THIRD AMENDMENT TO AGREEMENT
BETWEEN THE COUNTY OF SAN MATEO AND SERVICE LEAGUE OF SAN MATEO COUNTY

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

W I T N E S S E T H:

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

WHEREAS, the parties entered into an Agreement on June 7, 2016 for professional services in an amount not to exceed $1,751,425, for the term July 1, 2016 through June 30, 2017;

WHEREAS, on September 7, 2016 the Chief of the Health System approved a first amendment to the agreement to include bridge funding through September 30, 2016, with no change to the maximum amount or term of the agreement;

WHEREAS, on October 20, 2016 the Chief of the Health System approved a second amendment to the agreement to extend bridge funding through December 31, 2016, with no change to the maximum amount or term of the agreement; and

WHEREAS, the parties wish to amend the agreement to provide expanded residential substance use disorder treatment services under the DMC-ODS waiver, increasing the contract maximum by $540,961 to $2,292,386, and extending the term of the agreement through June 30, 2018.

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

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

   In consideration of the services provided by Contractor in accordance with all terms, conditions and specifications set forth herein and in Exhibit "A3," County shall make payment to Contractor based on the rates and in the manner specified in Exhibit "B3." The County reserves the right to withhold payment if

the County determines that the quantity or quality of the work performed is unacceptable. In no event shall the County's total fiscal obligation under this Agreement exceed TWO MILLION TWO HUNDRED NINETY-TWO THOUSAND THREE HUNDRED EIGHTY-SIX DOLLARS ($2,292,386).

2. Section 4. Term of the agreement is amended to read as follows:

   Subject to compliance with all terms and conditions, the term of this Agreement shall be July 1, 2016 through June 30, 2018.

3. Exhibit A2 is hereby deleted and replaced with Exhibit A3 attached hereto.

4. Exhibit B2 is hereby deleted and replaced with Exhibit B3 attached hereto.

5. All other terms and conditions of the agreement dated June 7, 2016, between the County and Contractor shall remain in full force and effect.

*** SIGNATURE PAGE FOLLOWS ***

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

COUNTY OF SAN MATEO

By:_____
President, Board of Supervisors
San Mateo County

Date:_____

ATTEST:

By:_____
Clerk of Said Board

SERVICE LEAGUE OF SAN MATEO COUNTY

Karen D Granowe
Contractor's Signature

Date: 12/12/16

EXHIBIT A3 – SERVICES
SERVICE LEAGUE OF SAN MATEO COUNTY
FY 2016 – 2018

County and Contractor hereby agree to amend this agreement to incorporate necessary language to meet Substance Use Disorder Treatment and Drug MediCal Organized Delivery System requirements, as referenced in the Department of Health Care Services Intergovernmental Agreement for substance use disorder (SUD) services. Contractor shall provide substance use treatment services to uninsured and MediCal beneficiaries.

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

This amendment does not change the current contract provisions of the DHCS SUD agreement except as noted in paragraph 1.B.2.G.viii and ix. or other non DMC funding sources. DMC-ODS is a new service delivery and billing system, therefore future amendments may occur as further guidance and clarity in program implementation develop.

In consideration of the payments set forth in Exhibit B3, Contractor shall provide the following services:

I. DESCRIPTION OF SERVICES TO BE PERFORMED BY CONTRACTOR

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

A. Substance Use Disorder Treatment Services

Contractor shall provide substance use disorder (SUD) treatment and recovery services, with structure and supervision, to further a participant's ability to improve his/her level of functioning. Any program staff providing

services to San Mateo County residents shall be certified or registered as defined in Title 9, CCR, Division 4, Chapter 8. SUD programs and facilities shall be licensed and/or certified by the DHCS Licensing and Certification Division.

1. Non-Drug MediCal SUD Treatment Service Description

   a. Adult Residential Treatment

      A minimum of twenty (20) hours per week of counseling and/or structured therapeutic activities shall be provided for each resident. Services may include: recovery or treatment planning, psycho-education, process and support groups, case management, and ancillary services. Individual counseling shall be provided for each client, at a minimum of thirty (30) minutes per week or one (1) hour bi-weekly.

   b. Perinatal Services

      Residential Treatment services for perinatal clients shall comply with the DHCS PSN guidelines located at: http://www.dhcs.ca.gov/services/adp/Documents/PSNG%20FY%202016-17.pdf

   c. Ancillary Therapy Services

      Ancillary therapy services do not directly refer to substance abuse treatment. Services shall include the following:

      i. Ancillary therapy, including individual, group, and/or conjoint family counseling/therapy.
      ii. The ancillary therapy services shall be provided by Licensed Marriage Family Therapist (LMFT), Licensed Clinical Social Worker (LCSW), Psychologist, or other Licensed Professional of the Healing Arts (LPHA). Any counseling services provided by non-licensed staff shall be under the supervision of a licensed professional and meet the guidelines required by State licensing.
      iii. Contractor shall provide monthly updates regarding the clients' participation to the Case Manager and/or Treatment Team with appropriate signed consents.

   d. Sober Living Environments

      Sober Living Environments (SLEs), are also known as Transitional Living Centers or Alcohol/Drug Free Housing.

SLE programs may not provide treatment, recovery, or detoxification services. SLE residents must be enrolled in DHCS certified Outpatient Treatment or Intensive Outpatient Treatment. Treatment coordination is required. Contractor shall provide monthly updates or updates as needed regarding the clients' participation to the Case Manager and/or Treatment Team as requested with the appropriate consents. Confidentiality releases compliant with CFR 42, part 2 shall be required.

e. Urinalysis Testing

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

Contractor shall provide monthly updates regarding the clients' participation to the Case Manager and/or Treatment Team, as requested and with appropriate client consent.

2. Drug MediCal Organized Delivery System SUD Treatment Service Description

The DMC-ODS is a pilot program to test a new paradigm for the organized delivery of health care services for MediCal eligible individuals with substance use disorders. Individuals who meet medical necessity criteria will have access to a continuum of care modeled after the ASAM criteria for placement, treatment and system interaction needed in order to achieve sustained recovery.

The Intergovernmental Agreement between California DHCS and San Mateo County BHRS describes the general requirements for contractors which deliver Drug MediCal treatment services. The 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 the Intergovernmental Agreement in any manner. The BHRS approved DMC-ODS implementation plan is included in the Intergovernmental Agreement. The Intergovernmental Agreement and the AOD Policy and Procedure Manual are incorporated by reference. Contractor will comply with all sections of the Intergovernmental Agreement that are applicable to the contractor. Key general requirements are included as follows:

a. Contractor shall receive DHCS DMC site certification prior to the date on which the Contractor begins to deliver services under this agreement.

b. Contractor of perinatal DMC services will be properly certified to provide these services and comply with the requirements contained in Title 22, Section 51341.1, Services for Pregnant and Postpartum Women.

c. Contractor shall be licensed, registered, DMC certified and/or approved in accordance with applicable laws and regulations. Contractor shall comply with the following regulations and guidelines:
   i. Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8;
   ii. Drug MediCal Certification Standards for Substance Abuse Clinic;
   iii. Title 22, CCR, Sections 51341.1, 51490.1, and 51516.1;
   iv. Standards for Drug Treatment Programs;
   v. Title 9, CCR, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq.; and
   vi. Title 22, CCR, Division 3, Chapter 3, sections 51000 et. seq.

   In the event of a conflict, the provisions that are more stringent shall prevail.

d. Contractor will not exclude from treatment, persons who require high risk, specialized services or special health needs. Contractor will work with health care providers of clients with special health care needs. Contractor will collaborate with BHRS and other service providers to meet the identified needs of such clients whenever possible.

e. Provider Specifications

   Staffing structure will ensure eligible personnel are available to provide the covered services.
   i. Professional staff must be licensed, registered, certified or recognized under California scope of practice statutes. Professional staff will 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) includes the following:
      1) Physician

2) Nurse Practitioners
3) Physician Assistants
4) Registered Nurses
5) Registered Pharmacists
6) Licensed Clinical Psychologists
7) Licensed Clinical Social Worker
8) Licensed Professional Clinical Counselor
9) Licensed Marriage and Family Therapists
10) License Eligible Practitioners working under the supervision of Licensed Clinicians

ii Non Professional staff will receive appropriate onsite orientation and training prior to performing assigned duties. Non-professional staff will be supervised by professional and/or administrative staff.

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

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

v. Prior to delivering services, the Medical Director is hired, enrolled with DHCS under applicable state regulations, has been screened in accordance with 42CFR455.50(a) as a limited categorical risk within one year prior to serving as a Medical director and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107

vi. Staff will undergo fingerprint background checks prior to hiring or delivering services, whichever comes first in accordance with CFR 455.34.

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

f. Client Eligibility

A client is a person who (a) has been determined eligible for MediCal; (b) is not institutionalized; and (c) has a substance – related disorder per the current Diagnostic and Statistical Manual (DSM) and meets the admissions criteria to receive DMC covered services.

DMC-ODS services shall be available as a MediCal benefit for individuals who meet the medical necessity criteria and

reside in San Mateo County. Determination of who may receive the DMC-ODS benefit will be performed as follows:

i. Contractor must verify the client is MediCal eligible in San Mateo County. Contractor shall conduct the initial eligibility verification, that verification will be reviewed and approved by the County 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 Indian Health Care Improvement Act. 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.

ii. 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 (as describe in I.A.2.f.iii.) by a Medical Director, licensed physician, or LPHA. 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.

iii. Telehealth Requirements

1) Contractor will utilize the following applications of telehealth:

(a) Online consultation to evaluate clients in SUD treatment programs.

In lieu of a client coming to a site, telehealth will be used to centralize the services thus improving client access, minimizing travel time, and maximizing the use of the LPHA time. The LPHA will operate out of one central site; meet with clients or staff over the online telehealth network providing direct care and consultation to the providers.

(b) Advanced service delivery using innovative technology provided in a secure manner to ensure patient confidentiality as described in the Health Insurance Portability and Accountability Act.

Contractor shall utilize telehealth services through mobile devices (tablets, mobile phones, and laptops) that will allow the 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. Contractor shall equip clients with self-care applications that connect them with their case managers beyond "office hours" and locations.

(c) Contractor shall monitor telehealth equipment and service locations to ensure 42 CFR part 2 and confidentiality are strictly protected.

1) Medical necessity for an adult (an individual age twenty-one [21] and over) is determined using the following criteria:

a) The individual must have received at least one (1) diagnosis from the DSM of Mental Disorders for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; and

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

2) Individuals under age twenty-one (21) are eligible to receive MediCal services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, clients under age twenty-one (21) are eligible to receive all appropriate and medically necessary services needed to correct and improve health conditions that are covered under section 1905(a) Medicaid authority. The DMC-ODS Pilot will not override any EPSDT requirements.

Medical necessity for an adolescent individual (an individual under the age of twenty-one [21]) is determined using the following criteria:

a) The adolescent individual must be assessed to be at risk for developing a SUD; and
b) 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 will reevaluate that individual's medical necessity qualification at least every six (6) 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.

g. The DMC-ODS establishes medically necessary Mandatory Covered Services compliant with CFR438.210 within a continuum of care as defined in the ASAM Criteria. Mandatory Covered services include:
   i. Withdrawal Management
   ii. Intensive Outpatient;
   iii. Outpatient;
   iv. Opioid (Narcotic) Treatment Programs;
   v. Recovery Services;
   vi. Case Management;
   vii. Physician Consultation;
   viii. Perinatal Residential Substance Abuse Services (excluding room and board). Room and board shall be reimbursable through the Substance Abuse Prevention and Treatment Block Grant (SAPT BG) treatment funding allocated to the Contractor.
   ix. Non Perinatal Residential Substance Abuse Services (excluding room and board). Room and board shall be reimbursable through the SAPT BG treatment funding allocated to the Contractor.
   x. San Mateo County has been approved to include additional Medication Assisted Treatment (MAT) as an optional service under the ODS.

xi. Contractor shall ensure services are sufficient in amount, duration or scope to reasonably be expected to achieve the purpose for which the services are being furnished.

xii. Contractor shall 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 client.

h. Access to Service

i. Contractor shall receive referrals for treatment from BHRS (i.e. Call Center, ARM, Oasis, Coordinated Care Team (CCT), IMAT), for client calls or visits to contractor's program sites. Contractor shall follow protocols and procedures as identified in the BHRS DMC-ODS Implementation Plan and any modifications that follow.

ii. Contractor shall obtain authorization of DMC-ODS services in accordance with the medical necessity criteria specified in Title 22, Section 51303 and the coverage provisions of the approved state MediCal Plan. For residential services, room and board are not reimbursable services through DMC. If services are denied, the Contractor shall inform the client in accordance with Title 22, Section 51341.1 (p) and 42 CFR 438.404.

iii. Contractor shall review the DSM and ASAM Criteria to ensure that the client meets the requirements for the service.

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

i. Timely Access to Service

Contractor shall deliver the client's first appointment for covered services within fifteen (15) days of request for non-urgent services.

Contractor shall ensure that a client experiencing a medical or psychiatric emergency will be directed to the nearest hospital for services.

Contractor shall advise all clients in their program of the County's twenty-four (24) hour on-call Access Call Center and shall ensure that the clients are aware of how to contact

the Contractor for treatment or other covered services after hours, weekends and holidays.

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.

i. Contractor must obtain prior authorization for residential services within twenty-four (24) hours of assessment of the identified need.
ii. Prior authorization is not required for non-residential DMC-ODS services.
iii. Contractor shall have hours of operation during which services are provided to MediCal clients that are no less than the hours of operation during which the Contractor offers services to non-MediCal clients. If the Contractor only serves MediCal clients, the hours of operation are comparable to the hours the Contractor makes available for MediCal services that are not covered by the Contractor.

j. Coordination of Care

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

i. Contractor shall ensure coordination and continuity of care within the standards in accordance with 42 CFR 438.208.
ii. Contractor shall ensure that, in the course of coordinating care, each client's privacy is protected in accordance with all Federal and State privacy laws, including but not limited to 45 CFR 160 and 164, to the extent that such provisions are applicable.
iii. Contractor shall ensure that female clients 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 clients designated source of

primary care if that source is not a women's health specialist, pursuant to 42 CFR 438.206(b)(2).

iv. Contractor will have procedures for linkage/integration for clients requiring Medication Assisted Treatment. Contractor will regularly communicate with physician of clients who are prescribed these medications unless the client refuses to consent to sign a 42 CFR part 2 compliant release of information for this purpose.

k. Assessment

Contractor shall collaborate with BHRS to establish assessment and referral procedures to ensure clients receive medically necessary services within a continuum of care, including services that Contractor may not provide.

i. All staff involved with intake, assessment, treatment planning and delivery will be trained and utilize a uniform SUD screening tool and decision tree based on ASAM. Contractor shall participate in and follow the screening, referral process, and provision of care as developed by BHRS in the DMC-ODS plan, approved by DHCS.

l. Sharing Information with Clients

Contractor will ensure that licensed, registered or certified professional staff who is acting within the lawful scope of practice is not prohibited or restricted from advising or advocating on behalf of a client for who the contractor is providing SUD treatment for any of the following:

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

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

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

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

m. Laboratory Requirements

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

n. Practice Guidelines

Contractor shall adopt the following practice guidelines:

i. Treatment decisions will be based on valid and reliable clinical evidence or a consensus of health care professions in the applicable field;
ii. Consider the needs of the clients;
iii. Adopted in consultation with contracting health professionals; and
iv. Reviewed and updated periodically as appropriate.

o. DMC-ODS Levels of Treatment Services

All services provided by Contractor under this amendment shall be safe, effective, patient centered, timely, culturally competent, efficient and equitable, as defined by the Institute of Medicine. Contractor shall implement evidence based practices (EBP) in the delivery of services. The EBP are included in the Standards of Care in the AOD Policy and Procedure Manual.

Contractor shall provide treatment services described herein as part of the San Mateo County DMC-ODS. Contractor shall work with other ODS providers to ensure a seamless service delivery system to clients who need levels of care not provided by the Contractor. The description of all levels of care to be provided by SMC DMC-ODS are contained in the AOD Policy and Procedure Manual.

i. **Residential Treatment Services (ASAM 3.1 and 3.5)**

Residential services shall be 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 one (1) to ninety (90) days with a ninety (90) day maximum for adults and thirty (30) day

maximum for adolescents, per a three hundred sixty-five (365) day period; unless medical necessity authorizes a one (1) time extension of up to thirty (30) days, per a three hundred sixty-five (365) day period.

3) Only two (2) non-continuous ninety (90) day regimens may be authorized in a one (1) year period, or three hundred sixty-five (365) days.
4) Contractor shall provide at a minimum a clinical and structured program based on ASAM treatment criteria for the residential level for which they are certified.
5.) Contractor shall provide perinatal DMC services in compliance with the requirements contained in Title 22, Section 51341.1, Services for Pregnant and Postpartum Women.

p. Authorization of Services

i. Contractor shall obtain authorization from the BHRS Call Center for client admission to a residential treatment program, pursuant to 42 CFR 438.210(b).
ii. Contractor's residential treatment program standards shall include the following:
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 treatment 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;
b) Ensure that residential treatment services may be provided in facilities with no bed capacity limit;
c) Ensure that the length of residential treatment services comply with the following time restrictions:
i) Adults, ages twenty-one (21) and over, may receive up to two (2) continuous short-term residential regimens, per three hundred sixty-five (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 three hundred sixty-five (365) day period.
An adult client may receive one (1) thirty (30) day extension, if that extension is medically necessary, per three hundred sixty-five (365) day period.

ii) Adolescents, under the age of twenty-one (21), shall receive continuous residential services for a maximum of thirty (30) days. Adolescent clients may receive a thirty (30) day extension if that extension is determined to be medically necessary. Adolescent clients are limited to one (1) extension per year. Adolescent clients receiving residential treatment will be stabilized as soon as possible and moved down to a less intensive level of treatment. The DMC-ODS Pilot will not override any EPSDT requirements.

iii) Perinatal clients may receive a longer length of stay than those described above. If determined to be medically necessary, perinatal clients may receive a length of stay up to the length of the pregnancy and postpartum period (sixty (60) days after the pregnancy ends).

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

q. Case Management

Case management services are defined as a service that assist a client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Services shall include the following:

i. Case management services that focus on coordination of SUD care, integration around primary care especially for clients with a chronic SUD, and interaction with the criminal justice system, if needed.

ii. Contractor shall coordinate a system of case management services with physical and/or mental health to ensure an appropriate level of care.

iii. Case management services shall be provided face-to-face, by telephone, or by telehealth with the client and may be provided anywhere in the community.

iv. Case management services include the following:

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

2) Transition to a higher or lower level SUD of care;

3) Development and periodic revision of a client plan that includes service activities;

4) Communication, coordination, referral and related activities;

5) Monitoring service delivery to ensure client access to service and the service delivery system;

6) Monitoring the client's progress;

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

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

r. Physician Consultation

i. 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 clients. Physician consultation services may address medication selection, dosing, side effect management, adherence to treatment regimen, drug-drug interactions, or level of care considerations.

ii. BHRS shall make physician consultation services available to DMC providers upon request. Only specified DMC-ODS providers may bill for physician consultation services.

3. Other Program Specifications

a. Criminal Justice Program
SUD treatment shall be provided to eligible offenders based on treatment need with available funding resources. A full continuum of SUD treatment services are available to Criminal Justice clients based on assessed treatment need.

i. Criminal Justice Realignment and Unified Reentry
Contractor shall provide authorized services to individuals meeting eligibility and referral criteria as determined by the Service Connect Team.

ii. Drug Court
Contractor shall provide authorized services to individuals meeting the Drug Court eligibility criteria as determined by the Drug Court Team.

4. Treatment Planning and Documentation

Documentation of client services and treatment progress shall be maintained in the client record. Contractor shall adhere to documentation requirements for services provided as described in the AOD Policy and Procedure Manual. Records shall be maintained in accordance with requirements listed in Exhibit A3.III.H.5. of this agreement.

II. PRIORITY POPULATIONS

A. Through the Substance Abuse Prevention and Treatment (SAPT) Block Grant, BHRS is required to serve priority population clients. Contractor shall establish partnerships for the provision of referral to interim or treatment services when capacity is not available, as described in the AOD Policy and Procedure Manual. Contractor shall give priority admission to the following populations:

1. Pregnant females who use drugs by injection;
2. Pregnant females who use substances;
3. Other persons who use drugs by injection;
4. As Funding is Available – all other clients with a SUD, regardless of gender or route of use, without insurance or for whom coverage is terminated for short periods of time;

B. San Mateo County residents who are referred by San Mateo County BHRS;

C. Referrals from other San Mateo County BHRS providers and Shelter referrals within San Mateo County.

D. Medically necessary care for MediCal clients.

III. ADMINISTRATIVE REQUIREMENTS

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

A. SUD Services under the Affordable Care Act

1. To maximize revenues and increase access to SUD treatment services, Contractor shall make every reasonable effort including the establishment of systems for eligibility determination, billing and collection, to secure payment in accordance with BHRS – AOD Policy 14-0 and the AOD Policy and Procedure Manual:

a. Screen all potential clients for health coverage;

b. DMC certified contractors shall verify health coverage for all individuals seeking services. Coverage may be verified on the https://www.medi-cal.ca.gov/Eligibility/Login.asp.

c. Collect reimbursement costs for services provided to persons entitled to insurance benefits, by a State compensated program, other public assistance program for medical expenses, grant program, private health insurance, or any other benefited program. Secure from clients or patients payment for services in accordance with their ability to pay.

d. Contractor will obtain prior authorization from the BHRS Call Center, for clients with private health insurance.

2. Uninsured Residents seeking SUD Services

Contractor may provide and bill BHRS for SUD services to low income residents who are uninsured using an approved sliding scale fee. Contractor shall make a good faith effort to facilitate client enrollment into health coverage, if client meets eligibility criteria for coverage.

3. Medicare beneficiaries seeking SUD Service

Contractor may bill BHRS to provide medically necessary SUD services for Medicare clients using an approved sliding fee scale. Contractor shall submit a good faith bill for any services using the process described below if client also has OHC.

4. MediCal Beneficiaries Seeking SUD Services

a. Contractor shall bill BHRS for services provided to MediCal clients, if providing a service covered by DMC.

b. If client has OHC in addition to MediCal, Contractor must follow the process established under DHCS ADP Bulletin 11-01 http://www.dhcs.ca.gov/services/MH/MHSUD/Documents/ADP_Bulletins/ADP_11-01.pdf including future DHCS process updates for DMC claims for clients with OHC.

c. Contractor may provide services to MediCal clients and bill BHRS for services when the following certification and program requirements have been met:
   i. Contractor has submitted DMC application for this service and facility, and certification is pending DHCS approval. The client cannot be referred to a DMC certified program and facility that is conveniently located for the client.
   ii. Contractor provides a medically necessary SUD service to a client that is not covered under the Centers for Medicare and Medicaid Services (CMS) California State Plan for Drug MediCal services.

d. Once Contractor obtains DMC certification, all MediCal client services shall be billed to the DMC program for reimbursement.

B. OHC Beneficiaries Seeking SUD Services

Services that are covered through an OHC will not be reimbursed through the County. Contractor shall bill the OHC for which the client is a beneficiary. If the Contractor is not a member of the provider network for an OHC, Contractor shall then refer client to the OHC network. More about information regarding OHC covered and non-covered services can be found in the AOD Policy and Procedure Manual.

C. System-Wide Improvements

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

1. Community Service Areas

   a. BHRS has designed a service delivery system to improve quality and access of services to clients. These services are divided into six (6) geographic Community Service Areas (CSA).

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

2. Standards of Care

   In providing its services and operations, Contractor shall maintain full compliance with SUD and DMC-ODS requirements (as referenced in the AOD Policy and Procedure Manual), and continue to evaluate compliance and the quality of each standard.

3. Complex Clients and Co-occurring Disorders

   a. Contractor shall establish a COD work plan to assess and address the needs of complex clients. This COD work plan may be a part of the Contractor's quality improvement program, Standards of Care plan, or it may be a separate process.

   b. Contractors receiving Mental Health Services Act funding to treat clients with COD shall comply with additional reporting requirements as outlined in the AOD Policy and Procedure Manual.

D. Qualified Service Organization

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

1. Centralized screening, assessment, and treatment referrals;

2. Billing supports and services;

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

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

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

6. Education, training and technical assistance as needed.

E. No Unlawful Use or Unlawful Use Messages Regarding Drugs

Contractor agrees that no aspect of its substance use treatment program services shall include any messaging in the responsible use, if the use is unlawful, of drugs or alcohol. This is including but not limited to: program standards, curricula, materials, and teachings. These materials and programs may include information on the health hazards of use of illegal drugs and alcohol, concepts promoting the well-being of the whole person, risk reduction, the addictive personality, development of positive self-esteem, productive decision-making skills, and other preventive concepts consistent with the "no unlawful use" of drugs and alcohol message. This does not apply to any program receiving state SAPT/NRC funding that provides education and prevention outreach to intravenous drug users with AIDS or AIDS-related conditions, or persons at risk of HIV-infection through intravenous drug use. (Health and Safety Code Sections 11999-11999.3).

F. Restriction on Distribution of Sterile Needles

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

G. AVATAR Electronic Health Record

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

2. Contractor shall maintain compliance with all documentation, reporting, billing and all other data requirements as required in the BHRS and AOD Policy and Procedure Manual, including additions and revisions.

3. Contractor shall submit electronically client wait list data to DHCS. This information shall be used to determine unmet treatment needs and wait times to enter treatment.

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

H. Quality Management and Compliance

1. Quality Management Program and Quality Improvement Plan

Contractor must have a Quality Management Program and submit a Quality Improvement Plan to BHRS Quality Management (QM) annually by November 30th. The Quality Improvement Plan should address 1) how the Contractor will comply with all elements of this Agreement, 2) how the Contractor will maintain an audit disallowance rate of less than five percent (5%), and 3) first appointment will be within fifteen (15) days of referral or request of service. BHRS QM will provide feedback if the submitted plan is missing critical components related to San Mateo County requirements. Additional feedback may be available if requested prior to the submission date.

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

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

c. Contractor shall establish and/or maintain mechanisms whereby processes and practices at the organizational level; which create inefficiencies and/or present barriers to client engagement, enrollment and retention in treatment, will be identified and addressed. An analysis of policies and practices which create barriers for complex clients shall be included.

2. Client Feedback

Contractor will solicit feedback from service recipients and family members on an annual basis, at minimum. Client feedback process may include, but is not limited to: focus groups and client satisfaction surveys. Consideration of client feedback will be incorporated into future QI plans.

3. Referring Individuals to Psychiatrist

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

4. Medication Support Services

Contractors that provide or store medications will store, dispense and/or administer medications in compliance with all pertinent State and Federal standards. Policies and procedures must be in place for dispensing, administering and storing medications consistent with BHRS Policy 99-03, Medication Room Management and BHRS Policy 04-08 Medication Monitoring located at www.smchealth.org/bhrs-documents. In particular:

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

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

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

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

e. Medications are stored in a locked area with access limited to those medical personnel authorized to prescribe, dispense or administer medication.

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

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

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

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

5. Record Retention

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

6. Documentation of Services

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

System of Care (SOC) Mental Health Providers shall document in accordance with the BHRS Documentation Manual located online at:
http://www.smchealth.org/sites/default/files/docs/BHRS/BHRSDocManual.pdf.

SOC contractor will utilize either documentation forms located on http://smchealth.org/SOCMHContractors or contractor's own forms that have been pre-approved.

Substance Use Disorder provider services shall be in compliance with the AOD Policy and Procedure Manual which is located online at http://www.smchealth.org/bhrs/aod/handbook.

Managed Care providers shall document services in accordance with the BHRS Managed Care Provider Manual: located online at http://www.smchealth.org/sites/default/files/docs/BHRS/Providers/ManagedCareProviderManual.pdf. Managed Care Providers will utilize documentation forms located at http://www.smchealth.org/bhrs/contracts.

7. Audits

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

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

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

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

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

d. Identify who will be responsible for ongoing compliance.

8. Client Rights and Satisfaction Surveys

a. Administering Satisfaction Surveys

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

b. Client/Patient's Rights and Problem Resolution

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

c. Advance Directives

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

9. Beneficiary Brochure and Provider Lists

Contractor must provide MediCal clients new to BHRS with a client brochure and the BHRS Provider list at the time of their first mental health or SUD service from the Contractor. Contractors are required to be aware of and make available to BHRS MediCal clients all mandatory postings listed at this website http://www.smchealth.org/bhrs/providers/mandpost.

10. Certification and Licensing

a. SUD Treatment Services

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

ii. Contractor shall submit a copy of any licensing complaint or corrective report issued by a licensing agency to BHRS QM, BHRS Deputy Director of Youth Services, BHRS Deputy Director of Adult and Older Adult Services, or the Manager of SUD Services or their designee, within ten (10) business days of Contractor's receipt of any such licensing report.

iii. Should Contractor cease to offer a DMC-ODS service, Contractor will work with BHRS to ensure participating clients are successfully transferred to another DMC-ODS provider.

b. DMC-ODS SUD Treatment Services

i. If at any time, Contractor's license, registration, certification, or approval to operate a substance use disorder program or provide a 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 and the BHRS Program Analyst within two (2) business days of knowledge of such change.

ii. Contractor's certification to participate in the DMC program shall automatically terminate in the event the Contractor or its owners, officers or directors are convicted of MediCal fraud, abuse or malfeasance. For purposes of this section, a conviction shall include a plea of guilty or nolo contendere.

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

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

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

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

c. Contractor agrees to comply with the provisions of 42 C.F.R. Part 2 as described below if records contain or contract possesses any PHI covered under 42 C.F.R Part 2:
   i. Acknowledge that in receiving, storing, processing, or otherwise using any information from BHRS about the clients in the program, it is fully bound by the provisions of the federal regulations governing Confidentiality of Behavioral Health and Recovery Services Patient Records, 42 C.F.R. Part 2;
   ii. Undertake to resist in judicial proceedings any effort to obtain access to information pertaining to clients otherwise than as expressly provided for in the federal confidentiality regulations, 42 C.F.R. Part 2; and
   iii. Agree to use appropriate safeguards to prevent the unauthorized use or disclosure of the protected information.

d. Confidentiality Training

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

12. Site Certification

a. Contractor will comply with all site certification requirements

b. Contractor is required to inform BHRS QM and BHRS Program Analyst in advance or no later than forty-eight (48) hours after an occurrence, of the following major changes:
   i. Major leadership or staffing changes.
   ii. Major organizational and/or corporate structure changes (example: conversion to non-profit status).
   iii. Any changes in the types of services being provided at that location; day treatment or medication support services when medications are administered or dispensed from the provider site.

iv. Significant changes in the physical plant of the provider site (some physical plant changes could require a new fire or zoning clearance).
v. Change of ownership or location.
vi. Complaints regarding the provider.

13. Critical Incident Reporting

Contractor is required to submit Critical Incident reports to BHRS QM (via fax # 650-525-1762) when there are unusual events, accidents, errors, violence or significant injuries requiring medical treatment for clients, staff or members of the community. (Policy #93-11 and 45 C.F.R. § 164, subpart C, in compliance with 45 C.F.R. § 164.316.)

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

14. Ineligible Employees

BHRS requires that Contractors identify the eligibility status to bill for MediCal services of ALL employees, interns or volunteers prior to hiring and on a monthly basis thereafter. These records should be maintained in the employee files. This process is meant to ensure that any person involved with delivering services to clients of BHRS or involved in MediCal billing or oversight are not currently excluded, suspended, debarred or have been convicted of a criminal offense as described below.

The Contractor must notify BHRS Quality Management (by completing the BHRS Critical Incident Reporting form, Policy #93-11 and faxing to 650-525-1762) should a current employee, intern or volunteer be identified as ineligible to bill MediCal services. Contractors are required to screen for ineligible employees, interns and volunteers by using the following websites:

a. Office of Inspector General

Contractor may not employ any persons deemed an Ineligible Person by the Office of the Inspector General in the provision of services for the County through this Agreement. Any employee(s) of Contractor determined to be an Ineligible Person will be removed from responsibility for, or involvement with County of San Mateo clients or

operations. An "Ineligible Person" is an individual who (1) is currently excluded, suspended, debarred or otherwise ineligible to participate in Federal health care programs, or (2) has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in the Federal health care programs after a period of exclusion, suspension, debarment or ineligibility. Ineligibility may be verified by checking: http://exclusions.oig.hhs.gov/.

b. California Department of Health Care Services

Contractor providing state funded health services may not employ any persons deemed an Ineligible Person by the California DHCS in the provision of services for the County through this Agreement. Any employee(s) of Contractor determined to be an Ineligible Person will be removed from responsibility for, or involvement with County clients or operations. An "Ineligible Person" is an individual who has been (1) convicted of a crime involving fraud or abuse of the MediCal program, or (2) suspended from the federal Medicare program for any reason. Ineligibility may be verified by checking: http://files.MediCal.ca.gov/pubsdoco/SandILanding.asp. Once there, scroll down to the bottom of the page and click on MediCal Suspended and Ineligible Provider List (Excel format). The list is in Alphabetical order. Search by the individual's last name.

15. Compliance Plan and Code of Conduct

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

Contractor is required to conduct, complete and maintain record of both Annual Compliance Training and Annual Fraud Waste & Abuse Training by all staff serving or accessing PHI of BHRS clients. Contractor may utilize BHRS trainings located at http://smchealth.org/bhrs/providers/ontrain.

16. Fingerprint Compliance

Any contractor staff that have on-the-job contact with children or other vulnerable clients whose safety may be compromised by an individual's criminal history (i.e. sex offense, abuse of dependent adults, etc.) shall be fingerprinted, including administrative staff who routinely interact with clients, case managers, peer support workers, etc. If said employees and/or subcontractors, assignees, and volunteers have such a criminal history, they will not be eligible for hire or retention in a position involving contact with a vulnerable population through this Agreement. Fingerprint information received from the Department of Justice (DOJ) shall be retained or disposed of pursuant to DOJ directive. A certificate of fingerprinting certification is attached hereto and incorporated by reference herein as Attachment E.

17. Credentialing

Contractor is responsible for implementing a process to verify, at time of employment, and ongoing, (at the clinician's license or registration renewal time) the credentials of its clinical staff at https://www.breeze.ca.gov/datamart/loginCADCA.do. Contractor will obtain a waiver when needed from BHRS Quality Management. All clinical personnel must comply with HIPAA regulations to obtain a National Provider Identifier (NPI) number. The license and NPI information shall be reported to the County through the completion of a County provided credentialing form located at http://www.smchealth.org/AvatarAccess and submitted to BHRS. Contractor is requirement to track expiration dates and verify all licenses and credentials are current and in good standing at all times. Contractor is required to keep proof of verification of credentials for each staff person. BHRS Quality Management and BHRS-AOD Program Analyst must be notified within twenty-four (24) hours of any violations. Contractor must notify BHRS Quality Management if an employee's license is not current or is not in good standing and must submit plan to correct to address the matter.

18. Staff Termination

Contractor shall inform BHRS, in a timely fashion, when staff have been terminated. BHRS Quality Management requires prompt notification to be able to terminate computer access and to safeguard access to electronic medical records by completing the BHRS Credentialing form.

19. Minimum Staffing Requirements

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

I. Cultural Competency

Implementations of these guidelines are based on the National Culturally and Linguistically Accessible Services (CLAS) Standards issued by the Department of Health and Human Services. For more information about these standards, please contact the Health Equity Initiatives Manager (HEIM) at 650-573-2714 or jafrica@smcgov.org.

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

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

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

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

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

   d. Staffing objectives that reflect the cultural and linguistic diversity of the clients. (Contractor will recruit, hire and retain

clinical staff members who can provide services in a culturally and linguistically appropriate manner.)

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

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

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

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

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

J. Physician Incentive Plans

Contractor shall obtain approval from County prior to implementing a Physician Incentive Plan as described by Title 42, CFR, Section 438.6(h). The County will submit the Physician Incentive Plan to the State for approval. The State shall approve the Contractor's request for a

Physician Incentive Plan only if the proposed Physician Plan complies with all applicable federal and state regulations.

K. Availability and Accessibility of Service

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

L. Surety Bond

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

M. Contractor shall establish written procedures of the following:

1. HIV Early Intervention;
2. Adolescent/Youth Treatment;
3. CalOMS Treatment;
4. Cultural Competency;
5. Primary Prevention;
6. Perinatal; and
7. Interim Services.

Compliance shall be conducted through monthly and quarterly monitoring and at the annual on-site visit.

N. Control Requirements

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

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

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

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

O. Trafficking Victims Protection Act of 2000

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

III. GOALS AND OBJECTIVES

Contractor shall ensure that the following outcome objective is pursued throughout the term of this Agreement:

GOAL: Program participants will achieve a successful treatment discharge.

OBJECTIVE: No less than ninety-five percent (95%) of program participants will have a successful treatment discharge. Successful treatment discharge occurs when a program participant completes his/her treatment/recovery plan or is transferred for continued treatment.

*** END OF EXHIBIT A3 ***

EXHIBIT B3 – PAYMENTS AND RATES
SERVICE LEAGUE OF SAN MATEO COUNTY
FY 2016 – 2018

In consideration of the services provided by Contractor in Exhibit A3, County shall pay Contractor based on the following fee schedule:

I. PAYMENTS

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

A. Maximum Obligation

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

In any event, the maximum amount County shall be obligated to pay for all services rendered under this contract shall not exceed TWO MILLION TWO HUNDRED NINETY-TWO THOUSAND THREE HUNDRED EIGHTY-SIX DOLLARS ($2,292,386).

The structure for payment for services is subject to change during this contract term. Prior to the Contractor being eligible and authorized to provide expanded ODS Drug MediCal (DMC) services (pre-Go Live), the payment structure is consistent with the FY 2015-16 Agreement with the County. Following the implementation of expanded DMC services (post-Go Live), the payment structure is revised as described herein. The Contractor will receive written authorization to provide ODS DMC services by the County. The Go Live start date will be at the beginning of the month following authorization. Payment for services will be made monthly throughout the agreement term.

B. Pre-Go Live Payment for Substance Use Disorder Treatment Services – July 1, 2016 – February 28, 2017

1. Fixed Rate Payments

The maximum amount County shall be obligated to pay for Fixed Rate Payments shall not exceed THREE HUNDRED FIFTY-TWO THOUSAND NINE HUNDRED FORTY-NINE DOLLARS ($352,949).

a. For the term July 1, 2016 through December 31, 2016, Contractor shall be paid a maximum of one-eighth (1/8th) or FORTY-EIGHT THOUSAND EIGHT HUNDRED NINETY-ONE DOLLARS ($48,891) per month. Rates are referenced in Schedule A3 – Fixed Rate Table and are subject to c. and d. below.

b. For the term January 1, 2017 through February 28, 2017, Contractor shall be paid a maximum of one-eighth (1/8th) or TWENTY-NINE THOUSAND EIGHT HUNDRED THREE DOLLARS ($29,803) per month. Rates are referenced in Schedule A3 – Fixed Rate Table and are subject to c. and d. below.

c. Contractor shall be reimbursed for the actual costs expended by Contractor for each type of service delivered, up to the Net Contract Amount for that type of service, unless otherwise limited by other provisions in this Exhibit B3. There will be no reimbursement for any costs that are disallowed or denied by the County audit process or through the California DHCS audit process.

d. If the County makes advance payments to Contractor for services, Contractor shall submit an invoice of actual expenses incurred for those services at the end of each quarter. If Contractor has expended at least ninety percent (90%) or more of the quarterly cost budgeted in this Exhibit B3, County will make full payment on the next monthly claim submitted by Contractor. If Contractor has not expended at least ninety percent (90%) of the quarterly budgeted cost, County will reduce the Contractor's next claim by the actual expenditures short of the ninety percent (90%) proration of the budget specified in Schedule A3 – Fixed Rate Payments. If in subsequent quarters of the fiscal year, Contractor expends total year-to-date costs in excess of ninety percent (90%) of year-to-date budget, County will restore previously subtracted amounts on the next monthly claim.

2. Fee for Service with Allocation

The maximum payment for fee for service with allocation services shall not exceed EIGHTY-FIVE THOUSAND SEVENTY-NINE DOLLARS ($85,079). Rates are referenced in Schedule B3 – Fee for Service with Allocation Rate Table.

Contractor will verify client MediCal eligibility each month prior to providing the service and billing DMC services for that month. Contractor will submit billing in accordance with DHCS DMC Provider Billing Manual and BHRS policy and procedures.

3. Fee for Service with Aggregate

The maximum payment for alcohol and drug treatment services shall not exceed an aggregate amount of EIGHT HUNDRED FIVE THOUSAND NINE HUNDRED FORTY DOLLARS ($805,940). Rates are referenced in Schedule C3 – Fee for Service Aggregate Rate Table.

C. (Post-Go Live) ODS Payment for Substance Use Disorder Treatment Services – March 1, 2017 – June 30, 2018

1. The start date for implementation of ODS Post-Go Live payments will be based upon Contractor readiness for the implementation of ODS services, which will be determined by AOD Management. The start date will be the first day of the month following the determination of Contractor's readiness for ODS implementation.

2. If preapproved during the contract development process by BHRS, Contractor shall submit monthly invoices for reimbursement of start-up costs in arrears. Invoices shall include an itemized list of expenses, and are subject to approval by the BHRS Manager.

3. The maximum amount County shall be obligated to pay for DMC-ODS services shall not exceed ONE MILLION FORTY-EIGHT THOUSAND FOUR HUNDRED SEVENTEEN DOLLARS ($1,048,417) for the term March 1, 2017 through June 30, 2018.

   a. For the term March 1, 2017 through June 30, 2017, Contractor shall be paid a maximum of TWO HUNDRED SIXTY-TWO THOUSAND ONE HUNDRED FOUR DOLLARS ($262,104).

   b. For the term July 1, 2017 through June 30, 2018, Contractor shall be paid a maximum of SEVEN HUNDRED EIGHTY-

SIX THOUSAND THREE HUNDRED THIRTEEN DOLLARS ($786,313).

4. Contractor shall submit monthly invoices for payment. Invoice amounts shall be SIXTY-FIVE THOUSAND FIVE HUNDRED TWENTY-SIX DOLLARS ($65,526), or the Contractor actual monthly costs, whichever is less. Contractor will submit invoices on forms and in manner prescribed by the County.

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

6. If County makes advance payments to Contractor, County will review the total number of units of services entered into the County data system at the end of each quarter. If the Contractor has provided (90/95%) of the budgeted units of service in the quarter, the County will make full budgeted payment for services for the following quarter. If the Contractor has not produced (90/95%) of the budgeted units of service, County will reduce the subsequent monthly payment by the percentage of units of service short of (90/95%). If in subsequent quarters the Contractor provides (90/95%) of the budgeted units of services, the monthly payment amount will revert to the original monthly pro-rated amount of the budget.

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

8. Costs for room and board services must be claimed and reported separately and distinctly from residential treatment services using the methodology for claiming and reporting for room and board services as approved by the County.

9. DMC-ODS Risk Pool

   DMC-ODS payments are based on accurate documentation and submission of billing claims. County recognizes that Contractor will be learning new processes both in service documentation and billing. BHRS will create a "risk pool" where the County will absorb risk at the start-up for disallowances related to new ODS implementation.

During year one of the DMC-ODS contract implementation, BHRS will guarantee payment of DMC billing submitted by contractor using a phased approach. The risk pool will be shared among all implementing contractors and is based on availability of funds. Once the risk pool is exhausted, contractors will be required to repay the County for disallowances. If risk pool funds are still available at the end of the ninth (9^{th}) month from contract start date, or at the end of FY 2016-2017, whichever comes first, BHRS will evaluate whether to continue the risk pool.

During the availability of the risk pool, County will hold the Contractor harmless for disallowances as outlined in the table below. Contractor is eligible for the risk pool, provided the following conditions are met:

a. Treatment staff are trained in documentation standards;

b. Fiscal staff are trained in MediCal billing processes;

c. Contractor shall submit a chart documentation review plan prior to ODS Go-Live date to ensure timeliness, accuracy and content standards are met; and

d. Contractor shall develop and implement an improvement plan to address deficient areas identified and provide the County status updates.

Contractor shall provide evidence of compliance with above requirements on a monthly basis to participate in the DMC-ODS risk pool.

ODS Implementation Month	Percent of Disallowance Covered by Risk Pool *
Month One	100% of disallowed funds
Month Two	90% of disallowed funds
Month Three	90% of disallowed funds
Month Four	75% of disallowed funds
Month Five	75% of disallowed funds
Month Six	75% of disallowed funds
Month Seven	50% of disallowed funds
Month Eight	50% of disallowed funds
Month Nine	50% of disallowed funds

* Once the risk pool fund is exhausted, Contractor will be required to repay the County for disallowances. This chart does not represent guaranteed payment of risk pool funds for a nine (9) month period by BHRS or the County.

Following the applicable period of the risk pool, there will be no reimbursement for any DMC service costs that are disallowed or denied by the County billing or audit processes, or through the State of California billing or audit processes.

10. Cost Settlement

Settlements of total amount due to Contractor for services provided during the Go-Live period will be made at the following times:

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

   DMC Cost Report requirements are described in section F.

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

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

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

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

11. DMC-ODS Administrative Requirements

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

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

c. Contractor shall prepare and retain for DHCS review as needed the following forms: a) multiple billing overrider certification (MC 6700), document 2K; b) Good Cause Certification (6065A) document 2L(a); and Good Cause Certification (6065B) Document 2LB. In the absence of good cause documented on the GCC 6065 a or b form, claims that

are not submitted within thirty (30) days of the end of the month of service will be denied.

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

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

F. Cost Report / Unspent Funds

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

   With the cost report, Contractor shall submit a written reconciliation of the total units of services delivered under this agreement with the total number of units reported by Contractor to the County data system. The County reserves the right to withhold payment due to Contractor under this Agreement or subsequent year's Agreement until such time as Contractor submits the required cost report and reconciliation report to the County.

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

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

4. Contractor may request that contract savings or "unspent funds" within the Agreement maximum are expended by Contractor in the

following year, provided that these funds are expended for SUD services approved by County in accordance with the following procedures.

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

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

c. If the specific purpose is not yet complete as of the end of the succeeding fiscal year, contractor may request to rollover the unspent funds to the succeeding second fiscal year by submitting a written request with the accounting report. The unspent balance shall be returned to the County with the submission of the written request. The request is subject to approval by the BHRS Director or the Director's designee. If such request is approved, the Agreement for the succeeding fiscal year will be amended as necessary to include the approved rollover amount.

e. A final accounting of the rollover funds shall be submitted ninety (90) days after the specific purpose has been completed, or ninety (90) days after the end of the succeeding fiscal year, whichever comes first. Any unspent rollover funds shall be returned to the County with the accounting report.

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

G. Modifications to the allocations in Paragraph I.A of this Exhibit B3 may be approved by the Chief of the Health System or designee, subject to the maximum amount set forth in Paragraph 3 of this Agreement.

H. Not used.

I. In the event that funds provided under this Agreement are expended prior to the end of the contract period, Contractor shall provide ongoing services under the terms of this Agreement through the end of the contract period.

J. In the event this Agreement is terminated prior to June 30, 2018, Contractor shall be paid on a prorated basis for only that portion of the contract term during which Contractor provided services pursuant to this Agreement. Such billing shall be subject to the approval of the Chief of the Health System or designee.

K. The contracting parties shall be subject to the examination and audit of the Department of Auditor General for a period of three years after County submits cost report for the period of service (Government Code, Section 8546.7).

L. Monthly Invoice and Payment

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

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

M. Contractor 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.

N. County anticipates revenues from various sources to be used to fund services provided by Contractor through this Agreement. Should actual revenues be less than the amounts anticipated for any period of this Agreement, the maximum payment obligation and/or payment obligations

for specific services may be reduced at the discretion of the Chief of the Health System or designee.

Adjustments may be made to the total of the Agreement and amounts may be withheld from payments otherwise due to the Contractor for nonperformance to the extent that nonperformance involves fraud, abuse, or failure to achieve the objectives of the provisions of Exhibit A3.

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

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

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

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

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

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

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

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

1. Contractor's usual and customary charges to the general public for the same or similar services;
2. Contractor's actual allowable costs.

Contractors 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 may not demand any additional payment from the State, client, or other third party payers

Q. Substance Abuse Prevention and Treatment Funding

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.

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.

R. Inadequate Performance

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

S. Election of Third Party Billing Process

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

1. Option One

a. Contractor shall bill all eligible third-party payors financially responsible for a beneficiary's health care services that Contractor provides through this Agreement. Within ten (10) days of the end of each month, Contractor shall provide to County copies of the Explanation of Benefits or other remittance advice for every third-party payment and/or denial of such third-party payments for services provided by Contractor during such month. The amount of any such third-party payment shall be deducted from the total actual costs for all services rendered by Contractor as reflected on the cost report as defined in Paragraph F of this Exhibit B3. County accepts no financial responsibility for services provided to beneficiaries where there is a responsible third-party payor, and to the extent that County inadvertently

makes payments to Contractor for such services rendered, County shall be entitled to recoup such reimbursement, through the cost report reconciliation.

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

2. Option Two

a. Contractor shall provide information to County so that County may bill applicable other third-parties before billing MediCal for services provided by Contractor through this Agreement. The amount of any such third-party payment shall be deducted from the total actual costs for all services rendered by Contractor as reflected on the cost report as defined in Paragraph F of this Exhibit B3. County accepts no financial responsibility for services provided to beneficiaries where there is a responsible third party payor, and to the extent that County inadvertently makes payments to Contractor for such services rendered, County shall be entitled to recoup such reimbursement through the cost report reconciliation.

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

T. Beneficiary Billing

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

U. Claims Certification and Program Integrity

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

2. Anytime Contractor submits a claim to the County for reimbursement for services provided under Exhibit A3 of this Agreement, Contractor shall certify by signature that the claim is true and accurate by stating the claim is submitted under the penalty of perjury under the laws of the State of California.

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

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

   Executed at _____ California, on _____20___

   Signed _____ Title _____

   Agency _____ "

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

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

b. The beneficiary was eligible to receive services described in Exhibit A3 of this Agreement at the time the services were provided to the beneficiary.

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

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

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

f. For each beneficiary with specialty mental health services included in the claim, all requirements for Contractor payment authorization for specialty mental health services were met, and any reviews for such service or services were conducted prior to the initial authorization and any re-authorization periods as established in this agreement.

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

4. Except as provided in Paragraph III.H.5. of Exhibit A3 relative to medical records, Contractor agrees to keep for a minimum period of three years from the last date of face-to-face service, a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. Contractor agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the MediCal Fraud Unit; California Department of Mental Health; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, Managed Risk Medical Insurance Board or their duly authorized representatives, and/or the County.

V. Audit Requirements

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

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

Objectives of 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 State Agreement with the State 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.

Unannounced visits may be made at the discretion of the State.

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

County shall monitor the activities of all of its Contractor to ensure that:

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

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

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

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

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.

AA. Drug MediCal Financial Audit Requirements

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

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 MediCal 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.

BB. Audit Requirements Narcotic Treatment Program

In addition to the audit requirements, the State may conduct financial audits of NTP programs. For NTP services, the audits will address items A.A.3 through A.A.5 above, except that the comparison of the provider's usual and customary charge in A.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 (2) and no more than twelve (12) clients at the same time, with at least one MediCal 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.

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

with funds provided by another federal funding source, or to repay federal funds with state funds, or to repay state funds with federal funds

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

DD. DMC Record Keeping

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

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

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

6. 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.

7. Contractor shall retain records of utilization review activities required for a minimum of three (3) years.

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

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

EE. Dispute Resolution Process

1. When a financial audit is conducted by the Federal Government, the

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

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

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

   Director, Behavioral Health and Recovery Services
   c/o John Klyver
   jklyver@smcgov.org
   Facsimile: 650-573-2841

*** END OF EXHIBIT B3 ***

SCHEDULE A3
SERVICE LEAGUE OF SAN MATEO COUNTY
FIXED RATE TABLE
JULY 1, 2016 - FEBRUARY 28, 2017

Services	Funding Amount	Monthly Funding Amount	Rate	Units of Service	Clients to be served	Slots
NRC Adult Residential	$91,805	$11,476	$122.00	752	4	2
NRC Perinatal	$21,303	$2,663	$122.00	175	1	0
County Funded Perinatal/Child	$38,540	$4,818	$124.45	310	2	1
County Funded Residential	$41,934	$5,242	$122.00	344	2	1
CalWORKS Residential	$33,273	$4,159	$122.00	273	1	1
MHSA Co-Occurring Disorders	$11,570	$1,446	$13.77	1260 Direct Staff Hours	7	3
County Bridge*	$57,262	$19,087	$122.00	939	5	3
County Match*	$57,262					
		$48,891	July 1, 2016 - December 31, 2016			
TOTAL	$352,949	$29,803	January 1, 2017 - February 28, 2017			

*7/1/2016 - 12/31/2016

SCHEDULE A3
SERVICE LEAGUE OF SAN MATEO COUNTY
FIXED RATE TABLE
JULY 1, 2016 - FEBRUARY 28, 2017

Services	Funding Amount	Monthly Funding Amount	Rate	Units of Service	Clients to be served	Slots
NRC Adult Residential	$91,805	$11,476	$122.00	752	4	2
NRC Perinatal	$21,303	$2,663	$122.00	175	1	0
County Funded Perinatal/Child	$38,540	$4,818	$124.45	310	2	1
County Funded Residential	$41,934	$5,242	$122.00	344	2	1
CalWORKS Residential	$33,273	$4,159	$122.00	273	1	1
MHSA Co-Occurring Disorders	$11,570	$1,446	$13.77	1260 Direct Staff Hours	7	3
County Bridge*	$57,262	$19,087	$122.00	939	5	3
County Match*	$57,262					
		$48,891	July 1, 2016 - December 31, 2016			
TOTAL	$352,949	$29,803	January 1, 2017 - February 28, 2017			

*7/1/2016 - 12/31/2016

SCHEDULE C3
SERVICE LEAGUE OF SAN MATEO COUNTY
FEE FOR SERVICE AGGREGATE RATE TABLE
JULY 1, 2016 - FEBRUARY 28, 2017

Funding Source & Services	Aggregate Maximum for all Providers	Unit Rate
Realignment Drug Court	$203,113	
Residential		$100.00 per day
Drug Testing/Urine Analysis		$30.00 per screening
Individual & Family Therapy		$2.61 per minute
Sober Living Environment		$25.00 per day
Unified Reentry	$416,908	
Residential		$100.00 per day
Drug Testing/Urine Analysis		$30.00 per screening
Individual & Family Therapy		$2.61 per minute
Sober Living Environment		$25.00 per day
Criminal Justice Realignment	$185,919	
Residential		$100.00 per day
Drug Testing/Urine Analysis		$30.00 per screening
Individual & Family Therapy		$2.61 per minute
Sober Living Environment		$25.00 per day
TOTAL	$805,940	

Attachment B – Substance Abuse and Prevention Treatment Block Grant and Drug MediCal Requirements

Contractor agrees to comply with the Substance Use Disorder Treatment and Drug MediCal Organized Delivery System requirements, as referenced in the Department of Health Care Services Intergovernmental Agreement for substance use disorder (SUD) services located at http://www.smchealth.org/general-information/program-standards-and-business-requirements. The following are highlighted to ensure compliance with new/revised reporting requirements. Licensed and/or Certified SUD and Drug MediCal (DMC) Contractors shall agree to the following:

1. Reporting
   Contractor shall report to their assigned BHRS Analyst within two (2) business days, the following items:
   a. Additions and/or changes in the DMC/SUD application previously submitted for certification. Contractor shall work in partnership with BHRS and report to Department of Health Care Services (DHCS) updates or the resubmission of a complete DMC SUD application relative to SUD or DMC reporting requirements;
   b. Written notification from a DMC/SUD facility that surrendered certification or announcement of a facility closure; and/or
   c. Any DMC/SUD recertification event, which may include: change in ownership; change in management; change in scope of services; remodeling of facility; or change in location.

2. Reduction or Relocation of Covered Services
   a. Contractor shall work in partnership with BHRS on any reduction of covered services or relocation proposals to DHCS.
   b. Contractor shall not implement any changes until approved by DHCS.
   c. Contractor shall notify BHRS of any proposal that changes the location where DMC covered services are provided, or reduces availability of services within ninety (90) days, prior to the proposed effective date.
   d. Contractor shall not implement proposed changes prior to DHCS approval. Contractor shall not implement the proposed changes if the State denies their DMC proposal.

3. Post Service Post Payment
   a. Annually, DHCS shall monitor Contractors' compliance with Post Service Post Payment (PSPP) utilization review requirements in accordance with Title 22 Section 51341.1. Rendered and/or paid DMC services are subject to a compliance review to ensure all applicable standards, regulations and program coverage requirements are met.
   b. Contractor shall notify BHRS Analyst/Supervisor at the time of a PSPP review from DHCS.
   c. If programmatic or fiscal deficiencies are identified, Contractor shall be required to submit a Corrective Action Plan (CAP) to BHRS for approval. All deficiencies identified in the PSPP review, whether or not this results in a recovery of funds, must be corrected. BHRS will submit the CAP to the DHCS PSPP Unit within sixty (60) days of the date of the PSSP report.
      The plan shall address:

1. Each demand for recovery of payment and/or programmatic deficiency;
2. Provide a specific description of how the deficiency shall be corrected;
3. Specify the date of implementation of the corrective action; and
4. Identify who will be responsible for correction and who will be responsible for on-going compliance.

d. DHCS will provide BHRS written approval of the CAP, with a copy to the Contractor. If the CAP is denied, DHCS will: provide guidance on the deficient areas; request an updated CAP from BHRS with a copy to the Contractor, and provide a new deadline for submission.

e. If the Contractor does not submit a CAP, or does not implement the approved CAP provisions within the designated timeline, BHRS may withhold funds until the Contractor is compliant. BHRS shall notify Contractor within thirty (30) days, prior to funds being withheld. (DMC)

4. Utilization Reviews
BHRS shall conduct an annual on-site programmatic and fiscal audit of DMC and SUD certified providers to assure an appropriate rendering of all services. All audit reports will be submitted to DHCS within two (2) weeks of audit completion. (DMC & SUD)

5. Notification to BHRS
Contractor shall notify the BHRS Analyst immediately if a DHCS division inspects, or reviews the Contractor's facility. Contractor shall submit copies of any DHCS reports, Corrective Action Plans, statement, or evaluation of the Contractor's facility and/or program to BHRS.

Contractor has read and agrees with the terms and conditions, and will comply with all Attachment B requirements under the Substance Use Disorder Treatment and Drug MediCal Organized Delivery System.

Karen Francone
Contractor Signature

Executive Director
Title of Authorized Official

12-8-2016
Date

ATTACHMENT L – DHCS LEGAL AND REGULATORY REQUIREMENTS

Contractor and staff are required to know and implement all federal, state and local legal and regulatory requirements that pertain to the provision of DHCS services.

	42 CFR	PUBLIC HEALTH
	Part 431 (Single state agency	A single state agency will be assigned to manage this contract. For California it is DHCS.
	431.107 (record keeping)	Provider Agreement required. Provide the fraud control unit any information regarding payments claimed by the provider for furnishing services.
	438	MANAGED CARE
Not applicable to the DMC-ODS waiver	438.104	Marketing activities
	438.114	Emergency post stabilization services
	438.116	Solvency standards
	438.206(b)(2)	Women's Health Services
	438.208(c)(1)	Individuals with special health care needs
	438.6(i)	Advanced directives
	438.210 (Managed care definitions) Covered services	Managed Care (Managed Care Organization, Prepaid Inpatient Health Plan, & Prepaid Ambulatory Health Plans) must specify the amount, duration, and scope of each service to assure that that the services are set reasonably to achieve the purpose for which services are furnished. May not arbitrarily reduce or deny services solely because of diagnosis, type of illness, or condition of a beneficiary. *1
	455 (Program Integrity: Medicaid)	Disclosure of Information by Providers and Fiscal Agents.
	455.101	Definitions of Agent, hospital, MediCare Intermediary, carrier, Health Insuring Organization, Managed Care Entity (MCE),MCO, PIHP, FPHP, PCCM and HIO's; ownership, controlling interest, indirect ownership, subcontractor, supplier, termination, & fraud.
	455.104	Disclosure by Medicaid providers and fiscal agents: of information on ownership and control, the means of providing identifications (SSN, DOB, address, etc..); relationships; when disclosures are due: application, renewal, upon investigation, etc....
	455.23	Suspension of payments in case of fraud. Payments can be suspended upon the initiation of a fraud investigation.
	455.34	
	455.450(c) program integrity)	Provide screening levels for Medicaid Providers and conduct screening at the level of assessed risk. Limited, moderate, or high.
	Part 8 (Medicated	Accreditation, responsibilities, evaluation, and withdrawal of accreditation. Certification and treatment standards.

ATTACHMENT L – DHCS LEGAL AND REGULATORY REQUIREMENTS

Contractor and staff are required to know and implement all federal, state and local legal and regulatory requirements that pertain to the provision of DHCS services.

	assisted treatment for opioid use disorder)	Procedures for review of suspension or proposed revocation of OTP certification, and of adverse action regarding withdrawal of approval of an accreditation body. Authorization to increase patient limit to 275.
	Part 2	Confidentiality of alcohol and drug abuse patient records.
CFR Title 21		Food and drug administration, Department of Health and Human services
	1300 et seg	Drug Enforcement Administration, Department of Justice. Quotas, records and reports of registrants, schedule I and II controlled substances, prescriptions, administrative functions, practices, and procedures.
W& I		WELFARE AND INSTITUTIONS CODE
	Chapter 7	BASIC HEALTH CARE
	14000 et seq	General provisions. The purpose of this chapter is to afford to qualifying individuals health care and related remedial or preventive services, including related social services which are necessary for those receiving health care under this chapter.
	14021.51-.53 14043.1	The department shall establish a NRT dosing fee for methadone and LAAM. Only covered services are eligible for reimbursement. Financial evaluation form instructions.
	14043.27	Termination of provisional provider status and preferred provisional provider status.
	14043.36	The department shall not enroll any applicant that has been convicted of any felony or misdemeanor involving fraud or abuse in any government program.
	14043.6	The department shall automatically suspend any entity upon the loss, revocation, suspension of their license or certificate.
	14043.61	A provider shall be subject to suspension if claims are submitted by entities listed on the suspended and ineligible provider list or any list published by the Federal Office of Inspector General.
	14100.2	California Privacy Law.
	14107.11	Upon receipt of a credible allegation of fraud for which an investigation is pending the provider shall be temporarily placed under payment suspension unless there is a good cause exception.
	14124.20-.25	The department may enter into a DMC Treatment

ATTACHMENT L – DHCS LEGAL AND REGULATORY REQUIREMENTS

Contractor and staff are required to know and implement all federal, state and local legal and regulatory requirements that pertain to the provision of DHCS services.

		Program contract with each county for the provision of AOD services within the county service area or the department can enter into contracts with individual providers. Defines reimbursable services including NTP and Perinatal Services. Goes into FFP and county funding, cost reports, criminal investigations, fair hearings, DMC's toll free number.
H& S		Health and Safety
	11848.5 a &b	(a) Once the negotiated rate with service providers has been approved by the county, all participating governmental funding sources, except the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), shall be bound to that rate as the cost of providing all or part of the total county alcohol and other drug program as described in the county contract for each fiscal year to the extent that the governmental funding sources participate in funding the county alcohol and other drug program. Where the State Department of Health Services adopts regulations for determining reimbursement of alcohol and other drug program services formerly allowable under the Short-Doyle program and reimbursed under the Medi-Cal Act, those regulations shall be controlling only as to the rates for reimbursement of alcohol and other drug program services allowable under the Medi-Cal program and rendered to Medi-Cal beneficiaries. Providers under this section shall report to the department and the county any information required by the department in accordance with the procedures established by the director of the department. (b) The Legislature recognizes that alcohol and other drug abuse services differ from mental health services provided through the State Department of Health Care Services and therefore should not necessarily be bound by rate determination methodology used for reimbursement of those services formerly provided under the Short-Doyle program and reimbursed under the Medi-Cal Act.
CCR		California Code of Regulations
	Title 22	Social Security
	Division 3,	Health Care Services

ATTACHMENT L – DHCS LEGAL AND REGULATORY REQUIREMENTS

Contractor and staff are required to know and implement all federal, state and local legal and regulatory requirements that pertain to the provision of DHCS services.

Chapter 51000 et seq	Counselor Certifications and allowed activities.
51341.1	Description of SUD Services
51490.1	Description of SUD Claim Submission
51516.1	Reimbursement rate methodology and baseline rates
Title 9	Rehabilitation and Developmental Services
Division 4	Department of Alcohol and Drug Programs

*1 - 438.210 (Managed Care definitions) Covered services§438.210 Coverage and authorization of services.

(a) *Coverage.* Each contract between a State and an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(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 FFS Medicaid, as set forth in §440.230 of this chapter, and for enrollees under the age of 21, as set forth in subpart B of part 440 of this chapter.

(3) Provide that the MCO, PIHP, or PAHP—

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

(ii) 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.

(4) Permit an MCO, PIHP, or PAHP to 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 that—

(A) The services furnished can reasonably achieve their purpose, as required in paragraph (a)(3)(i) of this section;

(B) The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and

(C) Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with §441.20 of this chapter.

(5) Specify what constitutes "medically necessary services" in a manner that—

(i) Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services that address:

(A) The prevention, diagnosis, and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability.

(B) The ability for an enrollee to achieve age-appropriate growth and development.

(C) The ability for an enrollee to attain, maintain, or regain functional capacity.

(D) The opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

(b) *Authorization of services.* For the processing of requests for initial and continuing authorizations of services, each contract must require—

ATTACHMENT L – DHCS LEGAL AND REGULATORY REQUIREMENTS

Contractor and staff are required to know and implement all federal, state and local legal and regulatory requirements that pertain to the provision of DHCS services.

(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP—

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

(ii) Consult with the requesting provider for medical services when appropriate.

(iii) Authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan.

(3) That 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 an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

(c) *Notice of adverse benefit determination.* Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs, PIHPs, and PAHPs, the enrollee's notice must meet the requirements of §438.404.

(d) *Timeframe for decisions.* Each MCO, PIHP, or PAHP contract must provide for the following decisions and notices:

(1) *Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously as the enrollee's condition requires and within State-established timeframes that may not 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 enrollee, or the provider, requests extension; or

(ii) The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(2) *Expedited authorization decisions.* (i) For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.

(ii) The MCO, PIHP, or PAHP may extend the 72 hour time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(3) *Covered outpatient drug decisions.* For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Act.

ATTACHMENT L – DHCS LEGAL AND REGULATORY REQUIREMENTS

Contractor and staff are required to know and implement all federal, state and local legal and regulatory requirements that pertain to the provision of DHCS services.

(e) *Compensation for utilization management activities.* Each contract between a State and MCO, PIHP, or PAHP must provide that, consistent with §438.3(i), and §422.208 of this chapter, 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 enrollee.

(f) *Applicability date.* This section applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2017. Until that applicability date, states are required to continue to comply with §438.210 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.