California Department of Health Care Services

INFORMATION EXCHANGE AGREEMENT
BETWEEN
THE SOCIAL SECURITY ADMINISTRATION (SSA)
AND
THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES (STATE AGENCY)

A. PURPOSE: The purpose of this Information Exchange Agreement ("IEA") is to establish terms, conditions, and safeguards under which SSA will disclose to the State Agency certain information, records, or data (herein "data") to assist the State Agency in administering certain federally funded state-administered benefit programs (including state-funded state supplementary payment programs under Title XVI of the Social Security Act) identified in this IEA. By entering into this IEA, the State Agency agrees to comply with:

- the terms and conditions set forth in the Computer Matching and Privacy Protection Act Agreement ("CMPPA Agreement") attached as **Attachment 1**, governing the State Agency's use of the data disclosed from SSA's Privacy Act System of Records; and
- all other terms and conditions set forth in this IEA.

B. PROGRAMS AND DATA EXCHANGE SYSTEMS: (1) The State Agency will use the data received or accessed from SSA under this IEA for the purpose of administering the federally funded, state-administered programs identified in **Table 1** below. In **Table 1**, the State Agency has identified: (a) each federally funded, state-administered program that it administers; and (b) each SSA data exchange system to which the State Agency needs access in order to administer the identified program. The list of SSA's data exchange systems is attached as **Attachment 2**:

TABLE 1

FEDERALLY FUNDED BENEFIT PROGRAMS	
Program	**SSA Data Exchange System(s)**
[X] Medicaid	BENDEX/SDX/EVS/SVES/SOLQ/SVES I-Citizenship /Quarters of Coverage/Prisoner Query
☐ Temporary Assistance to Needy Families (TANF)	
☐ Supplemental Nutrition Assistance Program (SNAP- formally Food Stamps)	
☐ Unemployment Compensation (Federal)	
☐ Unemployment Compensation (State)	
☐ State Child Support Agency	
☐ Low-Income Home Energy Assistance Program (LI-HEAP)	
☐ Workers Compensation	
☐ Vocational Rehabilitation Services	

☐ Foster Care (IV-E)	
☐ State Health Insurance Program (S-CHIP)	
☐ Women, Infants and Children (W.I.C.)	
[X] Medicare Savings Programs (MSP)	LIS File
[X] Medicare 1144 (Outreach)	Medicare 1144 Outreach File
☐ *Other Federally Funded, State-Administered Programs (List Below)*	
Program	SSA Data Exchange System(s)

(2) The State Agency will use each identified data exchange system ***only*** for the purpose of administering the specific program for which access to the data exchange system is provided. SSA data exchange systems are protected by the Privacy Act and federal law prohibits the use of SSA's data for any purpose other than the purpose of administering the specific program for which such data is disclosed. In particular, the State Agency will use: (a) the **tax return data** disclosed by SSA only to determine individual eligibility for, or the amount of, assistance under a state plan pursuant to Section 1137 programs and child support enforcement programs in accordance with 26 U.S.C. § 6103(1)(8); and (b) the **citizenship status data** disclosed by SSA under the Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. 111-3, only for the purpose of determining entitlement to Medicaid and CHIP program for new applicants. The State Agency also acknowledges that SSA's citizenship data may be less than 50 percent current. Applicants for SSNs report their citizenship data at the time they apply for their SSNs; there is no obligation for an individual to report to SSA a change in his or her immigration status until he or she files a claim for benefits.

C. **PROGRAM QUESTIONNAIRE:** Prior to signing this IEA, the State Agency will complete and submit to SSA a program questionnaire for each of the federally funded, state-administered programs checked in **Table 1** above. SSA will not disclose any data under this IEA until it has received and approved the completed program questionnaire for each of the programs identified in **Table 1** above.

D. TRANSFER OF DATA: SSA will transmit the data to the State Agency under this IEA using the data transmission method identified in **Table 2** below:

TABLE 2

TRANSFER OF DATA
☐ Data will be transmitted directly between SSA and the State Agency.
[X] Data will be transmitted directly between SSA and the California Office of Technology (State Transmission/Transfer Component ("STC")) by the File Transfer Management System, a secure mechanism approved by SSA. The STC will serve as the conduit between SSA and the State Agency pursuant to the State STC Agreement.
☐ Data will be transmitted directly between SSA and the Interstate Connection Network ("ICON"). ICON is a wide area telecommunications network connecting state agencies that administer the state unemployment insurance laws. When receiving data through ICON, the State Agency will comply with the "Systems Security Requirements for SSA Web Access to SSA Information Through the ICON," attached as **Attachment 3**.

E. SECURITY PROCEDURES: The State Agency will comply with limitations on use, treatment, and safeguarding of data under the Privacy Act of 1974 (5 U.S.C. 552a), as amended by the Computer Matching and Privacy Protection Act of 1988, related Office of Management and Budget guidelines, the Federal Information Security Management Act of 2002 (44 U.S.C. § 3541, et seq.), and related National Institute of Standards and Technology guidelines. In addition, the State Agency will comply with SSA's "Information System Security Guidelines for Federal, State and Local Agencies Receiving Electronic Information from the Social Security Administration," attached as **Attachment 4**. For any tax return data, the State Agency will also comply with the "Tax Information Security Guidelines for Federal, State and Local Agencies," Publication 1075, published by the Secretary of the Treasury and available at the following Internal Revenue Service (IRS) website: http://www.irs.gov/pub/irs-pdf/p1075.pdf. This IRS Publication 1075 is incorporated by reference into this IEA.

F. CONTRACTOR/AGENT RESPONSIBILITIES: The State Agency will restrict access to the data obtained from SSA to only those authorized State employees, contractors, and agents who need such data to perform their official duties in connection with purposes identified in this IEA. At SSA's request, the State Agency will obtain from each of its contractors and agents a current list of the employees of its contractors and agents who have access to SSA data disclosed under this IEA. The State Agency will require its contractors, agents, and all employees of such contractors or agents with authorized access to the SSA data disclosed under this IEA, to comply with the terms and conditions set forth in this IEA, and not to duplicate, disseminate, or disclose such data without obtaining SSA's prior written approval. In addition, the State Agency will comply with the limitations on use, duplication, and redisclosure of SSA data set forth in Section IX. of the CMPPA Agreement, especially with respect to its contractors and agents.

G. SAFEGUARDING AND REPORTING RESPONSIBILITIES FOR PERSONALLY IDENTIFIABLE INFORMATION ("PII"):

1. The State Agency will ensure that its employees, contractors, and agents:
   a. properly safeguard PII furnished by SSA under this IEA from loss, theft or inadvertent disclosure;
   b. understand that they are responsible for safeguarding this information at all times, regardless of whether or not the State employee, contractor, or agent is at his or her regular duty station;
   c. ensure that laptops and other electronic devices/media containing PII are encrypted and/or password protected;
   d. send emails containing PII only if encrypted or if to and from addresses that are secure; and
   e. limit disclosure of the information and details relating to a PII loss only to those with a need to know.

2. If an employee of the State Agency or an employee of the State Agency's contractor or agent becomes aware of suspected or actual loss of PII, he or she must immediately contact the State Agency official responsible for Systems Security designated below or his or her delegate. That State Agency official or delegate must then notify the SSA Regional Office Contact and the SSA Systems Security Contact identified below. If, for any reason, the responsible State Agency official or delegate is unable to notify the SSA Regional Office or the SSA Systems Security Contact within 1 hour, the responsible State Agency official or delegate must call SSA's Network Customer Service Center ("NCSC") at 410-965-7777 or toll free at 1-888-772-6661 to report the actual or suspected loss. The responsible State Agency official or delegate will use the worksheet, attached as **Attachment 5**, to quickly gather and organize information about the incident. The responsible State Agency official or delegate must provide to SSA timely updates as any additional information about the loss of PII becomes available.

3. SSA will make the necessary contact within SSA to file a formal report in accordance with SSA procedures. SSA will notify the Department of Homeland Security's United States Computer Emergency Readiness Team if loss or potential loss of PII related to a data exchange under this IEA occurs.

4. If the State Agency experiences a loss or breach of data, it will determine whether or not to provide notice to individuals whose data has been lost of breached and bear any costs associated with the notice or any mitigation.

H. POINTS OF CONTACT:

FOR SSA

San Francisco Regional Office:

Ellery Brown
Data Exchange Coordinator
Frank Hagel Federal Building
1221 Nevin Avenue
Richmond CA 94801
Phone: (510) 970-8243
Fax: (510) 970-8101
Email: Ellery.Brown@ssa.gov

Data Exchange Issues:

Guy Fortson
Office of Electronic Information Exchange
GD10 East High Rise
6401 Security Boulevard
Baltimore, MD 21235
Phone: (410) 597-1103
Fax: (410) 597-0841
Email: guy.fortson@ssa.gov

Systems Issues:

Pamela Riley
Office of Earnings, Enumeration &
Administrative Systems
DIVES/Data Exchange Branch
6401 Security Boulevard
Baltimore, MD 21235
Phone: (410) 965-7993
Fax: (410) 966-3147
Email: Pamela.Riley@ssa.gov

Systems Security Issues:

Michael G. Johnson
Acting Director
Office of Electronic Information Exchange
Office of Strategic Services
6401 Security Boulevard
Baltimore, MD 21235
Phone: (410) 965-0266
Fax: (410) 966-0527
Email: Michael.G.Johnson@ssa.gov

FOR STATE AGENCY

Agreement Issues:

Manuel Urbina
Chief, Security Unit
Policy Operations Branch
Medi-Cal Eligibility Division
1501 Capitol Avenue, MS 4607
Sacramento, CA 95814
Phone: (916) 650-0160
Email: Manuel.Urbina@dhcs.ca.gov

Technical Issues:

Fei Collier
Chief, Application Support Branch
Information Technology Services Division
1615 Capitol Ave, MS 6100
Sacramento, CA 95814
Phone: (916) 440-7036
Email: Fei.Collier@dhcs.ca.gov

I. DURATION: The effective date of this IEA is January 1, 2010. This IEA will remain in effect for as long as: (1) a CMPPA Agreement governing this IEA is in effect between SSA and the State or the State Agency; and (2) the State Agency submits a certification in accordance with Section J. below at least 30 days before the expiration and renewal of such CMPPA Agreement.

J. **CERTIFICATION AND PROGRAM CHANGES**: At least 30 days before the expiration and renewal of the State CMPPA Agreement governing this IEA, the State Agency will certify in writing to SSA that: (1) it is in compliance with the terms and conditions of this IEA; (2) the data exchange processes under this IEA have been and will be conducted without change; and (3) it will, upon SSA's request, provide audit reports or other documents that demonstrate review and oversight activities. If there are substantive changes in any of the programs or data exchange processes listed in this IEA, the parties will modify the IEA in accordance with Section K. below and the State Agency will submit for SSA's approval new program questionnaires under Section C. above describing such changes prior to using SSA's data to administer such new or changed program.

K. **MODIFICATION**: Modifications to this IEA must be in writing and agreed to by the parties.

L. **TERMINATION**: The parties may terminate this IEA at any time upon mutual written consent. In addition, either party may unilaterally terminate this IEA upon 90 days advance written notice to the other party. Such unilateral termination will be effective 90 days after the date of the notice, or at a later date specified in the notice.

SSA may immediately and unilaterally suspend the data flow under this IEA, or terminate this IEA, if SSA, in its sole discretion, determines that the State Agency (including its employees, contractors, and agents) has: (1) made an unauthorized use or disclosure of SSA-supplied data; or (2) violated or failed to follow the terms and conditions of this IEA or the CMPPA Agreement.

M. **INTEGRATION**: This IEA, including all attachments, constitutes the entire agreement of the parties with respect to its subject matter. There have been no representations, warranties, or promises made outside of this IEA. This IEA shall take precedence over any other document that may be in conflict with it.

ATTACHMENTS

1 – CMPPA Agreement
2 – SSA Data Exchange Systems
3 – Systems Security Requirements for SSA Web Access to SSA Information Through ICON
4 – Information System Security Guidelines for Federal, State and Local Agencies Receiving Electronic Information from the Social Security Administration
5 – PII Loss Reporting Worksheet

N. **SSA AUTHORIZED SIGNATURE:** The signatory below warrants and represents that he or she has the competent authority on behalf of SSA to enter into the obligations set forth in this IEA.

SOCIAL SECURITY ADMINISTRATION

Mary G Ann Garr for

Michael G. Gallagher
Assistant Deputy Commissioner
for Budget, Finance and Management

5/13/03
Date

O. REGIONAL AND STATE AGENCY SIGNATURES:

SOCIAL SECURITY ADMINISTRATION
REGION IX

Peter D. Spencer
San Francisco Regional Commissioner

10/26/09
Date

THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

The signatory below warrants and represents that he or she has the competent authority on behalf of the State Agency to enter into the obligations set forth in this IEA.

Toby Douglas
Chief Deputy Director, Health Care Programs

10/11/09
Date

CERTIFICATION OF COMPLIANCE
FOR
THE INFORMATION EXCHANGE AGREEMENT
BETWEEN
THE SOCIAL SECURITY ADMINISTRATION (SSA)
AND
THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES (STATE AGENCY)

(State Agency Level)

In accordance with the terms of the Information Exchange Agreement (IEA/F) between SSA and the State Agency, the State Agency, through its authorized representative, hereby certifies that, as of the date of this certification:

1. The State Agency is in compliance with the terms and conditions of the IEA/F.

2. The State Agency has conducted the data exchange processes under the IEA/F without change, except as modified in accordance with the IEA/F.

3. The State Agency will continue to conduct the data exchange processes under the IEA/F without change, except as may be modified in accordance with the IEA/F.

4. Upon SSA's request, the State Agency will provide audit reports or other documents that demonstrate compliance with the review and oversight activities required under the IEA/F and the governing Computer Matching and Privacy Protection Act Agreement.

5. In compliance with the requirements of the "Electronic Information Exchange Security Requirements and Procedures for State and Local Agencies Exchanging Electronic Information with the Social Security Administration," (last updated April 2014) Attachment 4 to the IEA/F, as periodically updated by SSA, the State Agency has not made any changes in the following areas that could potentially affect the security of SSA data:

   - General System Security Design and Operating Environment
   - System Access Control
   - Automated Audit Trail
   - Monitoring and Anomaly Detection
   - Management Oversight
   - Data and Communications Security
   - Contractors of Electronic Information Exchange Partners

   The State Agency will submit an updated Security Design Plan at least 30 days prior to making any changes to the areas listed above and provide updated contractor employee lists before allowing new employees' access to SSA provided data.

6. The State Agency agrees that use of computer technology to transfer the data is more economical, efficient, and faster than using a manual process. As such, the State Agency will continue to utilize data exchange to obtain data it needs to administer the programs for which it is authorized under the IEA/F. Further, before directing an individual to an SSA field office to obtain data, the State Agency will verify that the information it submitted to SSA via data exchanges is correct, and verify with the individual that the information he/she supplied is accurate. The use of electronic data exchange expedites program administration and limits SSA field office traffic.

The signatory below warrants and represents that he or she is a representative of the State Agency duly authorized to make this certification on behalf of the State Agency.

DEPARTMENT OF HEALTH CARE SERVICES OF CALIFORNIA

Toby Douglas
Director

10/31/14
Date

ATTACHMENT 1

COMPUTER MATCHING AND PRIVACY PROTECTION ACT AGREEMENT

COMPUTER MATCHING AND PRIVACY PROTECTION ACT AGREEMENT BETWEEN THE SOCIAL SECURITY ADMINISTRATION AND THE HEALTH AND HUMAN SERVICES AGENCY OF CALIFORNIA

I. Purpose and Legal Authority

A. Purpose

This Computer Matching and Privacy Protection Act (CMPPA) Agreement between the Social Security Administration (SSA) and the California Health and Human Services Agency (State Agency) sets forth the terms and conditions governing disclosures of records, information, or data (collectively referred to herein as "data") made by SSA to the State Agency that administers federally funded benefit programs, including those under various provisions of the Social Security Act (Act), such as section 1137 (42 U.S.C. § 1320b-7), as well as the state-funded state supplementary payment programs under Title XVI of the Act. The terms and conditions of this Agreement ensure that SSA makes such disclosures of data, and the State Agency uses such disclosed data, in accordance with the requirements of the Privacy Act of 1974, as amended by the CMPPA of 1988, 5 U.S.C. § 552a.

Under section 1137 of the Act, the State Agency is required to use an income and eligibility verification system to administer specified federally funded benefit programs, including the state-funded state supplementary payment programs under Title XVI of the Act. To assist the State Agency in determining entitlement to and eligibility for benefits under those programs, as well as other federally funded benefit programs, SSA discloses certain data about applicants (and in limited circumstances, members of an applicant's household), for state benefits from SSA Privacy Act Systems of Records (SOR) and verifies the Social Security numbers (SSN) of the applicants.

B. Legal Authority

SSA's authority to disclose data and the State Agency's authority to collect, maintain, and use data protected under SSA SORs for specified purposes is:

- Sections 1137, 453, and 1106(b) of the Act (42 U.S.C. §§ 1320b-7, 653, and 1306(b)) (income and eligibility verification data);
- 26 U.S.C. § 6103(l)(7) and (8) (tax return data);
- Section 202(x)(3)(B)(iv) of the Act (42 U.S.C. § 402(x)(3)(B)(iv)) (prisoner data);

- Section 1611(e)(1)(I)(iii) of the Act (42 U.S.C. § 1382(e)(1)(I)(iii) (Supplemental Security Income (SSI));
- Section 205(r)(3) of the Act (42 U.S.C. § 405(r)(3)) and the Intelligence Reform and Terrorism Prevention Act of 2004, Pub. L. 108-458, § 7213(a)(2) (death data);
- Sections 402, 412, 421, and 435 of Pub. L. 104-193 (8 U.S.C. §§ 1612, 1622, 1631, and 1645) (quarters of coverage data);
- Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Pub. L. 111-3 (citizenship data); and
- Routine use exception to the Privacy Act, 5 U.S.C. § 552a(b)(3) (data necessary to administer other programs compatible with SSA programs).

This Agreement further carries out section 1106(a) of the Act (42 U.S.C. § 1306), the regulations promulgated pursuant to that section (20 C.F.R. Part 401), the Privacy Act of 1974 (5 U.S.C. § 552a), as amended by the CMPPA, related Office of Management and Budget (OMB) guidelines, the Federal Information Security Management Act of 2002 (FISMA) (44 U.S.C. § 3541, et seq.), and related National Institute of Standards and Technology (NIST) guidelines, which provide the requirements that the State Agency must follow with regard to use, treatment, and safeguarding of data.

II. Scope

A. The State Agency will comply with the terms and conditions of this Agreement and the Privacy Act, as amended by the CMPPA.

B. The State Agency will execute one or more Information Exchange Agreements (IEA) with SSA, documenting additional terms and conditions applicable to those specific data exchanges, including the particular benefit programs administered by the State Agency, the data elements that will be disclosed, and the data protection requirements implemented to assist the State Agency in the administration of those programs.

C. The State Agency will use the SSA data governed by this Agreement to determine entitlement and eligibility of individuals for one or more of the following programs:

1. Temporary Assistance to Needy Families (TANF) program under Part A of Title IV of the Act;
2. Medicaid provided under an approved State plan or an approved waiver under Title XIX of the Act;
3. State Children's Health Insurance Program (CHIP) under Title XXI of the Act, as amended by the Children's Health Insurance Program Reauthorization Act of 2009;

4. Supplemental Nutritional Assistance Program (SNAP) under the Food Stamp Act of 1977 (7 U.S.C. § 2011, et seq.);
5. Women, Infants and Children Program (WIC) under the Child Nutrition Act of 1966 (42 U.S.C. § 1771, et seq.);
6. Medicare Savings Programs (MSP) under 42 U.S.C. § 1396a(10)(E);
7. Unemployment Compensation programs provided under a state law described in section 3304 of the Internal Revenue Code of 1954;
8. Low Income Heating and Energy Assistance (LIHEAP or home energy grants) program under 42 U.S.C. § 8621;
9. State-administered supplementary payments of the type described in section 1616(a) of the Act;
10. Programs under a plan approved under Titles I, X, XIV, or XVI of the Act;
11. Foster Care and Adoption Assistance under Title IV of the Act;
12. Child Support Enforcement programs under section 453 of the Act (42 U.S.C. § 653);
13. Other applicable federally funded programs administered by the State Agency under Titles I, IV, X, XIV, XVI, XVIII, XIX, XX, and XXI of the Act; and
14. Any other federally funded programs administered by the State Agency that are compatible with SSA's programs.

D. The State Agency will ensure that SSA data disclosed for the specific purpose of administering a particular federally funded benefit program is used only to administer that program.

III. Justification and Expected Results

A. Justification

This Agreement and related data exchanges with the State Agency are necessary for SSA to assist the State Agency in its administration of federally funded benefit programs by providing the data required to accurately determine entitlement and eligibility of individuals for benefits provided under these programs. SSA uses computer technology to transfer the data because it is more economical, efficient, and faster than using manual processes.

B. Expected Results

The State Agency will use the data provided by SSA to improve public service and program efficiency and integrity. The use of SSA data expedites the application process and ensures that benefits are awarded only to applicants that satisfy the State Agency's program criteria. A cost-benefit analysis for the exchange made under this Agreement is not required in accordance with the determination by the SSA Data Integrity Board (DIB) to waive such analysis pursuant to 5 U.S.C. § 552a(u)(4)(B).

IV. Record Description

A. Systems of Records

SSA SORs used for purposes of the subject data exchanges include:

- 60-0058 -- Master Files of SSN Holders and SSN Applications;
- 60-0059 -- Earnings Recording and Self-Employment Income System;
- 60-0090 -- Master Beneficiary Record;
- 60-0103 -- Supplemental Security Income Record (SSR) and Special Veterans Benefits (SVB);
- 60-0269 -- Prisoner Update Processing System (PUPS); and
- 60-0321 -- Medicare Part D and Part D Subsidy File.

The State Agency will only use the tax return data contained in **SOR 60-0059** (Earnings Recording and Self-Employment Income System) in accordance with 26 U.S.C. § 6103.

B. Data Elements

Data elements disclosed in computer matching governed by this Agreement are Personally Identifiable Information (PII) from specified SSA SORs, including names, SSNs, addresses, amounts, and other information related to SSA benefits and earnings information. Specific listings of data elements are available at:

http://www.ssa.gov/dataexchange/

C. Number of Records Involved

The number of records for each program covered under this Agreement is equal to the number of Title II, Title XVI, or Title XVIII recipients resident in the State as recorded in SSA's Annual Statistical Supplement found on the Internet at:

http://www.ssa.gov/policy/docs/statcomps/

This number will fluctuate during the term of this Agreement, corresponding to the number of Title II, Title XVI, and Title XVIII recipients added to, or deleted from, SSA databases.

V. Notice and Opportunity to Contest Procedures

A. Notice to Applicants

The State Agency will notify all individuals who apply for federally funded, state-administered benefits under the Act that any data they provide are subject to verification through computer matching with SSA. The State Agency and SSA

will provide such notice through appropriate language printed on application forms or separate handouts.

B. Notice to Beneficiaries/Recipients/Annuitants

The State Agency will provide notice to beneficiaries, recipients, and annuitants under the programs covered by this Agreement informing them of ongoing computer matching with SSA. SSA will provide such notice through publication in the Federal Register and periodic mailings to all beneficiaries, recipients, and annuitants describing SSA's matching activities.

C. Opportunity to Contest

The State Agency will not terminate, suspend, reduce, deny, or take other adverse action against an applicant for or recipient of federally funded, state-administered benefits based on data disclosed by SSA from its SORs until the individual is notified in writing of the potential adverse action and provided an opportunity to contest the planned action. "Adverse action" means any action that results in a termination, suspension, reduction, or final denial of eligibility, payment, or benefit. Such notices will:

1. Inform the individual of the match findings and the opportunity to contest these findings;

2. Give the individual until the expiration of any time period established for the relevant program by a statute or regulation for the individual to respond to the notice. If no such time period is established by a statute or regulation for the program, a 30-day period will be provided. The time period begins on the date on which notice is mailed or otherwise provided to the individual to respond; and

3. Clearly state that, unless the individual responds to the notice in the required time period, the State Agency will conclude that the SSA data are correct and will effectuate the threatened action or otherwise make the necessary adjustment to the individual's benefit or entitlement.

VI. Records Accuracy Assessment and Verification Procedures

Pursuant to 5 U.S.C. § 552a(p)(1)(A)(ii), SSA's DIB has determined that the State Agency may use SSA's benefit data without independent verification. SSA has independently assessed the accuracy of its benefits data to be more than 99 percent accurate when the benefit record is created.

Prisoner and death data, some of which is not independently verified by SSA, does not have the same degree of accuracy as SSA's benefit data. Therefore, the State

Agency must independently verify these data through applicable State verification procedures and the notice and opportunity to contest procedures specified in Section V of this Agreement before taking any adverse action against any individual.

Based on SSA's Office of Quality Performance "FY 2009 Enumeration Quality Review Report #2—The 'Numident' (January 2011)," the SSA Enumeration System database (the Master Files of SSN Holders and SSN Applications System) used for SSN matching is 98 percent accurate for records updated by SSA employees.

Individuals applying for SSNs report their citizenship status at the time they apply for their SSNs. There is no obligation for an individual to report to SSA a change in his or her immigration status until he or she files for a Social Security benefit. The State Agency must independently verify citizenship data through applicable State verification procedures and the notice and opportunity to contest procedures specified in Section V of this Agreement before taking any adverse action against any individual.

VII. Disposition and Records Retention of Matched Items

A. The State Agency will retain all data received from SSA to administer programs governed by this Agreement only for the required processing times for the applicable federally funded benefit programs and will then destroy all such data.

B. The State Agency may retain SSA data in hardcopy to meet evidentiary requirements, provided that they retire such data in accordance with applicable state laws governing the State Agency's retention of records.

C. The State Agency may use any accretions, deletions, or changes to the SSA data governed by this Agreement to update their master files of federally funded, state-administered benefit program applicants and recipients and retain such master files in accordance with applicable state laws governing the State Agency's retention of records.

D. The State Agency may not create separate files or records comprised solely of the data provided by SSA to administer programs governed by this Agreement.

E. SSA will delete electronic data input files received from the State Agency after it processes the applicable match. SSA will retire its data in accordance with the Federal Records Retention Schedule (44 U.S.C. § 3303a).

VIII. Security Procedures

The State Agency will comply with the security and safeguarding requirements of the Privacy Act, as amended by the CMPPA, related OMB guidelines, FISMA, related

NIST guidelines, and the current revision of Internal Revenue Service (IRS) Publication 1075, *Tax Information Security Guidelines for Federal, State and Local Agencies*, available at http://www.irs.gov. In addition, the State Agency will have in place administrative, technical, and physical safeguards for the matched data and results of such matches. Additional administrative, technical, and physical security requirements governing all data SSA provides electronically to the State Agency, including specific guidance on safeguarding and reporting responsibilities for PII, are set forth in the IEAs.

IX. Records Usage, Duplication, and Redisclosure Restrictions

A. The State Agency will use and access SSA data and the records created using that data only for the purpose of verifying eligibility for the specific federally funded benefit programs identified in the IEA.

B. The State Agency will comply with the following limitations on use, duplication, and redisclosure of SSA data:

1. The State Agency will not use or redisclose the data disclosed by SSA for any purpose other than to determine eligibility for, or the amount of, benefits under the state-administered income/health maintenance programs identified in this Agreement.

2. The State Agency will not extract information concerning individuals who are neither applicants for, nor recipients of, benefits under the state-administered income/health maintenance programs identified in this Agreement. In limited circumstances that are approved by SSA, the State Agency may extract information about an individual other than the applicant/recipient when the applicant/recipient has provided identifying information about the individual and the individual's income or resources affect the applicant's/recipient's eligibility for such program.

3. The State Agency will not disclose to an applicant/recipient information about another individual (i.e., an applicant's household member) without the written consent from the individual to whom the information pertains.

4. The State Agency will use the Federal tax information (FTI) disclosed by SSA only to determine individual eligibility for, or the amount of, assistance under a state plan pursuant to section 1137 programs and child support enforcement programs in accordance with 26 U.S.C. § 6103(l)(7) and (8). The State Agency receiving FTI will maintain all FTI from IRS in accordance with 26 U.S.C. § 6103(p)(4) and the IRS Publication 1075. Contractors and agents acting on behalf of the State Agency will only have access to tax return data where specifically authorized by 26 U.S.C. § 6103 and the current revision IRS Publication 1075.

5. The State Agency will use the citizenship status data disclosed by SSA under CHIPRA, Pub. L. 111-3, only for the purpose of determining entitlement to Medicaid and CHIP programs for new applicants.

6. The State Agency will restrict access to the data disclosed by SSA to only those authorized State employees, contractors, and agents who need such data to perform their official duties in connection with the purposes identified in this Agreement.

7. The State Agency will enter into a written agreement with each of its contractors and agents who need SSA data to perform their official duties whereby such contractor or agent agrees to abide by all relevant Federal laws, restrictions on access, use, and disclosure, and security requirements in this Agreement. The State Agency will provide its contractors and agents with copies of this Agreement, related IEAs, and all related attachments before initial disclosure of SSA data to such contractors and agents. Prior to signing this Agreement, and thereafter at SSA's request, the State Agency will obtain from its contractors and agents a current list of the employees of such contractors and agents with access to SSA data and provide such lists to SSA.

8. The State Agency's employees, contractors, and agents who access, use, or disclose SSA data in a manner or purpose not authorized by this Agreement may be subject to civil and criminal sanctions pursuant to applicable Federal statutes.

9. The State Agency will conduct triennial compliance reviews of its contractor(s) and agent(s) no later than three years after the initial approval of the security certification to SSA. The State Agency will share documentation of its recurring compliance reviews with its contractor(s) and agent(s) with SSA. The State Agency will provide documentation to SSA during its scheduled compliance and certification reviews or upon request.

C. The State Agency will not duplicate in a separate file or disseminate, without prior written permission from SSA, the data governed by this Agreement for any purpose other than to determine entitlement to, or eligibility for, federally funded benefits. The State Agency proposing the redisclosure must specify in writing to SSA what data are being disclosed, to whom, and the reasons that justify the redisclosure. SSA will not give permission for such redisclosure unless the redisclosure is required by law or essential to the conduct of the matching program and authorized under a routine use. To the extent SSA approves the requested redisclosure, the State Agency will ensure that any entity receiving the redisclosed data will comply with the procedures and limitations on use, duplication, and redisclosure of SSA data, as well as all administrative, technical, and physical security requirements governing all data SSA provides electronically to the State Agency including specific guidance on safeguarding and reporting

responsibilities for PII, as set forth in this Agreement and the accompanying IEAs.

X. Comptroller General Access

The Comptroller General (the Government Accountability Office) may have access to all records of the State Agency that the Comptroller General deems necessary to monitor and verify compliance with this Agreement in accordance with 5 U.S.C. § 552a(o)(l)(K).

XI. Duration, Modification, and Termination of the Agreement

A. Duration

1. This Agreement is effective from January 1, 2015 (Effective Date) through June 30, 2016 (Expiration Date).

2. In accordance with the CMPPA, SSA will: (a) publish a Computer Matching Notice in the Federal Register at least 30 days prior to the Effective Date; (b) send required notices to the Congressional committees of jurisdiction under 5 U.S.C. § 552a(o)(2)(A)(i) at least 40 days prior to the Effective Date; and (c) send the required report to OMB at least 40 days prior to the Effective Date.

3. Within 3 months prior the Expiration Date, the SSA DIB may, without additional review, renew this Agreement for a period not to exceed 12 months, pursuant to 5 U.S.C. § 552a(o)(2)(D), if:

   - the applicable data exchange will continue without any change; and
   - SSA and the State Agency certify to the DIB in writing that the applicable data exchange has been conducted in compliance with this Agreement.

4. If either SSA or the State Agency does not wish to renew this Agreement, it must notify the other party of its intent not to renew at least 3 months prior to the Expiration Date.

B. Modification

Any modification to this Agreement must be in writing, signed by both parties, and approved by the SSA DIB.

C. Termination

The parties may terminate this Agreement at any time upon mutual written consent of both parties. Either party may unilaterally terminate this Agreement upon 90 days advance written notice to the other party; such unilateral termination will be effective 90 days after the date of the notice, or at a later date specified in the notice.

SSA may immediately and unilaterally suspend the data flow or terminate this Agreement if SSA determines, in its sole discretion, that the State Agency has violated or failed to comply with this Agreement.

XII. Reimbursement

In accordance with section 1106(b) of the Act, the Commissioner of SSA has determined not to charge the State Agency the costs of furnishing the electronic data from the SSA SORs under this Agreement.

XIII. Disclaimer

SSA is not liable for any damages or loss resulting from errors in the data provided to the State Agency under any IEAs governed by this Agreement. Furthermore, SSA is not liable for any damages or loss resulting from the destruction of any materials or data provided by the State Agency.

XIV. Points of Contact

A. SSA Point of Contact

Regional Office

Dolores Dunnachie, Director
San Francisco Regional Office, Center for Programs Support
1221 Nevin Avenue
Richmond CA 94801
Phone: (510) 970-8444 Fax: (510) 970-8101
Dolores.Dunnachie@ssa.gov

B. State Agency Point of Contact

Sonia Herrera
California Health and Human Services Agency
1600 Ninth Street
Sacramento, CA 95814
Phone: (916) 654-3459 Fax: 916-440-5001
Sonia.Herrera@chhs.ca.gov

XV. SSA and Data Integrity Board Approval of Model CMPPA Agreement

The signatories below warrant and represent that they have the competent authority on behalf of SSA to approve the model of this CMPPA Agreement.

SOCIAL SECURITY ADMINISTRATION

Dawn S. Wiggins
Deputy Executive Director
Office of Privacy and Disclosure
Office of the General Counsel

6-12-14
Date

I certify that the SSA Data Integrity Board approved the model of this CMPPA Agreement.

Kirsten J. Moncada
Chair
SSA Data Integrity Board

7-2-14
Date

XVI. Authorized Signatures

The signatories below warrant and represent that they have the competent authority on behalf of their respective agency to enter into the obligations set forth in this Agreement.

SOCIAL SECURITY ADMINISTRATION

Grace M. Kim
Regional Commissioner
San Francisco

11/6/14
Date

HEALTH AND HUMAN SERVICES AGENCY

Diana S. Dooley
Secretary

October 29, 2014
Date

ATTACHMENT 2

AUTHORIZED DATA EXCHANGE SYSTEM(S)

Attachment 2

Authorized Data Exchange System(s)

BEER (Beneficiary Earnings Exchange Record): Employer data for the last calendar year.

BENDEX (Beneficiary and Earnings Data Exchange): Primary source for Title II eligibility, benefit and demographic data.

LIS (Low-Income Subsidy): Data from the Low-Income Subsidy Application for Medicare Part D beneficiaries -- used for Medicare Savings Programs (MSP).

Medicare 1144 (Outreach): Lists of individuals on SSA roles, who may be eligible for medical assistance for: payment of the cost of Medicare cost-sharing under the Medicaid program pursuant to Sections 1902(a)(10)(E) and 1933 of the Act; transitional assistance under Section 1860D-31(f) of the Act; or premiums and cost-sharing subsidies for low-income individuals under Section 1860D-14 of the Act.

PUPS (Prisoner Update Processing System): Confinement data received from over 2000 state and local institutions (such as jails, prisons, or other penal institutions or correctional facilities) -- PUPS matches the received data with the MBR and SSR benefit data and generates alerts for review/action.

QUARTERS OF COVERAGE (QC): Quarters of Coverage data as assigned and described under Title II of the Act -- The term "quarters of coverage" is also referred to as "credits" or “Social Security credits” in various SSA public information documents, as well as to refer to "qualifying quarters" to determine entitlement to receive Food Stamps.

SDX (SSI State Data Exchange): Primary source of Title XVI eligibility, benefit and demographic data as well as data for Title VIII Special Veterans Benefits (SVB).

SOLQ/SOLQ-I (State On-line Query/State On-line Query-Internet): A real-time online system that provides SSN verification and MBR and SSR benefit data similar to data provided through SVES.

Attachment 2

SVES (State Verification and Exchange System): A batch system that provides SSN verification, MBR benefit information, and SSR information through a uniform data response based on authorized user-initiated queries. The SVES types are divided into five different responses as follows:

SVES I:	This batch provides strictly SSN verification.
SVES I/Citizenship*	This batch provides strictly SSN verification and citizenship data.
SVES II:	This batch provides strictly SSN verification and MBR benefit information
SVES III:	This batch provides strictly SSN verification and SSR/SVB.
SVES IV:	This batch provides SSN verification, MBR benefit information, and SSR/SVB information, which represents all available SVES data.

** Citizenship status data disclosed by SSA under the Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. 111-3 is only for the purpose of determining entitlement to Medicaid and CHIP program for new applicants.*

ATTACHMENT 3 OMITTED

SENSITIVE DOCUMENT

ATTACHMENT 4

ELECTRONIC INFORMATION EXCHANGE SECURITY REQUIREMENTS AND PROCEDURES

This document is SENSITIVE and should not be released to the public without prior authorization from DHCS.

ELECTRONIC INFORMATION EXCHANGE SECURITY REQUIREMENTS AND PROCEDURES FOR STATE AND LOCAL AGENCIES EXCHANGING ELECTRONIC INFORMATION WITH THE SOCIAL SECURITY ADMINISTRATION

SENSITIVE DOCUMENT

VERSION 6.0.2
April 2014

Table of Contents

1. Introduction

2. Electronic Information Exchange Definition

3. Roles and Responsibilities

4. General Systems Security Standards

5. Systems Security Requirements
   - 5.1 Overview
   - 5.2 General System Security Design and Operating Environment
   - 5.3 System Access Control
   - 5.4 Automated Audit Trail
   - 5.5 Personally Identifiable Information
   - 5.6 Monitoring and Anomaly Detection
   - 5.7 Management Oversight and Quality Assurance
   - 5.8 Data and Communications Security
   - 5.9 Incident Reporting
   - 5.10 Security Awareness and Employee Sanctions
   - 5.11 Contractors of Electronic Information Exchange Partners

6. General--Security Certification and Compliance Review Programs
   - 6.1 The Security Certification Program
   - 6.2 Documenting Security Controls in the Security Design Plan
     - 6.2.1 When the SDP and Risk Assessment are Required
   - 6.3 The Certification Process
   - 6.4 The Compliance Review Program and Process
     - 6.5.1 EIEP Compliance Review Participation
     - 6.5.2 Verification of Audit Samples
   - 6.6 Scheduling the Onsite Review

7. Additional Definitions

8. Regulatory References

9. Frequently Asked Questions

10. Diagrams
    - Flow Chart of the OIS Certification Process
    - Flow Chart of the OIS Compliance Review Process
    - Compliance Review Decision Matrix

RECEIVING ELECTRONIC INFORMATION FROM THE SOCIAL SECURITY ADMINISTRATION

1. Introduction

The law requires the Social Security Administration (SSA) to maintain oversight and assure the protection of information it provides to its *Electronic Information Exchange Partners* (EIEP). EIEPs are entities that have information exchange agreements with SSA.

The overall aim of this document is twofold. First, to ensure that SSA can properly certify EIEPs as compliant by the SSA security requirements, standards, and procedures expressed in this document before we grant access to SSA information in a production environment. Second, to ensure that EIEPs continue to adequately safeguard electronic information provided to them by SSA.

This document (which SSA considers SENSITIVE[1] and should only be shared with those who need it to ensure SSA-provided information is safeguarded), describes the security requirements, standards, and procedures EIEPs must meet and implement to obtain information from SSA electronically. This document helps EIEPs understand criteria that SSA uses when evaluating and certifying the system design and security features used for electronic access to SSA-provided information.

The addition, elimination, and modification of security control factors determine which level of security and due diligence SSA requires for the EIEP to mitigate risks. The emergence of new threats, attack methods, and the availability of new technology warrants frequent reviews and revisions to our System Security Requirements (SSR). Consequently, EIEPs should expect SSA's System Security Requirements to evolve in concert with the industry.

EIEPs must comply with SSA's most current SSRs to gain access to SSA-provided data. SSA will work with its partners to resolve deficiencies that occur subsequent to, and after, approval for access if updates to our security requirements cause an agency to be uncompliant. EIEPs may proactively ensure their ongoing compliance with the SSRs by periodically requesting the most current SSR package from their SSA contact. Making periodic adjustments is often necessary.

2. Electronic Information Exchange Definition

For discussion purposes herein, Electronic Information Exchange (EIE) is any electronic process in which SSA discloses information under its control to any third party for any purpose, without the specific consent of the subject individual or agent acting on his or her behalf. EIE involves individual data transactions and data files processed within the systems of parties to electronic information sharing agreements with SSA. These processes include direct terminal access or DTA to SSA systems, batch processing, and variations thereof (e.g., online query) regardless of the systematic method used to accomplish the activity or to interconnect SSA with the EIEP.

[1] Sensitive data - "any information, the loss, misuse, or unauthorized access to or modification of which could adversely affect the national interest or the conduct of Federal programs, or the privacy to which individuals are entitled under 5 U.S.C. Section 552a (The Privacy Act), but that has not been specifically authorized under criteria established by an Executive Order or an Act of Congress to be kept classified in the interest of national defense or foreign policy but is to be protected in accordance with the requirements of the Computer Security Act of 1987 (P.L.100-235)."

3. Roles and Responsibilities

The SSA ***Office of Information Security (OIS)*** has agency-wide responsibility for interpreting, developing, and implementing security policy; providing security and integrity review requirements for all major SSA systems; managing SSA's fraud monitoring and reporting activities; developing and disseminating security training and awareness materials; and providing consultation and support for a variety of agency initiatives. SSA's security reviews ensure that external systems receiving information from SSA are secure and operate in a manner consistent with SSA's Information Technology (IT) security policies and in compliance with the terms of electronic information sharing agreements executed by SSA with outside entities. Within the context of SSA's security policies and the terms of electronic information sharing agreements with SSA's EIEPs, OIS exclusively conducts and brings to closure initial security certifications and periodic security compliance reviews of EIEPs that process, maintain, transmit, or store SSA-provided information in accordance with pertinent Federal requirements which include the following (see also ***Regulatory References***):

a. The **Federal Information Security Management Act (FISMA)** requires the protection of "Federal information in contractor systems, including those systems operated by state and local governments."

b. The Social Security Administration requires EIEPs to adhere to the policies, standards, procedures, and directives published in this Systems Security Requirements (SSR) document.

   Personally Identifiable Information (PII), covered under several Federal laws and statutes, is information about an individual including, but not limited to, personal identifying information including the Social Security Number (SSN).

   The data (last 4 digits of the SSN) that SSA provides to its EIEPs for purposes of the Help America Vote Act (HAVA) does not identify a specific individual; therefore, is not "PII" as defined by the Act.

   However, SSA is diligent in discharging its responsibility for establishing *appropriate* administrative, technical, and physical safeguards to ensure the security, confidentiality, and availability of its records and to protect against any anticipated threats or hazards to their security or integrity.

   NOTE: Disclosure of Federal Tax Information (FTI) is limited to certain Federal agencies and state programs supported by federal statutes under Sections 1137, 453, and 1106 of the Social Security Act. For information regarding safeguards for protecting FTI, consult IRS Publication 1075, **Tax Information Security Guidelines for Federal, State, and Local Agencies.**

   The SSA Regional ***Data Exchange Coordinators*** (DECs) serve as a bridge between SSA and state EIEPs. In the security arena, DECs assist OIS in coordinating data exchange security review activities with state and local EIEPs; e.g., they provide points of contact with state agencies, assist in setting up security reviews, etc. DECs are also the first points of contact for states if an employee of a state agency or an employee of a state agency's contractor or

agent becomes aware of a suspected or actual loss of SSA-provided Personally Identifiable Information (PII).

4. General Systems Security Standards

EIEPs that request and receive information electronically from SSA must comply with the following general systems security standards concerning access to and control of SSA-provided information.

NOTE: EIEPs may not create separate files or records comprised solely of the information provided by SSA.

a. EIEPs must ensure that means, methods, and technology used to process, maintain, transmit, or store SSA-provided information neither prevents nor impedes the EIEP's ability to

- safeguard the information in conformance with SSA requirements,
- efficiently investigate fraud, data breaches, or security events that involve SSA-provided information, or
- detect instances of misuse or abuse of SSA-provided information

For example, utilization of cloud computing may have the potential to jeopardize an EIEP's compliance with the terms of their agreement or SSA's associated system security requirements and procedures.

b. EIEPs must use the electronic connection established between the EIEP and SSA only in support of the current agreement(s) between the EIEP and SSA.

c. EIEPs must use the software and/or devices provided to the EIEP only in support of the current agreement(s) between the EIEP and SSA.

d. SSA prohibits modifying any software or devices provided to the EIEPs by SSA.

e. EIEPs must ensure that SSA-provided information is not processed, maintained, transmitted, or stored in or by means of data communications channels, electronic devices, computers, or computer networks located in geographic or virtual areas not subject to U.S. law.

f. EIEPs must restrict access to the information to authorized users who need it to perform their official duties.

NOTE: Contractors and agents (hereafter referred to as contractors) of the EIEP who process, maintain, transmit, or store SSA-provided information are held to the same security requirements as employees of the EIEP. Refer to the section Contractors of Electronic Information Exchange Partners in the Systems Security Requirements for additional information.

g. EIEPs must store information received from SSA in a manner that, at all times, is physically and electronically secure from access by unauthorized persons.

h. The EIEP must process SSA-provided information under the immediate supervision and control of authorized personnel.

i. EIEPs must employ both physical and technological safeguards to prevent unauthorized retrieval of SSA-provided information via computer, remote terminal, or other means.

j. EIEPs must have formal PII incident response procedures. When faced with a security incident caused by malware, unauthorized access, software issues, or acts of nature, the EIEP must be able to respond in a manner that protects SSA-provided information affected by the incident.

k. EIEPs must have an active and robust employee security awareness program, which is mandatory for all employees who access SSA-provided information.

l. EIEPs must advise employees with access to SSA-provided information of the confidential nature of the information, the safeguards required to protect the information, and the civil and criminal sanctions for non-compliance contained in the applicable Federal and state laws.

m. At its discretion, SSA or its designee must have the option to conduct onsite security reviews or make other provisions to ensure that EIEPs maintain adequate security controls to safeguard the information we provide.

5. Systems Security Requirements

5.1 Overview

SSA must certify that the EIEP has implemented controls that meet the requirements and work as intended, before we will authorize initiating transactions to and from SSA through batch data exchange processes or online processes such as State Online Query (SOLQ) or Internet SOLQ (SOLQ-I).

The Technical Systems Security Requirements (TSSRs) address management, operational, and technical aspects of security safeguards to ensure only the authorized disclosure and use of SSA-provided information by SSA's EIEPs.

SSA recommends that the EIEP develop and publish a comprehensive Systems Security Policy document that specifically addresses:

- the classification of information processed and stored within the network,
- administrative controls to protect the information stored and processed within the network,
- access to the various systems and subsystems within the network,
- Security Awareness Training,
- Employee Sanctions Policy,

- Incident Response Policy, and
- the disposal of protected information and sensitive documents derived from the system or subsystems on the network.

SSA's systems security requirements represent the current state-of-the-practice security controls, safeguards, and countermeasures required for Federal information systems by Federal regulations, statutes, standards, and guidelines. Additionally, SSA's systems security requirements also include organizationally defined interpretations, policies, and procedures mandated by the authority of the Commissioner of Social Security in areas when or where other cited authorities may be silent or non-specific.

5.2 General System Security Design and Operating Environment

EIEPs must provide descriptions and explanations of their overall system design, configuration, security features, and operational environment and include explanations of how they conform to SSA's requirements. Explanations must include the following:

- Descriptions of the operating environment(s) in which the EIEP will utilize, maintain, and transmit SSA-provided information
- Descriptions of the business process(es) in which the EIEP will use SSA-provided information
- Descriptions of the physical safeguards employed to ensure that unauthorized personnel cannot access SSA-provided information and details of how the EIEP keeps audit information pertaining to the use and access to SSA-provided information and associated applications readily available
- Descriptions of electronic safeguards, methods, and procedures for protecting the EIEP's network infrastructure and for protecting SSA-provided information while in transit, in use within a process or application, and at rest (stored or not in use)
- Descriptions of how the EIEP prevents unauthorized retrieval of SSA-provided information by computer, remote terminal, or other means, including descriptions of security software other than access control software (e.g., security patch and anti-malware software installation and maintenance, etc.)
- Descriptions of how the configurations of devices (e.g., servers, workstations, and portable devices) involving SSA-provided information comply with recognized industry standards and SSA's system security requirements
- Description of how the EIEP implements adequate security controls (e.g., passwords enforcing sufficient construction strength to defeat or minimize risk-based identified vulnerabilities)

5.3 System Access Control

EIEPs must utilize and maintain technological (logical) access controls that limit access to SSA-provided information and associated transactions and functions to only those users, processes acting on behalf of authorized users, or devices (including other information systems) authorized for such access based on their official duties or purpose(s). EIEPs must employ a recognized user access security software package (e.g. RAC-F, ACF-2, TOP SECRET) or a security software design which is equivalent to such products. The access control software must utilize personal identification numbers (PIN) and passwords or Biometric identifiers in combination with the user's system identification code (userID). The access control software must employ and enforce (1) PIN/password, and/or (2) PIN/biometric identifier, and/or (3) SmartCard/biometric identifier, etc., for authenticating users).

Depending on the computing platform (e.g., client/server (PC), mainframe) and the access software implementation, the terms "PIN" and "user system identification code (userID)" may be, for practical purposes, synonymous. For example, the PIN/password combination may be required for access to an individual's PC after which, the userID/password combination may be required for access to a mainframe application. A biometric identifier may supplant one element in the pair of those combinations. **SSA strongly recommends Two-Factor Authentication.**

The EIEP's implementation of the control software must comply with recognized industry standards. Password policies should enforce sufficient construction strength (length and complexity) to defeat or minimize risk-based identified vulnerabilities and ensure limitations for password repetition. Technical controls should enforce periodic password changes based on a risk-based standard (e.g., maximum password age of 90 days, minimum password age of 3 – 7 days) and enforce automatic disabling of user accounts that have been inactive for a specified period of time (e.g., 90 days).

The EIEP's password policies must also require more stringent password construction (e.g., passwords greater than eight characters in length requiring upper and lower case letters, numbers, and special characters; password phrases) for the user accounts of persons, processes, or devices whose functions require access privileges in excess of those of ordinary users.

EIEPs must have management control and oversight of the function of authorizing individual user access to SSA-provided information and to oversee the process of issuing and managing access control PINs, passwords, biometric identifiers, etc. for access to the EIEP's system.

The EIEP's systems access rules must cover least privilege and individual accountability. The EIEP's rules should include procedures for access to sensitive information and transactions and functions related to it. Procedures should include control of transactions by permissions module, the assignment and limitation of system privileges, disabling accounts of separated employees (e.g., within 24 hours), individual accountability, work at home, dial-up access, and connecting to the Internet.

5.4 Automated Audit Trail

SSA requires EIEPs to implement and maintain a fully automated audit trail system (ATS). The system must be capable of creating, storing, protecting, and efficiently retrieving and collecting records identifying the individual user who initiates a request for information from SSA or accesses SSA-provided information. At a minimum, individual audit trail records must contain the data needed (including date and time stamps) to associate each query transaction or access to SSA-provided information with its initiator, their action, if any, and the relevant business purpose/process (e.g., SSN verification for Medicaid). Each entry in the audit file must be stored as a separate record, not overlaid by subsequent records. The Audit Trail System must create transaction files to capture all input from interactive internet applications which access or query SSA-provided information.

If a State Transmission Component (STC) handles and audits the EIEP's transactions with SSA, the EIEP is responsible for ensuring that the STC's audit capabilities meet SSA's requirements for an automated audit trail system. The EIEP must also establish a process to obtain specific audit information from the STC regarding the EIEP's SSA transactions.

Access to the audit file must be restricted to authorized users with a "need to know." Audit file data must be unalterable (read-only) and maintained for a minimum of three (preferably seven) years. Information in the audit file must be retrievable by an automated method. EIEPs must have the capability to make audit file information available to SSA upon request. EIEPs must back-up audit trail records on a regular basis to ensure their availability. EIEPs must apply the same level of protection to backup audit files that apply to the original files.

If the EIEP retains SSA-provided information in a database (e.g., Access database, SharePoint, etc.), or if certain data elements within the EIEP's system indicate to users that SSA verified the information, the EIEP's system must also capture an audit trail record of users who viewed SSA-provided information stored within the EIEP's system. The retrieval requirements for SSA-provided information at rest and the retrieval requirements for regular transactions are identical.

5.5 Personally Identifiable Information (PII)

PII is any information about an individual maintained by an agency, including (1) any information that can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, or biometric records; and (2) any other information that is linked or linkable to an individual, such as medical, educational, financial, and employment information. An item such as date and place of birth, mother's maiden name, or father's surname is PII, regardless of whether combined with other data.

SSA defines ***a PII loss*** as a circumstance when SSA has reason to believe that information on hard copy or in electronic format, which contains PII provided by SSA, left the EIEP's custody or the EIEP disclosed it to an unauthorized individual or entity. PII loss is a reportable incident (refer to ***Incident Reporting***).

If a PII loss involving SSA-provided information occurs or is suspected, the EIEP must be able to quantify the extent of the loss and compile a complete list of the individuals potentially affected by the incident (refer to ***Incident Reporting***).

5.6 Monitoring and Anomaly Detection

SSA recommends that EIEPs use an Intrusion Protection System (IPS) or an Intrusion Detection System (IDS). The EIEP must establish and/or maintain continuous monitoring of its network infrastructure and assets to ensure the following:

- The EIEP's security controls continue to be effective over time
- Only authorized individuals, devices, and processes have access to SSA-provided information
- The EIEP detects efforts by external and internal entities, devices, or processes to perform unauthorized actions (i.e., data breaches, malicious attacks, access to network assets, software/hardware installations, etc.) as soon as they occur
- The necessary parties are immediately alerted to unauthorized actions performed by external and internal entities, devices, or processes
- Upon detection of unauthorized actions, measures are immediately initiated to prevent or mitigate associated risk
- In the event of a data breach or security incident, the EIEP can efficiently determine and initiate necessary remedial actions
- The trends, patterns, or anomalous occurrences and behavior in user or network activity that may be indicative of potential security issues are readily discernible

The EIEP's system must include the capability to prevent employees from unauthorized browsing of SSA records. SSA strongly recommends the use of a transaction-driven **permission module design**, whereby employees are unable to initiate transactions not associated with the normal business process. If the EIEP uses such a design, they then need anomaly detection to detect and monitor employee's unauthorized attempts to gain access to SSA-provided information and attempts to obtain information from SSA for clients not in the EIEP's client system. The EIEP should employ measures to ensure the permission module's integrity. Users should not be able to create a bogus case and subsequently delete it in such a way that it goes undetected.

If the EIEP's design does not ***currently*** use a permission module ***and*** is not transaction-driven, until at least one of these security features exists, the EIEP must develop and implement **compensating security controls** to deter employees from browsing SSA records. These controls must include monitoring and anomaly detection features, either systematic, manual, or a combination thereof. Such features must include the capability to detect anomalies in the volume and/or type of transactions or queries requested or initiated by individuals and include systematic or manual procedures for verifying that requests and queries of SSA-provided information comply with valid official business purposes. The system must also produce reports that allow management and/or supervisors to monitor user activity, such as the following:

- **User ID Exception Reports:**

  This type of report captures information about users who enter incorrect user IDs when attempting to gain access to the system or to the transaction that initiates requests for information from SSA, including failed attempts to enter a password.

- **Inquiry Match Exception Reports:**

  This type of report captures information about users who may be initiating transactions for SSNs that have no client case association within the EIEP's system **(the EIEP's management should review 100 percent of these cases).**

- **System Error Exception Reports:**

  This type of report captures information about users who may not understand or may be violating proper procedures for access to SSA-provided information.

- **Inquiry Activity Statistical Reports:**

  This type of report captures information about transaction usage patterns among authorized users and is a tool which enables the EIEP's management to monitor typical usage patterns in contrast to extraordinary usage patterns.

The EIEP must have a process for distributing these monitoring and exception reports to appropriate local managers/supervisors or to local security officers. The process must ensure that only those whose responsibilities include monitoring anomalous activity of users, to include those who have exceptional system rights and privileges, use the reports.

5.7 Management Oversight and Quality Assurance

The EIEP must establish and/or maintain ongoing management oversight and quality assurance capabilities to ensure that only authorized employees have access to SSA-provided information. They must ensure ongoing compliance with the terms of the EIEP's electronic information sharing agreement with SSA and the SSRs established for access to SSA-provided information. The entity responsible for management oversight must consist of one or more of the EIEP's management officials whose job functions include responsibility to ensure that the EIEP only grants access to the appropriate employees and position types which require SSA-provided information to do their jobs.

The EIEP must ensure that employees granted access to SSA-provided information receive adequate training on the sensitivity of the information, associated safeguards, operating procedures, and the penalties for misuse.

SSA recommends that EIEPs establish the following job functions and require that employees tasked with these job functions do not also share the same job functions as personnel who request or use information from SSA.

- Perform periodic self-reviews to monitor the EIEP's ongoing usage of SSA-provided information.

- Perform random sampling of work activity that involves SSA-provided information to determine if the access and usage comply with SSA's requirements.

5.8 Data and Communications Security

EIEPs must encrypt PII and SSA-provided information when transmitting across dedicated communications circuits between its systems, intrastate communications between its local office locations, and on the EIEP's mobile computers, devices and removable media. The EIEP's encryption methods should align with the Standards established by the National Institute of Standards and Technology (NIST). SSA recommends the Advanced Encryption Standard (AES) or triple DES (Data Encryption Standard 3), if AES is unavailable, encryption method for securing SSA-provided information during transport. Files encrypted for external users (when using tools such as Microsoft WORD encryption,) require a key length of nine characters. We also recommend that the key (also referred to as a *password*) contain both special characters and a number. SSA requires that the EIEP deliver the key so that the key does not accompany the media. The EIEP must secure the key when not in use or unattended.

SSA discourages the use of the public Internet for transmission of SSA-provided information. If however, the EIEP uses the public Internet or other electronic communications, such as emails and faxes to transmit SSA-provided information, they must use a secure encryption protocol such as Secure Socket Layer (SSL) or Transport Layer Security (TLS). SSA also recommends 256-bit encryption protocols or more secure methods such as Virtual Private Network technology. The EIEP should only send data to a secure address or device to which the EIEP can control and limit access to only specifically authorized individuals and/or processes. **SSA recommends that EIEPs use Media Access Control (MAC) Filtering and Firewalls to protect access points from unauthorized devices attempting to connect to the network.**

EIEPs should not retain SSA-provided information any longer than business purpose(s) dictate. The Information Exchange Agreement with SSA stipulates a time for data retention. The EIEP should delete, purge, destroy, or return SSA-provided information when the business purpose for retention no longer exists.

The EIEP may not save or create separate files comprised solely of information provided by SSA. The EIEP may apply specific SSA-provided information to the EIEP's matched record from a preexisting data source. Federal law prohibits duplication and redisclosure of SSA-provided information without written approval. The prohibition applies to both internal and external sources who do not have a "need-to-know[2]." **SSA recommends that EIEPs use either Trusted Platform Module (TPM) or Hardware Security Module (HSM) technology solutions to encrypt data at rest on hard drives and other data storage media.**

EIEPs must prevent unauthorized disclosure of SSA-provided information after they complete processing and after the EIEP no longer requires the information. The EIEP's operational processes must ensure that no residual SSA-provided information remains on the hard drives of user's workstations after the user exits the application(s) that use SSA-provided information. If the EIEP must send a computer, hard drive, or other computing or storage device offsite for repair, the EIEP must have a non-disclosure clause in their contract with the vendor. If the EIEP used the item in connection with a business process that involved SSA-provided information and the vendor will retrieve or may view SSA-provided information during servicing, SSA reserves the right to inspect

[2] Need-to-know - access to the information must be necessary for the conduct of one's official duties.

the EIEP's vendor contract. The EIEP must remove SSA-provided information from electronic devices before sending it to an external vendor for service. SSA expects the EIEP to render it unrecoverable or destroy the electronic device if they do not need to recover the data. The same applies to excessed, donated, or sold equipment placed into the custody of another organization.

To sanitize media, the EIEP should use one of the following methods:

- **Overwriting**

Overwrite utilities can only be used on working devices. Overwriting is appropriate only for devices designed for multiple reads and writes. The EIEP should overwrite disk drives, magnetic tapes, floppy disks, USB flash drives, and other rewriteable media. The overwrite utility must completely overwrite the media. SSA recommends the use of ***purging*** media sanitization to make the data irretrievable and to protect data against laboratory attacks or forensics. Please refer to ***Definitions*** for more information regarding ***Media Sanitization***). Reformatting the media does not overwrite the data.

- **Degaussing**

Degaussing is a sanitization method for magnetic media (e.g., disk drives, tapes, floppies, etc.). Degaussing is not effective for purging non-magnetic media (e.g., optical discs). Degaussing requires a certified tool designed for particular types of media. Certification of the tool is required to ensure that the magnetic flux applied to the media is strong enough to render the information irretrievable. The degaussing process must render data on the media irretrievable by a laboratory attack or laboratory forensic procedures (refer to ***Definitions*** for more information regarding ***Media Sanitization***).

- **Physical destruction**

Physical destruction is the method when degaussing or over-writing cannot be accomplished (for example, CDs, floppies, DVDs, damaged tapes, hard drives, damaged USB flash drives, etc.). Examples of physical destruction include shredding, pulverizing, and burning.

State agencies may retain SSA-provided information in hardcopy only if required to fulfill evidentiary requirements, provided the agencies retire such data in accordance with applicable state laws governing retention of records. The EIEP must control print media containing SSA-provided information to restrict its access to authorized employees who need such access to perform their official duties. EIEPs must destroy print media containing SSA-provided information in a secure manner when it is no longer required for business purposes. The EIEP should destroy paper documents that contain SSA-provided information by burning, pulping, shredding, macerating, or other similar means that ensure the information is unrecoverable.

NOTE: Hand tearing or lining through documents to obscure information does not meet SSA's requirements for appropriate destruction of PII.

The EIEP must employ measures to ensure that communications and data furnished to SSA contain no viruses or other malware.

Special Note: **If SSA-provided information will be stored in a commercial**

cloud, please provide the name and address of the cloud provider. Also, please describe the security features contractually required of the cloud provider to protect SSA-provided information.

5.9 Incident Reporting

SSA requires EIEPs to develop and implement policies and procedures to respond to data breaches or PII loses. You must explain how your policies and procedures conform to SSA's requirements. The procedures must include the following information:

> *If the EIEP experiences or suspects a breach or loss of PII or a security incident, which includes SSA-provided information, they must notify the State official responsible for Systems Security designated in the agreement. That State official or delegate must then notify the SSA Regional Office Contact and the SSA Systems Security Contact identified in the agreement. If, for any reason, the responsible State official or delegate is unable to notify the SSA Regional Office or the SSA Systems Security Contact* ***within one hour****, the responsible State Agency official or delegate must report the incident by contacting* ***SSA's National Network Service Center (NNSC) toll free at 877-697-4889*** *(select "Security and PII Reporting" from the options list). The EIEP will provide updates as they become available to the SSA contact, as appropriate. Refer to the worksheet provided in the agreement to facilitate gathering and organizing information about an incident.*

The EIEP must agree to absorb all costs associated with notification and remedial actions connected to security breaches, if SSA determines that the risk presented by the breach or security incident requires the notification of the subject individuals. **SSA recommends that EIEPs seriously consider establishing incident response teams to address PII breaches.**

5.10 Security Awareness and Employee Sanctions

The EIEP must designate a department or party to take the responsibility to provide ongoing security awareness training for employees who access SSA-provided information. Training must include:

- The sensitivity of SSA-provided information and address the Privacy Act and other Federal and state laws governing its use and misuse
- Rules of behavior concerning use and security in systems processing SSA-provided information
- Restrictions on viewing and/or copying SSA-provided information
- The employee's responsibility for proper use and protection of SSA-provided information including its proper disposal
- Security incident reporting procedures
- Basic understanding of procedures to protect the network from malware attacks

- Spoofing, Phishing, and Pharming scam prevention

- The possible sanctions and penalties for misuse of SSA-provided information

SSA requires the EIEP to provide security awareness training to all employees and contractors who access SSA-provided information. The training should be annual, mandatory, and certified by the personnel who receive the training. SSA also requires the EIEP to certify that each employee or contractor who views SSA-provided data also certify that they understand the potential criminal and administrative sanctions or penalties for unlawful disclosure.

5.11 Contractors of Electronic Information Exchange Partners

As previously stated in ***The General Systems Security Standards***, contractors of the EIEP must adhere to the same security requirements as employees of the EIEP. The EIEP is responsible for the oversight of its contractors and the contractor's compliance with the security requirements. The EIEP will enter into a written agreement with each of its contractors and agents who need SSA data to perform their official duties, whereby such contractors or agents agree to abide by all relevant Federal laws, restrictions on access, use, disclosure, and the security requirements in this Agreement.

The EIEP's employees, contractors, and agents who access, use, or disclose SSA data in a manner or purpose not authorized by this Agreement may be subject to both civil and criminal sanctions pursuant to applicable Federal statutes. The EIEP will provide its contractors and agents with copies of this Agreement, related IEAs, and all related attachments before initial disclosure of SSA data to such contractors and agents. Prior to signing this Agreement, and thereafter at SSA's request, the EIEP will obtain from its contractors and agents a current list of the employees of such contractors and agents with access to SSA data and provide such lists to SSA.

The EIEP must be able to provide proof of the contractual agreement If the contractor processes, handles, or transmits information provided to the EIEP by SSA or has authority to perform on the EIEP's behalf, the EIEP should clearly state the specific roles and functions of the contractor. The EIEP will provide SSA written certification that the contractor is meeting the terms of the agreement, including SSA security requirements. The certification will be subject to our final approval before redisclosing our information.

The EIEP must also require that contractors who will process, handle, or transmit information provided to the EIEP by SSA sign an agreement with the EIEP that obligates the contractor to follow the terms of the EIEP's data exchange agreement with SSA. The EIEP or the contractor must provide a copy of the data exchange agreement to each of the contractor's employees before disclosing data and make certain that the contractor's employees receive the same security awareness training as the EIEP's employees. The EIEP should maintain awareness-training records for the contractor's employees and require the same annual certification procedures.

The EIEP will be required to conduct the review of contractors and is responsible for ensuring compliance of its contractors with security and privacy requirements and limitations. As such, the EIEP will subject the contractor to ongoing security compliance

reviews that must meet SSA standards. The EIEP will conduct compliance reviews at least triennially commencing no later than three (3) years after the approved initial security certification to SSA; and must provide SSA with written documentation of recurring compliance reviews, with the contractor, subject to our approval.

If the EIEP's contractor will be involved with the processing, handling, or transmission of information provided to the EIEP by SSA offsite from the EIEP, the EIEP must have the contractual option to perform onsite reviews of that offsite facility to ensure that the following meet SSA's requirements:

- safeguards for sensitive information
- computer system safeguards
- security controls and measures to prevent, detect, and resolve unauthorized access to, use of, and redisclosure of SSA-provided information
- continuous monitoring of the EIEP contractors' network infrastructures and assets

6. General -- Security Certification and Compliance Review Programs

SSA's security certification and compliance review programs are distinct processes. The certification program is a one-time process when an EIEP initially requests electronic access to SSA-provided information. The certification process entails two rigorous stages intended to ensure that technical, management, and operational security measures work as designed. SSA must ensure that the EIEPs fully conform to SSA's security requirements and satisfy both stages of the certification process before SSA will permit online access to its data in a production environment.

The compliance review program, however, ensures that the suite of security measures implemented by an EIEP to safeguard SSA-provided information remains in full compliance with SSA's security standards and requirements. The compliance review program applies to both online and batch access to SSA-provided information. Under the compliance review program, EIEPs are subject to ongoing and periodic security reviews by SSA.

6.1 The Security Certification Program

The security certification process applies to EIEPs that seek online electronic access to SSA information and consists of two general phases:

- Phase One: The Security Design Plan (SDP) phase is a formal written plan authored by the EIEP to comprehensively document its technical and non-technical security controls to safeguard SSA-provided information (refer to ***Documenting Security Controls in the Security Design Plan***).+

  NOTE: **SSA may have legacy EIEPs (EIEPs not certified under the current process) who have not prepared an SDP. OIS strongly recommends that these EIEPs prepare an SDP.**

  The EIEP's preparation and maintenance of a current SDP will aid them in determining potential compliance issues prior to reviews, assuring continued compliance with SSA's security requirements, and providing for

more efficient security reviews.

- Phase 2: The SSA Onsite Certification phase is a formal onsite review conducted by SSA to examine the full suite of technical and non-technical security controls implemented by the EIEP to safeguard data obtained from SSA electronically (refer to ***The Certification Process***).

6.2 Documenting Security Controls in the Security Design Plan (SDP)

6.2.1 When the SDP and Risk Assessment are Required

EIEPs must submit an SDP and a security risk assessment (RA) for evaluation when one or more of the following circumstances apply. The RA must be in electronic format. It must include discussion of the measures planned or implemented to mitigate risks identified by the RA and (as applicable) risks associated with the circumstances below:

- to obtain approval for requested access to SSA-provided information for an initial agreement
- to obtain approval to reestablish previously terminated access to SSA-provided data
- to obtain approval to implement a new operating or security platform that will involve SSA-provided information
- to obtain approval for significant changes to the EIEP's organizational structure, technical processes, operational environment, data recovery capabilities, or security implementations planned or made since approval of their most recent SDP or of their most recent successfully completed security review
- to confirm compliance when one or more security breaches or incidents involving SSA-provided information occurred since approval of the EIEP's most recent SDP or of their most recent successfully completed security review
- to document descriptions and explanations of measures implemented as the result of a data breach or security incident
- to document descriptions and explanations of measures implemented to resolve non-compliancy issue(s)
- to obtain a new approval after SSA revoked approval of the most recent SDP

SSA may require a new SDP if changes occurred (other than those listed above) that may affect the terms of the EIEP's information sharing agreement with SSA.

SSA will not approve the SDP or allow the initiation of transactions and/or access to SSA-provided information before the EIEP complies with the SSRs.

An SDP must satisfactorily document the EIEP's compliance with all of SSA's SSRs in order to provide the minimum level of security acceptable to SSA for its EIEP's access to SSA-provided information.

EIEP's must correct deficiencies identified through the evaluation of the SDP and submit a revised SDP that incorporates descriptions and explanations of the measures implemented to

eliminate the deficiencies. SSA cannot grant access to SSA-provided information until the EIEP corrects the deficiencies, documents the SDP, and SSA approves the revisions. The EIEP will communicate the implementation of corrective actions to SSA on a regular basis. SSA will withhold final approval until the EIEP can rectify all deficiencies.

SSA may revoke the approval of the EIEP's SDP and its access to SSA-provided information if we learn the EIEP is non-compliant with one or more SSRs. The EIEP must submit a revised SDP, which incorporates descriptions and explanations of the measures the EIEP will implement to resolve the non-compliance issue(s). The EIEP must communicate the progress of corrective action(s) to SSA on a regular basis. SSA will consider the EIEP in non-compliant status until resolution of the issue(s), the EIEP's SDP documents the corrections, and we approve the SDP. If, within a reasonable time as determined by SSA, the EIEP is unable to rectify a deficiency determined by SSA to present a substantial risk to SSA-provided information or to SSA, SSA will withhold approval of the SDP and discontinue the flow of SSA-provided information.

NOTE: **EIEPs that function only as an STC, transferring SSA-provided information to other EIEPs must, per the terms of their agreements with SSA, adhere to SSA's System Security Requirements (SSR) and exercise their responsibilities regarding protection of SSA-provided information.**

6.3 The Certification Process

Once the EIEP has successfully satisfied Phase 1, SSA will conduct an onsite certification review. The objective of the onsite review is to ensure the EIEP's non-technical and technical controls safeguard SSA-provided information from misuse and improper disclosure and that those safeguards function and work as intended.

At its discretion, SSA may request that the EIEP participate in an onsite review and compliance certification of their security infrastructure.

The onsite review may address any or all of SSA's security requirements and include, when appropriate:

- a demonstration of the EIEP's implementation of each requirement
- random sampling of audit records and transactions submitted to SSA
- a walkthrough of the EIEP's data center to observe and document physical security safeguards
- a demonstration of the EIEP's implementation of electronic exchange of data with SSA
- discussions with managers/supervisors
- examination of management control procedures and reports (e.g., anomaly detection reports, etc.)
- demonstration of technical tools pertaining to user access control and if appropriate, browsing prevention, specifically:
    - If the design is based on a permission module or similar design, or it is transaction driven, the EIEP will demonstrate how the system triggers requests for information from SSA.

- If the design is based on a permission module, the EIEP will demonstrate how the process for requests for SSA-provided information prevent SSNs not present in the EIEP's system from sending requests to SSA. We will attempt to obtain information from SSA using at least one, randomly created, fictitious number not known to the EIEPs system.

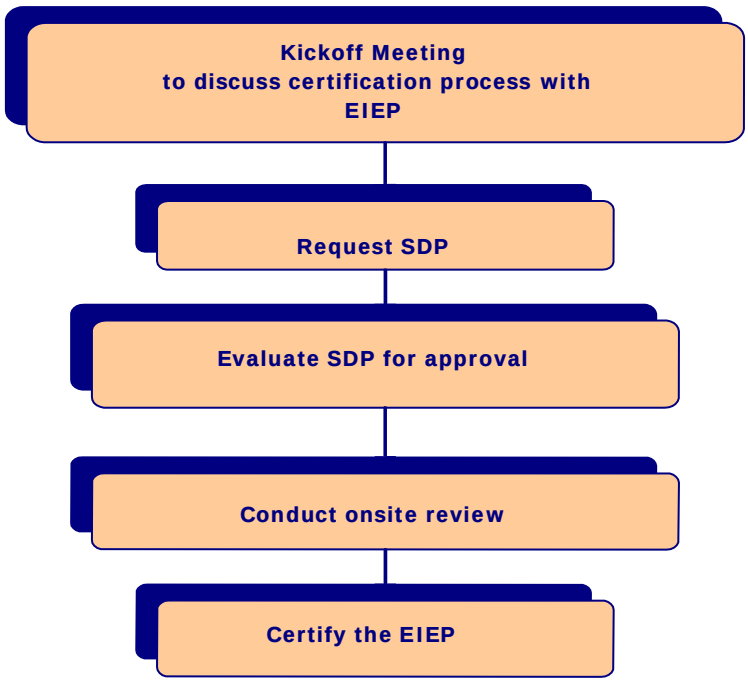
During a certification or compliance review, SSA or a certifier acting on its behalf, may request a demonstration of the EIEP's audit trail system (ATS) and its record retrieval capability. The certifier may request a demonstration of the ATS' capability to track the activity of employees who have the potential to access SSA-provided information within the EIEP's system. The certifier may request more information from those EIEPs who use an STC to handle and audit transactions. We will conduct a demonstration to see how the EIEP obtains audit information from the STC regarding the EIEP's SSA transactions.

If an STC handles and audits an EIEP's transactions, SSA requires the EIEP to demonstrate both their own in-house audit capabilities and the process used to obtain audit information from the STC.

If the EIEP employs a contractor who processes, handles, or transmits the EIEP's SSA-provided information offsite, SSA, at its discretion, may include the contractor's facility in the onsite certification review. The inspection may occur with or without a representative of the EIEP.

Upon successful completion of the onsite certification exercise, SSA will authorize electronic access to production data by the EIEP. SSA will provide written notification of its certification to the EIEP and all appropriate internal SSA components.

The following is a high-level flow chart of the OIS Certification Process:

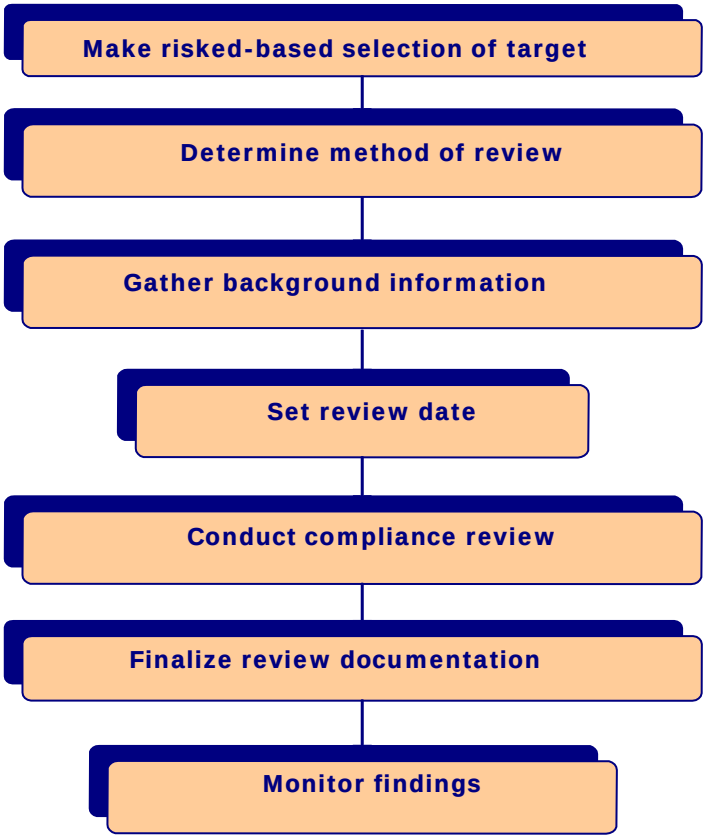


6.5 The Compliance Review Program and Process

Similar to the certification process, the compliance review program entails a rigorous process intended to ensure that EIEPs who receive electronic information from SSA are in full compliance with the Agency's security requirements and standards. As a practice, SSA attempts to conduct compliance reviews following a two to five year periodic review schedule. However, as circumstances warrant, a review may take place at any time. Three prominent examples that would trigger an ad hoc review are:

- a significant change in the outside EIEP's computing platform
- a violation of any of SSA's systems security requirements
- an unauthorized disclosure of SSA information by the EIEP

The following is a high-level flow chart of the OIS Compliance Review Process:



SSA may conduct onsite compliance reviews and include both the EIEP's main facility and a field office.

SSA may, also at its discretion, request that the EIEP participate in an onsite compliance review of their security infrastructure to confirm the implementation of SSA's security requirements.

The onsite review may address any or all of SSA's security requirements and include, where appropriate:

- a demonstration of the EIEP's implementation of each requirement
- random sampling of audit records and transactions submitted to SSA
- a walkthrough of the EIEP's data center to observe and document physical security safeguards
- a demonstration of the EIEP's implementation of online exchange of data with SSA
- discussions with managers/supervisors
- examination of management control procedures and reports (e.g. anomaly detection reports, etc.)
- demonstration of technical tools pertaining to user access control and, if appropriate, browsing prevention:
    - If the design uses a permission module or similar design, or is transaction driven, the EIEP will demonstrate how the system triggers requests for information from SSA.
    - If the design uses a permission module, the EIEP will demonstrate the process used to request SSA-provided information and prevent the EIEP's system from processing SSNs not present in the EIEP's system. We can accomplish this by attempting to obtain information from SSA using at least one, randomly created, fictitious number not known to the EIEP's system.

SSA may, at its discretion, perform an onsite or remote review for reasons including, but not limited to the following:

- the EIEP has experienced a security breach or incident involving SSA-provided information
- the EIEP has unresolved non-compliancy issue(s)
- to review an offsite contractor's facility that processes SSA-provided information
- the EIEP is a legacy organization that has not yet been through SSAs security certification and compliance review programs
- the EIEP requested that SSA perform an IV & V (Independent Verification and Validation review)

During the compliance review, SSA, or a certifier acting on its behalf, may request a demonstration of the system's audit trail and retrieval capability. The certifier may request a demonstration of the system's capability for tracking the activity of employees who view SSA-provided information within the EIEP's system. The certifier may request EIEPs that have STCs that handle and audit transactions with SSA to demonstrate the process used to obtain audit information from the STC.

If an STC handles and audits the EIEP's transactions with SSA, we may require the EIEP to demonstrate both their in-house audit capabilities and the processes used to obtain audit information from the STC regarding the EIEP's transactions with SSA.

If the EIEP employs a contractor who will process, handle, or transmit the EIEP's SSA-provided information offsite, SSA, at its discretion, may include in the onsite compliance review an onsite inspection of the contractor's facility. The inspection may occur with or without a representative of the EIEP. The format of the review in routine circumstances (i.e., the compliance review is not being conducted to address a special circumstance, such as a disclosure violation) will generally consist of reviewing and updating the EIEP's compliance with the systems security requirements described above in this document. At the conclusion of the review, SSA will issue a formal report to appropriate EIEP personnel. The Final Report will address findings and recommendations from SSA's compliance review, which includes a plan for monitoring each issue until closure.

NOTE: SSA handles documentation provided for compliance reviews as sensitive information. The information is only accessible to authorized individuals who have a need for the information as it relates to the EIEP's compliance with its electronic information sharing agreement with SSA and the associated system security requirements and procedures. SSA will not retain the EIEP's documentation any longer than required. SSA will delete, purge, or destroy the documentation when the retention requirement expires.

The following is a high-level example of the analysis that aids SSA in making a preliminary determination as to which review format is appropriate. We may also use additional factors to determine whether SSA will perform an onsite or remote compliance review.

- **High / Medium Risk Criteria**
  - undocumented closing of prior review finding(s)
  - implementation of technical/operational controls that affect security of SSA-provided information (e.g. implementation of new data access method)
  - PII breach
- **Low Risk Criteria**
  - no prior review finding(s) or prior finding(s) documented as closed
  - no implementation of technical/operational controls that impact security of SSA-provided information (e.g. implementation of new data access method)
  - no PII breach

6.5.1 EIEP Compliance Review Participation

SSA may request to meet with the following persons during the compliance review:

- a sample of managers and/or supervisors responsible for enforcing and monitoring ongoing compliance to security requirements and procedures to assess their level of training to monitor their employee's use of SSA-provided information, and for reviewing reports and taking necessary action
- the individuals responsible for performing security awareness and employee sanction functions to learn how you fulfill this requirement
- a sample of the EIEP's employees to assess their level of training and understanding of the requirements and potential sanctions applicable to the use and misuse of SSA-provided information

- the individual(s) responsible for management oversight and quality assurance functions to confirm how your agency accomplishes this requirement
- additional individuals as deemed appropriate by SSA

6.5.2 Verification of Audit Samples

Prior to or during the compliance review, SSA will present to the EIEP a sampling of transactions previously submitted to SSA for verification. SSA requires the EIEP to verify whether each transaction was, per the terms of their agreement with SSA, legitimately submitted by a user authorized to do so.

SSA requires the EIEP to provide a written attestation of the transaction review results. The document must provide:

- confirmation that each sample transaction located in the EIEP's audit file submitted by its employee(s) was for legitimate and authorized business purposes
- an explanation for each sample transaction located in the EIEP's audit file(s) determined to have been unauthorized
- an explanation for each sample transaction not found in the EIEP's ATS

When SSA provides the sample transactions to the EIEP, detailed instructions will be included. Only an official responsible for the EIEP is to provide the attestation.

6.6 Scheduling the Onsite Review

SSA will not schedule the onsite review until we approve the EIEP's SDP. SSA will send approval notification via email. There is no prescribed period for arranging the subsequent onsite review (***certification review*** for an EIEP requesting initial access to SSA-provided information for an initial agreement or ***compliance review*** for other EIEPs). Unless there are compelling circumstances precluding it, the onsite review will follow as soon as reasonably possible.

However, the scheduling of the onsite review may depend on additional factors including:

- the reason for submission of a plan
- the severity of security issues, if any
- circumstances of the previous review, if any
- SSA workload considerations

Although the scheduling of the review is contingent upon approval of the SDP, SSA may perform an onsite review prior to approval if we determine that it is necessary to complete our evaluation of a plan.

(THIS PAGE HAS BEEN LEFT BLANK INTENTIONALLY)

7. Additional Definitions

Back Button:

Refers to a button on a web browser's toolbar, the *backspace button* on a computer keyboard, a programmed keyboard button or mouse button, etc., that returns a user to a previously visited web page or application screen.

Breach:

Refers to actual loss, loss of control, compromise, unauthorized disclosure, unauthorized acquisition, unauthorized access, or any similar term referring to situations where unauthorized persons have access or potential access to PII or Covered Information, whether physical, electronic, or in spoken word or recording.

Browsing:

Requests for or queries of SSA-provided information for purposes not related to the performance of official job duties.

Choke Point:

The firewall between a local network and the Internet is a choke point in network security, because any attacker would have to come through that channel, which is typically protected and monitored.

Cloud Computing:

The term refers to Internet-based computing derived from the cloud drawing representing the Internet in computer network diagrams. Cloud computing providers deliver on-line and on-demand Internet services. Cloud Services normally use a browser or Web Server to deliver and store information.

Cloud Computing (NIST SP 800-145 Excerpt):

Cloud computing is a model for enabling ubiquitous, convenient, on-demand network access to a shared pool of configurable computing resources (e.g., networks, servers, storage, applications, and services) that can be rapidly provisioned and released with minimal management effort or service provider interaction. This cloud model is composed of five essential characteristics, three service models, and four deployment models.

Essential Characteristics:

On-demand self-service - A consumer can unilaterally provision computing capabilities, such as server time and network storage, as needed automatically without requiring human interaction with each service provider.

Broad network access - Capabilities are available over the network and accessed through standard mechanisms that promote use by heterogeneous thin or thick client platforms (e.g.,

mobile phones, tablets, laptops, and workstations).

Resource pooling - The provider's computing resources are pooled to serve multiple consumers using a multi-tenant model, with different physical and virtual resources dynamically assigned and reassigned according to consumer demand. There is a sense of location independence in that the customer generally has no control or knowledge over the exact location of the provided resources but may be able to specify location at a higher level of abstraction (e.g., country, state, or datacenter). Examples of resources include storage, processing, memory, and network bandwidth.

Rapid elasticity - Capabilities can be elastically provisioned and released, in some cases automatically, to scale rapidly outward and inward commensurate with demand. To the consumer, the capabilities available for provisioning often appear to be unlimited and can be appropriated in any quantity at any time.

Measured service - Cloud systems automatically control and optimize resource use by leveraging a metering capability1 at some level of abstraction appropriate to the type of service (e.g., storage, processing, bandwidth, and active user accounts). Resource usage can be monitored, controlled, and reported, providing transparency for both the provider and consumer of the utilized service.

Service Models:

Software as a Service (SaaS) - The capability provided to the consumer is to use the provider's applications running on a cloud infrastructure2. The applications are accessible from various client devices through either a thin client interface, such as a web browser (e.g., web-based email), or a program interface. The consumer does not manage or control the underlying cloud infrastructure including network, servers, operating systems, storage, or even individual application capabilities, with the possible exception of limited user-specific application configuration settings.

Platform as a Service (PaaS) - The capability provided to the consumer is to deploy onto the cloud infrastructure consumer-created or acquired applications created using programming languages, libraries, services, and tools supported by the provider.3 The consumer does not manage or control the underlying cloud infrastructure including network, servers, operating systems, or storage, but has control over the deployed applications and possibly configuration settings for the application-hosting environment.

Infrastructure as a Service (IaaS) - The capability provided to the consumer is to provision processing, storage, networks, and other fundamental computing resources where the consumer is able to deploy and run arbitrary software, which can include operating systems and applications. The consumer does not manage or control the underlying cloud infrastructure but has control over operating systems, storage, and deployed applications; and possibly limited control of select networking components (e.g., host firewalls).

Deployment Models:

Private cloud - The cloud infrastructure is provisioned for exclusive use by a single organization comprising multiple consumers (e.g., business units). It may be owned, managed, and operated by the organization, a third party, or some combination of them, and it may exist on or off premises.

Community cloud - The cloud infrastructure is provisioned for exclusive use by a specific community of consumers from organizations that have shared concerns (e.g., mission, security requirements, policy, and compliance considerations). It may be owned, managed, and operated by one or more of the organizations in the community, a third party, or some combination of them, and it may exist on or off premises.

Public cloud - The cloud infrastructure is provisioned for open use by the general public. It may be owned, managed, and operated by a business, academic, or government organization, or some combination of them. It exists on the premises of the cloud provider.

Hybrid cloud - The cloud infrastructure is a composition of two or more distinct cloud infrastructures (private, community, or public) that remain unique entities, but are bound together by standardized or proprietary technology that enables data and application portability (e.g., cloud bursting for load balancing between clouds).

_____

1 Typically this is done on a pay-per-use or charge-per-use basis.

2 A cloud infrastructure is the collection of hardware and software that enables the five essential characteristics of cloud computing. The cloud infrastructure can be viewed as containing both a physical layer and an abstraction layer. The physical layer consists of the hardware resources that are necessary to support the cloud services being provided, and typically includes server, storage and network components. The abstraction layer consists of the software deployed across the physical layer, which manifests the essential cloud characteristics. Conceptually the abstraction layer sits above the physical layer.

3 This capability does not necessarily preclude the use of compatible programming languages, libraries, services, and tools from other sources.

Cloud Drive:

A cloud drive is a Web-based service that provides storage space on a remote server.

Cloud Audit:

Cloud Audit is a specification developed at Cisco Systems, Inc. that provides cloud computing service providers a standard way to present and share detailed, automated statistics about performance and security.

Commingling:

Commingling is the creation of a common database or repository that stores and maintains both SSA-provided and preexisting EIEP PII.

Degaussing:

Degaussing is the method of using a "special device" (i.e., a device that generates a magnetic field) in order to disrupt magnetically recorded information. Degaussing can be effective for purging damaged media and media with exceptionally large storage capacities. Degaussing is not effective for purging non-magnetic media (e.g., optical discs).

Dial-up:

Sometimes used synonymously with *dial-in*, refers to digital data transmission over the wires of a local telephone network.

Function:

One or more persons or organizational components assigned to serve a particular purpose, or perform a particular role. The purpose, activity, or role assigned to one or more persons or organizational components.

Hub:

As it relates to electronic data exchange with SSA, a hub is an organization, which serves as an electronic information conduit or distribution collection point. The term Hub is interchangeable with the terms "StateTransmission Component," "State Transfer Component," or "STC."

ICON:

Interstate Connection Network (various entities use 'Connectivity' rather than 'Connection')

IV & V:

Independent Verification and Validation

Legacy System:

A term usually referring to a corporate or organizational computer system or network that utilizes outmoded programming languages, software, and/or hardware that typically no longer receives support from the original vendors or developers.

Manual Transaction:

A user-initiated operation (also referred to as a "user-initiated transaction"). This is the opposite of a system-generated automated process.

Example: A user enters a client's information including the client's SSN and presses the "ENTER" key to acknowledge that input of data is complete. A new screen appears with multiple options, which include "VERIFY SSN" and

"CONTINUE". The user has the option to verify the client's SSN or perform alternative actions.

Media Sanitization:

- Disposal: Refers to the discarding (e.g., recycling) of media that contains no sensitive or confidential data.

- Clearing: This type of media sanitization is adequate for protecting information from a robust keyboard attack. Clearing must prevent retrieval of information by data, disk, or file recovery utilities. Clearing must be resistant to keystroke recovery attempts executed from standard input devices and from data scavenging tools. For example, overwriting is an acceptable method for clearing media. Deleting items, however, is not sufficient for clearing.

  This process may include overwriting all addressable locations of the data, as well as its logical storage location (e.g., its file allocation table). The aim of the overwriting process is to replace or obfuscate existing information with random data. Most rewriteable media may be cleared by a single overwrite. This method of sanitization is not possible on un-writeable or damaged media.

- Purging: This type of media sanitization is a process that protects information from a laboratory attack. The terms *clearing* and *purging* are sometimes synonymous. However, for some media, clearing is not sufficient for purging (i.e., protecting data from a laboratory attack). Although most re-writeable media requires a single overwrite, purging may require multiple rewrites using different characters for each write cycle.
  This is because a laboratory attack involves threats with the capability to employ non-standard assets (e.g., specialized hardware) to attempt data recovery on media outside of that media's normal operating environment.

  Degaussing is also an example of an acceptable method for purging magnetic media. The EIEP should destroy media if purging is not a viable method for sanitization.

- Destruction: Physical destruction of media is the most effective form of sanitization. Methods of destruction include burning, pulverizing, and shredding. Any residual medium should be able to withstand a laboratory attack.

Permission module:

A utility or subprogram within an application, which automatically enforces the relationship of a request for or query of SSA-provided information to an authorized process or transaction before initiating a transaction. For example, requests for verification of an SSN for issuance of a driver's license happens automatically from within a state driver's license application. The System will not allow a user to request information from SSA unless the EIEP's client system contains a record of the subject individual's SSN.

Screen Scraping:

Screen scraping is normally associated with the programmatic collection of visual data from a source. Originally, screen scraping referred to the practice of reading text data from a computer display terminal's screen. This involves reading the terminal's memory through its auxiliary port, or by connecting the terminal output port of one computer system to an input port on another. The term screen scraping is synonymous with the term bidirectional exchange of data.

A screen scraper might connect to a legacy system via Telnet, emulate the keystrokes needed to navigate the legacy user interface, process the resulting display output, extract the desired data, and pass it on to a modern system.

More modern screen scraping techniques include capturing the bitmap data from a screen and running it through an optical character reader engine, or in the case of graphical user interface applications, querying the graphical controls by programmatically obtaining references to their underlying programming objects.

Security Breach:

An act from outside an organization that bypasses or violates security policies, practices, or procedures.

Security Incident:

A security incident happens when a fact or event signifies the possibility that a breach of security may be taking place, or may have taken place. All threats are security incidents, but not all security incidents are threats.

Security Violation:

An act from within an organization that bypasses or disobeys security policies, practices, or procedures.

Sensitive data:

Any information, the loss, misuse, or unauthorized access to or modification of which could adversely affect the national interest of the conduct of federal programs, or the privacy to which individuals are entitled under section 552a of title 5, United States Code (the Privacy Act), but which has not been specifically authorized under criteria established by an Executive Order or an Act of Congress to be kept secret in the interest of national defense or foreign policy.

SMDS (Switched Multimegabit Data Service (SMDS):

SMDS is a telecommunications service that provides connectionless, high-performance, packet-switched data transport. Although not a protocol, it supports standard protocols and communications interfaces using current technology.

SSA-provided data/information:

Synonymous with "SSA-supplied data/information." Defines information under the control of SSA that is provided to an external entity under the terms of an information exchange agreement with SSA. The following are examples of

SSA-provided data/information:

- SSA's response to a request from an EIEP for information from SSA (e.g., date of death)

- SSA's response to a query from an EIEP for verification of an SSN

SSA data/information:

This term, sometimes used interchangeably with "SSA-provided data/information", denotes information under the control of SSA that is provided to an external entity under the terms of an information exchange agreement with SSA. However, **"SSA data/information"** also includes information provided to the EIEP by a source other than SSA, but which the EIEP attests to that SSA verified it, or the EIEP couples the information with data from SSA as to to certify the accuracy of the information. The following are examples of SSA information:

- SSA's response to a request from an EIEP for information from SSA (e.g., date of death)

- SSA's response to a query from an EIEP for verification of an SSN

- Display by the EIEP of SSA's response to a query for verification of an SSN ***and*** the associated SSN provided by SSA

- Display by the EIEP of SSA's response to a query for verification of an SSN ***and*** the associated SSN provided to the EIEP by a source other than SSA

- Electronic records that contain only SSA's response to a query for verification of an SSN ***and*** the associated SSN whether provided to the EIEP by SSA or a source other than SSA

SSN:

Social Security Number

STC:

A State Transmission/Transfer Component is an organization that performs as an electronic information conduit or collection point for one or more other entities (also referred to as a hub).

System-generated transaction:

A transaction automatically triggered by an automated system process.

Example: A user enters a client's information including the client's SSN on an input screen and presses the "ENTER" key to acknowledge that input of data is complete. An automated process then matches the SSN against the organization's database and when the systems finds no match, automatically sends an electronic request for verification of the SSN to SSA.

Systems process:

The Term "Systems Process" refers to a software program module that runs in the background within an automated batch, online, or other process.

Third Party:

This term pertains to an entity (person or organization) provided access to SSA-provided information by an EIEP or other SSA business partner for which one or more of the following apply:

- is not stipulated access to SSA-provided information by an information-sharing agreement between an EIEP and SSA
- has no information-sharing agreement with SSA
- SSA does not directly authorize access to SSA-provided information

Transaction-driven:

This term pertains to an automatically initiated online query of or request for SSA information by an automated transaction process (e.g., driver license issuance, etc.). The query or request will only occur the automated process meets prescribed conditions.

Uncontrolled transaction:

This term pertains to a transaction that falls outside a permission module. An uncontrolled transaction is not subject to a systematically enforced relationship between an authorized process or application and an existing client record.

(THE REST OF THIS PAGE HAS BEEN LEFT BLANK INTENTIONALLY)

8. Regulatory References

Federal Information Processing Standards

(FIPS) Publications Federal Information

Security Management Act of 2002 (FISMA)

Homeland Security Presidential Directive

(HSPD-12)

National Institute of Standards and Technology (NIST) Special Publications

Office of Management and Budget (OMB) Circular A-123, *Management's Responsibility for Internal Control*

Office of Management and Budget (OMB) Circular A-130, Appendix III, *Management of Federal Information Resources*

Office of Management and Budget (OMB) Memo M-06-16, *Protection of Sensitive Agency Information, June 23, 2006*

Office of Management and Budget (OMB) Memo M-07-16, *Memorandum for the Heads of Executive Departments and Agencies May 22, 2007*

Office of Management and Budget (OMB) Memo M-07-17, *Safeguarding Against and Responding to the Breach of Personally Identifiable Information, May 22, 2007*

Privacy Act of 1974

(THE REST OF THIS PAGE HAS BEEN LEFT BLANK INTENTIONALLY)

9. Frequently Asked Questions

(Click links for answers or additional information)

1. Q: What is a breach of data?
   A: Refer also to Security Breach, Security Incident, and Security Violation.

2. Q: What is employee browsing?
   A: Requests for or queries of SSA-provided information for purposes not related to the performance of official job duties

3. Q: Okay, so the SDP was submitted. Can the Onsite Review be scheduled now?
   A: Refer to Scheduling the Onsite Review.

4. Q: What is a "Permission Module"?
   A: A utility or subprogram within an application, which automatically enforces the relationship of a request for or query of SSA-provided information to an authorized process or transaction before initiating a transaction. For example, if requests for verification of an SSN for issuance of a driver's license happens automatically from within a state driver's license application. The System will not allow a user to request information from SSA unless the EIEP's client system contains a record of the subject individual's SSN.

5. Q: What is meant by Screen Scraping?
   A: Screen scraping is normally associated with the programmatic collection of visual data from a source. Originally, screen scraping referred to the practice of reading text data from a computer display terminal's screen. This involves reading the terminal's memory through its auxiliary port, or by connecting the terminal output port of one computer system to an input port on another. The term screen scraping is synonymous with the term bidirectional exchange of data.

   A screen scraper might connect to a legacy system via Telnet, emulate the keystrokes needed to navigate the legacy user interface, process the resulting display output, extract the desired data, and pass it on to a modern system.

   More modern screen scraping techniques include capturing the bitmap data from a screen and running it through an optical character reader engine, or in the case of graphical user interface applications, querying the graphical controls by programmatically obtaining references to their underlying programming objects.

6. Q: When does an EIEP have to submit an SDP?
   A: Refer to When the SDP and RA are Required.

7. Q: Does an EIEP have to submit an SDP when the agreement is

renewed?

A: The EIEP does not have to submit an SDP ***because*** the agreement between the EIEP and SSA was renewed. There are, however, circumstances that require an EIEP to submit an SDP. Refer to When the SDP and RA are Required.

8. Q: Is it acceptable to save SSA data with a verified indicator on a (EIEP) workstation if the EIEP uses an encrypted hard drive? If not, what options does the agency have?

A: There is no problem with an EIEP saving SSA-provided information on the encrypted hard drives of computers used to process SSA data if the EIEP retains the information only as provided for in the EIEP's data-sharing agreement with SSA. Refer to Data and Communications Security.

9. Q: Does SSA allow EIEPs to use caching of SSA-provided information on the EIEP's workstations?

A: Caching during processing is not a problem. However, SSA-provided information must clear from the cache when the user exits the application. Refer to Data and Communications Security.

10. Q: What does the term "interconnections to other systems" mean?

A: As used in SSA's system security requirements document, the term "interconnections" is the same as the term "connections."

11. Q: Is it acceptable to submit the SDP as a .PDF file?

A: No, it is not. The document must remain editable.

12. Q: Should the EIEP write the SDP from the standpoint of my agency's SVES access itself, or from the standpoint of access to all data provided to us by SSA?

A: The SDP is to encompass your agency's electronic access to SSA-provided information as per the electronic data sharing agreement between your agency and SSA. Refer to Developing the SDP.

13. Q: If we have a "transaction-driven" system, do we still need a permission module? If employees cannot initiate a query to SSA, why would we need the permission module?

A: "Transaction driven" basically means that queries automatically submit requests (and it might depend on the transaction). Depending on the system's design, queries might not be automatic or it may still permit manual transactions. A system may require manual transactions to correct an error. SSA does not prohibit manual transactions if an ATS properly tracks such transactions. If a "transaction-driven" system permits any type of alternate access; it still requires a permission module, even if it restricts users from performing manual transactions. If the system does ***not*** require the user to be in a particular application or the query to be for an existing record in the EIEP's system ***before*** the system will allow a query to go through to SSA, it would still need a permission module.

14. Q: What is an Onsite Compliance Review?

A: The Onsite Compliance Review is the process wherein SSA performs periodic site visits to its Electronic Information Exchange Partners (EIEP) to certify whether the EIEP's technical, managerial, and operational security measures for protecting data obtained electronically from SSA continue to conform to the terms of the EIEP's data sharing agreements with SSA and SSA's associated system security requirements and procedures. Refer to the Compliance Review Program and Process.

15. Q: What are the criteria for performing an Onsite Compliance Review?
A: The following are criteria for performing the Onsite Compliance Review:

- EIEP initiating new access or new access method for obtaining information from SSA
- EIEP's cyclical review (previous review was performed remotely)
- EIEP has made significant change(s) in its operating or security platform involving SSA-provided information
- EIEP experienced a breach of SSA-provided personally identifying information (PII)
- EIEP has been determined to be high-risk

Refer also to the Review Determination Matrix.

16. Q: What is a Remote Compliance Review?
A: The Remote Compliance Review is when SSA conducts the meetings remotely (e.g., via conference calls). SSA schedules conference calls with its EIEPs to determine whether the EIEPs technical, managerial, and operational security measures for protecting data obtained electronically from SSA continue to conform to the terms of the EIEP's data sharing agreements with SSA and SSA's associated system security requirements and procedures. Refer to the Compliance Review Program and Process.

17. Q: What are the criteria for performing a Remote Compliance Review?
A: The EIEP must satisfy the following criteria to qualify for a Remote Compliance Review:

- EIEP's cyclical review (SSA's previous review yielded no findings or the EIEP satisfactorily resolved cited findings)
- EIEP has made no significant change(s) in its operating or security platform involving SSA-provided information
- EIEP has not experienced a breach of SSA-provided personally identifiable information (PII) since its previous compliance review.
- SSA rates the EIEP as a low-risk agency or state

Refer also to the Review Determination Matrix

ATTACHMENT 5

WORKSHEET FOR REPORTING LOSS OR POTENTIAL LOSS OF PERSONALLY IDENTIFIABLE INFORMATION

ATTACHMENT 5 **09/27/06**

Worksheet for Reporting Loss or Potential Loss of Personally Identifiable Information

1. Information about the individual making the report to the NCSC:

Name:					
Position:					
Deputy Commissioner Level Organization:					
Phone Numbers:					
Work:		Cell:		Home/Other:	
E-mail Address:					
Check one of the following:					
Management Official		Security Officer		Non-Management	

2. Information about the data that was lost/stolen:

Describe what was lost or stolen (e.g., case file, MBR data):

Which element(s) of PII did the data contain?

Name		Bank Account Info	
SSN		Medical/Health Information	
Date of Birth		Benefit Payment Info	
Place of Birth		Mother's Maiden Name	
Address		Other (describe):	

Estimated volume of records involved:

3. How was the data physically stored, packaged and/or contained?

Paper or Electronic? (circle one):

If Electronic, what type of device?

Laptop		Tablet		Backup Tape		Blackberry	
Workstation		Server		CD/DVD		Blackberry Phone #	
Hard Drive		Floppy Disk		USB Drive			
Other (describe):							

ATTACHMENT 5 **09/27/06**

Additional Questions if Electronic:

	Yes	No	Not Sure
a. Was the device encrypted?			
b. Was the device password protected?			
c. If a laptop or tablet, was a VPN SmartCard lost?			
Cardholder's Name:			
Cardholder's SSA logon PIN:			
Hardware Make/Model:			
Hardware Serial Number:			

Additional Questions if Paper:

	Yes	No	Not Sure
a. Was the information in a locked briefcase?			
b. Was the information in a locked cabinet or drawer?			
c. Was the information in a locked vehicle trunk?			
d. Was the information redacted?			
e. Other circumstances:			

4. **If the employee/contractor who was in possession of the data or to whom the data was assigned is not the person making the report to the NCSC (as listed in #1), information about this employee/contractor:**

Name:					
Position:					
Deputy Commissioner Level Organization:					
Phone Numbers:					
Work:		Cell:		Home/Other:	
E-mail Address:					

5. **Circumstances of the loss:**
   a. When was it lost/stolen?

   b. Brief description of how the loss/theft occurred:

   c. When was it reported to SSA management official (date and time)?

6. **Have any other SSA components been contacted? If so, who? (Include deputy commissioner level, agency level, regional/associate level component names)**

ATTACHMENT 5 **09/27/06**

7. Which reports have been filed? (include FPS, local police, and SSA reports)

Report Filed	Yes	No	Report Number
Federal Protective Service			
Local Police			

	Yes	No
SSA-3114 (Incident Alert)		
SSA-342 (Report of Survey)		
Other (describe)		

8. Other pertinent information (include actions under way, as well as any contacts with other agencies, law enforcement or the press):