

nor shall it be construed, to confer rights on any third party.

B. Control Requirements

- 1) Performance under the terms of this Exhibit A, Attachment I, is subject to all applicable federal and state laws, regulations, and standards. In accepting DHCS drug and alcohol combined program allocation pursuant to HSC Sections 11814(a) and (b), Contractor shall: (i) establish, and shall require its subcontractors to establish, written policies and procedures consistent with the following requirements; (ii) monitor for compliance with the written procedures; and (iii) be held accountable for audit exceptions taken by DHCS against the Contractor and its subcontractors for any failure to comply with these requirements:
  - a) HSC, Division 10.5, commencing with Section 11760;
  - b) Title 9, California Code of Regulations (CCR) (herein referred to as Title 9), Division 4, commencing with Section 9000;
  - c) Government Code Section 16367.8;
  - d) Government Code, Article 7, Federally Mandated Audits of Block Grant Funds Allocated to Local Agencies, Chapter 1, Part 1, Division 2, Title 5, commencing at Section 53130;
  - e) Title 42 United State Code (USC), Sections 300x-21 through 300x-31, 300x-34, 300x-53, 300x-57, and 330x-65 and 66;
  - f) The Single Audit Act Amendments of 1996 (Title 31, USC Sections 7501-7507) and the Office of Management and Budget (OMB) Circular A-133 revised June 27, 2003 and June 26, 2007.
  - g) Title 45, Code of Federal Regulations (CFR), Sections 96.30 through 96.33 and Sections 96.120 through 96.137;
  - h) Title 42, CFR, Sections 8.1 through 8.6;
  - i) Title 21, CFR, Sections 1301.01 through 1301.93, Department of Justice, Controlled Substances; and,
  - j) State Administrative Manual (SAM), Chapter 7200 (General Outline of Procedures).

Contractor shall be familiar with the above laws, regulations, and guidelines and shall assure that its subcontractors are also familiar with such requirements.
- 2) The provisions of this Exhibit A, Attachment I are not intended to abrogate any provisions of law or regulation, or any standards existing or enacted during the term

of this Intergovernmental Agreement.

- 3) Contractor shall adhere to the applicable provisions of Title 45, CFR, Part 96, Subparts C and L, as applicable, in the expenditure of the SAPTBG funds. Document 1A, 45 CFR 96, Subparts C and L, is incorporated by reference.
  - 4) Documents 1C incorporated by this reference, contains additional requirements that shall be adhered to by those Contractors that receive Document 1C. This document is:
    - a) Document 1C, Driving-Under-the-Influence Program Requirements;
- C. In accordance with the Fiscal Year 2011-12 State Budget Act and accompanying law (Chapter 40, Statutes of 2011 and Chapter 13, Statutes of 2011, First Extraordinary Session), contractors that provide Women and Children's Residential Treatment Services shall comply with the program requirements (Section 2.5, Required Supplemental/Recovery Support Services) of the Substance Abuse and Mental Health Services Administration's Grant Program for Residential Treatment for Pregnant and Postpartum Women, RFA found at <http://www.samhsa.gov/grants/grant-announcements/ti-14-005>.

## 28.1 Performance Provisions

### A. Monitoring

- 1) Contractor's performance under this Exhibit A, Attachment I, shall be monitored by DHCS during the term of this Intergovernmental Agreement. Monitoring criteria shall include, but not be limited to:
  - a) Whether the quantity of work or services being performed conforms to Exhibit B;
  - b) Whether the Contractor has established and is monitoring appropriate quality standards;
  - c) Whether the Contractor is abiding by all the terms and requirements of this Intergovernmental Agreement;
  - d) Whether the Contractor is abiding by the terms of the Perinatal Services Network Guidelines 2016 (Document 1G); and
  - e) Contractor shall conduct annual onsite monitoring reviews of services and subcontracted services for programmatic and fiscal requirements. Contractor shall submit copy of their monitoring and audit reports to DHCS within two weeks of issuance. Reports should be sent by secure, encrypted e-mail to:

[SUDCountyReports@dhcs.ca.gov](mailto:SUDCountyReports@dhcs.ca.gov)

or

Substance Use Disorder - Prevention, Treatment and Recovery Services



Division, Performance Management Branch  
Department of Health Care Services  
PO Box 997413, MS-2627  
Sacramento, CA 95899-7413;

- 2) Failure to comply with the above provisions shall constitute grounds for DHCS to suspend or recover payments, subject to the Contractor's right of appeal, or may result in termination of the Intergovernmental Agreement or both.

B. Performance Requirements

- 1) Contractor shall provide services based on funding set forth in Exhibit B, Attachment I, and under the terms of this Intergovernmental Agreement.
- 2) Contractor shall provide services to all eligible persons in accordance with federal and state statutes and regulations. Contractor shall assure that in planning for the provision of services, the following barriers to services are considered and addressed:
  - a) Lack of educational materials or other resources for the provision of services;
  - b) Geographic isolation and transportation needs of persons seeking services or remoteness of services;
  - c) Institutional, cultural, and/or ethnicity barriers;
  - d) Language differences;
  - e) Lack of service advocates;
  - f) Failure to survey or otherwise identify the barriers to service accessibility; and,
  - g) Needs of persons with a disability.
- 3) Contractor shall comply with any additional requirements of the documents that have been incorporated herein by reference, including, but not limited to, those in the Exhibit A – Scope of Work, Provision 6.
- 4) Amounts awarded pursuant to Exhibit A, Attachment I shall be used exclusively for providing alcohol and/or drug program services consistent with the purpose of the funding.
- 5) DHCS shall issue a report to Contractor after conducting monitoring, utilization, or auditing reviews of county or county subcontracted providers. When the DHCS report identifies non-compliant services or processes, it shall require a CAP. The Contractor, or in coordination with its subcontracted provider, shall submit a CAP to DHCS within 60 calendar days from the date of the report to:

Substance Use Disorder – Program, Policy and Fiscal Division, Performance Management Branch

Department of Health Care Services  
PO Box 997413, MS-2621  
Sacramento, CA 95899-7413;

Or by secure, encrypted email to: [SUDCountyReports@dhcs.ca.gov](mailto:SUDCountyReports@dhcs.ca.gov)

- 6) The CAP shall include a statement of the problem and the goal of the actions the Contractor and or its sub-contracted provider shall take to correct the deficiency or non-compliance. The CAP shall:
  - a) Address the specific actions to correct deficiency or non-compliance
  - b) Identify who/which unit(s) shall act; who/which unit(s) are accountable for acting; and
  - c) Provide a timeline to complete the actions.

## 29. Definitions

### 29.1 General Definitions.

The words and terms of this Intergovernmental Agreement are intended to have their usual meanings unless a particular or more limited meaning is associated with their usage pursuant to Division 10.5 of HSC, Section 11750 et seq., and Title 9, CCR, Section 9000 et seq.

- A. **"Available Capacity"** means the total number of units of service (bed days, hours, slots, etc.) that a Contractor actually makes available in the current fiscal year.
- B. **"Contractor"** means the county identified in the Standard Agreement or DHCS authorized by the County Board of Supervisors to administer substance use disorder programs.
- C. **"Corrective Action Plan" (CAP)** means the written plan of action document which the Contractor or its subcontracted service provider develops and submits to DHCS to address or correct a deficiency or process that is non-compliant with laws, regulations or standards.
- D. **"County"** means the county in which the Contractor physically provides covered substance use treatment services.
- E. **"County Realignment Funds"** means Behavioral Health Subaccount funds received by the County as per California Code Section 30025.
- F. **"Days"** means calendar days, unless otherwise specified.
- G. **"Dedicated Capacity"** means the historically calculated service capacity, by modality, adjusted for the projected expansion or reduction in services, which the Contractor agrees to make available to provide non-DMC substance use disorder services to persons eligible for Contractor services.



- H. **"Final Allocation"** means the amount of funds identified in the last allocation letter issued by the State for the current fiscal year.
- I. **"Final Settlement"** means permanent settlement of the Contractor's actual allowable costs or expenditures as determined at the time of audit, which shall be completed within three years of the date the year-end cost settlement report was accepted for interim settlement by the State. If the audit is not completed within three years, the interim settlement shall be considered as the final settlement.
- J. **"Interim Settlement"** means temporary settlement of actual allowable costs or expenditures reflected in the Contractor's year-end cost settlement report.
- K. **"Maximum Payable"** means the encumbered amount reflected on the Standard Agreement of this Intergovernmental Agreement and supported by Exhibit B, Attachment I.
- L. **"Modality"** means those necessary overall general service activities to provide substance use disorder services as described in Division 10.5 of the HSC.
- M. **"Non-Drug Medi-Cal Amount"** means the contracted amount of SAPT Block Grant funds for services agreed to by the State and the Contractor.
- N. **"Performance"** means providing the dedicated capacity in accordance with Exhibit B, Attachment I, and abiding by the terms of this Exhibit A, including all applicable state and federal statutes, regulations, and standards, including Alcohol and/or Other Drug Certification Standards (Document 1P), in expending funds for the provision of substance use services hereunder.
- O. **"Preliminary Settlement"** means the settlement of only SAPT funding for counties that do include DMC funding.
- P. **"Revenue"** means Contractor's income from sources other than the State allocation.
- Q. **"Service Area"** means the geographical area under Contractor's jurisdiction.
- R. **"Service Authorization Request"** means a beneficiary's request for the provision of a service.
- S. **"Service Element"** is the specific type of service performed within the more general service modalities. A list of the service modalities and service elements and service elements codes is incorporated into this Intergovernmental Agreement as Document 1H(a) "Service Code Descriptions".
- T. **"State"** means the Department of Health Care Services or DHCS.
- U. **"Threshold Language"** means a language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.



- V. **"Utilization"** means the total actual units of service used by beneficiaries and participants.

## 29.2 Definitions Specific to Drug Medi-Cal

The words and terms of this Intergovernmental Agreement are intended to have their usual meaning unless a specific or more limited meaning is associated with their usage pursuant to the HSC, Title 6, and/or Title 22. Definitions of covered treatment modalities and services are found in Title 22 (Document 2C) and are incorporated by this reference.

- A. **"Action"** - (1) The denial or limited authorization of a requested service, including the type or level of service; (2) The reduction, suspension, or termination of a previously authorized service; (3) The denial, in whole or in part, of payment for a service; (4) The failure to provide services in a timely manner, as defined by the State; or (5) The failure of a Contractor to act within the timeframes provided in §438.408(b).
- B. **"Administrative Costs"** means the Contractor's actual direct costs, as recorded in the Contractor's financial records and supported by source documentation, to administer the program or an activity to provide service to the DMC program. Administrative costs do not include the cost of treatment or other direct services to the beneficiary. Administrative costs may include, but are not limited to, the cost of training, programmatic and financial audit reviews, and activities related to billing. Administrative costs may include Contractor's overhead per the approved indirect cost rate proposal pursuant to OMB Circular A-87 and the State Controller's Office Handbook of Cost Plan Procedures.
- C. **"Appeal"** is the request for review of an "action".
- D. **"Authorization"** is the approval process for DMC Services prior to the submission of a DMC claim.
- E. **"Beneficiary"** means a person who: (a) has been determined eligible for Medi-Cal; (b) is not institutionalized; (c) has a substance-related disorder per the current "Diagnostic and Statistical Manual of Mental Disorders (DSM)" criteria; and (d) meets the admission criteria to receive DMC covered services.
- F. **"Case Management"** means a service to assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.
- G. **"Certified Provider"** means a substance use disorder clinic and/or satellite clinic location that has received certification to be reimbursed as a DMC clinic by the State to provide services as described in Title 22, California Code of Regulations, Section 51341.1.
- H. **"Covered Services"** means those DMC services authorized by Title XIX or Title XXI of the Social Security Act; Title 22 Section 51341.1; W&I Code, Section 14124.24; and California's Medicaid State Plan, including the DMC ODS 1115 Demonstration Waiver standard terms and conditions.



- I. **"Delivery System"** DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program. DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a county that opts into the Pilot program. Upon approval of an implementation plan, the State shall contract with the county to provide DMC-ODS services. The county shall, in turn, contract with DMC certified providers or provide county-operated services to provide all services outlined in the DMC-ODS. Counties may also contract with a managed care plan to provide services. Participating counties with the approval from the State may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design or comparability of services. Counties may act jointly in order to deliver these services.
- J. **"Drug Medi-Cal Program"** means the state system wherein beneficiaries receive covered services from DMC-certified substance use disorder treatment providers.
- K. **"Drug Medi-Cal Termination of Certification"** means the provider is no longer certified to participate in the Drug Medi-Cal program upon the State's issuance of a Drug Medi-Cal certification termination notice.
- L. **"Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)"** means the federally mandated Medicaid benefit that entitles full-scope Medi-Cal-covered beneficiaries less than 21 years of age to receive any Medicaid service necessary to correct or ameliorate a defect, mental illness, or other condition, such as a substance-related disorder, that is discovered during a health screening.
- M. **"Fair Hearing"** means the State hearing provided to beneficiaries upon denial of appeal pursuant to 22 CCR 50951 and 50953 and 9 CCR 1810.216.6. Fair hearings must comply with 42 CFR 431.220(a)(5), 438.408(f), 438.414, and 438.10(g)(1).
- N. **"Federal Financial Participation (FFP)"** means the share of federal Medicaid funds for reimbursement of DMC services.
- O. **"Grievance"** means an expression of dissatisfaction about any matter other than an "action".
- P. **"Key Points of Contact"** means common points of access to substance use treatment services from the county, including but not limited to the county's beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the county.
- Q. **"Medical Necessity"** means those substance use treatment services that are reasonable and necessary to protect life, prevent significant illness or disability, or alleviate severe pain through the diagnosis and treatment of a disease, illness or injury consistent with and 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.
- R. **"Minor Consent DMC Services"** are those covered services that, pursuant to Family Code Section 6929, may be provided to persons 12-20 years old without parental consent.



- S. **“Narcotic Treatment Program”** means an outpatient clinic licensed by the State to provide narcotic **replacement** therapy directed at stabilization and rehabilitation of persons who are opiate-addicted and have a substance use diagnosis.
- T. **“Non-Perinatal Residential Program”** services are provided in DHCS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria. These residential services are provided to the non-perinatal population and do not require the enhanced services found in the perinatal residential programs.
- U. **“Notice of Action”** means a formal communication of any action, as defined above and consistent with 42 CFR 438.404 and 438.10.
- V. **“Payment Suspension”** means the Drug Medi-Cal certified provider has been issued a notice **pursuant** to W&I Code, Section 14107.11 and is not authorized to receive payments after the payment suspension date for DMC services, regardless of when the service was provided.
- W. **“Perinatal DMC Services”** means covered services as well as mother/child habilitative and **rehabilitative** services; services access (i.e., provision or arrangement of transportation to and from medically necessary treatment); education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant; and coordination of ancillary services (Title 22, Section 51341.1(c) 4).
- X. **“Postpartum”**, as defined for DMC purposes, means the 60-day period beginning on the last day of **pregnancy**, regardless of whether other conditions of eligibility are met. Eligibility shall end on the last day of the calendar month in which the 60<sup>th</sup> day occurs.
- Y. **“Post Service Post Payment (PSPP) Utilization Review”** means the review for program compliance and medical necessity conducted by the State after service was rendered and paid. State may recover prior payments of Federal and State funds if such review determines that the services did not comply with the applicable statutes, regulations, or standards (Cal. Code Regs. CCR, Title 22, Section 51341.1 (k)).
- Z. **“Physician Consultation”** services are to support DMC physicians with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.
- AA. **“Projected Units of Service”** means the number of reimbursable DMC units of service, based on historical data and current capacity, the Contractor expects to provide on an annual basis.
- BB. **“Provider Certification”** means the provider must be certified in order to participate in the Medi-Cal program.
- CC. **“Provider of DMC Services”** means any person or entity that provides direct substance use treatment services and has been certified by the State as meeting the standards for participation in the DMC program set forth in the “DMC Certification Standards for Substance Abuse Clinics”, Document 2E and “Standards for Drug



Treatment Programs (October 21, 1981)", Document 2F.

- DD. **"Re-certification"** means the process by which the DMC certified clinic and/or satellite program is required to submit an application and specified documentation, as determined by DHCS, to remain eligible to participate in and be reimbursed in through the DMC program. Re-certification shall occur no less than every five years from the date of previous DMC certification or re-certification.
- EE. **"Recovery Services"** are available after the beneficiary has completed a course of treatment. Recovery services emphasize the patient's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to patients.
- FF. **"Short-Term Resident"** means any beneficiary receiving residential services pursuant to DMC-ODS, regardless of the length of stay, is a "short-term resident" of the residential facility in which they are receiving the services.
- GG. **"Subcontract"** means an agreement between the Contractor and its subcontractors. A subcontractor shall not delegate its obligation to provide covered services or otherwise subcontract for the provision of direct patient/beneficiary services.
- HH. **"Subcontractor"** means an individual or entity that is DMC certified and has entered into an agreement with the Contractor to be a provider of covered services. It may also mean a vendor who has entered into a procurement agreement with the Contractor to provide any of the administrative functions related to fulfilling the Contractor's obligations under the terms of this Exhibit A, Attachment I.
- II. **"Temporary Suspension"** means the provider is temporarily suspended from participating in the DMC program as authorized by W&I Code, Section 14043.36(a). The provider cannot bill for DMC services from the effective date of the temporary suspension.
- JJ. **"Withdrawal Management"** means detoxification services provided in either an ambulatory or non-ambulatory setting consistent with the ASAM level of care criteria to DMC ODS beneficiaries.

### 30. Contractor Specific Requirements

Beginning October 18, 2016 and ending June, 30, 2019, in addition to the general requirements outlined in Exhibit A, Attachment I, the Contractor agrees to the following Contractor specific requirements:

#### A. Covered Services

In addition to the Mandatory Covered Services outlined in Section 1.2(B) of Exhibit A, Attachment I, the Contractor shall establish assessment and referral procedures and shall arrange, provide, or subcontract for medically necessary Contractor Specific



Covered Services in the Contractor's service area in compliance with 42 CFR 438.210(a)(1), 438.210(a)(2), and 438.210(a)(3).

- 1) The Contractor shall deliver the Contractor Specific Covered Services within a continuum of care as defined in the ASAM criteria.
- 2) Contractor Specific Covered Services include:
  - a) Additional Medication Assisted Treatment (MAT);
  - b) Recovery Residences; and
  - c) Telehealth for addiction medicine.

## **B. Access to Services**

In addition to the general access to services requirements outlined in Section 2.2 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific access to services requirements:

- 1) There are typically three pathways of system entry: 1) calls or walk-ins to a SUD network provider, 2) calls to the Behavioral Health Referral System (BHRS) Access Call Center (ACC), 3) walk-ins or direct referrals to the BHRS County Care Coordination Team (CCCT). Regardless of the entry point, the Contractor shall ensure that each individual is registered and screened following the same process and tools described below.
- 2) Initial Service Screening
  - a) The Contractor shall ensure that all individuals are triaged for risk (suicidality, homelessness, emergent physical health needs), insurance coverage/eligibility verification, and are advised of the benefits to which they are entitled under the DMC-ODS.
  - b) A uniform SUD screening tool and decision tree based on the American Society of Addiction Medicine (ASAM) dimensions shall be developed and implemented by the Access Call Center staff, the Contractor's Care Coordinators, and network SUD providers.
  - c) The Contractor shall ensure that all screenings include beneficiary eligibility and demographics and preliminary SUD level of care (LOC) determination.
  - d) Contractor shall ensure that all screenings shall be completed by clinicians or certified SUD counselors.
- 3) Once screened, the Contractor shall ensure that the beneficiary is referred/linked to the appropriate ASAM level of care. Placement considerations include: findings from the screening, geographic accessibility, threshold language needs, and beneficiary preference.



- 4) The Contractor shall publish uniform referral procedures for all entry pathways established.
- 5) Beneficiaries may be referred directly to any SUD network provider for an intake appointment for the following services:
  - a) Outpatient and Intensive Outpatient Services;
  - b) Narcotic Treatment Program Services;
  - c) Withdrawal Management Services (Outpatient);
  - d) Medication Assisted Treatment Services;
  - e) Recovery Services; and
  - f) Case Management Services.
- 6) Contractor shall ensure that individuals with an initial screening suggestive of a residential placement shall be provided a residential evaluation prior to scheduling the intake appointment.
- 7) Re-Assessment
  - a) Re-assessments allow the treatment team to review beneficiary progress, comparing the most recent beneficiary functioning and severity to the initial assessment and to evaluate the beneficiary's response to care or treatment services. Each ASAM dimension is reviewed to determine the current level of functioning and severity. The Contractor shall ensure that all providers demonstrate that their beneficiaries continue to meet current level of care criteria or determine that an alternative is most appropriate.
  - b) The Contractor shall ensure that all beneficiaries shall be reassessed any time there is a significant change in his/her status, diagnosis, a revision to the beneficiary's individualized treatment plan, and as requested by the beneficiary.
  - c) The Contractor shall ensure that providers reassess beneficiaries for medical necessity and appropriate level of care within the following maximum timeframes:
    - i. Residential Detoxification, Level 3.2: 5 days;
    - ii. Residential Treatment, Levels 3.1, 3.3, 3.5: 30 days;
    - iii. Intensive Outpatient, Level 2.1: 60 days;
    - iv. Outpatient Treatment, Level 1: 90 days;
    - v. Narcotic Treatment Programs: 1 year;

- vi. Medication Assisted Treatment: 1 year;
- vii. Recovery Services: 6 months; and
- viii. Case Management: Evaluate as part of above service modalities.

### **C. Timely Access**

In addition to the general timely access requirements outlined in Section 2.3 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific timely access requirements:

#### **1) Timeliness of First Visit**

- a) The Contractor shall ensure that each beneficiary be offered a first appointment within 15 days of referral or request for service for non-urgent services.
- b) To improve timely access to services for all beneficiaries, the Contractor shall collect baseline data implementation year 1 to identify problem areas and solutions, with the goal of all beneficiaries being offered an appointment within 10 days of a request for non-urgent services by implementation year 3. A first appointment may be provided in any appropriate community setting, in-person, by telephone, or by telehealth.
- c) Urgent conditions require immediate attention but do not require inpatient hospitalization. At the time of first contact, the Contractor shall ensure that each beneficiary will be triaged to identify the presence of an urgent condition or emergent condition. Once the Contractor or one of its network providers is made aware of the beneficiary's urgent condition, the urgent condition shall be addressed (or the timeframe in which a beneficiary with an urgent condition must be seen) within 24 hours.
- d) The Contractor shall offer beneficiaries access to screening and assessment as part of "Same Day Assistance". The Contractor shall ensure that beneficiaries can walk into a clinic or be referred to a clinic for a same day appointment by the Contractor's Access Call Center.
- e) The Contractor shall ensure that all beneficiaries experiencing a medical or psychiatric emergency will be directed to the nearest hospital for services.
- f) The Contractor shall ensure that beneficiaries can access after-hours care by calling the 24-hour BHRS ACC, where callers are screened and triaged for risk and appropriate referrals are made. In addition, Contractor shall ensure that network providers maintain a system of 24-hour on-call services for beneficiaries in their programs and shall ensure that beneficiaries are aware of how to contact the treating or covering provider after-hours, and during weekends and holidays. Contractor shall also ensure the call center services will be available in all threshold languages. Contractor shall ensure that all provider contracts will



include performance standards that will be measured monthly and reported to assure transparency.

- g) Upon request from the beneficiary, the Contractor shall provide for a second opinion from a qualified health care professional within the network, or arrange for the enrollee to obtain one outside the network, at no cost to the enrollee.

2) Access for Persons with Disabilities

- a) The Contractor shall require all of its network providers to serve persons with disabilities in compliance with SAPT BG and DHCS requirements and the following policies and regulations:

- i. Americans with Disabilities Act of 1990;
- ii. Section 540 of Rehabilitation Act of 1973;
- iii. 45 Code of Federal Regulations (CFR), Part 84, Non-discrimination on the Basis of Handicap in programs or Activities Receiving Federal Financial Assistance;
- iv. Title 24, California Code of Regulations (CCR), Part 2, Activities Receiving Federal Financial Assistance;
- v. Unruh Civil Rights Act California Civil Code (CCC) Sections 51 through 51.3 and all applicable laws related to services and access to services for persons with disabilities; and
- vi. 42 CFR 438.6(d).

- 3) The Contractor shall require that providers make accommodations to serve persons with physical disabilities, including vision and hearing impairments. In addition, services must be made available to all individuals with mobility, communication or cognitive impairments as required by federal and state laws and regulations.
- 4) The Contractor shall maintain a reference list of SUD network treatment providers able to accommodate persons in wheelchairs. If a provider is unable to meet the needs of a person with a specific physical disability, the Contractor shall ensure that they must use the aforementioned list to refer the person to a provider who can meet the needs of the individual.
- 5) The Contractor shall require that the referring provider contact the new provider to expedite the person's transition to ensure the individual is successful in accessing needed support and services.
- 6) The Contractor shall ensure that its providers use the DHCS checklist for accessibility and BHRS staff monitors compliance with regulations through a biennial desk audit. The Contractor shall ensure that beneficiaries are advised of their right to receive services and any complaints and grievances are investigated and appropriate and timely action is taken to ensure access.



#### **D. Coordination and Continuity of Care**

In addition to the general coordination and continuity of care requirements outlined in Section 2.5 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor coordination and continuity of care requirements:

- 1) The Contractor's County Care Coordination Team (CCCT) shall connect individuals to the appropriate SUD service provider. Once connected and the transition has been completed, the CCCT no longer provides services. All case management and care coordination services and supports shall be provided by Contractor staff.
- 2) Contractor's CCCT shall facilitate connections to ancillary services and supports that are identified in the beneficiary's treatment and recovery plan.
- 3) Contractor's CCCT shall turn over case management responsibilities to the provider once the beneficiary is enrolled in the new program.
- 4) Below are responsibilities that are provided by either or both CCCT and Case Manager (CM):
  - a) Assesses beneficiary needs, motivation, and barriers to care (CCCT, CM);
  - b) Provides patient education and engagement (CCCT, CM);
  - c) Coordinates quality referrals to improve transitions into SUD and other needed services (CCCT, CM);
  - d) Provide SBIRT services, including comprehensive substance use, physical and mental health screening (CCCT) (SBIRT services are not paid for under the DMC-ODS system);
  - e) Engage beneficiaries and support their participation in integrated health programs (CCCT, CM);
  - f) Evaluate beneficiaries with SUD to determine residential treatment need (authorization and reauthorizations) and to identify the most appropriate service provider(s) for the beneficiary (CCCT);
  - g) Provide logistical support for beneficiaries to ensure seamless and timely entry or transitions between levels of care (CCCT, CM);
  - h) Provide services to high risk and high utilizers of emergency services with an emphasis on outreach, engagement, systems navigation, and collaborative care planning across SUD services, mental and physical health services, and other social and community based service providers (CCCT);



- i) Initiate complex case conferences and physician consultation (CCCT, CM); and
  - j) Receive referrals for individuals who are at-risk of or have histories of unsuccessful treatment engagements. Deliver engagement strategies including motivational interventions (CCCT).
- 5) CCCT and CM services may be provided to a beneficiary face-to-face, by telephone, or by telehealth and may be provided anywhere in the community and are provided in compliance with confidentiality of alcohol or drug patients as established by 42 CFR Part 2 and California law.

#### **E. Memorandum of Understanding**

In addition to the general memorandum of understanding requirements outlined in Section 2.5(C) of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor memorandum of understanding requirements:

- 1) The Contractor is a "one plan county" for Medi-Cal managed care and the plan is administered by the Health Plan of San Mateo (HPSM).
- 2) The Contractor and HPSM shall finalize details to amend the existing agreement to address the coordination of service delivery specific to the implementation of the DMC-ODS by September 30, 2016. A copy of the agreement shall be sent to DHCS when approved and will become an addendum to the Implementation Plan.

#### **F. Authorization of Services – Residential Programs**

In addition to the general authorization of residential services requirements outlined in Section 2.6 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific authorization of residential services requirements:

- 1) The Contractor shall ensure that all of its providers obtain authorization for residential services prior to admitting a beneficiary. Residential authorization processes shall be completed to assure beneficiaries access medically necessary services in a timely manner. The Contractor shall track all authorization and reauthorization through the Contractor's electronic health record. The Contractor shall utilize four primary pathways that will support beneficiaries in accessing and receiving timely authorization for residential services.
- 2) Path 1: Access Call Center - BHRS Care Coordination Team Authorizations:
  - a) Beneficiaries are advised to contact the Access Call Center (ACC) to inquire about services. When the ACC screening yields a residential withdrawal management need, an authorization and referral for Level 3.2 Withdrawal Management is created. When the ACC screenings yields a residential treatment need, an appointment shall be made by the ACC with the BHRS Care Coordination Team, provided the caller is open to exploring a residential placement. A beneficiary shall be offered an evaluation appointment within 24 hours of the initial call with a BHRS care coordinator staff. Evaluation



appointments may be provided face-to-face, by telephone, or by telehealth, and may be provided anywhere in the community.

- b) The BHRS County Care Coordination Team (CCCT) shall be staffed by certified AOD counselors and case managers who work under the directions of an LPHA. County Care Coordinators shall evaluate beneficiaries using ASAM and will authorize individuals for residential withdrawal management or residential treatment, or refer the beneficiary to a non-residential network provider. Time-limited case management services shall be provided by the CCCT to ensure smooth and timely admissions to care including referrals to other needed services such as mental health, housing, employment, psychiatric or medical services. If ongoing care coordination of the beneficiary is required outside of the direct treatment provider, it shall be provided by the CCCT.
  - c) In the event that an evaluation appointment cannot be made within 24 hours, such as on weekends or holidays, the ACC after-hours provider shall complete an additional residential evaluation with the beneficiary, and when indicated, shall provide the beneficiary with a preliminary 7-day authorization for residential treatment. Once admitted to care, the network provider must request a re-authorization (see below) for treatment for continued care at a residential level.
- 3) Path 2: Residential Detox/Withdrawal Management Authorizations
- a) Beneficiaries authorized and receiving 3.2-WM services from a stand-alone provider shall be assessed for further care needs and the 3.2-WM provider may provide an initial authorization for beneficiaries to a residential treatment facility, when medically necessary. The beneficiary shall be referred to a network provider offering the needed ASAM level of care and case management provided to ensure smooth and timely admission to the next appropriate level of care. The 3.2 WM provider and beneficiary shall consult with the BHRS Care Coordination Team regarding bed availability as needed.
- 4) Path 3: Residential Provider Initiated Authorization
- a) Prospective beneficiaries often are referred directly to residential treatment providers by family members, friends, clergy, social service and health providers. In order to ensure timely authorizations and admissions, the Contractor shall ensure that the provider conducts an initial ASAM screening. If the results from the screening indicate the likely need for residential treatment the provider shall enroll the beneficiary and within 24 hours inform the BHRS Care Coordination Team who will provide an ASAM evaluation to validate and authorize services. If the beneficiary is not eligible for that level of care the CCCT staff will facilitate a "warm hand off" to the provider that best matches the beneficiary's needs. If housing is an issue the CCCT staff will work to ensure the beneficiary is not discharged into homelessness working with Shelter Care providers, family and friends or other temporary housing options.
- 5) Path 4: Outpatient Provider Initiated Authorization



- a) Outpatient provider initiated residential authorization requests shall be made to the ACC including those made on weekends or holidays or after-hours for evaluation and authorization. When indicated, the beneficiary shall be granted a preliminary 7-day authorization for residential treatment. Once admitted to care, the residential provider shall request a re-authorization for treatment for continued care at a residential level.

6) Residential Treatment Re-Authorizations

- a) Contractor shall ensure that residential providers request a re-authorization, based on the results of the ASAM assessments, from the BHRS via the Avatar (electronic health record) system, at least 7 calendar days from the initial authorization expiration date. This will allow time for the provider to transition the beneficiary if the request is denied.

**G. Early Intervention (ASAM Level 0.5)**

In addition to the general early intervention services requirements outlined in Section 5 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific residential treatment services requirements:

- 1) The Contractor shall provide SBIRT for all substance use conditions in collaboration with the San Mateo Medical Center (SMMC) within primary care clinics, specialty care clinics, Emergency Department and Psychiatric Emergency Services Department.

**H. Residential Treatment Services**

In addition to the general residential treatment services requirements outlined in Section 8 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific residential treatment services requirements:

- 1) Residential services shall be provided in facilities designated by DHCS as capable of delivering care consistent with ASAM Level 3.1: Clinically-Managed Low-Intensity Residential, ASAM Level 3.3: Clinically Managed Population-Specific High-Intensity Residential Services (Adult only), and ASAM Level 3.5: Clinically-Managed High-Intensity Residential.
- 2) Beneficiaries shall be approved for residential treatment through a prior authorization process based on the results identified by the residential evaluation and ASAM assessment.
- 3) Residential treatment services shall include assessment, treatment planning, individual and group counseling, beneficiary education, family therapy, collateral services, crisis intervention services, treatment planning, transportation to medically necessary treatments, and discharge planning and coordination. The



Contractor shall ensure that all of its providers accept and support patients who are receiving medication-assisted treatments.

- 4) Contractor shall make available ASAM residential levels 3.1 and 3.5 in implementation year 1. The Contractor shall ensure that ASAM level 3.3 is available within 3 years of final approval of the County's implementation plan and will follow the Contractor's policy and process for selecting new providers.
- 5) For beneficiaries in any residential treatment program, case management services shall be provided to facilitate "step down" to lower levels of care and support.

#### **I. Case Management**

In addition to the general case management requirements outlined in Section 9 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific case management requirements:

- 1) Case management services support beneficiaries as they move through the DMC-ODS continuum of care from initial engagement and early intervention, through treatment, to recovery supports. The Contractor shall ensure that case management services are provided to beneficiaries who may be pre-contemplative and challenging to engage, and/or those needing assistance connecting to treatment services, and/or those beneficiaries stepping down to lower levels of care and support.
- 2) The Contractor shall use a comprehensive case management model based on the ASAM bio-psychosocial assessment to identify needs and develop a case plan and follow the SAMHSA/CSAT TIP 27 (Treatment Improvement Protocol) Comprehensive Case Management for Substance Abuse Treatment.
- 3) Case management services include: comprehensive assessment; level of care identification; beneficiary plan development; coordination of care with mental health and physical health; beneficiary advocacy and linkages to other supports including but not limited to mental health, housing, transportation, food, and benefits enrollment.
- 4) The Contractor shall ensure that case managers are trained and utilize Motivational Interviewing (MI) and Motivational Enhancement Therapy (MET), harm reduction, and strength based approaches. The Contractor shall ensure that all case management services are provided by contract providers and Contractor staff.
- 5) The Contractor shall ensure that high utilizers and complex beneficiaries have an assigned lead case manager from the BHRS CCCT to oversee SUD care and coordinate with other treatment services and systems. The CCCT shall communicate with the treatment provider to reduce risk of duplicated case management efforts and shall lead complex care coordination when the beneficiary needs services from multiple county systems.



- 6) The Contractor shall ensure that all other beneficiaries receive case management services exclusively from the provider agency where the beneficiary is admitted and receiving treatment services.
- 7) All case management services shall be consistent with confidentiality requirements identified in 42 CFR, Part 2, and California law, and the Health Insurance Portability and Accountability Act (HIPAA).

#### **J. Physician Consultation**

In addition to the general physician consultation requirements outlined in Section 10 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific physician consultation requirements:

- 1) Physician consultation services shall assist physicians and nurse practitioners seeking expert advice on complex beneficiary cases and designing the treatment plan in such areas as: medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.
- 2) The Contractor shall train psychiatrists and psychiatric nurse practitioners in integrated settings on medication guidelines and offer the opportunity for them to consult one-on-one with a psychiatrist who has an addiction medicine background. The Contractor shall make physician consultations to primary care and behavioral health providers for the use of Vivitrol, buprenorphine, other medications, and pain management available in an effort to build the capacity of the entire health system to treat beneficiaries with substance use disorders.
- 3) The Contractor may use existing staff, or contract with addiction medicine physicians, addiction psychiatrists, or clinical pharmacists to provide consultation services.

#### **K. Recovery Services**

In addition to the general recovery services requirements outlined in Section 11 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific recovery services requirements:

- 1) The Contractor shall make recovery services available to a beneficiary once he/she has completed the primary course of treatment and during the transition process. The Contractor shall ensure that beneficiaries accessing recovery services are supported to manage their own health and health care, use effective self-management support strategies, and use community resources to provide ongoing support.
- 2) Recovery services may be provided face-to-face, by telehealth/telephone, via the internet, or elsewhere in the community.
- 3) Recovery services include: outpatient individual or group counseling to support the stabilization of the beneficiary or reassess the need for further care; recovery monitoring/recovering coaching; peer-to-peer services and relapse prevention,



WRAP development, education and job skills; family support; support groups and linkages to various ancillary services.

- 4) Any eligible DMC provider within the network may provide medically necessary recovery services to beneficiaries.

#### **L. Withdrawal Management**

In addition to the general withdrawal management requirements outlined in Section 12 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific recovery services requirements:

- 1) Withdrawal Management services shall be provided as medically necessary to beneficiaries and include: assessment, observation, medication services, and discharge planning and coordination.
- 2) Beneficiaries receiving a residential withdrawal management shall reside at the facility for monitoring during the detoxification process.
- 3) The Contractor shall offer ASAM Levels 1-WM: Ambulatory Withdrawal Management without Extended On-Site Monitoring by the end of Implementation Year 1. BHRS will release a Request for Proposal (RFP) to identify qualified DMC-ODS providers for ASAM Level 3.2-WM: Clinically-Management Residential Withdrawal Management. The Contractor will not offer ASAM Level 2-WM. However, the Contractor shall review utilization and ASAM data and make a determination by the end of implementation year 2 whether there is a demonstrated need for this level of care within the Contractor's continuum. Should a need be substantiated an RFP would be released for ASAM L 2-WM.
- 4) The Contractor shall work with Sutter Health's Mills Peninsula Hospital and other area service providers to assist beneficiaries to access ASAM Levels 3.7-WM (Medically- Monitored Inpatient Withdrawal Management) and 4.0-WM (Medically-Managed Inpatient Withdrawal Management) when medically necessary. The Contractor shall coordinate with these providers to smoothly transition and support beneficiaries to less intensive levels of care available within the DMC-ODS.

#### **M. Opioid (Narcotic) Treatment Program Services**

In addition to the general opioid (narcotic) treatment program services requirements outlined in Section 13 of Exhibit A, Attachment I, the Contractor shall comply with the following Contractor specific opioid (narcotic) treatment program services requirements:

- 1) The Contractor shall contract with licensed Narcotic Treatment Programs to offer services to beneficiaries who meet medical necessity criteria requirements.
- 2) Services shall be provided in accordance with an individualized beneficiary plan determined by a licensed prescriber.
- 3) Prescribed medications offered include medications covered under the DMC-ODS formulary.



- 4) Services provided as part of an OTP shall include: assessment, treatment planning, individual and group counseling, patient education; medication services; collateral services; crisis intervention services; treatment planning; medical psychotherapy; and discharge services.
- 5) Beneficiaries shall receive between 50 and 200 minutes of counseling per calendar month with a therapist or counselor, and, when medically necessary, additional services may be provided.

#### **N. Additional Medication Assisted Treatment (MAT)**

As stated in Section 30(A) of Exhibit A, Attachment I, the Contractor has elected to provide MAT services as a Contractor specific service. Therefore, the Contractor shall comply with the following Contractor specific MAT requirements:

- 1) BHRS shall offer medically necessary MAT services through Contractor staff and contracted providers, an NTP program and a provider licensed as a primary care clinic.
- 2) MAT services shall include: assessment, treatment planning, treatment, case management, ordering, prescribing, administering, and monitoring of medication for substance use disorders.
- 3) The Contractor shall make available the following medications to beneficiaries:
  - a) For reduction of alcohol craving: naltrexone, both oral (ReVia) and extended release injectable (Vivitrol), topiramate (Topamax), gabapentin (Neurontin), acamprosate (Campral), and disulfiram (Antabuse);
  - b) For opiate overdose prevention: naloxone (Narcan); and
  - c) For opiate use treatment: buprenorphine-naloxone (Suboxone) and naltrexone (oral and extended release) (Note: Methadone will continue to be available through the licensed narcotic treatment program).
- 4) Additionally, the Contractor shall coordinate care and expand the availability of MAT outside the DMC-ODS by building the capacity of the entire health system to use these treatments for beneficiaries with a substance use disorder. The Contractor shall train physicians, nurse practitioners, and psychiatrists in primary care and specialty mental health clinics on the efficacy of using MAT, practice guidelines, and medication administration. Physician consultation shall support implementation in areas such as: medication selection, dosing, side effect management, adherence, and drug-drug interactions.

#### **O. Telehealth**

As stated in Section 30(A) of Exhibit A, Attachment I, the Contractor has elected to provide Telehealth services as a Contractor specific service. Therefore, the Contractor shall comply with the following Contractor specific Telehealth requirements:



- 1) The Contractor shall implement a telehealth pilot project based out of the BHRS Coastside Clinic in Half Moon Bay. This shall provide behavioral health services for the rural and hard to reach populations along the coast. Services include consultative and "direct" care including medication evaluation and management.
- 2) The Contractor shall expand the services throughout the County including consultation to substance use treatment providers on issues such as co-occurring mental health concerns, medication assisted treatment, physical health co-morbidities, and other categories.
- 3) The Contractor shall utilize the following applications of telehealth:
  - a) Consultation to evaluate clients in SUD treatment programs. In lieu of a client coming to a site or a psychiatrist providing on-site services at multiple locations telehealth shall be used to centralize the services thus improving client access, minimizing travel time, and maximizing the use of the psychiatrists' time. The psychiatrist shall operate out of one central site; meet with clients or staff over the telehealth network providing direct care and consultation to the providers.
  - b) Advanced service delivery using innovative technology. The Contractor shall utilize telehealth services through mobile devices (tablets, mobile phones, and laptops) that will allow provision of services regardless of the location of the client. Staff can then have complex case discussions while each member of the team is in a different location and view presentations together. The Contractor shall equip clients with self-care applications that connect them with their case managers beyond "office hours" and locations.
- 4) The Contractor shall monitor telehealth equipment and service locations to ensure 42 CFR part 2 and confidentiality are strictly protected.

**P. Recovery Residences**

As stated in Section 30(A) of Exhibit A, Attachment I, the Contractor has elected to provide Recovery Residence services as a Contractor specific service. Therefore, the Contractor shall comply with the following Contractor specific Recovery Residence requirements:

- 1) The Contractor shall make Recovery Residences (RR) available to beneficiaries who require housing assistance in order to support their health, wellness and recovery.
- 2) There is no formal treatment provided at these facilities; however, residents are required to actively participate in outpatient treatment and/or recovery supports during their stay.
- 3) There is no predetermined maximum length of stay. On a case by case basis the Contractor shall determine the length of stay.



- 4) The Contractor shall develop standards for contracted RR providers and shall monitor to these standards.
- 5) RRs are not reimbursable through Medi-Cal.



**Exhibit B**  
Budget Detail and Payment Provisions

**Part I – General Fiscal Provisions**

**Section 1 – General Fiscal Provisions**

A. Fiscal Provisions

For services satisfactorily rendered, and upon receipt and approval of documentation as identified in Exhibit A, Attachment I, Section 23.2, DHCS agrees to compensate the Contractor for actual expenditures incurred in accordance with the rates and/or allowable costs specified herein.

B. Use of State General Funds

Contractor may not use allocated Drug Medi-Cal State General Funds to pay for any non-Drug Medi-Cal services.

C. Funding Authorization

Contractor shall bear the financial risk in providing any substance use disorder services covered by this Intergovernmental Agreement.

D. Availability of Funds

It is understood that, for the mutual benefit of both parties, this Intergovernmental Agreement may have been written before ascertaining the availability of congressional appropriation of funds in order to avoid program and fiscal delays that would occur if this Intergovernmental Agreement were not executed until after that determination. If so, State may amend the amount of funding provided for in this Intergovernmental Agreement based on the actual congressional appropriation.

E. Subcontractor Funding Limitations

Pursuant to HSC Section 11818 (b)(2)(A), Contractor shall reimburse its Subcontractors that receive a combination of Drug Medi-Cal funding and other federal or county realignment funding for the same service element and location based on the Subcontractor's actual costs in accordance with Medicaid reimbursement requirements as specified in Title XIX or Title XXI of the Social Security Act; Title 22, and the State's Medicaid Plan. Payments at negotiated rates shall be settled to actual cost at year-end.



F. Budget Contingency Clause

It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this Intergovernmental Agreement does not appropriate sufficient funds for the program, this Intergovernmental Agreement shall be of no further force and effect. In this event, DHCS shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Intergovernmental Agreement and Contractor shall not be obligated to perform any provisions of this Intergovernmental Agreement.

If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, DHCS shall have the option to either cancel this Intergovernmental Agreement with no liability occurring to DHCS, or offer an amended Intergovernmental Agreement to Contractor to reflect the reduced amount.

G. Expense Allowability / Fiscal Documentation

1. Invoices, received from a Contractor and accepted and/or submitted for payment by DHCS, shall not be deemed evidence of allowable Intergovernmental Agreement costs.
2. Contractor shall maintain for review and audit and supply to DHCS upon request, adequate documentation of all expenses claimed pursuant to this Intergovernmental Agreement to permit a determination of expense allowability.
3. If the allowability or appropriateness of an expense cannot be determined by DHCS because invoice detail, fiscal records, or backup documentation is nonexistent or inadequate according to generally accepted accounting principles, and generally accepted governmental audit standards, all questionable costs may be disallowed and payment may be withheld by DHCS. Upon receipt of adequate documentation supporting a disallowed or questionable expense, reimbursement may resume for the amount substantiated and deemed allowable.
4. Costs and/or expenses deemed unallowable are subject to recovery by DHCS.

H. Maintenance of Effort for SAPT Block Grant

1. Notwithstanding any other provision in this Intergovernmental Agreement, the Director may reduce federal funding allocations, on a dollar-for-dollar basis, to a county that has a reduced or anticipates reduced expenditures in a way that would result in a decrease in California's receipt of federal Substance Abuse Prevention and Treatment Block Grant funds (42 U.S.C. Sect 300x-30).
2. Prior to making any reductions pursuant to this subdivision, the Director shall notify all counties that county underspending will reduce the federal Substance Abuse Prevention and Treatment Block Grant maintenance of effort (MOE). Upon receipt of notification, a county may submit a revision to the county budget initially submitted pursuant to subdivision (a) of Section 11798 in an effort to maintain the statewide SAPT Block Grant MOE.



3. Pursuant to 45 CFR 96.124 C 1-3 the Contractor shall expend a specified percentage of SAPT Block Grant funds for perinatal services, pregnant women, and women with dependent children each state fiscal year (SFY). The Contractor shall expend that percentage of SAPT Block Grant funds by, either establishing new programs or expanding the capacity of existing programs. In accordance with 45 CFR 96.124 (c)(1-3), the Contractor shall calculate the percentage of funds to be expended for perinatal services, pregnant women, and women with dependent children in the manner described in Exhibit G: County Share of SAPT Block Grant Women Services Expenditure Requirement.
4. Pursuant to subdivision (b) of Section 11798.1, a county shall notify the Department in writing of proposed local changes to the county's expenditure of funds. The Department shall review and may approve the proposed local changes depending on the level of expenditures needed to maintain the statewide SAPT Block Grant MOE.

## **Section 2 – General Fiscal Provisions – Non-Drug Medi-Cal**

### A. Revenue Collection

Contractor shall conform to revenue collection requirements in Division 10.5 of the HSC, Sections 11841, by raising revenues in addition to the funds allocated by the State. These revenues include, but are not limited to, fees for services, private contributions, grants, or other governmental funds. These revenues shall be used in support of additional alcohol and other drug services or facilities. Each alcohol and drug program shall set and collect client fees based on the client's ability to pay. The fee requirement shall not apply to prevention and early intervention services. Contractor shall identify in its annual cost report the types and amounts of revenues collected.

### B. Cost Efficiencies

It is intended that the cost to the Contractor in maintaining the dedicated capacity and units of service shall be met by the non-DMC funds allocated to the Contractor and other Contractor or Subcontractor revenues. Amounts awarded pursuant to Exhibit A, Attachment I, Section 27, shall not be used for services where payment has been made, or can reasonably be expected to be made under any other state or federal compensation or benefits program, or where services can be paid for from revenues.

## **Section 3 – General Fiscal Provisions – Drug Medi-Cal**

### A. Return of Unexpended Funds

Contractor assumes the total cost of providing covered services on the basis of the payments delineated in this Exhibit B, Part II. Any State General Funds or federal Medicaid funds paid to the Contractor, but not expended for DMC services shall be returned to the State.



B. Amendment or Cancellation Due to Insufficient Appropriation

This Intergovernmental Agreement is valid and enforceable only if sufficient funds are made available to the State by the United States Government for the purpose of the DMC program. It is mutually agreed that if the Congress does not appropriate sufficient funds for this program, State has the option to void this Intergovernmental Agreement or to amend the Intergovernmental Agreement to reflect any reduction of funds.

C. Exemptions

Exemptions to the provisions of Item B above, of this Exhibit, may be granted by the California Department of Finance provided that the Director of DHCS certifies in writing that federal funds are available for the term of the Intergovernmental Agreement.

D. Allowable costs

Allowable costs, as used in Section 51516.1 of Title 22 shall be determined in accordance with Title 42, CFR Parts 405 and 413, CMS-Pub 15-1 and 15-2, 2 CFR Part 200 Subpart E, CMS non-institutional reimbursement policy, and Centers for Medicare and Medicaid Services (CMS), "Medicare Provider Reimbursement Manual (Publication Number 15)," which can be obtained from the Centers for Medicare & Medicaid Services, or [www.cms.hhs.gov](http://www.cms.hhs.gov)." In accordance with W&IC Sections 14132.44 and 14132.47, funds allocated to the Contractor for DMC services, including funding for alcohol and other drug services for pregnant and postpartum women pursuant to Title 22, Section 51341.1(c), may not be used as match for targeted case management services or for Medi-Cal administrative activities.



**Exhibit B**  
Budget Detail and Payment Provisions

**Part II – Reimbursements**

**Section 1. General Reimbursement**

A. Prompt Payment Clause

Payment will be made in accordance with, and within the time specified in, Government Code Chapter 4.5, commencing with Section 927.

B. Amounts Payable

1. The amount payable under this Intergovernmental Agreement shall not exceed the amount identified on the Standard Intergovernmental Agreement.
2. Reimbursement shall be made for allowable expenses up to the amount annually encumbered commensurate with the state fiscal year in which services are performed and/or goods are received.
3. The funds identified for the fiscal years covered by under this Section, within this Exhibit, are subject to change depending on the availability and amount of funds appropriated by the Legislature and the Federal Government. The amount of funds available for expenditure by the Contractor shall be limited to the amount identified in the final allocations issued by the State for that fiscal year or the non-DMC amount, whichever is less. Changes to allocated funds will require written amendment to the Intergovernmental Agreement.
4. For each fiscal year, the State may settle costs for services based on each fiscal year year-end cost settlement report as the final amendment for the specific fiscal year cost settlement report to the approved single state/county Intergovernmental Agreement.

**Section 2. Non-Drug Medi-Cal**

A. Amounts Payable for Non-Drug Medi-Cal

1. State shall reimburse the Contractor monthly in arrears an amount equal to one-twelfth of the maximum amount allowed pursuant to Exhibit B of the Intergovernmental Agreement or the most recent allocation based on the Budget Act Allocation, whichever is less. Final allocations will reflect any increases or reductions in the appropriations as reflected in the State Budget Act allocation and any subsequent allocation revisions.
2. Monthly disbursement to the Intergovernmental Agreement at the beginning of each fiscal year of the Intergovernmental Agreement shall be based on the preliminary allocation of funds, as detailed in this Exhibit.



3. However, based on the expenditure information submitted by the counties in the Quarterly Federal Financial Management Report (QFFMR) (Document 30), State may adjust monthly payments of encumbered block grant federal funds to extend the length of time (not to exceed 21 months) over which payments of federal funds will be made.
4. Monthly disbursements to the Contractor at the beginning of each fiscal year of the Intergovernmental Agreement shall be based on the preliminary allocation of funds, as detailed in Exhibit B.
5. State may withhold monthly non-DMC payments if the Contractor fails to:
  - (a) submit timely reports and data required by the State, including but not limited to, reports required pursuant to Exhibit A, Attachment I, Section 23.2.
  - (b) submit the Intergovernmental Agreement amendment within 90 days from issuance from the State to the Contractor.
  - (c) submit and attest the completion of Corrective Action Plans for services provided pursuant to this Intergovernmental Agreement.
6. Upon the State's receipt of the complete and accurate reports, data, or signed Intergovernmental Agreement, the Contractor's monthly payment shall commence with the next scheduled monthly payment, and shall include any funds withheld due to late submission of reports, data and/or signed Intergovernmental Agreement.
7. Adjustments may be made to the total of the Intergovernmental Agreement and amounts may be withheld from payments otherwise due to the Contractor hereunder, for nonperformance to the extent that nonperformance involves fraud, abuse, or failure to achieve the objectives of the provisions of Exhibit A, Attachment I, Section 27.

B. Payment Provisions

For each fiscal year, the total amount payable by the State to the Contractor for services provided under Exhibit A, Attachment I, Section 27, shall not exceed the encumbered amount. The funds identified for the fiscal years covered by Exhibit A, Attachment I, Section 27, are subject to change depending on the availability and amount of funds appropriated by the Legislature and the Federal Government. Changes to encumbered funds will require written amendment to the Intergovernmental Agreement. State may settle costs for non-DMC services based on the year-end cost settlement report as the final amendment to the approved single state/county Intergovernmental Agreement.

- C. In the event of an Intergovernmental Agreement amendment, as required by the preceding paragraph, Contractor shall submit to the State information as identified in Exhibit E, Section 1.D. To the extent the Contractor is notified of the State Budget Act allocation prior to the execution of the Intergovernmental Agreement, the State and the Contractor may agree to amend the Intergovernmental Agreement after the issuance of the first Budget Act allocation.



D. Accrual of Interest

Any interest accrued from State-allocated funds and retained by the Contractor must be used for the same purpose as the State allocated funds from which the interest was accrued.

E. Expenditure Period

Substance Abuse Prevention and Treatment (SAPT) Block Grant funds are allocated based upon the Federal Grant award period. These funds must be expended for activities authorized pursuant to 42 USC Sections 300x-21(b) through 300x-66; and Title 45, CFR, Subpart L, within the availability period of the grant award. Any SAPT Block Grant funds that have not been expended by a Contractor at the end of the expenditure period identified below shall be returned to the State for subsequent return to the Federal government.

1. The expenditure period of the FFY 2016 award is October 1, 2015 through June 30, 2017.
2. The expenditure period of the FFY 2017 award is October 1, 2016 through June 30, 2018.
3. The expenditure period of the FFY 2018 award is October 1, 2017 through June 30, 2019.

F. Contractors receiving SAPT Block Grant funds shall comply with the financial management standards contained in Title 45, CFR, Part 92, Sections 92.20(b)(1) through (6), and Title 45, CFR, Part 96, Section 96.30.

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

H. Contractors receiving SAPT Block Grant funds shall track obligations and expenditures by individual SAPT Block Grant award, including, but not limited to, obligations and expenditures for primary prevention, services to pregnant women and women with dependent children. "Obligation" shall have the same meaning as used in Title 45, CFR, Part 92, Section 92.3."

I. Restrictions on the Use of SAPT Block Grant Funds

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

1. Provide inpatient services;
2. Make cash payment to intended recipients of health services;



3. Purchase or improve land, purchase, construct or permanently improve (other than minor remodeling) any building or other facility or purchase major medical equipment;
4. Satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;
5. Provide financial assistance to any entity other than a public or nonprofit private entity;
6. Pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of level I of the Executive Salary Schedule for the award year: see [http://grants.nih.gov/grants/policy/salcap\\_summary.htm](http://grants.nih.gov/grants/policy/salcap_summary.htm);
7. Purchase treatment services in penal or correctional institutions of this State of California; and
8. Supplant state funding of programs to prevent and treat substance abuse and related activities.

### **Section 3. Drug Medi-Cal**

- A. To the extent that the Contractor provides the covered services in a satisfactory manner and in accordance with the terms and conditions of this Intergovernmental Agreement, the State agrees to pay the Contractor federal Medicaid funds according to Exhibit A, Attachment I, Section 28.1. Subject to the availability of such funds, Contractor shall receive federal Medicaid funds and/or State General Funds for allowable expenditures as established by the federal government and approved by the State, for the cost of services rendered to beneficiaries.
- B. Any payment for covered services rendered pursuant to Exhibit A, Attachment I, shall only be made pursuant to applicable provisions of Title XIX or Title XXI of the Social Security Act; the W&IC; the HSC; California's Medicaid State Plan; and Sections 51341.1, 51490.1, 51516.1, and 51532 of Title 22.
- C. It is understood and agreed that failure by the Contractor or its Subcontractors to comply with applicable federal and state requirements in rendering covered services shall be sufficient cause for the State to deny payments to and/or recover payments from the Contractor and/or terminate the Contractor or its Subcontractor from DMC program participation. If the State or the Department of Health and Human Services (DHHS) disallows or denies payments for any claim, Contractor shall repay to the State the federal Medicaid funds and/or State General Funds it received for all claims so disallowed or denied. The overpayment shall be recovered by any of the methods allowed in Title 22, CCR, Sections 51047(a) and (b).
- D. Before such denial, recoupment, or disallowances are made, State shall provide the Contractor with written notice of its proposed action. Such notice shall include the reason for the proposed action and shall allow the Contractor sixty (60) days to submit additional information before the proposed action is taken, as required in Title 22, CCR, Section



51047(a). This requirement does not apply to the DMC Post Service Post Payment Utilization Reviews.

- E. The State shall refund to the Contractor any recovered Federal Drug Medi-Cal overpayment that is subsequently determined to have been erroneously collected, together with interest, in accordance with Title 22, CCR, Section 51047(e).
- F. Contractor shall be reimbursed by the State on the basis of its actual net reimbursable cost, not to exceed the unit of service maximum rate.
- G. Claims submitted to the contractor by a sub-contracted provider that is not certified or whose certification has been suspended pursuant to the Welfare and Institutions Code section 14107.11, and Code of Federal Regulations, Title 42, section 455.23 shall not be certified or processed for federal or state reimbursement by the contractor. Payments for any DMC services shall be held by the Contractor until the payment suspension is resolved.
- H. In the event an Intergovernmental Agreement amendment is required pursuant to the preceding paragraph, Contractor shall submit to the State information as identified in Exhibit E, Section 1.D. To the extent the Contractor is notified of the State Budget Act allocation prior to the execution of the Intergovernmental Agreement, the State and the Contractor may agree to amend the Intergovernmental Agreement after the issuance of the first revised allocation.
- I. Reimbursement for covered services, other than NTP services, shall be limited to the lower of:
  - 1. the provider's usual and customary charges to the general public for the same or similar services;
  - 2. the provider's actual allowable costs.
- J. Reimbursement to NTP's shall be limited to the lower of either the USDR rate, pursuant to W&IC Section 14021.51(h), or the provider's usual and customary charge to the general public for the same or similar service. However, reimbursement paid by a county to an NTP provider for services provided to any person subject to Penal Code Sections 1210.1 or 3063.1 and for which the individual client is not liable to pay, does not constitute a usual or customary charge to the general public. (W&IC Section 14021.51(h)(2)(A)).

- K. State shall reimburse the Contractor the State General Funds and/or federal Medicaid amount of the approved DMC claims and documents submitted in accordance with Exhibit A, Attachment I, Section 23.2.
- L. State will adjust subsequent reimbursements to the Contractor to actual allowable costs. Actual allowable costs are defined in the Medicare Provider Reimbursement Manual (CMS-Pub.15), which can be obtained from the Centers for Medicare & Medicaid Services, Baltimore, Maryland, or [www.cms.hhs.gov](http://www.cms.hhs.gov).
- M. Contractors and Subcontractors must accept, as payment in full, the amounts paid by the State in accordance with Title 22, CCR, Section 51516.1, plus any cost sharing charges (deductible, coinsurance, or copayment) required to be paid by the client. However, Contractors and Subcontractors may not deny services to any client eligible for DMC services on account of the client's inability to pay or location of eligibility. Contractors and Subcontractors may not demand any additional payment from the State, client, or other third party payers.



**Exhibit B**  
Budget Detail and Payment Provisions

**Part III - Financial Audit Requirements**

**Section 1. General Fiscal Audit Requirements**

- A. In addition to the requirements identified below, the Contractor and its Subcontracts are required to meet the audit requirements as delineated in Exhibit C, General Terms and Conditions, and Exhibit D(F), Special Terms and Conditions, of this Intergovernmental Agreement.
- B. All expenditures of county realignment funds, state and federal funds furnished to the Contractor and its Subcontractors pursuant to this Intergovernmental Agreement are subject to audit by the State. Such audits shall consider and build upon external independent audits performed pursuant to audit requirements of the Office of Management and Budget (OMB) Circular A-133 (Revised December 2013) and/or any independent Contractor audits or reviews. Objectives of such audits may include, but not limited to, the following:
1. To determine whether units of service claimed/reported are properly documented by service records and accurately accumulated for claiming/reporting;
  2. To validate data reported by the Contractor for prospective Intergovernmental Agreement negotiations;
  3. To provide technical assistance in addressing current year activities and providing recommendation on internal controls, accounting procedures, financial records, and compliance with laws and regulations;
  4. To determine the cost of services, net of related patient and participant fees, third-party payments, and other related revenues and funds;
  5. To determine that expenditures are made in accordance with applicable state and federal laws and regulations and Intergovernmental Agreement requirements, and/or;
  6. To determine the facts in relation to analysis of data, complaints, or allegations, which may be indicative of fraud, abuse, willful misrepresentation, or failure to achieve the Intergovernmental Agreement objectives of Exhibit C and D(F).
- C. Unannounced visits may be made at the discretion of the State.
- D. The refusal of the Contractor or its Subcontractors to permit access to and inspection of electronic or print books and records, physical facilities, and/or refusal to permit interviews with employees, as described in this part constitutes an express and immediate material



breach of this Intergovernmental Agreement and will be sufficient basis to terminate the Intergovernmental Agreement for cause or default.

- E. Reports of audits conducted by the State shall reflect all findings, recommendations, adjustments and corrective action as a result of it's finding in any areas.

**Section 2. Non-Drug Medi-Cal Financial Audits**

- A. Pursuant to OMB Circular A-133 §.400(d)(3), Contractor shall monitor the activities of all of its Subcontractors to ensure that:
  - 1. Subcontractors are complying with program requirements and achieving performance goals
  - 2. Subcontractors are complying with fiscal requirements, such as having appropriate fiscal controls in place, and are using awards for authorized purposes.
- B. Contractor can use a variety of monitoring mechanism, including limited scope audits, on-site visits, progress reports, financial reports, and review of documentation support requests for reimbursement, to meet the Contractor's monitoring objectives. The Contractor may charge federal awards for the cost of these monitoring procedures as outlined in OMB Circular A-133.
- C. The Contractor shall submit to the State a copy of the procedures and any other monitoring mechanism used to monitor non-profit Subcontracts at the time of the County's annual site visit or within 60 days thereafter. Contractor shall state the frequency that non-profit Subcontracts are monitored.
- D. Limited scope audits, as defined in the OMB Circular A-133, only include agreed-upon engagements that are (1) conducted in accordance with either the American Institute of Certified Public Accountants generally accepted auditing standards or attestation standards; (2) paid for and arranged by pass-through entities (counties); and (3) address one or more of the following types of compliance requirements: (i) activities allowed or unallowed; (ii) allowable costs/cost principals; (iii) eligibility; (9v) matching, level of effort and earmarking; and (v) reporting.
- E. On-site visits focus on compliance and controls over compliance areas. The reviewer must make site visits to the subcontractor locations(s), and can use a variety of monitoring mechanism to document compliance requirements. The finding and the corrective action will require follow-up by the Contractor.
- F. Contractor shall be responsible for any disallowance taken by the Federal Government, the State, or the California State Auditor, as a result of any audit exception that is related to the Contractor's responsibilities herein. Contractor shall not use funds administered by the State to repay one federal funding source with funds provided by another federal funding source, to repay federal funds with state funds, or to repay state funds with federal funds. State shall invoice Contractor 60 days after issuing the final audit report or upon resolution of an audit appeal. Contractor agrees to develop and implement any corrective action plans in a manner acceptable to the State in order to comply with recommendations



contained in any audit report. Such corrective action plans shall include time-specific objectives to allow for measurement of progress and are subject to verification by the state within one year from the date of the plan.

If differences cannot be resolved between the State and Contractor regarding the terms of the financial audit settlements for funds expended under Exhibit A, Attachment I, Section 27, Contractor may request an appeal in accordance with the appeal process described in Document 1J(a), "Non-DMC Audit Appeal Process," incorporated by this reference. When a financial audit is conducted by the Federal Government, the State, or the California State Auditor directly with a Subcontractor of the Contractor, and if the Subcontractor disagrees with audit disallowances related to its programs, claims or services, Contractor shall, at the Subcontractor's request, request an appeal to the State in accordance with Document 1J(a). Contractor shall include a provision in its subcontracts regarding the process by which its Subcontractors may file an appeal via the Contractors.

- G. Contractors that conduct financial audits of Subcontractors, other than a Subcontractor whose funding consists entirely of non-Department funds, shall develop a process to resolve disputed financial findings and notify Subcontractors of their appeal rights pursuant to that process. This section shall not apply to those grievances or compliances arising from the financial findings of an audit or examination made by or on behalf of the State.
- H. Pursuant to OMB Circular A-133, State may impose sanctions against the Contractor for not submitting single or program-specific audit reports, or failure to comply with all other audit requirements. The sanctions shall include:
  - 1. Withholding a percentage of federal awards until the audit is completed satisfactorily
  - 2. Withhold or disallowing overhead costs
  - 3. Suspending federal awards until the audit is conducted; or
  - 4. Terminating the federal award

### **Section 3. Drug Medi-Cal Financial Audits**

- A. In addition to the audit requirements set forth in Exhibit D(F), State may also conduct financial audits of DMC programs, exclusive of NTP services, to accomplish any of, but not limited to, the following audit objectives:
  - 1. To review reported costs for validity, appropriate allocation methodology, and compliance with Medicaid laws and regulations;
  - 2. To ensure that only the cost of allowable DMC activities are included in reported costs;
  - 3. To determine the provider's usual and customary charge to the general public in accordance with CMS (The Medicare Provider Reimbursement Manual) (CMS-Pub.15), which can be obtained from the Centers for Medicare & Medicaid Services, Baltimore, Maryland, or [www.cms.hhs.gov](http://www.cms.hhs.gov), for comparison to the DMC cost per unit;



4. To review documentation of units of service and determine the final number of approved units of service;
  5. To determine the amount of clients' third-party revenue and Medi-Cal share of cost to offset allowable DMC reimbursement; and,
  6. To compute final settlement based on the lower of actual allowable cost, the usual and customary charge, or the maximum allowance, in accordance with Title 22, Section 51516.1.
- B. In addition to the audit requirements set forth in Exhibit D(F), State may conduct financial audits of NTP programs. For NTP services, the audits will address items A(3) through A(5) above, except that the comparison of the provider's usual and customary charge in A(3) will be to the DMC USDR rate in lieu of DMC cost per unit. In addition, these audits will include, but not be limited to:
1. For those NTP providers required to submit a cost report pursuant to W&IC Section 14124.24, a review of cost allocation methodology between NTP and other service modalities, and between DMC and other funding sources;
  2. A review of actual costs incurred for comparison to services claimed;
  3. A review of counseling claims to ensure that the appropriate group or individual counseling rate has been used and that counseling sessions have been billed appropriately;
  4. A review of the number of clients in group sessions to ensure that sessions include no less than two and no more than twelve clients at the same time, with at least one Medi-Cal client in attendance;
  5. Computation of final settlement based on the lower of USDR rate or the provider's usual and customary charge to the general public; and,
  6. A review of supporting service, time, financial, and patient records to verify the validity of counseling claims.
- C. Contractor shall be responsible for any disallowances taken by the Federal Government, the State, or the Bureau of State Audits as a result of any audit exception that is related to its responsibilities. Contractor shall not use funds administered by the State to repay one federal funding source with funds provided by another federal funding source, or to repay federal funds with state funds, or to repay state funds with federal funds
- D. Contractor agrees to promptly develop and implement any corrective action plans in a manner acceptable to the State in order to comply with recommendations contained in any audit report. Such corrective action plans shall include time-specific objectives to allow for measurement of progress and are subject to verification by the State within six months from the date of the plan.



- E. Contractor, in coordination with the State, must provide follow-up on all significant findings in the audit report, including findings relating to a Subcontractor, and submit the results to the State.

If differences cannot be resolved between the State and the Contractor regarding the terms of the final financial audit settlements for funds expended under Exhibit B, Contractor may request an appeal in accordance with the appeal process described in the "DMC Audit Appeal Process," Document 1J(b), incorporated by this reference. When a financial audit is conducted by the Federal Government, the State, or the Bureau of State Audits directly with a Subcontractor of the Contractor, and if the Subcontractor disagrees with audit disallowances related to its programs, claims or services, Contractor shall, at the Subcontractor's request, request an appeal to the State in accordance with Document 1J(b). Contractor shall include a provision in its subcontracts regarding the process by which a Subcontractor may file an audit appeal via the Contractor.

- F. Providers of DMC services shall, upon request, make available to the State their fiscal and other records to assure that such provider have adequate recordkeeping capability and to assure that reimbursement for covered DMC services are made in accordance with Title 22, CCR, Section 51516.1. These records include, but are not limited to, matters pertaining to:

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

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

**Exhibit B**  
Budget Detail and Payment Provisions

**Part IV – Records**

**Section 1. General Provisions**

A. Maintenance of Records

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

1. Contractor shall include in any Intergovernmental Agreement with an audit firm a clause to permit access by the State to the working papers of the external independent auditor, and require that copies of the working papers shall be made for the State at its request.
2. Contractor shall keep adequate and sufficient financial records and statistical data to support the year-end documents filed with the State. All records must be capable of verification by qualified auditors.
3. Accounting records and supporting documents shall be retained for a three-year period from the date the year-end cost settlement report was approved by the State for interim settlement. When an audit by the Federal Government, the State, or the California State Auditor has been started before the expiration of the three-year period, the records shall be retained until completion of the audit and final resolution of all issues that arise in the audit. Final settlement shall be made at the end of the audit and appeal process. If an audit has not been completed within three years, the interim settlement shall be considered as the final settlement.
4. Financial records shall be kept so that they clearly reflect the source of funding for each type of service for which reimbursement is claimed. These documents include, but are not limited to, all ledgers, books, vouchers, time sheets, payrolls, appointment schedules, client data cards, and schedules for allocating costs. All records must be capable of verification by qualified auditors.
5. Contractor's subcontracts shall require that all Subcontractors comply with the requirements of Exhibit A, Attachment I, Section 19.



6. Should a Subcontractor discontinue its contractual agreement with the Contractor, or cease to conduct business in its entirety, Contractor shall be responsible for retaining the Subcontractor's fiscal and program records for the required retention period. The State Administrative Manual (SAM) contains statutory requirements governing the retention, storage, and disposal of records pertaining to state funds. Contractor shall follow SAM requirements located at <http://sam.dgs.ca.gov/TOC/1600.aspx>.

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

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

B. Dispute Resolution Process

1. In the event of a dispute, other than an audit dispute, Contractor shall provide written notice of the particulars of the dispute to the State before exercising any other available remedy. Written notice shall include the Intergovernmental Agreement number. The Director (or designee) of the State and the County Drug or Alcohol Program Administrator (or designee) shall meet to discuss the means by which they can effect an equitable resolution to the dispute. Contractor shall receive a written response from the State within sixty (60) days of the notice of dispute. The written response shall reflect the issues discussed at the meeting and state how the dispute will be resolved.
2. In the event of a dispute over financial audit findings between the State and the Contractor, Contractor may appeal the audit in accordance with the "non- DMC Audit Appeal Process" (Document 1J(a)). When a financial audit by the Federal Government, the State, or the California State Auditor is conducted directly with a Subcontractor of the Contractor, and if the Subcontractor disagrees with audit disallowances related to its programs, claims or services, Contractor shall, at the Subcontractor's request, request an appeal to the State in accordance with Document 1J(a). Contractor shall include a provision in its subcontracts regarding the process by which a Subcontractor may file an audit appeal via the Contractor.
3. As stated in Part III, Section 3, of this Exhibit, in the event of a dispute over financial audit findings between the State and the Contractor, Contractor may appeal the audit in accordance with "DMC Audit Appeal Process" (Document 1J(b)). When a financial audit by the Federal Government, the State, or the California State Auditor is conducted directly with a Subcontractor of the Contractor, and if the Subcontractor disagrees with audit disallowances related to its programs, claims or services, Contractor shall, at the Subcontractor's request, request an appeal to the State in accordance with "DMC Audit Appeal Process" (Document 1J(b)). Contractor shall include a provision in its subcontracts regarding the process by which a Subcontractor may file an audit appeal via the Contractor.

4. Contractors that conduct financial audits of Subcontractors, other than a Subcontractor whose funding consists entirely of non-Department funds, shall develop a process to resolve disputed financial findings and notify Subcontractors of their appeal rights pursuant to that process. This section shall not apply to those grievances or complaints arising from the financial findings of an audit or examination made by or on behalf of the State pursuant to Part II of this Exhibit.
5. To ensure that necessary corrective actions are taken, financial audit findings are either uncontested or upheld after appeal may be used by the State during prospective Intergovernmental Agreement negotiations.



**Exhibit B**  
 Budget Detail and Payment Provisions

**Part V. Drug Medi-Cal Reimbursement Rates**

**A. "Uniform Statewide Daily Reimbursement (USDR) Rate"** means the rate for NTP services based on a unit of service that is a daily treatment service provided pursuant to Title 22, Sections 51341.1 and 51516.1 and Title 9, commencing with Section 10000 (Document 3G), or the rate for individual or group counseling. The following table shows USDR rates.

| <b>Service</b>                | <b>Type of Unit of Service (UOS)</b> | <b>Non-Perinatal (Regular) Rate Per UOS</b> | <b>Perinatal Rate Per UOS</b> |
|-------------------------------|--------------------------------------|---|-------------------------------|
| NTP-Methadone Dosing          | Daily                                | \$11.95                                     | \$13.80                       |
| NTP-Individual Counseling (*) | One 10-minute increment              | \$13.90                                     | \$18.43                       |
| NTP Group Counseling (*)      | One 10-minute increment              | \$3.05                                      | \$6.07                        |

(\*) The NTP contractors may be reimbursed for up to 200 minutes (20-10 minute increments) of individual and/or group counseling per calendar month. If medical necessity is met that requires additional NTP counseling beyond 200 minutes per calendar month, NTP contractors may bill and be reimbursed for additional counseling (in 10 minute increments). Medical justification for the additional counseling must be clearly documented in the patient record.

Reimbursement for covered NTP services shall be limited to the lower of the NTP's usual and customary charge to the general public for the same or similar services or the USDR rate.

**B. “Unit of Service”** means a face-to-face contact on a calendar day for outpatient drug free, intensive outpatient treatment, partial hospitalization, and residential treatment services. Units of service are identified in the following table:

| <b>Service Modality (funded by DMS)</b>  | <b>Billing/Unit of Service</b> | <b>Revised Interim Rate per Unit of Service*</b> |
|--|--------------------------------|--|
| <b>Encounter Rates</b>                   |                                |  |
| Outpatient                               | 15 minute increments           | \$ 31.00   |
| Recovery Services                        | 15 minute increments           | \$ 19.80   |
| Case Management                          | 15 minute increments           | \$ 36.29   |
| Physician Consultation                   | 15 minute increments           | \$ 154.84  |
| Intensive Outpatient                     | 15 minute increments           | \$ 29.18   |
| <b>Daily Rates</b>                       |                                |  |
| Level 1-WM                               | Per Day                        | \$ 154.84  |
| Level 2-WM                               | Per Day                        | N/A  |
| Level 3.2-WM                             | Per Day                        | \$ 207.22  |
| Level 3.1 - Residential                  | Per Day                        | \$ 111.95  |
| Level 3.3 - Residential                  | Per Day                        | \$ 268.29  |
| Level 3.5 - Residential                  | Per Day                        | \$ 188.63  |
| <b>Optional</b>                          |                                |  |
| Additional Medication Assisted Treatment | 15 minute increments           | \$ 154.84  |
| Partial Hospitalization                  | N/A                            | N/A  |



**Exhibit B, Attachment I - Funding for Fiscal Year 2016-17 through FY 2018-19**

County: San Mateo

Contract Number: 16-93234

|          |            |
|----------|------------|
| Version: | Original   |
| Date:    | 10/18/2016 |

| Fiscal Year 2016-17   | 2016-17 Funding Amount |
|---|------------------------|
| <b>State General Funds (7/1/16 to 6/30/17)</b>                |                        |
| Drug Medi-Cal SGF   | 23,317                 |
| ODS Waiver SGF  | 148,368                |
| <b>TOTAL</b>  | <b>171,685</b>         |
| <b>SAPT Block Grant - FFY 2017 Award (10/1/16 to 6/30/18)</b> |                        |
| - Discretionary   | 3,390,718              |
| - Prevention Set-Aside  | 955,792                |
| - Friday Night Live/Club Live                                 | 30,000                 |
| - Perinatal   | 222,167                |
| - Adolescent/Youth  | 56,352                 |
| <b>TOTAL</b>  | <b>4,655,029</b>       |
| <b>Drug Medi-Cal Federal Share (7/1/16 to 6/30/17)</b>        |                        |
| - Non Perinatal Federal Share                                 | 1,596,333              |
| - Perinatal Federal Share                                     | 0                      |
| <b>TOTAL</b>  | <b>1,596,333</b>       |
| <b>GRAND TOTAL</b>  | <b>6,423,047</b>       |

| Fiscal Year 2017-18   | 2017-18 Funding Amount |
|---|------------------------|
| <b>State General Funds (7/1/17 to 6/30/18)</b>                |                        |
| Drug Medi-Cal SGF   | 23,317                 |
| ODS Waiver SGF  | 148,368                |
| <b>TOTAL</b>  | <b>171,685</b>         |
| <b>SAPT Block Grant - FFY 2018 Award (10/1/17 to 6/30/19)</b> |                        |
| - Discretionary   | 3,390,718              |
| - Prevention Set-Aside  | 955,792                |
| - Friday Night Live/Club Live                                 | 30,000                 |
| - Perinatal   | 222,167                |
| - Adolescent/Youth  | 56,352                 |
| <b>TOTAL</b>  | <b>4,655,029</b>       |
| <b>Drug Medi-Cal Federal Share (7/1/17 to 6/30/18)</b>        |                        |
| - Non Perinatal Federal Share                                 | 1,596,333              |
| - Perinatal Federal Share                                     | 0                      |
| <b>TOTAL</b>  | <b>1,596,333</b>       |
| <b>GRAND TOTAL</b>  | <b>6,423,047</b>       |

| Fiscal Year 2018-19   | 2018-19 Funding Amount |
|---|------------------------|
| <b>State General Funds (7/1/18 to 6/30/19)</b>                |                        |
| Drug Medi-Cal SGF   | 23,317                 |
| ODS Waiver SGF  | 148,368                |
| <b>TOTAL</b>  | <b>171,685</b>         |
| <b>SAPT Block Grant - FFY 2019 Award (10/1/18 to 6/30/20)</b> |                        |
| - Discretionary   | 3,390,718              |
| - Prevention Set-Aside  | 955,792                |
| - Friday Night Live/Club Live                                 | 30,000                 |
| - Perinatal   | 222,167                |
| - Adolescent/Youth  | 56,352                 |
| <b>TOTAL</b>  | <b>4,655,029</b>       |
| <b>Drug Medi-Cal Federal Share (7/1/18 to 6/30/19)</b>        |                        |
| - Non Perinatal Federal Share                                 | 1,596,333              |
| - Perinatal Federal Share                                     | 0                      |
| <b>TOTAL</b>  | <b>1,596,333</b>       |
| <b>GRAND TOTAL</b>  | <b>6,423,047</b>       |

|                         |                   |
|-------------------------|-------------------|
| <b>THREE-YEAR TOTAL</b> | <b>19,269,141</b> |
|-------------------------|-------------------|

**Special Terms and Conditions**

*(For federally funded service contracts or agreements and grant agreements)*

The use of headings or titles throughout this exhibit is for convenience only and shall not be used to interpret or to govern the meaning of any specific term or condition.

The terms "contract", "Contractor" and "Subcontractor" shall also mean, "agreement", "grant", "grant agreement", "Grantee" and "Subgrantee" respectively.

The terms "California Department of Health Care Services", "California Department of Health Services", "Department of Health Care Services", "Department of Health Services", "CDHCS", "DHCS", "CDHS", and "DHS" shall all have the same meaning and refer to the California State agency that is a party to this Agreement.

This exhibit contains provisions that require strict adherence to various contracting laws and policies. Some provisions herein are conditional and only apply if specified conditions exist (i.e., agreement total exceeds a certain amount; agreement is federally funded, etc.). The provisions herein apply to this Agreement unless the provisions are removed by reference on the face of this Agreement, the provisions are superseded by an alternate provision appearing elsewhere in this Agreement, or the applicable conditions do not exist.

**Index of Special Terms and Conditions**

|   |   |
|---|---|
| 1. Federal Equal Employment Opportunity Requirements              | 17. Human Subjects Use Requirements                     |
| 2. Travel and Per Diem Reimbursement (Revised 6/2014)             | 18. Novation Requirements                               |
| 3. Procurement Rules  | 19. Debarment and Suspension Certification              |
| 4. Equipment Ownership / Inventory / Disposition                  | 20. Smoke-Free Workplace Certification                  |
| 5. Subcontract Requirements                                       | 21. Covenant Against Contingent Fees                    |
| 6. Income Restrictions  | 22. Payment Withholds                                   |
| 7. Audit and Record Retention                                     | 23. Performance Evaluation                              |
| 8. Site Inspection  | 24. Officials Not to Benefit                            |
| 9. Federal Contract Funds   | 25. Four-Digit Date Compliance                          |
| 10. Intellectual Property Rights                                  | 26. Prohibited Use of State Funds for Software          |
| 11. Air or Water Pollution Requirements                           | 27. Use of Small, Minority Owned and Women's Businesses |
| 12. Prior Approval of Training Seminars, Workshops or Conferences | 28. Alien Ineligibility Certification                   |
| 13. Confidentiality of Information                                | 29. Union Organizing                                    |
| 14. Documents, Publications, and Written Reports                  | 30. Contract Uniformity (Fringe Benefit Allowability)   |
| 15. Dispute Resolution Process (Revised 2/2012)                   | 31. Suspension or Stop Work Notification                |
| 16. Financial and Compliance Audit Requirements                   | 32. Lobbying Restrictions and Disclosure Certification  |



## 1. Federal Equal Opportunity Requirements

(Applicable to all federally funded agreements entered into by the Department of Health Care Services)

- a. The Contractor will not discriminate against any employee or applicant for employment because of race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. The Contractor will take affirmative action to ensure that qualified applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex, national origin, physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era. Such action shall include, but not be limited to the following: employment, upgrading, demotion or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and career development opportunities and selection for training, including apprenticeship. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the Federal Government or DHCS, setting forth the provisions of the Equal Opportunity clause, Section 503 of the Rehabilitation Act of 1973 and the affirmative action clause required by the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212). Such notices shall state the Contractor's obligation under the law to take affirmative action to employ and advance in employment qualified applicants without discrimination based on their race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era and the rights of applicants and employees.
- b. The Contractor will, in all solicitations or advancements for employees placed by or on behalf of the Contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex, national origin physical or mental handicap, disability, age or status as a disabled veteran or veteran of the Vietnam era.
- c. The Contractor will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding a notice, to be provided by the Federal Government or the State, advising the labor union or workers' representative of the Contractor's commitments under the provisions herein and shall post copies of the notice in conspicuous places available to employees and applicants for employment.
- d. The Contractor will comply with all provisions of and furnish all information and reports required by Section 503 of the Rehabilitation Act of 1973, as amended, the Vietnam Era Veterans' Readjustment Assistance Act of 1974 (38 U.S.C. 4212) and of the Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and of the rules, regulations, and relevant orders of the Secretary of Labor.
- e. The Contractor will furnish all information and reports required by Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," and the Rehabilitation Act of 1973, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to its books, records, and accounts by the State and its designated representatives and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.
- f. In the event of the Contractor's noncompliance with the requirements of the provisions herein or with any federal rules, regulations, or orders which are referenced herein, this Agreement may be cancelled, terminated, or suspended in whole or in part and the Contractor may be declared ineligible for further federal and state contracts in accordance with procedures authorized in Federal Executive Order No. 11246 as amended and such other sanctions may be imposed and remedies invoked as provided in Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.



- g. The Contractor will include the provisions of Paragraphs a through g in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Federal Executive Order No. 11246 as amended, including by Executive Order 11375, 'Amending Executive Order 11246 Relating to Equal Employment Opportunity,' and as supplemented by regulation at 41 CFR part 60, "Office of the Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor," or Section 503 of the Rehabilitation Act of 1973 or (38 U.S.C. 4212) of the Vietnam Era Veteran's Readjustment Assistance Act, so that such provisions will be binding upon each subcontractor or vendor. The Contractor will take such action with respect to any subcontract or purchase order as the Director of the Office of Federal Contract Compliance Programs or DHCS may direct as a means of enforcing such provisions including sanctions for noncompliance provided, however, that in the event the Contractor becomes involved in, or is threatened with litigation by a subcontractor or vendor as a result of such direction by DHCS, the Contractor may request in writing to DHCS, who, in turn, may request the United States to enter into such litigation to protect the interests of the State and of the United States.

## 2. Travel and Per Diem Reimbursement

(Applicable if travel and/or per diem expenses are reimbursed with agreement funds.)

Reimbursement for travel and per diem expenses from DHCS under this Agreement shall, unless otherwise specified in this Agreement, be at the rates currently in effect, as established by the California Department of Human Resources (CalHR), for nonrepresented state employees as stipulated in DHCS' Travel Reimbursement Information Exhibit. If the CalHR rates change during the term of the Agreement, the new rates shall apply upon their effective date and no amendment to this Agreement shall be necessary. Exceptions to CalHR rates may be approved by DHCS upon the submission of a statement by the Contractor indicating that such rates are not available to the Contractor. No travel outside the State of California shall be reimbursed without prior authorization from DHCS. Verbal authorization should be confirmed in writing. Written authorization may be in a form including fax or email confirmation.

## 3. Procurement Rules

(Applicable to agreements in which equipment/property, commodities and/or supplies are furnished by DHCS or expenses for said items are reimbursed by DHCS with state or federal funds provided under the Agreement.)

### a. Equipment/Property definitions

Wherever the term equipment and/or property is used, the following definitions shall apply:

- (1) **Major equipment/property:** A tangible or intangible item having a base unit cost of **\$5,000 or more** with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement. Software and videos are examples of intangible items that meet this definition.
  - (2) **Minor equipment/property:** A tangible item having a base unit cost of **less than \$5,000** with a life expectancy of one (1) year or more and is either furnished by DHCS or the cost is reimbursed through this Agreement.
- b. **Government and public entities** (including state colleges/universities and auxiliary organizations), whether acting as a contractor and/or subcontractor, may secure all commodities, supplies, equipment and services related to such purchases that are required in performance of this Agreement. Said procurements are subject to Paragraphs d through h of Provision 3. Paragraph c of Provision 3 shall also apply, if equipment/property purchases are delegated to subcontractors that are nonprofit organizations or commercial businesses.
- c. **Nonprofit organizations and commercial businesses**, whether acting as a contractor and/or subcontractor, may secure commodities, supplies, equipment/property and services related to such purchases for performance under this Agreement.

- (1) Equipment/property purchases shall not exceed \$50,000 annually.

To secure equipment/property above the annual maximum limit of \$50,000, the Contractor shall



make arrangements through the appropriate DHCS Program Contract Manager, to have all remaining equipment/property purchased through DHCS' Purchasing Unit. The cost of equipment/property purchased by or through DHCS shall be deducted from the funds available in this Agreement. Contractor shall submit to the DHCS Program Contract Manager a list of equipment/property specifications for those items that the State must procure. DHCS may pay the vendor directly for such arranged equipment/property purchases and title to the equipment/property will remain with DHCS. The equipment/property will be delivered to the Contractor's address, as stated on the face of the Agreement, unless the Contractor notifies the DHCS Program Contract Manager, in writing, of an alternate delivery address.

- (2) All equipment/property purchases are subject to Paragraphs d through h of Provision 3. Paragraph b of Provision 3 shall also apply, if equipment/property purchases are delegated to subcontractors that are either a government or public entity.
- (3) Nonprofit organizations and commercial businesses shall use a procurement system that meets the following standards:
  - (a) Maintain a code or standard of conduct that shall govern the performance of its officers, employees, or agents engaged in awarding procurement contracts. No employee, officer, or agent shall participate in the selection, award, or administration of a procurement, or bid contract in which, to his or her knowledge, he or she has a financial interest.
  - (b) Procurements shall be conducted in a manner that provides, to the maximum extent practical, open, and free competition.
  - (c) Procurements shall be conducted in a manner that provides for all of the following:
    - [1] Avoid purchasing unnecessary or duplicate items.
    - [2] Equipment/property solicitations shall be based upon a clear and accurate description of the technical requirements of the goods to be procured.
    - [3] Take positive steps to utilize small and veteran owned businesses.
- d. Unless waived or otherwise stipulated in writing by DHCS, prior written authorization from the appropriate DHCS Program Contract Manager will be required before the Contractor will be reimbursed for any purchase of \$5,000 or more for commodities, supplies, equipment/property, and services related to such purchases. The Contractor must provide in its request for authorization all particulars necessary, as specified by DHCS, for evaluating the necessity or desirability of incurring such costs. The term "purchase" excludes the purchase of services from a subcontractor and public utility services at rates established for uniform applicability to the general public.
- e. In special circumstances, determined by DHCS (e.g., when DHCS has a need to monitor certain purchases, etc.), DHCS may require prior written authorization and/or the submission of paid vendor receipts for any purchase, regardless of dollar amount. DHCS reserves the right to either deny claims for reimbursement or to request repayment for any Contractor and/or subcontractor purchase that DHCS determines to be unnecessary in carrying out performance under this Agreement.
- f. The Contractor and/or subcontractor must maintain a copy or narrative description of the procurement system, guidelines, rules, or regulations that will be used to make purchases under this Agreement. The State reserves the right to request a copy of these documents and to inspect the purchasing practices of the Contractor and/or subcontractor at any time.
- g. For all purchases, the Contractor and/or subcontractor must maintain copies of all paid vendor invoices, documents, bids and other information used in vendor selection, for inspection or audit. Justifications supporting the absence of bidding (i.e., sole source purchases) shall also be maintained on file by the Contractor and/or subcontractor for inspection or audit.
- h. DHCS may, with cause (e.g., with reasonable suspicion of unnecessary purchases or use of inappropriate purchase practices, etc.), withhold, cancel, modify, or retract the delegated purchase authority granted under Paragraphs b and/or c of Provision 3 by giving the Contractor no less than 30 calendar days written notice.



#### 4. Equipment/Property Ownership / Inventory / Disposition

(Applicable to agreements in which equipment/property is furnished by DHCS and/or when said items are purchased or reimbursed by DHCS with state or federal funds provided under the Agreement.)

- a. Wherever the term equipment and/or property is used in Provision 4, the definitions in Paragraph a of Provision 3 shall apply.

Unless otherwise stipulated in this Agreement, all equipment and/or property that is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement shall be considered state equipment and the property of DHCS.

- (1) **Reporting of Equipment/Property Receipt** - DHCS requires the reporting, tagging and annual inventorying of all equipment and/or property that is furnished by DHCS or purchased/reimbursed with funds provided through this Agreement.

Upon receipt of equipment and/or property, the Contractor shall report the receipt to the DHCS Program Contract Manager. To report the receipt of said items and to receive property tags, Contractor shall use a form or format designated by DHCS' Asset Management Unit. If the appropriate form (i.e., Contractor Equipment Purchased with DHCS Funds) does not accompany this Agreement, Contractor shall request a copy from the DHCS Program Contract Manager.

- (2) **Annual Equipment/Property Inventory** - If the Contractor enters into an agreement with a term of more than twelve months, the Contractor shall submit an annual inventory of state equipment and/or property to the DHCS Program Contract Manager using a form or format designated by DHCS' Asset Management Unit. If an inventory report form (i.e., Inventory/Disposition of DHCS-Funded Equipment) does not accompany this Agreement, Contractor shall request a copy from the DHCS Program Contract Manager. Contractor shall:

- (a) Include in the inventory report, equipment and/or property in the Contractor's possession and/or in the possession of a subcontractor (including independent consultants).
- (b) Submit the inventory report to DHCS according to the instructions appearing on the inventory form or issued by the DHCS Program Contract Manager.
- (c) Contact the DHCS Program Contract Manager to learn how to remove, trade-in, sell, transfer or survey off, from the inventory report, expired equipment and/or property that is no longer wanted, usable or has passed its life expectancy. Instructions will be supplied by either the DHCS Program Contract Manager or DHCS' Asset Management Unit.
- b. Title to state equipment and/or property shall not be affected by its incorporation or attachment to any property not owned by the State.
- c. Unless otherwise stipulated, DHCS shall be under no obligation to pay the cost of restoration, or rehabilitation of the Contractor's and/or Subcontractor's facility which may be affected by the removal of any state equipment and/or property.
- d. The Contractor and/or Subcontractor shall maintain and administer a sound business program for ensuring the proper use, maintenance, repair, protection, insurance and preservation of state equipment and/or property.
- (1) In administering this provision, DHCS may require the Contractor and/or Subcontractor to repair or replace, to DHCS' satisfaction, any damaged, lost or stolen state equipment and/or property. In the event of state equipment and/or miscellaneous property theft, Contractor and/or Subcontractor shall immediately file a theft report with the appropriate police agency or the California Highway Patrol and Contractor shall promptly submit one copy of the theft report to the DHCS Program Contract Manager.
- e. Unless otherwise stipulated by the Program funding this Agreement, equipment and/or property purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, shall only be used for performance of this Agreement or another DHCS agreement.



- f. Within sixty (60) calendar days prior to the termination or end of this Agreement, the Contractor shall provide a final inventory report of equipment and/or property to the DHCS Program Contract Manager and shall, at that time, query DHCS as to the requirements, including the manner and method, of returning state equipment and/or property to DHCS. Final disposition of equipment and/or property shall be at DHCS expense and according to DHCS instructions. Equipment and/or property disposition instructions shall be issued by DHCS immediately after receipt of the final inventory report. At the termination or conclusion of this Agreement, DHCS may at its discretion, authorize the continued use of state equipment and/or property for performance of work under a different DHCS agreement.

g. **Motor Vehicles**

(Applicable only if motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under this Agreement.)

- (1) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, within thirty (30) calendar days prior to the termination or end of this Agreement, the Contractor and/or Subcontractor shall return such vehicles to DHCS and shall deliver all necessary documents of title or registration to enable the proper transfer of a marketable title to DHCS.
- (2) If motor vehicles are purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the State of California shall be the legal owner of said motor vehicles and the Contractor shall be the registered owner. The Contractor and/or a subcontractor may only use said vehicles for performance and under the terms of this Agreement.
- (3) The Contractor and/or Subcontractor agree that all operators of motor vehicles, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, shall hold a valid State of California driver's license. In the event that ten or more passengers are to be transported in any one vehicle, the operator shall also hold a State of California Class B driver's license.
- (4) If any motor vehicle is purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, the Contractor and/or Subcontractor, as applicable, shall provide, maintain, and certify that, at a minimum, the following type and amount of automobile liability insurance is in effect during the term of this Agreement or any extension period during which any vehicle remains in the Contractor's and/or Subcontractor's possession:

**Automobile Liability Insurance**

- (a) The Contractor, by signing this Agreement, hereby certifies that it possesses or will obtain automobile liability insurance in the amount of \$1,000,000 per occurrence for bodily injury and property damage combined. Said insurance must be obtained and made effective upon the delivery date of any motor vehicle, purchased/reimbursed with agreement funds or furnished by DHCS under the terms of this Agreement, to the Contractor and/or Subcontractor.
- (b) The Contractor and/or Subcontractor shall, as soon as practical, furnish a copy of the certificate of insurance to the DHCS Program Contract Manager. The certificate of insurance shall identify the DHCS contract or agreement number for which the insurance applies.
- (c) The Contractor and/or Subcontractor agree that bodily injury and property damage liability insurance, as required herein, shall remain in effect at all times during the term of this Agreement or until such time as the motor vehicle is returned to DHCS.
- (d) The Contractor and/or Subcontractor agree to provide, at least thirty (30) days prior to the expiration date of said insurance coverage, a copy of a new certificate of insurance evidencing continued coverage, as indicated herein, for not less than the remainder of the term of this Agreement, the term of any extension or continuation thereof, or for a period of not less than one (1) year.
- (e) The Contractor and/or Subcontractor, if not a self-insured government and/or public entity, must provide evidence, that any required certificates of insurance contain the following provisions: