

AGREEMENT FOR SERVICES #9595
Substance Use Disorder Services

THIS AGREEMENT is made and entered into by and between the County of El Dorado, a political subdivision of the State of California (hereinafter referred to as "County") and Muir Wood, LLC, a Limited Liability Company, duly qualified to conduct business in the State of California, whose principal place of business is 201 1st Street, Suite 111, Petaluma, California 94952, and whose Agent for Service Process is Daniel Pencak, 201 1st Street, Suite 111, Petaluma, California 94952 (hereinafter referred to as "Provider");

RECITALS

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

WHEREAS, County has determined that it is necessary to obtain a Provider to provide SUD Services to eligible beneficiaries;

WHEREAS, Provider has represented to County that it is specially trained, experienced, expert, and competent to perform the special services described in ARTICLE 2. General Provisions 2. Scope of Work that it is an independent and bona fide business operation, advertises and holds itself as such, is in possession of a valid business license, and is customarily engaged in an independently established business that provides similar services to others; and County relies upon those representations;

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

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

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

Table of Contents

ARTICLE 1. DEFINITIONS	4
ARTICLE 2. GENERAL PROVISIONS.....	4
ARTICLE 3. SERVICES AND ACCESS PROVISIONS	13
ARTICLE 4. AUTHORIZATION AND DOCUMENTATION PROVISIONS	16
ARTICLE 5. CHART AUDITING AND REASONS FOR RECOUPMENT	20
ARTICLE 6. CLIENT PROTECTIONS.....	23
ARTICLE 7. PROGRAM INTEGRITY	25
ARTICLE 8. QUALITY IMPROVEMENT PROGRAM	29
ARTICLE 9. FINANCIAL TERMS	31
ARTICLE 10. ADDITIONAL FINAL RULE PROVISIONS	32
ARTICLE 11. DATA, PRIVACY AND SECURITY REQUIREMENTS	36
ARTICLE 12. CLIENT RIGHTS.....	37
ARTICLE 13. RIGHT TO MONITOR.....	37
ARTICLE 14. SITE INSPECTION	38
ARTICLE 15. EXECUTIVE ORDER N-6-22 – RUSSIA SANCTIONS	39
ARTICLE 16. CONTRACT ADMINISTRATOR.....	39
ARTICLE 17. ELECTRONIC SIGNATURES	39
ARTICLE 18. COUNTERPARTS	39
ARTICLE 19. ENTIRE AGREEMENT.....	39

EXHIBITS

Exhibit A: Scope of Work

Exhibit B: Provider Rate Table

Exhibit C: Preauthorization and Enrollment Form

Exhibit D: Treatment Authorization Form

Exhibit E: California Levine Act Statement

Exhibit F: Notice of Adverse Benefit Determination (NOABD) Form

Exhibit G: Certification of Non-Exclusion or Suspension from Participation

Exhibit H: Provider Assurance of Compliance with Nondiscrimination in State and Federally Assisted Programs

Exhibit I: HIPAA Business Associate Agreement

ARTICLE 1. DEFINITIONS

1. BEHAVIORAL HEALTH INFORMATION NOTICE (BHIN): “Behavioral Health Information Notice” or “BHIN” means guidance from DHCS to inform counties and Providers of changes in policy or procedures at the federal or state levels. These were previously referred to as a Mental Health and SUD Services Information Notice (MHSUDS IN). BHINs and MHSUDS INs are available on the DHCS website.
2. BENEFICIARY OR CLIENT: “Beneficiary” or “client” means the individual(s) receiving services.
3. DHCS: “DHCS” means the California Department of Health Care Services.
4. DIRECTOR: “Director” means the Director of the County Behavioral Health Department, unless otherwise specified.

ARTICLE 2. GENERAL PROVISIONS

1. TERM
This Agreement shall become effective upon final execution by both parties hereto and shall cover the period of November 1, 2025, through October 31, 2028.
2. SCOPE OF WORK
Provider shall provide the services set forth in Exhibit A, marked “Scope of Work,” incorporated herein and made by reference a part hereof.
3. COMPENSATION FOR SERVICES
For services provided herein, including any deliverables that may be identified herein, Provider shall submit invoices for services thirty (30) days following the end of a “service month.” For billing purposes, a “service month” shall be defined as a calendar month during which Provider provides services in accordance with ARTICLE 2. General Provisions, 2. Scope of Work. For all satisfactory services provided herein, County agrees to pay Provider monthly in arrears and within forty-five (45) days following the County’s receipt and approval of invoice(s) identifying services rendered.
 - A. Rates: For the purposes of this Agreement, the billing rate shall be as defined in Exhibit B marked “Provider Rate Table,” incorporated herein and made by reference a part hereof.
 - B. Invoices: It is a requirement of this Agreement that Provider shall submit an original invoice, similar in content and format with the Health and Human Services Agency (HHSA) invoice template linked online at <https://ElDoradoCounty.ca.gov/HHSA-Contractor-Resources>, and shall reference this Agreement number on their faces.

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

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

or to such other location or email as County directs.

Supplemental Invoices: For the purpose of this Agreement, supplemental invoices shall be defined as invoices submitted for additional services, previously disallowed services, or inadvertently not submitted services rendered during a month for which a prior invoice has already been submitted to County. Supplemental invoices should include the standard invoice format with description of services rendered. The County will not accept nor pay any supplemental invoices for services provided during the period July 1st through June 30th for each fiscal year of this Agreement that are received by County after July 31st of the subsequent fiscal year, unless Provider requests an exception. Requests for exceptions to pay an invoice received after July 31st of the subsequent year must be submitted in writing, to include electronic communication, and approved by the HHSA’s Chief Fiscal Officer in his/her sole discretion.

In the event that Provider fails to deliver, in the format specified, the deliverables and reports required by this Agreement, County at its sole option may delay the payment for the period of time of the delay, cease all payments until such time as the required deliverables or reports are received, or proceed as set forth below in the ARTICLE 2. General Provisions, 13 Default, Termination, and Cancellation.

4. CLIENT FINANCIAL RESPONSIBILITIES AND SERVICE AUTHORIZATION

- A. Client Fees: Provider may charge a fee to clients for whom services are provided pursuant to this Agreement, assessing ability to pay based on individual expenses in relation to income, assets, estates, and responsible relatives. Client fees shall be based upon the person’s ability to pay for services, but shall not exceed the actual cost of service provided. No person shall be denied services because of inability to pay.
- B. Client Financial Assessment: Provider shall certify all clients whose alcohol and drug treatment services are subsidized under this Agreement as unable to pay the amount charged to this Agreement. The certification of each client who is unable to pay shall be documented in writing on a Client Financial Assessment Form, which is developed by Provider and approved by Contract Administrator. This completed document shall be maintained by the Provider in the client’s file.
- C. Written Authorization for Services: All services under this Agreement may only be provided if County HHSA SUDS staff refers a client to Provider via County’s written treatment authorization forms pre-authorizing said services. These forms are attached hereto as Exhibit C marked “Preauthorization and Enrollment Form” and Exhibit D marked “Treatment Authorization Form”, incorporated herein and made by reference a part hereof. County will

email the treatment authorization forms to the Provider. Provider shall submit the completed written treatment authorization forms along with the invoice when seeking reimbursement.

5. MAXIMUM OBLIGATION

The maximum obligation for services and deliverables provided under this Agreement shall not exceed \$375,000, inclusive of all costs, taxes and expenses.

6. RECORD RETENTION

A. Provider shall retain beneficiary records for a minimum of ten (10) years, in accordance with 42 CFR 438.3(h), from the finalized cost settlement process with the Department. When an audit by the Federal Government or DHCS has been started before the expiration of the 10-year period, the beneficiary records shall be maintained until completion of the audit and the final resolution of all issues.

B. Provider shall comply with, and include in any subcontract with providers, the mandate to keep and maintain records for each service rendered, to whom it was rendered, and the date of service, pursuant to Welfare and Institutions Code 14124.1 and 42 CFR 438.3(h) and 438.3(u).

C. County shall ensure that any Provider sites authorized shall keep a record of the beneficiaries/patients being treated at that location.

7. NOTICE TO PARTIES

All notices to be given by the parties hereto shall be in writing, with both the County HHSA and County Chief Administrative Office addressed in said correspondence and served by either United States Postal Service mail or electronic email. Notice by mail shall be served by depositing the notice in the United States Post Office, postage prepaid and return receipt requested, and deemed delivered and received five (5) calendar days after deposit. Notice by electronic email shall be served by transmitting the notice to all required email addresses and deemed delivered and received two (2) business days after service.

Notices to County shall be addressed as follows: with a copy to:

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

COUNTY OF EL DORADO
Chief Administrative Office
Procurement and Contracts Division
330 Fair Lane
Placerville, CA 95667
ATTN: Purchasing Agent
Email: procon@edcgov.us

or to such other location or email as the County directs.

Notices to Provider shall be addressed as follows:

MUIR WOOD, LLC
201 1st Street, Suite 111
Petaluma, CA 94952
ATTN: Heather Stratford
hstratford@muirwoodteen.com

or to such other location or email as the Provider directs.

8. CHANGE OF ADDRESS

In the event of a change in address for Provider's principal place of business, Provider's Agent for Service of Process, or Notices to Provider, Provider shall notify County in writing pursuant to the provisions contained herein above under the ARTICLE 2. General Provisions 7. Notice to Parties. Said notice shall become part of this Agreement upon acknowledgment in writing by the County Contract Administrator, and no further amendment of the Agreement shall be necessary provided that such change of address does not conflict with any other provisions of this Agreement.

9. INDEPENDENT PROVIDER

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

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

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

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

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

10. ASSIGNMENT AND DELEGATION

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

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

11. SUBCONTRACTS

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

12. CHANGES TO AGREEMENT

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

13. DEFAULT, TERMINATION, AND CANCELLATION

- A. Termination by Default: If either party becomes aware of an event of default, that party shall give written notice of said default to the party in default that shall state the following:
 - I. The alleged default and the applicable Agreement provision; and
 - II. That the party in default has ten (10) days upon receiving the notice to cure the default (Time to Cure).

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

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

- 1. County reserves the right to procure the goods or services, or both, similar to those terminated, from other sources and Provider shall be liable to County for any excess costs for those goods or services. County may deduct from any payment due, or that may thereafter become due to Consultant, the excess costs to procure from an alternate source.
- 2. County shall pay Provider the sum due to Provider under this Agreement prior to termination, unless the cost of completion to County exceeds the funds remaining in the Agreement. In which case the overage shall be deducted from any sum due Provider under this Agreement and the balance, if any, shall be paid to Provider upon demand.

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

The following will be events of default under this Agreement:

1. Failure by either party to perform in a timely and satisfactory manner any or all of its obligations under this Agreement.
 2. A representation or warranty made by Provider in this Agreement proves to have been false or misleading in any respect.
 3. Provider fails to observe and perform any covenant, condition or agreement on its part to be observed or performed under this Agreement, unless County agrees, in writing, to an extension of the time to perform before that time period expires.
 4. A violation of the ARTICLE 2. General Provisions, 16. Conflict of Interest.
- B. Bankruptcy: County may terminate this Agreement immediately in the case of bankruptcy, voluntary or involuntary, or insolvency of Provider.
- C. Ceasing Performance: County may terminate this Agreement immediately in the event Provider ceases to operate as a business or otherwise becomes unable to substantially perform any term or condition of this Agreement.
- D. Termination or Cancellation without Cause: County may terminate this Agreement, in whole or in part, for convenience upon thirty (30) calendar days' written Notice of Termination, in accordance with the ARTICLE 2. General Provisions, 7. Notice to Parties. If such termination is effected, County will pay for satisfactory services rendered before the effective date of termination, as set forth in the Notice of Termination provided to Provider, and for any other services that County agrees, in writing, to be necessary for contract resolution. In no event, however, shall County be obligated to pay more than the total amount of the Agreement. Upon receipt of a Notice of Termination, Provider shall promptly discontinue all services affected, as of the effective date of termination set forth in such Notice of Termination, unless the Notice directs otherwise.
- E. Funding Unavailable: County may terminate this Agreement immediately, without prior notice, at any time upon giving written notice to Provider that County has been notified the grant/allocation funds from the State of California, federal government, or other entity, or any portion thereof, for the purposes of carrying out this Agreement, are not available, to County, including if distribution of such funds are suspended or delayed.

14. INTERPRETATION; VENUE

- A. The headings used herein are for reference only. The terms of the Agreement are set out in the text under the headings.
- B. This Agreement shall be governed by the laws of the State of California without regard to the choice of law or conflicts.
- C. This Agreement is made in El Dorado County, California. The venue for any legal action in state court filed by either party to this Agreement for the purpose of interpreting or enforcing any provision of this Agreement shall be in the Superior Court of California, County of El Dorado. The venue for any legal action in federal court filed by either Party to this Agreement for the purpose of interpreting or enforcing any provision of this Agreement lying within the jurisdiction of the federal courts shall be the 5th District of California.

15. INSURANCE

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

- A. Full Worker's Compensation and Employer's Liability Insurance covering all employees of Provider as required by law in the State of California.
- B. Commercial General Liability Insurance of not less than \$1,000,000.00 combined single limit per occurrence for bodily injury and property damage and a \$2,000,000.00 aggregate limit.
- C. Automobile Liability Insurance of not less than \$1,000,000.00 is required in the event motor vehicles are used by the Provider in the performance of the Agreement.
- D. In the event Provider is a licensed professional or professional consultant, and is performing professional services under this Agreement, professional liability is required with a limit of liability of not less than \$1,000,000.00 per occurrence.
- E. Provider shall furnish a certificate of insurance satisfactory to the County of El Dorado Risk Manager as evidence that the insurance required above is being maintained.
- F. The insurance will be issued by an insurance company acceptable to Risk Management, or be provided through partial or total self-insurance likewise acceptable to Risk Management.
- G. Provider agrees that the insurance required above shall be in effect at all times during the term of this Agreement. In the event said insurance coverage expires at any time or times during the term of this Agreement, Provider agrees to provide at least thirty (30) days prior to said expiration date, a new certificate of insurance evidencing insurance coverage as provided for herein for not less than the remainder of term of the Agreement, or for a period of not less than one (1) year. New certificates of insurance are subject to the approval of Risk Management and Provider agrees that no work or services shall be performed prior to the giving of such approval. In the event the Provider fails to keep in effect at all times insurance coverage as herein provided, County may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.
- H. The certificate of insurance must include the following provisions stating that:
 - I. The insurer will not cancel the insured's coverage without prior written notice to County; and
 - II. The County of El Dorado, its officers, officials, employees and volunteers are included as additional insured on an additional insured endorsement, but only insofar as the operations under this Agreement are concerned. This provision shall apply to the general liability policy.
- I. The Provider's insurance coverage shall be primary insurance as respects the County, its officers, officials, employees and volunteers. Any insurance or self-insurance maintained by the County, its officers, officials, employees or volunteers shall be in excess of the Provider's insurance and shall not contribute with it.
- J. Any deductibles or self-insured retentions must be declared to and approved by the County, either: the insurer shall reduce or eliminate such deductibles or self-insured retentions as respects the County, its officers, officials, employees and volunteers; or the Provider shall procure a bond guaranteeing payment of losses and related investigations, claim administration and defense expenses.
- K. Any failure to comply with the reporting provisions of the policies shall not affect coverage provided to the County, its officers, officials, employees or volunteers.

- L. The insurance companies shall have no recourse against the County of El Dorado, its officers and employees or any of them for payment of any premiums or assessments under any policy issued by any insurance company.
- M. Provider's obligations shall not be limited by the foregoing insurance requirements and shall survive expiration of this Agreement.
- N. In the event Provider cannot provide an occurrence policy, Provider shall provide insurance covering claims made as a result of performance of this Agreement for not less than three (3) years following completion of performance of this Agreement.
- O. Certificate of insurance shall meet such additional standards as may be determined by the contracting County Department either independently or in consultation with Risk Management, as essential for protection of the County.

16. CONFLICT OF INTEREST

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

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

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

If Provider becomes aware of a conflict of interest related to this Agreement, Provider shall promptly notify County of the existence of that conflict, and County may, in its sole discretion, immediately terminate this Agreement by giving written notice as detailed in the ARTICLE 2. General Provisions, 13. Default, Termination, and Cancellation.

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

17. CALIFORNIA RESIDENCY (FORM 590)

If Provider is a California resident, Providers must file a State of California Form 590, certifying its California residency or, in the case of a corporation, certifying that it has a permanent place of business in California. The Provider shall be required to submit a Form 590 prior to execution of

an Agreement or County will withhold seven (7) percent of each payment made to the Provider during term of the Agreement. This requirement applies to any agreement/contract exceeding \$1,500.00.

18. COUNTY PAYEE DATA RECORD FORM

All independent Providers or corporations providing services to County who do not have a Department of the Treasury Internal Revenue Service Form W-9 (Form W-9) on file with County must file a County Payee Data Record Form with County.

19. COUNTY BUSINESS LICENSE

County's Business License Ordinance provides that it is unlawful for any person to furnish supplies or services, or transact any kind of business in the unincorporated territory of El Dorado County without possessing a County business license unless exempt under County Ordinance Code Section 5.08.070. Contractor warrants and represents that it shall comply with all of the requirements of County's Business License Ordinance, where applicable, prior to beginning work under this Agreement and at all times during the term of this Agreement.

20. FORCE MAJEURE

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

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

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

21. SEVERABILITY

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

22. AUTHORITY TO CONTRACT

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

23. CONFORMITY WITH STATE AND FEDERAL LAWS AND REGULATIONS

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

- I. Title 9, CCR;
 - II. California Welfare and Institutions Code, Division 5;
 - III. United States Code of Federal Regulations, Title 42, including but not limited to Part 2;
 - IV. United States Code of Federal Regulations, Title 45;
 - V. United States Code, Title 42 (The Public Health and Welfare), as applicable;
 - VI. Balanced Budget Act of 1997;
 - VII. Health Insurance Portability and Accountability Act (HIPAA); and
 - VIII. Applicable laws and regulations, including applicable sub-regulatory guidance, such as BHINs, MHSUDS INs, and provisions of County's state or federal contracts governing client services.
- B. In the event any law, regulation, or guidance referred to in subsection (A), above, is amended during the term of this Agreement, the Parties agree to comply with the amended authority as of the effective date of such amendment without amending this Agreement.

ARTICLE 3. SERVICES AND ACCESS PROVISIONS

1. ACCESS TO SUD SERVICES

- A. In collaboration with County, Provider will work to ensure that individuals to whom the Provider provides SUD services meet access criteria including maintaining residency in El Dorado County and having at least one Diagnostic and Statistical Manual of Mental Disorders (DSM) Diagnosis for a substance use disorder, and meeting the county's medically necessary criteria for residential treatment services as detailed in BHIN 24-001. Provider will ensure that the clinical record for each client includes information as a whole indicating that client's presentation and needs are aligned with the criteria applicable to their age at the time of service provision as specified below.
- B. Provider shall have written admission criteria for determining the client's eligibility and suitability for treatment and services. All clients admitted shall meet the admission criteria and this shall be documented in the client's record.
- C. Programs shall ensure that their policies, procedures, practices, and rules and regulations do not discriminate against the above special populations. Whenever the needs of the client cannot be reasonably accommodated, efforts shall be made to make referral(s) to appropriate programs.
- D. Provider should recognize and educate staff and collaborative partners that Probation status is not a barrier to SUD services.
- E. Provider will ensure that the clinical record for each client includes information as a whole indicating that client's presentation and needs are aligned with the criteria applicable to their age at the time-of-service provision as outlined in this Agreement.

2. ASAM LEVEL OF CARE DETERMINATION

- A. Provider shall use the ASAM Criteria to determine placement into the appropriate Level of Care (LOC) for all beneficiaries, which is separate and distinct from determining medical necessity. LOC determinations shall ensure that beneficiaries are able to receive care in the least restrictive LOC that is clinically appropriate to treat their condition.
- B. A full ASAM Criteria assessment, or brief screening ASAM Criteria tool for preliminary LOC recommendations, shall not be required to begin receiving SUD services.
- C. A full ASAM Criteria assessment does not need to be repeated unless the client's condition changes.

3. MEDICAL NECESSITY

- A. County will ensure that all clients placed into treatment meet medical necessity criteria as defined by BHIN 24-001.

4. COORDINATION AND CONTINUITY OF CARE

- A. Provider shall ensure that all care, treatment, and services provided pursuant to this Agreement are coordinated among all providers who are serving the client. Coordination and continuity of care procedures shall meet the following requirements:
- I. Ensure that each client has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the client. The client shall be provided information on how to contact their designated person or entity.
 - II. All services provided to clients shall be coordinated:
 - 1) Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.
 - 2) With the services the client receives from any other managed care organization.
 - 3) With the services the client receives from community and social support providers.
 - III. Share with other providers serving the client, as allowed by regulations, the results of any identification and assessment of that client's needs to prevent duplication of those activities.
 - IV. Ensure that each provider furnishing services to clients maintains and shares, as appropriate, a client health record in accordance with professional standards.
 - V. Ensure that in the process of coordinating care, each client's privacy is protected in accordance with the privacy requirements in 45 C.F.R. Parts 160 and 164 subparts A and E and 42 C.F.R. Part 2, to the extent that they are applicable.
- B. Provider shall engage in care coordination activities beginning at intake and throughout the treatment and discharge planning processes.
- C. To facilitate care coordination, Provider will request a HIPPA and California law compliant client authorization to share client information with and among all other providers involved in the client's care, in satisfaction of state, and federal privacy laws and regulations.

5. SITE LICENSES, CERTIFICATIONS, PERMITS REQUIREMENTS

- A. As specified in BHIN 21-001 and in accordance with Health and Safety Code § 11834.015, DHCS adopted the ASAM treatment criteria as the minimum standard of care for licensed AOD facilities. All licensed AOD facilities shall obtain at least one DHCS LOC Designation and/or at least one residential ASAM LOC Certification consistent with all of its program services. If an AOD facility opts to obtain an ASAM LOC Certification, then that facility will not be required to obtain a DHCS LOC Designation. However, nothing precludes a facility from obtaining both a DHCS LOC Designation and ASAM LOC Certification.
- B. Provider shall obtain and comply with ASAM designation or DHCS Level of Care (LOC) Designation for each type of contracted service being delivered, as well as any additional licensure, registration or accreditation required by regulations for the contracted service being delivered.
- C. Provider shall obtain and maintain all appropriate licenses, permits, and certificates required by all applicable federal, state, and county and/or municipal laws, regulations, guidelines, and/or directives.

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

6. MEDICATIONS

- A. If Provider provides or stores medications, the Provider shall store and monitor medications in compliance with all pertinent statutes and federal standards.
- B. Provider shall have written policies and procedures regarding the use of prescribed medications by clients, and for monitoring and storing of medications.
- C. Prescription and over the counter medications which expire and other bio-hazardous pharmaceuticals including used syringes or medications which are not removed by the client upon termination of services shall be disposed of by the program director or a designated substitute, and one other adult who is not a client. Both shall sign a record, to be retained for at least one year.
- D. Provider shall have at least one program staff on duty at all times trained to adequately monitor clients for signs and symptoms of their possible misuse of prescribed medications, adverse medication reactions and related medical complications.

7. ALCOHOL AND/OR DRUG-FREE ENVIRONMENT

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

8. ASSESSMENT OF TOBACCO USE DISORDER

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

9. NALOXONE REQUIREMENTS

- A. As required by Health and Safety Code, § 11834.26 (AB 381, Chapter 437 Statutes 2021 and BHIN 22-025, all licensed or certified SUD recovery or treatment facilities shall comply with the following requirements:

- I. Maintain, at all times, at least two (2) unexpired doses of naloxone, or any other opioid antagonist medication that is approved by the FDA for the treatment of an opioid overdose, on the premises of the licensed SUD recovery or treatment facility.
- II. Have at least one staff member, at all times, on the premises who knows the specific location of the naloxone, or other FDA-approved opioid antagonist medication, and who has been trained in its administration. Training shall include review of online resources and the National Harm Reduction Coalition's Opioid Overdose Basics website to respond effectively to an opioid-associated overdose emergency. Staff shall certify that they have reviewed and undergone training in opioid overdose prevention and treatment.
- III. The proof of completion of such training shall be documented in the staff member's individual personnel file, in accordance with Title 9, CCR, § 10564(k).

ARTICLE 4. AUTHORIZATION AND DOCUMENTATION PROVISIONS

1. SERVICE AUTHORIZATION

- A. Provider will collaborate with County to complete authorization requests in line with County and DHCS policy.
- B. Provider shall respond to County in a timely manner when consultation is necessary for County to make appropriate authorization determinations.
- C. For SUD Residential and Inpatient Levels of Care service authorization:
 - I. Provider shall have in place, and follow, County written authorization policies and procedures for processing requests for initial and continuing authorization, or prior authorization, for residential treatment services, including inpatient services, but excluding withdrawal management services.
 - II. County will review the DSM and ASAM Criteria to ensure that the beneficiary meets the requirements for the service.
 - III. Prior authorization for residential and inpatient services (excluding withdrawal management services) shall be made within 24 hours of the prior authorization request being submitted by the provider.
 - a. County will ensure that prior authorization processes are completed in a manner that assures the provision of a covered SUD service to a client in a timely manner appropriate for the client's condition.
 - IV. Provider shall alert County when an expedited service authorization decision is necessary due to a client's specific needs and circumstances that could seriously jeopardize the client's life or health, or ability to attain, maintain, or regain maximum function. Expedited service authorizations shall not exceed 72 hours after receipt of the request for service, with a possible extension of up to 14 calendar days if the client or provider requests an extension.
 - V. Provider shall alert County when a standard authorization decision is necessary. Standard service authorizations shall not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days if the client or provider requests an extension.
- D. Provider, if applicable, shall ensure that length of stay (LOS) in residential program complies with the following:
 - I. LOS shall be determined by individualized clinical need (statewide LOS goal is 30 days). LOS for clients shall be determined by an LPHA and authorized by the County as medically necessary.

- II. Clients receiving residential treatment must be transitioned to another LOC when clinically appropriate based on treatment progress.

2. DOCUMENTATION REQUIREMENTS

- A. Provider agrees to comply with documentation requirements for non-hospital services as specified in Article 4.2-4.9 inclusive in compliance with federal, state and County requirements.
- B. All Provider documentation shall be accurate, complete, legible, and shall list each date of service. Provider shall document the face-to-face duration of the service, including travel and documentation time for each service. Services must be identified as provided in-person, by telephone, or by telehealth.
- C. All services shall be documented utilizing County-approved templates and contain all required elements. Provider agrees to satisfy the chart documentation requirements set forth in BHIN 22-019 and the contract between County and DHCS. Failure to comply with documentation standards specified in this Article require corrective action plans.

3. ASSESSMENT

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

4. ICD-10

- A. Provider shall use the criteria set forth in the current edition of the DSM as the clinical tool to make diagnostic determinations.
- B. Once a DSM diagnosis is determined, the Provider shall determine the corresponding diagnosis in the current edition of ICD. Provider shall use the ICD diagnosis code(s) to submit a claim for SUD services to receive reimbursement from County.
- C. The ICD Tabular List of Diseases and Injuries is maintained by CMS and may be updated during the term of this Agreement. Changes to the lists of ICD diagnoses do not require an amendment to this Agreement, and County may implement these changes as provided by DHCS.

5. PHYSICAL EXAMINATION REQUIREMENTS

- A. If a beneficiary had a physical examination within the twelve-month period prior to the beneficiary's admission to treatment date, the physician or registered nurse practitioner or physician's assistant (physician extenders) shall review documentation of the beneficiary's most recent physical examination within thirty (30) calendar days of the beneficiary's admission to treatment date.

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

6. PROGRESS NOTES

- A. Provider shall create progress notes for the provision of all SUD services provided under this Agreement.
- B. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.
- C. Progress notes shall include all the following elements:
 - I. The type of service rendered
 - II. A narrative describing the service, including how the service addressed the client's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors)
 - III. The date that the service was provided to the beneficiary
 - IV. Duration of the service, including travel and documentation time
 - V. Location of the client at the time of receiving the service
 - VI. A typed or legibly printed name, signature of the service provider and date of signature
 - VII. Next steps, including, but not limited to, planned action steps by the provider or by the client, collaboration with the client, collaboration with other provider(s) and any update to the problem list as appropriate.
- D. Provider shall complete progress notes within three business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.
- E. Provider shall complete a daily progress note for services that are billed on a daily basis, such as residential and inpatient services, if applicable.
- F. When a group service is rendered by the Provider, the following conditions shall be met:
 - I. A list of participants is required to be documented and maintained by the Provider.
 - II. If more than one provider renders a group service, one progress note may be completed for a group session and signed by one provider. Provider shall ensure that in this case, the progress note clearly documents the specific involvement and the specific amount of time of involvement of each provider during the group activity, including documentation time.

7. PLAN OF CARE

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

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

- B. Provider shall develop plans of care for all clients, when required, and these plans of care shall include the following:
 - I. Statement of problems experienced by the client to be addressed.
 - II. Statement of objectives to be reached that address each problem.
 - III. Statement of actions that will be taken by the program and/or client to accomplish the identified objectives.
 - IV. Target date(s) for accomplishment of actions and objectives.
- C. Provider shall develop the plan of care with participation from the client in accordance with the timeframes specified below:
 - I. For outpatient programs, the plan of care shall be developed within 30 calendar days from the date of the client's admission. The client's progress shall be reviewed and documented within 30 calendar days after signing the plan of care and not later than every thirty (30) calendar days thereafter.
 - II. For residential programs, the plan of care shall be developed within 10 calendar days from the date of the client's admission.
 - III. An LPHA, registered or certified counselor shall ensure and document, that together with the client, the plan of care is reviewed and updated, as necessary, when a change in problem identification or focus of treatment occurs, or no later than 90 calendar days after signing the plan of care and no later than every 90 calendar days thereafter, whichever comes first.
- D. Provider is not required to complete a plan of care for clients under this Agreement, except in the below circumstances:
 - I. Peer Support Services require a specific care plan based on an approved Plan of Care. The plan of care shall be documented within the progress notes in the client's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services.
 - II. Narcotic Treatment Programs (NTP) are required to create a plan of care for clients as per federal law. This requirement is not impacted by the documentation requirements in BHIN 22-019. NTPs shall continue to comply with federal and state regulations regarding plans of care and documentation requirements.

8. TELEHEALTH

- A. Provider may use telehealth, when it deems clinically appropriate, as a mode of delivering behavioral health services in accordance with all applicable County, state, and federal requirements, including those related to privacy/security, efficiency, and standards of care. Such services will conform to the definitions and meet the requirements included in the Medi-Cal Provider Manual: Telehealth, available in the DHCS Telehealth Resources page at: <https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx>.
- B. All telehealth equipment and service locations must ensure that client confidentiality is maintained.
- C. Licensed providers and staff may provide services via telephone and telehealth as long as the service is within their scope of practice.
- D. Medical records for clients served by Provider under this Agreement must include documentation of written or verbal consent for telehealth or telephone services if such services are provided by Provider. Such consent must be obtained at least once prior to initiating

applicable health care services and consent must include all elements as specified in BHIN 22-019.

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

9. DISCHARGE PLANNING

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

I. Written criteria for discharge defining:

- 1) Successful completion of program;
- 2) Administrative discharge;
- 3) Involuntary discharge;
- 4) Transfers and referrals.

II. A discharge summary that includes:

- 1) Reason for discharge, including whether the discharge was voluntary or involuntary and whether the client successfully completed the program;
- 2) Description of treatment episodes;
- 3) Description of recovery services completed;
- 4) Current alcohol and/or other drug usage;
- 5) Vocational and educational achievements;
- 6) Client's continuing recovery or discharge plan signed by an LPHA, or registered or certified counselor and client;
- 7) Transfers and referrals; and
- 8) Client's comments

ARTICLE 5. CHART AUDITING AND REASONS FOR RECOUPMENT

1. MAINTENANCE OF RECORDS

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

2. ACCESS TO RECORDS

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

3. FEDERAL, STATE AND COUNTY AUDITS

In accordance with 42 C.F.R. § 438.66 and as applicable with 42 C.F.R. §§ 438.604, 438.606, 438.608, 438.610, 438.230, 438.808, 438.900 et seq., County will conduct monitoring and

oversight activities to review the Provider's SUD programs and operations. The purpose of these oversight activities is to verify that medically necessary services are provided to clients, in compliance with the applicable state and federal laws and regulations, and/or the terms of the Agreement between Provider and County, and future BHINs which may spell out other specific requirements.

4. INTERNAL AUDITING, COMPLIANCE, AND MONITORING

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

- I. Upon notification of an exception or finding of non-compliance, the Provider shall submit evidence of Corrective Action within thirty (30) days, or as otherwise specified in the notice of required corrective action provided by the County. Continued non-compliance beyond due date for submission of Corrective Action may lead to termination of this Agreement in accordance with ARTICLE 2. General Provisions, 12. Default, Termination, and Cancellation.
- J. Failure by County to notify or require Corrective Action does not constitute acceptance of the practice of waiver of the County's right to enforce.
- K. Provider shall be held accountable for audit exceptions taken by DHCS against the Provider and its subcontractors for any failure to comply with these requirements:
 - I. Title 9, CCR, Division 4, Chapter 8, commencing with Section 13000, Certification of Alcohol and Other Drug Counselors
 - II. Title 42, CFR, Sections 8.1 through 8.6, Medication Assisted Treatment for Opioid Use Disorders
 - III. Title 21, CFR, Sections 1301.01 through 1301.93, Department of Justice, Controlled Substances
 - IV. State Administrative Manual (SAM), Chapter 7200 (General Outline of Procedures)
- L. Provider shall be familiar with the above laws, regulations, and guidelines and shall ensure that its subcontractors are also familiar with such requirements.

5. CONFIDENTIALITY IN AUDIT PROCESS

- A. Provider and County mutually agree to maintain the confidentiality of Provider's client records and information, in compliance with all applicable state and federal statutes and regulations, including but not limited to HIPAA, 42 CFR Part 2, and California Welfare and Institutions Code, § 5328, to the extent that these requirements are applicable. Provider shall inform all of its officers, employees and agents of the confidentiality provisions of all applicable statutes.
- B. Provider's fiscal records shall contain sufficient data to enable auditors to perform a complete audit and shall be maintained in conformance with standard procedures and accounting principles.
- C. Provider's records shall be maintained as required by the Director and DHCS on forms furnished by DHCS or the County. All statistical data or information requested by the Director shall be provided by the Provider in a complete and timely manner.

6. REASONS FOR RECOUPMENT

- A. County will conduct periodic audits of Provider files to ensure appropriate clinical documentation, high quality service provision and compliance with applicable federal, state and county regulations.
- B. Such audits may result in requirements for Provider to reimburse County for services previously paid in the following circumstances:
 - I. Identification of Fraud, Waste or Abuse as defined in federal regulation.
 - 1) Fraud and abuse are defined in Code of Federal Regulations, Title 42, § 455.2 and Welfare & Institutions Code, § 14107.11, subdivision (d).
 - 2) Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf.

7. COOPERATION WITH AUDITS

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

8. INDEMNITY

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

The insurance obligations of Provider are separate, independent obligations under the Agreement, and the provisions of this defense and indemnity are not intended to modify nor should they be construed as modifying or in any way limiting the insurance obligations set forth in the Agreement.

Nothing herein shall be construed to seek indemnity in excess of that permitted by Civil Code section 2782, et seq. In the event any portion of this Article is found invalid, the Parties agree that this Article shall survive and be interpreted consistent with the provisions of Civil Code section 2782, et seq.

ARTICLE 6. CLIENT PROTECTIONS

1. GRIEVANCES, APPEALS AND NOTICES OF ADVERSE BENEFIT DETERMINATION

- A. All grievances (as defined by 42 C.F.R. § 438.400) and complaints received by Provider must be immediately forwarded to the County's Quality Management Department or other designated persons via a secure method (e.g., encrypted email or by fax) to allow ample time for the Quality Management staff to acknowledge receipt of the grievance and complaints and issue appropriate responses.

- B. Provider shall not discourage the filing of grievances and clients do not need to use the term “grievance” for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance.
- C. Aligned with MHSUDS 18-010E and 42 C.F.R. § 438.404, the appropriate and delegated Notice of Adverse Benefit Determination (NOABD) must be issued by Providers within the specified timeframes using the template provided by the County.
- D. All NOABDs are issued by County. Providers are required to submit a completed Exhibit F, marked “Notice of Adverse Benefit Determination (NOABD) Form,” incorporated herein and made by reference a part hereof, securely to email: SUDSQualityAssurance@edcgov.us to notify County of need for NOABD.
- E. NOABDs must be issued to clients anytime Provider has made or intends to make an adverse benefit determination that includes the reduction, suspension, or termination of a previously authorized service and/or the failure to provide services in a timely manner. The notice must have a clear and concise explanation of the reason(s) for the decision as established by DHCS and the County. Provider must inform the County immediately after issuing a NOABD.
- F. Procedures and timeframes for responding to grievances, issuing, and responding to adverse benefit determinations, appeals, and state hearings must be followed as per 42 C.F.R., Part 438, Subpart F (42 C.F.R. §§ 438.400 – 438.424).
- G. Provider must provide clients with any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal such as auxiliary aids and interpreter services.
- H. Provider must maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures. The record must be accurately maintained in a manner accessible to the County and available upon request to DHCS.

2. ADVANCED DIRECTIVES

Provider must comply with all County policies and procedures regarding Advanced Directives in compliance with the requirements of 42 C.F.R. §§ 422.128.

3. TRANSITION OF CARE

- A. Provider shall follow County’s transition of care policy in accordance with applicable state and federal regulations, MHSUDS IN 18-051: SUDS Continuity of Care Policy, and any BHINs issued by DHCS for parity in SUD and mental health benefits subsequent to the effective date of this Agreement (42 C.F.R. § 438.62(b)(1)-(2).)

4. ADVERTISING REQUIREMENTS

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

- II. Include on its internet website a picture, description, staff information, or the location of an entity, along with false contact information that surreptitiously directs the reader to a business that does not have a contract with the entity.
- III. Include on its internet website false information or an electronic link that provides false information or surreptitiously directs the reader to another internet website.
- C. Provider shall comply with these requirements and any subsequent regulations around advertising requirements for SUD recovery or treatment facilities issued by DHCS.

ARTICLE 7. PROGRAM INTEGRITY

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

- A. In accordance with Health and Safety Code section 11834.015, DHCS has adopted the ASAM treatment criteria, or other equivalent evidenced based criteria as the minimum standard of care for Alcohol and Other Drug (AOD) facilities.
- B. For this Agreement and subsequent services, Provider shall adopt ASAM as the evidenced based practice standard for LOC.
- C. Provider shall ensure treatment staff of all SUD treatment programs receive adequate training in ASAM criteria prior to providing services that includes but is not limited to in person or e-training modules:
 - I. ASAM Module I- Multidimensional Assessment
 - II. ASAM Module II- From Assessment to Service Planning and Level of Care (LOC)
 - III. ASAM Module III-Introduction to the ASAM Criteria

2. CREDENTIALING AND RE-CREDENTIALING OF PROVIDERS

- A. Providers must follow the uniform process for credentialing and recredentialing of network providers established by County, including disciplinary actions such reducing, suspending, or terminating provider's privileges. Failure to comply with specified requirements can result in suspension or termination of a provider.
- B. Upon request, Provider must demonstrate to the County that each of its providers are qualified in accordance with current legal, professional, and technical standards, and that they are appropriately licensed, registered, waived, and/or certified.
- C. Provider must not employ or subcontract with providers debarred, suspended or otherwise excluded (individually, and collectively referred to as "Excluded") from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. § 438.610. See relevant section below regarding specific requirements for exclusion monitoring.
- D. Providers shall ensure that all of their network providers, delivering covered services, sign and date an attestation statement on a form provided by County, in which each provider attests to the following:
 - I. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
 - II. A history of loss of license or felony convictions;
 - III. A history of loss or limitation of privileges or disciplinary activity;
 - IV. A lack of present illegal drug use; and
 - V. The application's accuracy and completeness
- E. Provider must file and keep track of attestation statements for all of their providers and must make those available to the County upon request at any time.

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

3. SCREENING AND ENROLLMENT REQUIREMENTS

- A. Provider shall ensure that they and any subcontracted providers consent to a criminal background check, including fingerprinting to the extent required under state law and 42 C.F.R. § 455.434(a). Provider shall provide evidence of completed consents when requested by the County, DHCS or the US Department of Health & Human Services (US DHHS).

4. COMPLIANCE PROGRAM, INCLUDING FRAUD PREVENTION AND OVERPAYMENTS

- A. Provider shall have in place a compliance program designed to detect and prevent fraud, waste and abuse, as per 42 C.F.R. § 438.608 (a)(1), that must include:
 - I. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Agreement, and all applicable federal and state requirements.
 - II. A Compliance Office (CO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Agreement and who reports directly to the CEO and the Board of Directors.
 - III. A Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Agreement.
 - IV. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the Agreement.
 - V. Effective lines of communication between the Compliance Officer and the organization's employees.
 - VI. Enforcement of standards through well-publicized disciplinary guidelines.
 - VII. The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, corrections of such problems promptly and thoroughly to reduce the potential for recurrence, and ongoing compliance with the requirements under the Agreement.

5. INTEGRITY DISCLOSURES

- A. Provider shall provide information on ownership and controlling interests, disclosures related to business transactions, and disclosures related to persons convicted of crimes in the form

and manner requested by the County, by the Effective Date, each time the Agreement is renewed and within 35 days of any change in ownership or controlling interest of Provider. (42 C.F.R. §§ 455.104, 455.105, and 455.106)

- B. Upon the execution of this Agreement, Provider shall furnish County a Provider Disclosure Statement, which, upon receipt by County, shall be kept on file with County and may be disclosed to DHCS. If there are any changes to the information disclosed in the Provider Disclosure Statement, an updated statement should be completed and submitted to the County within 35 days of the change. (42 C.F.R. § 455.104).
- C. Provider must disclose the following information as requested in the Provider Disclosure Statement:
 - I. Disclosure of 5% or More Ownership Interest:
 - 1) In the case of corporate entities with an ownership or control interest in the disclosing entity, the primary business address as well as every business location and P.O. Box address must be disclosed. In the case of an individual, the date of birth and Social Security Number must be disclosed.
 - 2) In the case of a corporation with ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five percent (5%) or more interest, the corporation tax identification number must be disclosed.
 - 3) For individuals or corporations with ownership or control interest in any subcontractor in which the disclosing entity has a five percent (5%) or more interest, the disclosure of familial relationship is required.
 - 4) For individuals with five percent (5%) or more direct or indirect ownership interest of a disclosing entity, the individual shall provide evidence of completion of a criminal background check, including fingerprinting, if required by law, prior to execution of Agreement. (42 C.F.R. § 455.434)
 - II. Disclosures Related to Business Transactions:
 - 1) The ownership of any subcontractor with whom Provider has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request.
 - 2) Any significant business transactions between Provider and any wholly owned supplier, or between Provider and any subcontractor, during the 5-year period ending on the date of the request. (42 C.F.R. § 455.105(b).)
 - III. Disclosures Related to Persons Convicted of Crimes:
 - 1) The identity of any person who has an ownership or control interest in the Provider or is an agent or managing employee of the Provider who has been convicted of a criminal offense related to that person's involvement in any program under the Medicare, Medicaid, or the Title XXI services program since the inception of those programs. (42 C.F.R. § 455.106.)
 - 2) County shall terminate the enrollment of Provider if any person with five percent (5%) or greater direct or indirect ownership interest in the disclosing entity has been convicted of a criminal offense related to the person's involvement with Medicare, Medicaid, or Title XXI program in the last 10 years.
- D. Provider must provide disclosure upon execution of Contract, extension for renewal, and within 35 days after any change in Provider ownership or upon request of County. County may refuse to enter into an Agreement or terminate an existing Agreement with a Provider if the Provider fails to disclose ownership and control interest information, information

related to business transactions and information on persons convicted of crimes, or if the Provider did not fully and accurately make the disclosure as required.

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

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

- A. Prior to the effective date of the Agreement, the Provider shall complete and sign the attached Exhibit G, marked “Certification of Non-Exclusion or Suspension from Participation in a Federal Health Care Program,” incorporated herein and made by reference a part hereof. Prior to the effective date of this Agreement, the Provider must certify that it is not excluded from participation in Federal Health Care Programs under either section 1128 or 1128A of the Social Security Act. Failure to certify will render all provisions of this Agreement null and void and may result in the immediate termination of the Agreement.
- B. Provider shall certify, prior to the execution of the Contract, that the Provider does not employ or subcontract with providers or have other relationships with providers Excluded from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. § 438.610. Provider shall conduct initial and monthly Exclusion & Suspension searches of the following databases and provide evidence of these completed searches when requested by County, DHCS or the US DHHS:
 - I. www.oig.hhs.gov/exclusions - LEIE Federal Exclusions
 - II. www.sam.gov/portal/SAM - GSA Exclusions Extract
 - III. www.Medi-Cal.ca.gov - Suspended & Ineligible Provider List
 - IV. <https://nppes.cms.hhs.gov/#/> - National Plan and Provider Enumeration System (NPPES)
 - V. Any other database required by DHCS or DHHS.
- C. Provider shall certify, prior to the execution of the Agreement, that Provider does not employ staff or individual Providers/vendors that are on the Social Security Administration’s Death Master File. Provider shall check the following database prior to employing staff or individual Providers/vendors and provide evidence of these completed searches when requested by the County, DHCS or the US DHHS.
 - I. <https://www.ssdmf.com/> - Social Security Death Master File
- D. Provider is required to notify County immediately if Provider becomes aware of any information that may indicate their (including employees/staff and individual Providers/vendors) potential placement on an exclusions list.
- E. Provider shall screen and periodically revalidate all network providers in accordance with the requirements of 42 C.F.R., Part 455, Subparts B and E.
- F. Provider must confirm the identity and determine the exclusion status of all its providers, as well as any person with an ownership or control interest, or who is an agent or managing employee of the contracted agency through routine checks of federal and state databases. This includes the Social Security Administration’s Death Master File, NPPES, the Office of Inspector General’s List of Excluded Individuals/Entities (LEIE), the Medi-Cal Suspended and Ineligible Provider List (S&I List) as consistent with the requirements of 42 C.F.R. § 455.436.
- G. If a Provider finds a provider that is Excluded, it must promptly notify the County as per 42 C.F.R. § 438.608(a)(2), (4). Provider shall not certify or pay any Excluded provider with

Medi-Cal funds, must treat any payments made to an Excluded provider as an overpayment, and any such inappropriate payments may be subject to recovery.

ARTICLE 8. QUALITY IMPROVEMENT PROGRAM

1. QUALITY IMPROVEMENT ACTIVITIES AND PARTICIPATION

- A. Provider shall comply with the County's ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program (42 C.F.R. § 438.330(a)) and work with the County to improve established outcomes by following structural and operational processes and activities that are consistent with current practice standards.
- B. Provider shall participate in quality improvement (QI) activities, including clinical and non-clinical performance improvement projects (PIPs), as requested by the County in relation to state and federal requirements and responsibilities, to improve health outcomes and clients' satisfaction over time. Other QI activities include quality assurance, collection and submission of performance measures specified by the County, mechanisms to detect both underutilization and overutilization of services, client and system outcomes, utilization management, utilization review, provider appeals, provider credentialing and re-credentialing, and client grievances. Provider shall measure, monitor, and annually report to the County its performance.
- C. Provider shall implement mechanisms to assess client/family satisfaction based on County's guidance. The Provider shall assess client/family satisfaction by:
 - I. Surveying client/family satisfaction with the Provider's services at least annually.
 - II. Evaluating client grievances, appeals and State Hearings at least annually.
 - III. Evaluating requests to change persons providing services at least annually.
 - IV. Informing the County and clients of the results of client/family satisfaction activities.
- D. Provider, if applicable, shall implement mechanisms to monitor the safety and effectiveness of medication practices. This mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs, at least annually.
- E. Provider shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The Provider shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the Provider at least annually and shared with the County.
- F. Provider shall collaborate with County to create a QI Work Plan with documented annual evaluations and documented revisions as needed. The QI Work Plan shall evaluate the impact and effectiveness of its quality assessment and performance improvement program.
- G. Provider shall attend and participate in the County's Quality Improvement Committee (QIC) to recommend policy decisions, review and evaluate results of QI activities, including PIPs, institute needed QI actions, and ensure follow-up of QI processes. Provider shall ensure that there is active participation by the Provider's practitioners and providers in the QIC.
- H. Provider shall assist County, as needed, with the development and implementation of Corrective Action Plans.
- I. Provider shall participate, as required, in annual, independent external quality reviews (EQR) of the quality, timeliness, and access to the services covered under this Contract, which are conducted pursuant to Subpart E of Part 438 of the Code of Federal Regulations. (42 C.F.R. §§ 438.350(a) and 438.320)

2. NETWORK ADEQUACY

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

3. DATA REPORTING REQUIREMENTS

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

4. PRACTICE GUIDELINES

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

5. EVIDENCE-BASED PRACTICES (EBPs)

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

6. REPORTING UNUSUAL OCCURRENCES

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

ARTICLE 9. FINANCIAL TERMS

1. FINANCIAL REQUIREMENTS

- A. County has the right to monitor the performance of this Agreement to ensure the accuracy of claims for reimbursement and compliance with all applicable laws and regulations.
- B. Provider must comply with the False Claims Act employee training and policy requirements set forth in 42 U.S.C. 1396a(a)(68) and as the Secretary of the US DHHS may specify.
- C. Provider agrees that no part of any federal funds provided under this Agreement shall be used to pay the salary of an individual per fiscal year at a rate in excess of Level 1 of the Executive Schedule at <https://www.opm.gov/> (U.S. Office of Personnel Management), as from time to time amended.
- D. Federal Financial Participation is not available for any amount furnished to an Excluded individual or entity, or at the direction of a physician during the period of exclusion when the person providing the service knew or had reason to know of the exclusion, or to an individual or entity when the County failed to suspend payments during an investigation of a credible allegation of fraud (42 U.S.C. §1396b(i)(2)).

2. FISCAL CONSIDERATIONS

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

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

In addition to the above, should the County's Board of Supervisors during the course of a given year for financial reasons reduce or order a reduction in the budget for any County department for

which services were contracted to be performed, pursuant to this paragraph in the sole discretion of County, this Agreement may be deemed to be canceled in its entirety subject to payment for services performed prior to cancellation.

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

- A. Provider may not redirect or transfer funds from one funded program to another funded program under which Provider provides services pursuant to this Agreement except through a duly executed amendment to this Agreement.
- B. Provider may not charge services delivered to an eligible client under one funded program to another funded program unless the client is also eligible for services under the second funded program.

ARTICLE 10. ADDITIONAL FINAL RULE PROVISIONS

1. NON-DISCRIMINATION

- A. Provider shall not discriminate against individuals seeking the provision of SUD services because of race, color, religion, ancestry, marital status, national origin, ethnic group identification, sex, sexual orientation, gender, gender identity, age, medical condition, genetic information, health status or need for health care services, or mental or physical disability as consistent with the requirements of applicable federal law, such as 42 C.F.R. § 438.3(d)(3) and (4), BHIN 22-060 Enclosure 4 and state law.
- B. Provider shall take affirmative action to ensure that services to intended Medi-Cal clients are provided without use of any policy or practice that has the effect of discriminating on the basis of race, color, religion, ancestry, marital status, national origin, ethnic group identification, sex, sexual orientation, gender, gender identity, age, medical condition, genetic information, health status or need for health care services, or mental or physical disability.
- C. By signing this Agreement, Provider certifies that under the laws of the United States and the State of California, incorporated into this Agreement by reference and made a part hereof as if set forth in full, Provider shall not unlawfully discriminate against any person.
- D. County may require Provider's services on projects involving funding from various state and/or federal agencies, and as a consequence, Provider shall comply with all applicable nondiscrimination statutes and regulations during the performance of this Agreement including but not limited to the following: Provider and its employees and representatives shall not unlawfully discriminate against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical handicap, medical condition, marital status, age, or sex; Provider shall, unless exempt, comply with the applicable provisions of the Fair Employment and Housing Act (Government Code, Sections 12900 et seq.) and applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Sections 11000 et seq.); the applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Subchapter 5 of Chapter 5 of Division 4.1 of Title 2 of the California Code of Regulations incorporated into this Agreement by reference and made a part hereof as if set forth in full; and Title VI of the Civil Rights Act of 1964, as amended, the California Family Rights Act (Government Code Section 12945.2), the Unruh Civil Rights Act (California Civil Code, Division I, Part 2, Section 51, et seq), the Ralph Civil Rights Act (California Civil Code, Division I, Part 2, Section 51.7), the California Trafficking Victims Protection Act (California Civil Code, Division I, Part 2, Section 52.5), the Disabled Persons Act (California Civil Code, Division I,

Part 2.5), and as applicable, Section 11135 et. seq., of the California Government Code, prohibiting discrimination in all state-funded programs. Provider and its employees and representatives shall give written notice of their obligations under this clause as required by law.

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

2. PHYSICAL ACCESSIBILITY

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

3. APPLICABLE FEES

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

4. CULTURAL COMPETENCE

All services, policies and procedures must be culturally and linguistically appropriate. Provider must participate in the implementation of the most recent Cultural Competency Plan for the County and shall adhere to all cultural competency standards and requirements. Provider shall participate in the County's efforts to promote the delivery of services in a culturally competent and equitable manner to all clients, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

5. CLIENT INFORMING MATERIALS

A. Basic Information Requirements

- I. Provider shall provide information in a manner and format that is easily understood and readily accessible to clients. (42 C.F.R. § 438.10(c)(1)). Provider shall provide all written materials for clients in easily understood language, format, and alternative formats that take into consideration the special needs of clients in compliance with 42 C.F.R. § 438.10(d)(6). Provider shall inform clients that information is available in alternate formats and how to access those formats in compliance with 42 C.F.R. § 438.10.
- II. Provider shall provide the required information in this section to each client receiving SUD services under this Agreement and upon request.
- III. Provider shall utilize the County's website that provides the content required in this section and 42 C.F.R. § 438.10 and complies with all the requirements regarding the same set forth in 42 C.F.R. § 438.10.
- IV. Provider shall use DHCS/County developed model beneficiary handbook and client notices. (42 C.F.R. §§ 438.10(c)(4)(ii), 438.62(b)(3)).
- V. Client information required in this section may only be provided electronically by the Provider if all of the following conditions are met:
 - 1) The format is readily accessible;
 - 2) The information is placed in a location on the Provider's website that is prominent and readily accessible;
 - 3) The information is provided in an electronic form which can be electronically retained and printed;
 - 4) The information is consistent with the content and language requirements of this Agreement; and
 - 5) The client is informed that the information is available in paper form without charge upon request and the Provider provides it upon request within five business days. (42 C.F.R. § 438.10(c)(6)).

B. Language and Format

- I. Provider shall provide all written materials for potential clients and clients in a font size no smaller than 12-point font. (42 C.F.R. § 438.10(d)(6)(ii).)
- II. Provider shall ensure its written materials that are critical to obtaining services are available in alternative formats, upon request of the client or potential client at no cost.
- III. Provider shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, beneficiary handbook, appeal and grievance notices, denial and termination notices, and the Provider's SUD health education materials, available in the prevalent non-English languages in the County. (42 C.F.R. § 438.10(d)(3).)
- IV. Provider shall notify clients, prospective clients, and members of the public that written translation is available in prevalent languages free of cost and how to access those materials. (42 C.F.R. § 438.10(d)(5)(i), (iii); Welfare & Institutions Code § 14727(a)(1); California Code of Regulations, tit. 9 § 1810.410, subd. (e), para. (4))
- V. Provider shall make auxiliary aids and services available upon request and free of charge to each client. (42 C.F.R. § 438.10(d)(3)-(4).)
- VI. Provider shall make oral interpretation and auxiliary aids, such as Teletypewriter Telephone/Text Telephone (TTY/TDY) and American Sign Language (ASL),

available and free of charge for any language in compliance with 42 C.F.R. § 438.10(d)(2), (4)-(5).

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

C. Beneficiary Informing Materials

- I. Each client entering services is guaranteed access to informing materials upon request when first receiving SUD services. Beneficiary informing materials include:
 - 1) Beneficiary Handbook (BHIN 22-060)
 - 2) Provider Directory
 - 3) Advance Health Care Directive Form (required for adult clients only)
 - 4) Notice of Language Assistance Services available upon request at no cost to the client
 - 5) Language Taglines
 - 6) Grievance/Appeal Process and Form
 - 7) Notice of Privacy Practices
 - 8) EPSDT poster (if serving clients under the age of 21)
- II. Informing materials must be made available upon request, at no cost, in alternate formats (i.e., Braille or Audio) and Auxiliary Aids (i.e., California Relay Service (CRS) 711 and American Sign Language) and must be provided to clients within five business days. Large print materials shall be in a minimum 18-point font size.
- III. Informing materials will be considered provided to the client if Provider does one or more of the following:
 - 1) Mails a printed copy of the information to the client's mailing address before the client first receives a SUD service;
 - 2) Mails a printed copy of the information upon the client's request to the client's mailing address;
 - 3) Provides the information by email after obtaining the client's agreement to receive the information by email;
 - 4) Posts the information on the Provider's website and advises the client in paper or electronic form that the information is available on the internet and includes applicable internet addresses, provided that clients with disabilities who cannot access this information online are provided auxiliary aids and services upon request and at no cost; or,
 - 5) Provides the information by any other method that can reasonably be expected to result in the client receiving that information. If the Provider provides informing materials in person, when the client first receives SUD services, the date and method of delivery shall be documented in the client's file.
 - 6) Facilitates receipt of informing materials by contacting SUDS quality assurance at sudsqualityassurance@edcgov.us requesting materials for client

D. Provider Directory

- I. Provider must follow the County's provider directory policy, in compliance with MHSUDS IN 18-020.
- II. Provider must make available to clients, in paper form upon request and electronic form, specified information about its provider network as per 42 C.F.R. § 438.10(h). The most current provider directory is electronically available on the County website and is updated by the County no later than 30 calendar days after information is

received to update provider information. A paper provider directory must be updated as set forth in 42 C.F.R. § 438.10(h)(3)(i).

- III. Any changes to information published in the provider directory must be reported to the County within two weeks of the change.
- IV. Provider will only need to report changes/updates to the provider directory for each licensed SUD service provider.

ARTICLE 11. DATA, PRIVACY AND SECURITY REQUIREMENTS

1. CONFIDENTIALITY AND SECURE COMMUNICATIONS

- A. Provider shall comply with all applicable federal and state laws and regulations pertaining to the confidentiality of individually identifiable protected health information (PHI) or personally identifiable information (PII), as defined in the Information Practices Act (IPA) at California Civil Code section 1798.3(a), including, but not limited to, requirements of the Health Insurance Portability and Accountability Act (HIPAA), the Health Information Technology for Economic and Clinical Health (HITECH) Act, the California Welfare and Institutions Code regarding confidentiality of client information and records, the IPA, and all relevant County policies and procedures.
- B. Provider will comply with all County policies and procedures related to confidentiality, privacy, and secure communications.
- C. Provider shall have all employees acknowledge an Oath of Confidentiality mirroring that of County, including confidentiality and disclosure requirements, as well as sanctions related to non-compliance.
- D. Provider shall not use or disclose PHI or PII other than as permitted or required by law.

2. ELECTRONIC PRIVACY AND SECURITY

- A. Provider shall have a secure email system and send any email containing PII or PHI in a secure and encrypted manner. Provider's email transmissions shall display a warning banner stating that data is confidential, systems activities are monitored and logged for administrative and security purposes, systems use is for authorized users only, and that users are directed to log off the system if they do not agree with these requirements.
- B. Provider shall institute compliant password management policies and procedures, which shall include but are not limited to procedures for creating, changing, and safeguarding passwords. Provider shall establish guidelines for creating passwords and ensuring that passwords expire and are changed at least once every 90 days.
- C. Any Electronic Health Records (EHRs) maintained by Provider that contain any PHI or PII for clients served through this Agreement shall contain a warning banner regarding the PHI or PII contained within the EHR. Provider that utilizes an EHR shall maintain all parts of the clinical record that are not stored in the EHR, including but not limited to the following examples of client signed documents: discharge plans, informing materials, and health questionnaire.
- D. Provider entering data into any County electronic systems shall ensure that staff are trained to enter and maintain data within this system.

3. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE

As a condition of Provider performing services for County, Provider shall execute Exhibit I, marked "HIPAA Business Associate Agreement," incorporated herein and made by reference a part hereof.

ARTICLE 12. CLIENT RIGHTS

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

ARTICLE 13. RIGHT TO MONITOR

1. County or any subdivision or appointee thereof, and the State of California or any subdivision or appointee thereof, including the Auditor General, shall have absolute right to review and audit all records, books, papers, documents, corporate minutes, financial records, staff information, client records, other pertinent items as requested, and shall have absolute right to monitor the performance of Provider in the delivery of services provided under this Agreement. Full cooperation shall be given by the Provider in any auditing or monitoring conducted, according to this Agreement.
2. Provider shall make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to Medi-Cal enrollees, Medi-Cal-related activities, services, and activities furnished under the terms of this Agreement, or determinations of amounts payable available at any time for inspection, examination, or copying by County, the State of California or any subdivision or appointee thereof, CMS, HHS Office of Inspector General, the United States Comptroller General or their designees, and other authorized federal and state agencies. This audit right will exist for at least 10 years from the final date of the Agreement period or in the event the Provider has been notified that an audit or investigation of this Agreement has commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later (42 CFR § 438.230(c)(3)(i)-(iii)).
3. County, DHCS, CMS, or the HHS Office of Inspector General may inspect, evaluate, and audit the Provider at any time if there is a reasonable possibility of fraud or similar risk. The Department's inspection shall occur at the Provider's place of business, premises or physical facilities (42 CFR § 438.230(c)(3)(iv)).
4. Provider shall cooperate with the County in the implementation, monitoring and evaluation of this Agreement and comply with any and all reporting requirements established by the County. Should the County identify an issue or receive notification of a complaint or potential/actual/suspected violation of requirements, the County may audit, monitor, and/or request information from the Provider to ensure compliance with laws, regulations, and requirements, as applicable.
5. County reserves the right to place Provider on probationary status, should Provider fail to meet performance requirements; including, but not limited to violations such as high disallowance rates, failure to report incidents and changes as contractually required, failure to correct issues, inappropriate invoicing, untimely and inaccurate data entry, not meeting performance outcomes expectations, and violations issued directly from the State. Additionally, Provider may be subject to Probationary Status or termination if contract monitoring and auditing corrective actions are not resolved within specified timeframes.

6. Provider shall retain all records and documents originated or prepared pursuant to Provider's performance under this Agreement, including client grievance and appeal records, and the data, information and documentation specified in 42 C.F.R. parts §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years from the term end date of this Agreement or until such time as the matter under audit or investigation has been resolved. Records and documents include but are not limited to all physical and electronic records and documents originated or prepared pursuant to Provider's or subcontractor's performance under this Agreement including working papers, reports, financial records and documents of account, client records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for clients.
7. Provider shall maintain all records and management books pertaining to service delivery and demonstrate accountability for contract performance and maintain all fiscal, statistical, and management books and records pertaining to the program. Records should include, but are not limited to, monthly summary sheets, sign-in sheets, and other primary source documents. Fiscal records shall be kept in accordance with Generally Accepted Accounting Principles and must account for all funds, tangible assets, revenue and expenditures. Fiscal records must also comply with the Code of Federal Regulations (CFR), Title II, Subtitle A, Chapter 11, Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.
8. All records shall be complete and current and comply with all Agreement requirements. Failure to maintain acceptable records per the preceding requirements shall be considered grounds for withholding of payments for billings submitted and for termination of Agreement.
9. Provider shall maintain client and community service records in compliance with all regulations set forth by local, state, and federal requirements, laws and regulations, and provide access to clinical records by County staff.
10. Provider shall comply with ARTICLE 11. Data, Privacy and Security Requirements, 1. Confidentiality and Secure Communications regarding relinquishing or maintaining medical records.
11. Provider shall agree to maintain and retain all appropriate service and financial records for a period of at least 10 years from the date of final payment, the final date of the contract period, final settlement, or until audit findings are resolved, whichever is later.
12. Provider shall submit audited financial reports on an annual basis to the County. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.
13. In the event the Agreement is terminated, ends its designated term or Provider ceases operation of its business, Provider shall deliver or make available to County all financial records that may have been accumulated by Provider or subcontractor under this Agreement, whether completed, partially completed or in progress within seven calendar days of said termination/end date.
14. Provider shall provide all reasonable facilities and assistance for the safety and convenience of the County's representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner that will not unduly delay the work of Provider.
15. County has the discretion to revoke full or partial provisions of the Agreement, delegated activities or obligations, or application of other remedies permitted by state or federal law when the County or DHCS determines Provider has not performed satisfactorily.

ARTICLE 14. SITE INSPECTION

Without limiting any other provision related to inspections or audits otherwise set forth in this Agreement, Provider shall permit authorized County, state, and/or federal agency(ies), through any

authorized representative, the right to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract support activities and the premises which it is being performed. Provider shall provide all reasonable assistance for the safety and convenience of the authorized representative in the performance of their duties. All inspections and evaluations shall be made in a manner that will not unduly delay the work.

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

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

ARTICLE 16. CONTRACT ADMINISTRATOR

The County Officer or employee with responsibility for administering this Agreement is Shaun O’Malley, Alcohol and Drug Program Manager, SUD Services, HHSA, or successor. In the instance where the named Contract Administrator no longer holds this title with County and a successor is pending, or HHSA has to temporarily delegate this authority, County Contract Administrator’s Supervisor shall designate a representative to temporarily act as the primary Contract Administrator of this Agreement and HHSA Administration shall provide the Provider with the name, title and email for this designee via notification in accordance with the ARTICLE 2, General Provisions, 7. Notice to Parties.

ARTICLE 17. ELECTRONIC SIGNATURES

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

ARTICLE 18. COUNTERPARTS

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

ARTICLE 19. ENTIRE AGREEMENT

This document and the documents referred to herein or exhibits hereto are the entire Agreement between the parties and they incorporate or supersede all prior written or oral Agreements or understandings.

Requesting Contract Administrator Concurrence:

By: 
[Shaun O'Malley \(Sep 18, 2025 13:45:33 PDT\)](#)
Shaun O'Malley
Alcohol and Drug Program Division Manager
Health and Human Services Agency

Dated: 09/18/2025

Requesting Department Head Concurrence:

By: 
[Olivia Byron-Cooper \(Sep 18, 2025 15:29:53 PDT\)](#)
Olivia Byron-Cooper, MPH
Director
Health and Human Services Agency

Dated: 09/18/2025

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

-- COUNTY OF EL DORADO --

Dated: _____

By: _____
Chair
Board of Supervisors
"County"

ATTEST:
Kim Dawson
Clerk of the Board of Supervisors

By: _____
Deputy Clerk

Dated: _____

-- MUIR WOOD, LLC --

By:  _____
[Daniel Pencak \(Sep 22, 2025 07:34:22 PDT\)](#)
Daniel Pencak
Chief Financial Officer
"Provider"

Dated: 09/22/2025

Muir Wood, LLC
Exhibit A
Scope of Work

1. INTRODUCTION

- A. As an organizational provider agency, Provider shall provide administrative and direct program services to County's clients between the ages of 12-17 years old. Provider shall provide all medically necessary Substance Use Disorder (SUD) services required pursuant to Section 1396d(r) of Title 42 of the United States Code (California Welfare and Institutions Code (WIC) 14184.402 (e)).
- B. Provider shall deliver services using evidence-based practice models. Provider shall provide said services in Provider's program(s) as described herein; and utilizing locations as described herein.

2. TARGET POPULATION

- A. Provider shall provide services to the following populations:
 - I. The target population for SUD services includes clients who are enrolled in Medi-Cal, reside in the County, and meet the DMC-ODS criteria for youth residential services as per established requirements above.
 - II. Clients referred by, and who have written to include electronic communication prior authorization from the County of El Dorado, SUD Division

3. SERVICES TO BE PROVIDED

All services provided pursuant to this Agreement shall be performed in accordance with the following requirements, or as may be amended, all of which constitute part of this Agreement, with items listed below (A-E) available online at: <https://www.eldoradocounty.ca.gov/Health-Well-Being/Health-and-Human-Services/HHSA-Contractor-Resources> (with alternate links listed below) or subsequent updates made thereof, to clients who meet access criteria for receiving SUD services:

- A. County of El Dorado SUD Best Practice Guidelines <https://www.eldoradocounty.ca.gov/files/assets/county/v/1/documents/health-amp-wellbeing/mental-health/sud/el-dorado-edcsuds-practice-guidelines-update-november-2024.pdf>
- B. Department of Health Care Services (DHCS) Licensing and Certification for Alcohol and Other Drug (AOD) Programs Guidelines – linked at: <https://www.dhcs.ca.gov/provgovpart/Documents/Certification-for-Alcohol-and-Other-Drug-Program.pdf>
- C. DHCS Adolescent SUD Best Practices Guidelines – linked at: https://www.dhcs.ca.gov/Documents/CSD_CMHCS/Adol%20Best%20Practices%20Guide/AdolBestPracGuideOCTOBER2020.pdf
- D. El Dorado County DMC-ODS Training Plan – linked at: <https://www.eldoradocounty.ca.gov/files/assets/county/v/1/documents/health-amp-wellbeing/mental-health/sud/edc-dmc-ods-training-plan-fiscal-year-2024-2025.pdf>

4. ALLOWABLE SERVICES UNDER CONTRACT

Provider shall perform services as follows:

- A. All licensed youth AOD recovery or treatment facilities must obtain a designation based on the American Society of Addiction Medicine (ASAM) treatment criteria, or an equivalent evidence-based standard, as a minimum standard of care in adherence with DHCS BHIN 24-001.
- B. ASAM Level 3.2 and 3.5 - Residential Treatment:
 - I. Residential Treatment Services are provided in a short-term residential program through one of the following level:
 - 1) Level 3.2 – Withdrawal Management Residential
 - 2) Level 3.5 - Clinically Managed High Intensity Residential Services
 - II. Service components:
 - 1) Assessment
 - 2) Care Coordination
 - 3) Counseling (individual and group)
 - 4) Family Therapy
 - 5) Medication Services
 - 6) Medication Assisted Treatment (MAT) for Opioid Use Disorder (OUD)
 - 7) MAT for Alcohol Use Disorder (AUD) and other non-opioid SUD services
 - 8) Patient Education
 - 9) Recovery Services
 - 10) SUD Crisis Intervention Services
 - III. Services shall address functional deficits documented in the ASAM Criteria©
 - 1) Services aimed to restore, maintain, and apply interpersonal and independent living skills and access community support systems.
 - IV. A beneficiary shall live on the premises and be considered a “short-term resident” of the residential facility where the beneficiary receives services under this level of care (LOC).
 - V. Services may be provided in facilities of any size.
 - VI. Services are driven by the beneficiary’s care needs and shall be transitioned to other levels of care when clinically appropriate and served in the least restrictive setting.
 - VII. Residential treatment services for youth under these levels are provided by providers who must be licensed and enrolled in accordance with all applicable state and federal laws and regulations. This includes residential facilities licensed by DHCS, residential facilities licensed by the Department of Social Services, Chemical Dependency Recovery Hospitals (CDRHs) licensed by the Department of Public Health or Freestanding Acute Psychiatric Hospitals (FAPHs) licensed by Department of Public Health (DPH).
 - VIII. DHCS LOC Designation and/or ASAM LOC Certification:
 - 1) All facilities delivering Residential Treatment services must also be designated as capable of delivering care consistent with the ASAM Criteria.
 - 2) Designation is required for facilities offering ASAM levels 3.2 and/or 3.5.
 - 3) All counties with residential facilities offering levels 3.2 and/or 3.5, licensed by a state agency other than DHCS, shall have an ASAM LOC Certification for each of the levels of care provided at the facility.
 - IX. Services may be provided in person, by telehealth, or by telephone.
 - 1) Most services shall be in person.

- 2) Telehealth and telephone services shall be used to supplement, not replace, the in-person services and in-person treatment milieu.
- X. Medication Assisted Treatment (MAT)
 - 1) Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving partial hospitalization services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient).
- XI. County shall monitor the referral process or provision of MAT services.
- XII. Length of Stay: The average statewide length of stay goal is 30 days; however, this is not a quantitative treatment limitation and there is no hard “cap” on individual length of stays. Lengths of stay shall be determined by individualized clinical need. Beneficiaries shall be transitioned to appropriate levels of care as medically necessary.
- C. Withdrawal Management (WM) Services – Level 3.2 WM
 - I. WM services are provided as a part of a continuum of care to beneficiaries experiencing withdrawal in the following outpatient, residential, and inpatient settings. Beneficiary shall be monitored during the detoxification process. Services are urgent and provided on a short-term basis.
 - II. A full ASAM Criteria© assessment shall not be required as a condition of admission to a facility providing WM. Service activities focus on the stabilization and management of psychological and physiological symptoms associated with withdrawal, engagement in care and effective transitions to a LOC where beneficiary can receive comprehensive treatment services.
 - 1) Level 3.2 WM: Clinically managed residential withdrawal management (24-hour support for moderate withdrawal symptoms that are not manageable in outpatient setting).
 - i. This is considered a residential LOC and therefore requires the facility to be designated as capable of delivering care consistent with ASAM Criteria©.
 - ii. A DHCS LOC designation and/or an ASAM LOC Certification is required.
 - III. Service components for residential, settings:
 - 1) Assessment
 - 2) Individual Sessions
 - 3) Group Sessions
 - 4) Care Coordination
 - 5) Medication Services
 - 6) MAT for OUD
 - 7) MAT for AUD and other non-opioid SUDS
 - 8) Observation
 - 9) Recovery Services
 - IV. Care transitions to facilitate additional services or transition to a comprehensive treatment program.
 - 1) WM services are urgent and provided on a short-term basis.
 - 2) Practitioner shall conduct a full ASAM Criteria© assessment, brief screening, or other tools to support referral to additional services as appropriate.

- 3) If a full ASAM Criteria© assessment was not completed as part of the withdrawal management service episode.
 - i. Receiving program shall adhere to initial assessment timeliness requirements.
- V. Level 3.2 WM services may be provided in a residential setting:
 - 1) For residential settings, each beneficiary shall reside at the facility.
 - 2) MAT providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (Defined as facilitating access to MAT off-site for beneficiaries while they are receiving partial hospitalization services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient.)

5. PROVISION OF SERVICES

- A. The following Provider specification requirements shall apply to the Provider, and the provider staff:
 - I. Professional staff shall:
 - 1) Be licensed, registered, certified, enrolled, and/or approved in accordance with all applicable state and federal laws and regulations.
 - 2) Abide by the definitions, rules, and requirements for stabilization and rehabilitation services established by the Department of Health Care Services.
 - 3) Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws.
 - II. Professional staff means any of the following:
 - 1) Licensed Practitioners of the Healing Arts (LPHA) include:
 - 2) Physician
 - 3) Nurse Practitioners
 - 4) Physician Assistants
 - 5) Registered Nurses
 - 6) Registered Pharmacists
 - 7) Licensed Clinical Psychologists
 - 8) Licensed Clinical Social Worker
 - 9) Licensed Professional Clinical Counselor
 - 10) Licensed Marriage and Family Therapists
 - 11) Licensed Eligible Practitioners registered with the Board of Psychology or Behavioral Science Board working under the supervision of a licensed clinician
 - 12) An AOD counselor that is 1) either certified or registered by an organization that is recognized by the Department of Health Care Services and accredited with the National Commission for Certifying Agencies (NCCA), and 2) meets all state of California education, training, and work experience requirements set forth in the Counselor Certification Regulations, Title 9, Division 4, Chapter 8.
 - 13) Medical Director of a Narcotic Treatment Program who is a licensed physician in the state of California.
 - III. Non-professional staff shall receive appropriate onsite orientation and training prior to performing assigned duties. A professional and/or administrative staff shall supervise non-professional staff.

- IV. Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring. Documentation of trainings, certifications, and licensure shall be contained in personnel files.
- V. Physicians shall receive a minimum of five hours of continuing medical education related to addiction medicine each calendar year.
- VI. Professional LPHA staff shall receive a minimum of five hours of continuing education related to addiction medicine calendar each year.
- VII. Registered and certified SUD counselors shall adhere to all requirements in California CCR, Title 9, Chapter 8, Certification of AOD Counselors.
- B. Confidentiality: All SUD treatment services shall be provided in a confidential setting in compliance with 42 Code of Federal Regulations (CFR), Part 2 requirements.
- C. SUD Medical Director:
 - I. The SUD Medical Director's responsibilities shall, at a minimum, include all the following:
 - 1) Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
 - 2) Ensure that physicians do not delegate their duties to non-physician personnel.
 - 3) Develop and implement written medical policies and standards for the Provider.
 - 4) Ensure that physicians, registered nurse practitioners, and physician assistants follow the Provider's medical policies and standards.
 - 5) Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
 - II. Ensure that Provider's physicians and LPHAs are adequately trained to perform diagnosis of SUD for beneficiaries and determine the medical necessity of treatment for beneficiaries.
 - III. Ensure that Provider's physicians are adequately trained to perform other physician duties, as outlined in this section.
 - IV. The SUD Medical Director may delegate his/her responsibilities to a physician consistent with the Provider's medical policies and standards; however, the SUD Medical Director shall remain responsible for ensuring all delegated duties are properly performed.

6. PROVIDER PERSONNEL

- A. Provider personnel files shall be maintained on all employees and volunteers/interns and shall contain the following:
 - I. Application for employment and/or resume
 - II. Signed employment confirmation statement/duty statement
 - III. Job description
 - IV. Performance evaluations
 - V. Health records/status as required by the Provider, AOD Certification or Title 9
 - VI. Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries)
 - VII. Training documentation relative to SUD and treatment
 - VIII. Current registration, certification, intern status, or licensure
 - IX. Proof of continuing education required by licensing or certifying agency and program

- X. Provider's Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying/licensing body's code of conduct as well
- B. Job descriptions shall be developed, revised as needed, and approved by the provider's governing body. The job descriptions shall include:
 - I. Position title and classification
 - II. Duties and responsibilities
 - III. Lines of supervision
 - IV. Education, training, work experience, and other qualifications for the position
- C. Written Provider code of conduct for employees and volunteers/interns shall be established which addresses at least the following:
 - I. Use of drugs and/or alcohol
 - II. Prohibition of social/business relationship with beneficiaries or their family members for personal gain
 - III. Prohibition of sexual contact with beneficiaries
 - IV. Conflict of interest
 - V. Providing services beyond scope
 - VI. Discrimination against beneficiaries or staff
 - VII. Verbally, physically, or sexually harassing, threatening or abusing beneficiaries, family members or other staff
 - VIII. Protection of beneficiary confidentiality
 - IX. Cooperate with complaint investigations
- D. If Provider utilizes the services of volunteers and/or interns, written procedures shall be implemented which address:
 - I. Recruitment
 - II. Screening and selection
 - III. Training and orientation
 - IV. Duties and assignments
 - V. Scope of practice
 - VI. Supervision
 - VII. Evaluation
 - VIII. Protection of beneficiary confidentiality
- E. Written roles and responsibilities and a code of conduct for the Medical Director shall be clearly documented, signed and dated by a Provider representative and the physician.

7. DISCHARGE CRITERIA AND PROCESS

- A. Provider will engage in discharge planning beginning at intake for each client served under this Agreement. Discharge planning will include regular reassessments of client functioning, attainment of goals, determination of treatment needs and establishment of discharge goals.
- B. When possible, discharge will include treatment at a lower LOC or intensity appropriate to client's needs and provision of additional referrals to community resources for client to utilize after discharge.
- C. Provider shall notify County of discharge of authorized clients by emailing the discharge plan, discharge summary and/or any incident reports to: SUDSQualityAssurance@edcgov.us within 72 hours.

8. PROGRAM OR SERVICE SPECIFIC AUTHORIZATION REQUIREMENTS

- A. The following services, as applicable, may only be provided if County refers a client to Provider via County's written treatment authorization forms, as outlined in Exhibits C and D:
 - I. Residential Treatment Services – Level 3.2 and 3.5
 - II. Opioid Settlement Funded Treatment Services

9. CONTRACT DELIVERABLES, OBJECTIVES AND OUTCOMES

- A. Provider shall comply with all requests regarding local, state, and federal performance outcomes measurement requirements and participate in the outcomes measurement processes as requested.
- B. Provider shall work collaboratively with County to develop process benchmarks and monitor progress in the following areas:
- C. Provider will collaborate with the County in the collection and reporting of performance outcomes data, including data relevant to Healthcare Effectiveness Data and Information Set (HEDIS®) measures, as required by DHCS. Measures relevant to this Agreement are indicated below (if applicable):
 - I. Follow up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA)
 - II. Initiation and Engagement of AOD Abuse or Dependence Treatment

10. REPORTING AND EVALUATION REQUIREMENTS

- A. Provider shall complete all reporting and evaluation activities as required by the County and described herein. Provider shall submit all reports electronically and securely to sudsqualityassurance@edcgov.us.
 - I. Monthly Progress Reports Due by the 10th of the month
 - II. Monthly Attestation of Compliance Due by the 10th of the month
 - III. LOC Reporting Due by the 10th of the month

11. ORIENTATION, TRAINING AND TECHNICAL ASSISTANCE

- A. County will endeavor to provide Provider with training and support in the skills and competencies to (a) conduct, participate in, and sustain the performance levels called for in the Agreement and (b) conduct the quality management activities called for by the Agreement.
- B. County will provide the Provider with all applicable standards for the delivery and accurate documentation of services.
- C. County will make ongoing technical assistance available in the form of direct consultation to Provider upon Provider's request to the extent that County has capacity and capability to provide this assistance. In doing so, the County is not relieving Provider of its duty to provide training and supervision to its staff or to ensure that its activities comply with applicable regulations and other requirements included in the terms and conditions of this Agreement.
- D. Any requests for technical assistance by Provider regarding any part of this Agreement shall be directed to the County's AOD Administrator by contacting him/her via email at sudsqualityassurance@edcgov.us.
- E. Provider shall require all new employees in positions designated as "covered individuals" to complete compliance training within the first thirty (30) days of their

first day of work. Provider shall require all covered individuals to attend, at minimum, one compliance training annually.

- I. These trainings shall be conducted by County or, at County's discretion, by Provider staff, or both, and may address any standards contained in this Agreement.
 - II. Covered individuals who are subject to this training are any Provider staff who have or will have responsibility for, or who supervises any staff who have responsibility for, ordering, prescribing, providing, or documenting client care or medical items or services.
- F. Provider shall require that physicians receive a minimum of five (5) hours of continuing medical education related to addiction medicine each calendar year.
 - G. Provider shall require that professional staff LPHAs receive a minimum of five (5) hours of continuing education related to addiction medicine each calendar year.
 - H. Provider shall adhere to the SUD Services Training Plan most current version.

Muir Wood, LLC
Exhibit B
Provider Rate Table

Substance Use Disorder (SUD) Residential Rates				
Description	Duration (Daily)	Year 1 Daily Rate (11/01/2025 – 10/31/2026)	Year 2 Daily Rate (11/01/2026 – 10/31/2027)	Year 2 Daily Rate (11/01/2027- 10/31/2028)
SUDS 3.2 Withdrawal Management Residential	One (1) 24-hour day	\$1200.00	\$1236.00	\$1,273.08
SUDS Residential 3.5 Clinically Managed High Intensity	One (1) 24-hour day	\$1200.00	\$1236.00	\$1,273.08



Muir Wood, LLC
Exhibit C
Preauthorization and Enrollment Form

El Dorado County Behavioral Health, Substance Use Disorder Services

This preauthorization verifies that the individual is authorized for the documented services, but this form cannot be used for billing purposes. Once the beneficiary enters treatment please submit this form securely as an enrollment notification to ODSAccess@edcgov.us verifying date of enrollment. Once received EDC ODS will generate billing authorization for services detailing specific authorized dates.

This preauthorization serves as notification that _____ has
(Beneficiary name)
been assessed by an EDCBH-SUDS practitioner and will be authorized for

(County practitioner documents preauthorized services here)

This form assures authorization of services and is valid for 30 days from the following date: _____
(Date of services authorization)

(EDC ODS staff print name and sign)

(EDC ODS supervisor print name and sign)

Enrollment Notification

Date: _____

Agency & Site Name: _____

Contact # _____

I confirm that _____ was enrolled into LOC _____ on
(Beneficiary name) (3,1,3,2,3,5 etc.)

(Date admitted to program)

(Provider print name and sign)

Enrollment Notification should be emailed securely to ODSAccess@edcgov.us within 48 hours of admission

Rev. 04/2021

Muir Wood, LLC
Exhibit D
Treatment Authorization Form

Exhibit A



EL DORADO COUNTY
HEALTH AND HUMAN SERVICES AGENCY
Behavioral Health

Substance Use Disorder Services
Treatment Authorization Form

Client Name: _____

Avatar #: _____

Provider:

☐ Muir Woods

☐ Granite Wellness, Inc

☐ Wellspace Health

Authorized Dates: _____ to _____

Funding Stream: _____

☐ Outpatient

Units = # of minutes

☐ Individual Counseling #: _____

☐ Group Counseling #: _____

☐ Intensive Outpatient #: _____

☐ Residential Treatment w/

Room and Board _____ Days

☐ Withdrawal Management 3.2 w/

Room and Board _____ Days

☐ Combo: WM 3.2 and Residential w/

Room and Board _____ Days

☐ Recovery Residences

Room and Board _____ Days

☐ Substance Abuse Testing* : Type: _____ #: _____

Comments: _____

Assigned Case Manager: _____

Authorization By:

Signature

Date

Name Title

Substance Use Disorder Services

Phone: /Fax:

Email: sudsqualityassurance@edcgov.us

Office Use Only

Muir Wood, LLC
Exhibit E
California Levine Act Statement

California Government Code section 84308, commonly referred to as the "Levine Act," prohibits any officer of El Dorado County from participating in any action related to a contract if he or she accepts, solicits, or directs any political contributions totaling more than five hundred dollars (\$500) within the previous twelve (12) months, and for twelve (12) months following the date a final decision concerning the contract has been made, from the person or company awarded the contract. The Levine Act also requires disclosure of such contribution by a party to be awarded a specific contract. An officer of El Dorado County includes the Board of Supervisors, any elected official, and the chief administrative officer (collectively "Officer"). It is the Provider's responsibility to confirm the appropriate "Officer" and name the individual(s) in their disclosure.

Have you or your company, or any agent on behalf of you or your company, made any political contribution(s), or been solicited to make a contribution by an Officer or had an Officer direct you to make a contribution of more than \$500 to an Officer of the County of El Dorado in the twelve months preceding the date of the submission of your proposals or the anticipated date of any Officer action related to this contract?

_____ YES ☒ _____ NO

If yes, please identify the person(s) by name:

If no, please type N/A. **NA**

Do you or your company, or any agency on behalf of you or your company, anticipate or plan to make any political contribution(s) of more than \$500 to an Officer of the County of El Dorado in the twelve months following any Officer action related to this contract?

_____ YES ☒ _____ NO

If yes, please identify the person(s) by name:

If no, please type N/A. **NA**

Answering YES to either of the two questions above does not preclude the County of El Dorado from awarding a contract to your firm or any taking any subsequent action related to the contract. It does, however, preclude the identified Officer(s) from participating in any actions related to this contract.

09/22/2025

Date

Muir Wood LLC

Type or write name of company


Daniel Pencak (Sep 22, 2025 07:34:22 PDT)

Signature of authorized individual

Daniel Pencak

Type or write name of authorized individual

Muir Wood, LLC
Exhibit F
Notice of Adverse Benefit Determination (NOABD) Form

Please submit an encrypted e-mail to: SUDSQualityAssurance@edcgov.us or FAX: 530-295-2596 NOT FOR CLIENT USE

SUD Provider Name:	
Client Name:	
Client SSN	
Client DOB	
Preferred Language	
Date of NOABD Decision:	

Instructions: Select one (1) applicable Notice of Adverse Benefit Determination listed below and complete all pertaining items

☐ Denial of Authorization for Requested Services	Provide clear concise explanation regarding authorization denial:	
	Provide clinical reasons for the authorization denial decision regarding medical necessity:	
	*ATTN SUD Residential Programs: SUDS Quality Assurance will issue NOABD Denial of Authorization for Requested Services to beneficiary and inform SUD Residential Provider.	
☐ Delivery System	Provide Diagnosis:	Provide ASAM Level of Care Score:
	Client does NOT meet (Select Applicable): ☐ Adult beneficiaries must have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, and must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria required by the The Drug Medi-Cal Organized Delivery System (DMC-ODS) Special Terms and Conditions (STC) 128(d). ☐ SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of a disease, illness or injury consistent with and 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.	
☐ Modification of Requested Services	Provide current services provided:	
	Provide details of modification of type of service (if applicable):	
	Provide current frequency of each service provided:	
	Provide details of modification (if applicable):	
☐ Termination of a Previously Authorized Service	Provide current duration / length of each service provided:	
	Provide details of modification (if applicable):	
☐ Delay in Processing Authorization of Services	Provide clear concise explanation regarding termination / involuntary discharge of a previously authorized service:	
	Provide clinical reasons for the termination denial / involuntary discharge decision regarding medical necessity:	
☐ Failure to Provide Timely Access to Services	Select this NOABD if the following condition applies: ☐ For a standard reauthorization, request was NOT completed within 7 calendar days of previous authorization end date ☐ The timeline can be extended If extension might be in beneficiary's interest is when the county thinks it might be able to approve your provider's request for authorization.	
	*ATTN SUD Residential Providers: SUDS Quality Assurance will issue NOABD Processing Authorization of Services and inform SUD Residential Provider.	
☐ Dispute of Financial Liability	For outpatient and intensive outpatient services	
	☐ Face-to-face appointment within 10 business days of service authorization request <i>was not completed</i>	
	Provide Date Face-to-Face Appointment Client was Seen:	Provide Days out of Compliance:
	For OTP	
☐ Denial of Payment for a Service Rendered by Provider	☐ Face-to-face appointment within three business days of service authorization request <i>was not completed</i> .	
	Provide Date Face-to-Face Appointment Client was Seen:	Provide Days out of Compliance:
	For Residential Providers	
	☐ Face-to-face appointment within 72 hours <i>was not completed</i> .	
☐ Failure to Timely Resolve Grievances and Appeals	Provide Date Face-to-Face Appointment Client was Seen:	Provide Days out of Compliance:
	Provide description of the disputed financial liability: cost-sharing, co-insurance, and other liabilities:	
SUDS Quality Assurance will issue Denial of Payment for a Service Rendered by Provider and inform SUD Provider and beneficiary.		
SUDS Quality Assurance will issue Failure to Timely Resolve Grievances and Appeals and inform SUD Provider and beneficiary.		

Once Completed please submit an encrypted e-mail to:
SUDSQualityAssurance@edcgov.us or FAX: 530-295-2596
NOT FOR CLIENT USE

Muir Wood, LLC
Exhibit G
Certification Of Non-Exclusion Or Suspension from Participation
in a Federal Health Care Program

Provider, through signature of this form, certifies to the following:

- A. Provider certifies that it is not excluded from participation in Federal Health Care Programs under either section 1128 or 1128A of the Social Security Act. Failure to certify will render all provisions of this Agreement null and void and may result in the immediate termination of the Agreement.
- B. Provider certifies that they do not employ or subcontract with providers or have other relationships with providers excluded from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. § 438.610. Provider shall conduct initial and monthly Exclusion & Suspension searches of the following databases and provide evidence of these completed searches when requested by County, DHCS or the US DHHS:
 - I. www.oig.hhs.gov/exclusions - LEIE Federal Exclusions
 - II. www.sam.gov/portal/SAM - GSA Exclusions Extract
 - III. www.Medi-Cal.ca.gov - Suspended & Ineligible Provider List
 - IV. <https://nppes.cms.hhs.gov/#/> - National Plan and Provider Enumeration System (NPPES)
 - V. any other database required by DHCS or DHHS.
- C. Provider certifies that he/she does not employ staff or individual Providers/vendors that are on the Social Security Administration's Death Master File. Provider shall check the following database prior to employing staff or individual Providers/vendors and provide evidence of these completed searches when requested by the County, DHCS or the US DHHS.
<https://www.ssdmf.com> - Social Security Death Master File
- D. Provider is required to notify County immediately if Provider becomes aware of any information that may indicate their (including employees/staff and individual Providers/vendors) potential placement on an exclusions list.
- E. Provider shall screen and periodically revalidate all network providers in accordance with the requirements of 42 C.F.R., Part 455, Subparts B and E.
- F. Provider must confirm the identity and determine the exclusion status of all its providers, as well as any person with an ownership or control interest, or who is an agent or managing employee of the contracted agency through routine checks of federal and state databases. This includes the Social Security Administration's Death Master File, NPPES, the Office of Inspector General's List of Excluded Individuals/Entities (LEIE), the Medi-Cal Suspended and Ineligible Provider List (S&I List) as consistent with the requirements of 42 C.F.R. § 455.436.

G. If a Provider finds a provider that is Excluded, it must promptly notify the County as per 42 C.F.R. § 438.608(a)(2), (4). Provider shall not certify or pay any Excluded provider with Medi-Cal funds, must treat any payments made to an Excluded provider as an overpayment, and any such inappropriate payments may be subject to recovery.

Muir Wood LLC

Provider Name

09/22/2025

Date


[Daniel Pencak \(Sep 22, 2025 07:34:22 PDT\)](#)

Provider Signature

Muir Wood, LLC

Exhibit H

Provider Assurance of Compliance with Nondiscrimination in State and Federally Assisted Programs

HEREBY AGREES THAT it will comply with Title VI and VII of the Civil Rights Act of 1964 as amended; Section 504 of the Rehabilitation Act of 1973 as amended; the Age Discrimination Act of 1975 as amended; the Food Stamp Act of 1977, as amended and in particular section 272.6; Title II of the Americans with Disabilities Act of 1990; California Civil Code Section 51 et seq., as amended; California Government Code section 11135-11139.5, as amended; California Government Code section 12940 (c), (h) (1), (i), and (j); California Government Code section 4450; Title 22, California Code of Regulations section 98000 – 98413; Title 24 of the California Code of Regulations, Section 3105A(e); the Dymally-Alatorre Bilingual Services Act (California Government Code Section 7290-7299.8); Section 1808 of the Removal of Barriers to Interethnic Adoption Act of 1996; and other applicable federal and state laws, as well as their implementing regulations [including 45 Code of Federal Regulations (CFR) Parts 80, 84, and 91, 7 CFR Part 15, and 28 CFR Part 42], by ensuring that employment practices and the administration of public assistance and social services programs are nondiscriminatory, to the effect that no person shall because of ethnic group identification, age, sex, color, disability, medical condition, national origin, race, ancestry, marital status, religion, religious creed or political belief be excluded from participation in or be denied the benefits of, or be otherwise subject to discrimination under any program or activity receiving federal or state financial assistance; and HEREBY GIVE ASSURANCE THAT it will immediately take any measures necessary to effectuate this agreement.

THIS ASSURANCE is given in consideration of and for the purpose of obtaining any and all federal and state assistance; and PROVIDER HEREBY GIVES ASSURANCE THAT administrative methods/procedures which have the effect of subjecting individuals to discrimination or defeating the objectives of the California Department of Social Services (CDSS) Manual of Policies and Procedures (MPP) Chapter 21, will be prohibited.

BY ACCEPTING THIS ASSURANCE, Provider agrees to compile data, maintain records and submit reports as required, to permit effective enforcement of the aforementioned laws, rules and regulations and permit authorized CDSS and/or federal government personnel, during normal working hours, to review such records, books and accounts as needed to ascertain compliance. If there are any violations of this assurance, CDSS shall have the right to invoke fiscal sanctions or other legal remedies in accordance with Welfare and Institutions Code section 10605, or Government Code section 11135-11139.5, or any other laws, or the issue may be referred to the appropriate federal agency for further compliance action and enforcement of this assurance.

THIS ASSURANCE is binding on the Provider directly or through contract, license, or other provider services, as long as it receives federal or state assistance.

09/22/2025

Date

201 1st Street, Ste 111 Petaluma, CA 94952

Address of Provider


Daniel Hancak (Sep 22, 2025 07:34:22 PDT)

Provider Signature

Muir Wood, LLC
Exhibit I
HIPAA Business Associate Agreement

This Business Associate Agreement is made part of the base contract (“Underlying Agreement”) to which it is attached, as of the date of commencement of the term of the Underlying Agreement (the “Effective Date”).

R E C I T A L S

WHEREAS, County and Provider (hereinafter referred to as Business Associate (“BA”) entered into the Underlying Agreement pursuant to which BA provides services to County, and in conjunction with the provision of such services, certain Protected Health Information (“PHI”) and Electronic Protected Health Information (“EPHI”) may be disclosed to BA for the purposes of carrying out its obligations under the Underlying Agreement;

WHEREAS, the County and BA intend to protect the privacy and provide for the security of PHI and EPHI disclosed to BA pursuant to the Agreement in compliance with the Health Insurance Portability and Accountability Act, Pub. L. No. 104-191 of 1996 (“HIPAA”), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 (the “HITECH” Act), and regulation promulgated thereunder by the U.S. Department of Health and Human Services (the “HIPAA Regulations”) and other applicable laws as may be amended from time to time;

WHEREAS, County is a Covered Entity, as defined in the Privacy Rule and Security Rule, including but not limited to 45 CFR Section 160.103;

WHEREAS, BA, when a recipient of PHI from County, is a Business Associate as defined in the Privacy Rule, the Security Rule, and the HITECH Act, including but not limited to 42 USC Section 17938 and 45 CFR Section 160.103;

WHEREAS, “Individual” shall have the same meaning as the term “individual” in 45 CFR § 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR § 164.202(g);

WHEREAS, “Breach” shall have the meaning given to such term under the HITECH Act under 42 USC Section 17921; and

WHEREAS, “Unsecured PHI” shall have the meaning to such term under the HITECH Act and any guidance issued pursuant to such Act including, but not limited to 42 USC Section 17932(h).

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein, the Parties agree as follows:

- I. Definitions. Unless otherwise provided in this Business Associate Agreement, capitalized terms shall have the same meanings as set forth in the Privacy Rule, as may be amended from time to time.
- II. Scope of Use and Disclosure by BA of County Disclosed PHI
 - A. BA shall not disclose PHI except for the purposes of performing BA's obligations under the Underlying Agreement. Further, BA shall not use PHI in any manner that would constitute a violation of the minimum necessary policies and procedures of the County, Privacy Rule, Security Rule, or the HITECH Act.
 - B. Unless otherwise limited herein, in addition to any other uses and/or disclosures permitted or authorized by this Business Associate Agreement or required by law, BA may:
 - 1. Use the PHI in its possession for its proper management and administration and to fulfill any legal obligations.
 - 2. disclose the PHI in its possession to a third party for the purpose of BA's proper management and administration or to fulfill any legal responsibilities of BA, or as required by law
 - 3. Disclose PHI as necessary for BA's operations only if:
 - a) Prior to making a disclosure to a third party, BA will obtain written assurances from such third party including:
 - (1) To hold such PHI in confidence and use or further disclose it only for the purpose of which BA disclosed it to the third party, or as required by law; and
 - (2) The third party will immediately notify BA of any breaches of confidentiality of PHI to the extent it has obtained knowledge of such breach.
 - 4. Aggregate the PHI and/or aggregate the PHI with that of other data for the purpose of providing County with data analyses related to the Underlying Agreement, or any other purpose, financial or otherwise, as requested by County.
 - 5. Not disclose PHI disclosed to BA by County not authorized by the Underlying Agreement or this Business Associate Agreement without patient authorization or de-identification of the PHI as authorized in writing by County.
 - 6. De-identify any and all PHI of County received by BA under this Business Associate Agreement provided that the de-identification conforms to the requirements of the Privacy Rule, 45 CFR and does not preclude timely payment and/or claims processing and receipt.
 - C. BA agrees that it will neither use nor disclose PHI it receives from County, or from another business associate of County, except as permitted or required by this Business Associate Agreement, or as required by law, or as otherwise permitted by law.
- III. Obligations of BA. In connection with its use of PHI disclosed by County to BA, BA agrees to:
 - A. Implement appropriate administrative, technical, and physical safeguards as are necessary to prevent use or disclosure of PHI other than as permitted by the Agreement that reasonably and appropriately protects the confidentiality, integrity, and availability of the PHI in accordance with Title 45 of the Code of Federal Regulations, Part 160 and Part 164, Subparts A and C (the "HIPAA Privacy Rule" and the "HIPAA Security Rule") in effect or as may be amended, including but not limited to 45 CFR 164.308,

- 164.310, 164.312, and 164.504(e)(2). BA shall comply with the policies, procedures, and documentation requirements of the HIPAA Security Rule.
- B. Report to County within 24 hours of any suspected or actual breach of security, intrusion, or unauthorized use or disclosure of PHI of which BA becomes aware and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations. BA shall take prompt corrective action to cure any such deficiencies and any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.
 - C. Report to County in writing of any access, use, or disclosure of PHI not permitted by the Underlying Agreement and this Business Associate Agreement, and any Breach of Unsecured PHI of which it becomes aware without unreasonable delay and in no case later than five (5) days. To the extent the Breach is solely a result of BA's failure to implement reasonable and appropriate safeguards as required by law, and not due in whole or part to the acts or omissions of the County, BA may be required to reimburse the County for notifications required under 45 CFR 164.404 and CFR 164.406.
 - D. BA shall not use or disclose PHI for fundraising or marketing purposes. BA shall not disclose PHI to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates. BA shall not directly or indirectly receive remuneration in exchange of PHI, except with the prior written consent of the County and as permitted by the HITECH Act, 42 USC Section 17935(d)(2); however, this prohibition shall not affect payment by County to BA for services provided pursuant to the Agreement.
- IV. PHI Access, Amendment, and Disclosure Accounting. BA agrees to:
- A. Provide access, at the request of County, within five (5) days, to PHI in a Designated Record Set, to the County, or to an Individual as directed by the County. If BA maintains an Electronic Health Record, BA shall provide such information in electronic format to enable County to fulfill its obligations under the HITECH Act, including, but not limited to, 42 USC Section 17935(e).
 - B. Within ten (10) days of receipt of a request from County, incorporate any amendments or corrections to the PHI in accordance with the Privacy Rule in the event that the PHI in BA's possession constitutes a Designated Record Set.
 - C. To assist the County in meeting its disclosure accounting under HIPAA:
 - 1. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents or subcontractors for at least six (6) years prior to the request. However, accounting of disclosure from Electronic Health Record for treatment, payment, or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent that BA maintains an electronic health record and is subject to this requirement. At the minimum, the information collected shall include: (i) the date of disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) a brief description of PHI disclosed and; (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure.

2. Within in 30 days of notice by the County, BA agrees to provide to County information collected in accordance with this section to permit the County to respond to a request by an Individual for an accounting of disclosures of PHI.
 - D. Make available to the County, or to the Secretary of Health and Human Services (the "Secretary"), BA's internal practices, books and records relating to the use of and disclosure of PHI for purposes of determining BA's compliance with the Privacy Rule, subject to any applicable legal restrictions. BA shall provide County a copy of any PHI that BA provides to the Secretary concurrently with providing such information to the Secretary.
- V. Obligations of County.
- A. County agrees that it will promptly notify BA in writing of any restrictions on the use and disclosure of PHI agreed to by County that may affect BA's ability to perform its obligations under the Underlying Agreement, or this Business Associate Agreement.
 - B. County agrees that it will promptly notify BA in writing of any changes in, or revocation of, permission by any Individual to use or disclose PHI, if such changes or revocation may affect BA's ability to perform its obligations under the Underlying Agreement, or this Business Associate Agreement.
 - C. County agrees that it will promptly notify BA in writing of any known limitation(s) in its notice of privacy practices to the extent that such limitation may affect BA's use of disclosure of PHI.
 - D. County shall not request BA to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by County, except as may be expressly permitted by the Privacy Rule.
 - E. County will obtain any authorizations necessary for the use or disclosure of PHI, so that BA can perform its obligations under this Business Associate Agreement and/or the Underlying Agreement.
- VI. Term and Termination.
- A. Term. This Business Associate Agreement shall commence upon the Effective Date and terminate upon the termination of the Underlying Agreement, as provided therein when all PHI provided by the County to BA, or created or received by BA on behalf of the County, is destroyed or returned to the County, or, or if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.
 - B. Termination for Cause. Upon the County's knowledge of a material breach by the BA, the County shall either:
 1. Provide an opportunity for the BA to cure the breach or end the violation and terminate this Agreement if the BA does not cure the breach or end the violation within the time specified by the County.
 2. Immediately terminate this Agreement if the BA has breached a material term of this Agreement and cure is not possible; or
 3. If neither termination nor cures are feasible, the County shall report the violation to the Secretary.
 - C. Effect of Termination.
 1. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, the BA shall, at the option of County, return or destroy

all PHI that BA or its agents or subcontractors still maintain in any form, and shall retain no copies of such PHI.

2. In the event that the County determines that returning or destroying the PHI is infeasible, BA shall provide to the County notification of the conditions that make return or destruction infeasible, and BA shall extend the protections of this Agreement to such PHI to those purposes that make the return or destruction infeasible, for so long as the BA maintains such PHI. If County elects destruction of the PHI, BA shall certify in writing to County that such PHI has been destroyed.

VII. Indemnity

- A. BA shall indemnify and hold harmless all Agencies, Districts, Special Districts and Departments of the County, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives (collectively "County") from any liability whatsoever, based or asserted upon any services of BA, its officers, employees, subcontractors, agents or representatives arising out of or in any way relating to BA's performance under this Business Associate Agreement, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever including fines, penalties or any other costs and resulting from any reason whatsoever to the extent arising from the performance of BA, its officers, agents, employees, subcontractors, agents or representatives under this Business Associate Agreement. BA shall defend, at its sole expense, all costs and fees including but not limited to attorney fees, cost of investigation, defense and settlements or awards against the County in any claim or action based upon such alleged acts or omissions.
- B. With respect to any action or claim subject to indemnification herein by BA, BA shall, at its sole cost, have the right to use counsel of its choice, subject to the approval of County, which shall not be unreasonably withheld, and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of County; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes BA's indemnification of County as set forth herein. BA's obligation to defend, indemnify and hold harmless County shall be subject to County having given BA written notice within a reasonable period of time of the claim or of the commencement of the related action, as the case may be, and information and reasonable assistance, at BA's expense, for the defense or settlement thereof. BA's obligation hereunder shall be satisfied when BA has provided to County the appropriate form of dismissal relieving County from any liability for the action or claim involved.
- C. The specified insurance limits required in the Underlying Agreement of this Business Associate Agreement shall in no way limit or circumscribe BA's obligations to indemnify and hold harmless the County herein from third party claims arising from the issues of this Business Associate Agreement.
- D. In the event there is conflict between this clause and California Civil Code Section 2782, this clause shall be interpreted to comply with Civil Code Section 2782. Such interpretation shall not relieve the BA from indemnifying the County to the fullest extent allowed by law.
- E. In the event there is a conflict between this indemnification clause and an indemnification clause contained in the Underlying Agreement of this Business

Associate Agreement, this indemnification shall only apply to the subject issues included within this Business Associate Agreement.

- VIII. Amendment. The parties agree to take such action as is necessary to amend this Business Associate Agreement from time to time as is necessary for County to comply with the Privacy Rule, 45 CFR, and HIPAA generally.
- IX. Survival. The respective rights and obligations of this Business Associate Agreement shall survive the termination or expiration of this Business Associate Agreement.
- X. Regulatory References. A reference in this Business Associate Agreement to a section in the Privacy Rule means the section as in effect or as amended.
- XI. Conflicts. Any ambiguity in this Business Associate Agreement and the Underlying Agreement shall be resolved to permit County to comply with the Privacy Rule, 45 CFR, and HIPAA generally.

Approval and Signatures

By: 
Daniel Pencak (Sep 22, 2025 07:34:22 PDT)
Daniel Pencak
Chief Financial Officer
Muir Wood, LLC
"BA Representative"

Dated: 09/22/2025

By: 
Shaun O'Malley (Sep 18, 2025 13:45:33 PDT)
Shaun O'Malley
Alcohol and Drug Programs Division Manager
El Dorado County Health and Human Services Agency (HHSA)
"HHSA Representative"

Dated: 09/18/2025