AGREEMENT FOR SERVICES #7910
Drug Medi-Cal Organized Delivery System Services

THIS AGREEMENT is made and entered into by and between the County of El Dorado, a political subdivision of the State of California (hereinafter referred to as "County") and Bi-Valley Medical Clinic, Inc., a California Corporation, doing business as BAART Programs Carmichael, duly qualified to conduct business in the State of California, whose principal place of business is 1720 Lakepointe Drive, Suite 117, Lewisville, Texas 75057 and whose local place of business is 6127 Fair Oaks Boulevard, Carmichael, California 95608, (hereinafter referred to as "Provider");

RECITALS

WHEREAS, County is under contract with the State of California to provide or arrange for the provision of certain mandated services, including substance use disorder (SUD) services, for Medi-Cal beneficiaries served by the County;

WHEREAS, County has determined that it is necessary to obtain a Provider to provide Drug Medi-Cal Organized Delivery System Services (DMC-ODS) to eligible beneficiaries;

WHEREAS, it is the intent of the parties hereto that such services be in conformity with all applicable federal, state and local laws;

WHEREAS, the parties hereto have mutually agreed that upon execution of this Agreement for Services 7910, the existing Agreement for Services 5863 and all amendments thereto shall automatically terminate, and Agreement 7910 shall supersede the Agreement 5863 in its entirety;

WHEREAS, County has determined that the provision of such services provided by Provider are in the public's best interest and that there are specialty skills, qualifications, and equipment not expressly identified in County classifications involved in the performance of the work in accordance with El Dorado County Ordinance Code, Chapter 3.13.030(B), El Dorado County Charter, Section 210(b)(6), and/or Government Code Section 31000; and

NOW, THEREFORE, County and Provider mutually agree as follows:

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ARTICLE 1. DEFINITIONS

1. BEHAVIORAL HEALTH INFORMATION NOTICE (BHIN): "Behavioral Health Information Notice" or "BHIN" means guidance from DHCS to inform counties and Providers of changes in policy or procedures at the federal or state levels. These were previously referred to as a Mental Health and Substance Use Disorder Services Information Notice (MHSUDS IN). BHINs and MHSUDS INs are available on the DHCS website.

2. BENEFICIARY OR CLIENT: "Beneficiary" or "client" means the individual(s) receiving services.

3. DHCS: "DHCS" means the California Department of Health Care Services.

4. DIRECTOR: "Director" means the Director of the County Behavioral Health Department, unless otherwise specified.

ARTICLE 2. GENERAL PROVISIONS

1. TERM
   This Agreement shall become effective upon final execution by both parties hereto and shall cover the period July 1, 2023, through June 30, 2026.

2. SCOPE OF WORK
   Provider shall provide the services set forth in Exhibit A, marked "Scope of Work," incorporated herein and made by reference a part hereof.

3. COMPENSATION FOR SERVICES
   A. **Rates:** For the purposes of this Agreement, the billing rate shall be as defined in Exhibit B, marked "Provider Rates," incorporated herein and made by reference a part hereof.

   B. **Invoices**: It is a requirement of this Agreement that Provider shall submit an original itemized invoice to be compensated for services. Itemized invoices shall follow the format specified by County Behavioral Health and shall reference this Agreement number on their faces and on any enclosures or backup documentation. Copies of Authorizations and back-up documentation must be attached to invoices shall reflect Provider's charges for the specific services billed on those invoices.

   Invoices shall be sent as follows, or as otherwise directed in writing by County:

Email (preferred method):	*U.S. Mail:*
BHinvoice@edcgov.us Please include in the subject line: "Contract #, Service Month, Description / Program	County of El Dorado Health and Human Services Agency Attn: Finance Unit 3057 Briw Road, Suite B Placerville, CA 95667-5321

   or to such other location as County directs.

   For services provided herein, Provider shall submit invoices for services fifteen (15) days following the end of a "service month." For billing purposes, a "service month" shall be defined as a calendar month during which Provider provides services in accordance with

ARTICLE 2, General Provisions, 2. Scope of Work. For all satisfactory services provided herein, County agrees to pay Provider monthly in arrears and within forty-five (45) days following the County's receipt and approval of itemized invoice(s) identifying services rendered. County may withhold or delay any payment if Provider fails to comply with any provision of this Agreement.

I. Invoicing shall be performed in a **Two-Step Process *(Drug Medi-Cal Services)***: Provider shall upload to County's Secured File Transfer Protocol (SFTP) server an Excel data file and draft invoice to County for payment.
   a. Step 1: Provider shall submit an Excel data file with columns as identified below. To avoid federal and state HIPAA violations, County requires that Providers submit client's protected private health information (PHI) via the County's SFTP server, or by using a secured and encrypted email protocol in compliance with HIPAA security regulations. To gain access the County's SFTP server, please email: HHSA-Billing@edcgov.us.

      The Excel data file shall include the following information:

      1. First Name
      2. Last Name
      3. Client Address
      4. Date of Birth
      5. CIN #
      6. Diagnosis
      7. Admission Date
      8. Date of Service
      9. Practitioner Name
      10. Units/Duration
      11. Billed Amount

   b. Step 2: County will perform a review and approval of the submitted Excel data file and notify Provider of services approved for billing. Upon approval by County, Provider shall follow Invoice Submittal/Remittance instructions below detailing services approved for billing.

II. Invoice Submittal/Remittance (All Services): Invoices shall be emailed to BHinvoice@edcgov.us, or as otherwise directed in writing by County. Invoices must include the following information:
   1. County Issued Agreement Number
   2. Provider Name & Address
   3. Service Month
   4. Invoice Total
   5. Service Totals (Units & Cost total per service code)
   6. Provider Contact Information
   7. Written Treatment Authorization (if applicable)

III. Supplemental Invoices: For the purpose of this Agreement, supplemental invoices shall be defined as invoices submitted for additional services rendered during a month for which a prior invoice has already been submitted to County. Supplemental Invoices shall follow the two-step process as defined herein above. Supplemental invoices should include the standard invoice format with description of services rendered and a detailed explanation why the invoice was not submitted in the approved timeframe. Written treatment authorization shall be submitted with invoices.
   a. For those situations where a service is disallowed by HHSA on an invoice, or inadvertently not submitted on an invoice, and a corrected invoice is later submitted ("Supplemental Invoice"), Supplemental Invoices for services provided during the period July 1st through June 30th for each fiscal year of this Agreement and received by HHSA after July 31 of the subsequent fiscal year, shall be neither accepted nor paid by the County. Requests for exceptions to pay an invoice received after July 31 of the subsequent year, must be submitted in writing and must be approved by HHSA's Agency Chief Fiscal Officer.

IV. Monthly payments for claimed services shall be based on the units of time assigned to each CPT or HCPCS code entered in the County's billing and transactional database multiplied by the rates included in Exhibit B.

V. In the event that Provider fails to deliver the services, documents or other deliverables required herein, County at its sole option may delay the monthly payment for the period of time of the delay, cease all payments until such time as the deliverables are received, or proceed as set forth herein below in ARTICLE 2. General Provisions, 12. Default, Termination, and Cancellation.

VI. Denied Invoices: DMC-ODS payments shall be made in the amount of the Provider's total claim, minus the amount of denied services. County will submit to Provider the amount of denials received for the prior months' services, as identified on documents received from the State. Provider shall make adjustment for denials on Provider's next submitted invoice.

4. FUNDING CATEGORIES

Funding sources include but may not be limited to DMC-ODS, Federal Financial Participation (FFP) or Federal match on DMC-ODS as defined below:

A. State General Fund and 2011 Realignment DMC-ODS: DMC-ODS is a treatment program as defined in Exhibit C, marked "Intergovernmental Agreement 21-10027," incorporated herein and made by reference a part hereof, or as may be amended. Effective July 1, 2011, Local Realignment Revenues are used to fund DMC services to DMC beneficiaries, including Minor Consent Services. As of June 1, 2019, revenues are used to fund DMC-ODS services to DMC-ODS El Dorado County beneficiaries, including minor consent services.
   1. Federal Financial Participation (FFP) or Federal match on DMC-ODS: This funding is the Federal share of the DMC Program. The match, which varies by year, is usually at or near fifty percent (50%).
   2. DMC Eligibility Accepted as Payment in Full: Except where a share of cost, as defined in Exhibit C, or as may be amended, is applicable. Providers shall accept proof of eligibility for DMC as payment in full for treatment services rendered. Providers shall

not charge fees to beneficiaries for access to DMC substance abuse services or for admission to a DMC treatment slot.

B. Client Fees: Provider may charge a fee to clients for whom services are provided pursuant to this Agreement, assessing ability to pay based on individual expenses in relation to income, assets, estates, and responsible relatives. Client fees shall be based upon the person's ability to pay for services, but shall not exceed the actual cost of service provided. No person shall be denied services because of inability to pay.

C. Client Financial Assessment: Provider shall certify all clients whose alcohol and drug treatment services are subsidized under this Agreement as unable to pay the amount charged to this Agreement. The certification of each client who is unable to pay shall be documented in writing on a Client Financial Assessment Form, which is developed by Provider and approved by Contract Administrator. This completed document shall be maintained by the Provider in the client's file.

5. MAXIMUM OBLIGATION

The maximum obligation for services and deliverables provided under this Agreement shall not exceed:

Funding Cateogories	**Amount Per Fiscal Year (FY)**	Total Not-To-Exceed by FY
Drug Medi-Cal w/ FFP or Realignment	23-24	$40,000
	24-25	$40,000
	25-26	$40,000

Total Maximum Contractual Obligation: $**120,000**, inclusive of all costs and expenses for the term of the Agreement.

A. In the performance of the scope of services to be provided in accordance with this budget, and subject to County budget and written County Contract Administrator, or designee approval, and HHSA Fiscal approval, County may reallocate the funding listed herein among funding categories and fiscal years, based on funding availability, during the term of this Agreement.
B. This Agreement shall be subject to any restrictions, limitations, and/or conditions imposed by County or state or federal funding sources that may in any way affect the fiscal provisions of, or funding for this Agreement. This Agreement is also contingent upon sufficient funds being made available by County, state, or federal funding sources for the term of the Agreement. If the federal or state governments reduce financial participation in the Medi-Cal program, County agrees to meet with Provider to discuss renegotiating the services required by this Agreement.
C. In no event shall the total maximum contractual obligation of the Agreement be exceeded. Further, Provider is responsible for managing their Maximum Annual Contractual Obligation and Provider holds the County harmless for any over-spending of the Maximum Annual Contractual Obligation by Service Category.

6. FEDERAL FUNDING NOTIFICATION

An award/subaward or contract associated with a covered transaction may not be made to a subrecipient or provider who has been identified as suspended or debarred from receiving federal funds. Additionally, counties must annually verify that the subrecipient and/or provider remains in good standing with the federal government throughout the life of the agreement/contract.

Provider agrees to comply with Federal procedures in accordance with 2 C.F.R. Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards. Any costs for which payment has been made to Provider that are determined by subsequent audit to be unallowable under 48 CFR Part 31 or 2 CFR Part 200 are subject to repayment by Provider to County.

Consistent with 2 CFR 180.300(a), County has elected to verify whether Provider has been suspended or using the federal System for Award Management (SAM). The federal SAM is an official website of the federal government through which counties can perform queries to identify if a subrecipient or Provider is listed on the federal SAM excluded list and thus suspended or debarred from receiving federal funds.

A. System for Award Management: Provider is required to obtain and maintain an active Universal Entity Identifier (UEI) No. in the System for Award Management (SAM) system at https://sam.gov/content/home. Noncompliance with this requirement shall result in corrective action, up to and including termination pursuant to the provisions contained herein this Agreement under ARTICLE 9. Financial Terms, 3. Fiscal Considerations or ARTICLE 2. General Provisions, 12. Default, Termination, and Cancellation.

B. Catalog of Federal Domestic Assistance: Pursuant to the Office of Management and Budget (OMB) Uniform Grants Guidance, all recipients and sub-recipients of federal funds must be provided the Assistance Listing Numbers (ALN) number at the time the contract is awarded. The following are ALN numbers, award specific information, and program titles for programs administered by the County on behalf of California Department of Health Care Services that may apply to this contract:

Federal Funding Information		
Provider:	Bi-Valley Medical Clinic, Inc., dba BAART Programs Carmichael	**UEI #:** MZX7ULMWCCB6
Award Term:	7/1/2023 - 6/30/2026	**EIN #:** 94-2415855
Total Federal Funds Obligated: $120,000		
Federal Award Information		
ALN Number	**Federal Award Date / Amount**	**Program Title**
93.778	06/01/2019	Drug Medi-Cal Organized Delivery System Services (DMC-ODS)
Project Description:	Substance Use Disorder Treatment Services for referred clients by The County of El Dorado, Health and Human Services Agency.	

Federal Funding Information			
Awarding Agency:		California Department of Health Care Services	
Pass-through Entity		County of El Dorado, Health and Human Services Agency	
Indirect Cost Rate or de minimus		Indirect Cost Rate: _____	De minimus ☒
Yes ☐	No ☒	Award is for Research and development.	

7. RECORD RETENTION
   A. Provider shall retain beneficiary records for a minimum of 10 years, in accordance with 42 CFR 438.3(h), from the finalized cost settlement process with the Department. When an audit by the Federal Government or DHCS has been started before the expiration of the 10-year period, the beneficiary records shall be maintained until completion of the audit and the final resolution of all issues.
   B. Provider shall comply with, and include in any subcontract with providers, the mandate to keep and maintain records for each service rendered, to whom it was rendered, and the date of service, pursuant to Welfare and Institutions Code 14124.1 and 42 CFR 438.3(h) and 438.3(u).
   C. County shall ensure that any Provider sites authorized shall keep a record of the beneficiaries/patients being treated at that location.

8. NOTICE TO PARTIES
   All notices to be given by the parties hereto shall be in writing and served by depositing same in the United States Post Office, postage prepaid and return receipt requested. Notices to County shall be addressed as follows:

   COUNTY OF EL DORADO
   Health and Human Services Agency
   3057 Briw Road, Suite B
   Placerville, CA 95667
   ATTN: Contracts Unit
   HHSA-contracts@edcgov.us

   or to such other location as the County directs.

   with a copy to

   COUNTY OF EL DORADO
   Chief Administrative Office
   Procurement and Contracts Division
   330 Fair Lane
   Placerville, CA 95667
   ATTN: Purchasing Agent

Notices to Provider shall be addressed as follows:

BAART Programs Carmichael
1720 Lakepointe Drive, Suite 117,
Lewisville, Texas 75057
ATTN: Jason Kletter, Chief Executive Officer
jkletter@baymark.com, and
Huy Chair, Regional Director of Operations
HChau@baymark.com

or to such other location as the Provider directs.

9. CHANGE OF ADDRESS

In the event of a change in in organizational name, Head of Service, address for Provider's principal place of business, Provider's Agent for Service of Process, or Notices to Provider, Provider shall notify County in writing at least 15 business days in advance of the change, pursuant to the provisions contained in this Agreement under ARTICLE 2. General Provisions, 8. Notice to Parties. Said notice shall become part of this Agreement upon acknowledgment in writing by the County Contract Administrator, and no further amendment of the Agreement shall be necessary provided that such change of address does not conflict with any other provisions of this Agreement.

A. Provider cannot reduce or relocate without first receiving approval by DHCS. A DMC certification application shall be submitted to the DHCS Provider Enrollment Division (PED) 60 days prior to the desired effective date of the reduction of covered services or relocation. Provider shall be subject to continuing certification requirements at least once every five years. Said notice shall become part of this Agreement upon acknowledgment in writing by the County, and no further amendment of the Agreement shall be necessary provided that such change of address does not conflict with any other provisions of this Agreement.
B. Provider must immediately notify County of a change in ownership, organizational status, licensure, or ability of Provider to provide the quantity or quality of the contracted services in a timely fashion.

10. INDEPENDENT CONTRACTOR

The parties intend that an independent contractor relationship will be created by this contract. Provider is, and shall be at all times, deemed independent and shall be wholly responsible for the manner in which it performs services required by the terms of this Agreement. Provider exclusively assumes responsibility for acts of its employees, agents, affiliates, and subcontractors, if any are authorized herein, as they relate to the services or work to be performed under this Agreement during the course and scope of their employment by Provider. Those persons will be entirely and exclusively under the direction, supervision, and control of Provider.

County may designate the tasks to be performed and the results to be accomplished under this Agreement, provide information concerning the work or services, approve or disapprove the final work product and/or services provided, and set deadlines for the completion of the work or services, but County will not control or direct the manner, means, methods, or sequence in which Provider performs the work or services for accomplishing the results. Provider understands and

agrees that Provider lacks the authority to bind County or incur any obligations on behalf of County.

Provider, including any subcontractor or employees of Provider, shall not receive, nor be eligible for, any benefits County provides for its employees, including, but not limited to, vacation pay, paid holidays, life insurance, health insurance, social security, disability insurance, pension, or 457 plans. Provider shall not receive, nor be eligible for, workers' compensation, including medical and indemnity payments. County is not responsible for withholding, and shall not withhold, Federal Income Contribution Act amounts or taxes of any kind from any payments which it owes Provider. Provider shall not be subject to the work schedules or vacation periods that apply to County employees.

Provider shall be solely responsible for paying its employees, and for withholding Federal Income Contribution Act amounts and other taxes, workers' compensation, unemployment compensation, medical insurance, life insurance, or any other benefit that Provider provides for its employees.

Provider acknowledges that it has no authority to bind the County or incur any obligations on behalf of the County with regard to any matter, and Contractor shall not make any agreements or representations on the County's behalf.

11. ASSIGNMENT AND DELEGATION

Provider is engaged by County for its unique qualifications and skills as well as those of its personnel. Provider shall not subcontract, delegate, or assign services to be provided, in whole or in part, to any other person or entity without prior written consent of County.

In the event Provider receives written consent to subcontract services under this Agreement, Provider is required to ensure subcontractor remains in compliance with the terms and conditions of this Agreement. In addition, Provider is required to monitor subcontractor's compliance with said terms and conditions and provide written evidence of monitoring to County upon request.

12. SUBCONTRACTS

A. Provider shall obtain prior written approval from the Contract Administrator before subcontracting any of its obligations to provide services under this Agreement. Approval is at the discretion of the Contract Administrator but shall not be unreasonably withheld. Provider shall ensure that all subcontracts are subject to the applicable terms and conditions of this Agreement, including, without limitation, the licensing, certification, privacy, data security and confidentiality requirements set forth herein, and include the applicable provisions of 42 Code of Federal Regulations (CFR) § 438.230.
B. Provider shall remain legally responsible for the performance of all terms and conditions of this Agreement, including, without limitation, all SUD services provided by third parties under subcontracts, whether approved by the County or not.

13. CHANGES TO AGREEMENT

This Agreement may be amended by mutual consent of the parties hereto. Said amendments shall become effective only when in writing and fully executed by duly authorized officers of the parties hereto.

14. DEFAULT, TERMINATION, AND CANCELLATION

A. Termination by Default: If either party becomes aware of an event of default, that party shall give written notice of said default to the party in default that shall state the following:

I. The alleged default and the applicable Agreement provision.

II. That the party in default has ten (10) days upon receiving the notice to cure the default (Time to Cure).

III. If the party in default does not cure the default within ten (10) days of the Time to Cure, then such party shall be in default and the party giving notice may terminate the Agreement by issuing a Notice of Termination. The party giving notice may extend the Time to Cure at their discretion. Any extension of Time to Cure must be in writing, prepared by the party in default for signature by the party giving notice, and must specify the reason(s) for the extension and the date in which the extension of Time to Cure expires.

If County terminates this Agreement, in whole or in part, for default:

IV. County reserves the right to procure the goods or services, or both, similar to those terminated, from other sources and Provider shall be liable to County for any excess costs for those goods or services. County may deduct from any payment due, or that may thereafter become due to Provider, the excess costs to procure from an alternate source.

V. County shall pay Provider the sum due to Provider under this Agreement prior to termination, unless the cost of completion to County exceeds the funds remaining in the Agreement. In which case the overage shall be deducted from any sum due Provider under this Agreement and the balance, if any, shall be paid to Provider upon demand.

VI. County may require Provider to transfer title and deliver to County any completed work under the Agreement.

The following shall be events of default under this Agreement:

VII. Failure by either party to perform in a timely and satisfactory manner any or all of its obligations under this Agreement.

VIII. A representation or warranty made by Provider in this Agreement proves to have been false or misleading in any respect.

IX. Provider fails to observe and perform any covenant, condition or agreement on its part to be observed or performed under this Agreement, unless County agrees, in writing, to an extension of the time to perform before that time period expires.

X. A violation ARTICLE 2. General Provisions, 17. Conflict of Interest.

B. Bankruptcy: County may terminate this Agreement immediately in the case of bankruptcy, voluntary or involuntary, or insolvency of Provider.

C. Ceasing Performance: County may terminate this Agreement immediately in the event Provider ceases to operate as a business or otherwise becomes unable to substantially perform any term or condition of this Agreement.

D. Termination or Cancellation without Cause: County may terminate this Agreement, in whole or in part, for convenience upon thirty (30) calendar days' written Notice of Termination. If such termination is effected, County will pay for satisfactory services rendered before the effective date of termination, as set forth in the Notice of Termination

provided to Provider, and for any other services that County agrees, in writing, to be necessary for contract resolution. In no event, however, shall County be obligated to pay more than the total amount of the Agreement. Upon receipt of a Notice of Termination, Provider shall promptly discontinue all services affected, as of the effective date of termination set forth in such Notice of Termination, unless the Notice directs otherwise.

15. INTERPRETATION; VENUE

A. The headings used herein are for reference only. The terms of the Agreement are set out in the text under the headings.

B. This Agreement shall be governed by the laws of the State of California without regard to the choice of law or conflicts.

C. This Agreement is made in El Dorado County, California. The venue for any legal action in state court filed by either party to this Agreement for the purpose of interpreting or enforcing any provision of this Agreement shall be in the Superior Court of California, County of El Dorado. The venue for any legal action in federal court filed by either Party to this Agreement for the purpose of interpreting or enforcing any provision of this Agreement lying withing the jurisdiction of the federal courts shall be the 5th District of California.

16. INSURANCE

Provider shall provide proof of a policy of insurance satisfactory to the County of El Dorado Risk Manager and documentation evidencing that Provider maintains insurance that meets the following requirements:

A. Full Worker's Compensation and Employer's Liability Insurance covering all employees of Provider as required by law in the State of California.

B. Commercial General Liability Insurance of not less than $1,000,000.00 combined single limit per occurrence for bodily injury and property damage and a $2,000,000.00 aggregate limit.

C. Automobile Liability Insurance of not less than $1,000,000.00 is required in the event motor vehicles are used by the Provider in the performance of the Agreement.

D. In the event Provider is a licensed professional or professional consultant, and is performing professional services under this Agreement, professional liability is required with a limit of liability of not less than $1,000,000.00 per occurrence.

E. Provider shall furnish a certificate of insurance satisfactory to the County of El Dorado Risk Manager as evidence that the insurance required above is being maintained.

F. The insurance will be issued by an insurance company acceptable to Risk Management, or be provided through partial or total self-insurance likewise acceptable to Risk Management.

G. Provider agrees that the insurance required above shall be in effect at all times during the term of this Agreement. In the event said insurance coverage expires at any time or times during the term of this Agreement, Provider agrees to provide at least thirty (30) days prior to said expiration date, a new certificate of insurance evidencing insurance coverage as provided for herein for not less than the remainder of term of the Agreement, or for a period of not less than one (1) year. New certificates of insurance are subject to the approval of Risk Management and Provider agrees that no work or services shall be performed prior to the giving of such approval. In the event the Provider fails to keep in effect at all times insurance coverage as herein provided,

County may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

H. The certificate of insurance must include the following provisions stating that:
   1. The insurer will not cancel the insured's coverage without prior written notice to County, and;
   2. The County of El Dorado, its officers, officials, employees and volunteers are included as additional insured on an additional insured endorsement, but only insofar as the operations under this Agreement are concerned. This provision shall apply to the general liability policy.

I. The Provider's insurance coverage shall be primary insurance as respects the County, its officers, officials, employees and volunteers. Any insurance or self-insurance maintained by the County, its officers, officials, employees or volunteers shall be in excess of the Provider's insurance and shall not contribute with it.

J. Any deductibles or self-insured retentions must be declared to and approved by the County, either: the insurer shall reduce or eliminate such deductibles or self-insured retentions as respects the County, its officers, officials, employees and volunteers; or the Provider shall procure a bond guaranteeing payment of losses and related investigations, claim administration and defense expenses.

K. Any failure to comply with the reporting provisions of the policies shall not affect coverage provided to the County, its officers, officials, employees or volunteers.

L. The insurance companies shall have no recourse against the County of El Dorado, its officers and employees or any of them for payment of any premiums or assessments under any policy issued by any insurance company.

M. Provider's obligations shall not be limited by the foregoing insurance requirements and shall survive expiration of this Agreement.

N. In the event Provider cannot provide an occurrence policy, Provider shall provide insurance covering claims made as a result of performance of this Agreement for not less than three (3) years following completion of performance of this Agreement.

O. Certificate of insurance shall meet such additional standards as may be determined by the contracting County Department either independently or in consultation with Risk Management, as essential for protection of the County.

17. CONFLICT OF INTEREST

The parties to this Agreement have read and are aware of the provisions of Government Code Section 1090 et seq. and the Political Reform Act of 1974 (Section 87100 et seq.), relating to conflict of interest of public officers and employees. Individuals who are working for Provider and performing work for County and who are considered to be a Consultant within the meaning of Title 2, California Code of Regulations (CCR), Section 18700.3, as it now reads or may thereafter be amended, are required to file a statement of economic interest in accordance with County's Conflict of Interest Code. County's Contract Administrator shall at the time this Agreement is executed make an initial determination whether or not the individuals who will provide services or perform work pursuant to this Agreement are Consultants within the meaning of the Political Reform Act and County's Conflict of Interest Code. Statements of economic interests are public records subject to disclosure under the California Public Records Act.

Provider covenants that during the term of this Agreement neither it, or any officer or employee of the Provider, has or shall acquire any interest, directly or indirectly, in any of the following:

A. Any other contract connected with, or directly affected by, the services to be performed by this Agreement.
B. Any other entities connected with, or directly affected by, the services to be performed by this Agreement.
C. Any officer or employee of County that are involved in this Agreement.

If Provider becomes aware of a conflict of interest related to this Agreement, Provider shall promptly notify County of the existence of that conflict, and County may, in its sole discretion, immediately terminate this Agreement by giving written notice as detailed in ARTICLE 2. General Provisions, 12. Default, Termination, and Cancellation.

Pursuant to Government Code section 84308 (SB 1439, the Levine Act), Provider shall complete and sign the attached Exhibit D, marked "California Levine Act Statement," incorporated herein and made by reference a part hereof, regarding campaign contributions by Provider, if any, to any officer of County.

18. FORCE MAJEURE

Neither party will be liable for any delay, failure to perform, or omission under this Agreement that is due to any cause that it is beyond its control, not due to its own negligence, and cannot be overcome by the exercise of due diligence. In that event, the affected party will:

A. Promptly give written notice to the other of the fact that it is unable to so perform and the cause(s) that is beyond its control; and
B. Once the cause(s) has ceased, provide written notice to the other party and immediately resume its performance under this Agreement.

For purposes of this section, "cause that is beyond its control" includes labor disturbances, riots, fires, earthquakes, floods, storms, lightning, epidemics, war, disorders, hostilities, expropriation or confiscation of properties, failure of and delays by carriers, interference by civil or military authorities, whether legal or de facto, and whether purporting to act under some constitution, decree, or law, or otherwise, or acts of God.

19. SEVERABILITY

If any provision of this Agreement, or any portion thereof, is found by any court of competent jurisdiction to be unenforceable or invalid for any reason, such provision shall be severable and shall not in any way impair the enforceability of any other provision of this Agreement.

20. AUTHORITY TO CONTRACT

County and Provider warrant that they are legally permitted and otherwise have the authority to enter into this Agreement, the signatories to this Agreement are authorized to execute this Agreement on behalf of their respective entities, and that any action necessary to bind each Party has been taken prior to execution of this Agreement.

21. CONFORMITY WITH STATE AND FEDERAL LAWS AND REGULATIONS

A. Provider shall provide services in conformance with all applicable state and federal statues, regulations and subregulatory guidance, as from time to time amended, including but not limited to:

I. Title 9, CCR;
II. Title 22, CCR;
III. California Welfare and Institutions Code, Division 5;
IV. United States Code of Federal Regulations, Title 42, including but not limited to Parts 2, 438 and 455;
V. United States Code of Federal Regulations, Title 45;
VI. United States Code, Title 42 (The Public Health and Welfare), as applicable;
VII. Balanced Budget Act of 1997;
VIII. Health Insurance Portability and Accountability Act (HIPAA); and
IX. Applicable Medi-Cal laws and regulations, including applicable sub-regulatory guidance, such as BHINs, MHSUDS INs, and provisions of County's state or federal contracts governing client services.

B. In the event any law, regulation, or guidance referred to in subsection (A), above, is amended during the term of this Agreement, the Parties agree to comply with the amended authority as of the effective date of such amendment without amending this Agreement.

ARTICLE 3. SERVICES AND ACCESS PROVISIONS

1. CERTIFICATION OF ELIGIBILITY

Provider will, in cooperation with County, comply with 42 C.F.R. § 455.1(a)(2) and BHIN 23-001, to obtain a certification of a client's eligibility for SUD services under Medi-Cal.

2. ACCESS TO SUBSTANCE USE DISORDER SERVICES

A. In collaboration with the County, Provider will work to ensure that individuals to whom the Provider provides SUD services meet access criteria and medical necessity requirements, as per DHCS guidance specified in BHIN 23-001. Specifically, the Provider will ensure that the clinical record for each client includes information as a whole indicating that client's presentation and needs are aligned with the criteria applicable to their age at the time of service provision as specified below.

B. Provider shall have written admission criteria for determining the client's eligibility and suitability for treatment and services. All clients admitted shall meet the admission criteria and this shall be documented in the client's record.

C. Programs shall ensure that their policies, procedures, practices, and rules and regulations do not discriminate against the above special populations. Whenever the needs of the client cannot be reasonably accommodated, efforts shall be made to make referral(s) to appropriate programs.

D. Provider should recognize and educate staff and collaborative partners that Parole and Probation status is not a barrier to SUD services.

E. Provider will ensure that the clinical record for each client includes information as a whole indicating that client's presentation and needs are aligned with the criteria applicable to their age at the time-of-service provision as outlined in this Agreement.

F. The initial assessment shall be performed face-to-face, by telehealth or by telephone by a Licensed Practitioner of the Healing Arts (LPHA) or registered or certified counselor and may be done in the community or the home, except for residential treatment services and narcotic treatment programs (NTPs). If the assessment of the client is completed by a registered or certified counselor, then an LPHA shall evaluate that assessment with the counselor and the LPHA shall make the final diagnosis. The consultation between the

LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.

G. Provider shall comply with beneficiaries' access criteria and services provided during the initial assessment process requirements:
   I. For beneficiaries 21 years of age and older, a full assessment using the American Society of Addiction Medicine (ASAM) Criteria shall be completed within 30 days of the beneficiary's first visit with an LPHA or registered or certified counselor, or Peer Support Specialist (except for residential treatment services)
   II. For beneficiaries under the age of 21, a full assessment using the ASAM Criteria shall be completed within 60 days of the beneficiary's first visit with an LPHA or registered or certified counselor (except for residential treatment services).
   III. For beneficiaries experiencing homelessness and where the provider documents that due to homelessness additional time is required to complete the assessment, a full assessment using the ASAM Criteria shall be completed within 60 days of the beneficiary's first visit with an LPHA or registered or certified counselor (except for residential treatment services).
   IV. If a client withdraws from treatment prior to completion of the assessment or prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorder, and later returns, the 30-day or 60-day time period starts over.

H. Provider shall comply with beneficiaries' access criteria after initial assessment requirements:
   I. Beneficiaries 21 years of age and older, to qualify for DMC-ODS services after the initial assessment, must meet one of the following criteria:
      a. Have at least one diagnosis from the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders for Substance-Related and Addictive Disorders, except for Tobacco-Related Disorders and Non-Substance-Related Disorders, OR
      b. Have had at least one diagnosis from the most current edition of the DSM for Substance-Related and Addictive Disorders, except for Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

I. Beneficiaries under the age of 21, qualify for DMC-ODS medically necessary services after the initial assessment, in the following circumstances:
   I. All services that are Medi-Cal-coverable, appropriate, and medically necessary, needed to correct and ameliorate health conditions shall be provided, as per federal Early & Periodic Screening, Diagnostic and Treatment (EPSDT) statutes and regulations.
   II. Services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and SUDs, consistent with federal guidance.
   III. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

3. ASAM LEVEL OF CARE DETERMINATION

A. Provider shall use the ASAM Criteria to determine placement into the appropriate Level of Care (LOC) for all beneficiaries, which is separate and distinct from determining

medical necessity. LOC determinations shall ensure that beneficiaries are able to receive care in the least restrictive LOC that is clinically appropriate to treat their condition.

B. A full ASAM Criteria assessment and an SUD diagnosis is not required to deliver prevention and early intervention services for beneficiaries under the age of 21; a brief screening ASAM Criteria tool is sufficient for these services.
C. For clients who withdraw from treatment prior to completing the ASAM Criteria assessment or prior to establishing a diagnosis from the DSM for Substance-Related and Addictive Disorders, and later return, the time period for initial assessment starts over.
D. A full ASAM Criteria assessment, or brief screening ASAM Criteria tool for preliminary LOC recommendations, shall not be required to begin receiving DMC-ODS services.
E. A full ASAM Criteria assessment does not need to be repeated unless the client's condition changes.
F. Requirements for ASAM LOC assessments apply to NTP clients and settings.

4. MEDICAL NECESSITY
   A. Pursuant to BHIN 23-001 and consistent with Welfare & Institutions Code § 14059.5, DMC-ODS services must be medically necessary.
   B. For beneficiaries 21 years of age and older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
   C. For beneficiaries under the age of 21, a service is "medically necessary" or a "medical necessity" if the service is necessary to correct or ameliorate screened health conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

5. ADDITIONAL COVERAGE REQUIREMENTS AND CLARIFICATIONS
   A. The target population for DMC-ODS SUD services includes clients who are enrolled in Medi-Cal, reside in the County, and meet the criteria for DMC-ODS services as per established requirements above.
   B. Consistent with Welfare & Institutions Code § 14184.402(f), covered SUD prevention, screening, assessment, treatment, and recovery services are reimbursable Medi-Cal services when:
      I. Services are provided before one of the following: the completion of an assessment, the determination of whether DMC-ODS access criteria are met, or the determination of a diagnosis.
         a. Clinically appropriate and covered DMC-ODS services provided to clients over the age of 21 are reimbursable during the assessment process. Similarly, if the assessment determines that the client does not meet the DMC-ODS access criteria after initial assessment, those clinically appropriate and covered DMC-ODS services provided are reimbursable.
         b. All Medi-Cal claims shall include a current CMS approved International Classification of Diseases (ICD) diagnosis code. In cases where services are provided due to a suspected SUD that has not yet been diagnosed, options are available in the CMS approved ICD-10 code list, for example, codes for "Other

specified" and "Unspecified" disorders, or "Factors influencing health status and contact with health services".

II. Prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan, or if the client signature was absent from the treatment plan.
   a. While most DMC-ODS providers are expected to adopt problem lists as specified in BHIN 22-019, treatment plans continue to be required for some services in accordance with federal law.
   b. Treatment plans are required by federal law for:
      1. Narcotic Treatment Programs (NTPs)
      2. Peer Support Services

III. The beneficiary has a co-occurring mental health condition.
   a. Medically necessary covered DMC-ODS services delivered by Provider shall be covered and reimbursable Medi-Cal services whether or not the client has a co-occurring mental health condition.

6. DIAGNOSIS DURING INITIAL ASSESSMENT

A. Provider may use the following options during the assessment phase of client's treatment when a diagnosis has yet to be established as specified in BHIN 22-013:

I. ICD-10 codes Z55-Z65 Potential health hazards related to socioeconomic and psychological circumstances: may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision, of, an LPHA.

II. ICD-10 code Z03.89 Encounter for observation for other suspected diseases and conditions ruled out: may be used by an LPHA during the assessment phase of a client's treatment when a diagnosis has yet to be established.

III. CMS approved diagnosis code on the ICD 10 tabular, available in the CMS 2022 ICD-10-CM page at: https://www.cms.gov/medicare/icd-10/2022-icd-10-cm, which may include Z codes. LPHAs may use any clinically appropriate ICD-10 code, for example, codes for "Other specified" and "Unspecified" disorders, or "Factors influencing health status and contact with health services".

7. COORDINATION AND CONTINUITY OF CARE

A. Provider shall comply with the care and coordination requirements established by the County and per 42 C.F.R. § 438.208.

B. Provider shall ensure that all care, treatment, and services provided pursuant to this Agreement are coordinated among all providers who are serving the client. Coordination and continuity of care procedures shall meet the following requirements:

I. Ensure that each client has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the client. The client shall be provided information on how to contact their designated person or entity.

II. All services provided to clients shall be coordinated:
   a. Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.
   b. With the services the client receives from any other managed care organization.
   c. With the services the client receives in FFS Medi-Cal.

d. With the services the client receives from community and social support providers.

III. Share with other providers serving the client, as allowed by regulations, the results of any identification and assessment of that client's needs to prevent duplication of those activities.

IV. Ensure that each provider furnishing services to clients maintains and shares, as appropriate, a client health record in accordance with professional standards.

V. Ensure that in the process of coordinating care, each client's privacy is protected in accordance with the privacy requirements in 45 C.F.R. Parts 160 and 164 subparts A and E and 42 C.F.R. Part 2, to the extent that they are applicable.

C. Provider shall engage in care coordination activities beginning at intake and throughout the treatment and discharge planning processes.

D. To facilitate care coordination, Provider will request a HIPPA and California law compliant client authorization to share client information with and among all other providers involved in the client's care, in satisfaction of state, and federal privacy laws and regulations.

8. SITE LICENSES, CERTIFICATIONS, PERMITS REQUIREMENTS

A. As specified in BHIN 21-001 and in accordance with Health and Safety Code § 11834.015, DHCS adopted the ASAM treatment criteria as the minimum standard of care for licensed AOD facilities. All licensed AOD facilities shall obtain at least one DHCS LOC Designation and/or at least one residential ASAM LOC Certification consistent with all of its program services. If an AOD facility opts to obtain an ASAM LOC Certification, then that facility will not be required to obtain a DHCS LOC Designation. However, nothing precludes a facility from obtaining both a DHCS LOC Designation and ASAM LOC Certification.

B. Provider shall obtain and comply with DMC site certification and ASAM designation or DHCS Level of Care (LOC) Designation for each type of contracted service being delivered, as well as any additional licensure, registration or accreditation required by regulations for the contracted service being delivered.

C. Provider shall obtain and maintain all appropriate licenses, permits, and certificates required by all applicable federal, state, and county and/or municipal laws, regulations, guidelines, and/or directives.

D. Provider shall have and maintain a valid fire clearance at the specified service delivery sites where direct services are provided to clients.

9. MEDICATIONS

A. If Provider provides or stores medications, the Provider shall store and monitor medications in compliance with all pertinent statutes and federal standards.

B. Provider shall have written policies and procedures regarding the use of prescribed medications by clients, and for monitoring and storing of medications.

C. Prescription and over the counter medications which expire and other bio-hazardous pharmaceutics including used syringes or medications which are not removed by the client upon termination of services shall be disposed of by the program director or a designated substitute, and one other adult who is not a client. Both shall sign a record, to be retained for at least one year.

D. Provider shall have at least one program staff on duty at all times trained to adequately monitor clients for signs and symptoms of their possible misuse of prescribed medications, adverse medication reactions and related medical complications.

10. ALCOHOL AND/OR DRUG-FREE ENVIRONMENT
    A. Provider shall provide an alcohol and/or drug-free environment for clients. The use of medications for the treatment of SUD, mental illness, or physical conditions, shall be allowed and controlled as per Provider's written policies and procedures.
    B. Provider shall have written policies regarding service delivery for when clients experience relapse episodes. These policies shall be supportive of and consistent with the alcohol and/or drug-free environment of the program.

11. ASSESSMENT OF TOBACCO USE DISORDER
    A. As required by Health and Safety Code § 11756.5 (Assembly Bill (AB) 541; Chapter 150, Statutes 2021) and BHIN 22-024, all licensed or certified SUD recovery or treatment facilities shall conduct an assessment of tobacco use at the time of the client's initial intake. The assessment shall include questions recommended in the most recent version of Diagnostic and Statistical Manual of Mental Disorders (DSM) under Tobacco Use Disorder, or County's evidence-based guidance, for determining whether a client has a tobacco use disorder.
    B. The licensed and/or certified SUD recovery or treatment facility shall do the following:
        I. Provide information to the client on how continued use of tobacco products could affect their long-term success in recovery from SUD.
        II. Recommend treatment for tobacco use disorder in the treatment plan.
        III. Offer either treatment, subject to the limitation of the license or certification issued by DHCS, or a referral for treatment for tobacco use disorder.
    C. Licensed or certified SUD recovery or treatment facilities can also adopt tobacco free campus policies, to change the social norm of tobacco use, promote wellness, and reduce exposure to secondhand smoke.

12. NALOXONE REQUIREMENTS
    A. As required by Health and Safety Code, § 11834.26 (AB 381, Chapter 437 Statutes 2021 and BHIN 22-025, all licensed or certified SUD recovery or treatment facilities shall comply with the following requirements:
        I. Maintain, at all times, at least 2 unexpired doses of naloxone, or any other opioid antagonist medication that is approved by the FDA for the treatment of an opioid overdose, on the premises of the licensed SUD recovery or treatment facility.
        II. Have at least one staff member, at all times, on the premises who knows the specific location of the naloxone, or other FDA-approved opioid antagonist medication, and who has been trained in its administration. Training shall include review of online resources and the National Harm Reduction Coalition's Opioid Overdose Basics website to respond effectively to an opioid-associated overdose emergency. Staff shall certify that they have reviewed and undergone training in opioid overdose prevention and treatment.
        III. The proof of completion of such training shall be documented in the staff member's individual personnel file, in accordance with Title 9, CCR, § 10564(k).

ARTICLE 4. AUTHORIZATION AND DOCUMENTATION PROVISIONS

1. SERVICE AUTHORIZATION
   A. For SUD Non-Residential and Non-Inpatient Levels of Care service authorization:
      I. Provider shall follow County's policies and procedures around non-residential/non-inpatient levels of care according to BHIN 23-001.
      II. Provider is not required to obtain service authorization for non-residential/non-inpatient levels of care. Prior authorization is prohibited for non-residential DMC-ODS services.

2. DOCUMENTATION REQUIREMENTS
   A. Provider agrees to comply with documentation requirements for non-hospital services as specified in ARTICLE 4. Authorization and Documentation Provisions, inclusive in compliance with federal, state and County requirements.
   B. All Provider documentation shall be accurate, complete, legible, and shall list each date of service. Provider shall document the face-to-face duration of the service, including travel and documentation time for each service. Services must be identified as provided in-person, by telephone, or by telehealth.
   C. All services shall be documented utilizing County-approved templates and contain all required elements. Provider agrees to satisfy the chart documentation requirements set forth in BHIN 22-019 and the contract between County and DHCS. Failure to comply with documentation standards specified require corrective action plans.

3. ASSESSMENT
   A. Provider shall use the American Society of Addiction Medicine (ASAM) Criteria assessment for DMC-ODS clients to determine the appropriate level of SUD care.
   B. The assessment shall include a typed or legibly printed name, signature of the service provider and date of signature. Assessment shall include the provider's LOC determination and recommendation for services. If the assessment of the client is completed by a registered or certified counselor, then the LPHA shall evaluate that assessment with the counselor and the LPHA shall make the initial diagnosis. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.
   C. The problem list and progress note requirements shall support the medically necessary services or medical necessity of each service provided.
   D. Assessments shall be updated as clinically appropriate when the beneficiary's condition changes. Additional information on assessment requirements to Substance Use Disorder Services can be found in BHIN 23-001.

4. ICD-10
   A. Provider shall use the criteria set forth in the current edition of the DSM as the clinical tool to make diagnostic determinations.
   B. Once a DSM diagnosis is determined, the Provider shall determine the corresponding diagnosis in the current edition of ICD. Provider shall use the ICD diagnosis code(s) to submit a claim for SUD services to receive reimbursement from County.
   C. Under the EPSDT mandate, for youth under the age of 21, a diagnosis from the ICD-10 for Substance-Related and Addictive Disorders is not required for early intervention services.

D. The ICD Tabular List of Diseases and Injuries is maintained by CMS and may be updated during the term of this Agreement. Changes to the lists of ICD diagnoses do not require an amendment to this Agreement, and County may implement these changes as provided by DHCS.

5. PHYSICAL EXAMINATION REQUIREMENTS
   A. If a beneficiary had a physical examination within the twelve-month period prior to the beneficiary's admission to treatment date, the physician or registered nurse practitioner or physician's assistant (physician extenders) shall review documentation of the beneficiary's most recent physical examination within thirty (30) calendar days of the beneficiary's admission to treatment date.
   B. If a provider is unable to obtain documentation of a beneficiary's most recent physical examination, the provider shall describe the efforts made to obtain this documentation in the beneficiary's individual patient record.
   C. As an alternative to complying with paragraph (A) above or in addition to complying with paragraph (A) above, the physician or physician extender may perform a physical examination of the beneficiary within thirty (30) calendar days of the beneficiary's admission to treatment date.
   D. If the physician or a physician extender, has not reviewed the documentation of the beneficiary's physical examination as provided for in paragraph (A), or the provider does not perform a physical examination of the beneficiary as provided for in paragraph (B), then the LPHA or counselor shall include in the beneficiary's initial and updated treatment plans the goal of obtaining a physical examination, until this goal has been met and the physician has reviewed the physical examination results. The physician shall type or legibly print their name, sign, and date documentation to support they have reviewed the physical examination results. The signature shall be adjacent to the typed or legibly printed name.

6. PROBLEM LIST
   A. Provider will create and maintain a Problem List for each client served under this Agreement. The problem list is a list of symptoms, conditions, diagnoses, or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.
   B. Provider must document a problem list that adheres to industry standards utilizing at minimum SNOMED International, Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) U.S. Edition, March 2021 Release, and ICD-10-CM 2023.
   C. A problem identified during a service encounter may be addressed by the service provider (within their scope of practice) during that service encounter and subsequently added to the problem list.
   D. The problem list shall be updated on an ongoing basis to reflect the current presentation of the client.
   E. The problem list shall include, but is not limited to the following:
      I. Diagnoses identified by a provider acting within their scope of practice, if any. Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable.
      II. Problems identified by a provider acting within their scope of practice, if any.
      III. Problems or illnesses identified by the client and/or significant support person, if any.

IV. The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.

F. Provider shall add to or remove problems from the problem list when there is a relevant change to a beneficiary's condition.

G. County does not require the problem list to be updated within a specific timeframe or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, Provider shall update the problem list within a reasonable time such that the problem list reflects the current issues facing the client, in accordance with generally accepted standards of practice and in specific circumstances specified in BHIN 22-019.

7. PROGRESS NOTES

A. Provider shall create progress notes for the provision of all DMC-ODS services provided under this Agreement.

B. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.

C. Progress notes shall include all elements specified in BHIN 22-019, whether the note be for an individual or group service, and shall include:

I. The type of service rendered

II. A narrative describing the service, including how the service addressed the client's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors)

III. The date that the service was provided to the beneficiary

IV. Duration of the service, including travel and documentation time

V. Location of the client at the time of receiving the service

VI. A typed or legibly printed name, signature of the service provider and date of signature

VII. ICD-10 code

VIII. Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code

IX. Next steps, including, but not limited to, planned action steps by the provider or by the client, collaboration with the client, collaboration with other provider(s) and any update to the problem list as appropriate.

D. Provider shall complete progress notes within three business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.

E. Provider shall complete a daily progress note for services that are billed on a daily basis, such as residential and inpatient services, if applicable.

F. When a group service is rendered by the Provider, the following conditions shall be met:

I. A list of participants is required to be documented and maintained by the Provider.

II. If more than one provider renders a group service, one progress note may be completed for a group session and signed by one provider. Provider shall ensure that in this case, the progress note clearly documents the specific involvement and the specific amount of time of involvement of each provider during the group activity, including documentation time.

8. PLAN OF CARE

A. As specified in BHIN 22-019, when a plan of care is required, Provider shall follow the DHCS requirements outlined in the Alcohol and/or Other Drug Program Certification

Standards document, available in the DHCS Facility Certification page at: https://www.dhcs.ca.gov/provgovpart/Pages/Licensing-and-Certification-Facility-Certification.aspx

B. Provider shall develop plans of care for all clients, when required, and these plans of care shall include the following:
   I. Statement of problems experienced by the client to be addressed.
   II. Statement of objectives to be reached that address each problem.
   III. Statement of actions that will be taken by the program and/or client to accomplish the identified objectives.
   IV. Target date(s) for accomplishment of actions and objectives.

C. Provider shall develop the plan of care with participation from the client in accordance with the timeframes specified below:
   I. For outpatient programs, the plan of care shall be developed within 30 calendar days from the date of the client's admission. The client's progress shall be reviewed and documented within 30 calendar days after signing the plan of care and not later than every 30 calendar days thereafter.
   II. An LPHA, registered or certified counselor shall ensure and document, that together with the client, the plan of care is reviewed and updated, as necessary, when a change in problem identification or focus of treatment occurs, or no later than 90 calendar days after signing the plan of care and no later than every 90 calendar days thereafter, whichever comes first.

D. Provider is not required to complete a plan of care for clients under this Agreement, except in the below circumstances:
   I. Narcotic Treatment Programs (NTP) are required to create a plan of care for clients as per federal law. This requirement is not impacted by the documentation requirements in BHIN 22-019. NTPs shall continue to comply with federal and state regulations regarding plans of care and documentation requirements.

9. TELEHEALTH

A. Provider may use telehealth, when it deems clinically appropriate, as a mode of delivering behavioral health services in accordance with all applicable County, state, and federal requirements, including those related to privacy/security, efficiency, and standards of care. Such services will conform to the definitions and meet the requirements included in the Medi-Cal Provider Manual: Telehealth, available in the DHCS Telehealth Resources page at: https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx.

B. All telehealth equipment and service locations must ensure that client confidentiality is maintained.

C. Licensed providers and staff may provide services via telephone and telehealth as long as the service is within their scope of practice.

D. Medical records for clients served by Provider under this Agreement must include documentation of written or verbal consent for telehealth or telephone services if such services are provided by Provider. Such consent must be obtained at least once prior to initiating applicable health care services and consent must include all elements as specified in BHIN 22-019.

E. County may at any time audit Provider's telehealth practices, and Provider must allow access to all materials needed to adequately monitor Provider's adherence to telehealth standards and requirements.

10. DISCHARGE PLANNING

A. Provider shall have written policies and procedures or shall adopt the County's policies and procedures regarding discharge. These procedures shall contain the following:

I. Written criteria for discharge defining:

a. Successful completion of program;
b. Administrative discharge;
c. Involuntary discharge;
d. Transfers and referrals.

II. A discharge summary that includes:

a. Reason for discharge, including whether the discharge was voluntary or involuntary and whether the client successfully completed the program;
b. Description of treatment episodes;
c. Description of recovery services completed;
d. Current alcohol and/or other drug usage;
e. Vocational and educational achievements;
f. Client's continuing recovery or discharge plan signed by an LPHA, or registered or certified counselor and client;
g. Transfers and referrals; and
h. Client's comments.

ARTICLE 5. CHART AUDITING AND REASONS FOR RECOUPMENT

1. MAINTENANCE OF RECORDS

Provider shall maintain proper clinical and fiscal records relating to clients served under the terms of this Agreement, as required by the Director, DHCS, and all applicable state and federal statutes and regulations. Client records shall include but not be limited to admission records, diagnostic studies and evaluations, client interviews and progress notes, and records of services provided. All such records shall be maintained in sufficient detail to permit evaluation of the services provided and to meet claiming requirements.

2. ACCESS TO RECORDS

Provider shall provide County with access to all documentation of services provided under this Agreement for County's use in administering this Agreement. Provider shall allow County, CMS, the Office of the Inspector General, the Controller General of the United States, and any other authorized federal and state agencies to evaluate performance under this Agreement, and to inspect, evaluate, and audit any and all records, documents, and the premises, equipment and facilities maintained by the Provider pertaining to such services at any time and as otherwise required under this Agreement.

3. FEDERAL, STATE AND COUNTY AUDITS

In accordance with 42 C.F.R. § 438.66 and as applicable with 42 C.F.R. §§ 438.604, 438.606, 438.608, 438.610, 438.230, 438.808, 438.900 et seq., County will conduct monitoring and oversight activities to review the Provider's SUD programs and operations. The purpose of these oversight activities is to verify that medically necessary services are provided to clients, who meet medical necessity and criteria for access to DMC-ODS as established in BHIN 23-001, in compliance with the applicable state and federal laws and regulations, and/or the terms

of the Agreement between Provider and County, and future BHINs which may spell out other specific requirements.

4. INTERNAL AUDITING, COMPLIANCE, AND MONITORING
   A. Providers of sufficient size as determined by County shall institute and conduct a Quality Assurance Process for all services provided hereunder. Said process shall include at a minimum a system for verifying that all services provided and claimed for reimbursement shall meet DMC-ODS definitions and be documented accurately.
   B. Provider shall provide County with notification and a summary of any internal audit within thirty (30) days of completion of said audit, consistent with 45 CFR Subpart F, including any exceptions and the specific corrective actions taken to sufficiently reduce the errors that are discovered through Provider's internal audit process as applicable.
   C. Audits or monitoring by the County may be performed by way of annual Contract Monitoring Surveys. Provider receiving a Contract Monitoring Survey shall, within sixty (60) days of receipt, complete and return the survey along with all documentation, details, and supporting materials required by the survey or otherwise necessary for the County to verify compliance with the terms and conditions of the Agreement. Failure to return the survey within the specified time period may result in the withholding of payment from the Provider until such time as compliance with the terms of the Agreement can be verified. Verifying compliance may necessitate additional on-site reviews should information submitted by the Provider be deemed insufficient or inaccurate.
   D. State Audits: Provider acknowledges that if total compensation under this agreement is greater than $10,000.00, this Agreement is subject to examination and audit by the California State Auditor for a period of three (3) years, or for any longer period required by law, after final payment under this Agreement, pursuant to California Government Code §8546.7. In order to facilitate these potential examinations and audits, Provider shall maintain, for a period of at least three (3) years, or for any longer period required by law, after final payment under the contract, all books, records and documentation necessary to demonstrate performance under the Agreement.
   E. The State, Center for Medicare and Medicaid Services (CMS), the Health and Human Services (HHS) Office of the Inspector General, the Comptroller General, the County, and their designees may, at any time, inspect and audit any records or documents of the County, or its Providers, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted. The right to audit under this section exists for 10 years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.
   F. The Provider will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid beneficiaries.
   G. The State, CMS, the HHS Inspector General, the Comptroller General, or their designees' right to audit the Provider will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
   H. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Provider at any time.

I. Upon notification of an exception or finding of non-compliance, the Provider shall submit evidence of Corrective Action within thirty (30) days, or as otherwise specified in the notice of required corrective action provided by the County. Continued non-compliance beyond due date for submission of Corrective Action may lead to termination of this Agreement in accordance with ARTICLE 2. General Provisions, 12. Default, Termination, and Cancellation.

J. Failure by County to notify or require Corrective Action does not constitute acceptance of the practice of waiver of the County's right to enforce.

K. Provider shall be held accountable for audit exceptions taken by DHCS against the Provider and its subcontractors for any failure to comply with these requirements:

I. Title 9, CCR, Division 4, Chapter 8, commencing with Section 13000, Certification of Alcohol and Other Drug Counselors

II. Title 42, CFR, Sections 8.1 through 8.6, Medication Assisted Treatment for Opioid Use Disorders

III. Title 21, CFR, Sections 1301.01 through 1301.93, Department of Justice, Controlled Substances

IV. State Administrative Manual (SAM), Chapter 7200 (General Outline of Procedures)

L. Provider shall be familiar with the above laws, regulations, and guidelines and shall ensure that its subcontractors are also familiar with such requirements.

5. CONFIDENTIALITY IN AUDIT PROCESS

A. Provider and County mutually agree to maintain the confidentiality of Provider's client records and information, in compliance with all applicable state and federal statutes and regulations, including but not limited to HIPAA, 42 CFR Part 2, and California Welfare and Institutions Code, § 5328, to the extent that these requirements are applicable. Provider shall inform all of its officers, employees and agents of the confidentiality provisions of all applicable statutes.

B. Provider's fiscal records shall contain sufficient data to enable auditors to perform a complete audit and shall be maintained in conformance with standard procedures and accounting principles.

C. Provider's records shall be maintained as required by the Director and DHCS on forms furnished by DHCS or the County. All statistical data or information requested by the Director shall be provided by the Provider in a complete and timely manner.

6. REASONS FOR RECOUPMENT

A. County will conduct periodic audits of Provider files to ensure appropriate clinical documentation, high quality service provision and compliance with applicable federal, state and county regulations.

B. Such audits may result in requirements for Provider to reimburse County for services previously paid in the following circumstances:

I. Identification of Fraud, Waste or Abuse as defined in federal regulation.

a. Fraud and abuse are defined in Code of Federal Regulations, Title 42, § 455.2 and Welfare & Institutions Code, § 14107.11, subdivision (d).

b. Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf.

II. Overpayment of Provider by County due to errors in claiming or documentation.

C. Provider shall reimburse County for all overpayments identified by Provider, County and/or state or federal oversight agencies as an audit exception within the timeframes required by law or Country or state or federal agency.

7. COOPERATION WITH AUDITS
   A. Provider shall cooperate with County in any review and/or audit initiated by County, DHCS, or any other applicable regulatory body. This cooperation may include such activities as onsite program, fiscal, or chart reviews and/or audits.
   B. In addition, Provider shall comply with all requests for any documentation or files including, but not limited to, client and personnel files.
   C. Provider shall notify the County of any scheduled or unscheduled external evaluation or site visits when it becomes aware of such visit. County shall reserve the right to attend any or all parts of external review processes.
   D. Provider shall allow inspection, evaluation and audit of its records, documents and facilities for 10 years from the term end date of this Agreement or in the event Provider has been notified that an audit or investigation of this Agreement has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later pursuant to 42 C.F.R. §§ 438.3(h) and 438.230(c)(3)(i-iii).

8. INDEMINITY
   To the fullest extent permitted by law, Provider shall defend at its own expense, indemnify, and hold the County harmless, its officers, employees, agents, and volunteers, against and from any and all liability, claims, suits, losses, damages, or expenses of every name, kind and description, including attorney's fees and costs incurred, brought for, or on account of, injuries to or death of any person, including but not limited to workers, County employees, and the public, or damage to property, or any economic or consequential losses, which are claimed to or in any way arise out of or are connected with the acts or omissions of Provider or its officers, agents, or employees in rendering the services, operations, or performance hereunder, except for liability, claims, suits, losses, damages or expenses arising from the sole negligence or willful acts of the County, its officers and employees, or as expressly prescribed by statute. This duty of Provider to indemnify and save County harmless includes the duties to defend set forth in California Civil Code Section 2778.

ARTICLE 6. CLIENT PROTECTIONS

1. GRIEVANCES, APPEALS AND NOTICES OF ADVERSE BENEFIT DETERMINATION
   A. All grievances (as defined by 42 C.F.R. § 438.400) and complaints received by Provider must be immediately forwarded to the County's Quality Management Department or other designated persons via a secure method (e.g., encrypted email or by fax) to allow ample time for the Quality Management staff to acknowledge receipt of the grievance and complaints and issue appropriate responses.
   B. Provider shall not discourage the filing of grievances and clients do not need to use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance.
   C. Aligned with MHSUDS 18-010E and 42 C.F.R. § 438.404, the appropriate and delegated Notice of Adverse Benefit Determination (NOABD) must be issued by Providers within the specified timeframes using the template provided by the County.

D. All NOABDs are issued by County. Providers are required to submit a completed Exhibit E, marked "Notice of Adverse Benefit Determination (NOABD) Form," incorporated herein and made by reference a part hereof, securely to email: SUDSQualityAssurance@edcgov.us or Fax to 530-295-2596 to notify County of need for NOABD.
E. NOABDs must be issued to clients anytime the Provider has made or intends to make an adverse benefit determination that includes the reduction, suspension, or termination of a previously authorized service and/or the failure to provide services in a timely manner. The notice must have a clear and concise explanation of the reason(s) for the decision as established by DHCS and the County. The Provider must inform the County immediately after issuing a NOABD.
F. Procedures and timeframes for responding to grievances, issuing, and responding to adverse benefit determinations, appeals, and state hearings must be followed as per 42 C.F.R., Part 438, Subpart F (42 C.F.R. §§ 438.400 – 438.424).
G. Provider must provide clients with any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal such as auxiliary aids and interpreter services.
H. Provider must maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures. The record must be accurately maintained in a manner accessible to the County and available upon request to DHCS.

2. ADVANCED DIRECTIVES
Provider must comply with all County policies and procedures regarding Advanced Directives in compliance with the requirements of 42 C.F.R. §§ 422.128 and 438.6(i) (l), (3) and (4).

3. TRANSITION OF CARE
A. Provider shall follow County's transition of care policy in accordance with applicable state and federal regulations, MHSUDS IN 18-051: DMC-ODS Transition of Care Policy, and any BHINs issued by DHCS for parity in SUD and mental health benefits subsequent to the effective date of this Agreement (42 C.F.R. § 438.62(b)(1)-(2).)
B. Clients shall be allowed to continue receiving covered DMC-ODS services with an out-of-network provider when their assessment determines that, in the absence of continued services, the client would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. DMC-ODS treatment services with the existing provider (out-of-network) provider shall continue for a period of no more than 90 days unless medical necessity requires the services to continue for a longer period of time, not exceeding 12 months. Specific criteria must be met.

4. ADVERTISING REQUIREMENTS
A. Provider, to protect the health, safety, and welfare of clients with a SUD, shall not use false or misleading advertisement for their medical treatment or medical services as per Health and Safety Code § 11831.9 and BHIN 22-022.
B. Licensed SUD recovery or treatment facilities and certified alcohol or other drug programs shall not do any of the following:
I. Make a false or misleading statement or provide false or misleading information about the entity's products, goods, services, or geographical locations in its marketing,

advertising materials, or media, or on its internet website or on a third-party internet website.

II. Include on its internet website a picture, description, staff information, or the location of an entity, along with false contact information that surreptitiously directs the reader to a business that does not have a contract with the entity.

III. Include on its internet website false information or an electronic link that provides false information or surreptitiously directs the reader to another internet website.

C. Provider shall comply with these requirements and any subsequent regulations around advertising requirements for SUD recovery or treatment facilities issued by DHCS.

ARTICLE 7. PROGRAM INTEGRITY

1. GENERAL

As a condition of receiving payment under a Medi-Cal managed care program, the Provider shall comply with the provisions of 42 C.F.R. §§ 438.604, 438.606, 438.608 and 438.610. (42 C.F.R. § 438.600 (b)).

2. American Society of Addiction (ASAM) STANDARDS OF CARE

A. In accordance with Health and Safety Code section 11834.015, DHCS has adopted the ASAM treatment criteria, or other equivalent evidenced based criteria as the minimum standard of care for Alcohol and Other Drug (AOD) facilities.

B. For this Agreement and subsequential services, Provider shall adopt ASAM as the evidenced based practice standard for LOC.

C. Provider shall ensure treatment staff of all SUD treatment programs receive adequate training in ASAM criteria prior to providing services that includes but is not limited to in person or e-training modules:

I. ASAM Module I- Multidimensional Assessment

II. ASAM Module II- From Assessment to Service Planning and Level of Care (LOC)

III. ASAM Module III-Introduction to the ASAM Criteria

3. CREDENTIALING AND RE-CREDENTIALING OF PROVIDERS

A. Providers must follow the uniform process for credentialing and recredentialing of network providers established by County, including disciplinary actions such reducing, suspending, or terminating provider's privileges. Failure to comply with specified requirements can result in suspension or termination of a provider.

B. Upon request, the Provider must demonstrate to the County that each of its providers are qualified in accordance with current legal, professional, and technical standards, and that they are appropriately licensed, registered, waivered, and/or certified.

C. Provider must not employ or subcontract with providers debarred, suspended or otherwise excluded (individually, and collectively referred to as "Excluded") from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. § 438.610. See relevant section below regarding specific requirements for exclusion monitoring.

D. Providers shall ensure that all of their network providers, delivering covered services, sign and date an attestation statement on a form provided by County, in which each provider attests to the following:

I. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;

II. A history of loss of license or felony convictions;
III. A history of loss or limitation of privileges or disciplinary activity;
IV. A lack of present illegal drug use; and
V. The application's accuracy and completeness

E. Provider must file and keep track of attestation statements for all of their providers and must make those available to the County upon request at any time.
F. Provider is required to sign an annual attestation statement at the time of Agreement renewal in which they will attest that they will follow County's Credentialing Policy and MHSUDS IN 18-019 and ensure that all of their rendering providers are credentialed as per established guidelines.
G. Provider is required to verify and document at a minimum every three years that each network provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements as per the County's uniform process for credentialing and recredentialing. If any of the requirements are not up-to-date, updated information should be obtained from network providers to complete the re-credentialing process.

4. SCREENING AND ENROLLMENT REQUIREMENTS
A. County shall ensure that all Provider providers are enrolled with the state as Medi-Cal providers consistent with the provider disclosure, screening, and enrollment requirements of 42 C.F.R. Part 455, subparts B and E. (42 C.F.R. § 438.608(b)).
B. County may execute this Agreement, pending the outcome of screening, enrollment, and revalidation of Provider, of up to 120 days but must terminate this Agreement immediately upon determination that Provider cannot be enrolled, or the expiration of one 120-day period without enrollment of the Provider, and notify affected clients (42 C.F.R. § 438.602(b)(2)).
C. Provider shall ensure that all Providers and/or subcontracted providers consent to a criminal background check, including fingerprinting to the extent required under state law and 42 C.F.R. § 455.434(a). Provider shall provide evidence of completed consents when requested by the County, DHCS or the US Department of Health & Human Services (US DHHS).

5. PROVIDER APPLICATION AND VALIDATION FOR ENROLLMENT (PAVE)
Provider shall ensure that all of its required clinical staff, who are rendering SUD services to Medi-Cal clients on behalf of Provider, are registered through DHCS' Provider Application and Validation for Enrollment (PAVE) portal, pursuant to DHCS requirements, the 21st Century Cures Act, and the CMS Medicaid and Children's Health Insurance Program (CHIP) Managed Care Final Rule.

6. COMPLIANCE PROGRAM, INCLUDING FRAUD PREVENTION AND OVERPAYMENTS
A. Provider shall have in place a compliance program designed to detect and prevent fraud, waste and abuse, as per 42 C.F.R. § 438.608 (a)(1), that must include:
I. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Agreement, and all applicable federal and state requirements.

II. A Compliance Office (CO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Agreement and who reports directly to the CEO and the Board of Directors.
III. A Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Agreement.
IV. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the Agreement.
V. Effective lines of communication between the Compliance Officer and the organization's employees.
VI. Enforcement of standards through well-publicized disciplinary guidelines.
VII. The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, corrections of such problems promptly and thoroughly to reduce the potential for recurrence, and ongoing compliance with the requirements under the Agreement.
VIII. The requirement for prompt reporting and repayment of any overpayments identified.

B. Provider must have administrative and management arrangements or procedures designed to detect and prevent fraud, waste and abuse of federal or state health care funding. Provider must report fraud and abuse information to the County including but not limited to:
I. Any potential fraud, waste, or abuse as per 42 C.F.R. § 438.608(a), (a)(7),
II. All overpayments identified or recovered, specifying the overpayment due to potential fraud as per 42C.F.R. § 438.608(a), (a)(2).
III. Information about change in a client's circumstances that may affect the client's eligibility including changes in the client's residence or the death of the client as per 42 C.F.R. § 438.608(a)(3).
IV. Information about a change in the Provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of this Agreement with the Provider as per 42 C.F.R. § 438.608 (a)(6).

C. Provider shall implement written policies that provide detailed information about the False Claims Act ("Act") and other federal and state Laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.
D. Provider shall make prompt referral of any potential fraud, waste or abuse to County or potential fraud directly to the State Medicaid Fraud Control Unit.
E. County may suspend payments to Provider if DHCS or County determine that there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23. (42 C.F.R. § 438.608 (a)(8)).
F. Provider shall report to the County all identified overpayments and reason for the overpayment, including overpayments due to potential fraud. Provider shall return any overpayments to the County within 60 calendar days after the date on which the overpayment was identified. (42 C.F.R. § 438.608 (a)(2), (c)(3)).

7. INTEGRITY DISCLOSURES

A. Provider shall provide information on ownership and controlling interests, disclosures related to business transactions, and disclosures related to persons convicted of crimes in the form and manner requested by the County, by the Effective Date, each time the Agreement is renewed and within 35 days of any change in ownership or controlling interest of Provider. (42 C.F.R. §§ 455.104, 455.105, and 455.106)

B. Upon the execution of this Agreement, Provider shall furnish County a Provider Disclosure Statement, which, upon receipt by County, shall be kept on file with County and may be disclosed to DHCS. If there are any changes to the information disclosed in the Provider Disclosure Statement, an updated statement should be completed and submitted to the County within 35 days of the change. (42 C.F.R. § 455.104).

C. Provider must disclose the following information as requested in the Provider Disclosure Statement:

   I. Disclosure of 5% or More Ownership Interest:
      a. In the case of corporate entities with an ownership or control interest in the disclosing entity, the primary business address as well as every business location and P.O. Box address must be disclosed. In the case of an individual, the date of birth and Social Security Number must be disclosed.
      b. In the case of a corporation with ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five percent (5%) or more interest, the corporation tax identification number must be disclosed.
      c. For individuals or corporations with ownership or control interest in any subcontractor in which the disclosing entity has a five percent (5%) or more interest, the disclosure of familial relationship is required.
      d. For individuals with five percent (5%) or more direct or indirect ownership interest of a disclosing entity, the individual shall provide evidence of completion of a criminal background check, including fingerprinting, if required by law, prior to execution of Agreement. (42 C.F.R. § 455.434)

   II. Disclosures Related to Business Transactions:
      a. The ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.
      b. Any significant business transactions between Provider and any wholly owned supplier, or between Provider and any subcontractor, during the 5-year period ending on the date of the request. (42 C.F.R. § 455.105(b).)

   III. Disclosures Related to Persons Convicted of Crimes:
      a. The identity of any person who has an ownership or control interest in the Provider or is an agent or managing employee of the Provider who has been convicted of a criminal offense related to that person's involvement in any program under the Medicare, Medicaid, or the Title XXI services program since the inception of those programs. (42 C.F.R. § 455.106.)
      b. County shall terminate the enrollment of Provider if any person with five percent (5%) or greater direct or indirect ownership interest in the disclosing entity has been convicted of a criminal offense related to the person's involvement with Medicare, Medicaid, or Title XXI program in the last 10 years.

D. Provider must provide disclosure upon execution of Contract, extension for renewal, and within 35 days after any change in Provider ownership or upon request of County. County

may refuse to enter into an Agreement or terminate an existing Agreement with a Provider if the Provider fails to disclose ownership and control interest information, information related to business transactions and information on persons convicted of crimes, or if the Provider did not fully and accurately make the disclosure as required.

E. Provider must provide the County with written disclosure of any prohibited affiliations under 42 C.F.R. § 438.610. Provider must not employ or subcontract with providers or have other relationships with providers Excluded from participating in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. § 438.610.

8. CERTIFICATION OF NON-EXCLUSION OR SUSPENSION FROM PARTICIPATION IN A FEDERAL HEALTH CARE PROGRAM

A. Prior to the effective date of this Agreement, the Provider must certify that it is not excluded from participation in Federal Health Care Programs under either section 1128 or 1128A of the Social Security Act. Failure to certify will render all provisions of this Agreement null and void and may result in the immediate termination of the Agreement.

B. Provider shall certify, prior to the execution of the Contract, that the Provider does not employ or subcontract with providers or have other relationships with providers Excluded from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. § 438.610. Provider shall conduct initial and monthly Exclusion & Suspension searches of the following databases and provide evidence of these completed searches when requested by County, DHCS or the US DHHS:
   I. www.oig.hhs.gov/exclusions - LEIE Federal Exclusions
   II. www.sam.gov/portal/SAM - GSA Exclusions Extract
   III. www.Medi-Cal.ca.gov - Suspended & Ineligible Provider List
   IV. https://nppes.cms.hhs.gov/#/ - National Plan and Provider Enumeration System (NPPES)
   V. any other database required by DHCS or DHHS.

C. Provider shall certify, prior to the execution of the Agreement, that Provider does not employ staff or individual Providers/vendors that are on the Social Security Administration's Death Master File. Provider shall check the following database prior to employing staff or individual Providers/vendors and provide evidence of these completed searches when requested by the County, DHCS or the US DHHS.
   I. https://www.ssdmf.com/ - Social Security Death Master File

D. Provider is required to notify County immediately if Provider becomes aware of any information that may indicate their (including employees/staff and individual Providers/vendors) potential placement on an exclusions list.

E. Provider shall screen and periodically revalidate all network providers in accordance with the requirements of 42 C.F.R., Part 455, Subparts B and E.

F. Provider must confirm the identity and determine the exclusion status of all its providers, as well as any person with an ownership or control interest, or who is an agent or managing employee of the contracted agency through routine checks of federal and state databases. This includes the Social Security Administration's Death Master File, NPPES, the Office of Inspector General's List of Excluded Individuals/Entities (LEIE), the Medi-Cal Suspended and Ineligible Provider List (S&I List) as consistent with the requirements of 42 C.F.R. § 455.436.

G. If a Provider finds a provider that is Excluded, it must promptly notify the County as per 42 C.F.R. § 438.608(a)(2), (4). Provider shall not certify or pay any Excluded provider with Medi-Cal funds, must treat any payments made to an Excluded provider as an overpayment, and any such inappropriate payments may be subject to recovery.
H. The Provider shall complete and sign the attached Exhibit F, marked "Certification of Non-Exclusion or Suspension from Participation in a Federal Health Care Program," incorporated herein and made by reference a part hereof, to certify to the Items A-G listed above.

ARTICLE 8. QUALITY IMPROVEMENT PROGRAM

1. QUALITY IMPROVEMENT ACTIVITIES AND PARTICIPATION
   A. Provider shall comply with the County's ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program (42 C.F.R. § 438.330(a)) and work with the County to improve established outcomes by following structural and operational processes and activities that are consistent with current practice standards.
   B. Provider shall participate in quality improvement (QI) activities, including clinical and non-clinical performance improvement projects (PIPs), as requested by the County in relation to state and federal requirements and responsibilities, to improve health outcomes and clients' satisfaction over time. Other QI activities include quality assurance, collection and submission of performance measures specified by the County, mechanisms to detect both underutilization and overutilization of services, client and system outcomes, utilization management, utilization review, provider appeals, provider credentialing and re-credentialing, and client grievances. Provider shall measure, monitor, and annually report to the County its performance.
   C. Provider shall implement mechanisms to assess client/family satisfaction based on County's guidance. The Provider shall assess client/family satisfaction by:
      I. Surveying client/family satisfaction with the Provider's services at least annually.
      II. Evaluating client grievances, appeals and State Hearings at least annually.
      III. Evaluating requests to change persons providing services at least annually.
      IV. Informing the County and clients of the results of client/family satisfaction activities.
   D. Provider, if applicable, shall implement mechanisms to monitor the safety and effectiveness of medication practices. This mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs, at least annually.
   E. Provider shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The Provider shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the Provider at least annually and shared with the County.
   F. Provider shall collaborate with County to create a QI Work Plan with documented annual evaluations and documented revisions as needed. The QI Work Plan shall evaluate the impact and effectiveness of its quality assessment and performance improvement program.
   G. Provider shall attend and participate in the County's Quality Improvement Committee (QIC) to recommend policy decisions, review and evaluate results of QI activities, including PIPs, institute needed QI actions, and ensure follow-up of QI processes. Provider shall ensure that there is active participation by the Provider's practitioners and providers in the QIC.

H. Provider shall assist County, as needed, with the development and implementation of Corrective Action Plans.
I. Provider shall participate, as required, in annual, independent external quality reviews (EQR) of the quality, timeliness, and access to the services covered under this Contract, which are conducted pursuant to Subpart E of Part 438 of the Code of Federal Regulations. (42 C.F.R. §§ 438.350(a) and 438.320)

2. NETWORK ADEQUACY
A. Provider shall ensure that all services covered under this Agreement are available and accessible to clients in a timely manner and in accordance with the network adequacy standards required by regulation. (42 C.F.R. § 438.206 (a),(c)).
B. Provider shall submit, when requested by County and in a manner and format determined by the County, network adequacy certification information to County, utilizing a provided template or other designated format.
C. Provider shall submit updated network adequacy information to the County any time there has been a significant change that would affect the adequacy and capacity of services. Significant changes include, but are not limited to, changes in services or providers available to clients, and changes in geographic service area.

3. TIMELY ACCESS
A. Provider shall comply with the requirements set forth in CCR, Title 9, § 1810.405, including meeting County and State Contract standards for timely access to care and services, taking into account the urgency of the need for services. County shall monitor Provider to determine compliance with timely access requirements and shall take corrective action in the event of noncompliance.
B. Timely access standards include:
I. Providers must have hours of operation during which services are provided to Medi-Cal clients that are no less than the hours of operation during which the Provider offers services to non-Medi-Cal clients. If the Provider's provider only serves Medi-Cal clients, the provider must provide hours of operation comparable to the hours the Provider makes available for Medi-Cal services that are not covered by the Agreement or another County.
II. Appointment data, including wait times for requested services, must be recorded and tracked by Provider, and submitted to the County on a monthly basis in a format specified by the County. Appointments' data should be submitted to the County's Quality Management department or other designated persons.
III. Provider shall ensure that all clients seeking NTP services are provided with an appointment within three business days of a service request.
IV. Provider shall ensure that all clients seeking outpatient and intensive outpatient (non-NTP) services are provided with an appointment within 10 business days of a non-NTP service request.
V. Provider shall ensure that all clients seeking non-urgent appointments with a non-physician SUD provider are provided within 10 business days of the request for the appointment. Similarly, Provider shall ensure that all clients seeking non-urgent follow-up appointments with a non-physician SUD provider are provided within 10 business days of the prior appointment for those undergoing a course of treatment for

an ongoing SUD condition. These timely standards must be followed, except in the following circumstances:

a. The referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, has determined and noted that in the relevant record that a longer waiting time will not have a detrimental impact on the client's health.
b. Preventive care services and periodic follow-up care, including office visits for SUD conditions, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice.

VI. Provider shall ensure that, if necessary for a client or a provider to reschedule an appointment, the appointment is promptly rescheduled in a manner that is appropriate for the client's health care needs and ensures continuity of care consistent with good professional practice.

VII. Provider shall ensure that during normal business hours, the waiting time for a client to speak by telephone with staff knowledgeable and competent regarding the client's questions and concerns does not exceed 10 minutes.

4. DATA REPORTING REQUIREMENTS

A. Provider shall comply with data reporting compliance standards as established by DHCS and/or SAMHSA depending on the specific source of funding.
B. Provider shall ensure that all data stored or submitted to the County, DHCS or other data collection sites is accurate and complete.
   I. California Outcomes Measurement System Treatment (CalOMS Tx)
      a. CalOMS Tx data shall be submitted by Provider to DHCS via electronic submission within 45 days from the end of the last day of the report month. This data shall be submitted during this time frame.
   II. Drug and Alcohol Treatment Access Report (DATAR)
      a. DATAR data shall be submitted by Provider as specified by County, either directly to DHCS or by other means established by County, by the 10th of the month following the report activity month.

5. TREATMENT PERCEPTION SURVEY (TPS)

Provider shall conduct the annual Treatment Perception Survey (TPS) consistent with DMC-ODS requirements and under the direction of County.

6. PRACTICE GUIDELINES

A. Provider shall adopt practice guidelines (or adopt County's practice guidelines) that meet the following requirements as per 42 C.F.R. § 438.236:
   I. Are based on valid and reliable clinical evidence or a consensus of providers in the field.
   II. Consider the needs of the Provider's clients
   III. Are adopted in consultation with network providers
   IV. Are reviewed and updated periodically as appropriate
B. Provider shall disseminate the guidelines to all affected providers and, upon request, to clients and potential clients.

7. EVIDENCE-BASED PRACTICES (EBPs)
   A. Providers will comply with County and DHCS standards related to Evidenced Based Practices (EBPs).
   B. Provider will implement at least two of the following EBP to fidelity per provider, per service modality:
      I. Motivational Interviewing
      II. Cognitive-Behavioral Services
      III. Relapse Prevention
      IV. Trauma-Informed Treatment
      V. Psycho-Education

8. REPORTING UNUSUAL OCCURRENCES
   A. Provider shall report unusual occurrences to the Director. An unusual occurrence is any event which jeopardizes the health and/or safety of clients, staff and/or members of the community, including, but not limited to, physical injury and death.
   B. Unusual occurrences are to be reported to the County within timelines specified in County policy after becoming aware of the unusual event. Reports are to include the following elements:
      I. Complete written description of event including outcome;
      II. Written report of Provider's investigation and conclusions;
      III. List of persons directly involved and/or with direct knowledge of the event.
   C. County and DHCS retain the right to independently investigate unusual occurrences and the Provider will cooperate in the conduct of such independent investigations.

ARTICLE 9. FINANCIAL TERMS

1. CLAIMING
   A. Provider shall enter claims data into the County's billing and transactional database system within the timeframes established by County. Provider shall use Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, as provided in the DHCS Billing Manual available at https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx, as from time to time amended.
   B. Claims shall be complete and accurate and must include all required information regarding the claimed services.
   C. Provider shall maximize the Federal Financial Participation (FFP) reimbursement by claiming all possible Medi-Cal services and correcting denied services for resubmission in a timely manner as needed.

2. ADDITIONAL FINANCIAL REQUIREMENTS
   A. County has the right to monitor the performance of this Agreement to ensure the accuracy of claims for reimbursement and compliance with all applicable laws and regulations.
   B. Provider must comply with the False Claims Act employee training and policy requirements set forth in 42 U.S.C. 1396a(a)(68) and as the Secretary of the US DHHS may specify.
   C. Provider agrees that no part of any federal funds provided under this Agreement shall be used to pay the salary of an individual per fiscal year at a rate in excess of Level 1 of the

Executive Schedule at https://www.opm.gov/ (U.S. Office of Personnel Management), as from time to time amended.

D. Federal Financial Participation is not available for any amount furnished to an Excluded individual or entity, or at the direction of a physician during the period of exclusion when the person providing the service knew or had reason to know of the exclusion, or to an individual or entity when the County failed to suspend payments during an investigation of a credible allegation of fraud (42 U.S.C. §1396b(i)(2)).

3. FISCAL CONSIDERATIONS

The parties to this Agreement recognize and acknowledge that County is a political subdivision of the State of California. As such, County is subject to the provisions of Article XVI, section 18 of the California Constitution and other similar fiscal and procurement laws and regulations and may not expend funds for products, equipment, or services not budgeted in a given fiscal year. It is further understood that in the normal course of County business, County will adopt a proposed budget prior to a given fiscal year, but that the final adoption of a budget does not occur until after the beginning of the fiscal year.

Notwithstanding any other provision of this Agreement to the contrary, County shall give notice of cancellation of this Agreement in the event of adoption of a proposed budget that does not provide for funds for the services, products, or equipment subject herein. Such notice shall become effective upon the adoption of a final budget, which does not provide funding for this Agreement. Upon the effective date of such notice, this Agreement shall be automatically terminated and County released from any further liability hereunder.

In addition to the above, should the Board of Supervisors during the course of a given year for financial reasons reduce or order a reduction in the budget for any County department for which services were contracted to be performed, pursuant to this paragraph in the sole discretion of County, this Agreement may be deemed to be canceled in its entirety subject to payment for services performed prior to cancellation.

4. PROVIDER PROHIBITED FROM REDIRECTION OF CONTRACTED FUNDS [IF APPLICABLE]

A. Provider may not redirect or transfer funds from one funded program to another funded program under which Provider provides services pursuant to this Agreement except through a duly executed amendment to this Agreement.

B. Provider may not charge services delivered to an eligible client under one funded program to another funded program unless the client is also eligible for services under the second funded program.

5. FINANCIAL AUDIT REPORT REQUIREMENTS FOR PASS-THROUGH ENTITIES

A. If County determines that Provider is a "subrecipient" (also known as a "pass-through entity") as defined in 2 C.F.R. § 200 et seq., Provider represents that it will comply with the applicable cost principles and administrative requirements including claims for payment or reimbursement by County as set forth in 2 C.F.R. § 200 et seq., as may be amended from time to time. Provider shall observe and comply with all applicable financial audit report requirements and standards.

B. Financial audit reports must contain a separate schedule that identifies all funds included in the audit that are received from or passed through the County. County programs must be identified by Agreement number, Agreement amount, Agreement period, and the amount expended during the fiscal year by funding source.
C. Provider will provide a financial audit report including all attachments to the report and the management letter and corresponding response within six months of the end of the audit year to the Director. The Director is responsible for providing the audit report to the County Auditor.
D. Provider must submit any required corrective action plan to the County simultaneously with the audit report or as soon thereafter as it is available. The County shall monitor implementation of the corrective action plan as it pertains to services provided pursuant to this Agreement.

ARTICLE 10. ADDITIONAL FINAL RULE PROVISIONS

1. NON-DISCRIMINATION
   A. Provider shall not discriminate against Medi-Cal eligible individuals in its County who require an assessment or meet medical necessity criteria for DMC-ODS in the provision of SUD services because of race, color, religion, ancestry, marital status, national origin, ethnic group identification, sex, sexual orientation, gender, gender identity, age, medical condition, genetic information, health status or need for health care services, or mental or physical disability as consistent with the requirements of applicable federal law, such as 42 C.F.R. § 438.3(d)(3) and (4), BHIN 22-060 Enclosure 4 and state law.
   B. Provider shall take affirmative action to ensure that services to intended Medi-Cal clients are provided without use of any policy or practice that has the effect of discriminating on the basis of race, color, religion, ancestry, marital status, national origin, ethnic group identification, sex, sexual orientation, gender, gender identity, age, medical condition, genetic information, health status or need for health care services, or mental or physical disability.
   C. By signing this Agreement, Provider certifies that under the laws of the United States and the State of California, incorporated into this Agreement by reference and made a part hereof as if set forth in full, Provider shall not unlawfully discriminate against any person.
   D. County may require Provider's services on projects involving funding from various state and/or federal agencies, and as a consequence, Provider shall comply with all applicable nondiscrimination statutes and regulations during the performance of this Agreement including but not limited to the following: Provider and its employees and representatives shall not unlawfully discriminate against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical handicap, medical condition, marital status, age, or sex; Provider shall, unless exempt, comply with the applicable provisions of the Fair Employment and Housing Act (Government Code, Sections 12900 et seq.) and applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Sections 11000 et seq.); the applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Subchapter 5 of Chapter 5 of Division 4.1 of Title 2 of the California Code of Regulations incorporated into this Agreement by reference and made a part hereof as if set forth in full; and Title VI of the Civil Rights Act of 1964, as amended, the California Family Rights Act (Government Code Section 12945.2), the Unruh Civil Rights Act (California Civil Code, Division I, Part 2, Section 51, et seq), the Ralph Civil Rights Act (California

Civil Code, Division I, Part 2, Section 51.7), the California Trafficking Victims Protection Act (California Civil Code, Division I, Part 2, Section 52.5), the Disabled Persons Act (California Civil Code, Division I, Part 2.5), and as applicable, Section 11135 et. seq., of the California Government Code, prohibiting discrimination in all state-funded programs. Provider and its employees and representatives shall give written notice of their obligations under this clause as required by law.

E. Where applicable, Provider shall include these nondiscrimination and compliance provisions in any of its agreements that affect or are related to the services performed herein.
F. Provider's signature shall provide any certifications necessary under the federal laws, the laws of the State of California, including but not limited to Government Code Section 12990 and Title 2, California Code of Regulations, Section 11102.
G. By signing this Agreement, Provider certifies that under the laws of the United States and the State of California, incorporated into this Agreement by reference and made a part hereof as if set forth in full, Provider shall not unlawfully discriminate against any person.
H. Provider shall comply Exhibit G, marked "Vendor Assurance of Compliance with Nondiscrimination in State and Federally Assisted Programs," incorporated herein and made by reference a part hereof. Provider shall acknowledge compliance by signing and returning Exhibit G upon request by County.

2. PHYSICAL ACCESSIBILITY

In accordance with the accessibility requirements of section 508 of the Rehabilitation Act and the Americans with Disabilities Act of 1973, Provider must provide physical access, reasonable accommodations, and accessible equipment for Medi-Cal clients with physical or mental disabilities.

3. APPLICABLE FEES

A. Provider shall not charge any clients or third-party payers any fee for service unless directed to do so by the Director at the time the client is referred for services. When directed to charge for services, Provider shall use the uniform billing and collection guidelines prescribed by DHCS.
B. Provider will perform eligibility and financial determinations for each beneficiary prior to rendering services in accordance with the Drug Medi-Cal Billing Manual, unless directed otherwise by the Director.
C. Provider shall not submit a claim to, or demand or otherwise collect reimbursement from, the client or persons acting on behalf of the client for any SUD or related administrative services provided under this Agreement, except to collect other health insurance coverage, share of cost, and co-payments (California Code of Regulations, tit. 9, § 1810.365(c)).
D. The Provider must not bill clients, for covered services, any amount greater than would be owed if the County provided the services directly as per and otherwise not bill client as set forth in 42 C.F.R. § 438.106.

4. CULTURAL COMPETENCE

All services, policies and procedures must be culturally and linguistically appropriate. Provider must participate in the implementation of the most recent Cultural Competency Plan for the County and shall adhere to all cultural competency standards and requirements. Provider shall participate in the County's efforts to promote the delivery of services in a culturally competent

and equitable manner to all clients, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

5. CLIENT INFORMING MATERIALS

A. Basic Information Requirements

I. Provider shall provide information in a manner and format that is easily understood and readily accessible to clients. (42 C.F.R. § 438.10(c)(1)). Provider shall provide all written materials for clients in easily understood language, format, and alternative formats that take into consideration the special needs of clients in compliance with 42 C.F.R. § 438.10(d)(6). Provider shall inform clients that information is available in alternate formats and how to access those formats in compliance with 42 C.F.R. § 438.10.

II. Provider shall provide the required information in this section to each client receiving SUD services under this Agreement and upon request.

III. Provider shall utilize the County's website that provides the content required in this section and 42 C.F.R. § 438.10 and complies with all the requirements regarding the same set forth in 42 C.F.R. § 438.10.

IV. Provider shall use DHCS/County developed model beneficiary handbook and client notices. (42 C.F.R. §§ 438.10(c)(4)(ii), 438.62(b)(3)).

V. Client information required in this section may only be provided electronically by the Provider if all of the following conditions are met:

a. The format is readily accessible;
b. The information is placed in a location on the Provider's website that is prominent and readily accessible;
c. The information is provided in an electronic form which can be electronically retained and printed;
d. The information is consistent with the content and language requirements of this Agreement;
e. The client is informed that the information is available in paper form without charge upon request and the Provider provides it upon request within five business days. (42 C.F.R. § 438.10(c)(6)).

B. Language and Format

I. Provider shall provide all written materials for potential clients and clients in a font size no smaller than 12 point. (42 C.F.R. § 438.10(d)(6)(ii).)

II. Provider shall ensure its written materials that are critical to obtaining services are available in alternative formats, upon request of the client or potential client at no cost.

III. Provider shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, beneficiary handbook, appeal and grievance notices, denial and termination notices, and the Provider's SUD health education materials, available in the prevalent non-English languages in the County. (42 C.F.R. § 438.10(d)(3).)

a. Provider shall notify clients, prospective clients, and members of the public that written translation is available in prevalent languages free of cost and how to access those materials. (42 C.F.R. § 438.10(d)(5)(i), (iii); Welfare & Institutions

Code § 14727(a)(1); California Code of Regulations. tit. 9 § 1810.410, subd. (e), para. (4))

IV. Provider shall make auxiliary aids and services available upon request and free of charge to each client. (42 C.F.R. § 438.10(d)(3)- (4).)

V. Provider shall make oral interpretation and auxiliary aids, such as Teletypewriter Telephone/Text Telephone (TTY/TDY) and American Sign Language (ASL), available and free of charge for any language in compliance with 42 C.F.R. § 438.10(d)(2), (4)-(5).

VI. Taglines for written materials critical to obtaining services must be printed in a conspicuously visible font size.

C. Beneficiary Informing Materials

I. Each client must receive and have access to the beneficiary informing materials upon request by the client and when first receiving SUD services. Beneficiary informing materials include but are not limited to:
   a. County DMC-ODS Beneficiary Handbook (BHIN 22-060)
   b. Provider Directory
   c. DMC-ODS Formulary
   d. Advance Health Care Directive Form (required for adult clients only)
   e. Notice of Language Assistance Services available upon request at no cost to the client
   f. Language Taglines
   g. Grievance/Appeal Process and Form
   h. Notice of Privacy Practices
   i. EPSDT poster (if serving clients under the age of 21)

II. Provider shall provide each client with a beneficiary handbook at the time the client first accesses services. The beneficiary handbook shall be provided to beneficiaries within 14 business days after receiving notice of enrollment.

III. Provider shall give each client notice of any significant change to the information contained in the beneficiary handbook at least 30 days before the intended effective date of change as per BHIN 22-060.

IV. Required informing materials must be electronically available on the Provider's website and must be physically available at the Provider agency facility lobby for clients' access.

V. Informing materials must be made available upon request, at no cost, in alternate formats (i.e., Braille or Audio) and Auxiliary Aids (i.e., California Relay Service (CRS) 711 and American Sign Language) and must be provided to clients within five business days. Large print materials shall be in a minimum 18-point font size.

VI. Informing materials will be considered provided to the client if Provider does one or more of the following:
   a. Mails a printed copy of the information to the client's mailing address before the client first receives a SUD service;
   b. Mails a printed copy of the information upon the client's request to the client's mailing address;
   c. Provides the information by email after obtaining the client's agreement to receive the information by email;
   d. Posts the information on the Provider's website and advises the client in paper or electronic form that the information is available on the internet and includes

applicable internet addresses, provided that clients with disabilities who cannot access this information online are provided auxiliary aids and services upon request and at no cost; or,

e. Provides the information by any other method that can reasonably be expected to result in the client receiving that information. If the Provider provides informing materials in person, when the client first receives SUD services, the date and method of delivery shall be documented in the client's file.

D. Provider Directory

I. Provider must follow the County's provider directory policy, in compliance with MHSUDS IN 18-020.

II. Provider must make available to clients, in paper form upon request and electronic form, specified information about its provider network as per 42 C.F.R. § 438.10(h). The most current provider directory is electronically available on the County website and is updated by the County no later than 30 calendar days after information is received to update provider information. A paper provider directory must be updated as set forth in 42 C.F.R. § 438.10(h)(3)(i).

III. Any changes to information published in the provider directory must be reported to the County within two weeks of the change.

IV. Provider will only need to report changes/updates to the provider directory for each licensed SUD service provider.

E. Medication Formulary

I. Provider shall make available in electronic or paper form, the following information about the County's formulary as outlined in 42 C.F.R. § 438.10(i):

a. Which medications are covered (for both generic and name brand).

b. What tier each medication resides on.

II. Provider shall inform clients about County's formulary drug lists availability in a machine-readable file and format on the County's website.

ARTICLE 11. DATA, PRIVACY AND SECURITY REQUIREMENTS

1. CONFIDENTIALITY AND SECURE COMMUNICATIONS

A. Provider shall comply with all applicable Federal and State laws and regulations pertaining to the confidentiality of individually identifiable protected health information (PHI) or personally identifiable information (PII) including, but not limited to, requirements of the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, the California Welfare and Institutions Code regarding confidentiality of client information and records and all relevant County policies and procedures.

B. Provider will comply with all County policies and procedures related to confidentiality, privacy, and secure communications.

C. Provider shall have all employees acknowledge an Oath of Confidentiality mirroring that of County, including confidentiality and disclosure requirements, as well as sanctions related to non-compliance.

D. Provider shall not use or disclose PHI or PII other than as permitted or required by law.

2. ELECTRONIC PRIVACY AND SECURITY

A. Provider shall have a secure email system and send any email containing PII or PHI in a secure and encrypted manner. Provider's email transmissions shall display a warning

banner stating that data is confidential, systems activities are monitored and logged for administrative and security purposes, systems use is for authorized users only, and that users are directed to log off the system if they do not agree with these requirements.

B. Provider shall institute compliant password management policies and procedures, which shall include but are not limited to procedures for creating, changing, and safeguarding passwords. Provider shall establish guidelines for creating passwords and ensuring that passwords expire and are changed at least once every 90 days.
C. Any Electronic Health Records (EHRs) maintained by Provider that contain any PHI or PII for clients served through this Agreement shall contain a warning banner regarding the PHI or PII contained within the EHR. Provider that utilize an EHR shall maintain all parts of the clinical record that are not stored in the EHR, including but not limited to the following examples of client signed documents: discharge plans, informing materials, and health questionnaire.
D. Provider entering data into any County electronic systems shall ensure that staff are trained to enter and maintain data within this system.

3. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE BUSINESS ASSOCIATE AGREEMENT (BAA)
   A. Provider may perform or assist County in the performance of certain health care administrative duties that involve the use and/or disclosure of client identifying information as defined by HIPAA. For these duties, the Provider shall be a Business Associate of the County and shall comply with the applicable provisions set forth in Exhibit H, marked "HIPAA Business Associate Agreement," incorporated herein and made by reference a part hereof.
   B. Provider shall follow all requirements listed within the BAA and shall comply with all applicable County policies, state laws and regulations and federal laws pertaining to breaches of confidentiality. Provider agrees to hold the County harmless for any breaches or violations.

ARTICLE 12. CLIENT RIGHTS

Provider shall take all appropriate steps to fully protect clients' rights, as specified in Welfare and Institutions Code § 5325 et seq; Title 9 California Code of Regulations (CCR), §§ 862, 883, 884; Title 22 CCR, § 72453 and § 72527; and 42 C.F.R. § 438.100.

ARTICLE 13. RIGHT TO MONITOR

1. County or any subdivision or appointee thereof, and the State of California or any subdivision or appointee thereof, including the Auditor General, shall have absolute right to review and audit all records, books, papers, documents, corporate minutes, financial records, staff information, client records, other pertinent items as requested, and shall have absolute right to monitor the performance of Provider in the delivery of services provided under this Agreement. Full cooperation shall be given by the Provider in any auditing or monitoring conducted, according to this Agreement.
2. Provider shall make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to Medi-Cal enrollees, Medi-Cal-related activities, services, and activities furnished under the terms of this Agreement, or determinations of amounts payable available at any time for inspection, examination, or copying by County, the State of California or any subdivision or appointee

thereof, CMS, U.S. Department of Health and Human Services (HHS) Office of Inspector General, the United States Comptroller General or their designees, and other authorized federal and state agencies. This audit right will exist for at least 10 years from the final date of the Agreement period or in the event the Provider has been notified that an audit or investigation of this Agreement has commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later (42 CFR § 438.230(c)(3)(I)-(ii)).

3. The County, DHCS, CMS, or the HHS Office of Inspector General may inspect, evaluate, and audit the Provider at any time if there is a reasonable possibility of fraud or similar risk. The Department's inspection shall occur at the Provider's place of business, premises or physical facilities (42 CFR § 438.230(c)(3)(iv)).
4. Provider shall cooperate with the County in the implementation, monitoring and evaluation of this Agreement and comply with any and all reporting requirements established by the County. Should the County identify an issue or receive notification of a complaint or potential/actual/suspected violation of requirements, the County may audit, monitor, and/or request information from the Provider to ensure compliance with laws, regulations, and requirements, as applicable.
5. County reserves the right to place Provider on probationary status, should Provider fail to meet performance requirements; including, but not limited to violations such as high disallowance rates, failure to report incidents and changes as contractually required, failure to correct issues, inappropriate invoicing, untimely and inaccurate data entry, not meeting performance outcomes expectations, and violations issued directly from the State. Additionally, Provider may be subject to Probationary Status or termination if contract monitoring and auditing corrective actions are not resolved within specified timeframes.
6. Provider shall retain all records and documents originated or prepared pursuant to Provider's performance under this Agreement, including client grievance and appeal records, and the data, information and documentation specified in 42 C.F.R. parts §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years from the term end date of this Agreement or until such time as the matter under audit or investigation has been resolved. Records and documents include but are not limited to all physical and electronic records and documents originated or prepared pursuant to Provider's or subcontractor's performance under this Agreement including working papers, reports, financial records and documents of account, client records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for clients.
7. Provider shall maintain all records and management books pertaining to service delivery and demonstrate accountability for contract performance and maintain all fiscal, statistical, and management books and records pertaining to the program. Records should include, but are not limited to, monthly summary sheets, sign-in sheets, and other primary source documents. Fiscal records shall be kept in accordance with Generally Accepted Accounting Principles and must account for all funds, tangible assets, revenue and expenditures. Fiscal records must also comply with the Code of Federal Regulations (CFR), Title II, Subtitle A, Chapter 11, Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.
8. All records shall be complete and current and comply with all Agreement requirements. Failure to maintain acceptable records per the preceding requirements shall be considered grounds for withholding of payments for billings submitted and for termination of Agreement.

9. Provider shall maintain client and community service records in compliance with all regulations set forth by local, state, and federal requirements, laws and regulations, and provide access to clinical records by County staff.
10. Provider shall comply with ARTICLE 11. Data, Privacy And Security Requirements, 1. Confidentiality and Secure Communications regarding relinquishing or maintaining medical records.
11. Provider shall agree to maintain and retain all appropriate service and financial records for a period of at least 10 years from the date of final payment, the final date of the contract period, final settlement, or until audit findings are resolved, whichever is later.
12. Provider shall submit audited financial reports on an annual basis to the County. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.
13. In the event the Agreement is terminated, ends its designated term or Provider ceases operation of its business, Provider shall deliver or make available to County all financial records that may have been accumulated by Provider or subcontractor under this Agreement, whether completed, partially completed or in progress within seven calendar days of said termination/end date.
14. Provider shall provide all reasonable facilities and assistance for the safety and convenience of the County's representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner that will not unduly delay the work of Provider.
15. County has the discretion to revoke full or partial provisions of the Agreement, delegated activities or obligations, or application of other remedies permitted by state or federal law when the County or DHCS determines Provider has not performed satisfactorily.

ARTICLE 14. SITE INSPECTION

Without limiting any other provision related to inspections or audits otherwise set forth in this Agreement, Provider shall permit authorized County, state, and/or federal agency(ies), through any authorized representative, the right to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract support activities and the premises which it is being performed. Provider shall provide all reasonable assistance for the safety and convenience of the authorized representative in the performance of their duties. All inspections and evaluations shall be made in a manner that will not unduly delay the work.

ARTICLE 15. EXECUTIVE ORDER N-6-22 – RUSSIA SANCTIONS

On March 4, 2022, Governor Gavin Newsom issued Executive Order N-6-22 (the EO) regarding Economic Sanctions against Russia and Russian entities and individuals. "Economic Sanctions" refers to sanctions imposed by the U.S. government in response to Russia's actions in Ukraine, as well as any sanctions imposed under state law. The EO directs state agencies to terminate contracts with, and to refrain from entering any new contracts with, individuals or entities that are determined to be a target of Economic Sanctions. Accordingly, if this Agreement is funded by state funds and County determines Provider is a target of Economic Sanctions or is conducting prohibited transactions with sanctioned individuals or entities, that shall be grounds for termination of this agreement. The County shall provide Provider advance written notice of such termination, allowing Provider at least thirty (30) calendar days to provide a written response. Termination shall be at the sole discretion of the County.

ARTICLE 16. ELECTRONIC SIGNATURES
Each party agrees that the electronic signatures, whether digital or encrypted, of the parties included in this Agreement, are intended to authenticate this writing and to have the same force and effect as manual signatures. Electronic Signature means any electronic visual symbol or signature attached to or logically associated with a record and executed and adopted by a party with the intent to sign such record, including facsimile or email electronic signatures, pursuant to the California Uniform Electronic Transactions Act (Cal. Civ. Code §§ 1633.1 to 1633.17) as amended from time to time.

ARTICLE 17. COUNTERPARTS
This Agreement may be executed in one or more counterparts, each of which will be deemed to be an original copy of this Agreement and all of which, when taken together, will be deemed to constitute one and the same agreement.

ARTICLE 18. ENTIRE AGREEMENT
This Agreement, including all schedules, addenda, exhibits and attachments, contains the entire understanding of the Parties in regard to Provider's provision of the services specified in Exhibit A ,"Scope of Work" and supersedes all prior representations in regard to the same subject matter, whether written or oral.

IN WITNESS WHEREOF, the Board of Supervisors of County has caused this Agreement to be subscribed by the Clerk thereof, and Provider has caused this Agreement to be subscribed on its behalf by its duly authorized officers, the day, month, and year first above written.

Requesting Contract Administrator Concurrence:

By: _____ Dated: _____

Salina Drennan
Alcohol and Drug Programs Division Manager
Health and Human Services Agency

Requesting Department Head Concurrence:

By: _____ Dated: _____

Olivia Byron-Cooper, MPH
Interim Director
Health and Human Services Agency

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the dates indicated below.

-- COUNTY OF EL DORADO --

Dated: _____

By: _____
Chair
Board of Supervisors
"County"

ATTEST:
Kim Dawson
Clerk of the Board of Supervisors

By: _____ Dated: _____
Deputy Clerk

-- BI-VALLEY MEDICAL CLINIC, INC.,
DOING BUSINESS AS BAART PROGRAMS CARMICHAEL --

By: _____ Dated: _____
Jason Kletter
Chief Executive Officer
"Provider"

By: _____ Dated: _____
Gilbert D'Andria
Chief Financial Officer

Bi-Valley Medical Clinic, Inc., doing business as BAART Programs Carmichael
Exhibit A
Scope of Work

1. INTRODUCTION

A. As an organizational provider agency, Provider shall provide administrative and direct program services to County's Medi-Cal clients as defined in Title 9, Division 1, Chapter 11 of the California Code of Regulations. For clients under the age of 21, the Provider shall provide all medically necessary SUD services required pursuant to Section 1396d(r) of Title 42 of the United States Code (Welfare & Institutions Code 14184.402 (e)).

B. Provider shall deliver services using evidence-based practice models. Provider shall provide said services in Provider's program(s) as described herein; and utilizing locations as described herein.

2. TARGET POPULATION

A. Provider shall provide services to the following populations:

I. The target population for DMC-ODS SUD services includes clients who are enrolled in Medi-Cal, reside in the County, and meet the criteria for DMC-ODS services as per established requirements above.

3. SERVICES TO BE PROVIDED

Provider shall provide SUD services as defined in:

A. Exhibit C marked Intergovernmental Agreement 21-10027, which is the County's Agreement with the DHCS for SUD Services, incorporated herein, or as may be amended;

B. All services provided pursuant to this Agreement shall be performed in accordance with the following DMC-ODS requirements, or as may be amended, all of which constitute part of this Agreement, available at the El Dorado County Contractor's page: https://www.edcgov.us/Government/hhsa/Pages/DMC-ODS.aspx

I. El Dorado County DMC-ODS Practice Guidelines
II. Minimum Quality Drug Treatment Standards – DMC
III. Perinatal Practice Guidelines
IV. Adolescent Substance Use Disorder Best Practices Guide
V. El Dorado County SUD Compliance Plan
VI. El Dorado County SUD DMC-ODS Training Plan

C. Billing for Drug Medi-Cal (DMC) services shall follow the DMC Billing Manual available in the DHCS County Claims Customer Services Library page at https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx, or subsequent updates to this billing manual, to clients who meet access criteria for receiving SUD services.

4. ALLOWABLE SERVICES UNDER CONTRACT

Provider shall perform services as follows:

A. Narcotic Treatment Program (This section supersedes MHSUDS IN 16-048)

I. Narcotic Treatment Program (NTP), also described in the ASAM Criteria© as an Opioid Treatment Program (OTP), is an outpatient program that provides Food and Drug Administration (FDA)-approved medications and biological products to treat SUDs when ordered by a physician as medically necessary. NTPs are required to administer, dispense, or prescribe medications to beneficiaries covered under the DMC-ODS formulary. NTPs shall comply with all federal and state NTP licensing requirements. If the NTP cannot comply with all federal and state NTP requirements, then the NTP must assist the beneficiary in choosing another MAT provider, ensure continuity of care, and facilitate a warm hand-off to ensure engagement. NTP services are provided in DHCS-licensed NTP facilities pursuant to the California Code of Regulations, title 9, Chapter 4, and Title 42 of the Code of Federal Regulations (CFR).

II. NTPs are required to administer, dispense, or prescribe medications to beneficiaries covered under the DMC-ODS formulary including:
    a. Methadone
    b. Buprenorphine (transmucosal and long-acting injectable)
    c. Naltrexone (oral and long-acting injectable)
    d. Disulfiram
    e. Naloxone

III. If the NTP is unable to directly administer or dispense medically necessary medications covered under the DMC-ODS formulary, the NTP must prescribe the medication for dispensing at a pharmacy or refer the beneficiary to a provider capable of dispensing the medication.

IV. Service components:
    a. Assessment
    b. Care Coordination
    c. Counseling (individual and group)
        1) The NTP shall offer the beneficiary a minimum of fifty (50) minutes of counseling services per calendar month
        2) Counseling services may be provided in-person, by telehealth, or by telephone
    d. Family Therapy
    e. Medical Psychotherapy
    f. Medication Services
    g. MAT for OUD
    h. MAT for AUD and other non-opioid SUDs
    i. Patient Education
    j. Recovery Services
    k. SUD Crisis Intervention Services
    l. Medical evaluation for methadone treatment
        1) Medical history
        2) Laboratory tests

3) Physical exam
4) Medical evaluation must be conducted in-person

5. PROVISION OF SERVICES

A. The following Provider Specifications requirements shall apply to the Provider, and the provider staff:

I. Professional staff shall:

a. Be licensed, registered, certified, enrolled, and/or approved in accordance with all applicable state and federal laws and regulations
b. Abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Health Care Services.
c. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws.

II. Professional staff means any of the following:

a. Licensed Practitioners of the Healing Arts (LPHA) include:
b. Physician
c. Nurse Practitioners
d. Physician Assistants
e. Registered Nurses
f. Registered Pharmacists
g. Licensed Clinical Psychologists
h. Licensed Clinical Social Worker
i. Licensed Professional Clinical Counselor
j. Licensed Marriage and Family Therapists
k. Licensed Eligible Practitioners registered with the Board of Psychology or Behavioral Science Board working under the supervision of a licensed clinician
l. An Alcohol or other drug (AOD) counselor that is 1) either certified or registered by an organization that is recognized by the Department of Health Care Services and accredited with the National Commission for Certifying Agencies (NCCA), and 2) meets all California State education, training, and work experience requirements set forth in the Counselor Certification Regulations, Cal. Code Regs., tit. 9, Div. 4, chapter 8.
m. Medical Director of a Narcotic Treatment Program who is a licensed physician in the State of California.

III. Non-professional staff shall receive appropriate onsite orientation and training prior to performing assigned duties. A professional and/or administrative staff shall supervise non-professional staff.

IV. Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring. Documentation of trainings, certifications, and licensure shall be contained in personnel files.

V. Physicians shall receive a minimum of five hours of continuing medical education related to addiction medicine each calendar year.

VI. Professional staff (LPHAs) shall receive a minimum of five hours of continuing education related to addiction medicine each calendar year.

VII. Registered and certified Substance Use Disorder (SUD) counselors shall adhere to all requirements in California Code of Regulations (CCR), Title 9, Chapter 8, Certification of Alcohol and Other Drug Counselors.

B. Confidentiality: All SUD treatment services shall be provided in a confidential setting in compliance with 42 Code of Federal Regulations (CFR), Part 2 requirements.

C. Substance Use Disorder Medical Director:
   I. The SUD Medical Director's responsibilities shall, at a minimum, include all of the following:
      a. Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
      b. Ensure that physicians do not delegate their duties to non-physician personnel
      c. Develop and implement written medical policies and standards for the Provider.
      d. Ensure that physicians, registered nurse practitioners, and physician assistants follow the Provider's medical policies and standards.
      e. Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
   II. Ensure that Provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries and determine the medical necessity of treatment for beneficiaries.
   III. Ensure that Provider's physicians are adequately trained to perform other physician duties, as outlined in this section.
   IV. The SUD Medical Director may delegate his/her responsibilities to a physician consistent with the Provider's medical policies and standards; however, the SUD Medical Director shall remain responsible for ensuring all delegated duties are properly performed.

6. PROVIDER PERSONNEL

A. Personnel files shall be maintained on all employees and volunteers/interns and shall contain the following:
   I. Application for employment and/or resume
   II. Signed employment confirmation statement/duty statement
   III. Job description
   IV. Performance evaluations
   V. Health records/status as required by the Provider, Alcohol and Other Drug (AOD) Certification or Title 9
   VI. Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries)
   VII. Training documentation relative to substance use disorders and treatment
   VIII. Current registration, certification, intern status, or licensure
   IX. Proof of continuing education required by licensing or certifying agency and program
   X. Provider’s Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying/licensing body’s code of conduct as well

B. Job descriptions shall be developed, revised as needed, and approved by the Provider's governing body. The job descriptions shall include:
   I. Position title and classification
   II. Duties and responsibilities
   III. Lines of supervision
   IV. Education, training, work experience, and other qualifications for the position

C. Written Provider code of conduct for employees and volunteers/interns shall be established which addresses at least the following:
   I. Use of drugs and/or alcohol
   II. Prohibition of social/business relationship with beneficiaries or their family members for personal gain
   III. Prohibition of sexual contact with beneficiaries
   IV. Conflict of interest
   V. Providing services beyond scope
   VI. Discrimination against beneficiaries or staff
   VII. Verbally, physically, or sexually harassing, threatening or abusing beneficiaries, family members or other staff
   VIII. Protection of beneficiary confidentiality
   IX. Cooperate with complaint investigations

D. If a Provider utilizes the services of volunteers and/or interns, written procedures shall be implemented which address:
   I. Recruitment
   II. Screening and Selection
   III. Training and orientation
   IV. Duties and assignments
   V. Scope of practice
   VI. Supervision
   VII. Evaluation
   VIII. Protection of beneficiary confidentiality

E. Written roles and responsibilities and a code of conduct for the Medical Director shall be clearly documented, signed and dated by a Provider representative and the physician.

7. DISCHARGE CRITERIA AND PROCESS

A. Provider will engage in discharge planning beginning at intake for each client served under this Agreement. Discharge planning will include regular reassessment of client functioning, attainment of goals, determination of treatment needs and establishment of discharge goals.

B. When possible, discharge will include treatment at a lower LOC or intensity appropriate to client's needs and provision of additional referrals to community resources for client to utilize after discharge.

C. Provider shall notify County of discharge of authorized clients by emailing the discharge plan, discharge summary and/or any incident reports to: SUDSQualityAssurance@edcgov.us within 72 hours.

8. CONTRACT DELIVERABLES, OBJECTIVES AND OUTCOMES

A. Provider shall comply with all requests regarding local, state, and federal performance outcomes measurement requirements and participate in the outcomes measurement processes as requested.

B. Provider shall work collaboratively with County to develop process benchmarks and monitor progress in the following areas:

C. Productivity- Provider shall ensure that staff maintain a productivity level of at least 50% and will report staff productivity levels on a quarterly basis to: SUDSQualityassurance@edcgov.us. Provider will collaborate with the County in the collection and reporting of performance outcomes data, including data relevant to Healthcare Effectiveness Data and Information Set (HEDIS®) measures, as required by DHCS. Measures relevant to this Agreement are indicated below (if applicable):

   I. Follow up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA)
   II. Use of Pharmacotherapy for Opioid Use Disorder (POD) In accordance with agreed upon processes detailed in the applicable POD performance improvement plan between the provider and the County.
   III. Pharmacotherapy of Opioid Use Disorder
   IV. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

9. REPORTING AND EVALUATION REQUIREMENTS

A. Provider shall complete all reporting and evaluation activities as required by the County and described herein.

   I. Productivity Reporting
   II. Monthly Attestation of Compliance Due by the 10th of the month
   III. Level of Care Reporting Due by the 10th of the month
   IV. Timeliness Reporting Due by the 10th of the month

10. ORIENTATION, TRAINING AND TECHNICAL ASSISTANCE

A. County will endeavor to provide Provider with training and support in the skills and competencies to (a) conduct, participate in, and sustain the performance levels called for in the Agreement and (b) conduct the quality management activities called for by the Agreement.

B. County will provide the Provider with all applicable standards for the delivery and accurate documentation of services.

C. County will make ongoing technical assistance available in the form of direct consultation to Provider upon Provider's request to the extent that County has capacity and capability to provide this assistance. In doing so, the County is not relieving Provider of its duty to provide training and supervision to its staff or to ensure that its activities comply with applicable regulations and other requirements included in the terms and conditions of this Agreement.

D. Any requests for technical assistance by Provider regarding any part of this Agreement shall be directed to the County's designated contract monitor.

E. Provider shall require all new employees in positions designated as "covered individuals" to complete compliance training within the first 30 days of their first day of work. Provider shall require all covered individuals to attend, at minimum, one compliance training annually.
   I. These trainings shall be conducted by County or, at County's discretion, by Provider staff, or both, and may address any standards contained in this Agreement.
   II. Covered individuals who are subject to this training are any Provider staff who have or will have responsibility for, or who supervises any staff who have responsibility for, ordering, prescribing, providing, or documenting client care or medical items or services.

F. Provider shall require that physicians receive a minimum of five hours of continuing medical education related to addiction medicine each calendar year.

G. Provider shall require that professional staff (LPHAs) receive a minimum of five hours of continuing education related to addiction medicine calendar each year.

H. Additional Requirements
   Provider shall adhere to the Substance Use Disorder Services Training Plan most current version.

Bi-Valley Medical Clinic, Inc., doing business as BAART Programs Carmichael
Exhibit B
Provider Rates

NTP COUNSELING SERVICES				
Description	**Duration (Minutes)**	**Practitioner**	**Rate**	
NTP Individual Counseling	15	AOD	$	45.15
		LPHA	$	54.45
		MD	$	151.07
		RN	$	76.71
		NP	$	93.91
		PA	$	84.70
NTP Group Counseling	15	AOD	$	10.03
		LPHA	$	12.10
		MD	$	33.57
		RN	$	17.05
		NP	$	20.87
		PA	$	18.82
MEDICATIONS				
Description	**UNITS (DAILY/MONTHLY/AS NEEDED)**	**Practitioner**		**Rate**
NTP - Methadone	1	Non-Perinatal	$	18.63
NTP - Methadone Peri	1	Perinatal	$	20.07
NTP - Buprenorphine Mono	1	Non-Perinatal	$	32.57
NTP - Buprenorphine Mono Peri	1	Perinatal	$	44.08
NTP - Combination Product Film	1	Non-Perinatal	$	29.44
NTP - Combination Product Film Peri	1	Perinatal	$	40.94
NTP - Combination Product Tablets	1	Non-Perinatal	$	33.07
NTP - Combination Product Tablets Peri	1	Perinatal	$	44.56
NTP - Disulfiram	1	Non-Perinatal	$	11.75
NTP - Disulfiram Peri	1	Perinatal	$	11.93
Buprenorphine Injectable (Monthly)	1	Non-Perinatal	$	2,048.98

MEDICATIONS			
Buprenorphine Injectable (Monthly) Peri	1	Perinatal	$ 2,048.98
Naltrexone Injectable (Monthly)	1	Non-Perinatal	$ 2,238.05
Naltrexone Injectable (Monthly) Peri	1	Perinatal	$ 2,238.05
Naloxone HCL Generic	1	Non-Perinatal	$ 106.07
Naloxone HCL Generic Peri	1	Perinatal	$ 106.07
Naloxone HCL Narcan	1	Non-Perinatal	$ 144.76
Naloxone HCL Narcan Peri	1	Perinatal	$ 144.76

STATE OF CALIFORNIA - DEPARTMENT OF GENERAL SERVICES
STANDARD AGREEMENT
STD 213 (Rev. 04/2020)

AGREEMENT NUMBER	PURCHASING AUTHORITY NUMBER (If Applicable)
21-10027	

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

CONTRACTING AGENCY NAME
Department of Health Care Services

CONTRACTOR NAME
County of El Dorado

2. The term of this Agreement is:

START DATE
July 1, 2021

THROUGH END DATE
June 30, 2024

3. The maximum amount of this Agreement is:
$38,574,276.00 (Thirty-Eight Million, Five Hundred Seventy-Four Thousand, Two Hundred Seventy-Six Dollars)

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

	Exhibits	Title	Pages
	Exhibit A	Scope of Work	4
	Exhibit A, Attachment I	Program Specification	174
	Exhibit B	Budget Detail and Payment Provisions	13
+ -	Exhibit B, Attachment I	Funding Amounts	1
+ -	Exhibit C*	General Terms and Conditions	
+ -	Exhibit D (F)	Special Terms and Conditions – Notwithstanding provision 4.g. which does not apply to this agreement.	27
+ -	Exhibit E	Additional Provisions	4
+ -	Exhibit F	Business Associate Addendum	6

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

IN WITNESS WHEREOF, THIS AGREEMENT HAS BEEN EXECUTED BY THE PARTIES HERETO.

CONTRACTOR

CONTRACTOR NAME (if other than an individual, state whether a corporation, partnership, etc.)
County of El Dorado

CONTRACTOR BUSINESS ADDRESS	CITY	STATE	ZIP
3057 Briw Road, Suite B	Placerville	CA	95667

PRINTED NAME OF PERSON SIGNING	TITLE
John Hidahl	Chair, Board of Supervisors

CONTRACTOR AUTHORIZED SIGNATURE

DATE SIGNED
9/21/21

SCO ID: 4260-2110027

STATE OF CALIFORNIA - DEPARTMENT OF GENERAL SERVICES **STANDARD AGREEMENT** STD 213 (Rev. 04/2020)	AGREEMENT NUMBER 21-10027	PURCHASING AUTHORITY NUMBER (If Applicable)

STATE OF CALIFORNIA

CONTRACTING AGENCY NAME			
Department of Health Care Services			
CONTRACTING AGENCY ADDRESS 1501 Capitol Ave, MS 4200	CITY Sacramento	STATE CA	ZIP 95814
PRINTED NAME OF PERSON SIGNING Robert M. Strom	TITLE Chief, Contracts Section		
CONTRACTING AGENCY AUTHORIZED SIGNATURE	DATE SIGNED 9/30/21		
CALIFORNIA DEPARTMENT OF GENERAL SERVICES APPROVAL	EXEMPTION (If Applicable) W&I Code 14087.4		

Contractor Certification Clauses

CCC 04/2017

CERTIFICATION

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

Contractor/Bidder Firm Name (Printed)	Federal ID Number
County of El Dorado	94-6000511

By (Authorized Signature)

Printed Name and Title of Person Signing

John Hidahl, Chair, County of El Dorado Board of Supervisors

Date Executed	Executed in the County of
9/21/21	El Dorado

CONTRACTOR CERTIFICATION CLAUSES

1. STATEMENT OF COMPLIANCE: Contractor has, unless exempted, complied with the nondiscrimination program requirements. (Gov. Code §12990 (a-f) and CCR, Title 2, Section 11102) (Not applicable to public entities.)

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

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

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

1) the dangers of drug abuse in the workplace;

2) the person's or organization's policy of maintaining a drug-free workplace;

3) any available counseling, rehabilitation and employee assistance programs; and,

4) penalties that may be imposed upon employees for drug abuse violations.

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

1) receive a copy of the company's drug-free workplace policy statement; and,

STATE OF CALIFORNIA
CALIFORNIA CIVIL RIGHTS LAWS ATTACHMENT
DGS OLS 04 (Rev. 01/17)

DEPARTMENT OF GENERAL SERVICES
OFFICE OF LEGAL SERVICES

Pursuant to Public Contract Code section 2010, a person that submits a bid or proposal to, or otherwise proposes to enter into or renew a contract with, a state agency with respect to any contract in the amount of $100,000 or above shall certify, under penalty of perjury, at the time the bid or proposal is submitted or the contract is renewed, all of the following:

1. CALIFORNIA CIVIL RIGHTS LAWS: For contracts executed or renewed after January 1, 2017, the contractor certifies compliance with the Unruh Civil Rights Act (Section 51 of the Civil Code) and the Fair Employment and Housing Act (Section 12960 of the Government Code); and

2. EMPLOYER DISCRIMINATORY POLICIES: For contracts executed or renewed after January 1, 2017, if a Contractor has an internal policy against a sovereign nation or peoples recognized by the United States government, the Contractor certifies that such policies are not used in violation of the Unruh Civil Rights Act (Section 51 of the Civil Code) or the Fair Employment and Housing Act (Section 12960 of the Government Code).

CERTIFICATION

I, the official named below, certify under penalty of perjury under the laws of the State of California that the foregoing is true and correct.

Proposer/Bidder Firm Name (Printed)	Federal ID Number
County of El Dorado	94-6000511

By (Authorized Signature)

Printed Name and Title of Person Signing

John Hidahl, Chair, County of El Dorado Board of Supervisors

Executed in the County of	Executed in the State of
El Dorado	CA

Date Executed

9-21-21

1. Service Overview

This Intergovernmental Agreement (hereinafter referred to as Agreement) is entered into by and between the California Department of Health Care Services (DHCS) and the Contractor for the purpose of identifying and providing covered Drug Medi-Cal Organized Delivery System (DMC-ODS) services for substance use disorder treatment in the Contractor's service area pursuant to Sections 11848.5(a) and (b) of the Health and Safety Code, Sections 14021.51–14021.53 and 14124.20–14124.25 of the Welfare and Institutions Code (hereinafter referred to as W&I Code), Part 438 of the Code of Federal Regulations, and the Special Terms and Conditions of the DMC-ODS waiver.

It is further agreed this Agreement is controlled by applicable provisions of: (a) W&I Code, Chapter 7, Sections 14000, *et seq.*, in particular, but not limited to, Sections 14100.2, 14021, 14021.5, 14021.6, 14043, *et seq.* and (b) Division 4 of Title 9 of the California Code of Regulations.

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

The objective of this Agreement is to make DMC-ODS services available to Medi-Cal beneficiaries through utilization of federal and state funds available pursuant to Title XIX or Title XXI of the Social Security Act for reimbursable covered services rendered by DMC providers.

2. Service Location

The services shall be performed at facilities in the County of El Dorado.

3. Service Hours

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

4. Project Representatives

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

Department of Health Care Services	**County of El Dorado**
Contract/Grant Manager: Donnie Boyett Telephone: (209) 261-0085 Fax: (916) 322-1176 Email: Donnie.Boyett@dhcs.ca.gov	Don Semon, Director HHSA Telephone: (530) 621-6270 Fax: (530) 622-1293 Email: don.semon@edcgov.us

Direct all inquiries to:

Department of Health Care Services	County of El Dorado
Department of Health Care Services MCBHD – Program Policy Section Attention: Scott Oros Mail Station Code 2702 1500 Capitol Avenue Sacramento, CA 95814 Telephone: (916) 713-8557 Fax: (916) 322-1176 Email: Scott.Oros@dhcs.ca.gov	El Dorado County Heath and Human Services Agency Attention: Don Semon, Director HHSA 3057 Briw Road, Suite B Placerville, CA 95667 Telephone: (530) 621-6270 Fax: (530) 622-1293 Email: don.semon@edcgov.us

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

5. Americans with Disabilities Act

Contractor agrees to ensure that deliverables developed and produced, pursuant to this Agreement shall comply with the accessibility requirements of Sections 7405 and 11135 of the California Government Code, Section 508 of the Rehabilitation Act of 1973 as amended (29 U.S.C. § 794d), regulations implementing the Rehabilitation Act of 1973 as set forth in Part 1194 of Title 36 of the Code of Federal Regulations, and the Americans with Disabilities Act of 1990 (42 U.S.C. § 12101 et seq.). In 1998, Congress amended the Rehabilitation Act of 1973 to require Federal agencies to make their electronic and information technology (EIT) accessible to people with disabilities. California Government Code Sections 7405 and 11135 codifies Section 508 of the Rehabilitation Act of 1973 requiring accessibility of EIT.

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

7. Should any part of the scope of work under this contract relate to a State program receiving Federal Financial Participation (FFP) that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Contractor must do no work on that part after the effective date of the loss of such program authority. DHCS must adjust payments to remove costs that are specific to any State program or activity receiving FFP that is no longer authorized by law. If Contractor works on a State program or activity receiving FFP that is no longer authorized by law after the date the legal authority for the work ends, Contractor will not be paid for that work. If DHCS has paid Contractor in advance to work on a no-longer-authorized

State program or activity receiving FFP and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to DHCS. However, if Contractor worked on a State program or activity receiving FFP prior to the date legal authority ended for that State program or activity, and DHCS included the cost of performing that work in its payments to Contractor, Contractor may keep the payment for that work even if the payment was made after the date the State program or activity receiving FFP lost legal authority.

8. Reference Documents

All DMC-ODS documents incorporated by reference into this Agreement may not be physically attached to the Agreement, but can be found at DHCS' website: https://www.dhcs.ca.gov/provgovpart/Pages/DMC-ODS-Contracts.aspx.

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

Document 1G: Perinatal Practice Guidelines

Document 1J: Attachment Y of the DMC-ODS Special Terms and Conditions

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

Document 1P: Alcohol and/or Other Drug Program Certification Standards

Document 1V: Youth Treatment Guidelines

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

Document 2G Drug Medi-Cal Billing Manual

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

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

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

Document 2P(a): DMC-ODS Cost Report Excel Workbook

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

Document 3H:	California Code of Regulations, Title 9 – Rehabilitation and Developmental Services, Division 4 – Department of Alcohol and Drug Programs, Chapter 8 – Certification of Alcohol and Other Drug Counselors
Document 3J:	CalOMS Treatment Data Collection Guide
Document 3S	CalOMS Treatment Data Compliance Standards
Document 3V	Culturally and Linguistically Appropriate Services (CLAS) National Standards
Document 4D :	Drug Medi-Cal Certification for Federal Reimbursement (DHCS 100224A)
Document 4F :	Drug Medi-Cal (DMC) MC # 5312 Services Quarterly Claim for Reimbursement of County Administrative Expenses
Document 5A :	Confidentiality Agreement

I. Preamble

A. This Intergovernmental Agreement (hereinafter referred to as Agreement) is entered into by and between the Department of Health Care Services (hereinafter referred to as DHCS, The Department, or the state) and the Contractor for the purpose of identifying and providing covered Drug Medi-Cal Organized Delivery System (DMC-ODS) services for substance use disorder (SUD) treatment in the Contractor's service area pursuant to Sections 11848.5(a) and (b) of the Health and Safety Code (hereinafter referred to as HSC), Sections 14021.51–14021.53 and 14124.20–14124.25 of the Welfare and Institutions Code (hereinafter referred to as WIC), Part 438 of the Code of Federal Regulations (hereinafter referred to as 42 CFR 438), and the Special Terms and Conditions (STCs) of the DMC-ODS waiver.

B. It is further agreed this Agreement is controlled by applicable provisions of: (a) the WIC, Chapter 7, Sections 14000, et seq., in particular, but not limited to, Sections 14100.2, 14021, 14021.5, 14021.6, 14043, et seq. and (b) Division 4 of Title 9 of the California Code of Regulations (hereinafter referred to as Title 9).

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

D. The objective of this Agreement is to make DMC-ODS services available to Medi-Cal beneficiaries through utilization of federal and state funds available pursuant to Title XIX or Title XXI of the Social Security Act (hereinafter referred to as the Act) for reimbursable covered services rendered by enrolled DMC providers.

E. DMC-ODS services shall be provided though a Prepaid Inpatient Health Plan (PIHP) as defined in 42 CFR §438.2.

F. This Agreement requires the Contractor to ensure the availability and accessibility of adequate numbers of facilities, service locations, service sites, and professional, allied, and supportive personnel to provide medically necessary services, and ensure the authorization of services for urgent conditions. The DMC-ODS provides for automatic mandatory enrollment of all Medi-Cal beneficiaries in the single PIHP operating in the county in which the beneficiary resides. PIHPs in a very small county or in any one geographic area may have a limited number of providers for a particular service. Except as required by 42 CFR §§438.62 and 438.206(b)(4), the Contractor is not obligated to subcontract with additional providers to provide more choices for an individual beneficiary.

II. Federal Requirements

A. Waived and Inapplicable Federal Requirements

1. The Contractor is operating as a PIHP. Accordingly, the following provisions of 42 CFR §438 are not applicable to this Intergovernmental Agreement: 42 CFR §438.3(s)(t) – Standard Contract Requirements; 42 CFR §438.4 – Actuarial Soundness; 48 CFR §438.5 – Rate Development Standards; 438 CFR §438.6 – Special Contract Provisions Related to Payment; 42 CFR §438.7 – CMS Review and Approval of the Rate Certifications; 42 C.F.R. §438.8 - Medical loss ratio (MLR) standards; 42 C.F.R. §438.9 - Provisions that apply to non-emergency medical transportation PAHPs; 42 CFR 438.10(g)(2)(ii)(A) and (B) – Information Requirements; 42 CFR §438.50 – State Plan Requirements; 42 CFR §438.54(c) – Voluntary Managed Care Enrollment; 42 CFR §438.71(b)(1)(i&iii)(c)(d) – Beneficiary Support System; 42 CFR §438.74 – State Oversight of Minimum MLR Requirements; 42 CFR §438.104 - Marketing Activities; 42 CFR §438.108 – Cost Sharing; 42 CFR §438.110 - Member Advisory Committee; 42 CFR §438.114 – Emergency and Poststabilization Services; 42 CFR §438.116 – Solvency Standards; 42 CFR §438.206(b)(2) – Women's Health Services (No women's health services are provided through the DMC-ODS Waiver); 42 CFR §438.208(c)(1) – Identification of Individuals with Special Health Care Needs; 42 CFR §§438.700-730 – Sanctions; 42 CFR §438.802 – Basic Requirements; 42 CFR §438.808 – Exclusion of Entities; 42 CFR §438.810 – Expenditures for Enrollment Broker Services; 42 CFR §431.51(b)(2) and §441.202 (No family planning services, including abortion procedures, are provided through the DMC-ODS Waiver); and 42 CFR §§455.100-104 – Disclosure Requirements.

2. Under DMC-ODS, free choice of providers is restricted. That is, beneficiaries enrolled in this program shall receive DMC-ODS services through the Contractor, operating as a PIHP. Based on this service delivery model, the Department has requested, and Centers for Medicare & Medicaid Services (CMS) has granted approval to waive the following 42 CFR §438 provisions for this Agreement: 42 CFR §438.10(f)(3) – Notice Requirements; 42 CFR §438.52 - Choice of MCOs, PIHPs, PAHPs, PCCMs, and PCCM Entities; 42 CFR §438.56 – Disenrollment: Requirements and Limitations.

B. General Provisions

1. Standard Contract Requirements (42 CFR §438.3).

i. CMS shall review and approve this Agreement.

ii. Enrollment discrimination is prohibited.

a. The Contractor shall accept individuals eligible for enrollment in the order in which they apply without restriction (unless authorized by CMS), up to the limits set under this Agreement.

b. Enrollment is mandatory.

c. The Contractor shall not, based on health status or need for health care services, discriminate against individuals eligible to enroll.

d. The Contractor shall follow all Federal and State civil rights laws. The Contractor shall not unlawfully discriminate, exclude people, or treat them differently, on any ground protected under Federal or State law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

e. The Contractor will not use any policy or practice that has the effect of discriminating on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

f. The Contractor shall provide information on how to file a Discrimination Grievance with:
    i. The Contractor and the Department if there is a concern of discrimination based on sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.
    ii. The United States Department of Health and Human Services Office of Civil Rights if there is a concern of discrimination based on race, color, national origin, sex, age, or disability.

iii. Services that may be covered by the Contractor.
    a. The Contractor may cover, for beneficiaries, services that are in addition to those covered under the State Plan as follows:
        i. Any services that the Contractor voluntarily agrees to provide.
        ii. Any services necessary for compliance by the Contractor with the parity requirements set forth in 42 CFR §438.900 et. al and only to the extent such services are necessary for the Contractor to comply with 42 CFR §438.910.

iv. Compliance with applicable laws and conflict of interest safeguards.
    a. The Contractor shall comply with all applicable Federal and state laws and regulations including:
        i. Title VI of the Civil Rights Act of 1964.
        ii. Title IX of the Education Amendments of 1972 (regarding education programs and activities).
        iii. The Age Discrimination Act of 1975; the Rehabilitation Act of 1973.
        iv. The Americans with Disabilities Act of 1990 as amended.
        v. Section 1557 of the Patient Protection and Affordable Care Act.

b. The Contractor shall comply with the conflict of interest safeguards described in 42 CFR §438.58 and with the prohibitions described in section 1902(a)(4)(C) of the Act applicable to contracting officers, employees, or independent Contractors.
c. Provider-preventable condition requirements:
    i. The Contractor shall comply with the requirements mandating provider identification of provider-preventable conditions as a condition of payment, as well as the prohibition against payment for provider-preventable conditions. The Contractor shall report all identified provider-preventable conditions to the Department.
    ii. The Contractor shall not make payments to a provider for provider-preventable conditions that meet the following criteria:
        1. Is identified in the state plan.
        2. Has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.
        3. Has a negative consequence for the beneficiary.
        4. Is auditable.
    iii. The Contractor shall use and submit the report using the DHCS Drug Medi-Cal Organized Delivery System Provider Preventable Conditions (PPC) Reporting Form at the time of discovery of any provider preventable conditions that are covered under this provision to:

    Department of Health Care Services
    Medi-Cal Behavioral Health Division

    1500 Capitol Avenue, MS-2623

Sacramento, CA 95814

Or by secure, encrypted email to:
ODSSubmissions@dhcs.ca.gov

v. Inspection and audit of records and access to facilities.
   a. The Department, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the Contractor, or its subcontractors, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted. The right to audit under this section exists for 10 years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.

vi. Subcontracts.
   a. All subcontracts shall fulfill the requirements or activity delegated under the subcontract in accordance with 42 CFR §438.230.
   b. The Contractor shall require that subcontractors not bill beneficiaries for covered services under a contractual, referral, or other arrangement with the Contractor in excess of the amount that would be owed by the individual if the Contractor had directly provided the services. (42 U.S.C. 1396u–2(b)(6)(C))

vii. Choice of network provider.
   a. The Contractor shall allow each beneficiary to choose his or her network provider to the extent possible and appropriate.

viii. Audited financial reports.
   a. The Contractor shall submit audited financial reports specific to this Agreement on an annual basis. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

ix. Recordkeeping requirements.

a. The Contractor shall retain, and require subcontractors to retain, as applicable, the following information: beneficiary grievance and appeal records in 42 CFR §438.416, and the data, information, and documentation specified in 42 CFR §§438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

2. Information Requirements (42 CFR §438.10).

i. Basic Rules

a. The Contractor shall provide all required information in this section to beneficiaries and potential beneficiaries in a manner and format that may be easily understood and is readily accessible by such beneficiaries and potential beneficiaries.

b. The Department shall operate a website that provides the content, either directly or by linking to the Contractor's website.

ii. For consistency in the information provided to beneficiaries, the Contractor shall use:

a. The Department developed definitions for managed care terminology, including appeal, emergency medical condition, emergency services, excluded services, grievance, health insurance, hospitalization, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services, and urgent care.

b. The Department developed model beneficiary handbooks and beneficiary notices.

iii. The Contractor shall provide the required information in this section to each beneficiary.

iv. Beneficiary information required in this section may not be provided electronically by the Contractor unless all of the following are met:

a. The format is readily accessible.

b. The information is placed in a location on the Department or the Contractor's website that is prominent and readily accessible.
c. The information is provided in an electronic form, which can be electronically retained and printed.
d. The information is consistent with the content and language requirements of this section.
e. The beneficiary is informed that the information is available in paper form without charge upon request and provides it upon request within five business days.

v. The Contractor shall have in place mechanisms to help beneficiaries and potential beneficiaries understand the requirements and benefits of the plan.

vi. Language and format:
a. The Department shall use the methodology below for identifying the prevalent non–English languages spoken by beneficiaries and potential beneficiaries throughout the state, and in the Contractor's service area.
i. A population group of mandatory Medi-Cal beneficiaries residing in the service area who indicate their primary language as other than English and that meet a numeric threshold of 3,000 or five percent of the beneficiary population, whichever is lower.
ii. A population group of mandatory Medi-Cal beneficiaries residing in the Contractor's service area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single ZIP code or 1,500 in two contiguous ZIP codes.

vii. The Department shall make oral interpretation available in all languages and written translation available in each prevalent non–English language. All written materials for potential beneficiaries shall include language taglines in at least the top 16 non-English languages spoken by individuals with limited English proficiency of the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information. Large print means printed in a font size no smaller than 18 point.

viii. The Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, beneficiary handbooks, appeal and grievance notices, and denial and termination notices, available in the prevalent non–English languages in its particular service area. Written materials shall also be made available in alternative formats upon request of the potential beneficiary or beneficiary at no cost. Auxiliary aids and services shall also be made available upon request of the potential beneficiary or beneficiary at no cost. Written materials shall include taglines in the prevalent non–English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided and the toll-free and TTY/TDY telephone number of the Contractor's member/customer service unit. Large print means printed in a font size no smaller than 18 point.

ix. Pursuant to WIC 14029.91(e)(1), the Contractor shall make interpretation services available free of charge and in a timely manner to each beneficiary. This includes oral interpretation and the use of auxiliary aids (e.g. TTY/TDY and American Sign Language) and services, including qualified interpreters for individuals with disabilities (WIC 14029.91(e)(2)). Oral interpretation requirements apply to all non–English languages, not just those that the Department identifies as prevalent.

a. Pursuant to WIC 14029.91(a)(1)(B), Oral interpretation services shall be provided by an interpreter that, at a minimum, meets all of the following qualifications:
    i. Demonstrated proficiency in speaking and understanding both spoken English and the language spoken by the limited-English-proficient beneficiary.
    ii. The ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from the language spoken by the limited-English-proficient beneficiary and English, using any necessary specialized vocabulary, terminology, and phraseology.
    iii. Adherence to generally accepted interpreter ethics principles, including client confidentiality.

x. Pursuant to WIC Section 14029.91(a)(1)(C), the Contractor shall not require a beneficiary with limited English proficiency to provide his or her own interpreter or rely on a staff member who does not meet the qualifications described in WIC 14029.91(a)(1)(B).

xi. The Contractor shall not rely on an adult or minor child accompanying the limited-English-proficient beneficiary to interpret or facilitate communication except under the circumstances described in WIC Section 14029.91 (a)(1)(D).

xii. The Contractor shall notify its beneficiaries:
    a. That oral interpretation is available for any language and written translation is available in prevalent languages to individuals whose primary language is not English. This may include, but is not limited to:
        i. Qualified interpreters;
        ii. Information written in other languages.
    b. That auxiliary aids and services are available upon request and at no cost for beneficiaries with disabilities. Free aids and services to people with disabilities to help them communicate better may include, but are not limited to:
        i. Qualified sign language interpreters;

ii. Written information in other formats (large print, audio, accessible electronic formats, other formats.)

c. How to access services.

xiii. The Contractor shall notify beneficiaries and prospective beneficiaries that written translation is available in prevalent languages free of cost and how to access those materials.

xiv. Pursuant to 45 CFR §92.201, the Contractor shall not require a beneficiary with limited English proficiency to accept language assistance services.

xv. The Contractor shall provide, all written materials for potential beneficiaries and beneficiaries consistent with the following:

a. Use easily understood language and format.
b. Use a font size no smaller than 12 point.
c. Be available in alternative formats and through the provision of auxiliary aids and services in an appropriate manner that takes into consideration the special needs of beneficiaries or potential beneficiaries with disabilities or limited English proficiency.
d. Include a large print tagline in at least the top 16 non-English languages and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats. Large print means printed in a font size no smaller than 18 point.

xvi. The Contractor shall post a DHCS-approved nondiscrimination notice and language taglines in at least the top 16 non-English languages in the State (as determined by DHCS), as well as large print, explaining the availability of free language assistance services, including written translation and oral interpretation to understand the information provided, and the toll-free and TTY/TDY telephone number of the Contractor's member/customer service unit, as follows:

a. In all conspicuous physical locations where the Contractor interacts with the public;

b. In a conspicuous location on the Contractor's website that is accessible on the Contractor's home page, and in a manner that allows beneficiaries and prospective beneficiaries to easily locate the information; and
c. In all significant communications and significant publications targeted to beneficiaries, enrollees, applicants, and members of the public, except for significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures.

xvii. The Contractor shall post a DHCS-approved nondiscrimination statement and language taglines in at least the top two non-English languages in the State (as determined by DHCS), explaining the availability of free language assistance services, and the toll-free and TTY/TDY telephone number of the Contractor's member/customer service unit, as follows:
a. In all significant publications and significant communications that are small-sized, such as postcards and tri-fold brochures.
b. The Contractor's nondiscrimination notice, nondiscrimination statement, and language taglines must be in a conspicuously visible font size no smaller than 12 point. Any large print tagline required must be in a font size no smaller than 18 point, and must include information on how to request auxiliary aids and services, including the provision of the materials in alternative formats.

xviii. Information for potential beneficiaries.
a. The Contractor shall provide the information specified in this section to each potential beneficiary, either in paper or in electronic format, at the time that the potential beneficiary is first required to enroll in the Contractor's program.
b. The information for potential beneficiaries shall include, at a minimum, all of the following:
i. The basic features of managed care.

ii. Which populations are subject to mandatory enrollment and the length of the enrollment period.
iii. The service area covered by the Contractor.
iv. Covered benefits including:
    1. Which benefits are provided by the Contractor.
    2. Which, if any, benefits are provided directly by the Department.
v. The provider directory and formulary information.
vi. The requirements for each Contractor to provide adequate access to covered services, including the network adequacy standards established in 42 CFR §438.68.
vii. The Contractor's entities responsible for coordination of beneficiary care.
viii. To the extent available, quality and performance indicators for the Contractor, including beneficiary satisfaction.

xix. Information for all beneficiaries of the Contractor.
    a. The Contractor shall make a good faith effort to give written notice of termination of a subcontracted provider, within 15 calendar days after receipt or issuance of the termination notice, to each beneficiary who received his or her primary care from, or was seen on a regular basis by, the terminated provider.

xx. Beneficiary handbook.
    a. The Contractor shall utilize, and require its subcontracted providers to utilize, the state developed model beneficiary handbook.
    b. The Contractor shall provide each beneficiary a beneficiary handbook, within a reasonable time after receiving notice of the beneficiary's enrollment, which serves as the summary of benefits and coverage described in 45 CFR § 147.200(a).

c. The content of the beneficiary handbook shall include information that enables the beneficiary to understand how to effectively use the managed care program. This information shall include at a minimum:
    i. Benefits provided by the Contractor, including Early Periodic Screening, Diagnostic and Treatment (EPSDT) benefits.
    ii. How and where to access any benefits, including EPSDT benefits, provided by the state and how transportation is provided.
    iii. The amount, duration, and scope of benefits available under the Agreement in sufficient detail to ensure that beneficiaries understand the benefits to which they are entitled.
    iv. Procedures for obtaining benefits, including any requirements for service authorizations and/or referrals for specialty care and for other benefits not furnished by the Contractor or a subcontracted provider.
    v. The extent to which, and how, after-hours care is provided.
    vi. Any restrictions on the beneficiary's freedom of choice among network providers.
    vii. The extent to which, and how, beneficiaries may obtain benefits from out-of-network providers.
    viii. Beneficiary rights and responsibilities, including:
        1. The beneficiary's right to receive beneficiary and plan information.
        2. The elements specified in 42 CFR §438.100, and outlined in Article II. ,D. ,1 of this Agreement.
    ix. Grievance, appeal, and fair hearing procedures and timeframes, consistent with Article II.G of this Agreement, in a state-developed or state-approved description (WIC 14029.91(e)(4)). Such information shall include:

1. The right to file grievances and appeals.
    a. The Contractor shall include information on filing a Discrimination Grievance with the Contractor, the DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights, and shall specifically include information stating that the Contractor complies with all State and Federal civil rights laws. If a beneficiary believes they have been unlawfully discriminated against, they have the right to file a Discrimination Grievance with the Contractor, the Department's Office of Civil Rights, and the United States Department of Health and Human Services, Office for Civil Rights.
2. The requirements and timeframes for filing a grievance or appeal.
3. The availability of assistance in the filing process.
4. The right to request a state fair hearing after the Contractor has made a determination on a beneficiary's appeal, which is adverse to the beneficiary.

5. The fact that, when requested by the beneficiary, benefits that the Contractor seeks to reduce or terminate will continue if the beneficiary files an appeal or a request for state fair hearing within the timeframes specified for filing, and that the beneficiary may, consistent with state policy, be required to pay the cost of services furnished while the appeal or state fair hearing is pending if the final decision is adverse to the beneficiary.

x. How to access auxiliary aids and services, including additional information in alternative formats or languages. The Contractor shall specifically include specific information regarding:
   1. The provision of cost free aids and services to individuals with disabilities (qualified sign language interpreters, written information in other formats).
   2. The provision of cost free language services to individuals whose primary language is not English (qualified interpreters, information written in other languages).

xi. The toll-free telephone number for member services, medical management, and any other unit providing services directly to beneficiaries.

xii. Information on how to report suspected fraud or abuse.

d. The beneficiary handbook will be considered to be provided if the Contractor:
   i. Mails a printed copy of the information to the beneficiary's mailing address.
   ii. Provides the information by email after obtaining the beneficiary's agreement to receive the information by email.

iii. Posts the information on the Contractor's website and advises the beneficiary in paper or electronic form that the information is available on the Internet and includes the applicable Internet address, provided that beneficiaries with disabilities who cannot access this information online are provided auxiliary aids and services upon request at no cost.
iv. Provides the information by any other method that can reasonably be expected to result in the beneficiary receiving that information.

e. The Contractor shall give each beneficiary notice of any significant change in the information specified above, at least 30 days before the intended effective date of the change.

xxi. Provider Directory.

a. The Contractor shall make available in electronic form and, upon request, in paper form, the following information about its network providers:
i. The provider's name as well as any group affiliation.
ii. Street address(es).
iii. Telephone number(s).
iv. Website URL, as appropriate.
v. Specialty, as appropriate.
vi. Whether the provider will accept new beneficiaries.
vii. The provider's cultural and linguistic capabilities, including languages (including American Sign Language) offered by the provider or a skilled medical interpreter at the provider's office, and whether the provider has completed cultural competence training.
viii. Whether the provider's office/facility has accommodations for people with physical disabilities, including offices, exam room(s) and equipment.

b. The Contractor shall include the following provider types covered under this Agreement in the provider directory:
    i. Physicians, including specialists
    ii. Hospitals
    iii. Pharmacies
    iv. Behavioral health providers
c. Information included in a paper provider directory shall be updated at least monthly and electronic provider directories shall be updated no later than 30 calendar days after the Contractor receives updated provider information.
d. Provider directories shall be made available on the Contractor's website in a machine-readable file and format as specified by the Secretary of Health and Human Services.

xxii. Formulary.
a. The Contractor shall make available in electronic or paper form, the following information about its formulary:
    i. Which medications are covered (both generic and name brand).
    ii. What tier each medication resides.
b. Formulary drug lists shall be made available on the Contractor's website in a machine-readable file and format as specified by the Secretary.

3. Provider Discrimination Prohibited (42 CFR § 438.12).

i. The Contractor shall not discriminate in the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification.

ii. If the Contractor declines to include individual or groups of providers in its provider network, it shall give the affected providers written notice of the reason for its decision.

iii. In all contracts with network providers, the Contractor shall comply with the requirements specified in 42 CFR §438.214.

iv. This section may not be construed to:

a. Require the Contractor to subcontract with providers beyond the number necessary to meet the needs of its beneficiaries.
b. Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty.
c. Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to beneficiaries.

4. **Requirements that Apply to Indians, Indian Health Care Providers (IHCPs), and Indian Managed Care Entities (IMCEs) (42 CFR §438.14).**
   i. The Contractor shall demonstrate that there are sufficient IHCPs participating in the Contractor's provider network to ensure timely access to services available under this Agreement from such providers for Indian beneficiaries who are eligible to receive services.
   ii. The Contractor shall pay IHCPs, whether participating or not, for the provision of covered services to Indian beneficiaries who are eligible to receive services from such providers.
   iii. The Contractor shall pay IHCPs at rates consistent with the requirements of 42 CFR §438.14, the California State Plan, and Department Information Notices and guidance.
   iv. The Contractor shall make payment to all IHCPs in its network in a timely manner as required for payments to practitioners in individual or group practices under 42 CFR 447.45 and 447.46.
   v. The Contractor shall permit Indian beneficiaries to obtain services covered under this Agreement between the State and the Contractor from out-of-network IHCPs from whom the beneficiary is otherwise eligible to receive such services.
   vi. If timely access to covered services cannot be ensured due to few or no IHCPs, the Contractor will be considered to have demonstrated that there are sufficient IHCPs participating in the Contractor's provider network to ensure timely access to services by permitting Indian beneficiaries to access out-of-state IHCPs.

vii. The Contractor shall permit an out-of-network IHCP to refer an Indian beneficiary to a network provider.

C. State Responsibilities

1. Conflict of Interest Safeguards (42 CFR §438.58).

i. The Department shall have in effect safeguards against conflict of interest on the part of Department and local officers and employees and agents of the Department who have responsibilities relating to this Agreement. These safeguards shall be at least as effective as the safeguards specified in section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423).

2. Prohibition of Additional Payments (42 CFR §438.60).

i. The Department shall ensure that no payment is made to a network provider other than by the Contractor for services covered under this Agreement, except when these payments are specifically required to be made by the Department in Title XIX of the Act, in 42 CFR chapter IV.

3. Continued Services to Beneficiaries (42 CFR §438.62).

i. The Department shall arrange for Medicaid services to be provided without delay to any Medicaid beneficiary of the Contractor if this Agreement is terminated.

ii. The Department shall have in effect a transition of care policy to ensure continued access to services during a transition from FFS to the Contractor or transition from one Contractor to another when a beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

iii. The Contractor shall implement a transition of care policy consistent with the requirements of the Department's transition of care policy.

iv. The Department shall make its transition of care policy publicly available and provide instructions on how beneficiaries and potential beneficiaries access continued services upon transition. At a minimum, the Contractor shall provide the transition of care policy to beneficiaries and potential beneficiaries in the beneficiary handbook and notices.

4. **State Monitoring Requirements (42 CFR §438.66).**
    i. The Department shall have in effect a monitoring system for the Contractor.
    ii. The Department's monitoring system is outlined in Article III.DD of this Agreement.
    iii. The Department shall use data collected from its monitoring activities to improve the performance of the Contractor. That data shall include, at minimum:
        a. Beneficiary grievance and appeal logs
        b. Provider complaint and appeal logs
        c. Findings from the State's External Quality Review process
        d. Results from any beneficiary or provider satisfaction survey conducted by the State or the Contractor
        e. Performance on required quality measures
        f. Medical management committee reports and minutes
        g. The annual quality improvement plan for the Contractor
        h. Customer service performance data submitted by the Contractor and performance data submitted by the beneficiary support system
5. **Network Adequacy Standards (42 CFR §438.68).**
    i. The Contractor shall adhere to, in all geographic areas within the county, all applicable time and distance standards for network providers developed by the Department, including those set forth in WIC Section 14197 and any Information Notices issued pursuant to that section.
        a. Pursuant to WIC Section 14197(d)(1)(A), the Contractor shall ensure that all beneficiaries seeking outpatient and intensive outpatient (non-OTP) services be provided with an appointment within 10 business days of a non-OTP service request.
        b. Pursuant to WIC Section 14197(d)(3), the Contractor shall ensure that all beneficiaries seeking OTP services are provided with an appointment within three business days of an OTP service request.

c. If the Contractor cannot meet the time and distance standards set forth in this section, the Contractor shall submit a request for alternative access standards to the Department.
d. Pursuant to WIC Section 14197(e), the Department may grant requests for alternative access standards if the Contractor has exhausted all other reasonable options to obtain providers to meet the applicable standard or if the Department determines that the Contractor has demonstrated that its delivery structure is capable of delivering the appropriate level of care and access.
    i. The Contractor shall include a description of the reasons justifying the alternative access standards.
        1. Requests for alternative access standards shall be approved or denied on a zip code and service type basis.
e. Pursuant to WIC Section 14197(e)(3), the Contractor shall submit a description on how they intend to arrange for beneficiaries to access covered services if the provider is located outside of the time and distance standards. Requests for alternative access standards may include seasonal considerations (e.g. winter road conditions), when appropriate. Furthermore, the Contractor shall include an explanation about gaps in the county's geographic service area, including information about uninhabitable terrain within the county (e.g., desert, forestland), as appropriate. The use of clinically appropriate telecommunications technology may be considered in determining compliance with the applicable standards established in the DHCS Information Notice 20-012 and/or for approving an alternative access request.
f. DHCS will make a decision to approve or deny the request within 90 days of submission by the Contractor. DHCS may stop the 90-day timeframe, on one or more occasions as necessary, in the event of an incomplete submission or to obtain additional information from the Contractor. (WIC 14197(e)(3))

g. If the Contractor does not comply with the applicable standards at any time, DHCS may impose additional corrective actions, including fines, penalties, the withholding of payments, special requirements, probationary or corrective actions, or any other actions deemed necessary to ensure compliance.
h. Fines and penalties imposed by the Department shall be in the amounts specified below:
    i. First violation: $500, plus $25 per day for each day that the Contractor continues to be out of compliance.
    ii. Second and subsequent violation: $500, plus $25 per day for each day that the Contractor continues to be out of compliance.

ii. The Department shall monitor beneficiary access to each provider type on an ongoing basis and communicate the findings to CMS in the managed care program assessment report required under 42 CFR §438.66.

D. Beneficiary Rights and Protections

1. Beneficiary Rights (42 CFR §438.100).

i. The Contractor shall have written policies guaranteeing the beneficiary's rights specified in 42 CFR 438.100.

ii. The Contractor shall comply with any applicable Federal and state laws that pertain to beneficiary rights, and ensures that its employees and subcontracted providers observe and protect those rights.

iii. Specific rights.
    a. The Contractor shall ensure that its beneficiaries have the right to:
        i. Receive information regarding the Contractor's PIHP and plan in accordance with 42 CFR §438.10.
        ii. Be treated with respect and with due consideration for his or her dignity and privacy.
        iii. Receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand.

iv. Participate in decisions regarding his or her health care, including the right to refuse treatment.
v. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
vi. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR § 164.524 and 164.526.

b. The Contractor shall ensure that its beneficiaries have the right to be furnished health care services in accordance with 42 CFR §§438.206 through 438.210.

iv. Free exercise of rights.

a. The Contractor shall ensure that each beneficiary is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the Contractor and its network providers treat the beneficiary.

v. Compliance with other Federal and state laws.

a. The Contractor shall comply with any other applicable Federal and state laws, including, but not limited to:
i. Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80.
ii. The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91.
iii. The Rehabilitation Act of 1973.
iv. Title IX of the Education Amendments of 1972 (regarding education programs and activities).
v. Titles II and III of the Americans with Disabilities Act.
vi. Section 1557 of the Patient Protection and Affordable Care Act.

2. Provider-Beneficiary Communications (42 CFR §438.102).

i. The Contractor shall not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a beneficiary who is his or her patient, for the following:
    a. The beneficiary's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
    b. Any information the beneficiary needs to decide among all relevant treatment options.
    c. The risks, benefits, and consequences of treatment or non-treatment.
    d. The beneficiary's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

3. Liability for Payment (42 CFR §438.106).

i. The Contractor shall ensure that its beneficiaries are not held liable for any of the following:
    a. The Contractor's debts, in the event of the Contractor's insolvency.
    b. Covered services provided to the beneficiary, for which:
        i. The state does not pay the Contractor; or
        ii. The Contractor or the Department does not pay the individual or health care provider that furnished the services under a contractual, referral, or other arrangement.
    c. Payments for covered services furnished under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount that the beneficiary would owe if the Contractor covered the services directly.

E. Contractor Standards as a PIHP

1. Availability of Services (42 CFR §438.206).

i. The Contractor shall ensure that all services covered under the State Plan are available and accessible to its beneficiaries in a timely manner. The Contractor's provider networks for services covered under this Agreement shall meet the standards developed by the Department in accordance with 42 CFR §438.68.

ii. The Contractor shall, consistent with the scope of its contracted services, meet the following requirements:
    a. Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under this Agreement for all beneficiaries, including those with limited English proficiency or physical or mental disabilities.
    b. Provide for a second opinion from a network provider, or arranges for the beneficiary to obtain one outside the network, at no cost to the beneficiary.
    c. If the provider network is unable to provide necessary services, covered under this Agreement, to a particular beneficiary, the Contractor shall adequately and timely cover these services out-of-network for the beneficiary, for as long as the Contractor's provider network is unable to provide them.
    d. Require out-of-network subcontracted providers to coordinate with the Contractor for payment and ensures the cost to the beneficiary is no greater than it would be if the services were furnished within the network.
    e. Demonstrate that its network providers are credentialed as required by 42 CFR §438.214.

iii. The Contractor shall comply with the following timely access requirements:
    a. Meet and require its network providers to meet Department standards for timely access to care and services, taking into account the urgency of the need for services.

b. Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid FFS, if the provider serves only Medicaid beneficiaries.
c. Make services included in this Agreement available 24 hours a day, 7 days a week, when medically necessary.
d. Establish mechanisms to ensure compliance by network providers.
e. Monitor network providers regularly to determine compliance.
f. Take corrective action if there is a failure to comply by a network provider.

iv. Access and cultural considerations (WIC §14029.91).
a. The Contractor shall participate in the Department's efforts to promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity.

v. Accessibility considerations (45 CFR §§ 92.204 & 92.205).

a. The Contractor shall ensure that their health programs or activities provided through electronic and information technology are accessible to individuals with disabilities, unless doing so would result in undue financial and administrative burdens or a fundamental alteration in the nature of the health programs or activities. When undue financial and administrative burdens or a fundamental alteration exist, the covered entity shall provide information in a format other than an electronic format that would not result in such undue financial and administrative burdens or a fundamental alteration but would ensure, to the maximum extent possible, that individuals with disabilities receive the benefits or services of the health program or activity that are provided through electronic and information technology
b. The Contractor shall ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid beneficiaries with physical or mental disabilities. The Contractor and its network providers shall make reasonable modifications to policies, practices, or procedures when such modifications are necessary to avoid discrimination on the basis of disability, unless the Contractor or its network providers can demonstrate that making the modifications would fundamentally alter the nature of the health program or activity. For the purposes of this section, the term ‘‘reasonable modifications’’ shall be interpreted in a manner consistent with the term as set forth in the ADA Title II regulation at 28 CFR 35.130(b)(7).

2. **Assurances of Adequate Capacity and Services (42 CFR §438.207).**
    i. The Contractor shall give assurances to the Department and provide supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with the Department's standards for access and timeliness of care under this part, including the standards at 42 CFR §438.68 and 42 CFR §438.206(c)(1).
    ii. The Contractor shall submit documentation to the Department to demonstrate that it complies with the following requirements:
        a. Offers an appropriate range of specialty services that are adequate for the anticipated number of beneficiaries for the service area.
        b. Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries in the service area.
    iii. The Contractor shall submit network adequacy documentation to the Medi-Cal Behavioral Health Division (MCBHD) via email to ODSSubmissions@dhcs.ca.gov:
        a. Upon entering into this Agreement with the Department.
        b. On an annual basis, on or before April 1.
        c. Within 10 business days of a significant change in the Contractor's operations that would affect the adequacy and capacity of services, including composition of the Contractor's provider network.
        d. As requested by the Department.
    iv. The Contractor's failure to submit network adequacy documentation in a timely manner shall subject the Contractor to fines, sanctions and penalties as described in this Agreement (Article II.C.5.ii.i and Article II.C.5.ii.j.)

v. Upon receipt of the Contractor's network adequacy documentation, the Department shall either certify the Contractor's network adequacy documentation or inform the Contractor that its documentation does not meet applicable time and distance standards, or Department approved alternate access standard.

vi. Upon receipt of the Department's determination that the Contractor does not meet the applicable time and distance standards, or a DHCS approved alternate access standard, the Contractor shall submit a Corrective Action Plan (CAP) for approval to DHCS that describes action steps that the Contractor will immediately implement to ensure compliance with applicable network adequacy standards within the Department's approved timeframe.

vii. The Contractor shall submit updated network adequacy documentation as requested by the Department.

viii. If the Department determines that the Contractor does not comply with the applicable standards at any time, the Department may require a CAP, impose fines, or penalties, withhold payments, or any other actions deemed necessary by the Department to ensure compliance with network adequacy standards.

a. Fines and penalties imposed by the Department for late submissions shall be in the amounts specified below:

i. First violation: $500, plus $25 per day for each day that the item to be submitted is late.

ii. Second and subsequent violation: $500, plus $25 per day for each day that the item to be submitted is late.

3. Coordination and Continuity of Care (42 CFR §438.208).

i. The Contractor shall comply with the care and coordination requirements of this section.

ii. As all beneficiaries receiving DMC-ODS services have special health care needs, the Contractor shall implement mechanisms for identifying, assessing, and producing a treatment plan for all beneficiaries that have been assessed to need a course of treatment, and as specified below.

iii. The Contractor shall implement procedures to deliver care to and coordinate services for all of its beneficiaries. These procedures shall meet Department requirements and shall do the following:

a. Ensure that each beneficiary has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary. The beneficiary shall be provided information on how to contact their designated person or entity.
b. Coordinate the services the Contractor furnishes to the beneficiary:
    i. Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays;
    ii. With the services the beneficiary receives from any other managed care organization;
    iii. With the services the beneficiary receives in FFS Medicaid; and
    iv. With the services the beneficiary receives from community and social support providers.
c. Make a best effort to conduct an initial screening of each beneficiary's needs, within 90 calendar days of the effective date of enrollment for all new beneficiaries, including subsequent attempts if the initial attempt to contact the beneficiary is unsuccessful.
d. Share with the Department or other managed care organizations serving the beneficiary, the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities.
e. Ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards.

f. Ensure that in the process of coordinating care, each beneficiary's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E and 42 CFR Part 2, to the extent that they are applicable.

iv. The Contractor shall implement mechanisms to comprehensively assess each Medicaid beneficiary identified by the Department as having special health care needs to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring. The assessment mechanisms shall use appropriate providers.

v. The Contractor shall produce a treatment or service plan meeting the criteria below for beneficiaries with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan shall be:
   a. Developed with beneficiary participation, and in consultation with any providers caring for the beneficiary.
   b. Developed by a person trained in person-centered planning using a person-centered process and plan, as defined in 42 CFR §441.301(c)(1) and (2).
   c. Approved by the Contractor in a timely manner, if this approval is required by the Contractor.
   d. In accordance with any applicable Department quality assurance and utilization review standards.
   e. Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the beneficiary's circumstances or needs change significantly, or at the request of the beneficiary per 42 CFR §441.301(c)(3).

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

4. **Coverage and Authorization of Services (42 CFR §438.210).**
    i. The Contractor shall furnish medically necessary services covered by this Agreement in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in 42 CFR §440.230, and for beneficiaries under the age of 21, as set forth in 42 CFR §441, subpart B.
    ii. The Contractor:
        a. Shall ensure that the medically necessary services provided are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
        b. Shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of diagnosis, type of illness, or condition of the beneficiary.
    iii. The Contractor may place appropriate limits on a service based on criteria applied under the State Plan, such as medical necessity.
    iv. The Contractor may place appropriate limits on a service for the purpose of utilization control, provided that:
        a. The services furnished can reasonably achieve their purpose.
        b. The services supporting individuals with ongoing or chronic conditions are authorized in a manner that reflects the enrollee's ongoing need for such services and supports.
    v. Authorization of services.
        a. The Contractor and its subcontractors shall have in place, and follow, written authorization policies and procedures.
        b. The Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.
        c. The Contractor shall consult with the requesting provider for medical services when appropriate.

d. Any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, shall be made by an individual who has appropriate expertise in addressing the beneficiary's medical and behavioral health.
e. Notice of adverse benefit determination (NOABD).
    i. The Contractor shall notify the requesting provider, and give the beneficiary written notice of any decision by the Contractor to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. The beneficiary's notice shall meet the requirements of 42 CFR §438.404.

vi. Standard authorization decisions.
a. For standard authorization decisions, the Contractor shall provide notice as expeditiously as the beneficiary's condition requires, not to exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days when:
    i. The beneficiary, or the provider, requests extension; or
    ii. The Contractor justifies (to the Department, upon request) a need for additional information and how the extension is in the beneficiary's interest.

vii. Expedited authorization decisions.
a. For cases in which a provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the beneficiary's life or health or ability to attain, maintain, or regain maximum function, the Contractor shall make an expedited authorization decision and provide notice as expeditiously as the beneficiary's health condition requires, and no later than 72 hours after receipt of the request for service.

b. The Contractor may extend the 72-hour time period by up to 14 calendar days if the beneficiary requests an extension, or if the Contractor justifies (to the Department, upon request) a need for additional information and how the extension is in the beneficiary's interest.

viii. Compensation for utilization management activities.

a. Consistent with 42 CFR §438.3(i) and 42 CFR §422.208, compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any beneficiary.

5. Provider Selection (42 CFR §438.214).

i. The Contractor shall implement written policies and procedures for selection and retention of network providers and the implemented policies and procedures, at a minimum, meet the following requirements:

a. Credentialing and re-credentialing requirements.

i. The Contractor shall follow the state's established uniform credentialing and re-credentialing policy that addresses behavioral and substance use disorders, outlined in DHCS Information Notice 18-019.

ii. The Contractor shall follow a documented process for credentialing and re-credentialing of network providers.

b. Nondiscrimination.

i. The Contractor's network provider selection policies and procedures, consistent with 42 CFR §438.12, shall not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment.

c. Excluded providers.
    i. The Contractor shall not employ or subcontract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Act.
d. Additional Department requirements.
    i. The Contractor shall comply with any additional requirements established by the Department.

6. Confidentiality (42 CFR §438.224).

i. For medical records and any other health and enrollment information that identifies a particular beneficiary, the Contractor shall use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E and 42 CFR Part 2, to the extent that these requirements are applicable.

7. Grievance and Appeal Systems (42 CFR §438.228).

i. The Contractor shall have in effect, a grievance and appeal system that meets the requirements outlined in Article II.G of this Agreement.

ii. The Contractor shall be responsible for issuing any NOABD under 42 CFR Part 431, subpart E. The Department shall conduct random reviews of the Contractor and its providers and subcontractors to ensure that they are notifying beneficiaries in a timely manner.

8. Subcontractual Relationships and Delegation (42 CFR §438.230).

i. The requirements of this section apply to any contract or written arrangement that the Contractor has with any subcontractor.

ii. Notwithstanding any relationship(s) that Contractor may have with any subcontractor, the Contractor shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Agreement.

iii. All contracts or written arrangements between the Contractor and any subcontractor shall specify the following:

a. The delegated activities or obligations, and related reporting responsibilities, are specified in the contract or written agreement.
b. The subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with the Contractor's Agreement obligations.
c. The contract or written arrangement shall either provide for revocation of the delegation of activities or obligations, or specify other remedies in instances where the Department or the Contractor determine that the subcontractor has not performed satisfactorily.
d. The subcontractor agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions.
e. The subcontractor agrees that—
    i. The Department, CMS, the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's Contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under this Agreement at any time.
    ii. The subcontractor will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid beneficiaries.

iii. The Department, CMS, the HHS Inspector General, the Comptroller General, or their designees' right to audit the subcontractor will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

iv. If the Department, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the Department, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.

9. Practice Guidelines (42 CFR §438.236).

i. The Contractor shall adopt practice guidelines that meet the following requirements:
   a. Are based on valid and reliable clinical evidence or a consensus of providers in the particular field.
   b. Consider the needs of the Contractor's beneficiaries.
   c. Are adopted in consultation with contracting health care professionals.
   d. Are reviewed and updated periodically as appropriate.

ii. The Contractor shall disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.

iii. The Contractor shall ensure that all decisions for utilization management, beneficiary education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

10. Health Information Systems (42 CFR §438.242).

i. The Contractor shall maintain a health information system that collects, analyzes, integrates, and reports data and can achieve the objectives of this part. The systems shall provide information on areas including, but not limited to, utilization, claims, and grievances and appeals.

ii. The Contractor shall comply with Section 6504(a) of the Affordable Care Act.

iii. The Contractor shall collect data on beneficiary and provider characteristics as specified by the Department, and on all services furnished to beneficiaries through an encounter data system or other methods as may be specified by the Department.

iv. The Contractor shall ensure that data received from providers is accurate and complete by—

a. Verifying the accuracy and timeliness of reported data, including data from network providers the Contractor is compensating.

b. Screening the data for completeness, logic, and consistency.

c. Collecting data from providers in standardized formats to the extent feasible and appropriate, including secure information exchanges and technologies utilized for Department Medicaid quality improvement and care coordination efforts.

v. The Contractor shall make all collected data available to the Department and upon request to CMS.

vi. The Contractor shall collect and maintain sufficient beneficiary encounter data to identify the provider who delivers any item(s) or service(s) to beneficiaries.

vii. The Contractor shall submit beneficiary encounter data to the Department, annually and upon request, as specified by CMS and the Department, based on program administration, oversight, and program integrity needs.

viii. The Contractor shall submit all beneficiary encounter data that the Department is required to report to CMS under 42 CFR §438.818.

ix. The Contractor shall submit encounter data to the Department in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate.

F. Quality Measurement and Improvement External Quality Review

1. Quality Assessment and Performance Improvement Program (PIP) (42 CFR §438.330).

i. The Contractor shall establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its beneficiaries.
ii. After consulting with states and other stakeholders and providing public notice and opportunity to comment, CMS may specify performance measures and performance improvement projects (PIPs), which shall be included in the standard measures identified and PIPs required by the Department. The Department may request an exemption from including the performance measures or PIPs established under this section by submitting a written request to CMS explaining the basis for such request.
iii. The Contractor's comprehensive quality assessment and performance improvement program shall include at least the following elements:
    a. Performance improvement projects.
    b. Collection and submission of performance measurement.
    c. Mechanisms to detect both underutilization and overutilization of services.
    d. Mechanisms to assess the quality and appropriateness of care furnished to beneficiaries with special health care needs, as defined by the Department in the quality strategy under 42 CFR §438.340.
iv. The Department shall identify standard performance measures, including those performance measures that may be specified by CMS, relating to the performance of the Contractor.
v. Annually, the Contractor shall:
    a. Measure and report to the Department on its performance, using the standard measures required by the Department.
    b. Submit to the Department data, specified by the Department, which enables the Department to calculate Contractor's performance using the standard measures identified by the Department.

c. Perform a combination of the activities described above.

vi. Performance improvement projects.

a. The Contractor shall conduct performance improvement projects, including any performance improvement projects required by CMS that focus on both clinical and nonclinical areas.

b. Each performance improvement project shall be designed to achieve significant improvement, sustained over time, in health outcomes and beneficiary satisfaction, and shall include the following elements:

i. Measurement of performance using objective quality indicators.

ii. Implementation of interventions to achieve improvement in the access to and quality of care.

iii. Evaluation of the effectiveness of the interventions based on the performance measures.

iv. Planning and initiation of activities for increasing or sustaining improvement.

c. The Contractor shall report the status and results of each project conducted to the Department as requested, but not less than once per year.

2. Department Review of the Contractor's Accreditation Status (42 CFR §438.332).

i. The Contractor shall inform the Department if it has been accredited by a private independent accrediting entity. The Contractor is not required to obtain accreditation by a private independent accrediting entity.

ii. If the Contractor has received accreditation by a private independent accrediting entity, then the Contractor shall authorize the private independent accrediting entity to provide the Department a copy of its most recent accreditation review, including:

a. Accreditation status, survey type, and level (as applicable).

b. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings.
c. Expiration date of the accreditation.

iii. The Department shall:
a. Make the accreditation status for the Contractor available on the website required under 42 CFR §438.10(c)(3), including whether the Contractor has been accredited and, if applicable, the name of the accrediting entity, accreditation program, and accreditation level.
b. Update this information at least annually.

G. Grievance and Appeal System

1. General Requirements (42 CFR §438.402).

i. The Contractor shall have a grievance and appeal system in place for beneficiaries.

ii. The Contractor shall have only one level of appeal for beneficiaries.

iii. Filing requirements:
a. Authority to file.
i. A beneficiary may file a grievance and request an appeal with the Contractor. A beneficiary may request a state fair hearing after receiving notice under 42 CFR §438.408 that the adverse benefit determination is upheld.
1. In the case that the Contractor fails to adhere to the notice and timing requirements in 42 CFR §438.408, the beneficiary is deemed to have exhausted the Contractor's appeals process. The beneficiary may initiate a state fair hearing.
2. The Department may offer and arrange for an external medical review if the following conditions are met.

a. The review shall be at the beneficiary's option and shall not be required before, or used as a deterrent to, proceeding to the state fair hearing.
b. The review shall be independent of both the Department and the Contractor.
c. The review shall be offered without any cost to the beneficiary.
d. The review shall not extend any of the timeframes specified in 42 CFR §438.408 and shall not disrupt the continuation of benefits in 42 CFR §438.420.

ii. With the written consent of the beneficiary, a provider or an authorized representative may request an appeal or file a grievance, or request a state fair hearing, on behalf of a beneficiary, with the exception that providers cannot request continuation of benefits as specified in 42 CFR §438.420(b)(5).

b. Timing:

i. Grievance:

1. The beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, may file a grievance with the Contractor at any time.

ii. Appeal:

1. The Contractor shall allow the beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, to file a request for an appeal to the Contractor within 60 calendar days from the date on the NOABD.

c. Procedures:
    i. Grievance:
        1. The beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, may file a grievance either orally or in writing and, as determined by the Department, either with the Department or with the Contractor.
    ii. Appeal:
        1. The beneficiary, an authorized provider, or an authorized representative acting on behalf of the beneficiary, as state law permits, may request an appeal either orally or in writing. Further, unless an expedited resolution is requested, an oral appeal shall be followed by a written, signed appeal.

2. Timely and Adequate Notice of Adverse Benefit Determination (42 CFR §438.404).

i. Notice.
    a. The Contractor shall give beneficiaries timely and adequate notice of an adverse benefit determination, in writing, consistent with the requirements below and in 42 CFR §438.10.

ii. Content of notice.
    a. The notice shall explain the following:
        i. The adverse benefit determination the Contractor has made or intends to make.

ii. The reasons for the adverse benefit determination, including the right of the beneficiary to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the beneficiary's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.
iii. The beneficiary's right to request an appeal of the Contractor's adverse benefit determination, including information on exhausting the Contractor's one level of appeal described at 42 CFR §438.402(b) and the right to request a state fair hearing consistent with 42 CFR §438.402(c).
iv. The procedures for exercising these appeal rights.
v. The circumstances under which an appeal process can be expedited and how to request it.
vi. The beneficiary's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances, consistent with state policy, under which the beneficiary may be required to pay the costs of these services.

iii. Timing of notice.
a. The Contractor shall mail the notice within the following timeframes:
i. At least 10 days before the date of the adverse benefit determination, when the adverse benefit determination is a termination, suspension, or reduction of previously authorized Medicaid-covered services.

ii. For denial of payment, at the time of any adverse benefit determination affecting the claim.
iii. For standard authorization decisions that deny or limit services, as expeditiously as the beneficiary's condition requires within state-established timeframes that shall not exceed 14 calendar days following receipt of the request for service.
    1. The Contractor shall be allowed to extend the 14 calendar day NOABD timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the beneficiary or the provider requests an extension.
    2. The Contractor shall be allowed to extend the 14 calendar day NOABD timeframe for standard authorization decisions that deny or limit services up to 14 additional calendar days if the Contractor justifies a need (to the Department, upon request) for additional information and shows how the extension is in the beneficiary's best interest. Consistent with 42 CFR §438.210(d)(1)(ii), the Contractor shall:
        a. Give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he or she disagrees with that decision.
        b. Issue and carry out its determination as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

iv. For service authorization decisions not reached within the timeframes specified in 42 CFR §438.210(d) (which constitutes a denial and is thus an adverse benefit determination), on the date that the timeframes expire.
v. For expedited service authorization decisions, within the timeframes specified in 42 CFR §438.210(d)(2).

b. The Contractor shall be allowed to mail the NOABD as few as five days prior to the date of action if the Contractor has facts indicating that action should be taken because of probable fraud by the beneficiary, and the facts have been verified, if possible, through secondary sources.
c. The Contractor shall mail the NOABD by the date of the action when any of the following occur:
    i. The recipient has died.
    ii. The beneficiary submits a signed written statement requesting service termination.
    iii. The beneficiary submits a signed written statement including information that requires service termination or reduction and indicates that he understands that service termination or reduction will result.
    iv. The beneficiary has been admitted to an institution where he or she is ineligible under the plan for further services.
    v. The beneficiary's address is determined unknown based on returned mail with no forwarding address.
    vi. The beneficiary is accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth.
    vii. A change in the level of medical care is prescribed by the beneficiary's physician.
    viii. The notice involves an adverse determination with regard to preadmission screening requirements of section 1919(e)(7) of the Act.

ix. The transfer or discharge from a facility will occur in an expedited fashion.

3. Discrimination Grievances (45 CFR §§ 92.7 and 92.8; WIC §14029.91)

i. For Discrimination Grievances, the Contractor shall designate a Discrimination Grievance Coordinator who is responsible for ensuring compliance with federal and state nondiscrimination requirements and investigating Discrimination Grievances related to any action that would be prohibited by, or out of compliance with, federal or state nondiscrimination law.

ii. The Contractor shall adopt Discrimination Grievance procedures that ensure the prompt and equitable resolution of discrimination-related complaints. The Contractor shall not require a beneficiary to file a Discrimination Grievance with the Contractor before filing the grievance directly with DHCS Office of Civil Rights and the U.S. Health and Human Services Office for Civil Rights.

iii. Within ten (10) calendar days of mailing a Discrimination Grievance resolution letter to a beneficiary, the Contractor shall submit detailed information regarding the grievance to DHCS Office of Civil Rights' designated Discrimination Grievance email box. The Contractor shall submit the following detailed information in a secure format to DHCS.DiscriminationGrievances@dhcs.ca.gov:

a. The original complaint.
b. The provider's or other accused party's response to the grievance.
c. Contact information for the Contractor's personnel responsible for the Contractor's investigation and response to the grievance.
d. Contact information for the beneficiary filing the grievance and for the provider or other accused party that is the subject of the grievance.
e. All correspondence with the beneficiary regarding the grievance, including, but not limited to, the Discrimination Grievance acknowledgment and resolution letter(s) sent to the beneficiary.

f. The results of the Contractor's investigation, copies of any corrective action taken, and any other information that is relevant to the allegation(s) of discrimination.

4. Handling of Grievances and Appeals (42 CFR §438.406).

i. In handling grievances and appeals, the Contractor shall give beneficiaries any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal. This includes, but is not limited to, auxiliary aids and services upon request, such as providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

ii. The Contractor's process for handling beneficiary grievances and appeals of adverse benefit determinations shall:

a. Acknowledge receipt of each grievance and appeal within five calendar days.

b. Ensure that the individuals who make decisions on grievances and appeals are individuals—

i. Who, were neither involved in any previous level of review or decision-making nor a subordinate of any such individual.

ii. Who, if deciding any of the following, are individuals who have the appropriate clinical expertise, as determined by the Department, in treating the beneficiary's condition or disease.

1. An appeal of a denial that is based on lack of medical necessity.
2. A grievance regarding denial of expedited resolution of an appeal.
3. A grievance or appeal that involves clinical issues.

iii. Who, take into account all comments, documents, records, and other information submitted by the beneficiary or their representative without regard to whether such information was submitted or considered in the initial adverse benefit determination.

c. Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and shall be confirmed in writing, unless the beneficiary or the provider requests expedited resolution.
d. Provide the beneficiary a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor shall inform the beneficiary of the limited time available for this sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c) in the case of expedited resolution.
e. Provide the beneficiary and his or her representative the beneficiary's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the Contractor (or at the direction of the Contractor) in connection with the appeal of the adverse benefit determination. This information shall be provided free of charge and sufficiently in advance of the resolution timeframe for appeals as specified in 42 CFR §438.408(b) and (c).
f. Include, as parties to the appeal:
    i. The beneficiary and his or her representative.
    ii. The legal representative of a deceased beneficiary's estate.

5. Resolution and Notification: Grievances and Appeals (42 CFR §438.408).

i. The Contractor shall resolve each grievance and appeal, and provide notice, as expeditiously as the beneficiary's health condition requires, within the following timeframes:
    a. Standard resolution of grievances: 90 calendar days from the day the Contractor receives the grievance.

b. Standard resolution of appeals: 30 calendar days from the day the Contractor receives the appeal. This timeframe may be extended in the manner described below.
c. Expedited resolution of appeals: 72 hours after the Contractor receives the appeal. This timeframe may be extended under in the manner described below.

ii. Extension of timeframes.
a. The Contractor may extend the timeframes for standard and expedited resolution of grievances and appeals by up to 14 calendar days if:
i. The beneficiary requests the extension; or
ii. The Contractor shows (to the satisfaction of the Department, upon its request) that there is need for additional information and how the delay is in the beneficiary's interest.

iii. If the Contractor extends the timeframes not at the request of the beneficiary, it shall complete all of the following:
a. Make reasonable efforts to give the beneficiary prompt oral notice of the delay.
b. Within two calendar days, give the beneficiary written notice of the reason for the decision to extend the timeframe and inform the beneficiary of the right to file a grievance if he or she disagrees with that decision.
c. Resolve the appeal as expeditiously as the beneficiary's health condition requires and no later than the date the extension expires.

iv. If the Contractor fails to adhere to the notice and timing requirements in this section, the beneficiary is deemed to have exhausted the Contractor's appeals process. The beneficiary may initiate a state fair hearing.

v. Format of notice:
a. Grievances.
i. The Contractor shall notify the beneficiary of the resolution of a grievance and ensure that such methods meet, at a minimum, the standards described at 42 CFR §438.10.
b. Appeals.

i. For all appeals, the Contractor shall provide written notice of resolution in a format and language that, at a minimum, meet the standards described at 42 CFR §438.10.
ii. For notice of an expedited resolution, the Contractor shall also make reasonable efforts to provide oral notice.

vi. The written notice of the resolution shall include the following:
a. The results of the resolution process and the date it was completed.
b. For appeals not resolved wholly in favor of the beneficiaries—
i. The right to request a state fair hearing.
ii. How to make the request a state fair hearing.
iii. The right to request and receive benefits, while the hearing is pending and how to make the request.
iv. That the beneficiary may, consistent with state policy, be held liable for the cost of those benefits if the hearing decision upholds the Contractor's adverse benefit determination.

vii. Requirements for state fair hearings—
a. A beneficiary may request a state fair hearing only after receiving notice that the Contractor is upholding the adverse benefit determination.
b. If the Contractor fails to adhere to the notice and timing requirements in 42 CFR §438.408, then the beneficiary is deemed to have exhausted the Contractor's appeals process. The beneficiary may initiate a state fair hearing.
c. The Department shall offer and arrange for an external medical review when the following conditions are met:
i. The review shall be at the beneficiary's request and shall not be required before, or used as a deterrent to, proceeding to the state fair hearing

ii. The review shall be independent of both the Department and the Contractor.
iii. The review shall be offered without any cost to the beneficiary.
iv. The review shall not extend any of the timeframes specified in 42 CFR §438.408 and shall not disrupt the continuation of benefits in 42 CFR §438.420.

d. State fair hearing.
i. The beneficiary shall request a state fair hearing no later than 120 calendar days from the date of the Contractor's Notice of Appeal Resolution.
ii. The parties to the state fair hearing include the Contractor, as well as the beneficiary and his or her representative or the representative of a deceased beneficiary's estate.

6. Expedited Resolution of Appeals (42 CFR §438.410).

i. The Contractor shall establish and maintain an expedited review process for appeals when the Contractor determines (for a request from the beneficiary) or the provider indicates (in making the request on the beneficiary's behalf or supporting the beneficiary's request) that taking the time for a standard resolution could seriously jeopardize the beneficiary's life, physical or mental health, or ability to attain, maintain, or regain maximum function.
ii. The Contractor shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a beneficiary's appeal.
iii. If the Contractor denies a request for expedited resolution of an appeal, it shall:
a. Transfer the appeal to the timeframe for standard resolution in accordance with 42 CFR §438.408(b)(2).
b. Follow the requirements in 42 CFR §438.408(c)(2).

7. Information About the Grievance and Appeal System to Providers and Subcontractors (42 CFR §438.414).

i. The Contractor shall provide the information specified in 42 CFR §438.10(g)(2)(xi) about the grievance and appeal system to all providers and subcontractors at the time they enter into a contract.

8. Recordkeeping Requirements (42 CFR §438.416).

i. The Contractor shall maintain records of grievances and appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the Department quality strategy.

ii. The record of each grievance or appeal shall contain, at a minimum, all of the following information:

a. A general description of the reason for the appeal or grievance.
b. The date received.
c. The date of each review or, if applicable, review meeting.
d. Resolution at each level of the appeal or grievance, if applicable.
e. Date of resolution at each level, if applicable.
f. Name of the covered person for whom the appeal or grievance was filed.

iii. The record shall be accurately maintained in a manner accessible to the Department and available upon request to CMS.

9. Continuation of Benefits While the Contractor's Appeal and the State Fair Hearing Are Pending (42 CFR §438.420).

i. Timely files mean files for continuation of benefits on or before the later of the following:

a. Within 10 calendar days of Contractor sending the NOABD.
b. The intended effective date of the Contractor's proposed adverse benefit determination.

ii. The Contractor shall continue the beneficiary's benefits if all of the following occur:

a. The beneficiary files the request for an appeal timely in accordance with 42 CFR §438.402(c)(1)(ii) and (c)(2)(ii).

b. The appeal involves the termination, suspension, or reduction of previously authorized services.
c. An authorized provider ordered the services.
d. The period covered by the original authorization has not expired.
e. The beneficiary timely files for continuation of benefits.

iii. At the beneficiary's request, the Contractor shall continue or reinstate the beneficiary's benefits while the appeal or state fair hearing is pending, the benefits shall be continued until one of following occurs:
a. The beneficiary withdraws the appeal or request for state fair hearing.
b. The beneficiary fails to request a state fair hearing and continuation of benefits within 10 calendar days after the Contractor sends the notice of an adverse resolution to the beneficiary's appeal under 42 CFR §438.408(d)(2).
c. A state fair hearing officer issues a hearing decision adverse to the beneficiary.

iv. If the final resolution of the appeal or state fair hearing is adverse to the beneficiary, that is, upholds the Contractor's adverse benefit determination, the Contractor may, consistent with the Department's usual policy on recoveries under 42 CFR §431.230(b) and as specified in this Agreement, recover the cost of services furnished to the beneficiary while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.

10. Effectuation of Reversed Appeal Resolutions (42 CFR §438.424).

i. The Contractor shall authorize or provide the disputed services promptly, and as expeditiously as the beneficiary's health condition requires (but no later than 72 hours from the date it receives notice reversing the determination) if the services were not furnished while the appeal was pending and if the Contractor or state fair hearing officer reverses a decision to deny, limit, or delay services.

ii. The Contractor shall pay for disputed services received by the beneficiary while the appeal is pending, unless state policy and regulations provide for the state to cover the cost of such services, when the Contractor or state fair hearing officer reverses a decision to deny authorization of the services.

H. Additional Program Integrity Safeguards

1. Basic Rule (42 CFR §438.600).

i. As a condition for receiving payment under a Medicaid managed care program, the Contractor shall comply with the requirements in 42 CFR §§438.604, 438.606, 438.608 and 438.610, as applicable and as outlined below.

2. State Responsibilities (42 CFR §438.602).

i. **Monitoring Contractor compliance.**

a. Consistent with 42 CFR §438.66, the Department shall monitor the Contractor's compliance, as applicable, with 42 CFR §§438.604, 438.606, 438.608, 438.610, 438.230, 438.808, 438.900 et seq.

ii. **Screening, enrollment, and revalidation of providers.**

a. The Department shall screen and enroll, and revalidate every five years, all of the Contactor's network providers, in accordance with the requirements of 42 CFR, Part 455, Subparts B and E. This provision does not require the network provider to render services to FFS beneficiaries.

iii. **Ownership and control information.**

a. The Department shall review the ownership and control disclosures submitted by the Contractor, and any subcontractors as required in 42 CFR §438.608(c).

iv. **Federal database checks.**

a. Consistent with the requirements in 42 CFR §455.436, the Department shall confirm the identity and determine the exclusion status of the Contractor, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the Contractor through routine checks of Federal databases. This includes the Social Security Administration's Death Master File, the National Plan and Provider Enumeration System (NPPES), the List of Excluded Individuals/Entities (LEIE), the System for Award Management (SAM), and any other databases as the state or Secretary may prescribe. These databases shall be consulted upon contracting and no less frequently than monthly thereafter. If the Department finds a party that is excluded, it shall promptly notify the Contractor and take action consistent with 42 CFR §438.610(c).

v. **Periodic audits.**

a. The Department shall periodically, but no less frequently than once every three years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter and financial data submitted by, or on behalf of, the Contractor.

vi. **Whistleblowers.**

a. The Department shall receive and investigate information from whistleblowers relating to the integrity of the Contractor, subcontractors, or network providers receiving Federal funds under 42 CFR, Part 438.

vii. **Transparency.**

a. The Department shall post on its website, as required in 42 CFR §438.10(c)(3), the following documents and reports:
    i. This Agreement.
    ii. The data at 42 CFR §438.604(a)(5).

iii. The name and title of individuals included in 42 CFR §438.604(a)(6).
iv. The results of any audits performed pursuant Article II, Section H, Paragraph (v) of this Agreement.

viii. **Contracting integrity.**
a. The Department shall have in place conflict of interest safeguards described in 42 CFR §438.58 and shall comply with the requirement described in section 1902(a)(4)(C) of the Act applicable to contracting officers, employees, or independent Contractors.

ix. **Entities located outside of the U.S.**
a. The Department shall ensure that the Contractor is not located outside of the United States and that no claims paid by the Contractor to a network provider, out-of-network provider, subcontractor, or financial institution located outside of the U.S. are considered in the development of actuarially sound capitation rates.

3. Data, Information, and Documentation that shall be submitted (42 CFR §438.604).

i. The Contractor shall submit to the Department the following data:
a. Encounter data in the form and manner described in 42 CFR §438.818.
b. Documentation described in 42 CFR §438.207(b) on which the Department bases its certification that the Contractor has complied with the Department's requirements for availability and accessibility of services, including the adequacy of the provider network, as set forth in 42 CFR §438.206.
c. Information on ownership and control described in 42 CFR §455.104 from the Contractor's subcontractors as governed by 42 CFR §438.230.
d. The annual report of overpayment recoveries as required in 42 CFR §438.608(d)(3).

ii. In addition to the data, documentation, or information above, the Contractor shall submit any other data, documentation, or information relating to the performance of the Contractor's program integrity safeguard obligations required by the Department or the Secretary.

4. Source, Content, and Timing of Certification (42 CFR §438.606).

i. The data, documentation, or information specified in 42 CFR §438.604, shall be certified by either the Contractor's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

ii. The certification shall attest that, based on best information, knowledge, and belief, the data, documentation, and information specified in 42 CFR §438.604 is accurate, complete, and truthful.

iii. The Contractor shall submit the certification concurrently with the submission of the data, documentation, or information required in 42 CFR §438.604(a) and (b).

5. Program Integrity Requirements (42 CFR §438.608).

i. The Contractor, and its subcontractors to the extent that the subcontractors are delegated responsibility by the Contractor for coverage of services and payment of claims under this Agreement, shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse.

ii. The arrangements or procedures shall include the following:

a. A compliance program that includes, at a minimum, all of the following elements:

i. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements.

ii. The designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Agreement and who reports directly to the County Behavioral Health Director and the Board of Supervisors.
iii. The establishment of a Regulatory Compliance Committee on the Board of Supervisors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under this Agreement.
iv. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and state standards and requirements under this Agreement.
v. Effective lines of communication between the compliance officer and the organization's employees.
vi. Enforcement of standards through well-publicized disciplinary guidelines.
vii. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement.

b. Provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the Department.
c. Provision for prompt notification to the Department when it receives information about changes in a beneficiary's circumstances that may affect the beneficiary's eligibility including all of the following:
    i. Changes in the beneficiary's residence.
    ii. The death of a beneficiary.
d. Provision for notification to the Department when it receives information about a change in a network provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of the provider agreement with the Contractor.
e. Provision for a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by beneficiaries and the application of such verification processes on a regular basis.
f. If the Contractor makes or receives annual payments under this Agreement of at least $5,000,000, provision for written policies for all employees of the entity, and of any subcontractor or agent, that provide detailed information about the False Claims Act and other Federal and state laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers
g. Provision for the prompt referral of any potential fraud, waste, or abuse that the Contractor identifies to the Department Medicaid program integrity unit or any potential fraud directly to the State Medicaid Fraud Control Unit.
h. Provision for the Contractor's suspension of payments to a network provider for which the Department determines there is a credible allegation of fraud in accordance with 42 CFR §455.23.

iii. The Contractor shall ensure that all network providers are enrolled with the Department as Medicaid providers consistent with the provider disclosure, screening and enrollment requirements of 42 CFR part 455, subparts B and E. This provision does not require the network provider to render services to FFS beneficiaries.

iv. The Contractor and all its subcontractors shall provide reports to the Department within 60 calendar days when it has identified payments in excess of amounts specified in this Contract.

v. Treatment of recoveries made by the Contractor of overpayments to providers.

a. The Contractor shall specify in accordance with this Exhibit A, Attachment I and Exhibit B of this Agreement:

i. The retention policies for the treatment of recoveries of all overpayments from the Contractor to a provider, including specifically the retention policies for the treatment of recoveries of overpayments due to fraud, waste, or abuse.

ii. The process, timeframes, and documentation required for reporting the recovery of all overpayments.

iii. The process, timeframes, and documentation required for payment of recoveries of overpayments to the state in situations where the Contractor is not permitted to retain some or all of the recoveries of overpayments.

iv. This provision does not apply to any amount of a recovery to be retained under False Claims Act cases or through other investigations.

b. The Contractor shall have a mechanism for a network provider to report to the Contractor when it has received an overpayment, to return the overpayment to the Contractor within 60 calendar days after the date on which the overpayment was identified, and to notify the Contractor in writing of the reason for the overpayment.
c. The Contractor shall annually report to the Department on their recoveries of overpayments.

6. Prohibited Affiliations (42 CFR §438.610).

i. The Contractor and its subcontractors shall not knowingly have a relationship of the type described in paragraph (iii) of this subsection with the following:
   a. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
   b. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in paragraph (a)(1) of this section.

ii. The Contractor and its subcontractors shall not have a relationship with an individual or entity that is excluded from participation in any Federal Health Care Program under section 1128 or 1128A of the Act.

iii. The relationships described in paragraph (i) of this section, are as follows:
   a. A director, officer, or partner of the Contractor.
   b. A subcontractor of the Contractor, as governed by 42 CFR §438.230.
   c. A person with beneficial ownership of five percent or more of the Contractor's equity.

d. A network provider or person with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Agreement.

iv. If the Department finds that the Contractor is not in compliance, the Department:
   a. Shall notify the Secretary of the noncompliance.
   b. May continue an existing Agreement with the Contractor unless the Secretary directs otherwise.
   c. May not renew or otherwise extend the duration of an existing Agreement with the Contractor unless the Secretary provides to the state and to Congress a written statement describing compelling reasons that exist for renewing or extending the Agreement despite the prohibited affiliations.
   d. Nothing in this section shall be construed to limit or otherwise affect any remedies available to the U.S. under sections 1128, 1128A or 1128B of the Act.

v. The Contractor shall provide the Department with written disclosure of any prohibited affiliation under this section by the Contractor or any of its subcontractors.

7. Disclosures on Information and Ownerships Control (42 CFR §455.104)

i. The Contractor and its subcontractors shall provide the following disclosures through the DMC certification process described in Article III.J:
   a. The name and address of any person (individual or corporation) with an ownership or control interest in the Contractor. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.
   b. Date of birth and Social Security Number (in the case of an individual).

c. Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a five percent or more interest.
d. Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a five percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.
e. The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.
f. The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

ii. Disclosures are due at any of the following times:
a. Upon the Contractor submitting the proposal in accordance with the Department's procurement process.
b. Upon the Contractor executing this Agreement with the Department.
c. Upon renewal or extension of this Agreement.
d. Within 35 days after any change in ownership of the Contractor.

iii. The Contractor shall provide all disclosures to the Department.

iv. Federal financial participation (FFP) shall be withheld from the Contractor if it fails to disclose ownership or control information as required by this section.

v. For the purposes of this section “person with an ownership or control interest” means a person or corporation that -

a. Has an ownership interest totaling five percent or more in a disclosing entity.

b. Has an indirect ownership interest equal to five percent or more in a disclosing entity.

c. Has a combination of direct and indirect ownership interests equal to five percent or more in a disclosing entity.

d. Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent of the value of the property or assets of the disclosing entity.

e. Is an officer or director of a disclosing entity that is organized as a corporation.

f. Is a partner in a disclosing entity that is organized as a partnership.

I. Conditions for FFP

1. Costs under this Nonrisk Contract (42 CFR §438.812).

i. The amount the Department pays for the furnishing of medical services to eligible beneficiaries is a medical assistance cost.

ii. The amount the Department pays for the Contractor’s performance of other functions is an administrative cost.

J. Parity in Mental Health and Substance Use Disorder Benefits (42 CFR §438.900 et seq.)

1. General Parity Requirement

i. To ensure compliance with the parity requirements set forth in 42 CFR §438.900 et seq., the Contractor shall not impose, or allow any of its subcontractors to impose, any financial requirements, Quantitative Treatment Limitations, or Non-Quantitative Treatment Limitations in any classification of benefit (inpatient, outpatient, emergency care, or prescription drugs) other than those limitations permitted and outlined in this Agreement.

ii. The Contractor shall not apply any financial requirement or treatment limitation to substance use disorder services in any classification of benefit that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification of benefit furnished to beneficiaries (whether or not the benefits are furnished by the Contractor). (42 CFR 438.910(b)(1))

iii. The Contractor shall provide substance use disorder services to beneficiaries in every classification in which medical/surgical benefits are provided. (42 CFR 438.910(b)(2))

2. Quantitative Limitations

i. The Contractor shall not apply any cumulative financial requirement for substance use disorder services in a classification that accumulates separately from any established for medical/surgical services in the same classification. (42 CFR 438.910(c)(3))

3. Non-Quantitative Limitations

i. The Contractor shall not impose a non-quantitative treatment limitation for substance use disorder benefits in any classification unless, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitation to substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification. (42 CFR §438.910(d))

ii. The Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for substance use disorder services that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits. (42 CFR §438.910(d)(3))

III. Program Specifications

A. Provision of Services

1. Provider Specifications

i. The following requirements shall apply to the Contractor, the provider, and the provider staff:

a. Professional staff shall be licensed, registered, certified, or recognized under California scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioners of the Healing Arts (LPHA) include:

i. Physician
ii. Nurse Practitioners
iii. Physician Assistants
iv. Registered Nurses
v. Registered Pharmacists
vi. Licensed Clinical Psychologists
vii. Licensed Clinical Social Worker
viii. Licensed Professional Clinical Counselor
ix. Licensed Marriage and Family Therapists
x. Licensed 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. A professional and/or administrative staff shall supervise non-professional staff.

iii. Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring. Documentation of trainings, certifications and licensure shall be contained in personnel files.

iv. Physicians shall receive a minimum of five hours of continuing medical education related to addiction medicine each year.
v. Professional staff (LPHAs) shall receive a minimum of five hours of continuing education related to addiction medicine each year.
vi. Registered and certified SUD counselors shall adhere to all requirements in CCR Title 9, §13000 et seq.

2. Services for Adolescents and Youth

i. Assessment and services for adolescents will follow the American Society of Addiction Medicine (ASAM) adolescent treatment criteria.

B. Organized Delivery System (ODS) Timely Coverage

1. Non-Discrimination - Member Discrimination Prohibition

i. Contractor shall accept individuals eligible for enrollment in the order in which they apply without restriction in accordance with this Agreement. Contractor shall take affirmative action to ensure that beneficiaries are provided covered services and will not discriminate against individuals eligible to enroll under the laws of the United States and the State of California. Contractor shall not unlawfully discriminate against any person pursuant to:
   a. Title VI of the Civil Rights Act of 1964.
   b. Title IX of the Education Amendments of 1972 (regarding education and programs and activities).
   c. The Age Discrimination Act of 1975.
   d. The Rehabilitation Act of 1973.
   e. The Americans with Disabilities Act.

2. DMC-ODS services shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in this opt-in County. Determination of who may receive the DMC-ODS benefits shall be performed in accordance with DMC-ODS Special Terms and Conditions (STC) 132(d), Article II.E.4 of this Agreement, and as follows:

i. The Contractor or its subcontracted provider shall verify the Medicaid eligibility determination of an individual. When the subcontracted provider conducts the initial eligibility verification, that verification shall be reviewed and approved by the Contractor prior to payment for services. If the individual is eligible to receive services from tribal health programs operating under the Indian Self-Determination and Education Assistance Act of 1975 (ISDEAA), then the determination shall be conducted as set forth in the Tribal Delivery System - Attachment BB to the STCs.

ii. All beneficiaries shall meet the following medical necessity criteria:
    a. The individual shall have received a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders.
    b. The individual shall meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.
    c. For beneficiaries in treatment prior to implementation of the DMC-ODS, the provider must conduct an ASAM assessment by the due date of the next updated treatment plan or continuing services justification, whichever occurs first.
        i. If the assessment determines a different level of care, the provider shall refer the beneficiary to the appropriate level of care.

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

iv. In addition to Article III.B.2.ii, the initial medical necessity determination for an individual to receive a DMC-ODS benefit, shall be performed by a Medical Director or an LPHA. If a beneficiary's assessment and intake information are completed by a counselor through a face-to-face review or telehealth, the Medical Director or LPHA shall evaluate each beneficiary's assessment and intake information with the counselor to establish whether that beneficiary meets medical necessity criteria. The ASAM Criteria shall be applied to determine placement into the level of assessed services.

v. For an individual to receive ongoing DMC-ODS services, the Medical Director or LPHA shall reevaluate that individual's medical necessity qualification at least every six months through the reauthorization process and document their determination that those services are still clinically appropriate for that individual. For an individual to receive ongoing Opioid Treatment Program/Narcotic Treatment Program (OTP/NTP) services, the Medical Director or LPHA shall reevaluate that individual's medical necessity qualification within two years from admission and annually thereafter through the reauthorization process and determine that those services are still clinically appropriate for that individual.

C. Covered Services

1. In addition to the coverage and authorization of services requirements set forth in Article II.E.4 of this Agreement, the Contractor shall:

i. Identify, define, and specify the amount, duration, and scope of each medically necessary service that the Contractor is required to offer.
ii. Require that the medically necessary services identified be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in 42 CFR 440.230.
iii. Specify the extent to which the Contractor is responsible for covering medically necessary services related to the following:
    a. The prevention, diagnosis, and treatment of health impairments.
    b. The ability to achieve age-appropriate growth and development.
    c. The ability to attain, maintain, or regain functional capacity.

2. The Contractor shall deliver the DMC-ODS Covered Services within a continuum of care as defined in the ASAM criteria.

3. Mandatory DMC-ODS Covered Services include:
i. Withdrawal Management (minimum one level)
ii. Intensive Outpatient
iii. Outpatient
iv. Opioid (Narcotic) Treatment Programs
v. Recovery Services
vi. Case Management
vii. Physician Consultation
viii. Perinatal Residential Treatment Services (excluding room and board)
    a. Room and board shall not be a covered expenditure under the DMC-ODS. Room and board may be paid with funding sources unrelated to the DMC-ODS.
ix. Non-perinatal Residential Treatment Services (excluding room and board)
    a. Room and board shall not be a covered expenditure under the DMC-ODS. Room and board may be paid with funding sources unrelated to DMC-ODS.

4. Contractor, to the extent applicable, shall comply with "Sobky v. Smoley" (Document 2A), 855 F. Supp. 1123 (E.D. Cal 1994), incorporated by this reference.
5. Contractor shall comply with federal and state mandates to provide SUD treatment services deemed medically necessary for Medi-Cal eligible: (1) pregnant and postpartum women, and (2) adolescents under age 21 who are eligible under the EPSDT Program.
6. In accordance with the requirements in Section 1905(r) of the Social Security Act, the Contractor is responsible for providing full-scope Medi-Cal beneficiaries under the age of 21 with a comprehensive, high quality array of preventive (such as screening), diagnostic, and treatment services under Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT).

D. Financing

1. Payment for Services

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

ii. The Contractor shall attest to the accuracy, completeness, and truthfulness of claims and payment data, under penalty of perjury.

iii. DHCS shall establish a CMS-approved Certified Public Expenditure (CPE) protocol before FFP associated with DMC-ODS services is made available to DHCS. This DHCS approved CPE protocol (Attachment AA of the STCs) shall explain the process DHCS shall use to determine costs incurred by the counties under this demonstration.

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

v. Pursuant to Title 42 CFR 433.138 and 22 CCR 51005(a), if a beneficiary has Other Heath Coverage (OHC), then the Contractor shall bill that OHC prior to billing DMC to receive either payment from the OHC, or a notice of denial from the OHC indicating that:
    a. The recipient's OHC coverage has been exhausted, or
    b. The specific service is not a benefit of the OHC.

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

2. Rate Setting

i. The Contractor shall propose county-specific fee-for-service (FFS) provider rates for all modalities except the OTP/NTP modality. DHCS shall approve or deny those proposed rates to determine if the rates are sufficient to ensure access to available DMC-ODS services.
    a. If DHCS denies the Contractor's proposed rates, the Contractor shall have an opportunity to adjust the rates and resubmit them to DHCS to determine if the adjusted rates are sufficient to ensure access to available DMC-ODS services. The Contractor shall receive DHCS approval of its rates prior to providing any covered DMC-ODS program services.

ii. DHCS, pursuant to the process set forth in WIC 14021.51 shall set the OTP/NTP reimbursement rate. The Contractor shall reimburse all OTP/NTP providers at this rate.

iii. Pursuant to WIC 14124.24, the Contractor shall require OTP/NTP providers to submit cost reports to DHCS.

E. Availability of Services

1. In addition to the availability of services requirements set forth in Article II.E.1 of this Agreement, the Contractor shall:

i. Consider the number and types (in terms of training, experience, and specialization) of providers required to ensure the availability and accessibility of medically necessary services.

ii. Maintain and monitor a network of appropriate providers that is supported by written agreements for subcontractors, and that is sufficient to provide its beneficiaries with adequate access to all services covered under this Agreement.

iii. In establishing and monitoring the network, document the following:

a. The anticipated number of Medi-Cal eligible beneficiaries.

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

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

d. The number of network providers who are not accepting new beneficiaries.

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

F. Access to Services

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

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

3. In addition to the coverage and authorization of service requirements set forth in Article II.E.4 of this Agreement, the Contractor shall:

i. Authorize DMC-ODS services in accordance with the medical necessity requirements specified in Title 22, Section 51303 and the coverage provisions of the approved State Medi-Cal Plan.
ii. Inform the beneficiary in accordance with Article II.G.2 of this Agreement if services are denied.
iii. Provide prior authorization for residential services within 24 hours of the prior authorization request being submitted by the provider.
    a. Prior authorization is prohibited for non-residential DMC-ODS services.
    b. The Contractor's prior authorization process shall comply with the parity requirements set forth in 42 CFR §438.910(d).
iv. Review the DSM and ASAM Criteria documentation to ensure that the beneficiary meets the requirements for the service.
v. Have written policies and procedures for processing requests for initial and continuing authorization of services.
vi. Have a mechanism in place to ensure that there is consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate.
vii. Track the number, percentage of denied, and timeliness of requests for authorization for all DMC-ODS services that are submitted, processed, approved, and denied.
viii. Pursuant to 42 CFR 438.3(l), allow each beneficiary to choose his or her health professional to the extent possible and appropriate.
ix. Require that treatment programs are accessible to people with disabilities in accordance with CFR Title 45, Part 84 and the Americans with Disabilities Act.
x. Have a 24/7 toll free number for prospective beneficiaries to call to access DMC-ODS services and make oral interpretation services available for beneficiaries, as needed.
xi. Must guarantee that it will not avoid costs for services covered in this Agreement by referring enrollees to publicly supported health care resources.

4. Covered services, whether provided directly by the Contractor or through subcontractor with DMC certified and enrolled programs, shall be provided to beneficiaries in the following manner:
    i. DMC-ODS services approved through the Special Terms and Conditions shall be available to all beneficiaries that reside in the ODS County and enrolled in the ODS Plan.
5. Access to State Plan services shall remain at the current, pre-implementation level or expand upon implementation.
   The Contractor is responsible for ensuring that its beneficiaries are able to receive all medically necessary DMC-ODS services. If the Contractor's provider network is unable to provide necessary services to a particular beneficiary, the Contractor shall adequately and timely cover these services out-of-network for as long as the Contractor's network is unable to provide them.
6. According to STC 147(c), the Contractor shall ensure that a beneficiary that resides in a county that does not participate in DMC-ODS does not experience a disruption of OTP/NTP services. The Contractor shall require all OTP/NTP subcontractors to provide any medically necessary NTP services covered by the California Medi-Cal State Plan to beneficiaries that reside in a county that does not participate in DMC-ODS. The Contractor shall require all OTP/NTP subcontractors that provide services to an out-of-county beneficiary to submit the claims for those services to the county in which the beneficiary resides (according to MEDS).

G. Coordination of Care

1. In addition to meeting the coordination and continuity of care requirements set forth in Article II.E.3, the Contractor shall develop a care coordination plan that provides for seamless transitions of care for beneficiaries with the DMC-ODS system of care. Contractor is responsible for developing a structured approach to care coordination to ensure that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient) without disruptions to services.

2. In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, the Contractor shall ensure that beneficiaries have access to recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.
3. Contractor shall enter into a Memorandum Of Understanding (MOU) with any Medi-Cal managed care plan that enrolls beneficiaries served by the DMC-ODS. This requirement may be met through an amendment to the Specialty Mental Health Managed Care Plan MOU.
    i. The following elements in the MOU should be implemented at the point of care to ensure clinical integration between DMC-ODS and managed care providers:
        a. Comprehensive substance use, physical, and mental health screening.
        b. Beneficiary engagement and participation in an integrated care program as needed.
        c. Shared development of care plans by the beneficiary, caregivers, and all providers.
        d. Collaborative treatment planning with managed care.
        e. Delineation of case management responsibilities.
        f. A process for resolving disputes between the Contractor and the Medi-Cal managed care plan that includes a means for beneficiaries to receive medically necessary services while the dispute is being resolved.
        g. Availability of clinical consultation, including consultation on medications.
        h. Care coordination and effective communication among providers including procedures for exchanges of medical information.
        i. Navigation support for patients and caregivers.
        j. Facilitation and tracking of referrals between systems including bidirectional referral protocol.

H. Authorization of Services – Residential Programs

1. The Contractor shall implement residential treatment program standards that comply with the authorization of services requirements set forth in Article II.E.4 and shall:
    i. Establish, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services for residential programs.
    ii. Ensure that residential services are provided in DHCS or Department of Social Services (DSS) licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.
    iii. Ensure that residential services may be provided in facilities with no bed capacity limit.
    iv. Ensure that the length of residential services comply with the following time restrictions:
        a. Adults, ages 21 and over, may receive up to two non-continuous short-term residential regimens per 365-day period. A short-term residential regimen is defined as one residential stay in a DHCS licensed facility for a maximum of 90 days per 365-day period.
            i. An adult beneficiary may receive one 30-day extension, if that extension is medically necessary, per 365-day period.
        b. Adolescents, under the age of 21, may receive up to two 30-day non-continuous regimens per 365-day period. Adolescent beneficiaries receiving residential treatment shall be stabilized as soon as possible and moved down to a less intensive level of treatment.
            i. Adolescent beneficiaries may receive a 30-day extension if that extension is determined to be medically necessary. Adolescent beneficiaries are limited to one extension per 365-day period.
        c. Nothing in the DMC-ODS overrides any EPSDT requirements. EPSDT beneficiaries may receive a longer length of stay based on medical necessity.

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

v. Ensure that at least one ASAM level of Residential Treatment Services is available to beneficiaries in the first year of implementation.

vi. Demonstrate ASAM levels of Residential Treatment Services (Levels 3.1-3.5) within three years of CMS approval of the county implementation plan and state-county Agreement and describe coordination for ASAM Levels 3.7 and 4.0.

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

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

2. Pursuant to 42 CFR 431.201, the Contractor shall define service authorization request in a manner that at least includes a beneficiary's request for the provision of a service.

I. Provider Selection and Certification

1. In addition to complying with the provider selection requirements set forth in Article II.E.5 and the provider discrimination prohibitions in Article II.B.3, the Contractor:

i. Shall have written policies and procedures for selection and retention of providers that comply with the terms and conditions of this Agreement and applicable federal and state laws and regulations.

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

iii. Shall not discriminate against persons who require high-risk or specialized services.

iv. Shall subcontract with providers in another state where out-of-state care or treatment is rendered on an emergency basis or is otherwise in the best interests of the person under the circumstances.
v. Shall select only providers that have a license and/or certification issued by the state that is in good standing.
vi. Shall select only providers that, prior to the furnishing of services under this Agreement, have enrolled with, or revalidated their current enrollment with, DHCS as a DMC provider under applicable federal and state regulations.

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

fingerprint based background checks required under 42 CFR 455.434.

2. **Disclosures that shall be provided.**
    i. A disclosure from any provider or disclosing entity is due at any of the following times:
        a. Upon the provider or disclosing entity submitting the provider application.
        b. Upon the provider or disclosing entity executing the provider agreement.
        c. Upon request of the Medicaid agency during the re-validation of enrollment process under 42 CFR 455.414.
        d. Within 35 days after any change in ownership of the disclosing entity.
    ii. All disclosures shall be provided to the Medicaid agency.
    iii. Consequences for failure to provide required disclosures.
        a. FFP is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.
3. The Contractor shall only select providers that have a Medical Director who, prior to the delivery of services under this Agreement, has enrolled with DHCS under applicable state regulations, has been screened in accordance with 42 CFR 455.450(a) as a “limited” categorical risk within a year prior to serving as a Medical Director under this Agreement, and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107.
4. The Contractor may contract individually with LPHAs to provide DMC-ODS services in the network.
5. The Contractor shall have a protest procedure for providers that are not awarded a subcontract. The Contractor’s protest procedure shall ensure that:
    i. Providers that submit a bid to be a subcontracted provider, but are not selected, shall exhaust the Contractor’s protest procedure if a provider wishes to appeal to DHCS.

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

J. DMC Certification and Enrollment

1. DHCS shall certify eligible providers to participate in the DMC program.
2. The DHCS shall certify any Contractor-operated or non-governmental providers. This certification shall be performed prior to the date on which the Contractor begins to deliver services under this Agreement at these sites.
3. Contractor shall require that providers of perinatal DMC services are properly certified to provide these services and comply with the applicable requirements contained in Article III.PP of this Exhibit A, Attachment I.
4. Contractor shall require all the subcontracted providers of services to be licensed, registered, DMC certified and/or approved in accordance with applicable laws and regulations. Contractor's subcontracts shall require that providers comply with the following regulations and guidelines:
   i. Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8
   ii. Title 22, Section 51490.1(a)
   iii. Exhibit A, Attachment I, Article III.PP – Requirements for Services
   iv. Title 9, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq
   v. Title 22, Division 3, Chapter 3, sections 51000 et. seq
5. In the event of conflicts, the provisions of Title 22 shall control if they are more stringent.
6. The Contractor shall notify Provider Enrollment Division (PED) of an addition or change of information in a providers pending DMC certification application within 35 days of receiving notification from the provider. The Contractor shall ensure that a new DMC certification application is submitted to PED reflecting the change.

7. The Contractor shall be responsible for ensuring that any reduction of covered services or relocations by providers are not implemented until the approval is issued by DHCS. Within 35 days of receiving notification of a provider's intent to reduce covered services or relocate, the Contractor shall submit, or require the provider to submit, a DMC certification application to PED. The DMC certification application shall be submitted to PED 60 days prior to the desired effective date of the reduction of covered services or relocation.
8. The Contractor shall notify DHCS PED by e-mail at DHCSDMCRecert@dhcs.ca.gov within two business days of learning that a subcontractor's license, registration, certification, or approval to operate an SUD program or provide a covered service is revoked, suspended, modified, or not renewed by entities other than DHCS.
    i. A provider's certification to participate in the DMC program shall automatically terminate in the event that the provider, or its owners, officers or directors are convicted of Medi-Cal fraud, abuse, or malfeasance. For purposes of this section, a conviction shall include a plea of guilty or nolo contendere.

K. Continued Certification

1. All DMC enrolled providers shall be subject to continuing certification requirements at least once every five years. DHCS may allow the Contractor to continue delivering covered services to beneficiaries at a site subject to on-site review by DHCS as part of the recertification process prior to the date of the on-site review, provided the site is operational, the certification remains valid, and has all required fire clearances.
2. DHCS shall conduct unannounced certification and recertification on-site visits at clinics pursuant to WIC 14043.7.

L. Laboratory Testing Requirements

1. 42 CFR Part 493 sets forth the conditions that all laboratories shall meet to be certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Except as specified in paragraph (2) of this section, a laboratory will be cited as out of compliance with section 353 of the Public Health Service Act unless it:

i. Has a current, unrevoked or unsuspended certificate of waiver, registration certificate, certificate of compliance, certificate for PPM procedures, or certificate of accreditation issued by HHS applicable to the category of examinations or procedures performed by the laboratory; or
ii. Is CLIA-exempt.

2. These rules do not apply to components or functions of:
i. Any facility or component of a facility that only performs testing for forensic purposes;
ii. Research laboratories that test human specimens but do not report patient specific results for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of individual patients; or
iii. Laboratories certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), in which drug testing is performed which meets SAMHSA guidelines and regulations. However, all other testing conducted by a SAMHSA-certified laboratory is subject to this rule.

3. Laboratories under the jurisdiction of an agency of the Federal Government are subject to the rules of 42 CFR 493, except that the Secretary may modify the application of such requirements as appropriate.

M. Recovery from Other Sources or Providers

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

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

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

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

N. Early Intervention (ASAM Level 0.5)

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

O. Outpatient Services (ASAM Level 1.0)

1. Outpatient services consist of up to nine hours per week of medically necessary services for adults and less than six hours per week of services for adolescents. Group size is limited to no less than two (2) and no more than twelve (12) beneficiaries.
2. Outpatient services includes: assessment, treatment planning, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, and discharge planning and coordination.
3. Services may be provided in-person, by telephone, or by telehealth, and in any appropriate setting in the community.

P. Intensive Outpatient Services (ASAM Level 2.1)

1. Intensive outpatient services involves structured programming provided to beneficiaries as medically necessary for a minimum of nine hours and a maximum of 19 hours per week for adult perinatal and non-perinatal beneficiaries. Adolescents are provided a minimum of six and a maximum of 19 hours per week. Group size is limited to no less than two (2) and no more than twelve (12) beneficiaries.
    i. The contractor-operated and subcontracted DMC-ODS providers may provide more than 19 hours per week to adults when determined by a Medical Director or an LPHA to be medical necessary, and in accordance with the individualized treatment plan.
    ii. The contractor-operated and subcontracted DMC-ODS providers may extend a beneficiary's length of treatment when determined by a Medical Director or an LPHA to be medically necessary, and in accordance with the individualized treatment plan.
2. Intensive outpatient services includes: assessment, treatment planning, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, and discharge planning and coordination.

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

Q. Residential Treatment Services

1. Residential services are provided in DHCS or DSS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.
2. Residential services can be provided in facilities with no bed capacity limit.
3. The length of residential services range from one to 90 days with a 90-day maximum for adults and 30-day maximum for adolescents per 365-day period, unless medical necessity warrants a one-time extension of up to 30 days per 365-day period.
    i. Only two non-continuous 30-day (adolescents) or 90-day (adults) regimens may be authorized in a one-year period (365 days). The average length of stay for residential services is 30 days.
    ii. Perinatal beneficiaries shall receive a length of stay for the duration of their pregnancy, plus 60 days postpartum.
    iii. EPSDT adolescent beneficiaries shall receive a longer length of stay, if found to be medically necessary.

R. Case Management

1. Case management services are defined as a service that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.
2. The Contractor shall ensure that case management services focus on coordination of SUD care, integration around primary care especially for beneficiaries with a chronic substance use disorder, and interaction with the criminal justice system, if needed.
3. The Contractor shall be responsible for determining which entity monitors the case management activities.
4. Case management services may be provided by an LPHA or a registered or certified counselor.

5. The Contractor shall coordinate a system of case management services with physical and/or mental health in order to ensure appropriate level of care.
6. Case management services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.

S. Physician Consultation Services

1. Physician Consultation Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are designed to assist DMC physicians by allowing them to seek expert advice when developing treatment plans for specific DMC-ODS beneficiaries. Physician consultation services may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.
2. Contractor may contract with one or more physicians or pharmacists in order to provide consultation services.
3. The Contractor shall only allow DMC providers to bill for physician consultation services.

T. Recovery Services

1. Recovery Services includes:
    i. Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care.
    ii. Recovery Monitoring: Recovery coaching, monitoring via telephone and internet.
    iii. Substance Abuse Assistance: Peer-to-peer services and relapse prevention.
    iv. Education and Job Skills: Linkages to life skills, employment services, job training, and education services.
    v. Family Support: Linkages to childcare, parent education, child development support services, and family/marriage education.
    vi. Support Groups: Linkages to self-help and support, spiritual and faith-based support.

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

2. Recovery services shall be utilized when the beneficiary is triggered, when the beneficiary has relapsed, or simply as a preventative measure to prevent relapse. As part of the assessment and treatment needs of Dimension 6, Recovery Environment of the ASAM Criteria and during the transfer/transition planning process, the Contractor shall provide beneficiaries with recovery services.
3. Additionally, the Contractor shall:
   i. Provide recovery services to beneficiaries as medically necessary.
   ii. Provide beneficiaries with access to recovery services after completing their course of treatment.
   iii. Provide recovery services either face-to-face, by telephone, or by telehealth, and in any appropriate setting in the community with the beneficiary.

U. Withdrawal Management

1. The Contractor shall provide, at a minimum, one of the five levels of withdrawal management (WM) services according to the ASAM Criteria, when determined by a Medical Director or LPHA as medically necessary, and in accordance with the beneficiary's individualized treatment plan.
2. The Contractor shall ensure that all beneficiaries receiving both residential services and WM services are monitored during the detoxification process.
3. The Contractor shall provide medically necessary habilitative and rehabilitative services in accordance with an individualized treatment plan prescribed by a licensed physician or licensed prescriber.

V. Opioid (Narcotic) Treatment Program Services (OTP/NTP)

1. Pursuant to WIC 14124.22, an OTP/NTP provider who is also enrolled as a Medi-Cal provider may provide medically necessary treatment of concurrent health conditions to Medi-Cal beneficiaries who are not enrolled in managed care plans as long as those services are within the scope of the provider's practice. OTP/NTP providers shall refer all Medi-Cal beneficiaries that are enrolled in managed care plans to their respective managed care plan to receive medically necessary medical treatment of their concurrent health conditions.
2. The diagnosis and treatment of concurrent health conditions of Medi-Cal beneficiaries that are not enrolled in managed care plans by an OTP/NTP provider may be provided within the Medi-Cal coverage limits. When the services are not part of the SUD treatment reimbursed pursuant to WIC 14021.51, the services rendered shall be reimbursed in accordance with the Medi-Cal program. Services reimbursable under this section shall include all of the following:
    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
    v. Medical supplies
3. An OTP/NTP provider who is enrolled as a Medi-Cal fee-for-service provider shall not seek reimbursement from a beneficiary for SUD treatment services, if the OTP/NTP provider bills the services for treatment of concurrent health conditions to the Medi-Cal fee-for-service program.
4. The Contractor shall subcontract with licensed NTPs to offer services to beneficiaries who meet medical necessity criteria requirements.
5. Services shall be provided in accordance with an individualized beneficiary plan determined by a licensed prescriber.
6. Offer and prescribe medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone, and disulfiram.

7. Services provided as part of an OTP/NTP includes: assessment, treatment planning, individual and group counseling, patient education, medication services, collateral services, crisis intervention services, treatment planning, medical psychotherapy, and discharge services.
    i. Beneficiaries shall receive between 50 and 200 minutes of counseling per calendar month with a therapist or counselor, and, when medically necessary, additional counseling services may be provided.

W. Cultural Competence Plan

1. The Contractor shall develop a cultural competency plan and subsequent plan updates.
2. Contractor shall promote the delivery of services in a culturally competent manner to all beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

X. Implementation Plan

1. The Contractor shall comply with the provisions of the Contractor's Implementation Plan (IP) as approved by DHCS.
2. The Contractor shall not provide DMC-ODS services without: 1) an approved IP approved by DHCS and CMS, and 2) a CMS approved Intergovernmental Agreement executed by DHCS and the Contractor's Board of Supervisors.
3. The Contractor shall obtain written approval by DHCS prior to making any changes to the IP.

Y. Additional Provisions

1. **Additional Intergovernmental Agreement Restrictions**
    i. This Agreement is subject to any additional restrictions, limitations, conditions, or statutes enacted or amended by the federal or state governments, which may affect the provisions, terms, or funding of this Agreement in any manner.

2. **Voluntary Termination of DMC-ODS Services**
    i. The Contractor may terminate this Agreement at any time, for any reason, by giving 60 days written notice to DHCS. The Contractor shall be paid for DMC-ODS services provided to beneficiaries up to the date of termination. Upon termination, the Contractor shall immediately begin providing DMC services to beneficiaries in accordance with the State Plan.
3. **Nullification of DMC-ODS Services**
    i. The parties agree that failure of the Contractor, or its subcontractors, to comply with W&I section 14124.24, the Special Terms and Conditions, and this Agreement, shall be deemed a breach that results in the termination of this Agreement for cause.
    ii. In the event of a breach, DMC-ODS services shall terminate. The Contractor shall immediately begin providing DMC services to the beneficiaries in accordance with the State Plan.
4. **Hatch Act**
    i. Contractor agrees to comply with the provisions of the Hatch Act (Title 5 USC, Sections 1501-1508), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.
5. **No Unlawful Use or Unlawful Use Messages Regarding Drugs**
    i. Contractor agrees that information produced through these funds, and which pertains to drug and alcohol related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug or alcohol related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (HSC Section 11999-11999.3). By signing this Agreement, Contractor agrees that it shall enforce, and shall require its subcontractors to enforce, these requirements.

6. **Noncompliance with Reporting Requirements**
    i. Contractor agrees that DHCS has the right to withhold payments until Contractor has submitted any required data and reports to DHCS, as identified in this Exhibit A, Attachment I or as identified in Document 1F(a), Reporting Requirement Matrix for Counties.
7. **Limitation on Use of Funds for Promotion of Legalization of Controlled Substances**
    i. None of the funds made available through this Agreement may be used for any activity that promotes the legalization of any drug or other substance included in Schedule I of Section 202 of the Controlled Substances Act (21 USC 812).
8. **Health Insurance Portability and Accountability Act (HIPAA) of 1996**
    i. If any of the work performed under this Agreement is subject to the HIPAA, Contractor shall perform the work in compliance with all applicable provisions of HIPAA. As identified in Exhibit F, DHCS and the Contractor shall cooperate to ensure mutual agreement as to those transactions between them, to which this Provision applies. Refer to Exhibit F for additional information.
    ii. **Trading Partner Requirements**
        a. No Changes. Contractor hereby agrees that for the personal health information (Information), it shall not change any definition, data condition or use of a data element or segment as proscribed in the federal HHS Transaction Standard Regulation. (45 CFR Part 162.915 (a))
        b. No Additions. Contractor hereby agrees that for the Information, it shall not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation. (45 CFR Part 162.915 (b))

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

iii. **Concurrence for Test Modifications to HHS Transaction Standards**

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

iv. **Adequate Testing**

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

v. **Deficiencies**

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

vi. **Code Set Retention**

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

vii. **Data Transmission Log**

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

9. **Counselor Certification**
    i. Any counselor or registrant providing intake, assessment of need for services, treatment or recovery planning, individual or group counseling to participants, patients, or residents in a DHCS licensed or certified program is required to be certified as defined in CCR Title 9, Division 4, Chapter 8. (Document 3H)
10. **Cultural and Linguistic Proficiency**
    i. To ensure equal access to quality care by diverse populations, each service provider receiving funds from this Agreement shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards (Document 3V) and comply with 42 CFR 438.206(c)(2).
11. **Trafficking Victims Protection Act of 2000**
    i. Contractor and its subcontractors that provide services covered by this Agreement shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(g)) as amended by section 1702. For full text of the award term, go to: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title22-section7104d&num=0&edition=prelim
12. **Participation in the County Behavioral Health Director's Association of California.**
    i. The Contractor's County AOD Program Administrator shall participate and represent the county in meetings of the County Behavioral Health Director's Association of California for the purposes of representing the counties in their relationship with DHCS with respect to policies, standards, and administration for SUD services.
    ii. The Contractor's County AOD Program Administrator shall attend any special meetings called by the Director of DHCS.

13. **Youth Treatment Guidelines**
    i. Contractor shall follow the guidelines in Document 1V, incorporated by this reference, “Youth Treatment Guidelines,” in developing and implementing adolescent treatment programs funded under this Exhibit, until such time new Youth Treatment Guidelines are established and adopted. No formal amendment of this Agreement is required for new guidelines to be incorporated into this Agreement.
14. **Nondiscrimination in Employment and Services**
    i. By signing this Agreement, Contractor certifies that under the laws of the United States and the State of California, incorporated into this Agreement by reference and made a part hereof as if set forth in full, Contractor shall not unlawfully discriminate against any person.
15. **Federal Law Requirements:**
    i. Title VI of the Civil Rights Act of 1964, Section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in federally funded programs.
    ii. Title IX of the Education Amendments of 1972 (regarding education and programs and activities), if applicable.
    iii. Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.
    iv. Age Discrimination Act of 1975 (45 CFR Part 90), as amended (42 USC Sections 6101 – 6107), which prohibits discrimination on the basis of age.
    v. Age Discrimination in Employment Act (29 CFR Part 1625).
    vi. Title I of the Americans with Disabilities Act (29 CFR Part 1630) prohibiting discrimination against the disabled in employment.
    vii. Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities.
    viii. Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.

ix. Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.
x. Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than $10,000 funded by federal financial assistance.
xi. Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.
xii. The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.
xiii. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism.

16. State Law Requirements:

i. Fair Employment and Housing Act (Government Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (California Administrative Code, Title 2, Section 7285.0 et seq.).
ii. Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135.
iii. Title 9, Division 4, Chapter 8, commencing with Section 10800.
iv. No state or Federal funds shall be used by the Contractor, or its subcontractors, for sectarian worship, instruction, and/or proselytization. No state funds shall be used by the Contractor, or its subcontractors, to provide direct, immediate, or substantial support to any religious activity.
v. Noncompliance with the requirements of nondiscrimination in services shall constitute grounds for state to withhold payments under this Agreement or terminate all, or any type, of funding provided hereunder.

17. **Investigations and Confidentiality of Administrative Actions**
    i. Contractor acknowledges that if a DMC provider is under investigation by DHCS or any other state, local or federal law enforcement agency for fraud or abuse, DHCS may temporarily suspend the provider from the DMC program, pursuant to WIC 14043.36(a). Information about a provider's administrative sanction status is confidential until such time as the action is either completed or resolved. DHCS may also issue a Payment Suspension to a provider pursuant to WIC 14107.11 and Code of Federal Regulations, Title 42, section 455.23. The Contractor is to withhold payments from a DMC provider during the time a Payment Suspension is in effect.
    ii. Contractor shall execute the Confidentiality Agreement, attached as Document 5A. The Confidentiality Agreement permits DHCS to communicate with Contractor concerning subcontracted providers that are subject to administrative sanctions.
18. **Subcontract Provisions**
    i. Contractor shall include all of the foregoing provisions in all of its subcontracts.

Z. **Beneficiary Problem Resolution Process**

1. The Contractor shall establish and comply with a beneficiary problem resolution process.
2. Contractor shall inform subcontractors and providers at the time they enter into a subcontract about:
    i. The beneficiary's right to a state fair hearing, how to obtain a hearing and the representation rules at the hearing.
    ii. The beneficiary's right to file grievances and appeals and the requirements and timeframes for filing.
    iii. The beneficiary's right to give written consent to allow a provider, acting on behalf of the beneficiary, to file an appeal. A provider may file a grievance or request a state fair hearing on behalf of a beneficiary, if the state permits the provider to act as the beneficiary's authorized representative in doing so.

iv. The beneficiary may file a grievance, either orally or in writing, and, as determined by DHCS, either with DHCS or with the Contractor.
v. The availability of assistance with filing grievances and appeals.
vi. The toll-free number to file oral grievances and appeals.
vii. The beneficiary's right to request continuation of benefits during an appeal or state fair hearing filing although the beneficiary may be liable for the cost of any continued benefits if the action is upheld.
viii. Any state determined provider's appeal rights to challenge the failure of the Contractor to cover a service.

3. The Contractor shall represent the Contractor's position in fair hearings, as defined in 42 CFR 438.408 dealing with beneficiaries' appeals of denials, modifications, deferrals or terminations of covered services. The Contractor shall carry out the final decisions of the fair hearing process with respect to issues within the scope of the Contractor's responsibilities under this Agreement. Nothing in this section is intended to prevent the Contractor from pursuing any options available for appealing a fair hearing decision.
i. Pursuant to 42 CFR 438.228, the Contractor shall develop problem resolution processes that enable beneficiary to request and receive review of a problem or concern he or she has about any issue related to the Contractor's performance of its duties, including the delivery of SUD treatment services.

4. The Contractor's beneficiary problem resolution processes shall include:
i. A grievance process
ii. An appeal process
iii. An expedited appeal process

AA. Subcontracts

1. In addition to complying with the subcontractual relationship requirements set forth in Article II.E.8 of this Agreement, the Contractor shall ensure that all subcontracts require that the Contractor oversee and is held accountable for any functions and responsibilities that the Contractor delegates to any subcontractor.
2. Each subcontract shall:
    i. Fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract.
    ii. Ensure that the Contractor evaluates the prospective subcontractor's ability to perform the activities to be delegated.
    iii. Require a written agreement between the Contractor and the subcontractor that specifies the activities and report responsibilities delegated to the subcontractor, and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.
    iv. Ensure the Contractor monitors the subcontractor's performance on an ongoing basis and subject it to an annual onsite review, consistent with statutes, regulations, and Article III.PP.
    v. Ensure the Contractor identifies deficiencies or areas for improvement, the subcontractor shall take corrective actions and the Contractor shall ensure that the subcontractor implements these corrective actions.
3. The Contractor shall include the following provider requirements in all subcontracts with providers:
    i. Culturally Competent Services: Providers are responsible to provide culturally competent services. Providers shall ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations. Translation services shall be available for beneficiaries, as needed.

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

iii. Evidence Based Practices (EBPs): Providers will implement at least two of the following EBPs based on the timeline established in the county implementation plan. The two EBPs are per provider per service modality. The Contractor will ensure the providers have implemented EBPs. The state will monitor the implementation and regular training of EBPs to staff during reviews. The required EBPs include:

   a. Motivational Interviewing: A beneficiary-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on beneficiaries' past successes.
   b. Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
   c. Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.
   d. Trauma-Informed Treatment: Services shall take into account an understanding of trauma, and place priority on trauma survivors’ safety, choice and control.

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

BB. Program Integrity Requirements

1. Service Verification. To assist DHCS in meeting its obligation under 42 CFR 455.1(a)(2), the Contractor shall establish a mechanism to verify whether services were actually furnished to beneficiaries.
2. **DMC Claims and Reports**
   i. Contractor or providers that bill DHCS or the Contractor for DMC-ODS services shall submit claims in accordance with Department of Health Care Service's DMC Provider Billing Manual.
   ii. Contractor and subcontractors that provide DMC services shall be responsible for verifying the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for DMC services to that beneficiary for that month. Medi-Cal eligibility verification should be performed prior to rendering service, in accordance with and as described in the DHCS DMC Provider Billing Manual. Options for verifying the eligibility of a Medi-Cal beneficiary are described in the Department of Health Care Services DMC Provider Billing Manual.
   iii. Claims for DMC reimbursement shall include DMC-ODS services covered under the Special Terms and Conditions of this Agreement, and any State Plan services covered under CCR Title 22, Section 51341.1(c-d) and administrative charges that are allowed under WIC, Sections 14132.44 and 14132.47.

a. Contractor shall submit to DHCS the "Certified Expenditure" form reflecting either: 1) the approved amount of the 837P claim file, after the claims have been adjudicated, or 2) the claimed amount identified on the 837P claim file, which could account for both approved and denied claims. Contractor shall submit to DHCS the Drug Medi-Cal Certification Form DHCS 100224A (Document 4D) for each 837P transaction approved for reimbursement of the federal Medicaid funds.
b. DMC service claims shall be submitted electronically in a HIPAA-compliant format (837P). All adjudicated claim information shall be retrieved by the Contractor via an 835 HIPAA compliant format (Health Care Claim Payment/Advice).

iv. The following forms shall be prepared as needed and retained by the provider for review by state staff:
a. Good Cause Certification (6065A), Document 2L(a)
b. Good Cause Certification (6065B), Document 2L(b)
c. In the absence of good cause documented on the Good Cause Certification (6065A or 6065B) form, claims that are not submitted within six months of the end of the month of service shall be denied. The existence of good cause shall be determined by DHCS in accordance with CCR Title 22, Sections 51008 and 51008.5.

3. Certified Public Expenditure - County Administration

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

a. Mail Form MC 5312 to:
Department of Health Care Services
Behavioral Health Financing Section
1500 Capitol Avenue, MS 2629
Sacramento, CA 95814

Alternatively, scan signed Form MC 5312 and email to:
sudfmab@dhcs.ca.gov

4. **Certified Public Expenditure – Quality Assurance and Utilization Review (QA/UR)**
   i. Separate from direct service claims as identified above, the Contractor may submit an invoice for QA/UR for administering the DMC-ODS quality management program on a quarterly basis. The form requesting reimbursement shall be submitted to DHCS.
      a. **Mail Form DHCS 5311 to:**
      Department of Health Care Services
      Behavioral Health Financing Section
      - Attention: QA/UR
      1500 Capitol Avenue MS 2621
      Sacramento, CA 95814

CC. Quality Management (QM) Program

1. The Contractor's QM Program shall improve Contractor's established treatment outcomes through structural and operational processes and activities that are consistent with current standards of practice.
2. The Contractor shall have a written description of the QM Program, which clearly defines the QM Program's structure and elements, assigns responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement.
3. Annually, each Contractor shall:
   i. Measure and report to DHCS its performance using standard measures required by DHCS including those that incorporate the requirements set forth in Article II.F.1 of this Agreement.
   ii. Submit to DHCS data specified by DHCS that enables DHCS to measure the Contractor's performance.
   iii. Perform a combination of the activities described above.
   iv. Evaluate and update the QM Program annually as necessary as set forth in Article II.F.1 of this Agreement.

4. During the Triennial Reviews, DHCS shall review the status of the Quality Improvement Plan and the Contractor's monitoring activities.
    i. This review shall include the counties service delivery system, beneficiary protections, access to services, authorization for services, compliance with regulatory and contractual requirements of the waiver, and a beneficiary records review.
    ii. This triennial review shall provide DHCS with information as to whether the counties are complying with their responsibility to monitor their service delivery capacity.
    iii. The counties shall receive a final report summarizing the findings of the triennial review, and if out of compliance, the Contractor shall submit a CAP within 60 days of receipt of the final report. DHCS shall follow-up with the CAP to ensure compliance.
5. The QM Program shall conduct performance-monitoring activities throughout the Contractor's operations. These activities shall include, but not be limited to, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, and resolution of beneficiary grievances.
6. The Contractor shall ensure continuity and coordination of care with physical health care providers. The Contractor shall coordinate with other human services agencies used by its beneficiaries. The Contractor shall assess the effectiveness of any MOU with a physical health care plan.
7. The Contractor shall have mechanisms to detect both underutilization of services and overutilization of services, as required by Article II.F.1 of this Agreement.
8. The Contractor shall implement mechanisms to assess beneficiary/family satisfaction. The Contractor shall assess beneficiary/family satisfaction by:
    a. Surveying beneficiary/family satisfaction with the Contractor's services at least annually.
    b. Evaluating beneficiary grievances, appeals and fair hearings at least annually.

c. Evaluating requests to change persons providing services at least annually.
d. The Contractor shall inform providers of the results of beneficiary/family satisfaction activities.

9. The Contractor shall implement mechanisms to monitor the safety and effectiveness of medication practices. The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs. Monitoring shall occur at least annually.

10. The Contractor shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The Contractor shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the Contractor at least annually.

11. The Contractor shall have a QM Work Plan covering the current Agreement cycle with documented annual evaluations and documented revisions as needed. The Contractor's QM Work Plan shall evaluate the impact and effectiveness of its quality assessment and performance improvement program. The QM Work Plan shall include:

i. Evidence of the monitoring activities including, but not limited to, review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Article II.F.1 and Article II.G.8 of this Agreement.
ii. Evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service.
iii. A description of completed and in-process QM activities, including performance improvement projects. The description shall include:
    a. Monitoring efforts for previously identified issues, including tracking issues over time.
    b. Objectives, scope, and planned QM activities for each year.
    c. Targeted areas of improvement or change in service delivery or program design.

iv. A description of mechanisms the Contractor has implemented to assess the accessibility of services within its service delivery area. This shall include goals for responsiveness for the Contractor's 24-hour toll-free telephone number, timeliness for scheduling of routine appointments, timeliness of services for urgent conditions, and access to after-hours care.

12. Evidence of compliance with the requirements for cultural competence and linguistic competence specified in Article II.B.2 of this Agreement and Article II.E.1 of this Agreement.

DD. State Monitoring - Postservice Postpayment and Postservice Prepayment Utilization Reviews

1. DHCS shall conduct Postservice Postpayment and Postservice Prepayment Utilization Reviews of the contracted DMC providers to determine whether the DMC services were provided in accordance with Article III.PP of this exhibit. DHCS shall issue the PSPP report to the Contractor with a copy to subcontracted DMC provider. The Contractor shall be responsible for their subcontracted providers and Contractor-operated programs to ensure any deficiencies are remediated pursuant to Article III.DD.2. The Contractor shall attest the deficiencies have been remediated and are complete, pursuant to Article III.EE.5 of this Agreement.

2. The Department shall recover payments made if Postservice Postpayment Utilization Review uncovers evidence that the claim(s) should not have been paid, DMC-ODS services have been improperly utilized, and requirements of Article III.PP were not met.

i. All deficiencies identified by PSPP reports, whether or not a recovery of funds results, shall be corrected and the Contractor shall submit a Contractor-approved CAP. The CAP shall be submitted to the DHCS Analyst that conducted the review, within 60 days of the date of the PSPP report.

a. The CAP shall:

i. Be documented on the DHCS CAP template.

ii. Provide a specific description of how the deficiency shall be corrected.

iii. Identify the title of the individual(s) responsible for:
    1. Correcting the deficiency
    2. Ensuring on-going compliance
iv. Provide a specific description of how the provider will ensure on-going compliance.
v. Specify the target date of implementation of the corrective action.

b. DHCS shall provide written approval of the CAP to the Contractor with a copy to the provider. If DHCS does not approve the CAP, DHCS shall provide guidance on the deficient areas and request an updated CAP from the Contractor with a copy to the provider. Contractor shall submit an updated CAP to the DHCS Analyst that conducted the review, within 30 days of notification.

c. If a CAP is not submitted, or, the provider does not implement the approved CAP provisions within the designated timeline, then DHCS may withhold funds from the Contractor until the entity that provided the services complies with this Exhibit A, Attachment I. DHCS shall inform the Contractor when funds shall be withheld.

3. The Contractor may appeal DMC dispositions concerning demands for recovery of payment and/or programmatic deficiencies of specific claims. Such appeals shall be handled as follows:

i. Requests for first-level appeals:

a. The Contractor shall initiate action by submitting a letter to:

Behavioral Health Compliance Section Chief
Medical Review Branch, Audits and Investigations Division
DHCS
PO Box 997413, MS 2621
Sacramento, CA 95899-7413

i. The Contractor shall submit the letter on the official stationery of the Contractor and it shall be signed by an authorized representative of the Contractor.
ii. The letter shall identify the specific claim(s) involved and describe the disputed (in)action regarding the claim.

b. The letter shall be submitted to the address listed in Subsection (a) above within 90 calendar days from the date the Contractor received written notification of the decision to disallow claims.
c. The MCBHD shall acknowledge Contractor letter within 15 calendar days of receipt.
d. The MCBHD shall inform the Contractor of MCBHD's decision and the basis for the decision within 15 calendar days after the MCBHD's acknowledgement notification. The MCBHD shall have the option of extending the decision response time if additional information is required from the Contractor. The Contractor will be notified if the MCBHD extends the response time limit.

4. A Contractor may initiate a second level appeal to the Office of Administrative Hearings and Appeals (OAHA).

i. The second level process may be pursued only after complying with first-level procedures and only when:
   a. The MCBHD has failed to acknowledge the grievance or complaint within 15 calendar days of its receipt, or
   b. The Contractor is dissatisfied with the action taken by the MCBHD where the conclusion is based on the MCBHD's evaluation of the merits.

ii. The second-level appeal shall be submitted to the Office of Administrative Hearings and Appeals within 30 calendar days from the date the MCBHD failed to acknowledge the first-level appeal or from the date of the MCBHD's first-level appeal decision letter.

iii. All second-level appeals made in accordance with this section shall be directed to:

Office of Administrative Hearings and Appeals
1029 J Street, Suite 200, MS 0016
Sacramento, CA 95814

iv. In referring an appeal to the OAHA, the Contractor shall submit all of the following:
    a. A copy of the original written appeal sent to the MCBHD.
    b. A copy of the MCBHD's report to which the appeal applies.

    If received by the Contractor, a copy of the MCBHD's specific finding(s), and conclusion(s) regarding the appeal with which the Contractor is dissatisfied.

5. The appeal process listed here shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of DHCS pursuant to Exhibit B of this Agreement.
6. State shall monitor the subcontractor's compliance with Contractor utilization review requirements, as specified in Article III.EE. Counties are also required to monitor the subcontractor's compliance pursuant to Article III.AA of this Agreement. The federal government may also review the existence and effectiveness of DHCS' utilization review system.
7. Contractor shall, at a minimum, implement and maintain compliance with the requirements described in Article III.PP for the purposes of reviewing the utilization, quality, and appropriateness of covered services and ensuring that all applicable Medi-Cal requirements are met.
8. Contractor shall ensure that subcontractor's sites shall keep a record of the beneficiaries/patients being treated at that location. Contractor shall retain beneficiary records for a minimum of 10 years, in accordance with 42 CFR 438.3(h), from the finalized cost settlement process with the Department. When an audit by the Federal Government or DHCS has been started before the expiration of the 10-year period, the beneficiary records shall be maintained until completion of the audit and the final resolution of all issues.

EE. Contractor Monitoring

1. Contractor shall conduct, at least annually, a utilization review of DMC providers to ensure covered services are being appropriately rendered. The annual review shall include an on-site visit of the service provider. Reports of the annual review shall be provided to DHCS' Performance & Integrity Branch at:

   Department of Health Care Services
   Medi-Cal Behavioral Health Division
   1500 Capitol Avenue, MS-2623
   Sacramento, CA 95814

   Or by secure, encrypted email to: SUDCountyReports@dhcs.ca.gov

   The Contractor's reports shall be provided to DHCS within 2 weeks of completion.

   Technical assistance is available to counties from MCBHD.

2. If significant deficiencies or significant evidence of noncompliance with the terms of the DMC-ODS waiver, or this Agreement, are found in a county, DHCS shall engage the Contractor to determine if there are challenges that can be addressed with facilitation and technical assistance. If the Contractor remains noncompliant, the Contractor shall submit a CAP to DHCS. The CAP shall detail how and when the Contractor shall remedy the issue(s). DHCS may remove the Contractor from participating in the Waiver if the CAP is not promptly implemented.
3. If the Contractor is removed from participating in the Waiver, the county shall provide DMC services in accordance with the California Medi-Cal State Plan.
4. Contractor shall ensure that DATAR submissions, detailed in Article III.FF of this Exhibit, are complied with by all treatment providers and subcontracted treatment providers. Contractor shall attest that each subcontracted provider is enrolled in DATAR at the time of execution of the subcontract.

5. The Contractor shall monitor and attest compliance and/or completion by providers with CAP requirements (detailed in Article III.DD) of this Exhibit as required by any PSPP review. The Contractor shall attest to DHCS, using the form developed by DHCS that the requirements in the CAP have been completed by the Contractor and/or the provider. Submission of DHCS Form 8049 by Contractor shall be accomplished within the timeline specified in the approved CAP, as noticed by DHCS.
6. Contractor shall attest that DMC claims submitted to DHCS have been subject to review and verification process for accuracy and legitimacy. (45 CFR 430.30, 433.32, 433.51). Contractor shall not knowingly submit claims for services rendered to any beneficiary after the beneficiary's date of death, or from disenrolled providers.

FF. Reporting Requirements

1. Contractor agrees that DHCS has the right to withhold payments until Contractor has submitted any required data and reports to DHCS, as identified in this Exhibit A, Attachment I or as identified in Document 1F(a), Reporting Requirement Matrix for Counties.
2. Contractor shall submit documentation to DHCS in a format specified by DHCS that complies with the following requirements:
    i. Offers an appropriate range of services that is adequate for the anticipated number of beneficiaries for the service area,
    ii. Maintains a network of providers that is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of beneficiaries in the area, and
    iii. Demonstrates the Contractor's compliance with the parity requirements set forth in 42 CFR §438.900 et seq.
3. The Contractor shall submit the documentation described in paragraph (2) of this section as specified by DHCS, but no less frequently than the following:
    i. At the time it enters into this Agreement with DHCS.
    ii. At any time there has been a significant change in the Contractor's operations that would affect adequate capacity, services, and parity, including:
        i. Changes in Contractor services, benefits, geographic service area or payments.
        ii. Enrollment of a new population in the Contractor.

iii. Changes in a quantitative limitation or non-quantitative limitation on a substance use disorder benefit.

iii. After DHCS reviews the documentation submitted by the Contractor, DHCS shall certify to CMS that the Contractor has complied with the state's requirements for availability of services, as set forth in 42 CFR 438.206, and parity requirements, as set forth in 42 CFR 438.900 et seq.

iv. CMS' right to inspect documentation. DHCS shall make available to CMS, upon request, all documentation collected by DHCS from the Contractor.

4. California Outcomes Measurement System (CalOMS) for Treatment (CalOMS-Tx)

i. The CalOMS-Tx business rules and requirements are:

a. Contractor shall contract with a software vendor that complies with the CalOMS-Tx data collection system requirements for submission of CalOMS-Tx data. A Business Associate Agreement (BAA) shall be established between the Contractor and the software vendor. The BAA shall state that DHCS is allowed to return the processed CalOMS-Tx data to the vendor that supplied the data to DHCS.

b. Contractor shall conduct information technology (IT) systems testing and pass state certification testing before commencing submission of CalOMS-Tx data. If the Contractor subcontracts with vendor for IT services, Contractor is responsible for ensuring that the subcontracted IT system is tested and certified by the DHCS prior to submitting CalOMS-Tx data. If Contractor changes or modifies the CalOMS-Tx IT system, then Contractor shall re-test and pass state re-certification prior to submitting data from new or modified system.

c. Electronic submission of CalOMS-Tx data shall be submitted by Contractor within 45 days from the end of the last day of the report month.

d. Contractor shall comply with data collection and reporting requirements established by the DHCS CalOMS-Tx Data Collection Guide (Document 3J) and all former Department of Alcohol and Drug Programs Bulletins and DHCS Information Notices relevant to CalOMS-Tx data collection and reporting requirements.
e. Contractor shall submit CalOMS-Tx admission, discharge, annual update, resubmissions of records containing errors or in need of correction, and "provider no activity" report records in an electronic format approved by DHCS.
f. Contractor shall comply with the CalOMS-Tx Data Compliance Standards established by DHCS identified in (Document 3S) for reporting data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method.
g. Contractor shall participate in CalOMS-Tx informational meetings, trainings, and conference calls.
h. Contractor shall implement and maintain a system for collecting and electronically submitting CalOMS-Tx data.
i. Contractor and their software vendor shall meet the requirements as identified in Exhibit F, Privacy and Information Security Provisions.

5. CalOMS-Tx General Information

i. If the Contractor experiences system or service failure or other extraordinary circumstances that affect its ability to timely submit CalOMS-Tx data, and or meet other CalOMS-Tx compliance requirements, Contractor shall report the problem in writing by secure, encrypted e-mail to DHCS at: ITServiceDesk@dhcs.ca.gov, before the established data submission deadlines. The written notice shall include a remediation plan that is subject to review and approval by DHCS. A grace period of up to 60 days may be granted, at DHCS' sole discretion, for the Contractor to resolve the problem before non-DMC payments are withheld.

ii. If DHCS experiences system or service failure, no penalties shall be assessed to the Contractor for late data submission.
iii. Contractor shall comply with the treatment data quality standards established by DHCS. Failure to meet these standards on an ongoing basis may result in withholding non-DMC funds.
iv. If the Contractor submits data after the established deadlines, due to a delay or problem, the Contractor shall still be responsible for collecting and reporting data from time of delay or problem.

6. Drug and Alcohol Treatment Access Report (DATAR)

i. The DATAR business rules and requirements:
   a. The Contractor shall be responsible for ensuring that the Contractor-operated treatment services and all treatment providers with whom Contractor subcontracts or otherwise pays for the services, submit a monthly DATAR report in an electronic copy format as provided by DHCS.
   b. In those instances where the Contractor maintains, either directly or indirectly, a central intake unit or equivalent, which provides intake services including a waiting list, the Contractor shall identify and begin submitting monthly DATAR reports for the central intake unit by a date to be specified by DHCS.
   c. The Contractor shall ensure that all DATAR reports are submitted to DHCS by the 10th of the month following the report activity month.
   d. The Contractor shall ensure that all applicable providers are enrolled in DHCS' web-based DATAR program for submission of data, accessible on the DHCS website when executing the subcontract.

e. If the Contractor or its subcontractor experiences system or service failure or other extraordinary circumstances that affect its ability to timely submit a monthly DATAR report, and/or to meet data compliance requirements, the Contractor shall report the problem in writing before the established data submission deadlines. The written notice shall include a CAP that is subject to review and approval by DHCS. A grace period of up to 60 days may be granted, at DHCS' sole discretion, for the Contractor to resolve the problem before non-DMC payments are withheld (See Exhibit B, Part II, Section 2).
f. If DHCS experiences system or service failure, no penalties shall be assessed to Contractor for late data submission.
g. The Contractor shall be considered compliant if a minimum of 95% of required DATAR reports from the Contractor's treatment providers are received by the due date.

7. Year-End Cost Settlement Reports

i. Pursuant to WIC 14124.24(g)(1) the Contractor shall submit the following year-end cost settlement data for the previous fiscal year to DHCS, no later than November 1 of each year:
   a. County Certification form (MC 6229): Submit via regular mail or overnight services. DHCS needs original signatures, not a copy.
   b. Drug Medi-Cal (DMC) data: Submit the data via the Substance Use Disorder Cost Report System (SUDCRS) and submit the individual provider Excel files via email, regular mail, or overnight services.
   c. DMC Provider Certification forms: Submit via regular mail or overnight services. DHCS needs original signatures, not a copy.

8. Failure to Meet Reporting Requirements

i. Failure to meet required reporting requirements shall result in:

a. DHCS shall issue a Notice of Deficiency to Contractor regarding specified providers with a deadline to submit the required data and a request for a CAP to ensure timely reporting in the future. DHCS shall approve or reject the CAP or request revisions to the CAP, which shall be resubmitted to DHCS within 30 days.
b. If the Contractor has not ensured compliance with the data submission or CAP request within the designated timeline, then DHCS may withhold funds until all data is submitted. DHCS shall inform the Contractor when funds shall be withheld.

GG. Training

1. MCBHD shall provide mandatory annual training to the Contractor on the DMC-ODS.

2. Contractor may request additional Technical Assistance or training from MCBHD on an ad hoc basis.

3. Training to DMC Subcontractors

i. The Contractor shall ensure that all subcontractors receive training on the DMC-ODS requirements, at least annually. The Contractor shall report compliance with this section to DHCS annually as part of the DHCS County Monitoring process.

ii. The Contractor shall require subcontractors to be trained in the ASAM Criteria prior to providing services.

a. The Contractor shall ensure that, at minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled “ASAM Multidimensional Assessment” and “From Assessment to Service Planning and Level of Care”. A third module entitled, “Introduction to The ASAM Criteria” is recommended for all county and provider staff participating in the Waiver. With assistance from the state, counties will facilitate ASAM provider trainings.

b. The Contractor shall ensure that all residential service providers meet the established ASAM criteria for each level of residential care they provide and receive an ASAM Designation prior to providing DMC-ODS services.

HH. Program Complaints

1. The Contractor shall report complaints to DHCS by secure, encrypted e-mail to MCBHDmonitoring@dhcs.ca.gov within two business days of completion.

2. Complaints for Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities, and counselor complaints may be made by using:
   The Complaint Form which is available and may be submitted online: http://www.dhcs.ca.gov/individuals/Pages/Sud-Complaints.aspx

3. Suspected Medi-Cal fraud, waste, or abuse must be reported to:

   DHCS Medi-Cal Fraud: (800) 822-6222 or
   Fraud@dhcs.ca.gov

II. Record Retention

1. Contractor shall include instructions on record retention and include in any subcontract with providers the mandate to keep and maintain records for each service rendered, to whom it was rendered, and the date of service, pursuant to WIC 14124.1 and 42 CFR 438.3(h) and 438.3(u).

JJ. Subcontract Termination

1. The Contractor shall notify the Department of the termination of any subcontract with a certified provider, and the basis for termination of the subcontract, within two business days. The Contractor shall submit the notification by secure, encrypted email to: SUDCountyReports@dhcs.ca.gov

KK. Corrective Action Plan

1. If the Contractor fails to ensure any of the foregoing oversight through an adequate system of monitoring, utilization review, and fiscal and programmatic controls, DHCS may request a CAP from the Contractor to address these deficiencies and a timeline for implementation. Failure to submit a CAP or adhere to the provisions in the CAP can result in a withholding of funds allocated to Contractor for the provision of services, and/or termination of this Agreement for cause.
2. Failure to comply with Monitoring requirements shall result in:
    i. DHCS shall issue a report to Contractor after conducting monitoring or utilization reviews of the Contractor. When the DHCS report identifies non-compliant services or processes, it shall require a CAP. The Contractor shall submit a CAP to DHCS within the timeframes required by DHCS.
        a. The CAP shall:
            i. Be documented on the DHCS CAP template.
            ii. Provide a specific description of how the deficiency shall be corrected.
            iii. Identify the title of the individual(s) responsible for:
                1. Correcting the deficiency
                2. Ensuring on-going compliance
            iv. Provide a specific description of how the provider will ensure on-going compliance.
            v. Specify the target date of implementation of the corrective action.
    ii. DHCS shall provide written approval of the CAP to the Contractor. If DHCS does not approve the CAP submitted by the Contractor, DHCS shall provide guidance on the deficient areas and request an updated CAP from the Contractor with a new deadline for submission.
    iii. If a CAP is not submitted, or, the Contractor does not implement the approved CAP provisions within the designated timeline, then DHCS may withhold funds until the Contractor is in compliance. DHCS shall inform the Contractor when funds shall be withheld.

LL. Quality Improvement (QI) Program

1. Contractor shall establish an ongoing quality assessment and performance improvement program consistent with Article II.F.1 of this Agreement.
2. CMS, in consultation with DHCS and other stakeholders, may specify performance measures and topics for performance improvement projects to be required by DHCS in this Agreement.
3. Performance improvement projects shall be designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and beneficiary satisfaction.
4. The monitoring of accessibility of services outlined in the Quality Improvement (QI) Plan will at a minimum include:
    i. Timeliness of first initial contact to face-to-face appointment.
    ii. Frequency of follow-up appointments in accordance with individualized treatment plans.
    iii. Timeliness of services of the first dose of OTP/NTP services.
    iv. Access to after-hours care.
    v. Responsiveness of the beneficiary access line.
    vi. Strategies to reduce avoidable hospitalizations.
    vii. Coordination of physical and mental health services with waiver services at the provider level.
    viii. Assessment of the beneficiaries' experiences.
    ix. Telephone access line and services in the prevalent non-English languages.
5. The Contractor's QI program shall monitor the Contractor's service delivery system with the aim of improving the processes of providing care and better meeting the needs of its beneficiaries. The QI Program shall be accountable to the Contractor's Director.
6. The Contractor shall establish a QI Committee to review the quality of SUD treatment services provided to beneficiaries. The QI Committee shall recommend policy decisions; review and evaluate the results of QI activities, including performance improvement projects; institute needed QI actions; ensure follow-up of QI processes; and document QI Committee meeting minutes regarding decisions and actions taken.

7. The Contractor's QI Committee shall review the following data at a minimum on a quarterly basis since external quality review (EQR) site reviews will begin after county implementation. The External Quality Review Organization (EQRO) shall measure defined data elements to assess the quality of service provided by the Contractor. These data elements shall be incorporated into the EQRO protocol:
    i. Number of days to first DMC-ODS service at appropriate level of care after referral.
    ii. Existence of a 24/7 telephone access line with prevalent non-English language(s).
    iii. Access to DMC-ODS services with translation services in the prevalent non-English language(s).
8. Operation of the QI program shall include substantial involvement by a licensed SUD staff person.
9. The QI Program shall include active participation by the Contractor's practitioners and providers, as well as beneficiaries and family members, in the planning, design and execution of the QI Program.
10. The Contractor shall maintain a minimum of two active Performance Improvement Projects (PIPs) that meet the criteria in 42 CFR 438.330(b)(1) and (d). Performance improvement projects shall focus on a clinical area, as well as one non-clinical area.
11. PIPs shall:
    i. Measure performance using required quality indicators.
    ii. Implement system interventions to achieve improvement in quality.
    iii. Evaluate the effectiveness of interventions.
    iv. Plan and initiate activities for increasing or sustaining improvement.
12. The Contractor shall report the status and results of each PIP to DHCS, as requested.
13. Each PIP shall be completed in a reasonable time period so as to generally allow information on the success of PIPs in the aggregate to produce new information on quality of care annually.

MM. Utilization Management (UM) Program

1. The Contractor shall have a Utilization Management (UM) Program assuring that beneficiaries have appropriate access to SUD services, medical necessity has been established, the beneficiary is at the appropriate ASAM level of care, and that the interventions are appropriate for the diagnosis and level of care. The Contractor shall have a documented system for collecting, maintaining and evaluating accessibility to care and waiting list information, including tracking the number of days to first DMC-ODS service at an appropriate level of care following initial request or referral for all DMC-ODS services.

NN. Formation and Purpose

1. **Authority**
   i. The state and the Contractor enter into this Agreement, by authority of Chapter 3 of Part 1, Division 10.5 of the Health and Safety Code (HSC) and with approval of Contractor's County Board of Supervisors (or designee) for the purpose of providing alcohol and drug services, which shall be reimbursed pursuant to Exhibit B. The state and the Contractor identified in the State Standard (STD) Form 213 are the only parties to this Intergovernmental Agreement. This Agreement is not intended, nor shall it be construed, to confer rights on any third party.
2. **Control Requirements**
   i. Performance under the terms of this Exhibit A, Attachment I, is subject to all applicable federal and state laws, regulations, and standards. The Contractor shall:
      a. Require its subcontractors to establish written policies and procedures consistent with the requirements listed in 2(c).
      b. Monitor for compliance with the written procedures.
      c. Be held accountable for audit exceptions taken by DHCS against the Contractor and its subcontractors for any failure to comply with these requirements:
         i. HSC, Division 10.5, commencing with Section 11760
         ii. Title 9, Division 4, Chapter 8, commencing with Section 13000

iii. Government Code Section 16367.8
iv. Title 42, CFR, Sections 8.1 through 8.6
v. Title 21, CFR, Sections 1301.01 through 1301.93, Department of Justice, Controlled Substances
vi. State Administrative Manual (SAM), Chapter 7200 (General Outline of Procedures)

3. The Contractor shall be familiar with the above laws, regulations, and guidelines and shall ensure that its subcontractors are also familiar with such requirements.
4. The provisions of this Exhibit A, Attachment I are not intended to abrogate any provisions of law or regulation, or any standards existing or enacted during the term of this Agreement.

OO. Performance Provisions

1. Monitoring

i. The Contractor's performance under this Exhibit A, Attachment I, shall be monitored by DHCS annually during the term of this Agreement. Monitoring criteria shall include, but not be limited to:
   a. Whether the quantity of work or services being performed conforms to this Exhibit.
   b. Whether the Contractor has established and is monitoring appropriate quality standards.
   c. Whether the Contractor is abiding by all the terms and requirements of this Agreement.
   d. Contractor shall conduct annual onsite monitoring reviews of services and subcontracted services for programmatic and fiscal requirements. Contractor shall submit copy of their monitoring and audit reports to DHCS within two weeks of issuance. Reports should be sent by secure, encrypted e-mail to:

      SUDCountyReports@dhcs.ca.gov

      Alternatively, mail to:

      Department of Health Care Services
      Medi-Cal Behavioral Health Division
      1500 Capitol Avenue, MS-2623
      Sacramento, CA 95814

ii. Failure to comply with the above provisions shall constitute grounds for DHCS to suspend or recover payments, subject to the Contractor's right of appeal, or may result in termination of this Agreement or both.

2. **Performance Requirements**
   i. The Contractor shall provide services based on funding set forth in Exhibit B, Attachment I, and under the terms of this Agreement.
   ii. The Contractor shall provide services to all eligible persons in accordance with federal and state statutes and regulations.
   iii. The Contractor shall ensure that in planning for the provision of services, the following barriers to services are considered and addressed:
      a. Lack of educational materials or other resources for the provision of services.
      b. Geographic isolation and transportation needs of persons seeking services or remoteness of services.
      c. Institutional, cultural, and/or ethnicity barriers.
      d. Language differences.
      e. Lack of service advocates.
      f. Failure to survey or otherwise identify the barriers to service accessibility.
      g. Needs of persons with a disability.
3. The Contractor shall comply with any additional requirements of the documents that have been incorporated by reference, including, but not limited to, those in the Exhibit A – Statement of Work.
4. Amounts awarded pursuant to Exhibit B, Attachment I shall be used exclusively for providing DMC-ODS services consistent with the purpose of the funding.

5. DHCS shall issue a report to Contractor after conducting monitoring or utilization reviews of county or county subcontracted providers. When the DHCS report identifies non-compliant services or processes, it shall require a CAP. The Contractor, or in coordination with its subcontracted provider, shall submit a CAP to the DHCS Analyst that conducted the review, within 60 calendar days from the date of the report. The CAP shall be electronically submitted, directly to the DHCS analyst who conducted the review.
6. The CAP shall follow the requirements in Article III.KK.2.

PP. Requirements for Services

1. **Confidentiality.**
   i. All SUD treatment services shall be provided in a confidential setting in compliance with 42 CFR, Part 2 requirements.
2. **Perinatal Services.**
   i. Perinatal services shall address treatment and recovery issues specific to pregnant and postpartum women, such as relationships, sexual and physical abuse, and development of parenting skills.
   ii. Perinatal services shall include:
      a. Mother/child habilitative and rehabilitative services (i.e., development of parenting skills, training in child development, which may include the provision of cooperative child care pursuant to Health and Safety Code Section 1596.792).
      b. Service access (i.e., provision of or arrangement for transportation to and from medically necessary treatment).
      c. Education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant.
      d. Coordination of ancillary services (i.e., assistance in accessing and completing dental services, social services, community services, educational/vocational training and other services which are medically necessary to prevent risk to fetus or infant).
   iii. Medical documentation that substantiates the beneficiary's pregnancy and the last day of pregnancy shall be maintained in the beneficiary record.

iv. Contractor shall comply with the perinatal program requirements as outlined in the Perinatal Practice Guidelines. The Perinatal Practice Guidelines are attached to this Agreement as Document 1G, incorporated by reference. The Contractor shall comply with the current version of these guidelines until new Perinatal Practice Guidelines are established and adopted. The incorporation of any new Perinatal Practice Guidelines into this Agreement shall not require a formal amendment.

3. **Narcotic Treatment Programs.**
   i. OTP/NTP services and regulatory requirements shall be provided in accordance with CCR Title 9, Chapter 4.
4. **Naltrexone Treatment Services.**
   i. For each beneficiary, all of the following shall apply:
      a. The provider shall confirm and document that the beneficiary meets all of the following conditions:
         i. Has a documented history of opiate addiction.
         ii. Is at least 18 years of age.
         iii. Has been opiate free for a period of time to be determined by a physician based on the physician's clinical judgment. The provider shall administer a body specimen test to confirm the opiate free status of the beneficiary.
         iv. Is not pregnant and is discharged from the treatment if she becomes pregnant.
      b. The physician shall certify the beneficiary's fitness for treatment based upon the beneficiary's physical examination, medical history, and laboratory results.
      c. The physician shall advise the beneficiary of the overdose risk should the beneficiary return to opiate use while taking Naltrexone and the ineffectiveness of opiate pain relievers while on Naltrexone.
5. **Substance Use Disorder Medical Director.**
   i. The SUD Medical Director's responsibilities shall, at a minimum, include all of the following:
      a. Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
      b. Ensure that physicians do not delegate their duties to non-physician personnel.

c. Develop and implement written medical policies and standards for the provider.
d. Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
e. Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
f. Ensure that provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries, and determine the medical necessity of treatment for beneficiaries.
g. Ensure that provider's physicians are adequately trained to perform other physician duties, as outlined in this section.

ii. The SUD Medical Director may delegate his/her responsibilities to a physician consistent with the provider's medical policies and standards; however, the SUD Medical Director shall remain responsible for ensuring all delegated duties are properly performed.

6. Provider Personnel.

i. Personnel files shall be maintained on all employees, contracted positions, volunteers, and interns, and shall contain the following:
a. Application for employment and/or resume
b. Signed employment confirmation statement/duty statement
c. Job description
d. Performance evaluations
e. Health records/status as required by the provider, AOD Certification or CCR Title 9
f. Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries)
g. Training documentation relative to substance use disorders and treatment
h. Current registration, certification, intern status, or licensure
i. Proof of continuing education required by licensing or certifying agency and program
j. Provider’s Code of Conduct.

ii. Job descriptions shall be developed, revised as needed, and approved by the provider's governing body. The job descriptions shall include:
    a. Position title and classification
    b. Duties and responsibilities
    c. Lines of supervision
    d. Education, training, work experience, and other qualifications for the position
iii. Written provider code of conduct for employees and volunteers/interns shall be established which addresses at least the following:
    a. Use of drugs and/or alcohol
    b. Prohibition of social/business relationship with beneficiaries or their family members for personal gain
    c. Prohibition of sexual contact with beneficiaries
    d. Conflict of interest
    e. Providing services beyond scope
    f. Discrimination against beneficiaries or staff
    g. Verbally, physically, or sexually harassing, threatening or abusing beneficiaries, family members or other staff
    h. Protection of beneficiary confidentiality
    i. Cooperate with complaint investigations
iv. If a provider utilizes the services of volunteers and/or interns, written procedures shall be implemented which address:
    a. Recruitment
    b. Screening and Selection
    c. Training and orientation
    d. Duties and assignments
    e. Scope of practice
    f. Supervision
    g. Evaluation
    h. Protection of beneficiary confidentiality
v. Written roles and responsibilities and a code of conduct for the Medical Director shall be clearly documented, signed and dated by a provider representative and the physician.

7. Beneficiary Admission.

i. Each provider shall include in its policies, procedures, and practice, written admission and readmission criteria for determining beneficiary's eligibility and the medical necessity for treatment. These criteria shall include, at a minimum:
    a. DSM diagnosis
    b. Use of alcohol/drugs of abuse
    c. Physical health status
    d. Documentation of social and psychological problems.
ii. If a potential beneficiary does not meet the admission criteria, the beneficiary shall be referred to an appropriate service provider.
iii. If a beneficiary is admitted to treatment, the beneficiary shall sign a consent to treatment form.
iv. The Medical Director or LPHA shall document the basis for the diagnosis in the beneficiary record.
v. All referrals made by the provider staff shall be documented in the beneficiary record.
vi. Copies of the following documents shall be provided to the beneficiary upon admission:
    a. Beneficiary rights, share of cost if applicable, notification of DMC funding accepted as payment in full, and consent to treatment.
vii. Copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries:
    a. A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay.
    b. Complaint process and grievance procedures.
    c. Appeal process for involuntary discharge.
    d. Program rules and expectations.
viii. Where drug screening by urinalysis is deemed medically appropriate the program shall:
    a. Establish written procedures, which protect against the falsification and/or contamination of any urine sample.
    b. Document urinalysis results in the beneficiary's file.

8. Assessment.

i. The provider shall ensure a counselor or LPHA completes a personal, medical, and substance use history for each beneficiary upon admission to treatment.
    a. Assessment for all beneficiaries shall include at a minimum:
        i. Drug/Alcohol use history
        ii. Medical history

iii. Family history
iv. Psychiatric/psychological history
v. Social/recreational history
vi. Financial status/history
vii. Educational history
viii. Employment history
ix. Criminal history, legal status, and
x. Previous SUD treatment history

b. The Medical Director or LPHA shall review each beneficiary's personal, medical, and substance use history if completed by a counselor within 30 calendar days of each beneficiary's admission to treatment date.

9. Beneficiary Record.

i. In addition to the requirements of 22 CCR § 51476(a), the provider shall:
   a. Establish, maintain, and update as necessary, an individual beneficiary record for each beneficiary admitted to treatment and receiving services.
   b. Each beneficiary's individual beneficiary record shall include documentation of personal information.
   c. Documentation of personal information shall include all of the following:
      i. Information specifying the beneficiary's identifier (i.e., name, number).
      ii. Date of beneficiary's birth, the beneficiary's sex, race and/or ethnic background, beneficiary's address and telephone number, and beneficiary's next of kin or emergency contact.

ii. Documentation of treatment episode information shall include documentation of all activities, services, sessions, and assessments, including, but not limited to all of the following:
   a. Intake and admission data including, a physical examination, if applicable.
   b. Treatment plans.
   c. Progress notes.
   d. Continuing services justifications.
   e. Laboratory test orders and results.
   f. Referrals.
   g. Discharge plan.

h. Discharge summary.
i. Contractor authorizations for Residential Services.
j. Any other information relating to the treatment services rendered to the beneficiary.

10. Diagnosis Requirements.

i. The Medical Director or LPHA shall evaluate each beneficiary's assessment and intake information if completed by a counselor through a face-to-face review or telehealth with the counselor to establish a beneficiary meets the medical necessity criteria in Article III.B.2.ii.

a. The Medical Director or LPHA shall document separately from the treatment plan the basis for the diagnosis in the beneficiary's record within 30 calendar days of each beneficiary's admission to treatment date.

i. The basis for the diagnosis shall be a narrative summary based on DSM-5 criteria, demonstrating the Medical Director or LPHA evaluated each beneficiary's assessment and intake information, including their personal, medical, and substance use history.

ii. The Medical Director or LPHA shall type or legibly print their name, and sign and date the diagnosis narrative documentation. The signature shall be adjacent to the typed or legibly printed name.

11. Physical Examination Requirements.

i. If a beneficiary had a physical examination within the twelve-month period prior to the beneficiary's admission to treatment date, the physician or registered nurse practitioner or physician's assistant (physician extenders) shall review documentation of the beneficiary's most recent physical examination within 30 calendar days of the beneficiary's admission to treatment date.

a. If a provider is unable to obtain documentation of a beneficiary's most recent physical examination, the provider shall describe the efforts made to obtain this documentation in the beneficiary's individual patient record.

ii. As an alternative to complying with paragraph (i) above or in addition to complying with paragraph (i) above, the physician or physician extender may perform a physical examination of the beneficiary within 30 calendar days of the beneficiary's admission to treatment date.

iii. If the physician or a physician extender, has not reviewed the documentation of the beneficiary's physical examination as provided for in paragraph (i), or the provider does not perform a physical examination of the beneficiary as provided for in paragraph (ii), then the LPHA or counselor shall include in the beneficiary's initial and updated treatment plans the goal of obtaining a physical examination, until this goal has been met and the physician has reviewed the physical examination results. The physician shall type or legibly print their name, sign, and date documentation to support they have reviewed the physical examination results. The signature shall be adjacent to the typed or legibly printed name.

12. Treatment Plan.

i. For each beneficiary admitted to treatment services, the LPHA or counselor shall prepare an individualized written initial treatment plan, based upon the information obtained in the intake and assessment process.

a. The LPHA or counselor shall attempt to engage the beneficiary to meaningfully participate in the preparation of the initial treatment plan and updated treatment plans.

i. The initial treatment plan and updated treatment plans shall include all of the following:

1. A statement of problems identified through the ASAM, other assessment tool(s) or intake documentation.
2. Goals to be reached which address each problem.
3. Action steps that will be taken by the provider and/or beneficiary to accomplish identified goals.
4. Target dates for the accomplishment of action steps and goals.

5. A description of the services, including the type of counseling, to be provided and the frequency thereof.
6. The assignment of a primary therapist or counselor.
7. The beneficiary's diagnosis as documented by the Medical Director or LPHA.
8. If a beneficiary has not had a physical examination within the 12-month period prior to the beneficiary's admission to treatment date, a goal that the beneficiary have a physical examination.
9. If documentation of a beneficiary's physical examination, which was performed during the prior 12 months, indicates a beneficiary has a significant medical illness, a goal that the beneficiary obtain appropriate treatment for the illness.

b. The provider shall ensure that the initial treatment plan meets all of the following requirements:
    i. The LPHA or counselor shall complete, type or legibly print their name, and sign and date the initial treatment plan within 30 calendar days of the admission to treatment date. The signature shall be adjacent to the typed or legibly printed name.
    ii. The beneficiary shall review, approve, type, or legibly print their name, sign and date the initial treatment plan, indicating whether the beneficiary participated in preparation of the plan, within 30 calendar days of the admission to treatment date.
        1. If the beneficiary refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment.

iii. If a counselor completes the initial treatment plan, the Medical Director or LPHA shall review the initial treatment plan to determine whether services are medically necessary (as defined in Article IV) and appropriate for the beneficiary.
    1. If the Medical Director or LPHA determines the services in the initial treatment plan are medically necessary, the Medical Director or LPHA shall type or legibly print their name, and sign and date the treatment plan within 15 calendar days of signature by the counselor. The signature shall be adjacent to the typed or legibly printed name.

ii. The provider shall ensure that the treatment plan is reviewed and updated as described below:
    a. The LPHA or counselor shall complete, type, or legibly print their name, sign and date the updated treatment plan no later than 90 calendar days after signing the initial treatment plan, and no later than every 90 calendar days thereafter, or when there is a change in treatment modality or significant event, whichever comes first. The signature shall be adjacent to the typed or legibly printed name. The updated treatment plan shall be updated to reflect the current treatment needs of the beneficiary.
    b. The beneficiary shall review, approve, type, or legibly print their name and, sign and date the updated treatment plan, indicating whether the beneficiary participated in preparation of the plan, within 30 calendar days of signature by the LPHA or counselor.
        i. If the beneficiary refuses to sign the updated treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment.
    c. If a counselor completes the updated treatment plan, the Medical Director or LPHA shall review each updated treatment plan to determine whether continuing services are medically necessary (as defined in Article IV) and appropriate for the beneficiary.

i. If the Medical Director or LPHA determines the services in the updated treatment plan are medically necessary, they shall type or legibly print their name and, sign and date the updated treatment plan, within 15 calendar days of signature by the counselor. The signature shall be adjacent to the typed or legibly printed name.

13. Sign-in Sheet.

i. Establish and maintain a sign-in sheet for every group counseling session, which shall include all of the following:
   a. The LPHA(s) and/or counselor(s) conducting the counseling session shall type or legibly print their name(s), sign, and date the sign-in sheet on the same day of the session. The signature(s) must be adjacent to the typed or legibly printed name(s). By signing the sign-in sheet, the LPHA(s) and/or counselor(s) attest that the sign-in sheet is accurate and complete.
   b. The date of the counseling session.
   c. The topic of the counseling session.
   d. The start and end time of the counseling session.
   e. A typed or legibly printed list of the participants' names and the signature of each participant that attended the counseling session. The participants shall sign the sign-in sheet at the start of or during the counseling session.

14. Progress Notes.

i. Progress notes shall be legible and completed as follows:
   a. For outpatient services, Naltrexone treatment services, and recovery services, each individual and group session, the LPHA or counselor who conducted the counseling session or provided the service shall record a progress note for each beneficiary who participated in the counseling session or treatment service.
      i. The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven calendar days of the counseling session. The signature shall be adjacent to the typed or legibly printed name.

ii. Progress notes are individual narrative summaries and shall include all of the following:
    1. The topic of the session or purpose of the service.
    2. A description of the beneficiary's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals.
    3. Information on the beneficiary's attendance, including the date, start and end times of each individual and group counseling session or treatment service.
    4. Identify if services were provided in-person, by telephone, or by telehealth.
    5. If services were provided in the community, identify the location and how the provider ensured confidentiality.

b. For intensive outpatient services and residential treatment services, the LPHA or counselor shall record, at a minimum, one progress note, per calendar week, for each beneficiary participating in structured activities including counseling sessions or other treatment services.
    i. The LPHA or counselor shall type or legibly print their name, and sign and date progress notes within the following calendar week. The signature shall be adjacent to the typed or legibly printed name.
    ii. Progress notes are individual narrative summaries and shall include all of the following:
        1. A description of the beneficiary's progress on the treatment plan, problems, goals, action steps, objectives, and/or referrals.
        2. A record of the beneficiary's attendance at each counseling session including the date, start and end times and topic of the counseling session.
        3. Identify if services were provided in-person, by telephone, or by telehealth.
        4. If services were provided in the community, identify the location and how the provider ensured confidentiality.

c. For each beneficiary provided case management services, the LPHA or counselor who provided the treatment service shall record a progress note.
    i. The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven calendar days of the case management service. The signature shall be adjacent to the typed or legibly printed name.
    ii. Progress notes shall include all of the following:
        1. Beneficiary's name.
        2. The purpose of the service.
        3. A description of how the service relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referrals.
        4. Date, start and end times of each service.
        5. Identify if services were provided in-person, by telephone, or by telehealth.
        6. If services were provided in the community, identify the location and how the provider ensured confidentiality.

d. For physician consultation services, additional medication assisted treatment, and withdrawal management, the Medical Director or LPHA working within their scope of practice who provided the treatment service shall record a progress note and keep in the beneficiary's file.
    i. The Medical Director or LPHA shall type or legibly print their name, and sign and date the progress note within seven calendar days of the service. The signature shall be adjacent to the typed or legibly printed name.
    ii. Progress notes shall include all of the following:
        1. Beneficiary's name.
        2. The purpose of the service.
        3. Date, start and end times of each service.
        4. Identify if services were provided face-to-face, by telephone or by telehealth.

15. Continuing Services.

i. Continuing services shall be justified as shown below:
    a. For outpatient services, intensive outpatient services, Naltrexone treatment, and case management:

i. For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the LPHA or counselor shall review the beneficiary's progress and eligibility to continue to receive treatment services, and recommend whether the beneficiary should or should not continue to receive treatment services at the same level of care.

ii. For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the Medical Director or LPHA shall determine medical necessity for continued services for the beneficiary. The determination of medical necessity shall be documented by the Medical Director or LPHA in the beneficiary's individual patient record and shall include documentation that all of the following have been considered:
    1. The beneficiary's personal, medical and substance use history.
    2. Documentation of the beneficiary's most recent physical examination.
    3. The beneficiary's progress notes and treatment plan goals.
    4. The LPHA’s or counselor's recommendation pursuant to Paragraph (i) above.
    5. The beneficiary's prognosis.
        i. The Medical Director or LPHA shall type or legibly print their name, and sign and date the continuing services information when completed. The signature shall be adjacent to the typed or legibly printed name.

iii. If the Medical Director or LPHA determines that continuing treatment services for the beneficiary is not medically necessary, the provider shall discharge the beneficiary from the current LOC and transfer to the appropriate services.

b. Residential services length of stay shall be in accordance with Article III.H of this Agreement.

16. Discharge.

i. Discharge of a beneficiary from treatment may occur on a voluntary or involuntary basis. For outpatient services, intensive outpatient services and residential services, in addition to the requirements of this subsection, an involuntary discharge is subject to the requirements set forth in Article II.G.2. of this Agreement.

ii. An LPHA or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom the provider loses contact.

a. The discharge plan shall include, but not be limited to, all of the following:

i. A description of each of the beneficiary's relapse triggers.

ii. A plan to assist the beneficiary to avoid relapse when confronted with each trigger.

iii. A support plan.

b. The discharge plan shall be prepared within 30 calendar days prior to the scheduled date of the last face-to-face treatment with the beneficiary.

i. If a beneficiary is transferred to a higher or lower level of care based on ASAM criteria within the same DMC certified program, they are not required to be discharged unless there has been more than a 30-calendar day lapse in treatment services.

c. During the LPHA’s or counselor's last face-to-face treatment with the beneficiary, the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. The signatures shall be adjacent to the typed or legibly printed name. A copy of the discharge plan shall be provided to the beneficiary and documented in the beneficiary record.

iii. The LPHA or counselor shall complete a discharge summary, for any beneficiary with whom the provider lost contact, in accordance with all of the following requirements:
    a. The LPHA or counselor shall complete the discharge summary within 30 calendar days of the date of the last face-to-face treatment contact with the beneficiary.
    b. The discharge summary shall include all of the following:
        i. The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment.
        ii. The reason for discharge.
        iii. A narrative summary of the treatment episode.
        iv. The beneficiary's prognosis.

17. Reimbursement of Documentation.

i. If the Contractor allows for the inclusion of the time spent documenting when billing for a unit of service delivered, the Contractor shall require its subcontracted providers to include the following information in their progress notes:
    a. The date the progress note was completed.
    b. The start and end time of the documentation of the progress note.

ii. Documentation activities shall be billed as a part of the covered service unit.

IV. Definitions

A. The words and terms of this Intergovernmental Agreement are intended to have their usual meaning unless a specific or more limited meaning is associated with their usage pursuant to the HSC, Title 6.

1. ***"Abuse"*** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

2. ***"Adolescents"*** means beneficiaries between the ages of twelve and under the age of twenty-one.

3. ***"Administrative Costs"*** means the Contractor's actual direct costs, as recorded in the Contractor's financial records and supported by source documentation, to administer the program or an activity to provide service to the DMC-ODS program. Administrative costs do not include the cost of treatment or other direct services to the beneficiary. Administrative costs may include, but are not limited to, the cost of training, programmatic and financial audit reviews, and activities related to billing. Administrative costs may include Contractor's overhead per the approved indirect cost rate proposal pursuant to OMB Omni-Circular and the State Controller's Office Handbook of Cost Plan Procedures.

4. ***"Adverse benefit determination"*** means, in the case of an MCO, PIHP, or PAHP, any of the following:

   (1) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

   (2) The reduction, suspension, or termination of a previously authorized service.

   (3) The denial, in whole or in part, of payment for a service.

   (4) The failure to provide services in a timely manner, as defined by the state

   (5) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in 42 CFR 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

   (6) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network.

   (7) The denial of an enrollee's request to dispute a financial liability, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

5. ***"Appeal"*** is the request for review of an adverse benefit determination.

6. ***"ASAM Assessment"*** means an assessment that utilizes the published ASAM criteria for the purpose of determining a level of care.

7. ***"ASAM Criteria-Medical Necessity"*** pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. It should not be restricted to acute care and narrow medical concerns (such as severity of withdrawal risk as in Dimension 1); acuity of physical health needs (as in Dimension 2); or Dimension 3 psychiatric issues (such as imminent suicidality). Rather, "medical necessity" encompasses all six assessment dimensions so that a more holistic concept would be "Clinical Necessity," "necessity of care," or "clinical appropriateness."

8. ***"Authorization"*** is the approval process for DMC-ODS Services prior to the submission of a DMC claim.

9. ***"Available Capacity"*** means the total number of units of service (bed days, hours, slots, etc.) that a Contractor actually makes available in the current fiscal year.

10. ***"Beneficiary"*** means a person who: (a) has been determined eligible for Medi-Cal; (b) is not institutionalized; (c) has a substance-related disorder per the current "Diagnostic and Statistical Manual of Mental Disorders (DSM)" criteria; and (d) meets the admission criteria to receive DMC covered services.

11. ***"Beneficiary/Enrollee Encounter Data"*** means the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a state and a MCO, PIHP, or PAHP that is subject to the requirements of §§438.242 and 438.818.

12. ***"Beneficiary Handbook"*** is the state developed model enrollee handbook.

13. ***"Calendar Week"*** means the seven-day period from Sunday through Saturday.

14. ***"Case Management"*** means a service to assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

15. ***"Certified Provider"*** means a substance use disorder clinic location that has received certification to be reimbursed as a DMC clinic by the state to provide services as described in Title 22, California Code of Regulations, Section 51341.1.

16. ***"Collateral Services"*** means sessions with therapists or counselors and significant persons in the life of a beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.

17. ***"Complaint"*** means requesting to have a problem solved or have a decision changed because you are not satisfied. A complaint is sometimes called a grievance or an appeal.

18. ***"Contractor"*** means the county identified in the Standard Agreement or DHCS authorized by the County Board of Supervisors to administer substance use disorder programs.

19. ***"Corrective Action Plan (CAP)"*** means the written plan of action document which the Contractor or its subcontracted service provider develops and submits to DHCS to address or correct a deficiency or process that is non-compliant with laws, regulations or standards.

20. ***"County"*** means the county in which the Contractor physically provides covered substance use treatment services.

21. ***"County Realignment Funds"*** means Behavioral Health Subaccount funds received by the County as per California Code Section 30025.

22. ***"Crisis Intervention"*** means a contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance, which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the beneficiary's emergency situation.

23. ***"Days"*** means calendar days, unless otherwise specified.

24. ***"Dedicated Capacity"*** means the historically calculated service capacity, by modality, adjusted for the projected expansion or reduction in services, which the Contractor agrees to make available to provide DMC-ODS services to persons eligible for Contractor services.

25. ***"Discharge services"*** means the process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

26. ***"Discrimination Grievance"*** means a complaint concerning the unlawful discrimination on the basis of any characteristic protected under federal or state law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

27. ***"DMC-ODS Services"*** means those DMC services authorized by Title XIX or Title XXI of the Social Security Act; Title 22 Section 51341.1; WIC 14124.24; and California's Medicaid State Plan, including the DMC ODS 1115 Demonstration Waiver special terms and conditions.

28. ***"Drug Medi-Cal Organized Delivery System"*** is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program. DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a county that opts into the Pilot program. Upon approval of an implementation plan, the state shall contract with the county to provide DMC-ODS services. The county shall, in turn, contract with DMC enrolled providers or provide county-operated services to provide all services outlined in the DMC-ODS. Counties may also contract with a managed care plan to provide services. Participating counties with the approval from the state may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design or comparability of services. Counties may act jointly in order to deliver these services.

29. ***"Drug Medi-Cal Program"*** means the state system wherein beneficiaries receive covered services from DMC-certified substance use disorder treatment providers.

30. ***"Drug Medi-Cal Termination of Certification"*** means the provider is no longer certified to participate in the Drug Medi-Cal program upon the state's issuance of a Drug Medi-Cal certification termination notice.

31. ***"Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT)"*** means the federal mandate under Section 1905(r) of the Social Security Act, which requires the Contractor to ensure that all beneficiaries under age 21 receive all applicable medically necessary services needed to correct and ameliorate health conditions that are coverable under Section 1905(a) of the Social Security Act.

32. ***"Education and Job Skills"*** means linkages to life skills, employment services, job training, and education services.

33. ***"Emergency medical condition"*** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

    (1) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

    (2) Serious impairment to bodily functions.

    (3) Serious dysfunction of any bodily organ or part.

34. ***"Emergency services"*** means covered inpatient and outpatient services that are as follows:

    (1) Furnished by a provider that is qualified to furnish these services under Title 42.

    (2) Needed to evaluate or stabilize an emergency medical condition.

35. ***"Excluded Services"*** means services that are not covered under this Agreement.

36. ***"Face-to-Face"*** means a service occurring in person.

37. ***"Family Support"*** means linkages to childcare, parent education, child development support services, and family and marriage education.

38. ***"Family Therapy"*** means including a beneficiary's family members and loved ones in the treatment process, and education about factors that are important to the beneficiary's recovery as well as their own recovery can be conveyed. Family members may provide social support to beneficiaries, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

39. ***"Fair Hearing"*** means the state hearing provided to beneficiaries upon denial of appeal pursuant to 22 CCR 50951 and 50953 and 9 CCR 1810.216.6. Fair hearings shall comply with 42 CFR 431.220(a)(5), 438.408(f), 438.414, and 438.10(g)(1).

40. ***"Federal Financial Participation (FFP)"*** means the share of federal Medicaid funds for reimbursement of DMC services.

41. ***"Final Settlement"*** means permanent settlement of the Contractor's actual allowable costs or expenditures as determined at the time of audit, which shall be completed within three years of the date the year-end cost settlement report was accepted for interim settlement by the state. If the audit is not completed within three years, the interim settlement shall be considered as the final settlement.

42. ***"Fraud"*** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or state law.

43. ***"Grievance"*** means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee's rights regardless of whether remedial action is requested. Grievance includes an enrollee's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.

44. ***"Grievance and Appeal System"*** means the processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.

45. ***"Group Counseling"*** means contacts in which one or more therapists or counselors treat two or more clients at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served. A beneficiary that is 17 years of age or younger shall not participate in-group counseling with any participants who are 18 years of age or older. However, a beneficiary who is 17 years of age or younger may participate in group counseling with participants who are 18 years of age or older when the counseling is at a provider's certified school site.

46. ***"Hospitalization"*** means that a patient needs a supervised recovery period in a facility that provides hospital inpatient care.

47. ***"Individual Counseling"*** means contact between a beneficiary and a therapist or counselor. Services provided in-person, by telephone or by telehealth qualify as Medi-Cal reimbursable units of service, and are reimbursed without distinction.

48. ***"Intake"*** means the process of determining whether a beneficiary meets the medical necessity criteria and whether a beneficiary is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for substance use disorder treatment and evaluation.

49. ***"Intensive Outpatient Services"*** means (ASAM Level 2.1) structured programming services consisting primarily of counseling and education about addiction-related problems a minimum of nine (9) hours with a maximum of 19 hours per week for adults, and a minimum of six (6) hours with a maximum of 19 hours per week for adolescents. Services may be provided in any appropriate setting in the community. Services may be provided in-person, by telephone or by telehealth. Also known as Intensive Outpatient Treatment.

50. ***"Interim Settlement"*** means temporary settlement of actual allowable costs or expenditures reflected in the Contractor's year-end cost settlement report.

51. ***"Key Points of Contact"*** means common points of access to substance use treatment services from the county, including but not limited to the county's beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the county.

52. ***"Long-Term Services and Supports (LTSS)"*** means services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a nursing facility, or other institutional setting.

53. ***"Licensed Practitioners of the Healing Arts (LPHA)"*** includes: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

54. ***"Managed Care Organization (MCO)"*** means an entity that has, or is seeking to qualify for, comprehensive risk contract under 42 CFR part 438, and that is-

    (1) A Federally qualified HMO that meets the advance directives requirements of subpart l of part 489 of Title 20 Chapter 4; or

(2) Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:

(i) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.

(ii) Meets the solvency standards of the §438.116.

55. ***"Managed Care Program"*** means a managed care delivery system operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act.

56. ***"Maximum Payable"*** means the encumbered amount reflected on the Standard Agreement of this Agreement and supported by Exhibit B, Attachment I.

57. ***"Medical Necessity" and "Medically Necessary Services"*** means those SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of a disease, illness, or injury consistent with 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Section 1905(r) of the Social Security Act.

58. ***"Medical Necessity Criteria"*** means adult beneficiaries must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, and must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria. Adults shall meet the ASAM Adult Dimensional Admission Criteria. Beneficiaries under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health.

59. ***"Medical psychotherapy"*** means a type of counseling service that has the same meaning as defined in 9 CCR § 10345.

60. ***"Medication Services"*** means the prescription or administration of medication related to substance use disorder treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services.

61. ***"Modality"*** means those necessary overall general service activities to provide substance use disorder services as described in Division 10.5 of the HSC.

62. ***"Opioid (Narcotic) Treatment Program"*** means an outpatient clinic licensed by the state to provide narcotic replacement therapy directed at stabilization and rehabilitation of persons who are opiate-addicted and have a substance use diagnosis.

63. ***"Naltrexone Treatment Services"*** means an outpatient treatment service directed at serving detoxified opiate addicts by using the drug Naltrexone, which blocks the euphoric effects of opiates and helps prevent relapse to opiate addiction.

64. ***"Network"*** means the group of entities that have contracted with the PIHP to provide services under this Agreement.

65. ***"Network Provider"*** means any provider, group of providers, or entity that has a network provider agreement with a MCO, PIHP, PAHP, or a subcontract, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP or PAHP. A network provider is not a subcontractor by virtue of the network provider agreement.

66. ***"Non-participating provider"*** means a provider that is not engaged in the continuum of services under this Agreement.

67. ***"Non-Perinatal Residential Program"*** services are provided in DHCS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria. These residential services are provided to the non-perinatal population and do not require the enhanced services found in the perinatal residential programs.

68. ***"Non-Quantitative Treatment Limitation (NQTL)"*** means a limit on the scope or duration of benefits that is not expressed numerically. Non-quantitative treatment limitations include:

a. Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
b. Formulary design for prescription drugs;
c. Network tier design;
d. Standards for provider admission to participate in a network, including reimbursement rates;
e. Methods for determining usual, customary, and reasonable charges;
f. Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
g. Exclusions based on failure to complete a course of treatment;
h. Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services; and
i. Standards for providing access to out-of-network providers.

69. ***"Nonrisk Contract"*** means a contract between the state and a PIHP or PAHP under which the Contractor-

(1) Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in 42 CFR 447.362, and

(2) May be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits

70. ***"Notice of Adverse Benefit Determination (NOABD)"*** means a formal communication of any action and consistent with 42 CFR 438.404 and 438.10.

71. ***"Observation"*** means the process of monitoring the beneficiary's course of withdrawal. It is to be conducted as frequently as deemed appropriate for the beneficiary and the level of care the beneficiary is receiving. This may include but is not limited to observation of the beneficiary's health status.

72. ***"Outpatient Services"*** means (ASAM Level 1.0) outpatient service directed at stabilizing and rehabilitating persons up to nine hours of service per week for adults, and less than six hours per week for adolescents.

73. ***"Overpayment"*** means any payment made to a network provider by a MCO, PIHP, or PAHP to which the network provider is not entitled to under Title XIX of the Act or any payment to a MCO, PIHP, or PAHP by a state to which the MCO, PIHP, or PAHP is not entitled to under Title XIX of the Act.

74. ***"Patient Education"*** means providing research based education on addiction, treatment, recovery and associated health risks.

75. ***"Participating provider"*** means a provider that is engaged in the continuum of services under this Agreement.

76. ***"Payment Suspension"*** means the Drug Medi-Cal certified provider has been issued a notice pursuant to WIC 14107.11 and is not authorized to receive payments after the payment suspension date for DMC services, regardless of when the service was provided.

77. ***"Performance"*** means providing the dedicated capacity in accordance with Exhibit B, Attachment I, and abiding by the terms of this Exhibit A, including all applicable state and federal statutes, regulations, and standards, including Alcohol and/or Other Drug Certification Standards (Document 1P), if applicable, in expending funds for the provision of SUD services hereunder.

78. ***"Perinatal DMC Services"*** means covered services as well as mother/child habilitative and rehabilitative services; services access (i.e., provision or arrangement of transportation to and from medically necessary treatment); education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant; and coordination of ancillary services (Title 22, Section 51341.1(c)(4)).

79. ***"Physician"*** as it pertains to the supervision, collaboration, and oversight requirements in sections 1861(aa)(2)(B) and (aa)(3) of the Act, a doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the State in which the function is performed.

80. ***"Physician Consultation"*** services are to support DMC physicians with complex cases, which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

81. ***"Physician services"*** means services provided by an individual licensed under state law to practice medicine.

82. ***"Plan"*** means any written arrangement, by one or more entities, to provide health benefits or medical care or assume legal liability for injury or illness.

83. ***"Postpartum"*** as defined for DMC purposes, means the 60-day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility for perinatal services shall end on the last day of the calendar month in which the 60th day occurs.

84. ***"Postservice Postpayment (PSPP) Utilization Review"*** means the review for program compliance and medical necessity, conducted by the state after service was rendered and paid. The Department may recover prior payments of Federal and state funds if such a review determines that the services did not comply with the applicable statutes, regulations, or terms as specified in Article III.PP of this Agreement.

85. ***"Potential Beneficiary/Enrollee"*** means a Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given MCO, PIHP, PAHP, PCCM or PCCM entity, but is not yet an enrollee of a specific MCO, PIHP, PAHP, PCCM, or PCCM entity.

86. ***"Preauthorization"*** means approval by the Plan that a covered service is medically necessary.

87. ***"Prepaid Ambulatory Health Plan (PAHP)"*** means an entity that:

    (1) Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State Plan payment rates.

    (2) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and

    (3) Does not have a comprehensive risk contract.

88. ***"Prepaid Inpatient Health Plan (PIHP)"*** means an entity that:

(1) Provides services to enrollees under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State Plan payment rates.

(2) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and

(3) Does not have a comprehensive risk contract.

89. ***"Prescription drugs"*** means simple substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are:

(1) Prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law

(2) Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and

(3) Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

90. ***"Primary Care"*** means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

91. ***"Primary Care Case Management Entity (PCCM entity)"*** means an organization that provides any of the following functions, in addition to primary care case management services, for the state:

(1) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line.

(2) Development of enrollee care plans.

(3) Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program.

(4) Provision of payments to FFS providers on behalf of the state.

(5) Provision of enrollee outreach and education activities.

(6) Operation of a customer service call center.

(7) Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement.

(8) Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers.

(9) Coordination with behavioral health systems/providers.

(10) Coordination with long-term services and supports systems/providers.

92. ***"Primary Care Case Manager (PCCM)"*** means a physician, a physician group practice or, at State option, any of the following:

(1) A physician assistant

(2) A nurse practitioner

(3) A certified nurse-midwife

93. ***"Primary care physician (PCP)"*** means a Physician responsible for supervising, coordinating, and providing initial and Primary Care to patients and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist.

94. ***"Primary care provider"*** means a person responsible for supervising, coordinating, and providing initial and Primary Care to patients, for initiating referrals, and for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.

95. ***"Projected Units of Service"*** means the number of reimbursable DMC units of service, based on historical data and current capacity, the Contractor expects to provide on an annual basis.

96. ***"Provider"*** means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services.

97. ***"Provider-preventable condition"*** means a condition that meets the definition of a health care-acquired condition — a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary under section 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State Plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act; other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients — or an "other provider-preventable condition," which is defined as a condition occurring in any health care setting that meets the following criteria:

    (1) Is identified in the State Plan.

    (2) Has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.

    (3) Has a negative consequence for the beneficiary.

    (4) Is auditable.

    (5) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

98. **"Quality Assessment/Utilization Review (QA/UR)"** activities are reviews of physicians, health care practitioners and providers of health care services in the provision of health care services and items for which payment may be made to determine whether:

    (1) Such services are or were reasonable and medically necessary and whether such services and items are allowable.
    (2) The quality of such services meets professionally recognized standards of health care.

99. ***"Quantitative Treatment Limitation (QTL)"*** means a limit on the scope or duration of a benefit that is expressed numerically.

100. ***"Re-certification"*** means the process by which the DMC certified clinic is required to submit an application and specified documentation, as determined by DHCS, to remain eligible to participate in and be reimbursed through the DMC program. Re-certification shall occur no less than every five years from the date of previous DMC certification or re-certification.

101. ***"Recovery monitoring"*** means recovery coaching, monitoring via telephone and internet. Recovery monitoring is only available in Recovery services.

102. ***"Recovery Services"*** are available after the beneficiary has completed a course of treatment. Recovery services emphasize the patient's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to patients.

103. ***"Rehabilitation Services"*** includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.

104. ***"Relapse"*** means a single instance of a beneficiary's substance use or a beneficiary's return to a pattern of substance use.

105. ***"Relapse Trigger"*** means an event, circumstance, place or person that puts a beneficiary at risk of relapse.

106. ***"Residential Treatment Services"*** means a non-institutional, 24-hour non-medical, short-term residential program of any size that provides rehabilitation services to beneficiaries. Each beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills, and access community support systems. Programs shall provide a range of activities and services. Residential treatment shall include 24-hour structure with available trained personnel, seven days a week, including a minimum of five hours of clinical service a week to prepare beneficiary for outpatient treatment.

107. ***"Revenue"*** means Contractor's income from sources other than the state allocation.

108. ***"Safeguarding medications"*** means facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.

109. ***"Service Area"*** means the geographical area under the Contractor's jurisdiction.

110. ***"Service Authorization Request"*** means a beneficiary's request for the provision of a service.

111. ***"Short-Term Resident"*** means any beneficiary receiving residential services pursuant to DMC-ODS, regardless of the length of stay, is a "short-term resident" of the residential facility in which they are receiving the services.

112. ***"State"*** means the Department of Health Care Services or DHCS.

113. ***"Subcontract"*** means an agreement between the Contractor and its subcontractors. A subcontractor shall not delegate its obligation to provide covered services or otherwise subcontract for the provision of direct patient/beneficiary services.

114. ***"Subcontractor"*** means an individual or entity that is DMC certified and has entered into an agreement with the Contractor to be a provider of covered services. It may also mean a vendor who has entered into a procurement agreement with the Contractor to provide any of the administrative functions related to fulfilling the Contractor's obligations under the terms of this Exhibit A, Attachment I.

115. ***"Substance Abuse Assistance"*** means peer-to-peer services and relapse prevention. Substance abuse assistance is only available in Recovery services.

116. ***"Substance Use Disorder Diagnoses"*** are those set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.

117. ***"Substance Use Disorder Medical Director"*** has the same meaning as in 22 CCR § 51000.24.4.

118. ***"Support Groups"*** means linkages to self-help and support, spiritual and faith-based support.

119. ***"Support Plan"*** means a list of individuals and/or organizations that can provide support and assistance to a beneficiary to maintain sobriety.

120. ***"Telehealth Between Provider and Beneficiary"*** means office or outpatient visits via interactive audio and video telecommunication systems.

121. ***"Telehealth Between Providers"*** means communication between two providers for purposes of consultation, performed via interactive audio and video telecommunications systems.

122. ***"Temporary Suspension"*** means the provider is temporarily suspended from participating in the DMC program as authorized by WIC 14043.36(a). The provider cannot bill for DMC services from the effective date of the temporary suspension.

123. ***"Threshold Language"*** means a language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

124. ***"Transportation Services"*** means provision of or arrangement for transportation to and from medically necessary treatment.

125. ***"Unit of Service"*** means:

    (A) For case management, intensive outpatient treatment, outpatient services, Naltrexone treatment services, and recovery services contact with a beneficiary in 15-minute increments on a calendar day.

    (B) For additional medication assisted treatment, physician services that includes ordering, prescribing, administering, and monitoring of all medications for substance use disorders per visit or in 15-minute increments.

    (C) For narcotic treatment program services, a calendar month of treatment services provided pursuant to this section and Chapter 4 commencing with 9 CCR § 10000.

    (D) For physician consultation services, consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists in 15-minute increments.

(E) For residential services, providing 24-hour daily service, per beneficiary, per bed rate.

(F) For withdrawal management per beneficiary per visit/daily unit of service.

126. ***"Urgent care"*** means a condition perceived by a beneficiary as serious, but not life threatening. A condition that disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 24-72 hours.

127. ***"Utilization"*** means the total actual units of service used by beneficiaries and participants.

128. ***"Withdrawal Management"*** means detoxification services provided in either an ambulatory or non-ambulatory setting consistent with the ASAM level of care criteria to DMC ODS beneficiaries.

V. Contractor Specific Requirements

Beginning July 1, 2021 and ending June 30, 2024, in addition to the general requirements outlined in Exhibit A, Attachment I, the Contractor agrees to the following Contractor specific requirements:

A. Covered Services

In addition to the Mandatory DMC-ODS Covered Services outlined in Article III.C of Exhibit A, Attachment I, the Contractor shall establish assessment and referral procedures and shall arrange, provide, or subcontract for medically necessary Contractor Specific Covered Services in the Contractor's service area in compliance with 42 CFR 438.210(a)(1), 438.210(a)(2), and 438.210(a)(3).

1. The Contractor shall deliver the Contractor Specific Covered Services within a continuum of care as defined in the ASAM criteria.

B. Access to Services

In addition to the general access to services requirements outlined in Article III.F of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific access to services requirements:

1. Beneficiary Access Line (BAL)
   i. The Contractor shall provide a toll-free 24/7 BAL to beneficiaries seeking access to Substance Use Disorder (SUD) services.
   ii. The Contractor's BAL shall provide oral and audio-logical (TTY/TDY) translations in the beneficiary's primary language.

iii. The Contractor shall publish the BAL information on the Contractor's web page, on all information brochures, and prevention materials in all threshold languages.
iv. The BAL shall provide 24/7 referrals to services for urgent conditions and medical emergencies.

2. The Contractor shall allow the beneficiary point of entry through the BAL. Alternatively, the Contractor shall allow beneficiaries to appear in person at designated Contractor-operated sites or subcontracted DMC-ODS service provider.
   i. BAL Point of Entry
      a. The Contractor shall screen beneficiaries over the phone to determine whether there is sufficient information to make a referral to the appropriate ASAM Level of Care (LOC).
   i. In the event the referral cannot be determined through the BAL, the Contractor's BAL shall refer and coordinate the beneficiary to a contractor-operated SUD site or subcontracted DMC-ODS service provider for a face-to-face ASAM screening to determine the beneficiary's appropriate LOC.
      b. The Contractor shall ensure that beneficiaries determined to be in crisis shall be immediately linked to appropriate support and case management.
      c. Beneficiaries screened as having an urgent need will be referred for an appointment with qualified staff within 72 hours.
      d. The Contractor shall provide eligible, non-urgent beneficiaries a face-to-face appointment with the appropriate LOC provider within ten business days from the initial referral.
      e. The BAL shall be staffed by certified/registered alcohol and drug counselors or Licensed Practitioner of the Healing Arts (LPHAs).
   ii. Contractor-Operated & Subcontracted DMC-ODS Provider Point of Entry
      a. The Contractor shall ensure beneficiaries:
         i. May appear in person at designated contractor-operated or subcontracted DMC-ODS provider sites to receive screening, assessment, and referral.
         ii. May be referred by:
            1. The BAL
            2. County behavioral health site(s)
            3. DMC-ODS subcontracted providers

4. Community Partners

b. The contractor-operated and subcontracted DMC-ODS provider site(s) shall be staffed by certified/registered alcohol and drug counselors or LPHAs.
c. The Contractor shall ensure ASAM screenings obtain relevant information to identify initial treatment needs to link beneficiaries to the most appropriate LOC.
    i. The beneficiary may choose to receive DMC-ODS services at the designated contacted DMC-ODS provider or choose to be referred to another appropriate DMC-ODS provider offering the initial LOC determined by the ASAM screening.
    ii. In all cases, DMC-ODS provider staff shall consider geographic location, language needs and individual preference when making placement and referrals within the parameters of the ASAM screening results.
d. The Contractor shall ensure trained clinical staff administer a preliminary ASAM screening. The ASAM screening will assist with the determination of where the beneficiary should be directed for a comprehensive ASAM assessment.
    i. Upon first contact, contractor-operated and subcontracted DMC-ODS providers shall inform beneficiaries of the benefits to which they are entitled.
    ii. If the beneficiary appears in person, the contractor-operated or subcontracted DMC-ODS providers shall allow beneficiaries to receive same-day screenings, ASAM assessments, and referral, if available.
        1. In the event the beneficiary's ASAM screening determines the need for a LOC not offered by the DMC-ODS provider, the contractor-operated or subcontracted DMC-ODS provider shall provide:
            a. The beneficiary a warm hand-off to the appropriate DMC-ODS provider.
            b. The completed ASAM tool to the appropriate DMC-ODS provider.

e. ASAM Assessment and Medical Necessity
    i. Contractor shall ensure:
        1. Contractor-operated and subcontracted DMC-ODS provider ASAM assessments are conducted by an LPHA or by a certified/registered SUD counselor. If completed by a counselor, the assessment shall be reviewed and approved by the Medical Director or an LPHA.
        2. Contractor-operated and subcontracted DMC-ODS providers utilize the Addiction Severity Index (ASI) or other Contractor approved biopsychosocial assessment tool and the Contractor's standardized ASAM assessment/placement tool.
        3. The Medical Director or an LPHA evaluates each beneficiary's ASAM assessment and intake information if completed by a counselor through a face-to-face review or via telehealth with the counselor to establish a beneficiary meets medical necessity criteria.
    iii. The Medical Director, a licensed physician, or an LPHA must diagnose the beneficiary as having at least one DSM 5 Substance Use Disorder.
    iv. Medical necessity for DMC-ODS services shall be determined as part of the assessment process and shall be performed through a face-to-face interview or via telehealth.
    v. In the event the full ASAM assessment yields an ASAM LOC recommendation that does not agree with the preliminary ASAM screening result, the beneficiary shall be transitioned to the appropriate LOC.
    vi. If the entity screening or assessing the beneficiary determines that the medical necessity criteria, pursuant to DMC-ODS Special Terms and Conditions (STCs) 132 (e), has not been met, then a written Notice of Adverse Benefit Determination shall be issued in accordance with 42 CFR 438.404.

C. Timely Access

In addition to the general timely access requirements outlined in Article II.E of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific timely access requirements:

1. Time and Distance Requirements
    i. The Contractor shall adhere to, in all geographic areas within the county, all applicable time and distance standards for network providers developed by the Department, including those set forth in WIC Section 14197 and any Information Notices pursuant to that section.
2. Timely Access Requirements
    i. For outpatient and intensive outpatient services, the Contractor shall ensure a face-to-face appointment within ten business days of the service authorization request.
    ii. For OTP, the Contractor shall ensure a face-to-face appointment within three business days of the service authorization request.
    iii. The BAL and DMC-ODS providers shall have policies and procedures in place to screen for emergency medical conditions and immediately refer beneficiaries to emergency medical care.
3. Network Adequacy
    i. The Contractor shall comply with the Department's network adequacy standards outlined in Article II.C of this Exhibit A, Attachment I.
4. Non-Compliance
    i. In the event of non-compliance with network adequacy standards or timely access requirements, the Contractor shall provide the subcontractor or provider technical assistance to adhere to the requirements. Contractor shall also issue a written report documenting the non-compliance and require the provider or subcontractor to submit a Corrective Action Plan (CAP) within 30 days of the report. Contractor shall be responsible for approving the CAP and verifying corrections have been made to resolve network adequacy and timely access requirements.

D. Coordination of Care

In addition to the general coordination and continuity of care requirements outlined in Article III.G of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor coordination and continuity of care requirements:

1. Reassessments:
    i. The Contractor shall ensure:

a. All outpatient beneficiaries are reassessed, at a minimum every 90 days for adults, unless medical necessity warrants more frequent reassessments as documented in the individualized treatment plan.
b. All intensive outpatient treatment beneficiaries are reassessed, at a minimum every 60 days for adults, unless medical necessity warrants more frequent reassessments as documented in the individualized treatment plan.
c. Reassessment of all beneficiaries initially authorized for residential treatment at minimum every 30 days for adults and adolescents unless medical necessity warrants more frequent reassessments as documented in the individualized treatment plan.

2. Transitions to Other Levels of Care:
   i. The Contractor shall ensure all case managers transition the beneficiaries to appropriate LOC. This may include step-up or step-down in SUD treatment services. Case Managers shall provide warm hand-offs and transportation to the new LOC when medically necessary and documented in the individualized treatment plan.
   ii. The Contractor shall ensure all case managers transition beneficiaries to the appropriate LOC, within 10 business days from the time of assessment or reassessment, with no interruption of current treatment services.
   iii. The Contractor shall ensure a beneficiary's transition of care to a DMC-ODS provider when that beneficiary has received, and no longer requires, inpatient SUD services (ASAM level 3.7 and 4.0 services) in an acute care hospital, or another Fee for Service (FFS) facility, when the county-operated or subcontracted DMC-ODS provider is notified by the facility.
   iv. The Contractor shall ensure a beneficiary's transition of care to a DMC-ODS provider when that beneficiary has received, and no longer requires, inpatient SUD services (ASAM level 3.7 and 4.0 services) in a subcontracted Chemical Dependency Recovery Hospital (CDRH) or Acute Freestanding Psychiatric hospital, when the county-operated or subcontracted DMC-ODS provider is notified by the facility.

E. Memorandum of Understanding

In addition to the general memorandum of understanding requirements outlined in Article III.G.3 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor Memorandum of Understanding (MOU) requirements:

1. The Contractor shall enter into MOUs with managed care plans. The MOU shall outline the mechanism for sharing information and coordination of service delivery pursuant to STC 155 (b) and (c).

F. Authorization of Services – Residential Programs

In addition to the general authorization of residential services requirements outlined in Article III.H of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific authorization of residential services requirements:

1. Authorization Requests
   i. The Contractor shall process prior authorization determinations for residential treatment within 24 hours of the prior authorization request being submitted by the provider.
   ii. The Contractor shall ensure the beneficiaries meet the DSM and ASAM criteria requirements to receive residential services.
   iii. Medical necessity for beneficiaries presenting for residential treatment shall be determined by either a Medical Director or an LPHA.
   iv. The Contractor shall ensure beneficiaries are continually assessed throughout treatment and prior to the end of the initial authorization period.
      a. Lengths of stay shall vary according to the assessed medical need for each beneficiary.
      b. The provider shall submit a request for continued residential services to the Contractor.
   v. The Contractor shall give written notice to the beneficiary of any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, determined by medical necessity.

G. Outpatient Services (ASAM Level 1)

In addition to the general outpatient services requirements outlined in Article III. O of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific outpatient services requirements:

1. The Contractor shall ensure outpatient services (ASAM Level 1) are provided to beneficiaries (up to nine hours a week for adults, and less than six hours a week for adolescents) when determined by a Medical Director or an LPHA to be medically necessary, and in accordance with an individualized treatment plan.
2. The Contractor may provide outpatient services in-person or by telephone by a licensed professional or a registered or certified counselor in any appropriate setting in the community, in accordance with HIPAA and 42 CFR Part 2.

3. The components of outpatient services include intake, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, treatment planning and discharge services.
4. The Contractor shall ensure case management services are provided to beneficiaries receiving outpatient services to coordinate care with ancillary service providers and facilitate transitions between LOC.

H. Intensive Outpatient Services (ASAM Level 2.1)

In addition to the general intensive outpatient services requirements outlined in Article III.P of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific intensive outpatient services requirements:

1. The Contractor shall ensure intensive outpatient services (ASAM Level 2.1) are provided to adult beneficiaries a minimum of nine hours with a maximum of 19 hours a week, when determined by a Medical Director or an LPHA to be medically necessary, and in accordance with an individualized treatment plan.
    i. The county-operated and subcontracted DMC-ODS providers may provide more than 19 hours per week to adults when determined by a Medical Director or an LPHA to be medical necessary, and in accordance with the individualized treatment plan.
    ii. The county-operated and subcontracted DMC-ODS providers may extend a beneficiary's length of treatment when determined by a Medical Director or an LPHA to be medically necessary, and in accordance with the individualized treatment plan.
2. The Contractor shall ensure intensive outpatient services (ASAM Level 2.1) are provided to adolescent beneficiaries a minimum of six hours with a maximum of 19 hours a week, when determined by a Medical Director or an LPHA to be medically necessary, and in accordance with an individualized treatment plan.
    i. The county-operated and subcontracted DMC-ODS providers may provide more than 19 hours per week to adolescents when determined by a Medical Director or an LPHA to be medical necessary, and in accordance with the individualized treatment plan.
    ii. The county-operated and subcontracted DMC-ODS providers may extend a beneficiary's length of treatment when determined by a Medical Director or an LPHA to be medically necessary, and in accordance with the individualized treatment plan.

3. The Contractor's county-operated and subcontracted DMC-ODS providers may provide intensive outpatient services in-person or by telephone by a licensed professional or a certified counselor in any appropriate setting in the community in accordance with HIPAA and 42 CFR Part 2.
4. Intensive outpatient services include counseling and education about addiction-related problems, with specific components including intake, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, treatment planning and discharge services.
5. The Contractor shall ensure case management services are provided to beneficiaries receiving intensive outpatient services to coordinate care with ancillary service providers and facilitate transitions between LOC.

I. Residential Treatment Services

In addition to the general residential treatment services requirements outlined in Article III.Q of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific residential treatment services requirements:

1. The Contractor shall ensure DMC-ODS subcontractors provide residential services to non-perinatal and perinatal beneficiaries in DHCS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.
2. The length of residential services ranges from one to 90 days with a 90-day maximum for adults, unless medical necessity authorizes a one-time extension of up to 30 days on an annual basis.
3. Adolescents, under the age of 21, shall receive continuous residential services for a maximum of 30 days. Adolescent beneficiaries may receive a 30-day extension if that extension is determined to be medically necessary. Adolescent beneficiaries are limited to one extension per year.
    i. Nothing in the DMC-ODS overrides any EPSDT requirements. Adolescent beneficiaries may receive a longer length of stay based on medical necessity.
4. For adult beneficiaries, only two non-continuous 90-day regimens shall be authorized in a one-year period.
5. Medical necessity for beneficiaries presenting for residential treatment shall be determined by either a Medical Director or an LPHA.

6. The components of Residential Treatment Services include intake, individual and group counseling, family therapy, patient education, safeguarding medications, collateral services, crisis intervention services, treatment planning, transportation services and discharge services
7. Pursuant to STC 138 (c), perinatal clients shall receive lengths of stay up to the length of the pregnancy and postpartum period (60 days after the pregnancy ends).
8. The Contractor shall make ASAM LOC Designations for 3.1 (Clinically Managed Low-Intensity Residential Services) and 3.5 (Clinically Managed High-Intensity Residential Services) available for adult and adolescent (18 and over) beneficiaries.
9. The Contractor shall make available to adolescent beneficiaries (ages 17 and under) ASAM 3.5 (Clinically Managed Population-Specific High-Intensity Residential Services).
    i. The Contractor shall subcontract for ASAM LOC 3.5 for adolescent beneficiaries (ages 17 and under) with a network provider.
10. In accordance with Article III, Section H(1)(vi) of this Agreement and STC 138(f), the Contractor shall make ASAM levels 3.1, 3.3, and 3.5 of Residential Treatment Services available within its provider network by June 1, 2022. If the Contractor fails to make all three ASAM levels of Residential Treatment Services available within its provider network by June 1, 2022, then the Contractor shall submit a CAP to DHCS in accordance with Article III, Section EE(2) of this Agreement. The CAP shall detail how and when the Contractor will make all three ASAM levels of Residential Treatment Services available within its provider network. In accordance with Article III, Section EE(2) and Article III, Section Y(3) of this Agreement, DHCS may remove the Contractor from participating in the Waiver if the CAP is not promptly implemented.
11. For residential ASAM LOC 3.7 (Medically Monitored Intensive Inpatient Services) and ASAM LOC 4.0 (Medically Managed Intensive Inpatient Services), the Contractor shall coordinate care for Residential Level 3.7 and Level 4.0, with managed care plans, who are responsible for managing and authorizing the inpatient benefit. In all instances, the Contractor shall ensure 42 CFR Part 2 compliant releases are in place to coordinate care with inpatient and out-of-county facilities accepting DMC beneficiaries that are El Dorado County residents.

J. Case Management

In addition to the general case management requirements outlined in Article III.R of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific case management requirements:

1. The Contractor shall ensure case management services are provided to all eligible beneficiaries, based on the frequency documented in the individualized treatment plan.
2. As documented on the treatment plan, case management provides advocacy and care coordination to physical health, mental health, transportation, housing, vocational, educational, and transition services for reintegration into the community.
3. The Contractor shall be responsible for the oversight and monitoring of case management services.
4. Case management activities and services shall be provided by a registered or certified counselor or LPHA.
5. Case management shall be consistent with and shall not violate confidentiality of alcohol and drug patients as set forth in 42 CFR Part 2, and California law.

K. Physician Consultation

In addition to the general physician consultation requirements outlined in Article III.S of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific physician consultation requirements:

1. Physician Consultation shall include DMC-ODS physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists for complex cases which may address medication selection, dosing, side effect management, adherence, drug-to-drug interactions or LOC considerations.
    i. Physician consultation services shall only be billed by and reimbursed to DMC-ODS providers.

L. Recovery Services

In addition to the general recovery services requirements outlined in Article III.T of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific recovery services requirements:

1. The Contractor shall offer DMC-ODS beneficiaries SUD recovery services, when a Medical Director or an LPHA has determined that recovery services are medically necessary and after the DMC-ODS beneficiary has been discharged from SUD treatment services.
    i. Recovery services shall be made available to DMC-ODS beneficiaries in accordance with their individualized treatment plan.
    ii. The Contractor shall not provide a DMC-ODS beneficiary with recovery services while the DMC-ODS beneficiary is receiving SUD treatment services.

2. The components of recovery services include:
    i. Outpatient individual or group counseling (relapse prevention).
    ii. Recovery monitoring/coaching (via telephone or the internet)
    iii. Peer-to-peer assistance.
    iv. Care coordination to services to education services, life skills, employment services, and job training.
    v. Care coordination to child care, child development and support services, and marriage/family counseling.
    vi. Care coordination to housing assistance, transportation, case management, and individual service coordination.

M. Withdrawal Management

In addition to the general withdrawal management requirements outlined in Article III.U of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific withdrawal management requirements:

1. The Contractor shall provide Withdrawal Management (ASAM Level 3.2 -WM) to beneficiaries.
2. Withdrawal Management services shall be determined by the Medical Director, LPHAs, by contracted and licensed physicians, or by nurse practitioners, as medically necessary, and in accordance with an individualized beneficiary's treatment plan.
3. The components of Withdrawal Management services include intake, observation, medication services, care coordination and discharge services.
4. For beneficiaries in Withdrawal Management, the Contractor shall ensure case management services are provided to coordinate care with ancillary service providers and facilitate transitions between LOCs.

N. Opioid (Narcotic) Treatment Program Services

In addition to the general opioid (narcotic) treatment program services requirements outlined in Article III.V of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific opioid (narcotic) treatment program services requirements.

1. The Contractor shall ensure DMC-ODS subcontractors provide Opioid (Narcotic) Treatment Program (ASAM OTP Level 1) services in Narcotic Treatment Provider licensed facilities. Medically necessary services shall be provided in accordance with an individualized treatment plan determined by a licensed physician and approved and authorized according to the State of California requirements.
2. The components of OTPs include intake, individual and group counseling, patient education, transportation services, medication services, collateral services, crisis intervention services, treatment planning, medical psychotherapy and discharge services.

3. The Contractor shall ensure the beneficiary, at minimum 50 minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity.
4. The Contractor shall ensure the beneficiaries are scheduled for their first face-to-face service and intake assessment on the same day they are admitted.
5. The Contractor shall ensure case management services are available to coordinate care with treatment and ancillary service providers and facilitate transitions between levels of care. Beneficiaries may be simultaneously participating in OTP services and other ASAM LOCs.

Part I - General Fiscal Provisions

Section 1 - General Fiscal Provisions

A. Fiscal Provisions

For services satisfactorily rendered, and upon receipt and approval of documentation as identified in Exhibit A, Attachment I, Article III, the Department of Health Care Services (DHCS) agrees to compensate the Contractor for actual expenditures incurred in accordance with the rates and/or allowable costs specified herein.

B. Use of State General Funds

Contractor may not use allocated Drug Medi-Cal (DMC) State General Funds to pay for any non-Drug Medi-Cal services.

C. Funding Authorization

Contractor shall bear the financial risk in providing any substance use disorder (SUD) services covered by this Agreement.

D. Availability of Funds

It is understood that, for the mutual benefit of both parties, this Intergovernmental Agreement may have been written before ascertaining the availability of congressional appropriation of funds in order to avoid program and fiscal delays that would occur if this Agreement were not executed until after that determination. In this event, DHCS may amend the amount of funding provided for in this Agreement based on the actual congressional appropriation.

E. Subcontractor Funding Limitations

Contractor shall reimburse its subcontractors that receive a combination of Drug Medi-Cal Organized Delivery System (DMC-ODS) funding and other federal or county realignment funding for the same service element and location based on the subcontractor's actual costs in accordance with Medicaid reimbursement requirements as specified in Title XIX or of the Social Security Act, DMC-ODS Special Terms and Conditions (STCs), and STCs' Attachments. Payments at interim rates shall be settled to lower of actual cost or customary charge at year-end.

F. Budget Contingency Clause

It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this Agreement does not appropriate sufficient funds for the program, this Agreement shall be of no further force and effect. In this event, DHCS

shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Agreement and Contractor shall not be obligated to perform any provisions of this Agreement.

If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, DHCS shall solely have the option to either cancel this Agreement with no liability occurring to DHCS, or offer an amended agreement to Contractor to reflect the reduced amount.

G. Expense Allowability/Fiscal Documentation

1. Invoices, received from a Contractor and accepted and/or submitted for payment by DHCS, shall not be deemed evidence of allowable agreement costs.

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

3. If the allowability or appropriateness of an expense cannot be determined by DHCS because invoice detail, fiscal records, or backup documentation is nonexistent or inadequate according to generally accepted accounting principles, and generally accepted governmental audit standards, all questionable costs may be disallowed and payment may be withheld by DHCS. Upon receipt of adequate documentation supporting a disallowed or questionable expense, reimbursement may resume for the amount substantiated and deemed allowable.

4. Costs and/or expenses deemed unallowable shall not be reimbursed or, if mistakenly reimbursed, those costs and/or expenses shall be subject to recovery by DHCS pursuant to Article III.DD of Exhibit A, Attachment I, the DMC-ODS STCs, and the STCs' Attachments.

Section 2 - General Fiscal Provisions - DMC-ODS

A. Return of Unexpended Funds

Contractor assumes the total cost of providing covered services on the basis of the payments delineated in this Exhibit B, Part II. Any State General Funds or Federal Medicaid funds paid to the Contractor, but not expended for DMC-ODS services shall be returned to DHCS.

B. Amendment or Cancellation Due to Insufficient Appropriation

This Agreement is valid and enforceable only if sufficient funds are made available to DHCS by the United States Government for the purpose of the DMC-ODS program. It is mutually agreed that if the Congress does not appropriate sufficient funds for this

program, DHCS solely has the option to void this Agreement or to amend the Agreement to reflect any reduction of funds.

C. Exemptions

Exemptions to the provisions of Item B above, of this Exhibit, may be granted by the California Department of Finance provided that the Director of DHCS certifies in writing that federal funds are available for the term of the Agreement.

D. Allowable costs

Allowable costs, as defined and in accordance with the DMC-ODS STCs and the STCs' Attachments, shall be determined in accordance with Title 42, Code of Federal Regulations (CFR), Chapter IV, Subchapter B, Parts 405 and 413, and Centers for Medicare and Medicaid Services (CMS), "Medicare Provider Reimbursement Manual (Publication Number 15)," which can be obtained from the Centers for Medicare & Medicaid Services, or www.cms.hhs.gov.

Part II - Reimbursements

Section 1 - General Reimbursement

A. Prompt Payment Clause

Payment will be made in accordance with, and within the time specified in, Government Code Chapter 4.5, commencing with Section 927.

B. Amounts Payable

1. The amount payable under this Agreement shall not exceed the amount identified on the State of California Standard Agreement form STD 213_DHCS.

2. Reimbursement shall be made for allowable expenses up to the amount annually encumbered commensurate with the state fiscal year in which services are performed and/or goods are received.

3. The funds identified for the fiscal years covered by under this Section, within this Exhibit, are subject to change depending on the availability and amount of funds appropriated by the Legislature and the Federal Government. The amount of funds available for expenditure by the Contractor shall be limited to the amount identified in the final allocations issued by DHCS for that fiscal year. Changes to allocated funds will require written amendment to the Agreement.

4. For each fiscal year, DHCS may settle costs for services to the Contractor and its subcontractors based on each fiscal year-end cost settlement report as the final amendment for the specific fiscal year cost settlement report to the approved Agreement.

Section 2 - DMC-ODS

A. To the extent that the Contractor provides the covered services in a satisfactory manner, in accordance with the terms and conditions of this Agreement, DHCS agrees to pay the Contractor Federal Medicaid funds according to Article III of Exhibit A, Attachment I. Subject to the availability of such funds, Contractor shall receive Federal Medicaid funds and/or State General Funds for allowable expenditures as established by the Federal Government and approved by DHCS, for the cost of services rendered to beneficiaries.

B. Any payment for covered services rendered pursuant to Exhibit A, Attachment I shall only be made pursuant to applicable provisions of Title XIX or Title XXI of the Social Security Act, the Welfare and Institutions (W&I) Code, the Health and Safety Code (HSC), the DMC-ODS STCs, and the STCs' Attachments.

C. It is understood and agreed that failure by the Contractor or its subcontractors to comply with applicable federal and state requirements in rendering covered services shall be sufficient cause for DHCS to deny payments, to recover payments, and/or terminate the Contractor or its subcontractor from DMC-ODS program participation. If DHCS or the Department of Health and Human Services (DHHS) disallows or denies payments for any claim, Contractor shall repay to DHCS 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 Division 9, Part 3, Chapter 7, Article 5.3 of the W&I Code and DMC-ODS STC 143(h)(vi).

D. Before a denial, recoupment, or disallowances are made, DHCS 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 60 days to submit additional information before the proposed action is taken. This requirement does not apply to the DMC-ODS Post Service Post Payment Utilization Reviews.

E. DHCS shall refund to the Contractor any recovered Federal DMC-ODS overpayment that is subsequently determined to have been erroneously collected, together with interest, in accordance with Division 9, Part 3, Chapter 7, Article 5.3 of the W&I Code.

F. Contractor shall be reimbursed by DHCS on the basis of its actual net reimbursable cost, not to exceed the unit of service maximum rate.

G. Claims submitted to the Contractor by a subcontractor that is not certified or whose certification has been suspended pursuant to the W&I Code section 14107.11 and 42 CFR 455.23, shall not be certified or processed for federal or state reimbursement by the Contractor. Payments for any DMC-ODS services shall be held by the Contractor until the payment suspension is resolved.

H. In the event an Agreement amendment is required pursuant to the preceding paragraph, Contractor shall submit to DHCS information as identified in Exhibit E, Section 1(D). To the extent the Contractor is notified of DHCS Budget Act allocation prior to the execution of the Agreement, DHCS and the Contractor may agree to amend the agreement after the issuance of the first revised allocation.

I. Reimbursement for covered services, other than Narcotic Treatment Program (NTP) services, shall be based on the interim rate set forth in Behavioral Health Information Notice (BHIN) 20-054.

J. Reimbursement to NTP shall be limited to the lower of either the Uniform Statewide Daily Reimbursement (USDR) rate, pursuant to W&I Code Section 14021.51(h), or the provider's usual and customary charge to the general public for the same or similar service. However, reimbursement paid by a county to an NTP provider for services provided to any person subject to Penal Code Sections 1210.1 or 3063.1 and for which the individual client is not liable to pay, does not constitute a usual or customary charge

to the general public for the purpose of this section (W&I Code Section 14021.51(h)(2)(A)).

K. DHCS shall reimburse the Contractor the State General Funds and/or Federal Medicaid fund amount of the approved DMC-ODS claims and documents submitted in accordance with Article III of Exhibit A, Attachment I.

L. DHCS will adjust subsequent reimbursements to the Contractor to actual allowable costs. Actual allowable costs are defined in the Medicare Provider Reimbursement Manual (CMS-Pub.15), which can be obtained from the Centers for Medicare & Medicaid Services, Baltimore, Maryland, or www.cms.hhs.gov.

M. Contractors and subcontractors must accept, as payment in full, the amounts paid by DHCS in accordance with the DMC-ODS STCs and the STCs' Attachments. Contractors and subcontractors may not demand any additional payment from DHCS, client, or other third party payers.

N. Contractor shall require all subcontractors to comply with 45 CFR 162.410(a)(1) for any subpart that would be a covered health care provider if it were a separate legal entity. For purposes of this paragraph, a covered health care provider shall have the same definition as set forth in 45 CFR 160.103. DHCS shall make payments for covered services only if Contractor is in compliance with federal regulations.

Part III - Financial Audit Requirements

Section 1 - General Fiscal Audit Requirements

A. In addition to the requirements identified below, the Contractor and its subcontractors are required to meet the audit requirements as delineated in Exhibit C, General Terms and Conditions, and Exhibit D(F), Special Terms and Conditions, of this Agreement.

B. All expenditures of county realignment funds, state and federal funds furnished to the Contractor and its subcontractors pursuant to this Agreement are subject to audit by DHCS. Objectives of such audits may include, but not limited to, the following:

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

2. To validate data reported by the Contractor for prospective agreement negotiations.

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

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

5. To determine that expenditures are made in accordance with applicable state and federal laws, regulations, and Agreement requirements.

6. To determine the facts in relation to analysis of data, complaints, or allegations, which may be indicative of fraud, abuse, willful misrepresentation, or failure to achieve the Agreement objectives of Exhibit C and D(F).

C. Unannounced visits may be made at the discretion of the DHCS to the Contractor and/or its subcontractors.

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

E. Reports of audits conducted by DHCS shall reflect all findings, recommendations, adjustments, and corrective action as a result of its finding in any areas.

Section 2 - DMC-ODS Financial Audits

A. In addition to the audit requirements set forth in Exhibit D(F), DHCS may also conduct financial audits of DMC-ODS programs to accomplish any of, but not limited to, the following audit objectives:

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

2. To ensure that only the cost of allowable DMC-ODS activities are included in reported costs.

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

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

5. To determine the amount of clients' third-party revenue and Medi-Cal share of cost to offset allowable DMC-ODS reimbursement.

6. To compute final settlement based on the lower of actual allowable cost or the usual and customary charge, in accordance with the DMC-ODS STCs and the STCs' Attachments.

B. In addition to the audit requirements set forth in Exhibit D(F), DHCS may conduct financial audits of NTP programs. For NTP services, the audits will address items A(3) through A(5) above, except that the comparison of the provider's usual and customary charge in A(3) will be to the DMC USDR rate in lieu of DMC-ODS cost per unit. In addition, these audits will include, but not be limited to:

1. NTP providers are required to submit a cost report pursuant to W&I Code Section 14124.24, and a review of cost allocation methodology between NTP and other service modalities, and between DMC-ODS and other funding sources may be conducted by DHCS.

2. A review of actual costs incurred for comparison to services claimed.

3. A review of counseling claims to ensure that the appropriate group or individual counseling rate has been used and that counseling sessions have been billed appropriately.

4. A review of the number of clients in group sessions to ensure that sessions include no less than two and no more than twelve clients at the same time, with at least one Medi-Cal client in attendance.

5. Computation of final settlement based on the lower of USDR or the provider's usual and customary charge to the general public.

6. A review of supporting service, time, financial, and patient records to verify the validity of counseling claims.

C. Contractor shall be responsible for any disallowances taken by the Federal Government, DHCS, 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 DHCS to repay one federal funding source with funds provided by another federal funding source, or to repay federal funds with state funds, or to repay state funds with federal funds.

D. Contractor agrees to promptly develop and implement any corrective action plans in a manner acceptable to DHCS 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 DHCS within six months from the date of the plan.

E. Contractor, in coordination with DHCS, shall provide follow-up on all significant findings in the audit report, including findings relating to a subcontractor, and submit the results to DHCS.

   If differences cannot be resolved between DHCS and the Contractor regarding the terms of the final financial audit settlements for funds expended under Exhibit B, Contractor may request an appeal in accordance with the appeal process described in the Exhibit A, Attachment I and Division 9, Part 3, Chapter 7, Article 5.3 of the W&I Code. Contractor shall include a provision in its subcontracts regarding the process by which a subcontractor may file an audit appeal via the Contractor.

F. Providers of DMC-ODS services shall, upon request, make available to DHCS their fiscal and other records to assure that such providers have adequate recordkeeping capability and to assure that reimbursement for covered DMC-ODS services are made in accordance with Exhibit A, Attachment I, the DMC-ODS STCs, and the STCs' Attachments. These records include, but are not limited to, matters pertaining to:

   1. Provider ownership, organization, and operation

   2. Fiscal, medical, and other recordkeeping systems

   3. Federal income tax status

4. Asset acquisition, lease, sale, or other action
5. Franchise or management arrangements
6. Patient service charge schedules
7. Costs of operation
8. Cost allocation methodology
9. Amounts of income received by source and purpose
10. Flow of funds and working capital

G. Contractor shall retain records of utilization review activities, required in Exhibit A, Attachment I, Article III.EE herein, for a minimum of ten (10) years.

Part IV - Records

Section 1 - General Provisions

A. Maintenance of Records

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

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

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

3. Accounting records and supporting documents shall be retained for ten years. When an audit by the Federal Government, DHCS, or the California State Auditor has been started, 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.

4. Financial records shall be kept so that they clearly reflect the source of funding for each type of service for which reimbursement is claimed. These documents include, but are not limited to, all ledgers, books, vouchers, time sheets, payrolls, appointment schedules, client data cards, and schedules for allocating costs. All records must be capable of verification by qualified auditors.

5. Contractor's subcontracts shall require that all subcontractors comply with the requirements of Exhibit A, Attachment I, Article II and Article III.

6. Should a subcontractor discontinue its contractual agreement with the Contractor, or cease to conduct business in its entirety, Contractor shall be responsible for retaining the subcontractor's fiscal and program records for the required retention period. DHCS Administrative Manual (SAM) contains statutory requirements governing the retention, storage, and disposal of records pertaining to state funds. Contractor shall follow SAM requirements located at http://sam.dgs.ca.gov/TOC/1600.aspx.

The Contractor shall retain all records required by W&I Code section 14124.1, 42 CFR 433.32, Exhibit A, Attachment I, the DMC-ODS STCs and STCs' Attachments for reimbursement of services and financial audit purposes.

7. In the expenditure of funds hereunder, Contractor shall comply with the requirements of SAM and the laws and procedures applicable to the obligation and expenditure of federal and state funds.

B. Dispute Resolution Process

1. In the event of a dispute under Exhibit A, Attachment I, Article III other than an audit dispute, Contractor shall provide written notice of the particulars of the dispute to DHCS before exercising any other available remedy. Written notice shall include the Agreement number. The Director (or designee) of DHCS and the County Drug or Alcohol Program Administrator (or designee) shall meet to discuss the means by which they can effect an equitable resolution to the dispute. Contractor shall receive a written response from DHCS within 60 days of the notice of dispute. The written response shall reflect the issues discussed at the meeting and state how the dispute will be resolved.

2. As stated in Part III, Section 2, of this Exhibit, in the event of a dispute over financial audit findings between DHCS and the Contractor, Contractor may appeal the audit in accordance with Exhibit A, Attachment I and Division 9, Part 3, Chapter 7, Article 5.3 of the W&I Code. Contractor shall include a provision in its subcontracts regarding the process by which a subcontractor may file an audit appeal via the Contractor.

3. Contractors that conduct financial audits of subcontractors, other than a subcontractor whose funding consists entirely of non-Department funds, shall develop a process to resolve disputed financial findings and notify subcontractors of their appeal rights pursuant to that process. This section shall not apply to those grievances or compliances arising from the financial findings of an audit or examination made by or on behalf of DHCS pursuant to Part III of this Exhibit.

4. To ensure that necessary corrective actions are taken, financial audit findings are either uncontested or upheld after appeal may be used by DHCS during prospective agreement negotiations.

Part V - DMC-ODS Reimbursement Rates

A. **"Uniform Statewide Daily Reimbursement Rate (USDR)"** means the rate for NTP services based on a unit of service that is a daily treatment service, developed in accordance with Section 14021.6 of the W&I Code Section, Section 11758.42 of the HSC and Title 9, CCR, commencing with Section 10000 (Document 3G). The USDRs are contained in BHIN 20-054, and any subsequently issued INs that supersede BHIN 20-054, and are incorporated as a part of this Intergovernmental Agreement by reference.

B. The **"Units of Service"**, as defined in Exhibit A, Attachment I, Section IV, Definition 125 of this Intergovernmental Agreement, for the services covered by this Intergovernmental Agreement are published at https://www.dhcs.ca.gov/provgovpart/Pages/DMC-ODS-County-Interim-Rates.aspx, and are incorporated as a part of this Intergovernmental Agreement by reference.

Exhibit B, Attachment I
Funding Amounts

Fiscal Year 2021-22	Funding Amount
	Original
State General Funds (7/1/21 to 6/30/22)	
Non Perinatal ODS Waiver SGF** (08)	646,000
Perinatal ODS Waiver SGF** (09)	50,000
Administration Costs & QA/UR SGF** (603)	104,000
TOTAL	**800,000**
Drug Medi-Cal Federal Share (7/1/21 to 6/30/22)	
Non Perinatal Federal Share (01)	8,388,238
Perinatal Federal Share (03)	2,097,059
Administration Costs & QA/UR (603)	1,572,795
TOTAL	**12,058,092**
GRAND TOTAL	**12,858,092**

Fiscal Year 2022-23	Funding Amount
	Original
State General Funds (7/1/22 to 6/30/23)	
Non Perinatal ODS Waiver SGF** (08)	646,000
Perinatal ODS Waiver SGF** (09)	50,000
Administration Costs & QA/UR SGF** (603)	104,000
TOTAL	**800,000**
Drug Medi-Cal Federal Share (7/1/22 to 6/30/23)	
Non Perinatal Federal Share (01)	8,388,238
Perinatal Federal Share (03)	2,097,059
Administration Costs & QA/UR (603)	1,572,795
TOTAL	**12,058,092**
GRAND TOTAL	**12,858,092**

Fiscal Year 2023-24	Funding Amount
	Original
State General Funds (7/1/23 to 6/30/24)	
Non Perinatal ODS Waiver SGF** (08)	646,000
Perinatal ODS Waiver SGF** (09)	50,000
Administration Costs & QA/UR SGF** (603)	104,000
TOTAL	**800,000**
Drug Medi-Cal Federal Share (7/1/23 to 6/30/24)	
Non Perinatal Federal Share (01)	8,388,238
Perinatal Federal Share (03)	2,097,059
Administration Costs & QA/UR (603)	1,572,795
TOTAL	**12,058,092**
GRAND TOTAL	**12,858,092**

Original THREE-YEAR TOTAL	**38,574,276**

** State General Fund amounts are based on biannual DMC estimates approved by the Department of Finance. DHCS will revise the amounts through the contract amendment process for each new allocation.

Special Terms and Conditions

(For federally funded service contracts or agreements and grant agreements)

The use of headings or titles throughout this exhibit is for convenience only and shall not be used to interpret or to govern the meaning of any specific term or condition.

The terms "contract", "Contractor" and "Subcontractor" shall also mean, “agreement”, "grant", “grant agreement”, "Grantee" and "Subgrantee" respectively.

The terms “California Department of Health Care Services”, “California Department of Health Services”, ‘Department of Health Care Services”, “Department of Health Services”, “CDHCS”, “DHCS”, “CDHS”, and “DHS” shall all have the same meaning and refer to the California State agency that is a party to this Agreement.

This exhibit contains provisions that require strict adherence to various contracting laws and policies. Some provisions herein are conditional and only apply if specified conditions exist (i.e., agreement total exceeds a certain amount; agreement is federally funded, etc.). The provisions herein apply to this Agreement unless the provisions are removed by reference on the face of this Agreement, the provisions are superseded by an alternate provision appearing elsewhere in this Agreement, or the applicable conditions do not exist.

Index of Special Terms and Conditions

1. Federal Equal Opportunity Requirements

(Applicable to all federally funded agreements entered into by the Department of Health Care Services)

a. The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. The Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.

b. The Contractor will, in all solicitations or advancements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.

c. The Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Contractor's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

d. The Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.

e. The Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

f. In the event of the Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

g. The Contractor will include the provisions of Paragraphs a through g in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event the Contractor becomes involved in, or is threatened with litigation by a subcontractor or vendor as a result of such direction by DHCS, the Contractor may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

2. Travel and Per Diem Reimbursement

(Applicable if travel and/or per diem expenses are reimbursed with agreement funds.)

Reimbursement for travel and per diem expenses from DHCS under this Agreement shall, unless otherwise specified in this Agreement, be at the rates currently in effect, as established by the California Department of Human Resources (CalHR), for nonrepresented state employees as stipulated in DHCS' Travel Reimbursement Information Exhibit. If the CalHR rates change during the term of the Agreement, the new rates shall apply upon their effective date and no amendment to this Agreement shall be necessary. Exceptions to CalHR rates may be approved by DHCS upon the submission of a statement by the Contractor indicating that such rates are not available to the Contractor. No travel outside the State of California shall be reimbursed without prior authorization from DHCS. Verbal authorization should be confirmed in writing. Written authorization may be in a form including fax or email confirmation.

3. Procurement Rules

(Applicable to agreements in which equipment/property, commodities and/or supplies are furnished by DHCS or expenses for said items are reimbursed by DHCS with state or federal funds provided under the Agreement.)

a. **Equipment/Property definitions**

Wherever the term equipment and/or property is used, the following definitions shall apply:

(1) **Major equipment/property**: A tangible or intangible item having a base unit cost of **$5,000 or more** with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement. Software and videos are examples of intangible items that meet this definition.

(2) **Minor equipment/property**: A tangible item having a base unit cost of **less than $5,000** with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement.

b. **Government and public entities** (including state colleges/universities and auxiliary organizations), whether acting as a contractor and/or subcontractor, may secure all commodities, supplies, equipment and services related to such purchases that are required in performance of this Agreement. Said procurements are subject to Paragraphs d through h of Provision 3. Paragraph c of Provision 3 shall also apply, if equipment/property purchases are delegated to subcontractors that are nonprofit organizations or commercial businesses.

c. **Nonprofit organizations and commercial businesses**, whether acting as a contractor and/or subcontractor, may secure commodities, supplies, equipment/property and services related to such purchases for performance under this Agreement.

(1) Equipment/property purchases shall not exceed $50,000 annually.

To secure equipment/property above the annual maximum limit of $50,000, the Contractor shall make arrangements through the appropriate DHCS Program Contract Manager, to have all remaining equipment/property purchased through DHCS' Purchasing Unit. The cost of equipment/property purchased by or through DHCS shall be deducted from the funds available in this Agreement. Contractor shall submit to the DHCS Program Contract Manager a list of equipment/property specifications for those items that the State must procure. DHCS may pay the vendor directly for such arranged equipment/property purchases and title to the equipment/property will remain with DHCS. The equipment/property will be delivered to the Contractor's address, as stated on the face of the Agreement, unless the Contractor notifies the DHCS Program Contract Manager, in writing, of an alternate delivery address.

(2) All equipment/property purchases are subject to Paragraphs d through h of Provision 3. Paragraph b of Provision 3 shall also apply, if equipment/property purchases are delegated to subcontractors that are either a government or public entity.

(3) Nonprofit organizations and commercial businesses shall use a procurement system that meets the following standards:

(a) Maintain a code or standard of conduct that shall govern the performance of its officers, employees, or agents engaged in awarding procurement contracts. No employee, officer, or agent shall participate in the selection, award, or administration of a procurement, or bid contract in which, to his or her knowledge, he or she has a financial interest.

(b) Procurements shall be conducted in a manner that provides, to the maximum extent practical, open, and free competition.

(c) Procurements shall be conducted in a manner that provides for all of the following:

[1] Avoid purchasing unnecessary or duplicate items.

[2] Equipment/property solicitations shall be based upon a clear and accurate description of the technical requirements of the goods to be procured.

[3] Take positive steps to utilize small and veteran owned businesses.

d. Unless waived or otherwise stipulated in writing by DHCS, prior written authorization from the appropriate DHCS Program Contract Manager will be required before the Contractor will be reimbursed for any purchase of $5,000 or more for commodities, supplies, equipment/property, and services related to such purchases. The Contractor must provide in its request for authorization all particulars necessary, as specified by DHCS, for evaluating the necessity or desirability of incurring such costs. The term "purchase" excludes the purchase of services from a subcontractor and public utility services at rates established for uniform applicability to the general public.

e. In special circumstances, determined by DHCS (e.g., when DHCS has a need to monitor certain purchases, etc.), DHCS may require prior written authorization and/or the submission of paid vendor receipts for any purchase, regardless of dollar amount. DHCS reserves the right to either deny claims for reimbursement or to request repayment for any Contractor and/or subcontractor purchase that DHCS determines to be unnecessary in carrying out performance under this Agreement.

f. The Contractor and/or subcontractor must maintain a copy or narrative description of the procurement system, guidelines, rules, or regulations that will be used to make purchases under this Agreement. The State reserves the right to request a copy of these documents and to inspect the purchasing practices of the Contractor and/or subcontractor at any time.

g. For all purchases, the Contractor and/or subcontractor must maintain copies of all paid vendor invoices, documents, bids and other information used in vendor selection, for inspection or audit. Justifications supporting the absence of bidding (i.e., sole source purchases) shall also be maintained on file by the Contractor and/or subcontractor for inspection or audit.

h. DHCS may, with cause (e.g., with reasonable suspicion of unnecessary purchases or use of inappropriate purchase practices, etc.), withhold, cancel, modify, or retract the delegated purchase authority granted under Paragraphs b and/or c of Provision 3 by giving the Contractor no less than 30 calendar days written notice.

4. Equipment/Property Ownership / Inventory / Disposition

(Applicable to agreements in which equipment/property is furnished by DHCS and/or when said items are purchased or reimbursed by DHCS with state or federal funds provided under the Agreement.)

a. Wherever the term equipment and/or property is used in Provision 4, the definitions in Paragraph a of Provision 3 shall apply.

Unless otherwise stipulated in this Agreement, all equipment and/or property that is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement shall be considered state equipment and the property of DHCS.

(1) **Reporting of Equipment/Property Receipt -** DHCS requires the reporting, tagging and annual inventorying of all equipment and/or property that is furnished by DHCS or purchased/reimbursed with funds provided through this Agreement.

Upon receipt of equipment and/or property, the Contractor shall report the receipt to the DHCS Program Contract Manager. To report the receipt of said items and to receive property tags, Contractor shall use a form or format designated by DHCS' Asset Management Unit. If the appropriate form (i.e., Contractor Equipment Purchased with DHCS Funds) does not accompany this Agreement, Contractor shall request a copy from the DHCS Program Contract Manager.

(2) **Annual Equipment/Property Inventory -** If the Contractor enters into an agreement with a term of more than twelve months, the Contractor shall submit an annual inventory of state equipment and/or property to the DHCS Program Contract Manager using a form or format designated by DHCS' Asset Management Unit. If an inventory report form (i.e., Inventory/Disposition of DHCS-Funded Equipment) does not accompany this Agreement, Contractor shall request a copy from the DHCS Program Contract Manager. Contractor shall:

(a) Include in the inventory report, equipment and/or property in the Contractor's possession and/or in the possession of a subcontractor (including independent consultants).

(b) Submit the inventory report to DHCS according to the instructions appearing on the inventory form or issued by the DHCS Program Contract Manager.

(c) Contact the DHCS Program Contract Manager to learn how to remove, trade-in, sell, transfer or survey off, from the inventory report, expired equipment and/or property that is no longer wanted, usable or has passed its life expectancy. Instructions will be supplied by either the DHCS Program Contract Manager or DHCS' Asset Management Unit.

b. Title to state equipment and/or property shall not be affected by its incorporation or attachment to any property not owned by the State.

c. Unless otherwise stipulated, DHCS shall be under no obligation to pay the cost of restoration, or rehabilitation of the Contractor's and/or Subcontractor's facility which may be affected by the removal of any state equipment and/or property.

d. The Contractor and/or Subcontractor shall maintain and administer a sound business program for ensuring the proper use, maintenance, repair, protection, insurance and preservation of state equipment and/or property.

(1) In administering this provision, DHCS may require the Contractor and/or Subcontractor to repair or replace, to DHCS' satisfaction, any damaged, lost or stolen state equipment and/or property. In the event of state equipment and/or miscellaneous property theft, Contractor and/or Subcontractor shall immediately file a theft report with the appropriate police agency or

the California Highway Patrol and Contractor shall promptly submit one copy of the theft report to the DHCS Program Contract Manager.

e. Unless otherwise stipulated by the Program funding this Agreement, equipment and/or property purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, shall only be used for performance of this Agreement or another DHCS agreement.

f. Within sixty (60) calendar days prior to the termination or end of this Agreement, the Contractor shall provide a final inventory report of equipment and/or property to the DHCS Program Contract Manager and shall, at that time, query DHCS as to the requirements, including the manner and method, of returning state equipment and/or property to DHCS. Final disposition of equipment and/or property shall be at DHCS expense and according to DHCS instructions. Equipment and/or property disposition instructions shall be issued by DHCS immediately after receipt of the final inventory report. At the termination or conclusion of this Agreement, DHCS may at its discretion, authorize the continued use of state equipment and/or property for performance of work under a different DHCS agreement.

g. **Motor Vehicles**

(Applicable only if motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under this Agreement.)

(1) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, within thirty (30) calendar days prior to the termination or end of this Agreement, the Contractor and/or Subcontractor shall return such vehicles to DHCS and shall deliver all necessary documents of title or registration to enable the proper transfer of a marketable title to DHCS.

(2) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the State of California shall be the legal owner of said motor vehicles and the Contractor shall be the registered owner. The Contractor and/or a subcontractor may only use said vehicles for performance and under the terms of this Agreement.

(3) The Contractor and/or Subcontractor agree that all operators of motor vehicles, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, shall hold a valid State of California driver's license. In the event that ten or more passengers are to be transported in any one vehicle, the operator shall also hold a State of California Class B driver's license.

(4) If any motor vehicle is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the Contractor and/or Subcontractor, as applicable, shall provide, maintain, and certify that, at a minimum, the following type and amount of automobile liability insurance is in effect during the term of this Agreement or any extension period during which any vehicle remains in the Contractor's and/or Subcontractor's possession:

Automobile Liability Insurance

(a) The Contractor, by signing this Agreement, hereby certifies that it possesses or will obtain automobile liability insurance in the amount of $1,000,000 per occurrence for bodily injury and property damage combined. Said insurance must be obtained and made effective upon the delivery date of any motor vehicle, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, to the Contractor and/or Subcontractor.

(b) The Contractor and/or Subcontractor shall, as soon as practical, furnish a copy of the certificate of insurance to the DHCS Program Contract Manager. The certificate of insurance shall identify the DHCS contract or agreement number for which the insurance applies.

(c) The Contractor and/or Subcontractor agree that bodily injury and property damage liability insurance, as required herein, shall remain in effect at all times during the term of this

Agreement or until such time as the motor vehicle is returned to DHCS.

(d) The Contractor and/or Subcontractor agree to provide, at least thirty (30) days prior to the expiration date of said insurance coverage, a copy of a new certificate of insurance evidencing continued coverage, as indicated herein, for not less than the remainder of the term of this Agreement, the term of any extension or continuation thereof, or for a period of not less than one (1) year.

(e) The Contractor and/or Subcontractor, if not a self-insured government and/or public entity, must provide evidence, that any required certificates of insurance contain the following provisions:

[1] The insurer will not cancel the insured's coverage without giving thirty (30) calendar days prior written notice to the State (California Department of Health Care Services).

[2] The State of California, its officers, agents, employees, and servants are included as additional insureds, but only with respect to work performed for the State under this Agreement and any extension or continuation of this Agreement.

[3] The insurance carrier shall notify the California Department of Health Care Services (DHCS), in writing, of the Contractor's failure to pay premiums; its cancellation of such policies; or any other substantial change, including, but not limited to, the status, coverage, or scope of the required insurance. Such notices shall contain a reference to each agreement number for which the insurance was obtained.

(f) The Contractor and/or Subcontractor is hereby advised that copies of certificates of insurance may be subject to review and approval by the Department of General Services (DGS), Office of Risk and Insurance Management. The Contractor shall be notified by DHCS, in writing, if this provision is applicable to this Agreement. If DGS approval of the certificate of insurance is required, the Contractor agrees that no work or services shall be performed prior to obtaining said approval.

(g) In the event the Contractor and/or Subcontractor fails to keep insurance coverage, as required herein, in effect at all times during vehicle possession, DHCS may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.

5. Subcontract Requirements

(Applicable to agreements under which services are to be performed by subcontractors including independent consultants.)

a. Prior written authorization will be required before the Contractor enters into or is reimbursed for any subcontract for services costing $5,000 or more. Except as indicated in Paragraph a(3) herein, when securing subcontracts for services exceeding $5,000, the Contractor shall obtain at least three bids or justify a sole source award.

(1) The Contractor must provide in its request for authorization, all information necessary for evaluating the necessity or desirability of incurring such cost.

(2) DHCS may identify the information needed to fulfill this requirement.

(3) Subcontracts performed by the following entities or for the service types listed below are exempt from the bidding and sole source justification requirements:

(a) A local governmental entity or the federal government,

(b) A State college or State university from any State,

(c) A Joint Powers Authority,

(d) An auxiliary organization of a California State University or a California community college,

(e) A foundation organized to support the Board of Governors of the California Community Colleges,

(f) An auxiliary organization of the Student Aid Commission established under Education Code § 69522,

(g) Firms or individuals proposed for use and approved by DHCS' funding Program via acceptance of an application or proposal for funding or pre/post contract award negotiations,

(h) Entities and/or service types identified as exempt from advertising and competitive bidding in State Contracting Manual Chapter 5 Section 5.80 Subsection B.2. View this publication at the following Internet address: https://www.dgs.ca.gov/OLS/Resources/Page-Content/Office-of-Legal-Services-Resources-List-Folder/State-Contracting

b. DHCS reserves the right to approve or disapprove the selection of subcontractors and with advance written notice, require the substitution of subcontractors and require the Contractor to terminate subcontracts entered into in support of this Agreement.

(1) Upon receipt of a written notice from DHCS requiring the substitution and/or termination of a subcontract, the Contractor shall take steps to ensure the completion of any work in progress and select a replacement, if applicable, within 30 calendar days, unless a longer period is agreed to by DHCS.

c. Actual subcontracts (i.e., written agreement between the Contractor and a subcontractor) of $5,000 or more are subject to the prior review and written approval of DHCS. DHCS may, at its discretion, elect to waive this right. All such waivers shall be confirmed in writing by DHCS.

d. Contractor shall maintain a copy of each subcontract entered into in support of this Agreement and shall, upon request by DHCS, make copies available for approval, inspection, or audit.

e. DHCS assumes no responsibility for the payment of subcontractors used in the performance of this Agreement. Contractor accepts sole responsibility for the payment of subcontractors used in the performance of this Agreement.

f. The Contractor is responsible for all performance requirements under this Agreement even though performance may be carried out through a subcontract.

g. The Contractor shall ensure that all subcontracts for services include provision(s) requiring compliance with applicable terms and conditions specified in this Agreement.

h. The Contractor agrees to include the following clause, relevant to record retention, in all subcontracts for services:

"(*Subcontractor Name*) agrees to maintain and preserve, until three years after termination of (*Agreement Number*) and final payment from DHCS to the Contractor, to permit DHCS or any duly authorized representative, to have access to, examine or audit any pertinent books, documents, papers and records related to this subcontract and to allow interviews of any employees who might reasonably have information related to such records."

i. Unless otherwise stipulated in writing by DHCS, the Contractor shall be the subcontractor's sole point of contact for all matters related to performance and payment under this Agreement.

j. Contractor shall, as applicable, advise all subcontractors of their obligations pursuant to the following numbered provisions of this Exhibit: 1, 2, 3, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 17, 19, 20, 24, 32 and/or other numbered provisions herein that are deemed applicable.

6. Income Restrictions

Unless otherwise stipulated in this Agreement, the Contractor agrees that any refunds, rebates, credits, or other amounts (including any interest thereon) accruing to or received by the Contractor under this Agreement shall be paid by the Contractor to DHCS, to the extent that they are properly allocable to costs for which the Contractor has been reimbursed by DHCS under this Agreement.

7. Audit and Record Retention

(Applicable to agreements in excess of $10,000.)

a. The Contractor and/or Subcontractor shall maintain books, records, documents, and other evidence, accounting procedures and practices, sufficient to properly reflect all direct and indirect costs of whatever nature claimed to have been incurred in the performance of this Agreement, including any matching costs and expenses. The foregoing constitutes "records" for the purpose of this provision.

b. The Contractor's and/or subcontractor's facility or office or such part thereof as may be engaged in the performance of this Agreement and his/her records shall be subject at all reasonable times to inspection, audit, and reproduction.

c. Contractor agrees that DHCS, the Department of General Services, the Bureau of State Audits, or their designated representatives including the Comptroller General of the United States shall have the right to review and to copy any records and supporting documentation pertaining to the performance of this Agreement. Contractor agrees to allow the auditor(s) access to such records during normal business hours and to allow interviews of any employees who might reasonably have information related to such records. Further, the Contractor agrees to include a similar right of the State to audit records and interview staff in any subcontract related to performance of this Agreement. (GC 8546.7, CCR Title 2, Section 1896.77)

d. The Contractor and/or Subcontractor shall preserve and make available his/her records (1) for a period of three years from the date of final payment under this Agreement, and (2) for such longer period, if any, as is required by applicable statute, by any other provision of this Agreement, or by subparagraphs (1) or (2) below.

(1) If this Agreement is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for a period of three years from the date of any resulting final settlement.

(2) If any litigation, claim, negotiation, audit, or other action involving the records has been started before the expiration of the three-year period, the records shall be retained until completion of the action and resolution of all issues which arise from it, or until the end of the regular three-year period, whichever is later.

e. The Contractor and/or Subcontractor may, at its discretion, following receipt of final payment under this Agreement, reduce its accounts, books and records related to this Agreement to microfilm, computer disk, CD ROM, DVD, or other data storage medium. Upon request by an authorized representative to inspect, audit or obtain copies of said records, the Contractor and/or Subcontractor must supply or make available applicable devices, hardware, and/or software necessary to view, copy and/or print said records. Applicable devices may include, but are not limited to, microfilm readers and microfilm printers, etc.

f. The Contractor shall, if applicable, comply with the Single Audit Act and the audit requirements set forth in 2 C.F.R. § 200.501 (2014).

8. Site Inspection

The State, through any authorized representatives, has the right at all reasonable times to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract supported activities and the premises in which it is being performed. If any inspection or evaluation is made of the premises of the Contractor or Subcontractor, the Contractor shall provide and shall require Subcontractors to provide all reasonable facilities and assistance for the safety and convenience of the authorized representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner as will not unduly delay the work.

9. Federal Contract Funds

(Applicable only to that portion of an agreement funded in part or whole with federal funds.)

a. It is mutually understood between the parties that this Agreement may have been written before ascertaining the availability of congressional appropriation of funds, for the mutual benefit of both parties, in order to avoid program and fiscal delays which would occur if the Agreement were executed after that determination was made.

b. This agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the fiscal years covered by the term of this Agreement. In addition, this Agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress or any statute enacted by the Congress which may affect the provisions, terms or funding of this Agreement in any manner.

c. It is mutually agreed that if the Congress does not appropriate sufficient funds for the program, this Agreement shall be amended to reflect any reduction in funds.

d. DHCS has the option to invalidate or cancel the Agreement with 30-days advance written notice or to amend the Agreement to reflect any reduction in funds.

10. Termination

a. **For Cause**

The State may terminate this Agreement, in whole or in part, and be relieved of any payments should the Contractor fail to perform the requirements of this Agreement at the time and in the manner herein provided. In the event of such termination, the State may proceed with the work in any manner deemed proper by the State. All costs to the State shall be deducted from any sum due the Contractor under this Agreement and the balance, if any, shall be paid to the Contractor upon demand. If this Agreement is terminated, in whole or in part, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials, related to the terminated portion of the Contract, including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The State shall pay contract price for completed deliverables delivered and accepted and items the State requires the Contractor to transfer as described in this paragraph above.

b. **For Convenience**

The State retains the option to terminate this Agreement, in whole or in part, without cause, at the State's convenience, without penalty, provided that written notice has been delivered to the Contractor at least ninety (90) calendar days prior to such termination date. In the event of termination, in whole or in part, under this paragraph, the State may require the Contractor to transfer title, or in the case of licensed software, license, and deliver to the State any completed deliverables, partially completed deliverables, and any other materials related to the terminated portion of the contract including but not limited to, computer programs, data files, user and operations manuals, system and program documentation, training programs related to the operation and maintenance of the system, and all information necessary for the reimbursement of any outstanding Medicaid claims. The Contractor will be entitled to compensation upon submission of an invoice and proper proof of claim for the services and products satisfactorily rendered, subject to all payment provisions of the Agreement. Payment is limited to expenses necessarily incurred pursuant to this Agreement up to the date of termination.

11. Intellectual Property Rights

a. Ownership

(1) Except where DHCS has agreed in a signed writing to accept a license, DHCS shall be and remain, without additional compensation, the sole owner of any and all rights, title and interest in all Intellectual Property, from the moment of creation, whether or not jointly conceived, that

are made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.

(2) For the purposes of this Agreement, Intellectual Property means recognized protectable rights and interest such as: patents, (whether or not issued) copyrights, trademarks, service marks, applications for any of the foregoing, inventions, trade secrets, trade dress, logos, insignia, color combinations, slogans, moral rights, right of publicity, author's rights, contract and licensing rights, works, mask works, industrial design rights, rights of priority, know how, design flows, methodologies, devices, business processes, developments, innovations, good will and all other legal rights protecting intangible proprietary information as may exist now and/or here after come into existence, and all renewals and extensions, regardless of whether those rights arise under the laws of the United States, or any other state, country or jurisdiction.

(a) For the purposes of the definition of Intellectual Property, "works" means all literary works, writings and printed matter including the medium by which they are recorded or reproduced, photographs, art work, pictorial and graphic representations and works of a similar nature, film, motion pictures, digital images, animation cells, and other audiovisual works including positives and negatives thereof, sound recordings, tapes, educational materials, interactive videos and any other materials or products created, produced, conceptualized and fixed in a tangible medium of expression. It includes preliminary and final products and any materials and information developed for the purposes of producing those final products. Works does not include articles submitted to peer review or reference journals or independent research projects.

(3) In the performance of this Agreement, Contractor will exercise and utilize certain of its Intellectual Property in existence prior to the effective date of this Agreement. In addition, under this Agreement, Contractor may access and utilize certain of DHCS' Intellectual Property in existence prior to the effective date of this Agreement. Except as otherwise set forth herein, Contractor shall not use any of DHCS' Intellectual Property now existing or hereafter existing for any purposes without the prior written permission of DHCS. **Except as otherwise set forth herein, neither the Contractor nor DHCS shall give any ownership interest in or rights to its Intellectual Property to the other Party.** If during the term of this Agreement, Contractor accesses any third-party Intellectual Property that is licensed to DHCS, Contractor agrees to abide by all license and confidentiality restrictions applicable to DHCS in the third-party's license agreement.

(4) Contractor agrees to cooperate with DHCS in establishing or maintaining DHCS' exclusive rights in the Intellectual Property, and in assuring DHCS' sole rights against third parties with respect to the Intellectual Property. If the Contractor enters into any agreements or subcontracts with other parties in order to perform this Agreement, Contractor shall require the terms of the Agreement(s) to include all Intellectual Property provisions. Such terms must include, but are not limited to, the subcontractor assigning and agreeing to assign to DHCS all rights, title and interest in Intellectual Property made, conceived, derived from, or reduced to practice by the subcontractor, Contractor or DHCS and which result directly or indirectly from this Agreement or any subcontract.

(5) Contractor further agrees to assist and cooperate with DHCS in all reasonable respects, and execute all documents and, subject to reasonable availability, give testimony and take all further acts reasonably necessary to acquire, transfer, maintain, and enforce DHCS' Intellectual Property rights and interests.

b. Retained Rights / License Rights

(1) Except for Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, Contractor shall retain title to all of its Intellectual Property to the extent such Intellectual Property is in existence prior to the effective date of this Agreement. Contractor hereby grants to DHCS, without additional compensation, a permanent, non-exclusive, royalty free, paid-up, worldwide, irrevocable, perpetual, non-terminable license to use, reproduce, manufacture, sell, offer to sell, import, export, modify, publicly and privately display/perform, distribute, and dispose Contractor's Intellectual Property with the right to sublicense through multiple layers, for any

purpose whatsoever, to the extent it is incorporated in the Intellectual Property resulting from this Agreement, unless Contractor assigns all rights, title and interest in the Intellectual Property as set forth herein.

(2) Nothing in this provision shall restrict, limit, or otherwise prevent Contractor from using any ideas, concepts, know-how, methodology or techniques related to its performance under this Agreement, provided that Contractor's use does not infringe the patent, copyright, trademark rights, license or other Intellectual Property rights of DHCS or third party, or result in a breach or default of any provisions of this Exhibit or result in a breach of any provisions of law relating to confidentiality.

c. Copyright

(1) Contractor agrees that for purposes of copyright law, all works [as defined in Paragraph a, subparagraph (2)(a) of this provision] of authorship made by or on behalf of Contractor in connection with Contractor's performance of this Agreement shall be deemed "works made for hire". Contractor further agrees that the work of each person utilized by Contractor in connection with the performance of this Agreement will be a "work made for hire," whether that person is an employee of Contractor or that person has entered into an agreement with Contractor to perform the work. Contractor shall enter into a written agreement with any such person that: (i) all work performed for Contractor shall be deemed a "work made for hire" under the Copyright Act and (ii) that person shall assign all right, title, and interest to DHCS to any work product made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement.

(2) All materials, including, but not limited to, visual works or text, reproduced or distributed pursuant to this Agreement that include Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement, shall include DHCS' notice of copyright, which shall read in 3mm or larger typeface: "© *[Enter Current Year e.g., 2010, etc.]*, California Department of Health Care Services. This material may not be reproduced or disseminated without prior written permission from the California Department of Health Care Services." This notice should be placed prominently on the materials and set apart from other matter on the page where it appears. Audio productions shall contain a similar audio notice of copyright.

d. Patent Rights

With respect to inventions made by Contractor in the performance of this Agreement, which did not result from research and development specifically included in the Agreement's scope of work, Contractor hereby grants to DHCS a license as described under Section b of this provision for devices or material incorporating, or made through the use of such inventions. If such inventions result from research and development work specifically included within the Agreement's scope of work, then Contractor agrees to assign to DHCS, without additional compensation, all its right, title and interest in and to such inventions and to assist DHCS in securing United States and foreign patents with respect thereto.

e. Third-Party Intellectual Property

Except as provided herein, Contractor agrees that its performance of this Agreement shall not be dependent upon or include any Intellectual Property of Contractor or third party without first: (i) obtaining DHCS' prior written approval; and (ii) granting to or obtaining for DHCS, without additional compensation, a license, as described in Section b of this provision, for any of Contractor's or third-party's Intellectual Property in existence prior to the effective date of this Agreement. If such a license upon the these terms is unattainable, and DHCS determines that the Intellectual Property should be included in or is required for Contractor's performance of this Agreement, Contractor shall obtain a license under terms acceptable to DHCS.

f. Warranties

(1) Contractor represents and warrants that:

(a) It is free to enter into and fully perform this Agreement.

(b) It has secured and will secure all rights and licenses necessary for its performance of this Agreement.

(c) Neither Contractor's performance of this Agreement, nor the exercise by either Party of the rights granted in this Agreement, nor any use, reproduction, manufacture, sale, offer to sell, import, export, modification, public and private display/performance, distribution, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement will infringe upon or violate any Intellectual Property right, non-disclosure obligation, or other proprietary right or interest of any third-party or entity now existing under the laws of, or hereafter existing or issued by, any state, the United States, or any foreign country. There is currently no actual or threatened claim by any such third party based on an alleged violation of any such right by Contractor.

(d) Neither Contractor's performance nor any part of its performance will violate the right of privacy of, or constitute a libel or slander against any person or entity.

(e) It has secured and will secure all rights and licenses necessary for Intellectual Property including, but not limited to, consents, waivers or releases from all authors of music or performances used, and talent (radio, television and motion picture talent), owners of any interest in and to real estate, sites, locations, property or props that may be used or shown.

(f) It has not granted and shall not grant to any person or entity any right that would or might derogate, encumber, or interfere with any of the rights granted to DHCS in this Agreement.

(g) It has appropriate systems and controls in place to ensure that state funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

(h) It has no knowledge of any outstanding claims, licenses or other charges, liens, or encumbrances of any kind or nature whatsoever that could affect in any way Contractor's performance of this Agreement.

(2) DHCS MAKES NO WARRANTY THAT THE INTELLECTUAL PROPERTY RESULTING FROM THIS AGREEMENT DOES NOT INFRINGE UPON ANY PATENT, TRADEMARK, COPYRIGHT OR THE LIKE, NOW EXISTING OR SUBSEQUENTLY ISSUED.

g. Intellectual Property Indemnity

(1) Contractor shall indemnify, defend and hold harmless DHCS and its licensees and assignees, and its officers, directors, employees, agents, representatives, successors, and users of its products, ("Indemnitees") from and against all claims, actions, damages, losses, liabilities (or actions or proceedings with respect to any thereof), whether or not rightful, arising from any and all actions or claims by any third party or expenses related thereto (including, but not limited to, all legal expenses, court costs, and attorney's fees incurred in investigating, preparing, serving as a witness in, or defending against, any such claim, action, or proceeding, commenced or threatened) to which any of the Indemnitees may be subject, whether or not Contractor is a party to any pending or threatened litigation, which arise out of or are related to (i) the incorrectness or breach of any of the representations, warranties, covenants or agreements of Contractor pertaining to Intellectual Property; or (ii) any Intellectual Property infringement, or any other type of actual or alleged infringement claim, arising out of DHCS' use, reproduction, manufacture, sale, offer to sell, distribution, import, export, modification, public and private performance/display, license, and disposition of the Intellectual Property made, conceived, derived from, or reduced to practice by Contractor or DHCS and which result directly or indirectly from this Agreement. This indemnity obligation shall apply irrespective of whether the infringement claim is based on a patent, trademark or copyright registration that issued after the effective date of this Agreement. DHCS reserves the right to participate in and/or control, at Contractor's expense, any such infringement action brought against DHCS.

(2) Should any Intellectual Property licensed by the Contractor to DHCS under this Agreement become the subject of an Intellectual Property infringement claim, Contractor will exercise its authority reasonably and in good faith to preserve DHCS' right to use the licensed Intellectual Property in accordance with this Agreement at no expense to DHCS. DHCS shall have the right to monitor and appear through its own counsel (at Contractor's expense) in any such claim or action. In the defense or settlement of the claim, Contractor may obtain the right for DHCS to continue using the licensed Intellectual Property; or, replace or modify the licensed Intellectual Property so that the replaced or modified Intellectual Property becomes non-infringing provided that such replacement or modification is functionally equivalent to the original licensed Intellectual Property. If such remedies are not reasonably available, DHCS shall be entitled to a refund of all monies paid under this Agreement, without restriction or limitation of any other rights and remedies available at law or in equity.

(3) Contractor agrees that damages alone would be inadequate to compensate DHCS for breach of any term of this Intellectual Property Exhibit by Contractor. Contractor acknowledges DHCS would suffer irreparable harm in the event of such breach and agrees DHCS shall be entitled to obtain equitable relief, including without limitation an injunction, from a court of competent jurisdiction, without restriction or limitation of any other rights and remedies available at law or in equity.

h. Federal Funding

In any agreement funded in whole or in part by the federal government, DHCS may acquire and maintain the Intellectual Property rights, title, and ownership, which results directly or indirectly from the Agreement; except as provided in 37 Code of Federal Regulations part 401.14; however, the federal government shall have a non-exclusive, nontransferable, irrevocable, paid-up license throughout the world to use, duplicate, or dispose of such Intellectual Property throughout the world in any manner for governmental purposes and to have and permit others to do so.

i. Survival

The provisions set forth herein shall survive any termination or expiration of this Agreement or any project schedule.

12. Air or Water Pollution Requirements

Any federally funded agreement and/or subcontract in excess of $100,000 must comply with the following provisions unless said agreement is exempt by law.

a. Government contractors agree to comply with all applicable standards, orders, or requirements issued under section 306 of the Clean Air Act (42 USC 7606) section 508 of the Clean Water Act (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations.

b. Institutions of higher education, hospitals, nonprofit organizations and commercial businesses agree to comply with all applicable standards, orders, or requirements issued under the Clean Air Act (42 U.S.C. 7401 et seq.), as amended, and the Clean Water Act (33 U.S.C. 1251 et seq.), as amended.

13. Prior Approval of Training Seminars, Workshops or Conferences

Contractor shall obtain prior DHCS approval of the location, costs, dates, agenda, instructors, instructional materials, and attendees at any reimbursable training seminar, workshop, or conference conducted pursuant to this Agreement and of any reimbursable publicity or educational materials to be made available for distribution. The Contractor shall acknowledge the support of the State whenever publicizing the work under this Agreement in any media. This provision does not apply to necessary staff meetings or training sessions held for the staff of the Contractor or Subcontractor to conduct routine business matters.

14. Confidentiality of Information

a. The Contractor and its employees, agents, or subcontractors shall protect from unauthorized disclosure names and other identifying information concerning persons either receiving services pursuant to this Agreement or persons whose names or identifying information become available or are disclosed to the Contractor, its employees, agents, or subcontractors as a result of services performed under this Agreement, except for statistical information not identifying any such person.

b. The Contractor and its employees, agents, or subcontractors shall not use such identifying information for any purpose other than carrying out the Contractor's obligations under this Agreement.

c. The Contractor and its employees, agents, or subcontractors shall promptly transmit to the DHCS Program Contract Manager all requests for disclosure of such identifying information not emanating from the client or person.

d. The Contractor shall not disclose, except as otherwise specifically permitted by this Agreement or authorized by the client, any such identifying information to anyone other than DHCS without prior written authorization from the DHCS Program Contract Manager, except if disclosure is required by State or Federal law.

e. For purposes of this provision, identity shall include, but not be limited to name, identifying number, symbol, or other identifying particular assigned to the individual, such as finger or voice print or a photograph.

f. As deemed applicable by DHCS, this provision may be supplemented by additional terms and conditions covering personal health information (PHI) or personal, sensitive, and/or confidential information (PSCI). Said terms and conditions will be outlined in one or more exhibits that will either be attached to this Agreement or incorporated into this Agreement by reference.

15. Documents, Publications and Written Reports

(Applicable to agreements over $5,000 under which publications, written reports and documents are developed or produced. Government Code Section 7550.)

Any document, publication or written report (excluding progress reports, financial reports and normal contractual communications) prepared as a requirement of this Agreement shall contain, in a separate section preceding the main body of the document, the number and dollar amounts of all contracts or agreements and subcontracts relating to the preparation of such document or report, if the total cost for work by nonemployees of the State exceeds $5,000.

16. Dispute Resolution Process

a. A Contractor grievance exists whenever there is a dispute arising from DHCS' action in the administration of an agreement. If there is a dispute or grievance between the Contractor and DHCS, the Contractor must seek resolution using the procedure outlined below.

(1) The Contractor should first informally discuss the problem with the DHCS Program Contract Manager. If the problem cannot be resolved informally, the Contractor shall direct its grievance together with any evidence, in writing, to the program Branch Chief. The grievance shall state the issues in dispute, the legal authority or other basis for the Contractor's position and the remedy sought. The Branch Chief shall render a decision within ten (10) working days after receipt of the written grievance from the Contractor. The Branch Chief shall respond in writing to the Contractor indicating the decision and reasons therefore. If the Contractor disagrees with the Branch Chief's decision, the Contractor may appeal to the second level.

(2) When appealing to the second level, the Contractor must prepare an appeal indicating the reasons for disagreement with Branch Chief's decision. The Contractor shall include with the appeal a copy of the Contractor's original statement of dispute along with any supporting evidence and a copy of the Branch Chief's decision. The appeal shall be addressed to the Deputy Director of the division in which the branch is organized within ten (10) working days from receipt of the Branch Chief's decision. The Deputy Director of the division in which the branch is organized or his/her designee shall meet with the Contractor to review the issues

raised. A written decision signed by the Deputy Director of the division in which the branch is organized or his/her designee shall be directed to the Contractor within twenty (20) working days of receipt of the Contractor's second level appeal.

b. If the Contractor wishes to appeal the decision of the Deputy Director of the division in which the branch is organized or his/her designee, the Contractor shall follow the procedures set forth in Health and Safety Code Section 100171.

c. Unless otherwise stipulated in writing by DHCS, all dispute, grievance and/or appeal correspondence shall be directed to the DHCS Program Contract Manager.

d. There are organizational differences within DHCS' funding programs and the management levels identified in this dispute resolution provision may not apply in every contractual situation. When a grievance is received and organizational differences exist, the Contractor shall be notified in writing by the DHCS Program Contract Manager of the level, name, and/or title of the appropriate management official that is responsible for issuing a decision at a given level.

17. Financial and Compliance Audit Requirements

a. The definitions used in this provision are contained in Section 38040 of the Health and Safety Code, which by this reference is made a part hereof.

b. Direct service contract means a contract or agreement for services contained in local assistance or subvention programs or both (see Health and Safety [H&S] Code Section 38020). Direct service contracts shall not include contracts, agreements, grants, or subventions to other governmental agencies or units of government nor contracts or agreements with regional centers or area agencies on aging (H&S Code Section 38030).

c. The Contractor, as indicated below, agrees to obtain one of the following audits:

(1) ***If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040)*** and receives **$25,000 or more** from any State agency under a direct service contract or agreement; the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit. Said audit shall be conducted according to Generally Accepted Auditing Standards. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit shall be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, **and/or**

(2) ***If the Contractor is a nonprofit organization (as defined in H&S Code Section 38040)*** and receives **less than $25,000** per year from any State agency under a direct service contract or agreement, the Contractor agrees to obtain a biennial single, organization wide financial and compliance audit, unless there is evidence of fraud or other violation of state law in connection with this Agreement. This audit does not fulfill the audit requirements of Paragraph c(3) below. The audit shall be completed by the 15th day of the fifth month following the end of the Contractor's fiscal year, **and/or**

(3) ***If the Contractor is a State or Local Government entity or Nonprofit organization (as defined by 2 C.F.R. §§ 200.64, 200.70, and 200.90)*** and expends $750,000 or more in Federal awards, the Contractor agrees to obtain an annual single, organization wide, financial and compliance audit according to the requirements specified in 2 C.F.R. 200.501 entitled "Audit Requirements". An audit conducted pursuant to this provision will fulfill the audit requirements outlined in Paragraphs c(1) and c(2) above. The audit shall be completed by the end of the ninth month following the end of the audit period. The requirements of this provision apply if:

(a) The Contractor is a recipient expending Federal awards received directly from Federal awarding agencies, or

(b) The Contractor is a subrecipient expending Federal awards received from a pass-through entity such as the State, County or community based organization.

(4) If the Contractor submits to DHCS a report of an audit other than a 2 C.F.R. 200.501audit, the Contractor must also submit a certification indicating the Contractor has not expended $750,000 or more in federal funds for the year covered by the audit report.

d. Two copies of the audit report shall be delivered to the DHCS program funding this Agreement. The audit report must identify the Contractor's legal name and the number assigned to this Agreement. The audit report shall be due within 30 days after the completion of the audit. Upon receipt of said audit report, the DHCS Program Contract Manager shall forward the audit report to DHCS' Audits and Investigations Unit if the audit report was submitted under Section 16.c(3), unless the audit report is from a City, County, or Special District within the State of California whereby the report will be retained by the funding program.

e. The cost of the audits described herein may be included in the funding for this Agreement up to the proportionate amount this Agreement represents of the Contractor's total revenue. The DHCS program funding this Agreement must provide advance written approval of the specific amount allowed for said audit expenses.

f. The State or its authorized designee, including the Bureau of State Audits, is responsible for conducting agreement performance audits which are not financial and compliance audits. Performance audits are defined by Generally Accepted Government Auditing Standards.

g. Nothing in this Agreement limits the State's responsibility or authority to enforce State law or regulations, procedures, or reporting requirements arising thereto.

h. Nothing in this provision limits the authority of the State to make audits of this Agreement, provided however, that if independent audits arranged for by the Contractor meet Generally Accepted Governmental Auditing Standards, the State shall rely on those audits and any additional audit work and shall build upon the work already done.

i. The State may, at its option, direct its own auditors to perform either of the audits described above. The Contractor will be given advance written notification, if the State chooses to exercise its option to perform said audits.

j. The Contractor shall include a clause in any agreement the Contractor enters into with the audit firm doing the single organization wide audit to provide access by the State or Federal Government to the working papers of the independent auditor who prepares the single organization wide audit for the Contractor.

k. Federal or state auditors shall have "expanded scope auditing" authority to conduct specific program audits during the same period in which a single organization wide audit is being performed, but the audit report has not been issued. The federal or state auditors shall review and have access to the current audit work being conducted and will not apply any testing or review procedures which have not been satisfied by previous audit work that has been completed.

The term "expanded scope auditing" is applied and defined in the U.S. General Accounting Office (GAO) issued Standards for *Audit of Government Organizations, Programs, Activities and Functions*, better known as the "yellow book".

18. Human Subjects Use Requirements

(Applicable only to federally funded agreements/grants in which performance, directly or through a subcontract/subaward, includes any tests or examination of materials derived from the human body.)

By signing this Agreement, Contractor agrees that if any performance under this Agreement or any subcontract or subagreement includes any tests or examination of materials derived from the human body for the purpose of providing information, diagnosis, prevention, treatment or assessment of disease, impairment, or health of a human being, all locations at which such examinations are performed shall meet the requirements of 42 U.S.C. Section 263a (CLIA) and the regulations thereunder.

19. Novation Requirements

If the Contractor proposes any novation agreement, DHCS shall act upon the proposal within 60 days after receipt of the written proposal. DHCS may review and consider the proposal, consult and negotiate with the Contractor, and accept or reject all or part of the proposal. Acceptance or rejection of the proposal may be made orally within the 60-day period and confirmed in writing within five days of said decision. Upon written acceptance of the proposal, DHCS will initiate an amendment to this Agreement to formally implement the approved proposal.

20. Debarment and Suspension Certification

(Applicable to all agreements funded in part or whole with federal funds.)

a. By signing this Agreement, the Contractor/Grantee agrees to comply with applicable federal suspension and debarment regulations including, but not limited to 2 CFR 180, 2 CFR 376

b. By signing this Agreement, the Contractor certifies to the best of its knowledge and belief, that it and its principals:

(1) Are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

(2) Have not within a three-year period preceding this application/proposal/agreement been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) violation of Federal or State antitrust statutes; ~~or~~ commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, receiving stolen property, making false claims, obstruction of justice, or the commission of any other offense indicating a lack of business integrity or business honesty that seriously affects its business honesty;

(3) Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State or local) with commission of any of the offenses enumerated in Paragraph b(2) herein; and

(4) Have not within a three-year period preceding this application/proposal/agreement had one or more public transactions (Federal, State or local) terminated for cause or default.

(5) Have not, within a three-year period preceding this application/proposal/agreement, engaged in any of the violations listed under 2 CFR Part 180, Subpart C as supplemented by 2 CFR Part 376.

(6) Shall not knowingly enter into any lower tier covered transaction with a person who is proposed for debarment under federal regulations (i.e., 48 CFR part 9, subpart 9.4), debarred, suspended, declared ineligible, or voluntarily excluded from participation in such transaction, unless authorized by the State.

(7) Will include a clause entitled, "Debarment and Suspension Certification" that essentially sets forth the provisions herein, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.

c. If the Contractor is unable to certify to any of the statements in this certification, the Contractor shall submit an explanation to the DHCS Program Contract Manager.

d. The terms and definitions herein have the meanings set out in 2 CFR Part 180 as supplemented by 2 CFR Part 376.

e. If the Contractor knowingly violates this certification, in addition to other remedies available to the Federal Government, the DHCS may terminate this Agreement for cause or default.

21. Smoke-Free Workplace Certification

(Applicable to federally funded agreements/grants and subcontracts/subawards, that provide health, day care, early childhood development services, education or library services to children under 18 directly or through local governments.)

a. Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by federal programs either directly or through state or local governments, by federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such federal funds. The law does not apply to children's services provided in private residences; portions of facilities used for inpatient drug or alcohol treatment; service providers whose sole source of applicable federal funds is Medicare or Medicaid; or facilities where WIC coupons are redeemed.

b. Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible party.

c. By signing this Agreement, Contractor or Grantee certifies that it will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The prohibitions herein are effective December 26, 1994.

d. Contractor or Grantee further agrees that it will insert this certification into any subawards (subcontracts or subgrants) entered into that provide for children's services as described in the Act.

22. Covenant Against Contingent Fees

(Applicable only to federally funded agreements.)

The Contractor warrants that no person or selling agency has been employed or retained to solicit/secure this Agreement upon an agreement of understanding for a commission, percentage, brokerage, or contingent fee, except *bona fide* employees or *bona fide* established commercial or selling agencies retained by the Contractor for the purpose of securing business. For breach or violation of this warranty, DHCS shall have the right to annul this Agreement without liability or in its discretion to deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, and brokerage or contingent fee.

23. Payment Withholds

(Applicable only if a final report is required by this Agreement. Not applicable to government entities.)

Unless waived or otherwise stipulated in this Agreement, DHCS may, at its discretion, withhold 10 percent (10%) of the face amount of the Agreement, 50 percent (50%) of the final invoice, or $3,000 whichever is greater, until DHCS receives a final report that meets the terms, conditions and/or scope of work requirements of this Agreement.

24. Performance Evaluation

(Not applicable to grant agreements.)

DHCS may, at its discretion, evaluate the performance of the Contractor at the conclusion of this Agreement. If performance is evaluated, the evaluation shall not be a public record and shall remain on file with DHCS. Negative performance evaluations may be considered by DHCS prior to making future contract awards.

25. Officials Not to Benefit

No members of or delegate of Congress or the State Legislature shall be admitted to any share or part of this Agreement, or to any benefit that may arise therefrom. This provision shall not be construed to extend to this Agreement if made with a corporation for its general benefits.

26. Four-Digit Date Compliance

(Applicable to agreements in which Information Technology (IT) services are provided to DHCS or if IT equipment is procured.)

Contractor warrants that it will provide only Four-Digit Date Compliant (as defined below) Deliverables and/or services to the State. "Four Digit Date compliant" Deliverables and services can accurately process, calculate, compare, and sequence date data, including without limitation date data arising out of or relating to leap years and changes in centuries. This warranty and representation is subject to the warranty terms and conditions of this Contract and does not limit the generality of warranty obligations set forth elsewhere herein.

27. Prohibited Use of State Funds for Software

(Applicable to agreements in which computer software is used in performance of the work.)

Contractor certifies that it has appropriate systems and controls in place to ensure that state funds will not be used in the performance of this Agreement for the acquisition, operation or maintenance of computer software in violation of copyright laws.

28. Use of Small, Minority Owned and Women's Businesses

(Applicable to that portion of an agreement that is federally funded and entered into with institutions of higher education, hospitals, nonprofit organizations or commercial businesses.)

Positive efforts shall be made to use small businesses, minority-owned firms and women's business enterprises, whenever possible (i.e., procurement of goods and/or services). Contractors shall take all of the following steps to further this goal.

(1) Ensure that small businesses, minority-owned firms, and women's business enterprises are used to the fullest extent practicable.

(2) Make information on forthcoming purchasing and contracting opportunities available and arrange time frames for purchases and contracts to encourage and facilitate participation by small businesses, minority-owned firms, and women's business enterprises.

(3) Consider in the contract process whether firms competing for larger contracts intend to subcontract with small businesses, minority-owned firms, and women's business enterprises.

(4) Encourage contracting with consortiums of small businesses, minority-owned firms and women's business enterprises when a contract is too large for one of these firms to handle individually.

(5) Use the services and assistance, as appropriate, of such organizations as the Federal Small Business Administration and the U.S. Department of Commerce's Minority Business Development Agency in the solicitation and utilization of small businesses, minority-owned firms and women's business enterprises.

29. Alien Ineligibility Certification

(Applicable to sole proprietors entering federally funded agreements.)

By signing this Agreement, the Contractor certifies that he/she is not an alien that is ineligible for state and local benefits, as defined in Subtitle B of the Personal Responsibility and Work Opportunity Act. (8 U.S.C. 1601, et seq.)

30. Union Organizing

(Applicable only to grant agreements.)

Grantee, by signing this Agreement, hereby acknowledges the applicability of Government Code Sections 16645 through 16649 to this Agreement. Furthermore, Grantee, by signing this Agreement, hereby certifies that:

a. No state funds disbursed by this grant will be used to assist, promote or deter union organizing.

b. Grantee shall account for state funds disbursed for a specific expenditure by this grant, to show those funds were allocated to that expenditure.

c. Grantee shall, where state funds are not designated as described in b herein, allocate, on a pro-rata basis, all disbursements that support the grant program.

d. If Grantee makes expenditures to assist, promote or deter union organizing, Grantee will maintain records sufficient to show that no state funds were used for those expenditures, and that Grantee shall provide those records to the Attorney General upon request.

31. Contract Uniformity (Fringe Benefit Allowability)

(Applicable only to nonprofit organizations.)

Pursuant to the provisions of Article 7 (commencing with Section 100525) of Chapter 3 of Part 1 of Division 101 of the Health and Safety Code, DHCS sets forth the following policies, procedures, and guidelines regarding the reimbursement of fringe benefits.

a. As used herein fringe benefits shall mean an employment benefit given by one's employer to an employee in addition to one's regular or normal wages or salary.

b. As used herein, fringe benefits do not include:

(1) Compensation for personal services paid currently or accrued by the Contractor for services of employees rendered during the term of this Agreement, which is identified as regular or normal salaries and wages, annual leave, vacation, sick leave, holidays, jury duty and/or military leave/training.
(2) Director's and executive committee member's fees.
(3) Incentive awards and/or bonus incentive pay.
(4) Allowances for off-site pay.
(5) Location allowances.
(6) Hardship pay.
(7) Cost-of-living differentials

c. Specific allowable fringe benefits include:

(1) Fringe benefits in the form of employer contributions for the employer's portion of payroll taxes (i.e., FICA, SUI, SDI), employee health plans (i.e., health, dental and vision), unemployment insurance, worker's compensation insurance, and the employer's share of pension/retirement plans, provided they are granted in accordance with established written organization policies and meet all legal and Internal Revenue Service requirements.

d. To be an allowable fringe benefit, the cost must meet the following criteria:

(1) Be necessary and reasonable for the performance of the Agreement.
(2) Be determined in accordance with generally accepted accounting principles.
(3) Be consistent with policies that apply uniformly to all activities of the Contractor.

e. Contractor agrees that all fringe benefits shall be at actual cost.

f. Earned/Accrued Compensation

(1) Compensation for vacation, sick leave and holidays is limited to that amount earned/accrued within the agreement term. Unused vacation, sick leave and holidays earned from periods prior to the agreement term cannot be claimed as allowable costs. See Provision f (3)(a) for an example.

(2) For multiple year agreements, vacation and sick leave compensation, which is earned/accrued but not paid, due to employee(s) not taking time off may be carried over and claimed within the overall term of the multiple years of the Agreement. Holidays cannot be carried over from one agreement year to the next. See Provision f (3)(b) for an example.

(3) For single year agreements, vacation, sick leave and holiday compensation that is earned/accrued but not paid, due to employee(s) not taking time off within the term of the Agreement, cannot be claimed as an allowable cost. See Provision f (3)(c) for an example.

(a) **Example No. 1:**

If an employee, John Doe, earns/accrues three weeks of vacation and twelve days of sick leave each year, then that is the maximum amount that may be claimed during a one year agreement. If John Doe has five weeks of vacation and eighteen days of sick leave at the beginning of an agreement, the Contractor during a one-year budget period may only claim up to three weeks of vacation and twelve days of sick leave as actually used by the employee. Amounts earned/accrued in periods prior to the beginning of the Agreement are not an allowable cost.

(b) **Example No. 2:**

If during a three-year (multiple year) agreement, John Doe does not use his three weeks of vacation in year one, or his three weeks in year two, but he does actually use nine weeks in year three; the Contractor would be allowed to claim all nine weeks paid for in year three. The total compensation over the three-year period cannot exceed 156 weeks (3 x 52 weeks).

(c) **Example No. 3:**

If during a single year agreement, John Doe works fifty weeks and used one week of vacation and one week of sick leave and all fifty-two weeks have been billed to DHCS, the remaining unused two weeks of vacation and seven days of sick leave may not be claimed as an allowable cost.

32. Suspension or Stop Work Notification

a. DHCS may, at any time, issue a notice to suspend performance or stop work under this Agreement. The initial notification may be a verbal or written directive issued by the funding Program's Contract Manager. Upon receipt of said notice, the Contractor is to suspend and/or stop all, or any part, of the work called for by this Agreement.

b. Written confirmation of the suspension or stop work notification with directions as to what work (if not all) is to be suspended and how to proceed will be provided within 30 working days of the verbal notification. The suspension or stop work notification shall remain in effect until further written notice is received from DHCS. The resumption of work (in whole or part) will be at DHCS' discretion and upon receipt of written confirmation.

(1) Upon receipt of a suspension or stop work notification, the Contractor shall immediately comply with its terms and take all reasonable steps to minimize or halt the incurrence of costs allocable to the performance covered by the notification during the period of work suspension or stoppage.

(2) Within 90 days of the issuance of a suspension or stop work notification, DHCS shall either:

(a) Cancel, extend, or modify the suspension or stop work notification; or

(b) Terminate the Agreement as provided for in the Cancellation / Termination clause of the Agreement.

c. If a suspension or stop work notification issued under this clause is canceled or the period of suspension or any extension thereof is modified or expires, the Contractor may resume work only upon written concurrence of funding Program's Contract Manager.

d. If the suspension or stop work notification is cancelled and the Agreement resumes, changes to the services, deliverables, performance dates, and/or contract terms resulting from the suspension or stop work notification shall require an amendment to the Agreement.

e. If a suspension or stop work notification is not canceled and the Agreement is cancelled or terminated pursuant to the provision entitled Cancellation / Termination, DHCS shall allow reasonable costs resulting from the suspension or stop work notification in arriving at the settlement costs.

f. DHCS shall not be liable to the Contractor for loss of profits because of any suspension or stop work notification issued under this clause.

33. Public Communications

"Electronic and printed documents developed and produced, for public communications shall follow the following requirements to comply with Section 508 of the Rehabilitation Act and the American with Disabilities Act:

A. Ensure visual-impaired, hearing-impaired and other special needs audiences are provided material information in formats that provide the most assistance in making informed choices."

34. Compliance with Statutes and Regulations

a. The Contractor shall comply with all California and federal law, regulations, and published guidelines, to the extent that these authorities contain requirements applicable to Contractor's performance under the Agreement.

b. These authorities include, but are not limited to, Title 2, Code of Federal Regulations (CFR) Part 200, subpart F, Appendix II; Title 42 CFR Part 431, subpart F; Title 42 CFR Part 433, subpart D; Title 42 CFR Part 434; Title 45 CFR Part 75, subpart D; and Title 45 CFR Part 95, subpart F. To the extent applicable under federal law, this Agreement shall incorporate the contractual provisions in these federal regulations and they shall supersede any conflicting provisions in this Agreement.

35. Lobbying Restrictions and Disclosure Certification

(Applicable to federally funded agreements in excess of $100,000 per Section 1352 of the 31, U.S.C.)

a. Certification and Disclosure Requirements

(1) Each person (or recipient) who requests or receives a contract or agreement, subcontract, grant, or subgrant, which is subject to Section 1352 of the 31, U.S.C., and which exceeds $100,000 at any tier, shall file a certification (in the form set forth in Attachment 1, consisting of one page, entitled "Certification Regarding Lobbying") that the recipient has not made, and will not make, any payment prohibited by Paragraph b of this provision.

(2) Each recipient shall file a disclosure (in the form set forth in Attachment 2, entitled "Standard Form-LLL 'disclosure of Lobbying Activities'") if such recipient has made or has agreed to make any payment using nonappropriated funds (to include profits from any covered federal action)

in connection with a contract, or grant or any extension or amendment of that contract, or grant, which would be prohibited under Paragraph b of this provision if paid for with appropriated funds.

(3) Each recipient shall file a disclosure form at the end of each calendar quarter in which there occurs any event that requires disclosure or that materially affect the accuracy of the information contained in any disclosure form previously filed by such person under Paragraph a(2) herein. An event that materially affects the accuracy of the information reported includes:

(a) A cumulative increase of $25,000 or more in the amount paid or expected to be paid for influencing or attempting to influence a covered federal action;

(b) A change in the person(s) or individuals(s) influencing or attempting to influence a covered federal action; or

(c) A change in the officer(s), employee(s), or member(s) contacted for the purpose of influencing or attempting to influence a covered federal action.

(4) Each person (or recipient) who requests or receives from a person referred to in Paragraph a(1) of this provision a contract or agreement, subcontract, grant or subgrant exceeding $100,000 at any tier under a contract or agreement, or grant shall file a certification, and a disclosure form, if required, to the next tier above.

(5) All disclosure forms (but not certifications) shall be forwarded from tier to tier until received by the person referred to in Paragraph a(1) of this provision. That person shall forward all disclosure forms to DHCS Program Contract Manager.

b. Prohibition

Section 1352 of Title 31, U.S.C., provides in part that no appropriated funds may be expended by the recipient of a federal contract or agreement, grant, loan, or cooperative agreement to pay any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with any of the following covered federal actions: the awarding of any federal contract or agreement, the making of any federal grant, the making of any federal loan, entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract or agreement, grant, loan, or cooperative agreement.

Attachment 1
State of California
Department of Health Care Services

CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the making, awarding or entering into of this Federal contract, Federal grant, or cooperative agreement, and the extension, continuation, renewal, amendment, or modification of this Federal contract, grant, or cooperative agreement.

(2) If any funds other than Federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency of the United States Government, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, or cooperative agreement, the undersigned shall complete and submit Standard Form LLL, “Disclosure of Lobbying Activities" in accordance with its instructions.

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontractors, subgrants, and contracts under grants and cooperative agreements) of $100,000 or more, and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, Title 31, U.S.C., any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Name of Contractor	Printed Name of Person Signing for Contractor
Contract / Grant Number	Signature of Person Signing for Contractor
Date	Title

After execution by or on behalf of Contractor, please return to:

California Department of Health Care Services

DHCS reserves the right to notifiy the contractor in writing of an alternate submission address.

Attachment 2

CERTIFICATION REGARDING LOBBYING

Approved by OMB
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure)

1. Type of Federal Action:	2. Status of Federal Action:	3. Report Type:
[ ] a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	[ ] a. bid/offer/application b. initial award c. post-award	[ ] a. initial filing b. material change For Material Change Only: Year _____ quarter _____ date of last report _____.

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
☐ Prime ☐ Subawardee Tier ___, if known: Congressional District, If known:	Congressional District, If known:
6. Federal Department/Agency	7. Federal Program Name/Description: CDFA Number, if applicable: _____
8. Federal Action Number, if known:	9. Award Amount, if known: $
10.a. Name and Address of Lobbying Registrant *(If individual, last name, first name, MI)*:	b. Individuals Performing Services *(including address if different from 10a.* *(Last name, First name, MI):*
11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be available for public inspection. Any person that fails to file the required disclosure shall be subject to a not more than $100,000 for each such failure.	Signature: _____ Print Name: _____ Title: Telephone No.: Date:

Federal Use Only	Authorized for Local Reproduction Standard Form-LLL (Rev. 7-97)

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriateclassification of this report. If this is a followup report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, State and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if itis, or expects to be,a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks "Subawardee," then enter the full name, address, city, State and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizationallevel below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 (e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency). Include prefixes, e.g., "RFP-DE-90-001".

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, State and zip code of the lobbying registrant under the Lobbying Disclosure Act of 1995 engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10 (a). Enter Last Name, First Name, and Middle Initial (MI).

11. The certifying official shall sign and date the form, print his/her name, title, and telephone number.

1. Amendment Process

A. The Department of Health Care Services (DHCS) may amend the Intergovernmental Agreement (IA).

B. Should either DHCS or the Contractor, during the term of this IA, desire any amendments to this IA, such amendments shall be proposed in writing to the other party, who will respond in writing as to whether the proposed amendments are accepted or rejected. If accepted, the agreed upon amendments shall be made through DHCS' official agreement amendment process. No amendment shall be binding on either party until it is formally approved by both parties and the Department of General Services (DGS), if DGS approval is required.

C. Any proposed amendments to the IA shall be requested by the Contractor by May 1 of the current fiscal year in order for the amendment to be effective the following fiscal year.

1) The proposed amendment submitted by the Contractor shall include the proposed changes, and a statement of the reason and basis for the proposed change.

2) Amendments shall be duly approved by the County Board of Supervisors or its authorized designee, and signed by a duly authorized representative.

D. Contractor acknowledges that any newly allocated funds that are in excess of the initial amount for each fiscal year may be forfeited if DHCS does not receive a fully executable IA amendment on or before June 30th of the final year of the IA.

E. DHCS may settle costs for DMC-ODS services based on the year-end cost settlement report as the final amendment to the approved IA.

2. Cancellation / Termination

A. This IA may be cancelled by DHCS without cause upon 90 calendar days advance written notice to the Contractor.

B. DHCS reserves the right to cancel or terminate this IA immediately for cause. The Contractor may submit a written request to terminate this IA only if DHCS substantially fails to perform its responsibilities as provided herein.

C. The term "for cause" shall mean that the Contractor failed to meet any terms, conditions, and/or responsibilities of this IA.

D. IA termination or cancellation shall be effective as of the date indicated in DHCS' notification to the Contractor. The notice shall stipulate any final performance, invoicing or payment requirements.

E. Upon receipt of a notice of termination or cancellation, the Contractor shall take immediate steps to stop performance and to cancel or reduce subsequent agreement costs.

F. In the event of early termination or cancellation, the Contractor shall be entitled to payment for all allowable costs authorized under this IA and incurred up to the date of termination or cancellation, including authorized non-cancelable obligations, provided such expenses do not exceed the stated maximum amounts payable.

G. In the event of changes in law that affect provisions of this IA, the parties agree to amend the affected provisions to conform to the changes in law retroactive to the effective date of such changes in law. The parties further agree that the terms of this IA are severable and in the event that changes in law render provisions of the IA void, the unaffected provisions and obligations of this IA will remain in full force and effect.

H. The following additional provisions regarding termination apply only to Exhibit A, Attachment I, of this IA:

1) In the event the federal Department of Health and Human Services (hereinafter referred to as DHHS), or DHCS determines that the Contractor does not meet the requirements for participation in DMC-ODS, the DHCS will terminate payments for services provided pursuant to Exhibit A, Attachment I, of this IA for cause.

2) All obligations to provide covered services under this IA will automatically terminate on the effective date of any termination of this IA. Contractor will be responsible for providing or arranging for covered services to beneficiaries until the effective date of termination or expiration of the IA.

Contractor shall remain liable for processing and paying invoices and statements for covered services and utilization review requirements prior to the expiration or termination until all obligations have been met.

3) In the event this IA is nullified, cancelled, or terminated, the Contractor shall refer DMC beneficiaries to providers who are enrolled to provide DMC State Plan services.

I. In the event this IA is nullified, cancelled, or terminated, the Contractor shall deliver its entire fiscal and program records pertaining to the performance of

this IA to DHCS, which will retain the records for the required retention period.

3. Avoidance of Conflicts of Interest by Contractor

A. DHCS intends to avoid any real or apparent conflict of interest on the part of the Contractor, the subcontractor, or employees, officers and directors of the Contractor or subcontractor. Thus, DHCS reserves the right to determine, at its sole discretion, whether any information, assertion or claim received from any source indicates the existence of a real or apparent conflict of interest; and, if a conflict is found to exist, to require the Contractor to submit additional information or a plan for resolving the conflict, subject to DHCS review and prior approval.

B. Conflicts of interest include, but are not limited to:

1) An instance where the Contractor or subcontractor, or any employee, officer, or director of the Contractor or subcontractor has an interest, financial or otherwise, whereby the use or disclosure of information obtained while performing services under the IA would allow for private or personal benefit or for any purpose that is contrary to the goals and objectives of the IA.

2) An instance where the Contractor's or subcontractor's employees, officers, or directors use their positions for purposes that are, or give the appearance of being, motivated by a desire for private gain for themselves or others, such as those with whom they have family, business or other ties.

C. If DHCS is or becomes aware of a known or suspected conflict of interest, the Contractor will be given an opportunity to submit additional information or to resolve the conflict. A Contractor with a suspected conflict of interest will have five (5) working days from the date of notification of the conflict by DHCS to provide complete information regarding the suspected conflict. If a conflict of interest is determined to exist by DHCS and cannot be resolved to the satisfaction of DHCS, the conflict will be grounds for terminating the Agreement. DHCS may, at its discretion upon receipt of a written request from the Contractor, authorize an extension of the timeline indicated herein.

D. Contractor acknowledges that state laws on conflict of interest, found in the Political Reform Act, Public Contract Code Section 10365.5, and Government Code Section 1090, apply to this IA.

4. Freeze Exemptions

A. Contractor agrees that any hiring freeze adopted during the term of this IA shall not be applied to the positions funded, in whole or part, by this IA.

B. Contractor agrees not to implement any personnel policy, which may adversely affect performance or the positions funded, in whole or part, by this IA.

C. Contractor agrees that any travel freeze or travel limitation policy adopted during the term of this IA shall not restrict travel funded, in whole or part, by this IA.

D. Contractor agrees that any purchasing freeze or purchase limitation policy adopted during the term of this IA shall not restrict or limit purchases funded, in whole or part, by this IA.

5. Force Majeure

Neither party shall be responsible for delays or failures in performance resulting from acts beyond the control of either parties. Such acts shall include but not be limited to acts of God, fire, flood, earthquake, other natural disaster, nuclear accident, strike, lockout, riot, freight-embargo, related-utility, or governmental statutes or regulations super-imposed after the fact. If a delay or failure in performance by the Contractor arises out of a default of its subcontractor, and if such default of its subcontractor arises out of causes beyond the control of both the Contractor and subcontractor, and without the fault or negligence of either of them, the Contractor shall not be liable for damages of such delay or failure, unless the supplies or services to be furnished by the subcontractor were obtainable from other sources in sufficient time to permit the Contractor to meet the required performance schedule.

6. Identification of Contractor versus Subrecipient

DHCS has classified this Agreement as a procurement contract. Therefore, the Contractor is considered a contractor, and not a subrecipient, for the purposes of U.S. Office of Management and Budget Uniform Guidance pursuant to 2 CFR 200.330.

Exhibit F
Business Associate Addendum

1. This Agreement has been determined to constitute a business associate relationship under the Health Insurance Portability and Accountability Act (HIPAA) and its implementing privacy and security regulations at 45 Code of Federal Regulations, Parts 160 and 164 (collectively, and as used in this Agreement)

2. The term “Agreement” as used in this document refers to and includes both this Business Associate Addendum and the contract to which this Business Associate Agreement is attached as an exhibit, if any.

3. For purposes of this Agreement, the term “Business Associate” shall have the same meaning as set forth in 45 CFR section 160.103.

4. The Department of Health Care Services (DHCS) intends that Business Associate may create, receive, maintain, transmit or aggregate certain information pursuant to the terms of this Agreement, some of which information may constitute Protected Health Information (PHI) and/or confidential information protected by Federal and/or state laws.

   4.1 As used in this Agreement and unless otherwise stated, the term “PHI” refers to and includes both “PHI” as defined at 45 CFR section 160.103 and Personal Information (PI) as defined in the Information Practices Act (IPA) at California Civil Code section 1798.3(a). PHI includes information in any form, including paper, oral, and electronic.

   4.2 As used in this Agreement, the term “confidential information” refers to information not otherwise defined as PHI in Section 4.1 of this Agreement, but to which state and/or federal privacy and/or security protections apply.

5. Contractor (however named elsewhere in this Agreement) is the Business Associate of DHCS acting on DHCS's behalf and provides services or arranges, performs or assists in the performance of functions or activities on behalf of DHCS, and may create, receive, maintain, transmit, aggregate, use or disclose PHI (collectively, “use or disclose PHI”) in order to fulfill Business Associate’s obligations under this Agreement. DHCS and Business Associate are each a party to this Agreement and are collectively referred to as the "parties.”

6. The terms used in this Agreement, but not otherwise defined, shall have the same meanings as those terms in HIPAA and/or the IPA. Any reference to statutory or regulatory language shall be to such language as in effect or as amended.

7. **Permitted Uses and Disclosures of PHI by Business Associate**. Except as otherwise indicated in this Agreement, Business Associate may use or disclose PHI, inclusive of de-identified data derived from such PHI, only to perform functions, activities or services specified in this Agreement on behalf of DHCS, provided that such use or disclosure would not violate HIPAA or other applicable laws if done by DHCS.

   7.1 Specific Use and Disclosure Provisions. Except as otherwise indicated in this Agreement, Business Associate may use and disclose PHI if necessary for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate. Business Associate may disclose PHI for this purpose if the disclosure is required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person. The person shall notify the Business Associate of any instances of which the person is aware that the confidentiality of the information has been breached, unless such person is a treatment provider not acting as a business associate of Business Associate.

8. Compliance with Other Applicable Law

8.1 To the extent that other state and/or federal laws provide additional, stricter and/or more protective (collectively, more protective) privacy and/or security protections to PHI or other confidential information covered under this Agreement beyond those provided through HIPAA, Business Associate agrees:

8.1.1 To comply with the more protective of the privacy and security standards set forth in applicable state or federal laws to the extent such standards provide a greater degree of protection and security than HIPAA or are otherwise more favorable to the individuals whose information is concerned; and

8.1.2 To treat any violation of such additional and/or more protective standards as a breach or security incident, as appropriate, pursuant to Section 18. of this Agreement.

8.2 Examples of laws that provide additional and/or stricter privacy protections to certain types of PHI and/or confidential information, as defined in Section 4. of this Agreement, include, but are not limited to the Information Practices Act, California Civil Code sections 1798-1798.78, Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, Welfare and Institutions Code section 5328, and California Health and Safety Code section 11845.5.

8.3 If Business Associate is a Qualified Service Organization (QSO) as defined in 42 CFR section 2.11, Business Associate agrees to be bound by and comply with subdivisions (2)(i) and (2)(ii) under the definition of QSO in 42 CFR section 2.11.

9. Additional Responsibilities of Business Associate

9.1 Nondisclosure. Business Associate shall not use or disclose PHI or other confidential information other than as permitted or required by this Agreement or as required by law.

9.2 Safeguards and Security.

9.2.1 Business Associate shall use safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of PHI and other confidential data and comply, where applicable, with subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of the information other than as provided for by this Agreement. Such safeguards shall be based on applicable Federal Information Processing Standards (FIPS) Publication 199 protection levels.

9.2.2 Business Associate shall, at a minimum, utilize an industry-recognized security framework when selecting and implementing its security controls, and shall maintain continuous compliance with its selected framework as it may be updated from time to time. Examples of industry-recognized security frameworks include but are not limited to

9.2.2.1 NIST SP 800-53 – National Institute of Standards and Technology Special Publication 800-53

9.2.2.2 FedRAMP – Federal Risk and Authorization Management Program

9.2.2.3 PCI – PCI Security Standards Council

9.2.2.4 ISO/ESC 27002 – International Organization for Standardization / International Electrotechnical Commission standard 27002

9.2.2.5 IRS PUB 1075 – Internal Revenue Service Publication 1075

9.2.2.6 HITRUST CSF – HITRUST Common Security Framework

9.2.3 Business Associate shall employ FIPS 140-2 compliant encryption of PHI at rest and in motion unless Business Associate determines it is not reasonable and appropriate to do so based upon a risk assessment, and equivalent alternative measures are in place and documented as such. In addition, Business Associate shall maintain, at a minimum, the most current industry standards for transmission and storage of PHI and other confidential information.

9.2.4 Business Associate shall apply security patches and upgrades, and keep virus software up-to-date, on all systems on which PHI and other confidential information may be used.

9.2.5 Business Associate shall ensure that all members of its workforce with access to PHI and/or other confidential information sign a confidentiality statement prior to access to such data. The statement must be renewed annually.

9.2.6 Business Associate shall identify the security official who is responsible for the development and implementation of the policies and procedures required by 45 CFR Part 164, Subpart C.

9.3 Business Associate's Agent. Business Associate shall ensure that any agents, subcontractors, subawardees, vendors or others (collectively, "agents") that use or disclose PHI and/or confidential information on behalf of Business Associate agree to the same restrictions and conditions that apply to Business Associate with respect to such PHI and/or confidential information.

10. **Mitigation of Harmful Effects**. Business Associate shall mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of PHI and other confidential information in violation of the requirements of this Agreement.

11. **Access to PHI.** Business Associate shall make PHI available in accordance with 45 CFR section 164.524.

12. **Amendment of PHI.** Business Associate shall make PHI available for amendment and incorporate any amendments to protected health information in accordance with 45 CFR section 164.526.

13. **Accounting for Disclosures.** Business Associate shall make available the information required to provide an accounting of disclosures in accordance with 45 CFR section 164.528.

14. **Compliance with DHCS Obligations.** To the extent Business Associate is to carry out an obligation of DHCS under 45 CFR Part 164, Subpart E, comply with the requirements of the subpart that apply to DHCS in the performance of such obligation.

15. **Access to Practices, Books and Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI on behalf of DHCS available to DHCS upon reasonable request, and to the federal Secretary of Health and Human Services for purposes of determining DHCS' compliance with 45 CFR Part 164, Subpart E.

16. **Return or Destroy PHI on Termination; Survival.** At termination of this Agreement, if feasible, Business Associate shall return or destroy all PHI and other confidential information received from, or created or received by Business Associate on behalf of, DHCS that Business Associate still maintains in any form and retain no copies of such information. If return or destruction is not feasible, Business Associate shall notify DHCS of the conditions that make the return or destruction infeasible, and DHCS and Business Associate shall determine the terms and conditions under which Business Associate may retain the PHI. If such return or destruction is not feasible, Business Associate shall extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

17. **Special Provision for SSA Data.** If Business Associate receives data from or on behalf of DHCS that was verified by or provided by the Social Security Administration (SSA data) and is subject to an agreement between DHCS and SSA, Business Associate shall provide, upon request by DHCS, a list of all employees and agents and employees who have access to such data, including employees and agents of its agents, to DHCS.

18. **Breaches and Security Incidents.** Business Associate shall implement reasonable systems for the discovery and prompt reporting of any breach or security incident, and take the following steps:

18.1 Notice to DHCS.

18.1.1 Business Associate shall notify DHCS **immediately** upon the discovery of a suspected breach or security incident that involves SSA data. This notification will be provided by email upon discovery of the breach. If Business Associate is unable to provide notification by email, then Business Associate shall provide notice by telephone to DHCS.

18.1.2 Business Associate shall notify DHCS **within 24 hours by email** (or by telephone if Business Associate is unable to email DHCS) of the discovery of the following, unless attributable to a treatment provider that is not acting as a business associate of Business Associate:

18.1.2.1 Unsecured PHI if the PHI is reasonably believed to have been accessed or acquired by an unauthorized person;

18.1.2.2 Any suspected security incident which risks unauthorized access to PHI and/or other confidential information;

18.1.2.3 Any intrusion or unauthorized access, use or disclosure of PHI in violation of this Agreement; or

18.1.2.4 Potential loss of confidential information affecting this Agreement.

18.1.3 Notice shall be provided to the DHCS Program Contract Manager (as applicable), the DHCS Privacy Office, and the DHCS Information Security Office (collectively, "DHCS Contacts") using the DHCS Contact Information at Section 18.6. below.

Notice shall be made using the current DHCS "Privacy Incident Reporting Form" ("PIR Form"; the initial notice of a security incident or breach that is submitted is referred to as an "Initial PIR Form") and shall include all information known at the time the incident is reported. The form is available online at http://www.dhcs.ca.gov/formsandpubs/laws/priv/Pages/DHCSBusinessAssociatesOnly.aspx.

Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use or disclosure of PHI, Business Associate shall take:

18.1.3.1 Prompt action to mitigate any risks or damages involved with the security incident or breach; and

18.1.3.2 Any action pertaining to such unauthorized disclosure required by applicable Federal and State law.

18.2 Investigation. Business Associate shall immediately investigate such security incident or confidential breach.

18.3 Complete Report. To provide a complete report of the investigation to the DHCS contacts within ten (10) working days of the discovery of the security incident or breach. This "Final PIR" must include any applicable additional information not included in the Initial Form. The Final PIR Form shall include an assessment of all known factors relevant to a determination of whether a breach occurred under

HIPAA and other applicable federal and state laws. The report shall also include a full, detailed corrective action plan, including its implementation date and information on mitigation measures taken to halt and/or contain the improper use or disclosure. If DHCS requests information in addition to that requested through the PIR form, Business Associate shall make reasonable efforts to provide DHCS with such information. A "Supplemental PIR" may be used to submit revised or additional information after the Final PIR is submitted. DHCS will review and approve or disapprove Business Associate's determination of whether a breach occurred, whether the security incident or breach is reportable to the appropriate entities, if individual notifications are required, and Business Associate's corrective action plan.

18.3.1 If Business Associate does not complete a Final PIR within the ten (10) working day timeframe, Business Associate shall request approval from DHCS within the ten (10) working day timeframe of a new submission timeframe for the Final PIR.

18.4 **Notification of Individuals**. If the cause of a breach is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate shall notify individuals accordingly and shall pay all costs of such notifications, as well as all costs associated with the breach. The notifications shall comply with applicable federal and state law. DHCS shall approve the time, manner and content of any such notifications and their review and approval must be obtained before the notifications are made.

18.5 **Responsibility for Reporting of Breaches to Entities Other than DHCS.** If the cause of a breach of PHI is attributable to Business Associate or its agents, other than when attributable to a treatment provider that is not acting as a business associate of Business Associate, Business Associate is responsible for all required reporting of the breach as required by applicable federal and state law.

18.6 **DHCS Contact Information**. To direct communications to the above referenced DHCS staff, the Contractor shall initiate contact as indicated here. DHCS reserves the right to make changes to the contact information below by giving written notice to Business Associate. These changes shall not require an amendment to this Agreement.

DHCS Program Contract Manager	**DHCS Privacy Office**	**DHCS Information Security Office**
See the Scope of Work exhibit for Program Contract Manager information. If this Business Associate Agreement is not attached as an exhibit to a contract, contact the DHCS signatory to this Agreement.	Privacy Office c/o: Office of HIPAA Compliance Department of Health Care Services P.O. Box 997413, MS 4722 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov Telephone: (916) 445-4646	Information Security Office DHCS Information Security Office P.O. Box 997413, MS 6400 Sacramento, CA 95899-7413 Email: incidents@dhcs.ca.gov

19. Responsibility of DHCS. DHCS agrees to not request the Business Associate to use or disclose PHI in any manner that would not be permissible under HIPAA and/or other applicable federal and/or state law.

20. Audits, Inspection and Enforcement

20.1 From time to time, DHCS may inspect the facilities, systems, books and records of Business Associate to monitor compliance with this Agreement. Business Associate shall promptly remedy any violation of this Agreement and shall certify the same to the DHCS Privacy Officer in writing. Whether or how

DHCS exercises this provision shall not in any respect relieve Business Associate of its responsibility to comply with this Agreement.

20.2 If Business Associate is the subject of an audit, compliance review, investigation or any proceeding that is related to the performance of its obligations pursuant to this Agreement, or is the subject of any judicial or administrative proceeding alleging a violation of HIPAA, Business Associate shall promptly notify DHCS unless it is legally prohibited from doing so.

21. Termination

21.1 **Termination for Cause**. Upon DHCS' knowledge of a violation of this Agreement by Business Associate, DHCS may in its discretion:

21.1.1 Provide an opportunity for Business Associate to cure the violation and terminate this Agreement if Business Associate does not do so within the time specified by DHCS; or

21.1.2 Terminate this Agreement if Business Associate has violated a material term of this Agreement.

21.2 **Judicial or Administrative Proceedings.** DHCS may terminate this Agreement if Business Associate is found to have violated HIPAA, or stipulates or consents to any such conclusion, in any judicial or administrative proceeding.

22. Miscellaneous Provisions

22.1 **Disclaimer**. DHCS makes no warranty or representation that compliance by Business Associate with this Agreement will satisfy Business Associate's business needs or compliance obligations. Business Associate is solely responsible for all decisions made by Business Associate regarding the safeguarding of PHI and other confidential information.

22.2. **Amendment**.

22.2.1 Any provision of this Agreement which is in conflict with current or future applicable Federal or State laws is hereby amended to conform to the provisions of those laws. Such amendment of this Agreement shall be effective on the effective date of the laws necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

22.2.2 Failure by Business Associate to take necessary actions required by amendments to this Agreement under Section 22.2.1 shall constitute a material violation of this Agreement.

22.3 **Assistance in Litigation or Administrative Proceedings**. Business Associate shall make itself and its employees and agents available to DHCS at no cost to DHCS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against DHCS, its directors, officers and/or employees based upon claimed violation of HIPAA, which involve inactions or actions by the Business Associate.

22.4 **No Third-Party Beneficiaries**. Nothing in this Agreement is intended to or shall confer, upon any third person any rights or remedies whatsoever.

22.5 **Interpretation**. The terms and conditions in this Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA and other applicable laws.

22.6 **No Waiver of Obligations**. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

Bi-Valley Medical Clinic, Inc., doing business as BAART Programs Carmichael
Exhibit D
California Levine Act Statement

California Government Code section 84308, commonly referred to as the "Levine Act," prohibits any officer of El Dorado County from participating in any action related to a contract if he or she receives any political contributions totaling more than two hundred and fifty dollars ($250) within the previous twelve (12) months, and for twelve (12) months following the date a final decision concerning the contract has been made, from the person or company awarded the contract. The Levine Act also requires disclose of such contribution by a party to be awarded a specific contract. An officer of El Dorado County includes the Board of Supervisors, and any elected official (collectively "Officer"). It is the Contractor's/Consultant's responsibility to confirm the appropriate "officer" and name the individual(s) in their disclosure.

Have you or your company, or any agent on behalf of you or your company, made any political contributions of more than $250 to an Officer of the County of El Dorado in the twelve months preceding the date of the submission of your proposals or the anticipated date of any Officer action related to this contract?

_____YES _____NO
If yes, please identify the person(s) by name:
If no, please type N/A.

Do you or your company, or any agency on behalf of you or your company, anticipate or plan to make any political contribution of more than $250 to an Officer of the County of El Dorado in the twelve months following any Officer action related to this contract?

_____YES _____NO
If yes, please identify the person(s) by name:
If no, please type N/A.

Answering YES to either of the two questions above does not preclude the County of El Dorado from awarding a contract to your firm or any taking any subsequent action related to the contract. It does, however, preclude the identified Officer(s) from participating in any actions related to this contract.

Date	Signature of authorized individual
Bi-Valley Medical Clinic, Inc dba BAART Programs Carmichael	
Type or write name of company	Type or write name of authorized individual

Bi-Valley Medical Clinic, Inc., doing business as BAART Programs Carmichael
Exhibit E
Notice of Adverse Benefit Determination (NOABD) Form

Please submit an encrypted e-mail to: SUDSQualityAssurance@edcgov.us or FAX: 530-295-2596 NOT FOR CLIENT USE

SUD Provider Name:	
Client Name:	
Client SSN	
Client DOB	
Preferred Language	
Date of NOABD Decision:	

Instructions: Select one (1) applicable Notice of Adverse Benefit Determination listed below and complete all pertaining items

☐ **Denial of Authorization for Requested Services**	Provide clear concise explanation regarding authorization denial:	
	Provide clinical reasons for the authorization denial decision regarding medical necessity:	
	*__ATTN SUD Residential Programs__: SUDS Quality Assurance will issue NOABD Denial of Authorization for Requested Services to beneficiary and inform SUD Residential Provider.	
☐ **Delivery System**	Provide Diagnosis:	Provide ASAM Level of Care Score:
	Client does NOT meet (Select Applicable): ☐ Adult beneficiaries must have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, **and** must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria required by the The Drug Medi-Cal Organized Delivery System (DMC-ODS) Special Terms and Conditions (STC) 128(d). ☐ SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of a disease, illness or injury consistent with and 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.	
☐ **Modification of Requested Services**	Provide current services provided: Provide details of modification of type of service (if applicable):	
	Provide current frequency of each service provided: Provide details of modification (if applicable):	
	Provide current duration / length of each service provided: Provide details of modification (if applicable):	
☐ **Termination of a Previously Authorized Service**	Provide clear concise explanation regarding termination / involuntary discharge of a previously authorized service:	
	Provide clinical reasons for the termination denial / involuntary discharge decision regarding medical necessity:	
☐ **Delay in Processing Authorization of Services**	Select this NOABD if the following condition applies: ☐ For a standard reauthorization, request was NOT completed within 7 calendar days of previous authorization end date ☐ The timeline can be extended If extension might be in beneficiary's interest is when the county thinks it might be able to approve your provider's request for authorization.	
	*__ATTN SUD Residential Providers:__ SUDS Quality Assurance will issue NOABD Processing Authorization of Services and inform SUD Residential Provider.	
☐ **Failure to Provide Timely Access to Services**	For outpatient and intensive outpatient services ☐ Face-to-face appointment within 10 business days of service authorization request *was not completed* Provide Date Face-to-Face Appointment Client was Seen:	Provide Days out of Compliance:
	For OTP ☐ Face-to-face appointment within three business days of service authorization request *was not completed.* Provide Date Face-to-Face Appointment Client was Seen:	Provide Days out of Compliance:
	For Residential Providers ☐ Face-to-face appointment within 72 hours *was not completed.* Provide Date Face-to-Face Appointment Client was Seen:	Provide Days out of Compliance:
☐ **Dispute of Financial Liability**	Provide description of the disputed financial liability: cost-sharing, co-insurance, and other liabilities:	
Denial of Payment for a Service Rendered by Provider	SUDS Quality Assurance will issue Denial of Payment for a Service Rendered by Provider and inform SUD Provider and beneficiary.	
Failure to Timely Resolve Grievances and Appeals	SUDS Quality Assurance will issue Failure to Timely Resolve Grievances and Appeals and inform SUD Provider and beneficiary.	

Once Completed please submit an encrypted e-mail to:
SUDSQualityAssurance@edcgov.us or FAX: 530-295-2596
NOT FOR CLIENT USE

Bi-Valley Medical Clinic, Inc., doing business as BAART Programs Carmichael
Exhibit F
"Vendor Assurance of Compliance with
Nondiscrimination in State and Federally Assisted Programs"

HEREBY AGREES THAT it will comply with Title VI and VII of the Civil Rights Act of 1964 as amended; Section 504 of the Rehabilitation Act of 1973 as amended; the Age Discrimination Act of 1975 as amended; the Food Stamp Act of 1977, as amended and in particular section 272.6; Title II of the Americans with Disabilities Act of 1990; California Civil Code Section 51 et seq., as amended; California Government Code section 11135-11139.5, as amended; California Government Code section 12940 (c), (h) (1), (i), and (j); California Government Code section 4450; Title 22, California Code of Regulations section 98000 – 98413; Title 24 of the California Code of Regulations, Section 3105A(e); the Dymally-Alatorre Bilingual Services Act (California Government Code Section 7290-7299.8); Section 1808 of the Removal of Barriers to Interethnic Adoption Act of 1996; and other applicable federal and state laws, as well as their implementing regulations [including 45 Code of Federal Regulations (CFR) Parts 80, 84, and 91, 7 CFR Part 15, and 28 CFR Part 42], by ensuring that employment practices and the administration of public assistance and social services programs are nondiscriminatory, to the effect that no person shall because of ethnic group identification, age, sex, color, disability, medical condition, national origin, race, ancestry, marital status, religion, religious creed or political belief be excluded from participation in or be denied the benefits of, or be otherwise subject to discrimination under any program or activity receiving federal or state financial assistance; and HEREBY GIVE ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all federal and state assistance; and THE VENDOR/RECIPIENT HEREBY GIVES ASSURANCE THAT administrative methods/procedures which have the effect of subjecting individuals to discrimination or defeating the objectives of the California Department of Social Services (CDSS) Manual of Policies and Procedures (MPP) Chapter 21, will be prohibited.

BY ACCEPTING THIS ASSURANCE, the vendor/recipient agrees to compile data, maintain records and submit reports as required, to permit effective enforcement of the aforementioned laws, rules and regulations and permit authorized CDSS and/or federal government personnel, during normal working hours, to review such records, books and accounts as needed to ascertain compliance. If there are any violations of this assurance, CDSS shall have the right to invoke fiscal sanctions or other legal remedies in accordance with Welfare and Institutions Code section 10605, or Government Code section 11135-11139.5, or any other laws, or the issue may be referred to the appropriate federal agency for further compliance action and enforcement of this assurance.

THIS ASSURANCE is binding on the vendor/recipient directly or through contract, license, or other provider services, as long as it receives federal or state assistance.

_____ _____
Date Signature

_____
Address of vendor/recipient

Bi-Valley Medical Clinic, Inc., doing business as BAART Programs Carmichael
Exhibit G
Certification Of Non-Exclusion Or Suspension from Participation in a Federal Health Care Program

Provider, through signature of this form, certifies to the following:

A. Provider certifies that it is not excluded from participation in Federal Health Care Programs under either section 1128 or 1128A of the Social Security Act. Failure to certify will render all provisions of this Agreement null and void and may result in the immediate termination of the Agreement.

B. Provider certifies that they do not employ or subcontract with providers or have other relationships with providers excluded from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. § 438.610. Provider shall conduct initial and monthly Exclusion & Suspension searches of the following databases and provide evidence of these completed searches when requested by County, DHCS or the US DHHS:
   I. www.oig.hhs.gov/exclusions - LEIE Federal Exclusions
   II. www.sam.gov/portal/SAM - GSA Exclusions Extract
   III. www.Medi-Cal.ca.gov - Suspended & Ineligible Provider List
   IV. https://nppes.cms.hhs.gov/#/ - National Plan and Provider Enumeration System (NPPES)
   V. any other database required by DHCS or DHHS.

C. Provider certifies that he/she does not employ staff or individual Providers/vendors that are on the Social Security Administration's Death Master File. Provider shall check the following database prior to employing staff or individual Providers/vendors and provide evidence of these completed searches when requested by the County, DHCS or the US DHHS.
   https://www.ssdmf.com - Social Security Death Master File

D. Provider is required to notify County immediately if Provider becomes aware of any information that may indicate their (including employees/staff and individual Providers/vendors) potential placement on an exclusions list.

E. Provider shall screen and periodically revalidate all network providers in accordance with the requirements of 42 C.F.R., Part 455, Subparts B and E.

F. Provider must confirm the identity and determine the exclusion status of all its providers, as well as any person with an ownership or control interest, or who is an agent or managing employee of the contracted agency through routine checks of federal and state databases. This includes the Social Security Administration's Death Master File, NPPES, the Office of Inspector General's List of Excluded Individuals/Entities (LEIE), the Medi-Cal Suspended and Ineligible Provider List (S&I List) as consistent with the requirements of 42 C.F.R. § 455.436.

G. If a Provider finds a provider that is Excluded, it must promptly notify the County as per 42 C.F.R. § 438.608(a)(2), (4). Provider shall not certify or pay any Excluded provider with Medi-Cal funds, must treat any payments made to an Excluded provider as an overpayment, and any such inappropriate payments may be subject to recovery.

_____ _____

Provider Name Date

_____

Provider Signature

Bi-Valley Medical Clinic, Inc., doing business as BAART Programs Carmichael
Exhibit H
HIPAA Business Associate Agreement

This Business Associate Agreement is made part of the base contract ("Underlying Agreement") to which it is attached, as of the date of commencement of the term of the Underlying Agreement (the "Effective Date").

R E C I T A L S

WHEREAS, County and Contractor (hereinafter referred to as Business Associate ("BA") entered into the Underlying Agreement pursuant to which BA provides services to County, and in conjunction with the provision of such services, certain Protected Health Information ("PHI") and Electronic Protected Health Information ("EPHI") may be disclosed to BA for the purposes of carrying out its obligations under the Underlying Agreement;

WHEREAS, the County and BA intend to protect the privacy and provide for the security of PHI and EPHI disclosed to BA pursuant to the Agreement in compliance with the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191 of 1996 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 (the "HITECH" Act), and regulation promulgated thereunder by the U.S. Department of Health and Human Services (the "HIPAA Regulations") and other applicable laws as may be amended from time to time;

WHEREAS, County is a Covered Entity, as defined in the Privacy Rule and Security Rule, including but not limited to 45 CFR Section 160.103;

WHEREAS, BA, when a recipient of PHI from County, is a Business Associate as defined in the Privacy Rule, the Security Rule, and the HITECH Act, including but not limited to 42 USC Section 17938 and 45 CFR Section 160.103;

WHEREAS, "Individual" shall have the same meaning as the term "individual" in 45 CFR § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.202(g);

WHEREAS, "Breach" shall have the meaning given to such term under the HITECH Act under 42 USC Section 17921; and

WHEREAS, "Unsecured PHI" shall have the meaning to such term under the HITECH Act and any guidance issued pursuant to such Act including, but not limited to 42 USC Section 17932(h).

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the Parties agree as follows:

I. Definitions. Unless otherwise provided in this Business Associate Agreement, capitalized terms shall have the same meanings as set forth in the Privacy Rule, as may be amended from time to time.

II. Scope of Use and Disclosure by BA of County Disclosed PHI

A. BA shall not disclose PHI except for the purposes of performing BA's obligations under the Underlying Agreement. Further, BA shall not use PHI in any manner that would constitute a violation of the minimum necessary policies and procedures of the County, Privacy Rule, Security Rule, or the HITECH Act.

B. Unless otherwise limited herein, in addition to any other uses and/or disclosures permitted or authorized by this Business Associate Agreement or required by law, BA may:

1. Use the PHI in its possession for its proper management and administration and to fulfill any legal obligations.
2. disclose the PHI in its possession to a third party for the purpose of BA's proper management and administration or to fulfill any legal responsibilities of BA, or as required by law
3. Disclose PHI as necessary for BA's operations only if:
   a) Prior to making a disclosure to a third party, BA will obtain written assurances from such third party including:
      (1) To hold such PHI in confidence and use or further disclose it only for the purpose of which BA disclosed it to the third party, or as required by law; and
      (2) The third party will immediately notify BA of any breaches of confidentiality of PHI to the extent it has obtained knowledge of such breach.
4. Aggregate the PHI and/or aggregate the PHI with that of other data for the purpose of providing County with data analyses related to the Underlying Agreement, or any other purpose, financial or otherwise, as requested by County.
5. Not disclose PHI disclosed to BA by County not authorized by the Underlying Agreement or this Business Associate Agreement without patient authorization or de-identification of the PHI as authorized in writing by County.
6. De-identify any and all PHI of County received by BA under this Business Associate Agreement provided that the de-identification conforms to the requirements of the Privacy Rule, 45 CFR and does not preclude timely payment and/or claims processing and receipt.

C. BA agrees that it will neither use nor disclose PHI it receives from County, or from another business associate of County, except as permitted or required by this Business Associate Agreement, or as required by law, or as otherwise permitted by law.

III. Obligations of BA. In connection with its use of PHI disclosed by County to BA, BA agrees to:

A. Implement appropriate administrative, technical, and physical safeguards as are necessary to prevent use or disclosure of PHI other than as permitted by the Agreement that reasonably and appropriately protects the confidentiality, integrity, and availability of the PHI in accordance with Title 45 of the Code of Federal Regulations, Part 160 and Part 164, Subparts A and C (the "HIPAA Privacy Rule" and the "HIPAA Security Rule") in effect or as may be amended, including but not limited to 45 CFR 164.308,

164.310, 164.312, and 164.504(e)(2). BA shall comply with the policies, procedures, and documentation requirements of the HIPAA Security Rule.

B. Report to County within 24 hours of any suspected or actual breach of security, intrusion, or unauthorized use or disclosure of PHI of which BA becomes aware and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations. BA shall take prompt corrective action to cure any such deficiencies and any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.

C. Report to County in writing of any access, use, or disclosure of PHI not permitted by the Underlying Agreement and this Business Associate Agreement, and any Breach of Unsecured PHI of which it becomes aware without unreasonable delay and in no case later than five (5) days. To the extent the Breach is solely a result of BA's failure to implement reasonable and appropriate safeguards as required by law, and not due in whole or part to the acts or omissions of the County, BA may be required to reimburse the County for notifications required under 45 CFR 164.404 and CFR 164.406.

D. BA shall not use or disclose PHI for fundraising or marketing purposes. BA shall not disclose PHI to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates. BA shall not directly or indirectly receive remuneration in exchange of PHI, except with the prior written consent of the County and as permitted by the HITECH Act, 42 USC Section 17935(d)(2); however, this prohibition shall not affect payment by County to BA for services provided pursuant to the Agreement.

IV. PHI Access, Amendment, and Disclosure Accounting. BA agrees to:

A. Provide access, at the request of County, within five (5) days, to PHI in a Designated Record Set, to the County, or to an Individual as directed by the County. If BA maintains an Electronic Health Record, BA shall provide such information in electronic format to enable County to fulfill its obligations under the HITECH Act, including, but not limited to, 42 USC Section 17935(e).

B. Within ten (10) days of receipt of a request from County, incorporate any amendments or corrections to the PHI in accordance with the Privacy Rule in the event that the PHI in BA's possession constitutes a Designated Record Set.

C. To assist the County in meeting its disclosure accounting under HIPAA:

1. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents or subcontractors for at least six (6) years prior to the request. However, accounting of disclosure from Electronic Health Record for treatment, payment, or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent that BA maintains an electronic health record and is subject to this requirement. At the minimum, the information collected shall include: (i) the date of disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) a brief description of PHI disclosed and; (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure.

2. Within in 30 days of notice by the County, BA agrees to provide to County information collected in accordance with this section to permit the County to respond to a request by an Individual for an accounting of disclosures of PHI.

D. Make available to the County, or to the Secretary of Health and Human Services (the "Secretary"), BA's internal practices, books and records relating to the use of and disclosure of PHI for purposes of determining BA's compliance with the Privacy Rule, subject to any applicable legal restrictions. BA shall provide County a copy of any PHI that BA provides to the Secretary concurrently with providing such information to the Secretary.

V. Obligations of County.

A. County agrees that it will promptly notify BA in writing of any restrictions on the use and disclosure of PHI agreed to by County that may affect BA's ability to perform its obligations under the Underlying Agreement, or this Business Associate Agreement.

B. County agrees that it will promptly notify BA in writing of any changes in, or revocation of, permission by any Individual to use or disclose PHI, if such changes or revocation may affect BA's ability to perform its obligations under the Underlying Agreement, or this Business Associate Agreement.

C. County agrees that it will promptly notify BA in writing of any known limitation(s) in its notice of privacy practices to the extent that such limitation may affect BA's use of disclosure of PHI.

D. County shall not request BA to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by County, except as may be expressly permitted by the Privacy Rule.

E. County will obtain any authorizations necessary for the use or disclosure of PHI, so that BA can perform its obligations under this Business Associate Agreement and/or the Underlying Agreement.

VI. Term and Termination.

A. Term. This Business Associate Agreement shall commence upon the Effective Date and terminate upon the termination of the Underlying Agreement, as provided therein when all PHI provided by the County to BA, or created or received by BA on behalf of the County, is destroyed or returned to the County, or, or if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

B. Termination for Cause. Upon the County's knowledge of a material breach by the BA, the County shall either:

1. Provide an opportunity for the BA to cure the breach or end the violation and terminate this Agreement if the BA does not cure the breach or end the violation within the time specified by the County.
2. Immediately terminate this Agreement if the BA has breached a material term of this Agreement and cure is not possible; or
3. If neither termination nor cures are feasible, the County shall report the violation to the Secretary.

C. Effect of Termination.

1. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, the BA shall, at the option of County, return or destroy

all PHI that BA or its agents or subcontractors still maintain in any form, and shall retain no copies of such PHI.

2. In the event that the County determines that returning or destroying the PHI is infeasible, BA shall provide to the County notification of the conditions that make return or destruction infeasible, and BA shall extend the protections of this Agreement to such PHI to those purposes that make the return or destruction infeasible, for so long as the BA maintains such PHI. If County elects destruction of the PHI, BA shall certify in writing to County that such PHI has been destroyed.

VII. Indemnity

A. BA shall indemnify and hold harmless all Agencies, Districts, Special Districts and Departments of the County, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives (collectively "County") from any liability whatsoever, based or asserted upon any services of BA, its officers, employees, subcontractors, agents or representatives arising out of or in any way relating to BA's performance under this Business Associate Agreement, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever including fines, penalties or any other costs and resulting from any reason whatsoever to the extent arising from the performance of BA, its officers, agents, employees, subcontractors, agents or representatives under this Business Associate Agreement. BA shall defend, at its sole expense, all costs and fees including but not limited to attorney fees, cost of investigation, defense and settlements or awards against the County in any claim or action based upon such alleged acts or omissions.

B. With respect to any action or claim subject to indemnification herein by BA, BA shall, at its sole cost, have the right to use counsel of its choice, subject to the approval of County, which shall not be unreasonably withheld, and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of County; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes BA's indemnification of County as set forth herein. BA's obligation to defend, indemnify and hold harmless County shall be subject to County having given BA written notice within a reasonable period of time of the claim or of the commencement of the related action, as the case may be, and information and reasonable assistance, at BA's expense, for the defense or settlement thereof. BA's obligation hereunder shall be satisfied when BA has provided to County the appropriate form of dismissal relieving County from any liability for the action or claim involved.

C. The specified insurance limits required in the Underlying Agreement of this Business Associate Agreement shall in no way limit or circumscribe BA's obligations to indemnify and hold harmless the County herein from third party claims arising from the issues of this Business Associate Agreement.

D. In the event there is conflict between this clause and California Civil Code Section 2782, this clause shall be interpreted to comply with Civil Code Section 2782. Such interpretation shall not relieve the BA from indemnifying the County to the fullest extent allowed by law.

E. In the event there is a conflict between this indemnification clause and an indemnification clause contained in the Underlying Agreement of this Business

Associate Agreement, this indemnification shall only apply to the subject issues included within this Business Associate Agreement.

VIII. Amendment. The parties agree to take such action as is necessary to amend this Business Associate Agreement from time to time as is necessary for County to comply with the Privacy Rule, 45 CFR, and HIPAA generally.

IX. Survival. The respective rights and obligations of this Business Associate Agreement shall survive the termination or expiration of this Business Associate Agreement.

X. Regulatory References. A reference in this Business Associate Agreement to a section in the Privacy Rule means the section as in effect or as amended.

XI. Conflicts. Any ambiguity in this Business Associate Agreement and the Underlying Agreement shall be resolved to permit County to comply with the Privacy Rule, 45 CFR, and HIPAA generally.

Approval and Signatures

By: _____ Dated: _____

Name
"BA Representative"

By: _____ Dated: _____

Name
"HHSA Representative"