AGREEMENT FOR SERVICES #5781
Drug Medi-Cal Organized Delivery System Services

THIS AGREEMENT is made and entered into by and between the County of El Dorado, a political subdivision of the State of California (hereinafter referred to as "County") and Volunteers of America Northern California Northern Nevada, a California Domestic Non-Profit, duly qualified to conduct business in the State of California, whose principal place of business is 3434 Marconi Avenue, Sacramento, CA 95821 (hereinafter referred to as "Provider");

RECITALS

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

WHEREAS, Provider has represented to County that it is specially trained, experienced, expert, and competent to perform the special services described in **ARTICLE I, Responsibilities and Services;** 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; and

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

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

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

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Exhibits

ARTICLE I – Responsibilities and Services

1. **County Responsibilities:**
   County shall be responsible for the following:
   A. Annual site inspection of all Provider-operated or Provider-contracted sites located within El Dorado County to evaluate the work performed or being performed hereunder, including subcontracted supported activities and the premises in which it is being performed. For Provider-operated or Provider-contracted sites located outside El Dorado County, the County may accept the annual site inspection documentation prepared by the host county if all El Dorado County Compliance Monitoring requirements are contained within.
   B. Monitoring of invoices and services to verify adherence to the funding requirements.
   C. Monitoring of program to verify adherence to terms and conditions pursuant to this Agreement.

2. **Authorization of Services**: The following services, as applicable, may only be provided if County refers a client to Provider via County's written treatment authorization form available at https://www.edcgov.us/Government/hhsa/Pages/hhsa_contractor_resources.aspx:

   A. AB 109 Funded Treatment Services
   B. Recovery Residences Services per Exhibit 7
   C. Residential Services per Exhibit 11
   D. SABG Funded per Exhibit 2
   E. Withdrawal Management per Exhibit 10

3. **Scope of Services:** Provider agrees to furnish the personnel and equipment necessary to provide services as defined in Intergovernmental Agreement #18-95146 (Exhibit 1), or as may be amended or replaced, DHCS Performance Agreement Re: Substance Abuse Prevention and Treatment Block Grant (SABG) Agreement #18-95241 (Exhibit 2), or as may be amended or replaced, and Exhibits 3 through 12, as applicable and attached, and incorporated by reference herein, as well as substance abuse testing and client progress reports. To the extent that the terms and conditions of the Intergovernmental Agreement and the SABG Agreement conflict, the terms and conditions of the Agreement with the most stringent provisions shall prevail.

   In addition, 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, available at https://www.edcgov.us/Government/hhsa/Pages/hhsa_contractor_resources.aspx

   A. Drug Medi-Cal Billing Manual
   B. El Dorado County DMC-ODS Practice Guidelines
   C. Minimum Quality Drug Treatment Standards – DMC
   D. Minimum Quality Drug Treatment Standards – SABG
   E. SABG Policy Manual
   F. Substance Abuse Prevention and Treatment (SAPT) Block Grant Contracts – SABG Incorporated Document Links
   G. SABG Perinatal Practices Guidelines

4. **Provision of Services:**
   The following requirements shall apply to the Provider, and the provider staff:
   A. Professional staff shall be licensed, registered, certified, or recognized under California scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioners of the Healing Arts (LPHA) include:
      1. Physician
      2. Nurse Practitioners
      3. Physician Assistants
      4. Registered Nurses
      5. Registered Pharmacists
      6. Licensed Clinical Psychologists
      7. Licensed Clinical Social Worker
      8. Licensed Professional Clinical Counselor
      9. Licensed Marriage and Family Therapists
      10. Licensed Eligible Practitioners working under the supervision of Licensed Clinicians
   B. 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.
   C. 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.
   D. Physicians shall receive a minimum of five hours of continuing medical education related to addiction medicine each year.
   E. Professional staff (LPHAs) shall receive a minimum of five hours of continuing education related to addiction medicine each year.
   F. Registered and certified Substance Use Disorder (SUD) counselors shall adhere to all requirements in Title 9, Chapter 8.

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

6. **Substance Use Disorder Medical Director:**
   A. The SUD Medical Director's responsibilities shall, at a minimum, include all of 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.
      6. Ensure that Provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries, and determine the medical necessity of treatment for beneficiaries.

7. Ensure that Provider's physicians are adequately trained to perform other physician duties, as outlined in this section.

B. 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.

7. **Provider Personnel:**

A. Personnel files shall be maintained on all employees and volunteers/interns and shall contain the following:
   1. Application for employment and/or resume
   2. Signed employment confirmation statement/duty statement
   3. Job description
   4. Performance evaluations
   5. Health records/status as required by the Provider, Alcohol and Other Drug (AOD) Certification or Title 9
   6. Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries)
   7. Training documentation relative to substance use disorders and treatment
   8. Current registration, certification, intern status, or licensure
   9. Proof of continuing education required by licensing or certifying agency and program
   10. 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:
   1. Position title and classification
   2. Duties and responsibilities
   3. Lines of supervision
   4. 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:
   1. Use of drugs and/or alcohol
   2. Prohibition of social/business relationship with beneficiaries or their family members for personal gain
   3. Prohibition of sexual contact with beneficiaries
   4. Conflict of interest
   5. Providing services beyond scope
   6. Discrimination against beneficiaries or staff
   7. Verbally, physically, or sexually harassing, threatening or abusing beneficiaries, family members or other staff
   8. Protection of beneficiary confidentiality
   9. Cooperate with complaint investigations

D. If a Provider utilizes the services of volunteers and/or interns, written procedures shall be implemented which address:
   1. Recruitment
   2. Screening and Selection
   3. Training and orientation
   4. Duties and assignments

5. Scope of practice
6. Supervision
7. Evaluation
8. 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.

8. **Beneficiary Eligibility:**

A. All beneficiaries shall meet the following medical necessity criteria:
   1. The individual shall have received a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders or be assessed to be at risk for developing substance use disorder (for youth under 21).
   2. The individual shall meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.
   3. For beneficiaries in treatment prior to implementation of the DMC-ODS, the Provider must conduct an ASAM assessment by the due date of the next updated treatment plan or continuing services justification, whichever occurs first.
      a. If the assessment determines a different level of care, the Provider shall refer the beneficiary to the appropriate level of care.

B. In addition the initial medical necessity determination, for an individual to receive a DMC-ODS benefit, shall be performed by a Medical Director or an LPHA. The Medical Director or LPHA shall evaluate each beneficiary's assessment and intake information if completed by a counselor through a face-to-face review or telehealth with the counselor to establish a beneficiary meets medical necessity criteria. After establishing a diagnosis and documenting the basis for diagnosis, the ASAM Criteria shall be applied to determine placement into the level of assessed services.

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

D. Provider shall be responsible for verifying the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for DMC services to that beneficiary for that month. Medi-Cal eligibility verification should be performed prior to rendering service, in accordance with and as described in the DHCS DMC Provider Billing Manual. Options for verifying the eligibility of a Medi-Cal beneficiary are described in the Department of Health Care Services DMC Provider Billing Manual.

9. **Beneficiary Admission:**
   A. Each provider shall include in its policies, procedures, and practice, written admission and readmission criteria for determining beneficiary's eligibility and the medical necessity for treatment. These criteria shall include, at a minimum:
      1. Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis
      2. Use of alcohol/drugs of abuse
      3. Physical health status
      4. Documentation of social and psychological problems.
   B. If a potential beneficiary does not meet the admission criteria, the beneficiary shall be referred to an appropriate service provider.
   C. If a beneficiary is admitted to treatment, the beneficiary shall sign a consent to treatment form.
   D. The Medical Director or Licensed Practitioner of Healing Arts (LPHA) shall document the basis for the diagnosis in the beneficiary record.
   E. All referrals made by the provider staff shall be documented in the beneficiary record.
   F. Copies of the following documents shall be provided to the beneficiary upon admission:
      1. Beneficiary rights, share of cost if applicable, notification of Drug Medi-Cal (DMC) funding accepted as payment in full, and consent to treatment.
   G. Copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries:
      1. A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay.
      2. Complaint process and grievance procedures.
      3. Appeal process for involuntary discharge.
      4. Program rules and expectations.
   H. Where drug screening by urinalysis is deemed medically appropriate the program shall:
      1. Establish written procedures, which protect against the falsification and/or contamination of any urine sample.
      2. Document urinalysis results in the beneficiary's file.

10. **Assessment:**
   A. The provider shall ensure a counselor or LPHA completes a personal, medical, and substance use history for each beneficiary upon admission to treatment.
      1. Assessment for all beneficiaries shall include at a minimum:
         a. Drug/Alcohol use history
         b. Medical history
         c. Family history
         d. Psychiatric/psychological history
         e. Social/recreational history
         f. Financial status/history
         g. Educational history
         h. Employment history
         i. Criminal history
         j. Legal status
         k. Previous SUD treatment history

B. The Medical Director or LPHA shall review each beneficiary's personal, medical, and substance use history if completed by a counselor within thirty (30) calendar days of each beneficiary's admission to treatment date.

11. **Beneficiary Record**
    A. In addition to the requirements of 22 California Code of Regulations (CCR) § 51476(a), the provider shall:
        1. Establish, maintain, and update as necessary, an individual beneficiary record for each beneficiary admitted to treatment and receiving services.
        2. Each beneficiary's individual beneficiary record shall include documentation of personal information.
        3. Documentation of personal information shall include all of the following:
        4. Information specifying the beneficiary's identifier (i.e., name, number).
        5. Date of beneficiary's birth, the beneficiary's sex, race and/or ethnic background, beneficiary's address and telephone number, and beneficiary's next of kin or emergency contact.
    B. Documentation of treatment episode information shall include documentation of all activities, services, sessions, and assessments, including, but not limited to all of the following:
        1. Intake and admission data including, a physical examination, if applicable.
        2. Treatment plans.
        3. Progress notes.
        4. Continuing services justifications.
        5. Laboratory test orders and results.
        6. Referrals.
        7. Discharge plan.
        8. Discharge summary.
        9. County authorizations for Residential Services.
        10. Any other information relating to the treatment services rendered to the beneficiary.

12. **Diagnosis Requirements.**
    A. The Medical Director or LPHA shall evaluate each beneficiary's assessment and intake information if completed by a counselor through a face-to-face review or telehealth with the counselor to establish a beneficiary meets the medical necessity criteria in **ARTICLE I, Section 9, Beneficiary Eligibility** of this contract.
        1. The Medical Director or LPHA shall document separately from the treatment plan the basis for the diagnosis in the beneficiary's record within thirty (30) calendar days of each beneficiary's admission to treatment date.
            a. The basis for the diagnosis shall be a narrative summary based on DSM-5 criteria, demonstrating the Medical Director or LPHA evaluated each beneficiary's assessment and intake information, including their personal, medical, and substance use history.
            b. The Medical Director or LPHA shall type or legibly print their name, and sign and date the diagnosis narrative documentation. The signature shall be adjacent to the typed or legibly printed name.

13. **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.
        1. 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.
    B. 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.
    C. 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.

14. **Treatment Plan:** For each beneficiary admitted to treatment services, the LPHA or counselor shall prepare an individualized written initial treatment plan, based upon the information obtained in the intake and assessment process.

    The LPHA or counselor shall attempt to engage the beneficiary to meaningfully participate in the preparation of the initial treatment plan and updated treatment plans.

    A. The initial treatment plan and updated treatment plans shall include all of the following:
        1. A statement of problems identified through the ASAM, other assessment tool(s) or intake documentation.
        2. Goals to be reached which address each problem.
        3. Action steps that will be taken by the provider and/or beneficiary to accomplish identified goals.
        4. Target dates for the accomplishment of action steps and goals.
        5. A description of the services, including the type of counseling, to be provided and the frequency thereof.
        6. The assignment of a primary therapist or counselor.
        7. The beneficiary's diagnosis as documented by the Medical Director or LPHA.
        8. If a beneficiary has not had a physical examination within the 12-month period prior to the beneficiary's admission to treatment date, a goal that the beneficiary have a physical examination.
        9. If documentation of a beneficiary's physical examination, which was performed during the prior 12 months, indicates a beneficiary has a significant medical illness, a goal that the beneficiary obtain appropriate treatment for the illness.

B. The provider shall ensure that the initial treatment plan meets all of the following requirements:
   1. The LPHA or counselor shall complete, type or legibly print their name, and sign and date the initial treatment plan within thirty (30) calendar days of the admission to treatment date. The signature shall be adjacent to the typed or legibly printed name.
   2. The beneficiary shall review, approve, type, or legibly print their name, sign and date the initial treatment plan, indicating whether the beneficiary participated in preparation of the plan, within thirty (30) calendar days of the admission to treatment date.
   3. If the beneficiary refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment.
   4. If a counselor completes the initial treatment plan, the Medical Director or LPHA shall review the initial treatment plan to determine whether services are medically necessary and appropriate for the beneficiary.

C. If the Medical Director or LPHA determines the services in the initial treatment plan are medically necessary, the Medical Director or LPHA shall type or legibly print their name, and sign and date the treatment plan within fifteen (15) calendar days of signature by the counselor. The signature shall be adjacent to the typed or legibly printed name.

D. The provider shall ensure that the treatment plan is reviewed and updated as described below:
   1. The LPHA or counselor shall complete, type, or legibly print their name, sign and date the updated treatment plan no later than ninety (90) calendar days after signing the initial treatment plan, and no later than every ninety (90) calendar days thereafter, or when there is a change in treatment modality or significant event, whichever comes first. The signature shall be adjacent to the typed or legibly printed name. The updated treatment plan shall be updated to reflect the current treatment needs of the beneficiary.
   2. The beneficiary shall review, approve, type, or legibly print their name and, sign and date the updated treatment plan, indicating whether the beneficiary participated in preparation of the plan, within thirty (30) calendar days of signature by the LPHA or counselor.
   3. If the beneficiary refuses to sign the updated treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment.
   4. If a counselor completes the updated treatment plan, the Medical Director or LPHA shall review each updated treatment plan to determine whether continuing services are medically necessary and appropriate for the beneficiary.
   5. If the Medical Director or LPHA determines the services in the updated treatment plan are medically necessary, they shall type or legibly print their name and, sign and date the updated treatment plan, within fifteen (15) calendar days of signature by the counselor. The signature shall be adjacent to the typed or legibly printed name.

15. **Sign-In Sheet:** Establish and maintain a sign-in sheet for every group counseling session, which shall include all of the following:
   A. The LPHA(s) and/or counselor(s) conducting the counseling session shall type or legibly print their name(s), sign, and date the sign-in sheet on the same day of the session. The

signature(s) must be adjacent to the typed or legibly printed name(s). By signing the sign-in sheet, the LPHA(s) and/or counselor(s) attest that the sign-in sheet is accurate and complete.

B. The date of the counseling session.
C. The topic of the counseling session.
D. The start and end time of the counseling session.
E. A typed or legibly printed list of the participants' names and the signature of each participant that attended the counseling session. The participants shall sign the sign-in sheet at the start of or during the counseling session.

16. **Progress Notes:**
    A. Progress notes shall be legible and completed as follows:
        1. For outpatient services, Naltrexone treatment services, and recovery services, each individual and group session, the LPHA or counselor who conducted the counseling session or provided the service shall record a progress note for each beneficiary who participated in the counseling session or treatment service.
            a. The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven (7) calendar days of the counseling session. The signature shall be adjacent to the typed or legibly printed name.
            b. Progress notes are individual narrative summaries and shall include all of the following:
                i. The topic of the session or purpose of the service.
                ii. A description of the beneficiary's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals.
                iii. Information on the beneficiary's attendance, including the date, start and end times of each individual and group counseling session or treatment service.
                iv. Identify if services were provided in-person, by telephone, or by telehealth.
                v. If services were provided in the community, identify the location and how the provider ensured confidentiality.
    B. For intensive outpatient services and residential treatment services, the LPHA or counselor shall record, at a minimum, one progress note, per calendar week, for each beneficiary participating in structured activities including counseling sessions or other treatment services.
        1. The LPHA or counselor shall type or legibly print their name, and sign and date progress notes within the following calendar week. The signature shall be adjacent to the typed or legibly printed name.
        2. Progress notes are individual narrative summaries and shall include all of the following:
            a. A description of the beneficiary's progress on the treatment plan, problems, goals, action steps, objectives, and/or referrals.
            b. A record of the beneficiary's attendance at each counseling session including the date, start and end times and topic of the counseling session.
            c. Identify if services were provided in-person, by telephone, or by telehealth.
            d. If services were provided in the community, identify the location and how the provider ensured confidentiality.

C. For each beneficiary provided case management services, the LPHA or counselor who provided the treatment service shall record a progress note.
   1. The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven (7) calendar days of the case management service. The signature shall be adjacent to the typed or legibly printed name.
   2. Progress notes shall include all of the following:
      a. Beneficiary's name.
      b. The purpose of the service.
      c. A description of how the service relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referrals.
      d. Date, start and end times of each service.
      e. Identify if services were provided in-person, by telephone, or by telehealth.
      f. If services were provided in the community, identify the location and how the provider ensured confidentiality.

D. For physician consultation services, additional medication assisted treatment, and withdrawal management, the Medical Director or LPHA working within their scope of practice who provided the treatment service shall record a progress note and keep in the beneficiary's file.
   1. The Medical Director or LPHA shall type or legibly print their name, and sign and date the progress note within seven (7) calendar days of the service. The signature shall be adjacent to the typed or legibly printed name.
   2. Progress notes shall include all of the following:
      a. Beneficiary's name.
      b. The purpose of the service.
      c. Date, start and end times of each service.
      d. Identify if services were provided face-to-face, by telephone or by telehealth.

17. **Continuing Services:**

A. Continuing services shall be justified as shown below:
   1. For outpatient services, intensive outpatient services, Naltrexone treatment, and case management:
      a. For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the LPHA or counselor shall review the beneficiary's progress and eligibility to continue to receive treatment services, and recommend whether the beneficiary should or should not continue to receive treatment services at the same level of care.
      b. For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the Medical Director or LPHA shall determine medical necessity for continued services for the beneficiary. The determination of medical necessity shall be documented by the Medical Director or LPHA in the beneficiary's individual patient record and shall include documentation that all of the following have been considered:
         i. The beneficiary's personal, medical and substance use history.
         ii. Documentation of the beneficiary's most recent physical examination.
         iii. The beneficiary's progress notes and treatment plan goals.

iv. The LPHA's or counselor's recommendation pursuant to Paragraph (i) above.
v. The beneficiary's prognosis.
vi. The Medical Director or LPHA shall type or legibly print their name, and sign and date the continuing services information when completed. The signature shall be adjacent to the typed or legibly printed name.

2. If the Medical Director or LPHA determines that continuing treatment services for the beneficiary is not medically necessary, the Provider shall discharge the beneficiary from the current Level of Care (LOC) and transfer to the appropriate services.

B. Residential services length of stay shall be in accordance with County procedures for request of authorized residential services and the Intergovernmental Agreement #18-95146.

18. **Discharge:**

A. Discharge of a beneficiary from treatment may occur on a voluntary or involuntary basis. For outpatient services, intensive outpatient services and residential services, in addition to the requirements of this subsection, an involuntary discharge is subject to the requirements set forth in Health and Human Services Agency Policy N-SUDS-003 DMC-ODS Grievances, Appeals & Fair Hearing, which constitutes part of this Agreement, available at https://www.edcgov.us/Government/hhsa/Pages/hhsa_contractor_resources.aspx

B. An LPHA or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom the provider loses contact.

1. The discharge plan shall include, but not be limited to, all of the following:
   a. A description of each of the beneficiary's relapse triggers.
   b. A plan to assist the beneficiary to avoid relapse when confronted with each trigger.
   c. A support plan.
2. The discharge plan shall be prepared within thirty (30) calendar days prior to the scheduled date of the last face-to-face treatment with the beneficiary.
   a. If a beneficiary is transferred to a higher or lower level of care based on ASAM criteria within the same DMC certified program, they are not required to be discharged unless there has been more than a thirty (30) calendar day lapse in treatment services.
3. During the LPHA's or counselor's last face-to-face treatment with the beneficiary, the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. The signatures shall be adjacent to the typed or legibly printed name. A copy of the discharge plan shall be provided to the beneficiary and documented in the beneficiary record.

C. The LPHA or counselor shall complete a discharge summary, for any beneficiary with whom the provider lost contact, in accordance with all of the following requirements:

1. The LPHA or counselor shall complete the discharge summary within thirty (30) calendar days of the date of the last face-to-face treatment contact with the beneficiary.
2. The discharge summary shall include all of the following:
   a. The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment.
   b. The reason for discharge.
   c. A narrative summary of the treatment episode.
   d. The beneficiary's prognosis.

19. **Certifications:** Any counselor or registrant providing intake, assessment of need for services, treatment or recovery planning, individual or group counseling to participants, patients, or residents in a DHCS licensed or certified program is required to be certified as defined in Title 9, CCR Division 4, Chapter 8.

20. **Cultural Competency:**
    A. Providers are responsible to provide culturally competent services. Providers shall ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations. Translation services shall be available for beneficiaries, as needed.
    B. To ensure equal access to quality care by diverse populations, each service provider receiving funds from this Agreement shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards (Document 3V) and comply with 42 CFR 438.206(c)(2).
    C. Provider shall ensure that the Client's primary spoken language and self-identified race and ethnicity are included in the California Outcomes Measurement Systems (CalOMS) AVATAR system, the Provider's management information system, as well as any Client records used by provider staff.

21. **Evidence Based Practices (EBPs):** Providers will implement at least two of the following EBPs based on the timeline established in the county implementation plan. The two EBPs are per provider per service modality. The County will ensure the Providers have implemented EBPs. The state will monitor the implementation and regular training of EBPs to staff during reviews. The required EBPs include:
    A. Motivational Interviewing: A beneficiary-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on beneficiaries' past successes.
    B. Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.
    C. Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.
    D. Trauma-Informed Treatment: Services shall take into account an understanding of trauma, and place priority on trauma survivors' safety, choice, and control.
    E. Psycho-Education: Psycho-educational groups are designed to educate beneficiaries about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries' lives, to instill self- awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

22. **Program Integrity:**
    A. Service Verification. To assist DHCS in meeting its obligation under 42 CFR 455.1(a)(2), the Provider shall establish a mechanism to verify whether services were actually furnished

to beneficiaries. Provider will participate in service verification activities as required by this agreement. Provider shall utilize the following documents, all of which constitute part of this Agreement, available at https://www.edcgov.us/Government/hhsa/Pages/hhsa_contractor_resources.aspx

a. DMC-ODS Service Verification Process
b. DMC-ODS Service Verification Card Template
c. DMC-ODS Service Verification Monthly Report Form

A. Provider shall adhere to the DMC-ODS Compliance Plan which constitutes part of this Agreement, available at https://www.edcgov.us/Government/hhsa/Pages/hhsa_contractor_resources.aspx

B. Requirements of a Compliance Program are set forth in 42 Code of Federal Regulations Sections 455.1 and 438.608. Further requirements for Program Integrity, which includes the Compliance Program, are established pursuant to the DMC-ODS Intergovernmental Agreement between the State of California Department of Health Care Services (DHCS) and El Dorado County HHSA, as well as through Information Notices issued by DHCS.

C. The requirements of the Compliance Program apply to all individuals who provide services, including billing or coding functions, in support the DMC-ODS operated by or through the County, including employees, volunteers, interns, and others working on behalf of the County in the provision of DMC-ODS Services. These individuals are generally referred to within this document as the "County workforce" or "County workforce members". In addition, the law specifies contractors that furnish, or authorize the furnishing of, Medi-Cal services, perform billing or coding functions, or are involved in the monitoring of services provided by the County, are covered under DMC-ODS Compliance Program. This includes contracted providers, contracted psychiatrists, and other network and organizational providers.

D. Suspected Medi-Cal fraud, waste, or abuse must be reported to: DHCS Medi-Cal Fraud: (800) 822-6222 or Fraud@dhcs.ca.gov

23. **Training:** Provider shall ensure that, at minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled "American Society of Additive Medicine (ASAM) Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care." A third module entitled, "Introduction to The ASAM Criteria" is recommended for all provider staff providing services under this Agreement.

    The Provider shall ensure that all residential service providers meet the established criteria for each level of residential care they provide and have obtained a Level of Care Designation by DHCS prior to providing DMC-ODS services.

24. **Medication Assisted Treatment (MAT):** Provider will have procedures for linkage/integration for beneficiaries requiring MAT. Provider will regularly communicate with physicians of beneficiaries who are prescribed these medications unless the beneficiary refuses to consent to sign a 42 CFR part 2 compliant Release of Information for this purpose.

25. **Drug and Alcohol Treatment Access Report (DATAR):**
    A. All treatment providers shall be enrolled in DATAR.
    B. County shall be responsible for ensuring that treatment services and all treatment providers submit a monthly DATAR report in an electronic copy format as provided by California

Department of Health Care Services (DHCS) and according to the DATAR Web Manual, which constitutes part of this Agreement, available at https://www.edcgov.us/Government/hhsa/Pages/hhsa_contractor_resources.aspx

C. Reports shall be submitted by the 10th of the month following the report activity month.

26. **California Outcomes Measurement Systems (CalOMS):** Provider shall enter treatment admissions and discharge information into a specific database as directed by County and shall, on a monthly basis, submit same to HHSA Alcohol and Drug Program designee for submission to the State CalOMS database. All CalOMS data submission shall be in accordance with CalOMS Data Compliance Standards available at https://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Data_Cmpliance%20Standards%202014.pdf

ARTICLE II – Term

This Agreement shall become effective upon final execution by both parties hereto and shall continue through June 30, 2023.

ARTICLE III – Funding Categories

A. AB 109 Treatment Services: ***Written authorization required.*** Funding for services provided herein is provided by the 2011 El Dorado Public Safety Realignment Implementation Plan, and is subject to all laws and regulations promulgated under California Assembly Bill (AB) 109, AB 116, AB 117, ABXI 16 and ABXI 17, Statutes of 2011. El Dorado County DMC-ODS eligible beneficiaries who are also identified by County as eligible for AB 109 Treatment Services shall use their DMC-ODS benefits as their primary source of funding. AB109 treatment services funding will be used for beneficiary services that are not covered by DMC-ODS.

B. State General Fund and 2011 Realignment DMC-ODS: DMC-ODS is a treatment program as defined in Intergovernmental Agreement 18-95146, or as may be amended. Effective July 1, 2011, Local Realignment Revenues are used to fund DMC services to DMC beneficiaries, including Minor Consent Services. As of June 1, 2019, revenues are used to fund DMC-ODS services to DMC-ODS El Dorado County beneficiaries, including minor consent services.
    1. Federal Financial Participation (FFP) or Federal match on DMC-ODS: This funding is the Federal share of the DMC Program. The match, which varies by year, is usually at or near fifty percent (50%).
    2. DMC Eligibility Accepted as Payment in Full: Except where a share of cost, as defined in Intergovernmental Agreement 18-95146, or as may be amended, is applicable, Providers shall accept proof of eligibility for DMC as payment in full for treatment services rendered. Providers shall not charge fees to beneficiaries for access to DMC substance abuse services or for admission to a DMC treatment slot.

C. Substance Abuse Prevention and Treatment Block Grant (SABG): ***Written authorization required.*** Services under the Alcohol and Other Drug Counseling and Treatment Services category that are not funded by DMC may be funded by the Federal Block Grant – Substance Abuse Prevention and Treatment Block Grant (SABG): These are Federal funds which are to be used for specific services as follows:
    1. SABG Discretionary: These are Federal block grant funds, which are to be used in a discretionary manner for substance abuse treatment, prevention, and recovery services.

2. SABG Federal Block Grant Perinatal Set Aside: These funds are for substance abuse services designated for pregnant/postpartum women.

For services provided under SABG, Provider shall ensure that Federal Block Grant funds are the "payment of last resort" for Alcohol and Other Drug Treatment Services subsidized under this Agreement. For that reason, Provider shall comply with the following guidelines with regard to charges for services, including the establishment of a sliding scale fee schedule. The sole purpose of the sliding scale is for use in billing clients for Alcohol and Other Drug Counseling Treatment Services.

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. Determination of fees shall be established in accordance with a sliding fee schedule developed by Provider approved by the Contract Administrator, and **attached hereto as Exhibit 13.**
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 Contractor in the client's file.

In addition, Provider must demonstrate that Provider cannot collect at the "County Standardized Rate" from an insurance carrier or other benefit program, including but not limited to (1) the Social Security Act, including Title 19 CCR and Title 22 CCR programs, (2) any State compensation program, and (3) any other public assistance program for medical expenses, any grant program, or any other benefit program.

ARTICLE IV – Compensation for Services
Rates for services provided herein shall be in accordance with the following:

Rates		
Description	**Units of Service**	**Amount**
Residential Level 3.1	Per Bed Day	$125.42
Residential Room & Board Level 3.1	Per Bed Day	$35.83
Residential Withdrawal Management Level 3.2	Per Bed Day	$192.05
Residential Withdrawal Management Room & Board Level 3.2	Per Bed Day	$51.26

"Unit of Service" means a contact on a calendar day for outpatient drug free, intensive outpatient treatment and residential treatment services.

DMC-ODS claims may be submitted with either minutes or fractional units of service in accordance with the DHCS DMC Provider Billing Manual.

A. Invoices: For services provided herein, Provider shall submit invoices, along with written treatment authorization, if applicable, for services fifteen (15) days following the end of a "service month." For billing purposes, a "service month" shall be defined as a calendar month during which Provider provides services in accordance with **ARTICLE I, Responsibilities and Services, Section 3, Scope of Services**. For all satisfactory services provided herein, County agrees to pay Provider monthly in arrears and within forty-five (45) days following County receipt and approval of itemized invoice(s) detailing services rendered and the date(s) services were rendered. County may withhold or delay any payment if Provider fails to comply with any provision of this Agreement.

County shall not pay for any invoices for AB 109 funded treatment services, additional case management services, recovery residences services, residential, SABG funded services, or withdrawal management services that have not been approved in writing by the Contract Administrator or designee, incomplete services, "no show" cancellations, telephone calls or for the preparation of progress reports.

Two-Step Process *(Drug Medi-Cal Services)*: Provider shall upload to County's Secured File Transfer Protocol (SFTP) server an Excel data file **and** draft invoice to County for payment.

Step 1: Provider shall submit an Excel data file with columns as identified below. To avoid federal and state HIPAA violations, County requires that Providers submit client's protected private health information (PHI) via the County's SFTP server, or by using a secured and encrypted email protocol in compliance with HIPPA security regulations. To gain access the County's SFTP server, please email: dmc-odsinvoices@edcgov.us.

The Excel data file shall include the following information:

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

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

Invoice Submittal/Remittance *(All Services)*: Invoices shall be emailed to BHinvoice@edcgov.us, or as otherwise directed in writing by County. Invoices must include the following information:

1. County Issued Agreement Number
2. Provider Name & Address
3. Service Month
4. Invoice Total
5. Service Totals (Units & Cost total per service code)
6. Provider Contact Information
7. Written Treatment Authorization (if applicable)

A. Supplemental Invoices: For the purpose of this Agreement, supplemental invoices shall be defined as invoices submitted for additional services rendered during a month for which a prior invoice has already been submitted to County. Supplemental Invoices shall follow the two-step process as defined herein above. Supplemental invoices should include the standard invoice format with description of services rendered and a detailed explanation why the invoice was not submitted in the approved timeframe. Written treatment authorization shall be submitted with invoices.

1. For those situations where a service is disallowed by HHSA on an invoice, or inadvertently not submitted on an invoice, and a corrected invoice is later submitted ("Supplemental Invoice"), Supplemental Invoices for services provided during the period July 1st through June 30th for each fiscal year of this Agreement and received by HHSA after July 31 of the subsequent fiscal year, shall be neither accepted nor paid by the County. Requests for exceptions to pay an invoice received after July 31 of the subsequent year, must be submitted in writing and must be approved by HHSA's Agency Chief Fiscal Officer.

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

ARTICLE V – Maximum Obligation

The total obligation for services provided during the term of this Agreement as stated herein below:

	Maximum Annual Obligation	
Funding	**Fiscal Year 2021/22**	**Fiscal Year 2022/23**
AB 109 Funding	$ 30,000	$ 30,000
SABG Discretionary Funding	$ 85,000	$ 85,000
SABG Perinatal Funding	$ 25,000	$ 25,000
Other (DMC w/FFP, Realignment, State General Fund)	$ 400,000	$ 400,000
Maximum Obligation:	**$ 540,000**	**$ 540,000**

ARTICLE VI – Federal Funding Notification

A. DUNS Number, and System for Award Management: As a government agency responsible for the administration of Federal funding, County has an obligation under Title 12, Subtitle A, Chapter 1 Part 180 of the Code of Federal Regulations to ensure those contractors receiving federal funds are not debarred or suspended. Therefore, Provider is required to obtain and maintain an active DUNS number, as well as an active registration in the System Award Management (SAM.gov). Noncompliance with these two requirements shall result in corrective action, up to and including termination pursuant to the provisions contained herein under **ARTICLE XVIII, Default, Termination, and Cancellation, or ARTICLE XV, Fiscal Considerations.**

1. Business entities may register for a DUNS number at https://www.dnb.com/duns-number/get-a-duns.html
2. The Provider must register the DUNS number and maintain an "Active" status within the federal System for Award Management available online at https://www.sam.gov/SAM/
3. If County cannot access or verify "Active" status the Provider's DUNS information, which is related to this federal subaward on the Federal Funding Accountability and Transparency Act Subaward Reporting System (SAM.gov) due to errors in the Provider's data entry for its DUNS number, the Provider must immediately update the information as required.

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

Federal Funding Subrecipient Information			
Provider:	**Volunteers of America Northern CA Northern Nevada**		**DUNS #: 166026653**
Award Term:	**Upon execution – June 30, 2023**		**EIN #: 94-6001984**
Total Federal Funds Obligated: Up to $1,080,000			
Federal Award Information			
CFDA Number	**Federal Award ID Number (FAIN)**	**Federal Award Date / Amount**	**Program Title**
93.778		06/01/2019	Drug Medi-Cal Organized Delivery System Services (DMC-ODS)
93.959		07/01/2021	Substance Abuse Prevention and Treatment Block Grant (SABG)

Federal Funding Subrecipient Information			
Provider:	**Volunteers of America Northern CA Northern Nevada**		**DUNS #: 166026653**
Award Term:	**Upon execution – June 30, 2023**		**EIN #: 94-6001984**
Total Federal Funds Obligated: Up to $1,080,000			
Federal Award Information			
CFDA Number	**Federal Award ID Number (FAIN)**	**Federal Award Date / Amount**	**Program Title**
Project Description:	Substance Use Disorder Treatment Services for referred clients by The County of El Dorado, Health and Human Services Agency.		
Awarding Agency:	California Department of Health Care Services		
Pass-through Entity	County of El Dorado, Health and Human Services Agency		
Indirect Cost Rate or de minimus	Indirect Cost Rate: _____		De minimus ☒
Yes ☐ No ☒	Award is for Research and development.		

ARTICLE VII – Cost Report

A. Provider shall submit a State DMC-ODS Cost Report to HHSA on or before September 15 for each year of this Agreement, covering all expenditures for services provided herein.

B. Provider shall prepare the Cost Report in accordance with all federal, state, and County requirements and generally accepted accounting principles (GAAP). Provider shall allocate direct and indirect costs to, and between, programs, cost centers, services, and funding sources in accordance with such requirements and consistent with prudent business practice. Such costs and allocations shall be supported by source documentation maintained by Provider and available at any time to Contract Administrator upon reasonable notice.

C. Provider shall document that costs are reasonable and allowable, and directly or indirectly related to the services provided hereunder. The Provider Cost Report shall be the final financial record of services rendered under this Agreement for subsequent audits, if any.

D. If the Provider Cost Report shows the actual and reimbursable cost of services provided pursuant to this Agreement is lower than the aggregate of monthly payments to Provider, Provider shall remit 90 percent of the difference to County. Such reimbursement shall be repaid by Provider to County in cash within forty-five (45) days of submission of the Provider Cost Report.

E. Initial Cost Report Settlement between Provider and County shall be based upon the actual and reimbursable costs for services hereunder. Provider shall not claim expenditures to County that are not reimbursable pursuant to applicable federal, state, and County laws, regulations, and requirements. Any payment made by County to Provider, which is subsequently determined to have been for a non-reimbursable expenditure or service, shall be repaid by Provider to County in cash within forty-five (45) days of submission of the Provider Cost Report or post payment settlement review.

F. When the State reconciliation of costs occurs, if the State settlement shows that the aggregate of monthly payments to Provider for covered services provided under this agreement exceeds Provider's allowable cost, in accordance with Title 22 CCR Section 51516.1, Provider shall remit the difference to County. Provider shall pay County the difference within forty-five (45) days after the date of settlement or the completion of an Appeal Process through County, whichever comes first. The amount due to County will be inclusive of any amount initially paid to County with the submission of the Cost Report. Amount due to County for the Fiscal Year will be finalized upon the State settlement of the Cost Report. If the State settlement identifies payment due to Provider, for costs reported in accordance with the terms and conditions of the contract in which State funding was received, funding will be passed to Provider through County after finalization of the settlement with the State. In the event of a State cost report audit and/or program audit, both Local Realignment Revenue and Federal Medicaid portions of all Provider disallowances shall be reimbursed to County within forty-five (45) days of the final audit report or of completion of an appeal process following receipt of a final Audit Report or the completion of an Appeal Process through County, whichever comes first. Any amounts due County that remain unpaid by the forty-five (45) days will be paid through a 50 percent offset of current invoices, that are pending payment to Provider, until paid in full.

G. In the event of an appeal from Provider to County, Provider shall, within thirty (30) days, submit the appeal in writing identifying the reason for the appeal, detailed account of discrepancies, and supporting documentation. County shall respond within thirty (30) days following receipt of a completed appeal. Final determination, if necessary, is dependent on the State.

ARTICLE VIII – Record Retention

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

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

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

ARTICLE IX – Health Information Portability and Accountability Act (HIPAA) and Confidentiality (42 CFR Section 438.224):

A. If any of the work performed under this Agreement is subject to the HIPAA, Provider shall perform the work in compliance with all applicable provisions of HIPAA. By signing this Agreement, Provider agrees to the terms and conditions of the HIPAA Business Associate Agreement, **attached hereto as Exhibit 14**, and incorporated by reference herein.

B. For medical records and any other health and enrollment information that identifies a particular beneficiary, the Provider shall use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and

164, subparts A and E and 42 CFR Part 2, to the extent that these requirements are applicable.

ARTICLE X – Taxes

Provider certifies that as of today's date, it is not in default on any unsecured property taxes or other taxes or fees owed by Provider to County. Provider agrees that it shall not default on any obligations to County during the term of this Agreement.

ARTICLE XI – 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.

ARTICLE XII – Provider to County

It is understood that the services provided under this Agreement shall be prepared in and with cooperation from County and its staff. It is further understood that this Agreement does not create an exclusive relationship between County and Provider, and Provider may perform similar work or services for others. However, Provider shall not enter into any agreement with any other party, or provide any information in any manner to any other party, that would conflict with Provider's responsibilities or hinder Provider's performance of services hereunder, unless County's Contract Administrator, in writing, authorizes that agreement or sharing of information.

ARTICLE XIII – 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.

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

ARTICLE XIV – Independent Contractor

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

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

Provider, 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 shall not make any agreements or representations on the County's behalf.

ARTICLE XV – Fiscal Considerations

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

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

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

ARTICLE XVI – Training for Provider

A. Monitoring Training: The County shall ensure that Provider receive training on the DMC-ODS requirements, at least annually.

ARTICLE XVII – Audits, Compliance, and Monitoring

A. Program Integrity Safeguards: Consistent with 42 CFR Section 438.66, the County shall monitor the Provider's compliance, as applicable, with 42 CFR Sections 438.604, 438.606, 438.608, 438.620, 438.230,438.808, 438.900 et seq

B. County is also required to monitor the Provider compliance pursuant to Agreement 18-95146, Exhibit A, Attachment I, Article III.AA.

1. Provider shall provide a copy of any Audit to County within thirty (30) days of completion of said audit, consistent with 45 CFR Subpart F, as applicable.
2. 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.

C. 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.

D. The State, CMS, the 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.

E. The State, CMS, the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Provider, that pertain to any aspect of services and activities performed, or determination of amounts payable under this Agreement at any time;

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 XVIII, 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. Health and Safety Code (HSC), Division 10.5, commencing with Section 11760
   ii. Title 9, Division 4, Chapter 8, commencing with Section 13000
   iii. Government Code Section 16367.8
   iv. Title 42, CFR, Sections 8.1 through 8.6
   v. Title 21, CFR, Sections 1301.01 through 1301.93, Department of Justice, Controlled Substances
   vi. State Administrative Manual (SAM), Chapter 7200 (General Outline of Procedures)

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

ARTICLE XVIII – Default, Termination, and Cancellation:

A. Default: Upon the occurrence of any default of the provisions of this Agreement, a party shall give written notice of said default to the party in default (notice). If the party in default does not cure the default within ten (10) days of the date of notice (time to cure), then such party shall be in default. The time to cure may be extended at the discretion of the party giving notice. 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 on which the extension of time to cure expires.

Notice given under this section shall specify the alleged default and the applicable Agreement provision and shall demand that the party in default perform the provisions of this Agreement within the applicable period of time. No such notice shall be deemed a termination of this Agreement unless the party giving notice so elects in this notice, or the party giving notice so elects in a subsequent written notice after the time to cure has expired. In the event of termination for default, County reserves the right to take over and complete the work by contract or by any other means.

Nullification of Agreement: The parties hereto agree that failure of the Provider, to comply with the terms and conditions of this Agreement and Welfare and Institutions Code Section 14124.24, available at https://leginfo.legislature.ca.gov/faces/codes_display

Text.xhtml?lawCode=WIC&division=9.&title=&part=3.&chapter=7.&article=1, shall be deemed a breach that results in the termination of this Agreement for cause.

B. Bankruptcy: This Agreement, at the option of the County, shall be terminable in the case of bankruptcy, voluntary or involuntary, or insolvency of Provider.

C. Ceasing Performance: County may terminate this Agreement 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 upon seven (7) calendar day written notice by County without cause. If such prior termination is effected, County will pay for satisfactory services rendered prior to the effective dates as set forth in the Notice of Termination provided to Provider, and for such other services, which County may agree to in writing as necessary for contract resolution. In no event, however, shall County be obligated to pay more than the total amount of the contract. 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.

ARTICLE XIX – Notice to Parties

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

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

or to such other location as the County directs.

with a copy to

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

Notices to Provider shall be addressed as follows:

VOLUNTEERS OF AMERICA NORTHERN CALIFORNIA NORTHERN NEVADA
3434 Marconi Avenue
Sacramento, CA 95821
ATTN: Chief Executive Officer
info@voa-ncnn.org

or to such other location as the Provider directs.

ARTICLE XX – 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 in this Agreement under **ARTICLE XIX, 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.

ARTICLE XXI – Indemnity

To the fullest extent permitted by law, Contractor 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 Contractor 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 Contractor to indemnify and save County harmless includes the duties to defend set forth in California Civil Code Section 2778.

ARTICLE XXII – Litigation

A. County, promptly after receiving notice thereof, shall notify the Contractor in writing of the commencement of any claim, suit, or action against the County or State of California or its officers or employees for which the Contractor must provide indemnification under this Agreement. The failure of the County to give such notice, information, authorization, or assistance shall not relieve the Contractor of its indemnification obligations.

B. Contractor, promptly after receiving notice thereof, shall immediately notify the County in writing of any claim or action against it which affects, or may affect, this Agreement, the terms and conditions hereunder, or the County or State of California, and shall take such action with respect to said claim or action which is consistent with the terms of this Agreement and the interest of the County and State.

ARTICLE XXIII – 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 Workers' Compensation and Employer's Liability Insurance covering all employees of Provider as required by law in the State of California.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE XXIV – Interest of Public Official

No official or employee of County who exercises any functions or responsibilities in review or approval of services to be provided by Provider under this Agreement shall participate in or attempt to influence any decision relating to this Agreement which affects personal interest or interest of any corporation, partnership, or association in which he/she is directly or indirectly interested; nor shall any such official or employee of County have any interest, direct or indirect, in this Agreement or the proceeds thereof.

ARTICLE XXV – Interest of Provider

Provider covenants that Provider presently has no personal interest or financial interest, and shall not acquire same in any manner or degree in either: 1) any other contract connected with or directly affected by the services to be performed by this Agreement; or, 2) any other entities connected with or directly affected by the services to be performed by this Agreement. Provider further covenants that in the performance of this Agreement no person having any such interest shall be employed by Provider.

ARTICLE XXVI – Conflict of Interest

The parties to this Agreement have read and are aware of the provisions of Government Code Section 1090 et seq. and Section 87100 relating to conflict of interest of public officers and employees. Provider attests that it has no current business or financial relationship with any County employee(s) that would constitute a conflict of interest with provision of services under this contract and will not enter into any such business or financial relationship with any such employee(s) during the term of this Agreement. County represents that it is unaware of any financial or economic interest of any public officer or employee of Provider relating to this Agreement. It is further understood and agreed that if such a financial interest does exist at the inception of this Agreement either party may immediately terminate this Agreement by giving written notice as detailed in **ARTICLE XVIII, Default, Termination and Cancellation.**

ARTICLE XXVII – Nondiscrimination:

A. 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.

B. 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 7285.0 et seq.); the applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 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.

C. 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.

D. 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 8103.

E. 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.

F. Contractor shall comply with **Exhibit 15**, "Vendor Assurance of Compliance with the County of El Dorado Health and Human Services Agency Nondiscrimination in State and Federally Assisted Programs," attached hereto, incorporated by reference herein, and thus made a part hereof. Contractor shall acknowledge compliance by signing and returning **Exhibit 15** upon request by County.

ARTICLE XXVIII – 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 will be required to submit a Form 590 prior to execution of an Agreement or County shall 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.

ARTICLE XXIX – Nonresident Withholding
If Provider is not a California resident, Provider shall provide documentation that the State of California has granted a withholding exemption or authorized reduced withholding prior to execution of this Agreement or County shall withhold seven (7%) percent of each payment made to the Provider during term of the Agreement as required by law. This requirement applies to any agreement/contract exceeding $1,500.00. Provider shall indemnify and hold the County harmless for any action taken by the California Franchise Tax Board.

ARTICLE XXX – County Payee Data Record Form
All independent Contractors 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.

ARTICLE XXXI – County Business License
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 Code Section 5.08.070.

ARTICLE XXXII – Licenses
Provider hereby represents and warrants that Provider and any of its employees under this Agreement has all the applicable licenses, permits, and certifications that are legally required for Provider and its employees to practice its profession or provide the services or work contemplated under this Agreement in the State of California. Provider shall obtain or maintain said applicable licenses, permits, or certificates in good standing throughout the term of this Agreement.

ARTICLE XXXIII – Administrator
The County Officer or employee with responsibility for administering this Agreement is Salina Drennan, Alcohol and Drug Programs Division Manager, or successor.

ARTICLE XXXIV – Authorized Signatures
The parties to this Agreement represent that the undersigned individuals executing this Agreement on their respective behalf are fully authorized to do so by law or other appropriate instrument and to bind upon said parties to the obligations set forth herein.

ARTICLE XXXV – Partial Liability
If any provision of this Agreement is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions will continue in full force and effect without being impaired or invalidated in any way.

ARTICLE XXXVI – California Forum and Law
Any dispute resolution action arising out of this Agreement, including, but not limited to, litigation, mediation, or arbitration, shall be brought in El Dorado County, California, and shall be resolved in accordance with the laws of the State of California.

ARTICLE XXXVII – No Third Party Beneficiaries
Nothing in this Agreement is intended, nor will be deemed, to confer rights or remedies upon any person or legal entity not a party to this agreement.

ARTICLE XXXVIII – Additional Terms and Conditions
Provider shall comply with all applicable provisions of the Agreement #18-95416 between the County and State of California Department of Health Care Services, which constitute part of this Agreement, available at https://www.edcgov.us/Government/hhsa/Pages/hhsa_contractor_resources.aspx. Noncompliance with the aforementioned agreement and its terms and conditions may result in termination of this Agreement by giving written notice as detailed in **ARTICLE XVIII, Default, Termination, and Cancellation.**

Additional terms and conditions include, but are not limited to the following:

A. Licenses: Provider shall comply with the following:
   1. Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8
   2. Title 22, Sections 51490.1(a)
   3. Agreement 18-95146, Exhibit A, Attachment I, Article III. – PP "Requirements for Services."
   4. Title 9, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq
   5. Title 22, Division 3, Chapter 3, sections 51000 et. seq

B. Hatch Act: Provider agrees to comply with the provisions of the Hatch Act (Title 5 USC, Sections 1501-1508), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.

C. No Unlawful Use or Unlawful Use Messages Regarding Drugs: Provider agrees that information produced through these funds, and which pertains to drug and alcohol related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug or alcohol related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (HSC Section 11999-11999.3). By signing this Agreement, Provider agrees that it shall enforce, these requirements.

D. Drug-Free Workplace: Provider agrees to maintain a drug-free workplace and remain in compliance with the Federal Drug-Free Workplace Act of 1988 (41 U.S.C. Chapter 10) and the California Drug-Free Workplace Act of 1990 (Government Code Section 8350 et seq.)

and any subsequent amendments to either Act thereto. A "drug free workplace" means the site(s) for the performance of work done by Provider at which Provider and employees of the Provider are prohibited from engaging in the unlawful manufacture, distribution, dispensing, possession, or use of any controlled substance. A list of controlled substances can be found in Schedules I through V of Section 202 of the Controlled Substances Act (21 U.S.C. 812) and as further defined in Regulation 21 CFR 1308.11 – 1308.15. Provider will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:

1. Publish a statement notifying employees that unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited and specifying actions to be taken against employees for violations.
2. Establish a Drug-Free Awareness Program to inform employees about:
    a. The dangers of drug abuse in the workplace;
    b. The person's or organization's policy of maintaining a drug-free workplace;
    c. Any available counseling, rehabilitation and employee assistance programs, and
    d. Penalties that may be imposed upon employees for drug abuse violations.
3. Every employee who works on the proposed Agreement will:
    a. Receive a copy of the company's drug-free workplace policy statement, and
    b. Agree to abide by the terms of the company's statement as a condition of employment on the Agreement.

Failure to comply with these requirements may result in suspension of payments under the Agreement or termination of the Agreement or both, and Provider may be ineligible for award of any future State agreements if the department determines that any of the following has occurred: the Provider has made false certification, or violated certification by failing to carry out the requirements as noted above (Government Code Section 8350 et seq.)

E. Recordkeeping Requirements:
    1. The Provider shall retain, , as applicable, the following information: beneficiary grievance and appeal records in 42 CFR §438.416, and the data, information, and documentation specified in 42 CFR §§438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.
    2. Provider shall ensure that all Provider sites shall keep a record of the beneficiaries/patients being treated at that location. Provider shall retain beneficiary records for a minimum of 10 years, in accordance with 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.

F. Limitation on Use of Funds for Promotion of Legalization of Controlled Substances: None of the funds made available through this Agreement may be used for any activity that promotes the legalization of any drug or other substance included in Schedule I of Section 202 of the Controlled Substances Act (21 USC 812).

G. Federal Law Requirements:

1. Title VI of the Civil Rights Act of 1964, Section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in federally funded programs.
2. Title IX of the education amendments of 1972 (regarding education and programs and activities), if applicable. iii. Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.
3. Age Discrimination Act of 1975 (45 CFR Part 90), as amended (42 USC Sections 6101 – 6107), which prohibits discrimination on the basis of age.
4. Age Discrimination in Employment Act (29 CFR Part 1625).
5. Title I of the Americans with Disabilities Act (29 CFR Part 1630) prohibiting discrimination against the disabled in employment.
6. Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities.
7. Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.
8. Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.
9. Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than $10,000 funded by federal financial assistance.
10. Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency. xii. The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.
11. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism.

H. State Law Requirements:
1. Fair Employment and Housing Act (Government Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (California Administrative Code, Title 2, Section 7285.0 et seq.).
2. Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135.
3. Title 9, Division 4, Chapter 8, commencing with Section 10800.
4. No state or Federal funds shall be used by the Provider, for sectarian worship, instruction, and/or proselytization. No state funds shall be used by the Provider to provide direct, immediate, or substantial support to any religious activity.
5. Noncompliance with the requirements of nondiscrimination in services shall constitute grounds for state to withhold payments under this Agreement or terminate all, or any type, of funding provided hereunder.

I. Trading Partner Requirements:
1. No Changes. Provider hereby agrees that for the personal health information (Information), it shall not change any definition, data condition or use of a data element or segment as proscribed in the federal HHS Transaction Standard Regulation. (45 CFR Part 162.915 (a))
2. No Additions. Provider hereby agrees that for the Information, it shall not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation. (45 CFR Part 162.915 (b))

3. No Unauthorized Uses. Provider hereby agrees that for the Information, it shall not use any code or data elements that either are marked "not used" in the HHS Transaction's Implementation specification or are not in the HHS Transaction Standard's implementation specifications. (45 CFR Part 162.915 (c))
4. No Changes to Meaning or Intent. Provider hereby agrees that for the Information, it shall not change the meaning or intent of any of the HHS Transaction Standard's implementation specification. (45 CFR Part 162.915 (d))

J. Confidentiality (42 CFR §438.224): For medical records and any other health and enrollment information that identifies a particular beneficiary, the Provider shall use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E and 42 CFR Part 2, to the extent that these requirements are applicable.

K. Trafficking Victims Protection Act of 2000: Provider shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(g)) as amended by section 1702.

L. National Labor Relations Board Certification: Provider certifies that no more than one (1) final un-appealable finding of contempt of court by a Federal court has been issued against Provider within the immediately preceding two-year period because of Provider's failure to comply with an order of a Federal court, which orders Provider to comply with an order of the National Labor Relations Board (Public Contract Code Section 10296).

M. Domestic Partners: For contracts of $100,000 or more, Provider certifies that Provider is in compliance with Public Contract Code Section 10295.3.

N. Gender Identity: For contracts of $100,000 or more, Provider certifies that Provider is in compliance with Public Contract Code Section 10295.35.

O. Americans with Disabilities Act: Provider assures that it complies with the Americans with Disability Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA (42 U.S.C. 12101 et seq).

P. Prohibited Affiliations (42 CFR Section 438.610): The Provider shall not knowingly have a relationship of the type described in paragraph (iii) of this subsection with the following:
1. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
2. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in paragraph (a)(1) of this section.
    a. The Provider shall not have a relationship with an individual or entity that is excluded from participation in any Federal Health Care Program under section 1128 or 1128A of the Act.
    b. The relationships described in paragraph (i) of this section, are as follows:
        i. A director, officer, or partner of the Provider.
        ii. A subcontractor (Provider) of the County, as governed by 42 CFR §438.230.
        iii. A person with beneficial ownership of five percent or more of the Provider's equity.
        iv. A network provider or person with an employment, consulting, or other arrangement with the Provider for the provision of items and

services that are significant and material to the Provider's obligations under this Agreement.

Q. Sobky v. Smoley – Service Requirements: Provider, to the extent applicable, shall comply with "Sobky v. Smoley" (Document 2A), 855 F. Supp. 1123 (E.D. Cal 1994), incorporated by this reference.

ARTILCE XXXIX – Counterparts

This Agreement may be executed in any number of counterparts and by the parties hereto in separate counterparts, each of which when so executed shall be deemed to be an original and all of which taken together shall constitute one and the same agreement.

ARTICLE XL – 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: Salina Drennan (Sep 30, 2021 10:56 PDT) Dated: 09/30/2021

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

Requesting Department Head Concurrence:

By: Don Semon (Sep 30, 2021 10:58 PDT) Dated: 09/30/2021

Donald Semon, Director
Health and Human Services Agency

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

-- COUNTY OF EL DORADO --

Dated: 10-26-21

By: _____
John Hidahl, Chair
Board of Supervisors
"County"

ATTEST:
Kim Dawson
Clerk of the Board of Supervisors

By: _____ Dated: 10-26-21
Deputy Clerk

-- PROVIDER --

VOLUNTEERS OF AMERICA NORTHERN CALIFORNIA NORTHERN NEVADA
(A California Domestic Non-Profit)

By: _____ Dated: 10/14/2021
Leo McFarland (Oct 14, 2021 15:32 PDT)
Leo McFarland
Chief Executive Officer
"Provider"

By: _____ Dated: 10/14/2021
Joel Rusco (Oct 14, 2021 15:26 PDT)
Joel Rusco
Chief Financial Officer
"Provider"

lkk

CASE MANAGEMENT SERVICES

Authorization Information:

1. Case management services are available to EDC beneficiaries during their treatment episode without prior authorization as follows:
    a. Outpatient Services – Up to 10 hours per treatment episode
    b. Intensive Outpatient Services – Up to 10 hours per treatment episode
    c. Residential Treatment Services – Up to 5 hours per treatment episode
    d. Residential Withdrawal Management (Level 3.2) – Up to 3 hours per treatment episode
    e. OTP/NTP Services – Up to 3 hours per treatment episode
    f. Additional hours may be requested by contacting the county at: sudsqualityassurance@edcgov.us

1. **Licensing and Certification Requirement:**
    a. Provider shall have and maintain a license to operate, Drug Medi-Cal (DMC) certification and a Level of Care Designation with DHCS.

2. **Case Management Services**
    a. Case management services are defined as a service that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.
    b. The Provider shall ensure that case management services focus on coordination of SUD care, integration around primary care especially for beneficiaries with a chronic substance use disorder, and interaction with the criminal justice system, if needed.
    c. Case management services may be provided by an LPHA or a registered or a registered or certified counselor.
    d. Case management services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.

3. **In addition to the general outpatient services requirements outlined above the Provider shall comply with the following County specific outpatient services requirements:**
    a. Case management services are provided based on the frequency documented in the individualized treatment plan.
    b. As documented on the treatment plan, case management provides advocacy and care coordination to physical health, mental health, transportation, housing, vocational, educational, and transition services for reintegration into the community.
    c. Case management activities and services shall be provided by a registered or certified counselor or LPHA.
    d. Case management shall be consistent with and shall not violate confidentiality of alcohol and drug patients as set forth in 42 CFR Part 2, and California law.

ADULTS – LEVEL 3.2 WM CLINICALLY MANAGED RESIDENTIAL WITHDRAWAL MANAGEMENT

1) The facility shall be licensed and certified by the Department of Health Care Services to provide Drug Medi-cal Services Level 3.2 Clinically Managed Residential Withdrawal Management (WM)
2) Clinically Managed Residential Withdrawal Management services are provided when determined medically necessary by a Medical Director or Licensed Practitioner of the Healing Arts (LPHA), and in accordance with an individualized client plan.
3) Each beneficiary shall reside at the facility if receiving a residential service and will be monitored during the detoxification process.
4) Medically necessary habilitative and rehabilitative services are provided in accordance with the individualized treatment plan prescribed by a licensed physician or licensed prescriber, and approved and authorized according to the state of California requirements.
5) The components of Withdrawal Management services include:
   a. Intake: The process of admitting a beneficiary into a substance use disorder (SUD) treatment program. Intake includes the evaluation or analysis of SUD, the diagnosis of SUD, the assessment of treatment needs, and may include a physical examination and laboratory testing necessary for SUD treatment.
   b. Observation: The process of monitoring the beneficiary's course of withdrawal as frequently as deemed appropriate for the beneficiary. This may include, but is not limited to, observation of the beneficiary's health status.
   c. Medication Services: The prescription or administration related to SUD treatment services, and/or the assessment of the side effects and results of that medication.
   d. Discharge Services: Preparing the beneficiary for referral into another level of care, post treatment return, re-entry into the community, and/or the linkage of the individual to community treatment, housing, and human services
6) Provider shall adhere to the El Dorado County DMC-ODS Practice Guidelines.

ADULT LEVEL 3.1 – CLINICALLY MANAGED LOW-INTENSITY RESIDENTIAL SERVICES (PERINATAL AND NON PERINATAL)

1) Residential services are provided in DHCS licensed residential facilities that also have DMC certification and have a DHCS Level of Care Designation as a Level 3.1 Residential Treatment Provider.
2) Perinatal residential service providers must have approval from the Department of Health Care Services to provide perinatal services.
3) Residential treatment is a non-institutional, 24-hour, short-term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis when determined by a Medical Director or Licensed Practitioner of the Healing Arts as medically necessary and in accordance with the individual treatment plan.
4) Residential Treatment Services means a non-institutional, 24- hour non-medical, short-term residential program of any size that provides rehabilitation services to beneficiaries. Each beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills, and access community support systems. Programs shall provide a range of activities and services.
5) Residential treatment shall include 24-hour structure with available trained personnel, seven days a week, including a minimum of 20 hours of clinical service a week to prepare beneficiaries for outpatient treatment.
6) Medical necessity for beneficiaries presenting for residential treatment shall be determined by either a Medical Director or an LPHA.
7) The components of Residential Treatment Services include:
    a. Intake: The process of determining that a beneficiary meets the medical necessity criteria and admitting the beneficiary into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
    b. Individual and Group Counseling: Contacts between a beneficiary and a therapist or counselor. Services are provided in-person or by telephone qualify as Medi-Cal reimbursable units of service, and are reimbursed without distinction.
    c. Patient Education: Provide research-based education on addiction, treatment, recovery, and associated health risks
    d. Family Therapy: The effects of addiction are far-reaching and the patient's family members and loved ones also are affected by the disorder. By including family members in the treatment process, education about factors that are important to the patient's recovery, as well as their own recovery, can be conveyed. Family members can provide social support to the patient, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.
    e. Safeguarding Medications: Facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.
    f. Collateral Services: Sessions with therapists or counselors and significant persons in the life of the beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.

g. Crisis Intervention Services: Contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the beneficiary's emergency situation.
h. Treatment Planning: The provider shall prepare an individualized written treatment plan, based upon information obtained in the intake and assessment process. The treatment plan will be completed within regulatory timeframes, reviewed every 30 days, and then updated every 90 days unless there is a change in treatment modality or significant event that would then require a new treatment plan.
i. Transportation Services: Provision of or arrangement for transportation to and from medically necessary treatment.
j. Discharge Services: The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

8) A client's length of stay for residential treatment services shall be determined by a Licensed Practitioner of the Healing Arts (LPHA) based on medical necessity. In accordance with CMS State Medicaid Director Letter #17-0003, the statewide goal for the average length of stay for residential treatment services provided by participating counties is 30 days or less. In furtherance of that goal, counties shall adhere to the length of stay monitoring requirements set forth by DHCS.
9) Perinatal beneficiaries shall receive a length of stay for the duration of their pregnancy, plus 60 days postpartum.
    a. Services must be determined to be medically necessary.
10) Provider shall adhere to the most recent version of the Perinatal Practice Guidelines
11) Provider shall adhere to the El Dorado County DMC-ODS Practice Guidelines.

EL DORADO COUNTY
HEALTH AND HUMAN SERVICES AGENCY

EXHIBIT 12

SUBSTANCE USE DISORDER SERVICES DMC-ODS
NETWORK PROVIDER PERFORMANCE STANDARDS AND MEASURES

	OP/IOT	Residential	WM 3.2	Case Management	Recovery Services
Access to Care Timely access data—including date of initial contact, date of first offered appointment and date of scheduled assessment—shall be documented within seven (7) days of the intake provided to County on a monthly basis and upon request.					
First face-to-face appointment shall occur within five (5) and no later than 10 business days of initial contact.	X	X	X	X	X
Timely access data will be documented within seven (7) days of first contact for 100% of beneficiaries.	X	X	X	X	X
At least 75% of beneficiaries completing the Treatment Perceptions Survey reported being satisfied (3.5 out of 5.0) with the location and time of services	X	X	X		
Transitions Between Levels of Care Appropriate Case managers/clinicians from both the discharging and admitting provider agencies shall be responsible to facilitate the transition between levels of care, including assisting in scheduling an intake appointment, ensuring a minimal delay between discharge and admission at the next level of care, providing transportation as needed, and documenting all information in client file.					
Transitions between levels of care shall occur within five (5) and no later than 10 business days from the time of re-assessment indicating the need for a different level of care.	X	X	X	X	X
Care Coordination and Linkage with Ancillary Services The Provider shall ensure 42 CFR Part 2 compliant releases are in place in order to coordinate care. The Provider shall screen for and link clients with mental and physical health, as indicated.					
There is documentation of physical health and mental health screening in 100% of beneficiary records	X	X	X	X	X
At least 80% of beneficiaries have 42 CFR compliant releases in place to coordinate care with physical health providers	X	X	X	X	X

At least 70% of beneficiary records have documentation of coordination with physical health	X	X	X	X	X
At least 80% of beneficiaries engaged for at least 30 days will have an assigned Primary Care Provider	X	X	X	X	X
At least 80% of beneficiaries who screen positive for mental health disorders have 42 CFR compliant releases in place to coordinate care with mental health providers	X	X	X	X	X
At least 70% of beneficiary records for individuals who screen positive for mental health disorders have documentation of coordination with mental health (e.g. referral for mental health assessment or consultation with existing providers).	X	X	X	X	X
Medication Assisted Treatment Providers will have procedures for linkage/integration for beneficiaries requiring medication assisted treatment for substance use disorders. Provider staff will regularly communicate with physicians of beneficiaries who are prescribed these medications unless the beneficiary refuses to consent a 42 CFR, Part 2 compliant release of information for this purpose.					
At least 80% of beneficiary records for individuals receiving Medication Assisted Treatment for substance use disorders will have 42 CFR compliant releases in place to coordinate care.	X	X	X	X	X
At least 80% of beneficiaries with a primary opioid or alcohol use disorder will be linked to an MAT assessment and/or MAT services.	X	X	X	X	X
Culturally Competent Services Contractors are responsible to provide culturally competent services. Contractors must ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to- day operations. Translation and oral interpreter services must be available for beneficiaries, as needed and at no cost to the beneficiary.					
100% of beneficiaries that speak a threshold language are provided services in their preferred language.	X	X	X	X	X
At least 80% of beneficiaries completing the Treatment Perceptions Survey reported being satisfied (3.5+ out of 5.0) with cultural sensitivity of services.	X	X	X	X	X

Delivery of Individualized and Quality Care Evidence-Based Practices (EBPs): Contractors will implement—and assess fidelity to—at the least two of the following EBPs per service modality: Motivational Interviewing, Cognitive-Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment and Psycho-Education.					
Contractor will implement with fidelity at least two approved EBPs.	X	X	X	X	X
Delivery of Individualized and Quality Care Beneficiary Satisfaction: DMC-ODS Providers (serving adults 18+) shall participate in the annual statewide Treatment Perceptions Survey (administration period to be determined by DHCS).					
At least 80% of beneficiaries will report an overall satisfaction score of at least 3.5 or higher on the Treatment Perceptions Survey	X	X	X		
At least 80% of beneficiaries completing the Treatment Perceptions Survey reported that they were involved in choosing their own treatment goals (overall score of 3.5+ out of 5.0);	X	X	X		
Delivery of Individualized and Quality Care ASAM Level of Care: All beneficiaries participate in an assessment using ASAM dimensions. The assessed and actual level of care (and justification if the levels differ) shall be recorded in the ASAM Level of Care report within seven (7) days of the assessment.					
100% of beneficiaries participated in an assessment using ASAM dimensions and are provided with a recommendation regarding ASAM level of care.	X	X	X	X	X
100% of beneficiaries are re-assessed within 90 days of the initial assessment.	X	X	X	X	X
At least 70% of beneficiaries admitted to treatment do so at the ASAM level of care recommended by their ASAM assessment	X	X	X		

Exhibit 13

Sliding Fee Schedule

Based on Federal Poverty Monthly Income Levels (2021)

	Percent of FPL (Federal Poverty Level)							
	100%	150%	200%	250%	300%	350%	400%	500%
Per Service - Client Share of Charges / Flat Fee:	$10 Flat Fee	30%	40%	50%	60%	70%	80%	90%

Family Size	Annual 2019 FPL	Monthly Income (Income is Equal to or Less Than)							
1	$ 12,880	$ 1,073	$ 1,611	$ 2,147	$ 2,684	$ 3,221	$ 3,757	$ 4,295	$ 5,368
2	$ 17,420	$ 1,452	$ 2,178	$ 2,903	$ 3,630	$ 4,356	$ 5,081	$ 5,809	$ 7,259
3	$ 21,960	$ 1,830	$ 2,745	$ 3,660	$ 4,576	$ 5,491	$ 6,405	$ 7,322	$ 9,151
4	$ 26,500	$ 2,208	$ 3,313	$ 4,417	$ 5,522	$ 6,626	$ 7,729	$ 8,835	$ 11,043
5	$ 31,040	$ 2,587	$ 3,880	$ 5,173	$ 6,468	$ 7,761	$ 9,053	$ 10,349	$ 12,934
6	$ 35,580	$ 2,965	$ 4,448	$ 5,930	$ 7,414	$ 8,896	$ 10,378	$ 11,862	$ 14,826
7	$ 40,120	$ 3,343	$ 5,016	$ 6,687	$ 8,359	$ 10,031	$ 11,702	$ 13,375	$ 16,718
8	$ 44,600	$ 3,717	$ 5,576	$ 7,433	$ 9,293	$ 11,151	$ 13,008	$ 14,869	$ 18,584
9	$ 49,140	$ 4,095	$ 6,144	$ 8,190	$ 10,239	$ 12,286	$ 14,333	$ 16,381	$ 20,476
10	$ 53,680	$ 4,473	$ 6,711	$ 8,947	$ 11,184	$ 13,421	$ 15,657	$ 17,894	$ 22,368

Source: https://aspe.hhs.gov/poverty-guidelines

Drug Medi-Cal: Except where share of cost is applicable, providers shall accept proof of eligibility for Drug Medi-Cal as payment in full for treatment services rendered. Providers shall not charge fees to beneficiaries for access to Drug Medi-Cal substance use disorder treatment services or for admission to a Drug Medi-Cal treatment slot.

#5781

EXHIBIT 14
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").

RECITALS

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

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; and

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 ; and

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; and

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:

1. 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.

2. 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:

(i) 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,

(ii) the third party will immediately notify BA of any breaches of confidentiality of PHI to 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.

3. 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 45 CFR 164.308,164.310,164.312, and 164.504(e)(2). BA shall comply with the policies and 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.

4. 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 know, 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.

5. 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.

6. 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.

7. 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.

8. 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.

9. Survival The respective rights and obligations of this Business Associate Agreement shall survive the termination or expiration of this Business Associate Agreement.

10 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.

11. 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.

EXHIBIT 15
"VENDOR ASSURANCE OF COMPLIANCE WITH THE COUNTY OF EL DORADO HEALTH AND HUMAN SERVICES AGENCY NONDISCRIMINATION IN STATE AND FEDERALLY ASSISTED PROGRAMS"

NAME OF VENDOR/RECIPIENT: Volunteers of America Northern California Northern Nevada, Inc.

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

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

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

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

10/14/2021
Date

Leo McFarland (Oct 14, 2021 15:32 PDT)
Signature

3434 Marconi Avenue, Sacramento, CA 95821
Address of vendor/recipient

(08/13/01)