

**AGREEMENT BETWEEN THE COUNTY OF SAN MATEO
AND ADDICTION RESEARCH AND TREATMENT, INC.**

This Agreement is entered into this _____ day of _____, 20____, by and between the County of San Mateo, a political subdivision of the state of California, hereinafter called "County," and Addiction Research and Treatment, Inc. (ART), hereinafter called "Contractor."

* * *

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

Whereas, it is necessary and desirable that Contractor be retained for the purpose of professional services.

Now, therefore, it is agreed by the parties to this Agreement as follows:

1. Exhibits and Attachments

The following exhibits and attachments are attached to this Agreement and incorporated into this Agreement by this reference:

- Exhibit A—Services
- Exhibit B—Payments and Rates
- Attachment B—Substance Abuse and Prevention Treatment Block Grant and Drug MediCal Requirements
- Attachment C—Election of the Third-Party Billing Process
- Attachment D—Payor Financial Form
- Attachment E—Fingerprinting Certification
- Attachment I—§ 504 Compliance
- Attachment L—DHCS Legal and Regulatory Requirements

2. Services to be performed by Contractor

In consideration of the payments set forth in this Agreement and in Exhibit B, Contractor shall perform services for County in accordance with the terms, conditions, and specifications set forth in this Agreement and in Exhibit A.

3. Payments

In consideration of the services provided by Contractor in accordance with all terms, conditions, and specifications set forth in this Agreement and in Exhibit A, County shall

make payment to Contractor based on the rates and in the manner specified in Exhibit B. County reserves the right to withhold payment if County determines that the quantity or quality of the work performed is unacceptable. In no event shall County's total fiscal obligation under this Agreement exceed FOUR MILLION ONE HUNDRED FIVE THOUSAND NINE HUNDRED THIRTY DOLLARS (\$4,105,930). In the event that the County makes any advance payments, Contractor agrees to refund any amounts in excess of the amount owed by the County at the time of contract termination or expiration. Contractor is not entitled to payment for work not performed as required by this agreement.

4. Term

Subject to compliance with all terms and conditions, the term of this Agreement shall be from July 1, 2019 through June 30, 2021.

5. Termination

This Agreement may be terminated by Contractor or by the Chief of San Mateo County Health or his/her designee at any time without a requirement of good cause upon thirty (30) days' advance written notice to the other party. Subject to availability of funding, Contractor shall be entitled to receive payment for work/services provided prior to termination of the Agreement. Such payment shall be that prorated portion of the full payment determined by comparing the work/services actually completed to the work/services required by the Agreement.

County may terminate this Agreement or a portion of the services referenced in the Attachments and Exhibits based upon the unavailability of Federal, State, or County funds by providing written notice to Contractor as soon as is reasonably possible after County learns of said unavailability of outside funding.

6. Contract Materials

At the end of this Agreement, or in the event of termination, all finished or unfinished documents, data, studies, maps, photographs, reports, and other written materials (collectively referred to as "contract materials") prepared by Contractor under this Agreement shall become the property of County and shall be promptly delivered to County. Upon termination, Contractor may make and retain a copy of such contract materials if permitted by law.

7. Relationship of Parties

Contractor agrees and understands that the work/services performed under this Agreement are performed as an independent contractor and not as an employee of

County and that neither Contractor nor its employees acquire any of the rights, privileges, powers, or advantages of County employees.

8. Hold Harmless

a. General Hold Harmless

Contractor shall indemnify and save harmless County and its officers, agents, employees, and servants from all claims, suits, or actions of every name, kind, and description resulting from this Agreement, the performance of any work or services required of Contractor under this Agreement, or payments made pursuant to this Agreement brought for, or on account of, any of the following:

- (A) injuries to or death of any person, including Contractor or its employees/officers/agents;
- (B) damage to any property of any kind whatsoever and to whomsoever belonging;
- (C) any sanctions, penalties, or claims of damages resulting from Contractor's failure to comply, if applicable, with the requirements set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all Federal regulations promulgated thereunder, as amended; or
- (D) any other loss or cost, including but not limited to that caused by the concurrent active or passive negligence of County and/or its officers, agents, employees, or servants. However, Contractor's duty to indemnify and save harmless under this Section shall not apply to injuries or damage for which County has been found in a court of competent jurisdiction to be solely liable by reason of its own negligence or willful misconduct.

The duty of Contractor to indemnify and save harmless as set forth by this Section shall include the duty to defend as set forth in Section 2778 of the California Civil Code.

9. Assignability and Subcontracting

Contractor shall not assign this Agreement or any portion of it to a third party or subcontract with a third party to provide services required by Contractor under this Agreement without the prior written consent of County. Any such assignment or subcontract without County's prior written consent shall give County the right to automatically and immediately terminate this Agreement without penalty or advance notice.

10. Insurance

a. General Requirements

Contractor shall not commence work or be required to commence work under this Agreement unless and until all insurance required under this Section has been obtained and such insurance has been approved by County's Risk Management, and Contractor shall use diligence to obtain such insurance and to obtain such approval. Contractor shall furnish County with certificates of insurance evidencing the required coverage, and there shall be a specific contractual liability endorsement extending Contractor's coverage to include the contractual liability assumed by Contractor pursuant to this Agreement. These certificates shall specify or be endorsed to provide that thirty (30) days' notice must be given, in writing, to County of any pending change in the limits of liability or of any cancellation or modification of the policy.

b. Workers' Compensation and Employer's Liability Insurance

Contractor shall have in effect during the entire term of this Agreement workers' compensation and employer's liability insurance providing full statutory coverage. In signing this Agreement, Contractor certifies, as required by Section 1861 of the California Labor Code, that (a) it is aware of the provisions of Section 3700 of the California Labor Code, which require every employer to be insured against liability for workers' compensation or to undertake self-insurance in accordance with the provisions of the Labor Code, and (b) it will comply with such provisions before commencing the performance of work under this Agreement.

c. Liability Insurance

Contractor shall take out and maintain during the term of this Agreement such bodily injury liability and property damage liability insurance as shall protect Contractor and all of its employees/officers/agents while performing work covered by this Agreement from any and all claims for damages for bodily injury, including accidental death, as well as any and all claims for property damage which may arise from Contractor's operations under this Agreement, whether such operations be by Contractor, any subcontractor, anyone directly or indirectly employed by either of them, or an agent of either of them. Such insurance shall be combined single limit bodily injury and property damage for each occurrence and shall not be less than the amounts specified below:

| | |
|--|-------------|
| (a) Comprehensive General Liability... | \$1,000,000 |
| (b) Motor Vehicle Liability Insurance... | \$1,000,000 |
| (c) Professional Liability..... | \$1,000,000 |

County and its officers, agents, employees, and servants shall be named as additional insured on any such policies of insurance, which shall also contain a provision that (a) the insurance afforded thereby to County and its officers, agents, employees, and servants shall be primary insurance to the full limits of liability of the policy and (b) if the County or its officers, agents, employees, and servants have other insurance against the loss covered by such a policy, such other insurance shall be excess insurance only.

In the event of the breach of any provision of this Section, or in the event any notice is received which indicates any required insurance coverage will be diminished or canceled, County, at its option, may, notwithstanding any other provision of this Agreement to the contrary, immediately declare a material breach of this Agreement and suspend all further work and payment pursuant to this Agreement.

11. Compliance With Laws

All services to be performed by Contractor pursuant to this Agreement shall be performed in accordance with all applicable Federal, State, County, and municipal laws, ordinances, and regulations, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Federal Regulations promulgated thereunder, as amended (if applicable), the Business Associate requirements set forth in Attachment H (if attached), the Americans with Disabilities Act of 1990, as amended, and Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination on the basis of disability in programs and activities receiving any Federal or County financial assistance. Such services shall also be performed in accordance with all applicable ordinances and regulations, including but not limited to appropriate licensure, certification regulations, provisions pertaining to confidentiality of records, and applicable quality assurance regulations. In the event of a conflict between the terms of this Agreement and any applicable State, Federal, County, or municipal law or regulation, the requirements of the applicable law or regulation will take precedence over the requirements set forth in this Agreement.

Further, Contractor certifies that it and all of its subcontractors will adhere to all applicable provisions of Chapter 4.106 of the San Mateo County Ordinance Code, which regulates the use of disposable food service ware. Accordingly, Contractor shall not use any non-recyclable plastic disposable food service ware when providing prepared food on property owned or leased by the County and instead shall use biodegradable, compostable, reusable, or recyclable plastic food service ware on property owned or leased by the County.

Contractor will timely and accurately complete, sign, and submit all necessary documentation of compliance.

12. Non-Discrimination and Other Requirements

a. General Non-discrimination

No person shall be denied any services provided pursuant to this Agreement (except as limited by the scope of services) on the grounds of race, color, national origin, ancestry, age, disability (physical or mental), sex, sexual orientation, gender identity, marital or domestic partner status, religion, political beliefs or affiliation, familial or parental status (including pregnancy), medical condition (cancer-related), military service, or genetic information.

b. Equal Employment Opportunity

Contractor shall ensure equal employment opportunity based on objective standards of recruitment, classification, selection, promotion, compensation, performance evaluation, and management relations for all employees under this Agreement. Contractor's equal employment policies shall be made available to County upon request.

c. Section 504 of the Rehabilitation Act of 1973

Contractor shall comply with Section 504 of the Rehabilitation Act of 1973, as amended, which provides that no otherwise qualified individual with a disability shall, solely by reason of a disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination in the performance of any services this Agreement. This Section applies only to contractors who are providing services to members of the public under this Agreement.

d. Compliance with County's Equal Benefits Ordinance

Contractor shall comply with all laws relating to the provision of benefits to its employees and their spouses or domestic partners, including, but not limited to, such laws prohibiting discrimination in the provision of such benefits on the basis that the spouse or domestic partner of the Contractor's employee is of the same or opposite sex as the employee.

e. Discrimination Against Individuals with Disabilities

The nondiscrimination requirements of 41 C.F.R. 60-741.5(a) are incorporated into this Agreement as if fully set forth here, and Contractor and any subcontractor shall abide by the requirements of 41 C.F.R. 60-741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities.

f. History of Discrimination

Contractor certifies that no finding of discrimination has been issued in the past 365 days against Contractor by the Equal Employment Opportunity Commission, the California Department of Fair Employment and Housing, or any other investigative entity. If any finding(s) of discrimination have been issued against Contractor within the past 365 days by the Equal Employment Opportunity Commission, the California Department of Fair Employment and Housing, or other investigative entity, Contractor shall provide County with a written explanation of the outcome(s) or remedy for the discrimination prior to execution of this Agreement. Failure to comply with this Section shall constitute a material breach of this Agreement and subjects the Agreement to immediate termination at the sole option of the County.

g. Reporting; Violation of Non-discrimination Provisions

Contractor shall report to the County Manager the filing in any court or with any administrative agency of any complaint or allegation of discrimination on any of the bases prohibited by this Section of the Agreement or the Section titled "Compliance with Laws". Such duty shall include reporting of the filing of any and all charges with the Equal Employment Opportunity Commission, the California Department of Fair Employment and Housing, or any other entity charged with the investigation or adjudication of allegations covered by this subsection within 30 days of such filing, provided that within such 30 days such entity has not notified Contractor that such charges are dismissed or otherwise unfounded. Such notification shall include a general description of the circumstances involved and a general description of the kind of discrimination alleged (for example, gender-, sexual orientation-, religion-, or race-based discrimination).

Violation of the non-discrimination provisions of this Agreement shall be considered a breach of this Agreement and subject the Contractor to penalties, to be determined by the County Manager, including but not limited to the following:

- i. termination of this Agreement;
- ii. disqualification of the Contractor from being considered for or being awarded a County contract for a period of up to 3 years;
- iii. liquidated damages of \$2,500 per violation; and/or
- iv. imposition of other appropriate contractual and civil remedies and sanctions, as determined by the County Manager.

To effectuate the provisions of this Section, the County Manager shall have the authority to offset all or any portion of the amount described in this Section against amounts due to Contractor under this Agreement or any other agreement between Contractor and County.

h. Compliance with Living Wage Ordinance

As required by Chapter 2.88 of the San Mateo County Ordinance Code, Contractor certifies all contractor(s) and subcontractor(s) obligated under this contract shall fully comply with the provisions of the County of San Mateo Living Wage Ordinance, including, but not limited to, paying all Covered Employees the current Living Wage and providing notice to all Covered Employees and Subcontractors as required under the Ordinance.

13. Compliance with County Employee Jury Service Ordinance

Contractor shall comply with Chapter 2.85 of the County's Ordinance Code, which states that Contractor shall have and adhere to a written policy providing that its employees, to the extent they are full-time employees and live in San Mateo County, shall receive from the Contractor, on an annual basis, no fewer than five days of regular pay for jury service in San Mateo County, with jury pay being provided only for each day of actual jury service. The policy may provide that such employees deposit any fees received for such jury service with Contractor or that the Contractor may deduct from an employee's regular pay the fees received for jury service in San Mateo County. By signing this Agreement, Contractor certifies that it has and adheres to a policy consistent with Chapter 2.85. For purposes of this Section, if Contractor has no employees in San Mateo County, it is sufficient for Contractor to provide the following written statement to County: "For purposes of San Mateo County's jury service ordinance, Contractor certifies that it has no full-time employees who live in San Mateo County. To the extent that it hires any such employees during the term of its Agreement with San Mateo County, Contractor shall adopt a policy that complies with Chapter 2.85 of the County's Ordinance Code." The requirements of Chapter 2.85 do not apply if this Agreement's total value listed in the Section titled "Payments", is less than one-hundred thousand dollars (\$100,000), but Contractor acknowledges that Chapter 2.85's requirements will apply if this Agreement is amended such that its total value meets or exceeds that threshold amount.

14. Retention of Records; Right to Monitor and Audit

(a) Contractor shall maintain all required records relating to services provided under this Agreement for three (3) years after County makes final payment and all other pending matters are closed, and Contractor shall be subject to the examination and/or audit by County, a Federal grantor agency, and the State of California.

(b) Contractor shall comply with all program and fiscal reporting requirements set forth by applicable Federal, State, and local agencies and as required by County.

(c) Contractor agrees upon reasonable notice to provide to County, to any Federal or State department having monitoring or review authority, to County's authorized representative, and/or to any of their respective audit agencies access to and the right to examine all records and documents necessary to determine compliance with relevant Federal, State, and local statutes, rules, and regulations, to determine compliance with this Agreement, and to evaluate the quality, appropriateness, and timeliness of services performed.

15. Merger Clause; Amendments

This Agreement, including the Exhibits and Attachments attached to this Agreement and incorporated by reference, constitutes the sole Agreement of the parties to this Agreement and correctly states the rights, duties, and obligations of each party as of this document's date. In the event that any term, condition, provision, requirement, or specification set forth in the body of this Agreement conflicts with or is inconsistent with any term, condition, provision, requirement, or specification in any Exhibit and/or Attachment to this Agreement, the provisions of the body of the Agreement shall prevail. Any prior agreement, promises, negotiations, or representations between the parties not expressly stated in this document are not binding. All subsequent modifications or amendments shall be in writing and signed by the parties.

16. Controlling Law; Venue

The validity of this Agreement and of its terms, the rights and duties of the parties under this Agreement, the interpretation of this Agreement, the performance of this Agreement, and any other dispute of any nature arising out of this Agreement shall be governed by the laws of the State of California without regard to its choice of law or conflict of law rules. Any dispute arising out of this Agreement shall be venued either in the San Mateo County Superior Court or in the United States District Court for the Northern District of California.

17. Notices

Any notice, request, demand, or other communication required or permitted under this Agreement shall be deemed to be properly given when both: (1) transmitted via facsimile to the telephone number listed below or transmitted via email to the email address listed below; and (2) sent to the physical address listed below by either being deposited in the United States mail, postage prepaid, or deposited for overnight delivery, charges prepaid, with an established overnight courier that provides a tracking number showing confirmation of receipt.

In the case of County, to:

Name/Title: Diana Hill, Health Services Manager I
Address: 310 Harbor Blvd., Building E, Belmont, CA 94002
Telephone: (650) 802-6429
Facsimile: (650) 802-6440
Email: dhill@smcgov.org

In the case of Contractor, to:

Name/Title: Daniel Gutschenritter / Chief Financial Officer
Address: 1720 Lakepointe Drive, Suite 117, Lewisville, Tx 75057
Telephone: (214) 379-3302
Email: dgutschenritter@baymark.com

18. Electronic Signature

Both County and Contractor wish to permit this Agreement and future documents relating to this Agreement to be digitally signed in accordance with California law and County's Electronic Signature Administrative Memo. Any party to this Agreement may revoke such agreement to permit electronic signatures at any time in relation to all future documents by providing notice pursuant to this Agreement.

19. Payment of Permits/Licenses

Contractor bears responsibility to obtain any license, permit, or approval required from any agency for work/services to be performed under this Agreement at Contractor's own expense prior to commencement of said work/services. Failure to do so will result in forfeit of any right to compensation under this Agreement.

* * *

In witness of and in agreement with this Agreement's terms, the parties, by their duly authorized representatives, affix their respective signatures:

COUNTY OF SAN MATEO

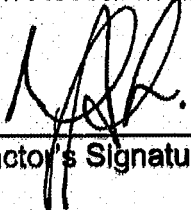
By: _____
President, Board of Supervisors, San Mateo County

Date: _____

ATTEST:

By: _____
Clerk of Said Board

Addition Research and Treatment, Inc.



Contractor's Signature

Date: 8.15.19

EXHIBIT A – SCOPE OF WORK
ADDICTION RESEARCH & TREATMENT INC.
FY 2019 – 2021

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

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

I. DESCRIPTION OF SERVICES TO BE PERFORMED BY CONTRACTOR

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

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

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

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

Services will include the following:

1. Physician Consultation

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

2. Recovery Services

Recovery Services shall be provided to clients following completion of treatment, when medically necessary. Recovery services may be provided face-to-face or by telephone with the client, in any appropriate setting in the community. Recovery services shall include:

- a. Periodic outpatient counseling services in the form of individual or group counseling as needed to stabilize the client and reassess if client is in need of further care;
- b. Recovery coaching, monitoring via telephone and internet;
- c. Peer-to-peer services and relapse prevention;
- d. Linkages to life skills, employment services, job training, and education services;
- e. Linkages to childcare, parent education, child development support services, family/marriage education;
- f. Linkages to self-help and support, spiritual and faith-based support; and
- g. Linkages to housing assistance, transportation, case management, individual services coordination.
- h. Avatar service codes for Recovery Services are:

| Service Description | Service Code |
|-----------------------|--------------|
| Individual Counseling | AD501ODSRSI |

| | |
|---------------------|--------------|
| Group Counseling | AD502ODSRSG |
| Case Management | AD503ODSRSCM |
| Recovery Monitoring | AD504ODSRSRM |

3. Opioid (Narcotic) Treatment Services

- a. Contractor shall offer and prescribe medications to clients covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone, and disulfiram.
- b. Services provided shall include: intake, individual and group counseling, patient education; medication services; collateral services; crisis intervention services; treatment planning; medical psychotherapy; and discharge planning and care coordination. Avatar service codes for Opioid (Narcotic) Treatment Services are:

| Service Description | Service Codes |
|-----------------------|---------------|
| Methadone Dosing | AD401ODS |
| | AD401ODSPERI |
| Individual Counseling | AD402ODS |
| | AD402ODSPERI |
| Group Counseling | AD403ODS |
| | AD403ODSPERI |

- i. Clients shall receive a minimum of fifty (50) minutes and a maximum of two hundred (200) minutes of counseling per calendar month with a therapist or counselor. When medically necessary, additional counseling services may be provided.
- c. Contractor's physicians may provide medically necessary treatment of concurrent health conditions to Medi-Cal beneficiaries without a primary care physician as long as services are within the scope of the provider's practice, pursuant to W&I Code Section 14124.22, and as long as they fall within the limits of Medi-Cal coverage. If the beneficiary is receiving health care services from a primary care physician, Contractor's physician shall refer Medi-Cal beneficiaries to that respective primary care physician for treatment of concurrent health conditions.

When medically necessary treatment of concurrent health conditions not part of the SUD treatment reimbursement pursuant to W&I Code Section 14021.51, the services rendered will be reimbursed in accordance with the Medi-Cal

program. Reimbursable services shall include all of the following:

- i. Medical treatment visits;
 - ii. Diagnostic blood, urine, and X-rays;
 - iii. Psychological and psychiatric tests and services;
 - iv. Quantitative blood and urine toxicology assays; and
 - v. Medical supplies.
 - vi. Contractor shall not seek reimbursement from the beneficiary for treatment of concurrent health conditions.
- d. Services shall be provided in accordance with the beneficiary's individualized treatment plan as determined by a licensed prescriber.

4. Community-Based Services

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

- a. All service locations shall comply with 42 CFR Part 2, and client confidentiality shall be maintained.
- b. Contractor may provide services in multiple community settings. However, Contractor's staff may not be assigned a primary worksite that is not DMC certified without informing BHRS QM and BHRS AOD Administration. Contractor may be required to apply for DMC certification and SUDS licensure for that setting.

5. Telehealth

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

- a. The professional determining medical necessity is located onsite, and the client receiving the services is located remotely.
- b. All telehealth equipment and service locations comply with 42 CFR Part 2, and client confidentiality is maintained.

6. Additional DMC-ODS Services Required

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

| Service Description | Service Code |
|--------------------------|---|
| | |
| Recovery Residences | AD96 |
| | AD997 – when client is on a leave of absence |
| Sober Living Environment | AD95 |
| Sobering Station | N/A - Sobering Station episodes are not entered into Avatar |

7. Contractor Requirements

a. Licensure/Agency

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

- i. Title 21, CFR Part 1300, et seq.,
- ii. Title 42, CFR, Part 8;
- iii. Drug Medi-Cal Organized Delivery System Special Terms and Conditions
- iv. Title 22, CCR, Sections 51341.1, 51490.1, and 51516.1;
- v. DHCS Alcohol and/or Other Drug Program Certification Standards;
- vi. Title 9, CCR, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq.; and

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

b. Staffing Requirements

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

i. Professional staff must be licensed, registered, certified or recognized under California scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. A Licensed Practitioner of the Healing Arts (LPHA) includes the following:

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

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

Contractor shall comply with HSC Section 11833(b)(1): Any individual who provides counseling services in a licensed or certified alcohol and other drug (AOD)

program, except for licensed professionals, must be registered or certified with a DHCS approved certifying organization prior to providing counseling services.

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

- iii. Professional and Non-Professional staff shall have appropriate experience and all necessary training at the time of hiring.
- iv. Registered and certified SUD counselors providing treatment services shall adhere to all certification requirements in the CCR Title 9, Division 4, Chapter 8 and HSC Section 11833 (b)(1).
- v. Prior to delivery of services under this Agreement, Contractor shall employ a Medical Director enrolled with DHCS under applicable state regulations, screened as a limited categorical risk within one (1) year prior to serving as Medical Director in accordance with 42CFR455.50(a), and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107.
- vi. All staff of Contractor shall undergo fingerprint background checks prior to hiring or service delivery, whichever comes first in accordance with CFR 455.34.
- vii. Prior to the delivery of services, all treatment staff shall be trained in ASAM criteria, which consists of two e-training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care".

c. Other Requirements

Contractor shall comply with all DHCS DMC-ODS mandated reporting requirements, and is required to inform BHRS QM

and BHRS Program Analyst within forty-eight (48) hours after an occurrence, of the following:

- i. Leadership or staffing changes.
- ii. Organizational and/or corporate structure changes (example: conversion to non-profit status).
- iii. Changes in the type of services being provided at that location; day treatment or medication support services when medications are administered or dispensed from the provider site.
- iv. Significant changes in the physical plant of the provider site (some physical plant changes could require a new fire or zoning clearance).
- v. Change of ownership or location.
- vi. Complaints regarding the provider

8. Client Eligibility

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

transient in San Mateo County. A statement of verification shall be kept in the client's file.

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

d. Medical Necessity

- i. Medical necessity shall be determined by the Medical Director, licensed physician, or LPHA. After establishing a DSM-V diagnosis, the diagnosing professional shall apply ASAM criteria to determine the appropriate level of care for placement.
- ii. Medical necessity for adults age twenty-one (21) and over is determined by the following:
 - 1) The individual has at least one (1) substance-related diagnosis from the DSM-V, excluding tobacco-related disorders.
 - 2) The individual meets the ASAM Criteria definition of medical necessity to receive services.
- iii. Medical necessity for youth and adults under the age of twenty-one (21) is determined by the following:
 - 1) The individual is assessed to be at risk for developing a substance use disorder, and
 - 2) The individual meets the ASAM Criteria definition of medical necessity for adolescent services.
- iv. Medical necessity shall be re-evaluated and re-determined at each Treatment Plan update, each Level of Care change, and at least once every six (6) months for the duration of treatment services.
 - 1) Narcotic Treatment Programs/Opioid Treatment Programs shall re-evaluate and re-determine medical necessity at least annually for the duration of treatment services.

9. Timely Access to Service

- a. Contractor shall deliver the client's first appointment for for NTP services within twenty-four (24) hours of the initial request.
- b. Contractor shall ensure that a client experiencing a medical or psychiatric emergency will be transported to the nearest hospital for treatment.
- c. Contractor shall advise clients in the program of the County's twenty-four (24) hour on-call Access Call Center. Contractor shall advise clients how to receive treatment or other covered services after hours, weekends and holidays.
- d. Contractor's hours of operation shall be no less than the hours of operation to non-Medi-Cal clients.

10. Coordination of Care

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

- a. Contractor shall ensure coordination and continuity of care within the standards in accordance with 42 CFR 438.208.
- b. Contractor shall ensure that through the course of coordinating care, the client's privacy is protected in accordance with all Federal and State privacy laws, including but not limited to 45 CFR 160 and 164, to the extent that such provisions are applicable.
- c. Contractor shall ensure that female and transgender male clients have direct access to a women's health specialist, to provide routine and preventive health care services necessary, within the network for covered care. This is in addition to the clients designated source of primary care if that source is not a women's health specialist, pursuant to 42 CFR 438.206(b)(2).

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

11. Sharing Information with Clients

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

- a. The client's health status, medical care or treatment options including any alternative treatment that may be self-administered.
- b. Any information the client needs in order to decide among all relevant treatment options,
- c. The risks, benefits and consequences of treatment or non-treatment,
- d. The clients' right to participate in decisions regarding his/her healthcare including the right to refuse treatment and to express preference regarding future treatment decisions.

12. Laboratory Requirements

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

B. Non-Drug MediCal Organized Delivery System Services

Contractor shall provide substance use disorder (SUD) treatment and recovery services, with structure and supervision, to further a participant's ability to improve his/her level of functioning. These services do not fall within the Drug MediCal Organized Delivery System but are offered by Contractor. 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. Narcotic Replacement Treatment

Contractor shall provide Narcotic Replacement Treatment (NRT) services to uninsured San Mateo County residents. Services shall include: intake, assessment and diagnosis, medical supervision, urinalysis, medication, individual and group counseling sessions. Services shall be provided under direction of the physician and may include the following:

- a. Medically Managed Detox (MMD) for a period of twenty-one (21) to one hundred eighty (180) days. Avatar service codes for Opioid (Narcotic) Treatment Services are:

| Service Description | Service Codes |
|-----------------------|---------------|
| Methadone Dosing | AD401ODS |
| | AD401ODSPERI |
| Individual Counseling | AD402ODS |
| | AD402ODSPERI |
| Group Counseling | AD403ODS |
| | AD403ODSPERI |

- b. Medically Managed Treatment (MMT) to reduce or eliminate chronic opiate addiction. Avatar service codes for Opioid (Narcotic) Treatment Services are:

| Service Description | Service Codes |
|-----------------------|---------------|
| Methadone Dosing | AD401ODS |
| | AD401ODSPERI |
| Individual Counseling | AD402ODS |
| | AD402ODSPERI |
| Group Counseling | AD403ODS |
| | AD403ODSPERI |

MMD or MMT may be provided to eligible opioid dependent inmates in the San Mateo County Jail receiving NRT at the time of incarceration.

2. Urinalysis Testing

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

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

C. Priority Populations

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

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

II. ADMINISTRATIVE REQUIREMENTS

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

A. System-Wide Improvements

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

1. Community Service Areas

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

2. External Quality Reviews

DHCS has contracted with an External Quality Review (EQR) organization to conduct a review of the overall quality of services,

service accessibility, and availability provided under the ODS. The EQR also requires annual Performance Improvement Projects (PIP) that improve both clinical and administrative performance of the ODS.

- a. Contractor shall participate in EQR focus groups, surveys, and other performance measurement and data collection activities.
- b. Contractor shall participate in all PIPs implemented by BHRS as part of the EQR process.

3. Direct Service Time

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

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

B. Qualified Service Organization

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

- 1. Centralized screening, assessment, and treatment referrals;
- 2. Billing supports and services;

3. Data gathering and submission in compliance with Federal, State, and local requirements;
4. Policies and procedures related to the service provision, documentation, and billing;
5. Quality Management and utilization review, including problem resolution;
6. Education, training and technical assistance as needed.

C. No Unlawful Use or Unlawful Use Messages Regarding Drugs

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

D. Restriction on Distribution of Sterile Needles

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

E. AVATAR Electronic Health Record

1. Contractor shall enter client data into Avatar for services provided that includes: date of service, service type, service units and service duration.
2. Contractor shall maintain compliance with all documentation, reporting, billing and all other data requirements as required in the BHRS Documentation Manual, Title 22, DMC-ODS STCs, the DHCS AOD Program Certification Standards, CalOMS Tx Data Collection Guide, DMC Billing Manual, and the AOD Policy and Procedure Manual, including additions and revisions.

3. Contractor shall submit electronically treatment capacity and waitlist data to DHCS via DATAR. Contractor shall comply with all BHRS tracking methods for client waitlist times and capacity. This information shall be used to determine unmet treatment needs and wait times to enter treatment.
4. Contractor shall participate in Avatar trainings and monthly Avatar User Group (AUG) meetings to ensure data quality and integrity, and provide input into system improvements to enhance the system.

F. Quality Management and Compliance

1. Clinical Standards of Care and Evidence-Based Practices

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

- a. In providing its services and operations, Contractor shall maintain full compliance with the San Mateo County BHRS Standards of Care, Best Practice Guidelines for Working with Limited English Proficiency and LGBTQ Clients, Federal Cultural and Linguistic Access Standards (CLAS) requirements. Contractor shall comply with at least two (2) of the five (5) DMC-ODS Evidence-Based Practices. Annually, Contractor shall provide a written report on the status of compliance with, and annual staff training on, the following:

- i. Standards of Care
- ii. Best Practice Guidelines for Working with Limited English Proficiency and LGBTQ Clients
- iii. At least two (2) of the DMC-ODS Evidenced-Based Practices. The DMC-ODS Evidenced-Based Practices include: Motivational Interviewing, Cognitive-Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psycho-Education
- iv. Federal CLAS requirements

2. Complex Clients and Co-occurring Disorders

- a. Contractor shall implement co-occurring capable policies, procedures, assessments, treatment planning, program content, and discharge planning. Contractor shall coordinate and collaborate with behavioral and physical health services,

and: initiate and coordinate with mental health services when appropriate, provide medication monitoring, coordinate with primary health services, and addiction and psychological assessment and consultation.

- b. Contractor shall not exclude from treatment, persons who require high risk, specialized services or special health needs. Contractor shall work with the health care providers of clients with special health care needs. Contractor shall collaborate with BHRS and other service providers to meet the identified needs of such clients. Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of services solely because of the client's diagnosis, type of illness, or condition of the client. Contractor shall provide Medi-Cal beneficiaries with a NOABD each time Contractor denies or reduces the amount, duration, or scope of services the beneficiary is receiving.
 - i. Contractor shall seek ongoing training and support for staff to stay current with best practices for serving individuals with co-occurring disorders.
 - ii. A Contractor that provides SAPT Block Grant Perinatal services to pregnant and postpartum individuals shall comply with the requirements contained in Title 22, Section 51341.1, Services for Pregnant and Postpartum Women, and with the DHCS Perinatal Practice Guidelines.
 - iii. Women, transgender men, and gender nonconforming Medi-Cal beneficiaries who are pregnant or up to sixty (60) days postpartum are eligible to receive DMC-ODS Perinatal services.
 - iv. A Contractor that provides adolescent treatment services shall comply with the Youth Treatment Services Guidelines. Assessments and services for adolescents shall follow the ASAM Adolescent Treatment Criteria.

3. Quality Management Program and Quality Improvement Plan

Contractor must have a Quality Management Program and submit a Quality Improvement Plan to Behavioral Health and Recovery Services (BHRS) Quality Management (QM) annually by June 30. The Quality Improvement Plan should address 1) how the Contractor will comply with all elements of this Agreement, 2) the Contractor will

maintain an audit disallowance rate of less than five percent (5%), and 3) first appointment will be within ten (10) days of referral or request of service for outpatient services; twenty-four (24) hours for residential treatment; and three (3) calendar days for NRT.

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

- a. Contractor shall have an established Quality Improvement (QI) plan and committee.
- b. The QI committee shall include staff from all levels of the Agency and will guide the development and implementation of the annual QI plan. The QI committee shall review quarterly utilization and service quality, performance data, compliance with BHRS SOC, co-occurring and complex client capability, and client feedback.
- c. Contractor shall establish and/or maintain mechanisms whereby processes and practices at the organizational level; which create inefficiencies and/or present barriers to client engagement, enrollment and retention in treatment, will be identified and addressed. An analysis of policies and practices which create barriers for complex clients shall be included.

4. Grievance Process

Contractor shall notify beneficiaries of their right to the following:

- a. A state fair hearing, how to obtain a hearing and representation rules at the hearing;
- b. File grievances and appeals, and the requirements and timeframes for filing;
 - i. Beneficiaries may file a grievance, either orally or in writing, either with DHCS, the County, or the Contractor
 - ii. Beneficiaries may request assistance with filing grievances and appeals
 - iii. If the beneficiary is grieving or appealing the termination, denial, or a change in type or frequency of

services, the beneficiary may request services be continued during the appeal or state fair hearing filing although the beneficiary may be liable for the cost of any continued benefits if the action is upheld.

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

5. Referring Individuals to Psychiatrist

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

6. Medication Storage and Monitoring

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

- a. Medications are logged in, verified, counted and added to inventory sheets.
- b. All medications obtained by prescription are labeled in compliance with federal and state laws. Prescription labels are altered only by persons legally authorized to do so.
- c. Medications intended for external use only are stored separately from medications intended for internal use; food and blood samples are stored in separate refrigerators.
- d. All medications are stored at proper temperatures: room temperature drugs at 59-86 degrees Fahrenheit and refrigerated drugs at 36-46 degrees Fahrenheit.
- e. Medications are stored in a locked area with access limited to staff authorized to monitor medication.
- f. Medications are disposed of after the expiration date and recorded.
- g. Injectable multi-dose vials are dated and initialed when opened.

- h. A medications log is maintained to ensure that expired, contaminated, deteriorated and abandoned medications are disposed in a manner consistent with state and federal laws.
- i. Over the counter medications that are not prescribed by the client's physician may not be used (for example, Tylenol).

7. Record Retention

Paragraph 14 of the Agreement notwithstanding, Contractor shall maintain medical records required by the California Code of Regulations. Notwithstanding the foregoing, Contractor shall maintain beneficiary medical and/or clinical records for a period of ten (10) years, except the records of persons under age eighteen (18) at the time of treatment shall be maintained: a) until ten (10) years beyond the person's eighteenth (18th) birthday or b) for a period of ten (10) years beyond the date of discharge, whichever is later. This rule does not supersede professional standards. Contractor may maintain records for a longer period of time if required by other regulations or licenses.

8. Documentation of Services

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

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

9. Audits

Behavioral Health and Recovery Services QM and/or BHRS analyst will conduct regular chart audits of Contractors. Contractor is required to provide either the original or copies of charts, including

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

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

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

- a. Address each demand for recovery of payment and/or programmatic deficiency;
- b. Provide a specific description of how the deficiency will be corrected;
- c. Specify the date of implementation of the corrective action; and
- d. Identify who will be responsible for ongoing compliance.

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

10. Client Rights and Satisfaction Surveys

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

- ii. Contractor shall participate in Treatment Perception Survey collection processes. Treatment Perception Surveys collect client satisfaction data. Contractor may solicit additional feedback from service recipients and family members. All feedback surveys shall be incorporated into Contractor quality improvement processes and plans.
- iii. Contractor shall develop and administer client and family satisfaction surveys on an annual basis for quality improvement and quality assurance purposes.

b. Client/Patient's Rights

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

c. Advance Directives

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

11. Beneficiary Brochure and Provider Lists

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

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

12. Notice of Adverse Benefit Determination

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

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

13. Certification and Licensing

a. SUD Treatment Services

- i. Contractors providing SUD treatment services to San Mateo County residents shall be certified and/or licensed by DHCS Licensing and Certification Division. Contractor shall maintain all applicable certifications through San Mateo County and/or DHCS to provide any of the following reimbursable services: Substance Abuse and Treatment Services, and Drug Medi-Cal reimbursed services.
- ii. Contractor shall submit a copy of any licensing complaint, deficiency findings, or corrective action report issued by a licensing agency to BHRS QM and the AOD Administrator or their designee, within two (2) business days of Contractor's receipt of any such licensing report.
- iii. Should Contractor cease to offer a DMC-ODS service, Contractor will work with BHRS to ensure participating clients are successfully transferred to another DMC-ODS provider.
- iv. Contractor shall provide written notification to the AOD Administrator of any changes in DMC-ODS offered services at least ninety (90) days prior to implementing the changes in services.

b. DMC-ODS SUD Treatment Services

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

Contractor or its owners, officers or directors are convicted of Medi-Cal fraud, abuse or malfeasance. For purposes of this section, a conviction shall include a plea of guilty or nolo contendere.

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

14. Licensing Reports

Contractor shall submit a copy of any licensing complaint or corrective report issued by a licensing agency to BHRS Quality Management and Manager of SUD Services or their designee, within ten (10) business days of Contractor's receipt of any such licensing report.

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

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

the Contractor's operations and the nature and scope of its activities.

- i. On an annual basis, Contractor shall require all staff accessing client PHI or PI to sign a confidentiality statement that includes, as a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies.
- c. Contractor shall install and actively use comprehensive antivirus software on all workstations, laptops and other systems that process and/or store PHI or PI. The antivirus software solution must have automatic updates scheduled at least daily.
- d. All workstations, laptops and other systems that process and/or store PHI or PI shall have critical security patches applied, with system reboot if necessary. Contractor shall document the patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within thirty (30) days of vendor release. Applications and systems that cannot be patched within this timeframe due to significant operational reasons must have compensatory controls implemented to minimize risk until the patches can be installed. Applications and systems that cannot be patched must have compensatory controls implemented to minimize risk, where possible.
- e. Contractor agrees to comply with the provisions of 42 C.F.R. Part 2 as described below if records contain or contract possesses any PHI covered under 42 C.F.R Part 2:
 - i. Acknowledge that in receiving, storing, processing, or otherwise using any information from BHRS about the clients in the program, it is fully bound by the provisions of the federal regulations governing Confidentiality of Behavioral Health and Recovery Services Patient Records, 42 C.F.R. Part 2;
 - ii. Undertake to resist in judicial proceedings any effort to obtain access to information pertaining to clients otherwise than as expressly provided for in the federal confidentiality regulations, 42 C.F.R. Part 2; and

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

f. Confidentiality Training

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

16. Critical Incident Reporting

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

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

- a. Contractor shall submit the written Critical Incident report via fax on the same day the incident occurred, or within twenty-four (24) hours.
- b. Contractor shall not file or reference a Critical Incident report in the client's chart. However, Contractor shall document the circumstances of the event and services provided.
- c. Contractor shall not collect and submit Critical Incident reports in batches.
- d. Contractor shall not permit hard copies or electronic copies of the Critical Incident report to be kept by the person reporting the incident. Internal copies may only be maintained by the Contractor's compliance officer/quality management as part of quality oversight. These shall be stored in a secure location without general access. All other copies shall then be shredded or deleted.

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

17. Ineligible Employees

Behavioral Health and Recovery Services (BHRS) requires that contractors comply with Federal requirements as outlined in 42 CFR (438.608) Managed Care Regulations. Contractors must identify the eligibility of employees, interns, or volunteers prior to hiring and on a monthly basis thereafter. Results of the eligibility screenings are to be maintained in the employee files. This process is meant to ensure that any person delivering services to clients of BHRS are not currently excluded, suspended, debarred or have been convicted of a criminal offense as described below. The Contractor must notify BHRS Quality Management (by completing the BHRS Critical Incident Reporting Form, Policy#93-11) should a current employee, intern, or volunteer be identified as ineligible. Contractors are required to screen for ineligible employees, interns, and volunteers by following procedures included in BHRS Policy # 04-01, which can be found online at: <http://www.smchealth.org/bhrs-policies/compliance-policy-funded-services-provided-contracted-organizational-providers-04-01>. BHRS Quality Management must be notified within twenty-four (24) hours of any violations. Contractor must notify BHRS Quality Management if an employee's license is not current or is not in good standing and must submit a plan to correct to address the matter.

a. Credentialing Check – Initial

During the initial contract process, BHRS will send a packet of contract documents that are to be completed by the Contractor and returned to BHRS. Attachment A – Agency/Group Credentialing Information will be included in

the contract packet. Contractor must complete Attachment A and return it along with all other contract forms.

b. Credentialing Check – Monthly

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

18. Compliance Plan and Code of Conduct

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

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

19. Fingerprint Compliance

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

- a. Adhere to CCR Title 9 Section 13060 (Code of Conduct) when providing services to individuals with whom they have contact as a part of their employment with the contractor; OR
- b. Obtain an exemption from Community Care Licensing allowing the employee to provide services to individuals with whom they have contact as a part of their employment with the contractor.

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

20. Staff Termination

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

21. Minimum Staffing Requirements

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

G. Cultural Competency

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

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

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

- a. Implementation of policies and practices that are related to promoting diversity and cultural competence, such as ongoing organizational assessments on disparities and needs, client's rights to receive language assistance.
- b. Contractor forum for discussing relevant and appropriate cultural competence-related issues (such as a cultural

competence committee, grievance, or conflict resolution committee).

- c. Ongoing collection of client cultural demographic information, including race, ethnicity, primary language, gender and sexual orientation in health records to improve service provision and help in planning and implementing CLAS standards.
 - d. Staffing objectives that reflect the cultural and linguistic diversity of the clients. (Contractor will recruit, hire and retain clinical staff members who can provide services in a culturally and linguistically appropriate manner.)
 - e. Contractor will ensure that all program staff receive at least 8 hours of external training per year (i.e. sponsored by BHRS or other agencies) on how to provide culturally and linguistically appropriate services including the CLAS and use of interpreters.
- 2. Contractor will actively participate in at least one cultural competence effort within BHRS and/or to send a representative to attend the Cultural Competence Council (CCC) for the term of the Agreement. Participation in the CCC allows for the dissemination of CLAS as well as ongoing collaborations with diverse stakeholders. Contractor shall submit to BHRS Office of Diversity and Equity (ODE) by March 31st, a list of staff who have participated in these efforts. For more information about the CCC, and other cultural competence efforts within BHRS, contact HEIM.
 - 3. Contractor will establish the appropriate infrastructure to provide services in County identified threshold languages. Currently the threshold languages are: Spanish, Tagalog and Chinese (Mandarin and Cantonese). If Contractor is unable to provide services in those languages, Contractor is expected to contact Access Call Center or their BHRS Analyst/Program Manager for consultation. If additional language resources are needed, please contact HEIM.
 - 4. Contractor will translate relevant and appropriate behavioral health-related materials (such as forms, signage, etc.) in County identified threshold languages in a culturally and linguistically appropriate manner. BHRS strongly encourages its contractors to use BHRS-sponsored forms in an effort to create uniformity within the system of care. Contractor shall submit to HEIM by March 31st, copies of Contractor's health-related materials in English and as translated.
 - 5. Should Contractor be unable to comply with the cultural competence requirements, Contractor will meet with the BHRS Analyst/Program

Manager at ode@smcgov.org to plan for appropriate technical assistance.

H. Availability and Accessibility of Service

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

I. 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.

J. Trafficking Victims Protection Act of 2000

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

III. PERFORMANCE STANDARDS, GOAL AND OBJECTIVE

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

PERFORMANCE STANDARDS

- A. Timely Access to Care: Contractor shall track and document timely access data, including the date of initial contact, the date of first offered

appointment, and the date of first actual appointment, using the UCLA ASAM Level of Care spreadsheet.

1. For NTP Services, the first appointment shall occur within twenty-four (24) hours of the initial request for services.
- B. Transitions Between Levels of Care: Both the admitting and discharging Contractors shall be responsible for facilitating the client's transition between levels of care, including assisting the client in scheduling their first appointment and ensuring a minimal delay between discharge and admission at the next level of care, providing or arranging for transportation as appropriate, and documenting the transition in the client's chart.
1. Transitions between levels of care shall occur within ten (10) business days from the time of the ASAM LOC Re-Assessment indicating the need for a different level of care.
 2. At least seventy-five percent (75%) of clients discharged from Residential Treatment are subsequently admitted to another level of care (IOP, OP or Recovery Services) within ten (10) business days from the date of discharge.
 3. At least seventy-five percent (75%) of clients discharged from Residential Withdrawal Management care are subsequently admitted to another level of care within ten (10) business days from the date of discharge.
 4. At least fifty percent (50%) of clients discharged from Intensive Outpatient or Outpatient Treatment are subsequently admitted to another level of care (including Recovery Services) within ten (10) business days from the date of discharge.
- C. Care Coordination: Contractors shall ensure 42 CFR compliant releases are in place for all clients in order to coordinate care. The Contractor shall screen for and link clients with mental health and primary care, as indicated.
1. One hundred percent (100%) of clients are screened for mental health and primary health care needs.
 2. At least seventy percent (70%) of clients who screen positive for mental health disorders have documentation of referrals to and coordination with mental health providers.
 3. At least eighty percent (80%) of clients who screen positive for primary health care needs have documentation of referrals to and/or coordination with primary care providers.

- D. Medication Assisted Treatment: Contractors shall have procedures for referrals to and integration of medication assisted treatment for substance use disorders. Contractor staff shall regularly communicate with physicians of clients prescribed these medications unless the client refuses to sign a Release of Information.
1. At least eighty percent (80%) of clients with a primary opioid or alcohol use disorder will be referred for a MAT assessment and/or MAT services.
- E. Culturally Competent Services: Contractors shall be responsible for providing culturally competent and linguistically appropriate services. Translation and interpretation services shall be available to all clients, as needed and at no cost to the client.
1. One hundred percent (100%) of clients who speak a threshold language are provided services in their preferred language.
 2. One hundred percent (100%) of clients who read a threshold language are provided written treatment materials in their preferred language.

GOAL AND OBJECTIVE:

GOAL: Provide narcotic replacement therapy services to all eligible applicants on demand.

OBJECTIVE: Ninety percent (90%) of the time, Contractor shall provide intake and treatment services within twenty-four (24) hours to program participants.

*** END OF EXHIBIT A ***

EXHIBIT B – PAYMENTS AND RATES
ADDICTION RESEARCH & TREATMENT INC.
FY 2019 – 2021

In consideration of the services provided by Contractor in Exhibit A, 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/regs>.

In any event, the maximum amount County shall be obligated to pay for all services rendered under this contract shall not exceed FOUR MILLION ONE HUNDRED FIVE THOUSAND NINE HUNDRED THIRTY DOLLARS (\$4,105,930).

1. FY 2019 – 2020

Contractor shall be paid a maximum of TWO MILLION TWELVE THOUSAND SEVEN HUNDRED ELEVEN DOLLARS (\$2,012,711). Contractor shall submit monthly invoices for payment. Contractor will submit invoices on forms and in manner prescribed by the County.

2. FY 2019-2021

Contractor shall be paid a maximum of TWO MILLION NINETY-THREE THOUSAND TWO HUNDRED NINETEEN DOLLARS (\$2,093,219). Contractor shall submit monthly invoices for payment. Contractor will submit invoices on forms and in manner prescribed by the County.

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

1. Narcotic Treatment Program

a. Contractor shall be paid for the following:

- i. MMT - Methadone Maintenance
- ii. MMD - Methadone Detox
- iii. NTP - Individual Counseling
- iv. NTP - Group Counseling
- v. NTP Buprenorphine Dispensing
- vi. NTP -Buprenorphine-Naloxone Combination Product
- vii. NTP Disulfiram
- viii. NTP Naloxone - 2-pack Nasal Spray

"Uniform Statewide Daily Reimbursement (USDR) Rate" means the rate for NTP services based on a unit of service that is a daily treatment service provided pursuant to Title 22, Sections 51341.1 and 51516.1 and Title 9, commencing with Section 10000 (Document 3G), or the rate for individual or group counseling. The USDR rates for FY 19/20 and FY 20/21 will be published by DHCS.

- b. County rates for reimbursement are based on the current California Department of Health Services rate schedules and are subject to change. The Narcotic Treatment Program rate schedules are located at www.dhcs.ca.gov and are incorporated in this agreement by reference herein. County shall not pay or be obligated to pay more than the amounts for each component of service required under this agreement.
2. 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.
3. County shall make monthly payments to Contractor for invoiced amounts within thirty (30) days of receipt of invoices.
4. Billing for DMC Services
- a. Contractor shall bill BHRS for services provided to Medi-Cal clients, covered under the DMC-ODS.

- b. Contractor must follow the process established under DHCS ADP Bulletin 11-01, for clients that have other healthcare coverage (OHC) in addition to Medi-Cal including future DHCS process updates for DMC claims for clients with OHC: http://www.dhcs.ca.gov/services/MH/MHSUD/Documents/ADP_Bulletins/ADP_11-01.pdf.
- c. Services covered through another healthcare provider shall not be reimbursed through the County. Contractor shall bill the other healthcare coverage for which the client is a beneficiary. If Contractor is not a member of the provider network for that healthcare coverage, Contractor shall then refer client to the healthcare provider network

5. 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 Medi-Cal 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 over rider 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 Medi-Cal clients as define by CCR Title 9, Section 1840.1000. Contractor will meet the FFP eligibility criteria.

6. Cost Report / Unspent Funds (DMC-ODS providers only)

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

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

- b. If the annual cost report provided to County shows that total payment to Contractor exceeds the total actual costs for all of the services rendered by Contractor to eligible patients during the reporting period, a single payment in the total amount of the unearned funds shall be made by Contractor to County, unless otherwise authorized by the BHRS Director. This payment shall be submitted with the cost report.
- c. If the annual cost report provided to County shows that Contractor had costs that were higher than the payments received (and less than the Agreement maximum), Contractor may submit an invoice to the County for any additional amount owed up to the balance of the Agreement maximum. County will make payment for approved costs within forty-five (45) days of receipt of such invoice.
- d. Contractor may request that contract savings or "unspent funds" within the Agreement maximum are expended by Contractor in the following year, provided that these funds are expended for SUD services approved by County in accordance with the following procedures. County reserves the right to deny the request and is under no obligation to approve unspent funds from the previous year (no multiple year roll over.)

- i. Contractor shall submit a detailed budget and summary calculation of any savings ninety (90) days

after end of the fiscal year. The detailed budget and summary calculation will be a separate report from the year-end cost report.

- ii. At the time of the submission of the detailed budget and summary calculation Contractor may request to rollover some or all of any savings. The request must be made in writing to the BHRS Director or the Director's designee. The request shall identify specifically how the rollover funds will be spent, including a detailed budget by expenditure line items. Approved rollover funds shall be spent only for the succeeding fiscal year and only for the specific purpose(s) requested and approved. If approved, the Agreement for the succeeding fiscal year will be amended as necessary to include the approved rollover amount.
- iii. Unspent funds may only be used for one-time expenses and not for ongoing costs. Unspent funds will be reimbursed based on actual expenditures incurred and submitted as a separate line item in invoices.

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

C. All Services

1. Contractor will be responsible for all expenses incurred during the performance of services rendered under this Agreement.
2. Modifications to the allocations in Paragraph A of this Exhibit B may be approved by the Chief of San Mateo County Health or designee, subject to the maximum amount set forth in Paragraph 3 of this Agreement.
3. The Chief of San Mateo County Health or designee is authorized to execute contract amendments which modify the County's maximum fiscal obligation by no more than \$25,000 (in aggregate), and/or modify the contract term and/or services so long as the modified term or services is/are within the current or revised fiscal provisions.
4. In the event that funds provided under this Agreement are expended prior to the end of the contract period, Contractor shall provide ongoing services under the terms of this Agreement through the end of the contract period without further payment from County.

5. In the event this Agreement is terminated prior to June 30, 2021, Contractor shall be paid on a prorated basis for only that portion of the contract term during which Contractor provided services pursuant to this Agreement. Such billing shall be subject to the approval of the Chief of San Mateo County Health or designee.
6. Disallowances that are attributable to an error or omission on the part of County shall be the responsibility of County. This shall include but not be limited to quality assurance (QA) audit disallowances as a result of QA Plan error or format problems with County-designed service documents.
7. The contracting parties shall be subject to the examination and audit of the Department of Auditor General for a period of three years after final payment under contract (Government Code, Section 8546.7).
8. Monthly Invoice and Payment

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

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

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

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

obligations for specific services may be reduced at the discretion of the Chief of San Mateo County Health or designee.

10. 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 A.
11. 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.
12. Contractor shall provide all pertinent documentation required for Medi-Cal, Medicare, and any other federal and state regulation applicable to reimbursement including assessment and service plans, and progress notes. The County may withhold payment for any and all services for which the required documentation is not provided, or if the documentation provided does not meet professional standards as determined by the San Mateo County BHRS Quality Improvement Manager.

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

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

It is understood and agreed that failure by the County or Contractor to comply with applicable federal and state requirements in rendering covered services shall be sufficient cause for the State to deny payments to and/or recover payments from the County and/or

terminate the Contractor from DMC program participation. If the State or the Department of Health Care Services (DHCS) disallows or denies payments for any claim, County shall repay to the State the federal Medicaid funds and/or State General Funds it received for all claims so disallowed or denied. The overpayment shall be recovered by any of the methods allowed in Title 22, CCR, Sections 51047(a) and (b).

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

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

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

13. Substance Abuse Prevention and Treatment Funding

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

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

- a. Provide inpatient services;
- b. Make cash payment to intended recipients of health services;
- c. Purchase or improve land, purchase, construct or permanently improve (other than minor remodeling) any building or other facility or purchase major medical equipment;
- d. Satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
- e. Provide financial assistance to any entity other than a public or nonprofit private entity;

- f. Pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of level I of the Executive Salary Schedule for the award year: see http://grants.nih.gov/grants/policy/salcap_summary.htm;
- g. Purchase treatment services in penal or correctional institutions of this State of California; and
- h. Supplant state funding of programs to prevent and treat substance abuse and related activities.

14. County May Withhold Payment

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

15. 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.

16. Election of Third Party Billing Process

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

a. Option One

- i. Contractor shall bill all eligible third-party payors financially responsible for a beneficiary's health care services that Contractor provides through this Agreement. Within ten (10) days of the end of each month, Contractor shall provide to County copies of the Explanation of Benefits or other remittance advice for every third-party payment and/or denial of such third-party payments for services provided by Contractor during such month. The amount of any such third-party payment shall be deducted from the total actual costs for all services rendered by Contractor as reflected on the Cost Report as defined in Paragraph I.B.7 of this Exhibit B. County accepts no financial responsibility for services provided to beneficiaries where there is a responsible third-party payor, and to the extent that County inadvertently makes payments to Contractor for such services rendered, County shall be entitled to recoup such reimbursement, through the Cost Report reconciliation.
- ii. Contractor shall provide a copy of each completed Payor Financial Form (Attachment D) and subsequent annual updates for all clients who receive services through this Agreement. For clients who begin to receive services during the term of this Agreement, completed Payor Financial Forms shall be provided to the County with client registration forms. For clients who were receiving services prior to the start date of this Agreement and who continue to receive services through this Agreement, completed Payor Financial Forms are due within ten (10) days of the end of the first month of the Agreement.

b. Option Two

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

where there is a responsible third-party payor, and to the extent that County inadvertently makes payments to Contractor for such services rendered, County shall be entitled to recoup such reimbursement through the Cost Report reconciliation.

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

17. Beneficiary Billing

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

18. Claims Certification and Program Integrity

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

- b. Anytime Contractor submits a claim to the County for reimbursement for services provided under Exhibit A 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 _____ "

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

- i. An assessment of the beneficiary was conducted in compliance with the requirements established in this agreement.
- ii. The beneficiary was eligible to receive services described in Exhibit A of this Agreement at the time the services were provided to the beneficiary.
- iii. The services included in the claim were actually provided to the beneficiary.
- iv. Medical necessity was established for the beneficiary as defined under California Code of Regulations, Title 9, Division 1, Chapter 11, for the service or services provided, for the timeframe in which the services were provided.
- v. A client plan was developed and maintained for the beneficiary that met all client plan requirements established in this agreement.
- vi. For each beneficiary with specialty mental health services included in the claim, all requirements for

Contractor payment authorization for specialty mental health services were met, and any reviews for such service or services were conducted prior to the initial authorization and any re-authorization periods as established in this agreement.

- vii. Services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.
- d. Except as provided in Paragraph II.F.7 of Exhibit A relative to medical records, Contractor agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose fully the extent of services furnished to the client. Contractor agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Mental Health; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, Managed Risk Medical Insurance Board or their duly authorized representatives, and/or the County.

19. Audit Requirements

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

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

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

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

- b. To validate data reported by the Contractor for prospective Intergovernmental Agreement negotiations;
- c. To provide technical assistance in addressing current year activities and providing recommendation on internal controls, accounting procedures, financial records, and compliance with laws and regulations;
- d. To determine the cost of services, net of related patient and participant fees, third- party payments, and other related revenues and funds;
- e. To determine that expenditures are made in accordance with applicable state and federal laws and regulations and State Agreement with the State requirements, and/or;
- f. To determine the facts in relation to analysis of data, complaints, or allegations, which may be indicative of fraud, abuse, willful misrepresentation.

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

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

County shall monitor the activities of Contractor to ensure that:

- a. Contractor is complying with program requirements and achieving performance goals; and
- b. Contractor is complying with fiscal requirements, such as having appropriate fiscal controls in place, and using awards for authorized purposes.

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

Pursuant to OMB Circular A-133, State may impose sanctions against the Contractor for not submitting single or program-specific audit reports, or failure to comply with all other audit requirements.

Should such sanctions be due to noncompliance by the Contractor, such sanctions will be passed on to the Contractor by the County. The sanctions may include:

- a. Withholding a percentage of federal awards until the audit is completed satisfactorily;
- b. Withhold or disallowing overhead costs;
- c. Suspending federal awards until the audit is conducted; or
- d. Terminating the federal award.

20. 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.1 through A.A.6 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:

- a. 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;
- b. A review of actual costs incurred for comparison to services claimed;
- c. 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;
- d. 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;
- e. Computation of final settlement based on the lower of USDR rate or the provider's usual and customary charge to the general public; and,
- f. A review of supporting service, time, financial, and patient records to verify the validity of counseling claims.

21. 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.

22. DMC Record Keeping

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

- a. Contractor shall include in any Agreement with an audit firm a clause to permit access by the State to the working papers of the external independent auditor, and require that copies of the working papers shall be made for the State at its request.
- b. Contractor shall keep adequate and sufficient financial records and statistical data to support the year-end documents filed with the State. All records must be capable of verification by qualified auditors.
- c. Accounting records and supporting documents shall be retained for a ten (10) year period from the date the year-end cost settlement report was approved by the State for interim settlement. When an audit by the Federal Government, the State, or the California State Auditor has been started before the expiration of the ten (10) year period, the records shall be retained until completion of the audit and final resolution of all issues that arise in the audit. Final settlement shall be made at the end of the audit and appeal process. If an audit has not

been completed within three years, the interim settlement shall be considered as the final settlement.

- d. Financial records shall be kept so that they clearly reflect the source of funding for each type of service for which reimbursement is claimed. These documents include, but are not limited to, all ledgers, books, vouchers, time sheets, payrolls, appointment schedules, client data cards, and schedules for allocating costs. All records must be capable of verification by qualified auditors.
- e. Should Contractor discontinue its contractual agreement with the County, or cease to conduct business in its entirety, Contractor shall provide fiscal and program records for the Agreement period to the County. Records shall be provided in compliance with the State Administrative Manual (SAM), located at <http://sam.dgs.ca.gov/TOC/1600.aspx>.

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

- f. In the expenditure of funds hereunder, and as required by 45 CFR Part 96, Contractor shall comply with the requirements of SAM and the laws and procedures applicable to the obligation and expenditure of federal and state funds.
- g. Contractor shall retain records of utilization review activities required for a minimum of ten (10) years.

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

- Provider ownership, organization, and operation;
- Fiscal, medical, and other recordkeeping systems;
- Federal income tax status;
- Asset acquisition, lease, sale, or other action;
- Franchise or management arrangements;
- Patient service charge schedules;

- Costs of operation;
- Cost allocation methodology;
- Amounts of income received by source and purpose; and
- Flow of funds and working capital.

23. Dispute Resolution Process

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

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

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

*** END OF EXHIBIT B ***

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 Contractor's compliance with Post Service Post Payment (PSP) 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 PSP 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 PSP review, whether or not this results in a recovery of funds, must be corrected. BHRS will submit the CAP to the DHCS PSP Unit within sixty (60) days of the date of the PSP report.

The plan shall:

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

1. Address 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.



Contractor Signature

VP, Treasurer

Title of Authorized Official

8.19.17

Date

Attachment C
Election of Third Party Billing Process

Effective July 1, 2005, San Mateo County Behavioral Health and Recovery Services (SMCBHRS) will be required to bill all other insurance (including Medicare) before billing Medi-Cal for beneficiaries who have other coverage in addition to Medi-Cal. This is called "serial billing." All claims sent to Medi-Cal without evidence of other insurance having been billed first will be denied.

In order to comply with the serial billing requirement you must elect which of the two following options to use in our contract with you. In either case, you will need to establish the eligibility of your clients through the completion of the standard form (Payor Financial Form) used to collect this information. Please select and complete one of the two options below:

Option One

Our agency will bill other insurance, and provide SMCBHRS with a copy of the Explanation of Benefits provided by that insurance plan before billing SMCBHRS for the remainder.

We Addiction Research and Treatment, Inc. elect option one.



Signature of authorized agent

Daniel Gutschenritter

Name of authorized agent

214.379.3300

Telephone number

Option Two

Our agency will provide information to San Mateo County Behavioral Health and Recovery Services (SMCBHRS) so that SMCBHRS may bill other insurance before billing Medi-Cal on our agency's behalf. This will include completing the attached client Payor Financial Form and providing it to the SMCBHRS Billing Office with the completed "assignment" that indicates the client's permission for SMCBHRS to bill their insurance.

We Addiction Research and Treatment, Inc. elect option two.

Signature of authorized agent

Name of authorized agent

Telephone number

Please note if your agency already bills private insurance including Medicare for services you provide, then you must elect Option One. This is to prevent double billing. Please return this completed form to:

Doreen Avery, Business Systems Manager
Behavioral Health and Recovery Services
2000 Alameda de las Pulgas, Suite 280
San Mateo, CA 94403
(650) 573-2284

Attachment D – Agency Payor Financial

| | | | | | |
|--|--|---|------------|--|------|
| Client ID (Do name search): | | Client Date of Birth (Required): | | SSN (Required): | |
| Last Name: | | First Name: | | | M.I. |
| Alias or other names used: | | | | Undocumented? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Does Client have Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No Share of Cost Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Client's Medi-Cal Number (CIN Number)? _____ | | | | | |
| <i>Please attach copy of MEDS screen. If client has Full Scope Medi-Cal and no other insurance coverage, skip the remaining sections of this form and fax to MIS/Billing Unit (650) 573-2110.</i> | | | | | |
| Is client potentially eligible for Medi-Cal benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No Client referred to Medi-Cal? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Date of Referral: _____ Is this a Court-ordered Placement? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| Does Client have Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | | |
| If yes, please check all that apply _____ Part A _____ Part B _____ Part D | | | | | |
| What is the Client's Medicare Number (HIC Number)? _____ | | | | | |
| Signed Assignment of Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No Please attach copy of Medicare card | | | | | |
| Responsible Party's Information (Guarantor): | | | | | |
| Name: _____ | | Phone: _____ | | | |
| Relationship to Client: _____ | | <input type="checkbox"/> Self | | | |
| Address: _____ | | City: _____ | | | |
| State: _____ | | Zip Code: _____ | | | |
| <input type="checkbox"/> Refused to provide Financial Information and will be charged full cost of service. | | | | | |
| 3 rd Party Health Insurance Information | | | | | |
| Health Plan or Insurance Company (Not employer) | | | | | |
| Company Name: _____ | | Policy Number: _____ | | | |
| Street Address: _____ | | Group Number: _____ | | | |
| City: _____ | | Name of Insured Person: _____ | | | |
| State: _____ | | Zip: _____ | | Relationship to Client: _____ | |
| Insurance Co. phone number: _____ | | SSN of Insured Person (if other than client): _____ | | | |
| Please attach copy of insurance card (front & back) | | Signed Assignment of Benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | |
| Does the client have Healthy Kids Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please attach copy of insurance card (front & back) | | | | | |
| Does the client has HealthWorx Insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please attach copy of insurance card (front & back) | | | | | |
| Client Authorization | | | | | |
| I affirm that the statements made herein are true and correct. I understand that I am responsible for paying the UMDAP liability amount or cost of treatment received by myself or by members of my household during each 1-year period. If the cost of service is more than the UMDAP liability amount, I will pay the lesser amount. It is my responsibility and I agree to provide verification of income, assets and expenses. If I do not authorize, I will be billed in full for services received. I authorize San Mateo County Mental Health to bill all applicable mental health services to Medi-Care and/or my insurance plan, including any services provided un 26.5. I authorize payment of healthcare benefits to San Mateo County Mental Health. | | | | | |
| Signature of Client or Authorized Person _____ | | | Date _____ | | |
| Client refused to sign Authorization: <input type="checkbox"/> Please check, if applicable Date: _____ Reason _____ | | | | | |
| Name of Interviewer: _____ | | Phone Number: _____ | | Best time to contact _____ | |
| Fax completed copy to: MIS/Billing Unit (650)573-2110 | | | | | |

ATTACHMENT E

FINGERPRINTING CERTIFICATION

Contractor hereby certifies that its employees, trainees, and/or its subcontractors, assignees, volunteers, and any other persons who provide services under this agreement, who have direct contact with any client will be fingerprinted in order to determine whether they have a criminal history which would compromise the safety of individuals with whom the Contractor's employees, trainees and/or its subcontractors, assignees, or volunteers have contact. Additionally, Contractor's employees, volunteers, consultants, agents, and any other persons who provide services under this Agreement and who has/will have supervisory or disciplinary power over a child (Penal Code Section 11105.3) (the "Applicant") shall be fingerprinted in order to determine whether each such Applicant has a criminal history which would compromise the safety of children with whom each such Applicant has/will have contact.

Contractor's employees, volunteers, consultants, agents, and any other persons who provide services under this Agreement will be fingerprinted and: (check a or b)

- ☒ a. do NOT exercise supervisory or disciplinary power over children (Penal 11105.3).
- ☐ b. do exercise supervisory or disciplinary power over children (Penal 11105.3).

Addiction Research and Treatment, Inc.

Name of Contractor

Signature of Authorized Official

Daniel Gutschenritter

Name (please print)

VP, Treasurer

Title (please print)

Date

8.19.19

ATTACHMENT I

Assurance of Compliance with Section 504 of the Rehabilitation Act of 1973, as Amended

The undersigned (hereinafter called "Contractor(s)") hereby agrees that it will comply with Section 504 of the Rehabilitation Act of 1973, as amended, all requirements imposed by the applicable DHHS regulation, and all guidelines and interpretations issued pursuant thereto.

The Contractor(s) gives/give this assurance in consideration of for the purpose of obtaining contracts after the date of this assurance. The Contractor(s) recognizes/recognize and agrees/agree that contracts will be extended in reliance on the representations and agreements made in this assurance. This assurance is binding on the Contractor(s), its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Contractor(s).

The Contractor(s): (Check a, b, or c)

- ☐ a. Has no employees
☐ b. Employs fewer than 15 persons
☒ c. Employs 15 or more persons and, pursuant to section 84.7 (a) of the regulation (45 C.F.R. 84.7 (a), has designated the following person(s) to coordinate its efforts to comply with the DHHS regulation.

Name of 504 Person: Nadine Robbins-Laurent

Name of Contractor(s): Addiction Treatment and Research, Inc.

Street Address or P.O. Box: 1720 Lakepointe Drive, Suite 117

City, State, Zip Code: Lewisville, TX 75057-6425

I certify that the above information is complete and correct to the best of my knowledge

Signature:

Title of Authorized Official: VP, Treasurer

Date:

8.19.19

*Exception: DHHS regulations state that: "If a recipient with fewer than 15 employees finds that, after consultation with a disabled person seeking its services, there is no method of complying with (the facility accessibility regulations) other than making a significant alteration in its existing facilities, the recipient may, as an alternative, refer the handicapped person to other providers of those services that are accessible."

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 |
|---|--|
| Not applicable to the DMC- ODS waiver | <p><u>Part 431</u> (Single state agency 431.107 (record keeping) 438 438.104 438.114 438.116 438.206(b)(2) 438.208(c)(1) 438.6(i) 438.210 (Managed care definitions) Covered services 455 (Program Integrity: Medicaid) 455.101 455.104 455.23 455.34 455.450(c) (program integrity) <u>Part 8</u> (Medicated</p> <p>A single state agency will be assigned to manage this contract. For California it is DHCS.</p> <p>Provider Agreement required. Provide the fraud control unit any information regarding payments claimed by the provider for furnishing services.</p> <p>MANAGED CARE</p> <p>Marketing activities</p> <p>Emergency post stabilization services</p> <p>Solvency standards</p> <p>Women's Health Services</p> <p>Individuals with special health care needs</p> <p>Advanced directives</p> <p>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</p> <p>Disclosure of Information by Providers and Fiscal Agents.</p> <p>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.</p> <p>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....</p> <p>Suspension of payments in case of fraud. Payments can be suspended upon the initiation of a fraud investigation.</p> <p>Provide screening levels for Medicaid Providers and conduct screening at the level of assessed risk. Limited, moderate, or high.</p> <p>Accreditation, responsibilities, evaluation, and withdrawal of accreditation. Certification and treatment standards.</p> |

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. |
| <u>CFR</u> <u>Title 21</u> | Food and drug administration, Department of Health and Human services |
| 1300 et seq | Drug Enforcement Administration, Department of Justice. Quotas, records and reports of registrants, schedule I and II controlled substances, prescriptions, administrative functions, practices, and procedures. |
| <u>W&I</u> | WELFARE AND INSTITUTIONS CODE |
| <u>Chapter 7</u> | 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 | The department shall establish a NRT dosing fee for methadone and LAAM. Only covered services are eligible for reimbursement. Financial evaluation form Instructions. |
| 14043.1 | |
| 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 |
| <u>Title 9</u> | 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

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.

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.