ARTICLE IV. FISCAL PROVISIONS

A. Reimbursements

To the extent that the Contractor provides the covered services in a satisfactory manner and in accordance with the terms and conditions of this Contract, the State agrees to pay the Contractor federal Medicaid funds according to Article V. Subject to the availability of such funds, Contractor shall receive federal Medicaid funds for allowable expenditures as established by the federal government and approved by the State, for the cost of services rendered to beneficiaries.

1. Reimbursement for covered services shall be made in accordance with applicable provisions of Title 22 and all other currently applicable policies and procedures.

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

   Before such denial, recoupment, or disallowances are made, State shall provide the Contractor with written notice of its proposed action. Such notice shall include the reason for the proposed action and shall allow the Contractor sixty (60) days to submit additional information before the proposed action is taken, as required in Title 22, CCR, Section 51047(a). This requirement does not apply to the DMC PSPP Utilization Reviews.

   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).

B. Return of Unexpended Funds

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

C. Availability of Funds

It is understood that, for the mutual benefit of both parties, this Contract 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 Contract were not executed until after that determination. If so, State may amend the amount of funding provided for in this Contract based on the actual congressional appropriation.

D. Additional Restrictions

This Contract is subject to any additional restrictions, limitations, or conditions enacted by the Congress, or any statute enacted by the Congress, which may affect the provisions, terms, or funding of this Contract in any manner.

E. Amendment or Cancellation Due to Insufficient Appropriation

This Contract 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 contract or to amend the Contract to reflect any reduction of funds.

F. Exemptions

Exemptions to the provisions of Section E, above, 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 contract.

G. Payment for Covered Services

Any payment for covered services rendered pursuant to this Exhibit D 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.

1. Contractor shall be reimbursed by the State on the basis of its actual net reimbursable cost, including any allowable county administrative costs, not to exceed the unit of service maximum rate.

   Pursuant to W&IC Section 14021.51(h), reimbursement to NTP providers shall be limited to the lower of either the uniform statewide monthly reimbursement rate, or the provider's usual and customary charge to the general public for the same or similar service. However, reimbursement paid by a Contractor 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))

2. Pursuant to HSC Section 11818(2)(A), Contractor shall reimburse providers that receive a combination of Medi-Cal funding and other federal funding for the same service element and location based on the provider's actual costs in accordance with Medi-Cal 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.

3. 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. 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, and Centers for Medicare and Medicaid Services (CMS), "Medicare Provider Reimbursement Manual (Publication Number 15)," which can be obtained from the Centers for Medicare & Medicaid Services, or www.cms.hhs.gov." In accordance with W&IC Sections 14132.44 and 14132.47, funds allocated to the Contractor for DMC services, including funding for alcohol and other drug services for pregnant and postpartum women pursuant to Title 22, Section 51341.1(c), may not be used as match for targeted case management services or for Medi-Cal administrative activities.

I. Records and Additional Audit Requirements

1. Accurate fiscal records and supporting documentation shall be maintained by the Contractor and its Subcontractors to support all claims for reimbursement. All records must be capable of verification by auditors.

2. Should a Subcontractor discontinue operations, Contractor shall retain 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 retaining to state funds. Contractor shall follow SAM requirements.

   If the Contractor cannot physically maintain the fiscal and program records of the Subcontractor, then arrangements shall be made with the State to take possession and maintain all records.

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.

Contractor shall retain client records for a minimum of three (3) years from the date of the last face-to-face contact. When an audit by the Federal Government or the State has been started before the expiration of the three-year period, the client records shall be maintained until completion of the audit and the final resolution of all audit issues.

4. In addition to the audit requirements set forth in Exhibit B, State may also conduct financial audits of DMC programs, exclusive of NTP services provided on or after July 1, 1997, to accomplish any of, but not limited to, the following audit objectives:

   (a) To review reported costs for validity, appropriate allocation methodology, and compliance with Medicaid laws and regulations;

   (b) To ensure that only the cost of allowable DMC activities are included in reported costs;

   (c) To determine the provider's usual and customary charge to the general public in accordance with CMS (The Medicare Provider Reimbursement Manual) (CMS-Pub.15), which can be obtained from the Centers for Medicare & Medicaid Services, Baltimore, Maryland, or www.cms.hhs.gov, for comparison to the DMC cost per unit;

   (d) To review documentation of units of service and determine the final number of approved units of service;

   (e) To determine the amount of clients' third-party revenue and Medi-Cal share of cost to offset allowable DMC reimbursement; and,

   (f) 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.

5. In addition to the audit requirements set forth in Exhibit B, State may conduct financial audits of NTP programs. For NTP services on or after July 1, 1997, the audits will address items 4(c) through 4(e) above, except that the comparison of the provider's usual and customary charge in 4(c) will be to the DMC USDR rate in lieu of DMC cost per unit. In addition, these audits will include, but not be limited to:

(a) For those NTP providers required to submit a cost report pursuant to W&IC Section 14124.24, a review of cost allocation methodology between NTP and other service modalities, and between DMC and other funding sources;

(b) A review of actual costs incurred for comparison to services claimed;

(c) A review of counseling claims to ensure that the appropriate group or individual counseling rate has been used and that counseling sessions have been billed appropriately;

(d) A review of the number of clients in group sessions to ensure that sessions include no less than four and no more than ten clients at the same time, with at least one Medi-Cal client in attendance;

(e) Computation of final settlement based on the lower of USDR rate or the provider's usual and customary charge to the general public; and,

(f) A review of supporting service, time, financial, and patient records to verify the validity of counseling claims.

6. Audit reports by the State shall reflect all findings and any recommendations, adjustments, or corrective action necessary as a result of those findings.

7. Contractor shall be responsible for any disallowances taken by the Federal Government, the State, or the California State Auditor 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

8. 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 one year from the date of the plan.

9. 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.

10. 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 D, 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 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(b). Contractor shall include a provision in its subcontracts regarding the process by which a Subcontractor may file an audit appeal via the Contractor.

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.

11. 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:

    (a) Provider ownership, organization, and operation;

    (b) Fiscal, medical, and other recordkeeping systems;

    (c) Federal income tax status;

    (d) Asset acquisition, lease, sale, or other action;

    (e) Franchise or management arrangements;

    (f) Patient service charge schedules;

    (g) Costs of operation;

    (h) Cost allocation methodology;

    (i) Amounts of income received by source and purpose; and,

    (j) Flow of funds and working capital.

12. In the event this Contract is terminated, Contractor shall deliver its entire fiscal and program records pertaining to the performance of this Contract to the State, which will retain the records for the required retention period.

13. Contractor shall retain records of utilization review activities required in Article VI herein for a minimum of three (3) years.

14. If an audit or review of "Administrative Costs" results in a disallowance, any recoupment and/or appeal of any such disallowances will be subject to that of the Department of Health Care Services W&IC Section 14124.21, 14170, and 14171 appeals and recoupment process and not that of the State Controller's Office.

J. Direct Provider Contracts

Pursuant to Exhibit B, Section G.1., and in accordance with Government Code section 30029.7 and W&IC Section 14124.21, effective July 1, 2012, the State shall, through the use of county-approved subcontractors, provide specified DMC services on the Contractor's behalf.

The State will invoice the Contractor for the county realignment share of approved DMC claims received by the State from the State's subcontractor. Contractor shall reimburse the State for the county realignment share of the approved DMC claims within 30 days of receipt of the invoice. If Contractor does not reimburse the State within 30 days of receipt of the invoice, the State may offset the amount owed from any other funding owed to Contractor by the State. The parties acknowledge that the State's subcontractor shall be responsible for repayment of any disallowed claims. However, in no event shall the State be liable for Medicaid reimbursement for any disallowed claims

Effective July 1, 2012, any Contractor contracting with the State for the provision of services through NTP providers may receive reimbursement of the NTP administrative rate.

ARTICLE V. INVOICE/CLAIM AND PAYMENT PROCEDURES

A. Payments

1. State shall reimburse the Contractor:

   (a) State General Funds and the federal Medicaid amount of the approved DMC claims and documents submitted in accordance with Article V of Section B, below:

   (b) State General Funds and the federal Medicaid share:

      I. At either the USDR or the provider's usual or customary charge to the general public for NTP's; or,

      II. At a rate that is lesser of the projected cost or the maximum rate allowance for other DMC modalities.

2. 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.

3. 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.

B. Drug Medi-Cal Claims and Reports

1. Contractors or providers that bill the State or the County for services identified in Section 51516.1 of Title 22 shall submit claims in accordance with the DMC Provider Billing manual. Contractor shall certify the public expenditure was made prior to submitting a claim for reimbursement.

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

(b) Contractor shall submit to the State the Drug Medi-Cal Certification Form for Federal Reimbursement (ADP 100224 - Document 4D) certifying the public expenditure for each claim file submitted for reimbursement of the federal Medicaid funds, 42 CFR Section 433.51.

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

- Multiple Billing Override Certification (MC 6700), Document 2K
- Good Cause Certification (MC 6065A), Document 2L(a)
- Good Cause Certification (MC 6065B), Document 2L(b)

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

3. Claims for reimbursement shall include only those services covered under Title 22, Section 51341.1(c-d) and administrative charges that are allowed under W&IC, Sections 14132.44 and 14132.47.

C. Year-End Cost Settlement Reports

1. Pursuant to W&IC Section 14124.24 Contractor shall submit to the State, on November 1 of each year, the following year-end cost settlement documents by paper or electronic submission for the previous fiscal year:

(a) Document 2P, County Certification Year-End Claim for Reimbursement

(b) Document 2P(a) and 2P(b), Drug Medi-Cal Cost Report Forms for Day Care Rehabilitative for Non-Perinatal or Perinatal (if applicable)

(c) Document 2P(c) and 2P(d), Drug Medi-Cal Cost Report Forms for Outpatient Drug Free Individual Counseling for Non-Perinatal or Perinatal (if applicable)

(d) Document 2P(e) and 2P(f), Drug Medi-Cal Cost Report Forms for Outpatient Drug Free Group Counseling for Non-Perinatal or Perinatal (if applicable)

(e) Document 2P(g), Drug Medi-Cal Cost Report Forms for Residential for Perinatal (if applicable)

(f) Document 2P(h) and 2P(i), Drug Medi-Cal Expenditure Forms for Narcotic Treatment Programs for Non-Perinatal or Perinatal (if applicable)

(g) Electronic program as prescribed by the State that contains the detailed cost report data

2. Cost reports for direct contract providers will be settled prior to the settlement of the Contractor's cost report. As a result of the direct contract provider's settled cost report, any County Realignment funds owed to the direct contract provider will be handled through an invoice process to the Contractor. Additionally, as a result of the direct contract provider's settled cost report, any County Realignment funds owed to the State will be returned to the Contractor.

3. State may settle costs for DMC services based on the year-end cost settlement report as the final amendment to the approved single State/County contract.

4. Reimbursement for covered services, other than NTP services, shall be limited to the lower of: (a) the provider's usual and customary charges to the general public for the same or similar services; (b) the provider's actual allowable costs; or (c) the DMC SMA for the modality.

5. Reimbursement to NTP's shall be limited to the lower of either the USDR, 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)).

ARTICLE VI. POSTSERVICE POSTPAYMENT UTILIZATION REVIEW

A. State shall conduct Postservice Postpayment (PSPP) utilization reviews in accordance with Title 22 Section 51341.1. Any claimed DMC service may be reviewed for compliance with all applicable standards, regulations and program coverage after services are rendered and the claim paid.

B. State shall take appropriate steps in accordance with Title 22, CCR, Section 51341.1 to recover payments made if subsequent investigation uncovers evidence that the claim(s) should not have been paid or that DMC services have been improperly utilized, and/or shall take the corrective action as appropriate.

Contractor and/or Subcontractor may appeal DMC dispositions concerning demands for recovery of payment and/or programmatic deficiencies of specific claims. Such appeals shall be handled pursuant to Title 22, CCR, Section 51015. 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 Article IV, Section I, of this Contract.

C. State shall monitor the Subcontractor's compliance with PSPP utilization review requirements in accordance with Title 22. The federal government may also review the existence and effectiveness of the State's utilization review system.

D. Contractor shall implement and maintain compliance with the system of review described in Title 22, Section 51341.1, for the purposes of reviewing the utilization, quality, and appropriateness of covered services and ensuring that all applicable Medi-Cal requirements are met.

E. Satellite sites must keep a record of the clients/patients being treated at that location. Contractor shall retain client records for a minimum of three (3) years from the date of the last face-to-face contact. When an audit by the Federal Government or the State has been started before the expiration of the three-year period, the client records shall be maintained until completion of the audit and the final resolution of all issues as a result of the audit.

LIST OF EXHIBIT D DOCUMENTS INCORPORATED BY REFERENCE*
FISCAL YEAR 13-14

The following documents are hereby incorporated by reference into Exhibit D of the combined County contract though they may not be physically attached to the contract:

Document 1F(a):	Reporting Requirement Matrix – County Submission Requirements for the Department of Alcohol and Drug Programs and the Department of Health Care Services
Document 1H(a):	Service Code Descriptions
Document 1H(b):	Program Code Listing
Document 1H(c) :	Funding Line Descriptions
Document 1J(b):	DMC Audit Appeals Process
Document 1K:	Drug and Alcohol Treatment Access Report (DATAR) http://www.adp.ca.gov/datar/manuals/DATARWeb_manual.pdf
Document 1P:	Alcohol and/or Other Drug Program Certification Standards (March 15, 2004) http://www.adp.ca.gov/Licensing/doc/Alcohol_andor_Other_Drug_Program_Certification_Standards.doc
Document 1V:	Youth Treatment Guidelines http://www.adp.ca.gov/youth/pdf/Youth_Treatment_Guidelines.pdf
Document 1W:	Certification Regarding Lobbying
Document 1X:	Disclosure of Lobbying Activities – Standard Form LLL http://www.whitehouse.gov/omb/grants/sfllllin.pdf
Document 2A:	Sobky v. Smoley, Judgment, Signed February 1, 1995
Document 2C:	Title 22, California Code of Regulations http://ccr.oal.ca.gov
Document 2E:	Drug Medi-Cal Certification Standards for Substance Abuse Clinics (Updated July 1, 2004) http://www.adp.ca.gov/dmc/pdf/DMCA_Drug_Medi-

Document 3H:	California Code of Regulations, Title 9 – Rehabilitation and Developmental Services, Division 4 – Department of Alcohol and Drug Programs, Chapter 8 – Certification of Alcohol and Other Drug Counselors http://www.calregs.com
Document 3J:	CalOMS Treatment Data Collection Guide http://www.adp.ca.gov/CalOMS/pdf/CalOMS_Tx_Data_Collection_Guide.pdf
Document 3S	CalOMS Treatment Data Compliance Standards http://www.adp.ca.gov/CalOMS/pdf/CalOMS_Data_Compliance.pdf
Document 3T	Non-Drug Medi-Cal and Drug Medi-Cal Local Assistance Funding Matrix
Document 3V	Culturally and Linguistically Appropriate Services (CLAS) National Standards http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15
Document 4A :	Drug Medi-Cal Claim Submission Certification – County Contracted Provider – DHCS Form MC 8186 with Instructions
Document 4B :	Drug Medi-Cal Claim Submission Certification – County Operated Provider – DHCS Form MC 8187 with Instructions
Document 4D :	Drug Medi-Cal Certification for Federal Reimbursement (ADP 100224) http://www.adp.ca.gov/adpltrs/doc/11-17exA.doc
Document 4E :	Treatment Standards for Substance Use Diagnosis : A Guide for Services (Spring 2010) http://www.adp.ca.gov/treatment/standards/pdf/treatment_standards_spring_2010.pdf
Exhibit G	Privacy and Information Security Provisions

Cal Certification Standards.pdf

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

http://www.adp.ca.gov/dmc/pdf/DMCA Standards for Drug Treatment Programs.pdf

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

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

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

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

Document 2P(a): Drug Medi-Cal Cost Report Forms – Day Care Rehabilitative – Non-Perinatal (form and instructions)

Document 2P(b): Drug Medi-Cal Cost Report Forms – Day Care Rehabilitative – Perinatal (form and instructions)

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

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

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

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

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

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

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

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

http://www.calregs.com