AGREEMENT FOR SERVICES #XXXX
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 _____, a _____, duly qualified to conduct business in the State of California, whose principal place of business is _____, and whose Agent for Service of Process is Company name, physical address, (hereinafter referred to as "Provider");

RECITALS

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

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

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

WHEREAS, Provider has represented to County that it is specially trained, experienced, expert, and competent to perform the special services described in ARTICLE III, Scope of 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;

WHEREAS, the parties hereto have mutually agreed that upon execution of this Agreement for Services #XXXX, the existing Agreement for Services #XXXX and all amendments thereto shall automatically terminate the day prior to the final execution date of this Agreement, and Agreement #XXXX shall supersede the Agreement #XXXX in its entirety;

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

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

ARTICLE I
Definitions: For the purposes of this Agreement, the following terms are defined:

A. Behavioral Health Information Notice (BHIN): "Behavioral Health Information Notice" or "BHIN" means guidance from DHCS to inform counties and Providers of changes in policy or procedures at the federal or state levels. These were previously referred to as a Mental Health

and Substance Use Disorder Services Information Notice (MHSUDS IN). BHINs and MHSUDS INs are available on the DHCS website.

B. Beneficiary Or Client: "Beneficiary" or "client" means the individual(s) receiving services.
C. DHCS: "DHCS" means the California Department of Health Care Services.
D. Director: "Director" means the Director of the County Behavioral Health Department, unless otherwise specified.

ARTICLE II

Term: This Agreement shall become effective upon final execution by both parties hereto and shall cover the period Month DD, Year through Month DD, Year. The parties shall have the option to extend the term for an additional one (1) year term after the initial expiration date through Month DD, Year. The option to extend shall be subject to County Contract Administrator and Provider approval**.** Upon mutual parties' approval to extend the Agreement, the extension notice will be shared by County to Provider in accordance with the Article titled "Notice to Parties."

ARTICLE III

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

ARTICLE IV

Compensation For Services: For services provided herein, Provider shall submit invoices for services thirty (30) days following the end of a "service month." For billing purposes, a "service month" shall be defined as a calendar month during which Provider provides services in accordance with ARTICLE III marked "Scope of Services." For all satisfactory services provided herein, County agrees to pay Provider monthly in arrears and within forty-five (45) days following the County's receipt and approval of itemized invoice(s) identifying services rendered. County may withhold or delay any payment if Provider fails to comply with any provision of this Agreement.

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

   Rate change requests are subject to written approval by the County Contract Administrator or designee. Provider shall submit rate change requests in writing to County at least thirty (30) days in advance of a rate change request to include the reason for the change which may include:
   1. Increases to Provider's cost of doing business (no more than once per twelve **(**12**)** months);
   2. Rate changes due to state or federal rate changes or billing methodology;
   3. Changes to staffing levels;
   4. Changes to billing units or budget modifications; or
   5. Other reason which is substantiated by County staff based on the Provider justification provided.

   County acceptance or denial of rate changes will be submitted to Provider via written notice in accordance with the Article titled "Notice to Parties." In no event shall the maximum obligation of the Agreement be exceeded.

B. **Invoices**: It is a requirement of this Agreement that Provider shall submit an original invoice, similar in content and format with the Health and Human Services Agency (HHSA) invoice template linked online at https://ElDoradoCounty.ca.gov/HHSA-Provider-Resources, and shall reference this Agreement number on their invoice coversheet and on any enclosures or backup documentation. Copies of Authorizations and back-up documentation must be attached to invoices shall reflect Provider's charges for the specific services billed on those invoices.

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

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

or to such other location as County directs.

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

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

   The Excel data file shall include the following information:
   a. First Name
   b. Last Name
   c. Client Address
   d. Date of Birth
   e. CIN #
   f. Diagnosis
   g. Admission Date
   h. Date of Service
   i. Practitioner Name
   j. Units/Duration
   k. Billed Amount

2. 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.
3. 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:
   a. County Issued Agreement Number
   b. Provider Name & Address

c. Service Month
d. Invoice Total
e. Service Totals (Units & Cost total per service code)
f. Provider Contact Information
g. Written Treatment Authorization (if applicable)

4. Supplemental Invoices: For the purpose of this Agreement, supplemental invoices shall be defined as invoices submitted for additional services rendered during a month for which a prior invoice has already been submitted to County. Supplemental Invoices shall follow the two-step process as defined herein above. Supplemental invoices should include the standard invoice format with description of services rendered and a detailed explanation why the invoice was not submitted in the approved timeframe. Written treatment authorization shall be submitted with invoices.
    a. For those situations where a service is disallowed by HHSA on an invoice, or inadvertently not submitted on an invoice, and a corrected invoice is later submitted ("Supplemental Invoice"), the County will not accept nor pay any Supplemental Invoices for services provided during the period July 1st through June 30th for each fiscal year of this Agreement that are received by HHSA after July 31 of the subsequent fiscal year unless Contractor requests an exception. 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 or designee in his/her sole discretion.
5. Monthly payments for claimed services shall be based on the units of time assigned to each Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code entered in the County's billing and transactional database multiplied by the rates included in Exhibit B.
6. In the event that Provider fails to deliver the services, documents or other deliverables required herein, County at its sole option may delay the monthly payment for the period of time of the delay, cease all payments until such time as the deliverables are received, or proceed as set forth herein below in the Article titled "Default, Termination, and Cancellation."
7. Denied Invoices: DMC-ODS payments shall be made in the amount of the Provider's total claim, minus the amount of denied services. County will submit to Provider the amount of denials received for the prior months' services, as identified on documents received from the State. Provider shall make adjustment for denials on Provider's next submitted invoice.

In Article V below, (Non-applicable funding may be removed per provider specifications in final contract.)

ARTICLE V

Funding Categories: Funding sources include but may not be limited to DMC-ODS, Federal Financial Participation (FFP) or federal match on DMC-ODS, Opioid Settlement Funds, Realignment funds, Substance Use Prevention and Treatment Block Grant (SUBG) Discretionary, and SUBG - Adolescent and Youth Treatment. These mentioned funding sources are defined as follows:

A. Opioid Settlement Funds (OSF): County was provided OSF monies distributed to local jurisdictions through BrownGreer PLC with the California Department of Health Care Services (DHCS) acting as the oversight and monitoring agency pursuant to the California State Subdivision Agreements and Government Code, Title 2, Division 3, Part 2, Chapter 6, Article 2,

Section 12534. OSF are utilized towards certain specified allowable expenses to mitigate the effects of substance abuse within the community, including opioid remediation activities such as activities tied to the ending, reduction or lessening the effects of the opioid epidemic in communities and include prevention, intervention, harm reduction, treatment, and recovery services. Following authorization from County's Health and Human Services Agency (HHSA) for these services, Provider shall provide the requested Opioid Treatment Services to County clients.

B. State General Fund and 2011 Realignment DMC-ODS: Provider acknowledges that this Agreement meets the requirements for the distribution of DMC-ODS funding in the County's Intergovernmental Agreement (IA) 25-50096 (County Agreement 9726), or as amended or replaced, available online under the category labeled Behavioral Health Funding and/or Governing Agreements at: https://www.eldoradocounty.ca.gov/Health-Well-Being/Health-and-Human-Services/HHSA-Provider-Resources. Provider agrees to provide DMC-ODS services in conformance with applicable provisions set forth in County's IA 25-50096, as amended or replaced.
   1. Local Realignment Revenues This funds Drug Medi-Cal (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.
   2. Federal Financial Participation (FFP) or Federal match on DMC-ODS: This funding is the federal share of the DMC Program.
   3. Drug Medi-Cal (DMC) Eligibility Accepted as Payment in Full: 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 except where a share of cost is required, as defined in WIC 14005.12.

C. Substance Use Block Grant (SUBG): *County written authorization for SUBG funded services is required. If applicable, County HHSA SUD staff will email said pre-authorization to the Provider*. 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 Use Block Grant (SUBG): These are federal funds which are to be used for specific services as follows:
   1. SUBG 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. SUBG Federal Block Grant Adolescent and Youth Treatment Programs: These funds are for substance abuse services to youth aged 12 through 17 years (inclusive), as described in the Alcohol and Drug Program Youth Treatment Guidelines (2002).
   3. For services provided under SUBG, 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.

D. 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.

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

F. Written Authorization for Services: The following services may only be provided if County HHSA SUDS staff refers a client to Provider via a written treatment authorization form pre-authorizing said services. If applicable, this written treatment authorization will be emailed to the Provider. Provider shall submit written treatment authorization along with the invoice when seeking reimbursement of these services:
(Non-applicable services may be removed per provider specifications in final contract)
   1. Substance Use Block Grant (SUBG) Services; and
   2. Opioid Treatment Services.

ARTICLE VI

Maximum Obligation: The maximum obligation for services and deliverables provided under this Agreement shall not exceed $XXX,XXX. In the event that the term of this Agreement is extended in accordance with ARTICLE II Term, the maximum obligation shall be $XXX,XXX.

Service Categories	**Not-To-Exceed Amounts Per Fiscal Year (FY)**			
	FY 25-26	**FY 26-27**	**FY 27-28**	**Total Not-To-Exceed**
Totals				

A. The above table represents the composition of the total not-to-exceed budget for this Agreement. In the performance of the scope of services to be provided in accordance with this budget, subject to written Contract Administrator, or designee and Chief Fiscal Officer, or designee approval, County may reallocate the funding listed herein among service types and fiscal years, based on funding availability.

B. This Agreement shall be subject to any restrictions, limitations, and/or conditions imposed by County or state or federal funding sources that may in any way affect the fiscal provisions of, or funding for this Agreement. This Agreement is also contingent upon sufficient funds being made available by County, state, or federal funding sources for the term of the Agreement. If the federal or state governments reduce financial participation in the Medi-Cal program, County agrees to meet with Provider to discuss renegotiating the services required by this Agreement.

C. In no event shall the total maximum contractual obligation of the Agreement be exceeded. Provider is responsible for managing their Maximum Annual Contractual Obligation and Provider holds the County harmless for any over-spending of the Maximum Annual Contractual Obligation by Service Category.

ARTICLE VII

Federal Funding Notification: An award/subaward or contract associated with a covered transaction may not be made to a subrecipient or provider who has been identified as suspended or debarred from

receiving federal funds. Additionally, counties must annually verify that the subrecipient and/or provider remains in good standing with the federal government throughout the life of the agreement/contract.

Loss of Federal Authority**:** Should any part of the scope of work under this Agreement relate to a state program receiving Federal Financial Participation (FFP) that is no longer authorized by law (e.g. which has been vacated by a court of law, or for which is the subject of a legislative repeal), Provider must do no work on that part after the effective date of the loss of such program authority. County will adjust payments that are specific to any scope of work receiving FFP that is no longer authorized by law. If Provider works on any scope of work receiving FFP that is no longer authorized by law after the date the legal authority for the work ends, Provider will not be paid for that work.

Provider agrees to comply with federal procedures in accordance with 2 C.F.R. Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

Any costs for which payment has been made to Provider that are determined by subsequent audit to be unallowable under 48 CFR Part 31 or 2 CFR Part 200 are subject to repayment by Provider to County.

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

A. System for Award Management: Provider is required to obtain and maintain an active Universal Entity Identifier (UEI) No. in the System for Award Management (SAM) system at https://sam.gov/content/home. Noncompliance with this requirement shall result in corrective action, up to and including termination pursuant to the provisions contained herein this Agreement under the Article titled "Default, Termination, and Cancellation".
B. Catalog of Federal Domestic Assistance: Pursuant to the Office of Management and Budget (OMB) Uniform Grants Guidance, all recipients and sub-recipients of federal funds must be provided the Assistance Listing Numbers (ALN) number at the time the contract is awarded. The following are ALN numbers, award specific information, and program titles for programs administered by the County on behalf of California Department of Health Care Services that may apply to this contract:

Federal Funding Information			
Provider:			UEI #:
Award Term:			EIN #:
Total Federal Funds Obligated: $			
Federal Award Information (Non-applicable services may be removed per provider specifications in final contract)			
ALN Number	Federal Award Date / Amount	Program Title	
93.778	7/1/25	Drug Medi-Cal Organized Delivery System Services (DMC-ODS)	
93.959	07/01/2025	Substance Use Block Grant (SUBG)	
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 VIII

Record Retention: Provider shall comply with the following record retention requirements:

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

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

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

Notices to County shall be addressed as follows:

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

with a copy to:

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

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

Notices to Provider shall be addressed as follows:
(COMPANY NAME)
(Address)
(City, State, Zip)
ATTN: (Name), (Title)
vendoremail@vendor.com

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

ARTICLE X

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

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

ARTICLE XI

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

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

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

Provider shall be solely responsible for paying its employees, and for withholding Federal Income Contribution Act amounts and other taxes, workers' compensation, unemployment compensation, medical insurance, life insurance, or any other benefit that Provider provides for its employees.
Provider acknowledges that it has no authority to bind the County or incur any obligations on behalf of the County with regard to any matter, and Provider shall not make any agreements or representations on the County's behalf.

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

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

ARTICLE XIII
Subcontracts: Provider shall obtain prior written approval from the County Contract Administrator before subcontracting any of its obligations to provide services under this Agreement. Approval is at the discretion of the County Contract Administrator but shall not be unreasonably withheld. Provider shall ensure that all subcontracts are subject to the applicable terms and conditions of this Agreement, including, without limitation, the licensing, certification, privacy, data security and confidentiality requirements set forth herein, and include the applicable provisions of 42 Code of Federal Regulations (CFR) §438.230.

Provider shall remain legally responsible for the performance of all terms and conditions of this Agreement, including, without limitation, all SUD services provided by third parties under subcontracts, whether approved by the County or not.

ARTICLE XIV

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 XV

Default, Termination, and Cancellation:

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

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

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

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

The following will be events of default under this Agreement:

1. Failure by either party to perform in a timely and satisfactory manner any or all of its obligations under this Agreement.
2. A representation or warranty made by Provider in this Agreement proves to have been false or misleading in any respect.
3. Provider fails to observe and perform any covenant, condition or agreement on its part to be observed or performed under this Agreement, unless County agrees, in writing, to an extension of the time to perform before that time period expires.
4. A violation of the Article titled "Conflict of Interest."

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

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

D. Termination or Cancellation without Cause: County may terminate this Agreement, in whole or in part, for convenience upon thirty (30) calendar days' written Notice of Termination, in accordance with the Article titled "Notice to Parties." If such termination is effected, County will pay for satisfactory services rendered before the effective date of termination, as set forth in the Notice of Termination provided to Provider, and for any other services that County agrees, in writing, to be necessary for contract resolution. In no event, however, shall County be obligated to pay more than the total amount of the Agreement. Upon receipt of a Notice of Termination, Provider shall promptly discontinue all services affected, as of the effective date of termination set forth in such Notice of Termination, unless the Notice directs otherwise.
E. Funding Unavailable: County may terminate this Agreement immediately, without prior notice, at any time upon giving written notice to Provider that County has been notified the grant/allocation funds from the State of California, federal government, or other entity, or any portion thereof, for the purposes of carrying out this Agreement, are not available, to County, including if distribution of such funds are suspended or delayed.

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

ARTICLE XVII
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. Worker's Compensation insurance as require by the State of California, with Statutory Limits, and Employer's Liability Insurance with limit of no less than $1,000,000 per accident for bodily injury or disease.
B. Commercial General Liability Insurance (CGL): Insurance Services Office Form CG 00 01 covering CGL on an 'occurrence" basis including products and completed operations, property damage, bodily injury, and personal & advertising injury with limits no less than $2,000,000 per occurrence.
C. Automobile Liability: Is required in the event motor vehicles are used by the Provider in the performance of the Agreement. Coverage shall be on a form equivalent to Insurance Services Office Form Number CA 0001 covering all owned, non-owned and hired autos in an amount not less than $1,000,000.00
D. Professional Liability: Insurance appropriate to the Provider's profession, with limits no less than $2,000,000 per occurrence or claim, $2,000,000 aggregate.

If Provider maintains broader coverage and/or higher limits than the minimums shown above, County requires and shall be entitled to the broader coverage and/or the higher limits maintained

by the Provider. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to County.

The insurance policies are to contain, or be endorsed to contain, the following provisions:

A. Additional Insured Status: The County of El Dorado, its officers, officials, employees, and volunteers are to be covered as additional insureds on the CGL policy with respect to liability arising out of work or operations performed by or on behalf of the Provider. General liability coverage can be provided in the form of an endorsement to the Provider's insurance (at least as broad as ISO Form CG 20 10 11 85 or if not available, through the addition of both CG 20 10, CG 20 26, CG 20 33, or CG 20 38; and CG 20 37 if a later edition is used).
B. Primary Coverage: For any claims related to this contract, Provider's insurance coverage shall be primary and non-contributory and at least as broad as ISO CG 20 01 04 13 as respects the County of El Dorado, its officers, officials, employees, and volunteers. Any insurance or self-insurance maintained by County, its officers, officials, employees, or volunteers shall be excess of Provider's insurance and shall not contribute with it. This requirement shall also apply to any Excess or Umbrella liability policies.
C. Umbrella or Excess Policy: Provider may use Umbrella or Excess Policies to provide the liability limits as required in this Agreement. This form of insurance will be acceptable provided that all of Primary and Umbrella or Excess Policies shall provide all of the insurance coverages herein required, including, but not limited to, primary and non-contributory, additional insured, Self-Insured Retentions (SIRs), indemnity, and defense requirements. The Umbrella or Excess policies shall be provided on a true "following form" or broader coverage basis, with coverage at least as broad as provided on the underlying Commercial General Liability insurance. No insurance policies maintained by the Additional Insureds, whether primary or excess, and which also apply to a loss covered hereunder, shall be called upon to contribute to a loss until the Provider's primary and excess liability policies are exhausted.
D. Notice of Cancellation: Each insurance policy required above shall provide that coverage shall not be canceled, except with notice to County.
E. Waiver of Subrogation: Provider hereby grants to the County of El Dorado a waiver of any right to subrogation which any insurer of said Provider may acquire against the County by virtue of the payment of any loss under such insurance. Provider agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not County has received a waiver of subrogation endorsement from the insurer.
F. Self-Insured Retentions: Self-insured retentions must be declared to and approved by County. County may require the Provider to provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention. The policy language shall provide, or be endorsed to provide, that the self-insured retention may be satisfied by either the named insured or County. The CGL and any policies, including Excess liability policies, may not be subject to a self-insured retention (SIR) or deductible that exceeds $25,000 without prior approval from County. Any and all deductibles and SIRs shall be the sole responsibility of Provider or subcontractor who procured such insurance and shall not apply to the Indemnified Additional Insured Parties. County may deduct from any amounts otherwise due Provider to fund the SIR/deductible. Policies shall NOT contain any self-insured retention (SIR) provision that limits the satisfaction of the SIR to the Named Insured. The policy must also provide that Defense costs, including the Allocated Loss Adjustment Expenses, will satisfy the SIR or deductible. County reserves the right to obtain a copy of any policies and endorsements for verification.

G. Acceptability of Insurers: Insurance is to be placed with insurers authorized to conduct business in the state with a current A.M. Best's rating of no less than A:VII, unless otherwise acceptable to County.
H. Claims Made Policies (Professional Liability)**:** If any of the required policies provide claims-made coverage:
    1. The Retroactive Date must be shown, and must be before the date of the Agreement or the beginning of contract work.
    2. Insurance must be maintained, and evidence of insurance must be provided for at least three (3) years after completion of the contract of work.
    3. If coverage is canceled or non-renewed, and not replaced *with another claims-made policy form with a Retroactive Date prior to* the contract effective date, Provider must purchase "extended reporting" coverage for a minimum of *three (3)* years after completion of work.
I. Verification of Coverage: Provider shall furnish the County with original certificates and amendatory endorsements or copies of the applicable policy language effecting coverage required by this clause. All certificates and endorsements are to be received and approved by the County's Risk Management Division before work commences. However, failure to obtain the required documents prior to the work beginning shall not waive the Provider's obligation to provide them. County reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time. County reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.
J. Subcontractors: Provider shall require and verify that all subcontractors maintain insurance meeting all the requirements stated herein, and Provider shall ensure that the County of El Dorado is an additional insured on insurance required from subcontractors.

ARTICLE XVIII

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

Provider covenants that during the term of this Agreement neither it, or any officer or employee of the Provider, has or shall acquire any interest, directly or indirectly, in any of the following:
A. Any other contract connected with, or directly affected by, the services to be performed by this Agreement.
B. Any other entities connected with, or directly affected by, the services to be performed by this Agreement.
C. Any officer or employee of County that are involved in this Agreement.

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

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

ARTICLE XIX

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

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

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

ARTICLE XX

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

ARTICLE XXI

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

ARTICLE XXII

Conformity With State And Federal Laws And Regulations:

A. Provider shall provide services in conformance with all applicable state and federal statues, regulations and sub-regulatory guidance, as from time to time amended, including but not limited to:
    1. Title 9, CCR;
    2. Title 22, CCR;
    3. California Welfare and Institutions Code, Division 5;
    4. United States Code of Federal Regulations, Title 42, including but not limited to Parts 2, 438 and 455;
    5. United States Code of Federal Regulations, Title 45;

6. United States Code, Title 42 (The Public Health and Welfare), as applicable;
7. Balanced Budget Act of 1997;
8. Health Insurance Portability and Accountability Act (HIPAA); and
9. Applicable Medi-Cal laws and regulations, including applicable sub-regulatory guidance, such as BHINs, MHSUDS INs, and provisions of County's state or federal contracts governing client services.

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

ARTICLE XXIII

Services And Access Provisions:

A. Certification of Eligibility: Provider will, in cooperation with County, comply with 42 C.F.R. §455.1(a)(2) and BHIN 24-001, to obtain a certification of a client's eligibility for SUD services under Medi-Cal.

B. Access to Substance Use Disorder Services:
   1. In collaboration with the County, Provider will work to ensure that individuals to whom the Provider provides SUD services meet access criteria and medical necessity requirements, as per DHCS guidance specified in BHIN 24-001. Specifically, the Provider will ensure that the clinical record for each client includes information as a whole indicating that client's presentation and needs are aligned with the criteria applicable to their age at the time-of-service provision as specified below.
   2. Provider shall have written admission criteria for determining the client's eligibility and suitability for treatment and services. All clients admitted shall meet the admission criteria and this shall be documented in the client's record.
   3. Programs shall ensure that their policies, procedures, practices, and rules and regulations do not discriminate against the above special populations. Whenever the needs of the client cannot be reasonably accommodated, efforts shall be made to make referral(s) to appropriate programs.
   4. Provider should recognize and educate staff and collaborative partners that Parole and Probation status is not a barrier to SUD services.
   5. Provider will ensure that the clinical record for each client includes information as a whole indicating that client's presentation and needs are aligned with the criteria applicable to their age at the time-of-service provision as outlined in this Agreement.
   6. The initial assessment shall be performed face-to-face, by telehealth or by telephone by a Licensed Practitioner of the Healing Arts (LPHA) or registered or certified counselor and may be done in the community or the home, except for residential treatment services and narcotic treatment programs (NTPs). If the assessment of the client is completed by a registered or certified counselor, then an LPHA shall evaluate that assessment with the counselor and the LPHA shall make the final diagnosis. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.

C. Provider shall comply with beneficiaries' access criteria and services provided during the initial assessment process requirements:
   1. For beneficiaries 21 years of age and older, a full assessment using the ASAM Criteria shall be completed within 30 days of the beneficiary's first visit with an LPHA or

registered or certified counselor, or Peer Support Specialist (except for residential treatment services)

2. For beneficiaries under the age of 21, a full assessment using the ASAM Criteria shall be completed within 60 days of the beneficiary's first visit with an LPHA or registered or certified counselor (except for residential treatment services).
3. For beneficiaries experiencing homelessness and where the provider documents that due to homelessness additional time is required to complete the assessment, a full assessment using the ASAM Criteria shall be completed within 60 days of the beneficiary's first visit with an LPHA or registered or certified counselor (except for residential treatment services).
4. If a client withdraws from treatment prior to completion of the assessment or prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorder, and later returns, the 30-day or 60-day time period starts over.

D. Provider shall comply with beneficiaries' access criteria after initial assessment requirements:
   1. Beneficiaries 21 years of age and older, to qualify for DMC-ODS services after the initial assessment, must meet one of the following criteria:
      a. Have at least one diagnosis from the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders for Substance-Related and Addictive Disorders, except for Tobacco-Related Disorders and Non-Substance-Related Disorders, OR
      b. Have had at least one diagnosis from the most current edition of the DSM for Substance-Related and Addictive Disorders, except for Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.
   2. Beneficiaries under the age of 21, qualify for DMC-ODS medically necessary services after the initial assessment, in the following circumstances:
      a. All services that are Medi-Cal-coverable, appropriate, and medically necessary, needed to correct and ameliorate health conditions shall be provided, as per federal Early & Periodic Screening, Diagnostic and Treatment (EPSDT) statutes and regulations.
      b. Services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and SUDs, consistent with federal guidance.
      c. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

ARTICLE XXIV

ASAM Level Of Care Determination: Provider shall use the ASAM Criteria to determine placement into the appropriate Level of Care (LOC) for all beneficiaries, which is separate and distinct from determining medical necessity. LOC determinations shall ensure that beneficiaries are able to receive care in the least restrictive LOC that is clinically appropriate to treat their condition. A full ASAM Criteria assessment and an SUD diagnosis is not required to deliver prevention and early intervention services for beneficiaries under the age of 21; a brief screening ASAM Criteria tool is sufficient for these services.

A. For clients who withdraw from treatment prior to completing the ASAM Criteria assessment or prior to establishing a diagnosis from the DSM for Substance-Related and Addictive Disorders, and later return, the time period for initial assessment starts over.

B. A full ASAM Criteria assessment, or brief screening ASAM Criteria tool for preliminary LOC recommendations, shall not be required to begin receiving DMC-ODS services.
C. A full ASAM Criteria assessment does not need to be repeated unless the client's condition changes.
D. Requirements for ASAM LOC assessments apply to NTP clients and settings.

ARTICLE XXV
Medical Necessity:

A. Pursuant to BHIN 24-001 and consistent with WIC §14059.5, DMC-ODS services must be medically necessary.
B. For beneficiaries 21 years of age and older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.
C. For beneficiaries under the age of 21, a service is "medically necessary" or a "medical necessity" if the service is necessary to correct or ameliorate screened health conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

ARTICLE XXVI
Additional Coverage Requirements and Clarifications:

A. The target population for DMC-ODS SUD services includes clients who are enrolled in Medi-Cal, reside in El Dorado County, and meet the criteria for DMC-ODS services as per established requirements above.
B. Consistent with WIC 14184.402(f), covered SUD prevention, screening, assessment, treatment, and recovery services are reimbursable Medi-Cal services when:
    1. Services are provided before one of the following: the completion of an assessment, the determination of whether DMC-ODS access criteria are met, or the determination of a diagnosis.
        a. Clinically appropriate and covered DMC-ODS services provided to clients over the age of 21 are reimbursable during the assessment process. Similarly, if the assessment determines that the client does not meet the DMC-ODS access criteria after initial assessment, those clinically appropriate and covered DMC-ODS services provided are reimbursable.
        b. All Medi-Cal claims shall include a current CMS approved International Classification of Diseases (ICD) diagnosis code. In cases where services are provided due to a suspected SUD that has not yet been diagnosed, options are available in the CMS approved ICD-10 code list, for example, codes for "Other specified" and "Unspecified" disorders, or "Factors influencing health status and contact with health services".
    2. Prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan, or if the client signature was absent from the treatment plan.
        a. While most DMC-ODS providers are expected to adopt problem lists as specified in BHIN 23-068, treatment plans continue to be required for some services in accordance with federal law.
        b. Treatment plans are required by federal law for:
            i. Narcotic Treatment Programs (NTPs); and

ii. Peer Support Services.

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

ARTICLE XXVII

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

A. ICD-10 codes Z55-Z65 Potential health hazards related to socioeconomic and psychological circumstances: may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision, of, an LPHA.
B. ICD-10 code Z03.89 Encounter for observation for other suspected diseases and conditions ruled out: may be used by an LPHA during the assessment phase of a client's treatment when a diagnosis has yet to be established.
C. CMS approved diagnosis code on the ICD 10 tabular, available in the CMS 2022 ICD-10-CM page at: https://www.cms.gov/medicare/icd-10/2022-icd-10-cm, which may include Z codes. LPHAs may use any clinically appropriate ICD-10 code, for example, codes for "Other specified" and "Unspecified" disorders, or "Factors influencing health status and contact with health services".

ARTICLE XXVIII

Coordination and Continuity Of Care

A. Provider shall comply with the care and coordination requirements established by the County and per 42 C.F.R. §438.208.
B. Provider shall ensure that all care, treatment, and services provided pursuant to this Agreement are coordinated among all providers who are serving the client. Coordination and continuity of care procedures shall meet the following requirements:
   1. Ensure that each client has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the client. The client shall be provided information on how to contact their designated person or entity.
   2. All services provided to clients shall be coordinated:
      a. Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays;
      b. With the services the client receives from any other managed care organization;
      c. With the services the client receives in FFS Medi-Cal; and
      d. With the services the client receives from community and social support providers.
   3. Share with other providers serving the client, as allowed by regulations, the results of any identification and assessment of that client's needs to prevent duplication of those activities.
   4. Ensure that each provider furnishing services to clients maintains and shares, as appropriate, a client health record in accordance with professional standards.
   5. Ensure that in the process of coordinating care, each client's privacy is protected in accordance with the privacy requirements in 45 C.F.R. Parts 160 and 164 subparts A and E and 42 C.F.R. Part 2, to the extent that they are applicable.

C. Provider shall engage in care coordination activities beginning at intake and throughout the treatment and discharge planning processes.
D. To facilitate care coordination, Provider will request a HIP**A**A and California law compliant client authorization to share client information with and among all other providers involved in the client's care, in satisfaction of state, and federal privacy laws and regulations.

ARTICLE XXIX
Site Licenses, Certifications, Permits Requirements:
A. As specified in BHIN 21-001 and in accordance with Health and Safety Code §11834.015, DHCS adopted the ASAM treatment criteria as the minimum standard of care for licensed AOD facilities. All licensed AOD facilities shall obtain at least one DHCS LOC Designation and/or at least one residential ASAM LOC Certification consistent with all of its program services. If an AOD facility opts to obtain an ASAM LOC Certification, then that facility will not be required to obtain a DHCS LOC Designation. However, nothing precludes a facility from obtaining both a DHCS LOC Designation and ASAM LOC Certification.
B. Provider shall obtain and comply with DMC site certification and ASAM designation or DHCS LOC Designation for each type of contracted service being delivered, as well as any additional licensure, registration or accreditation required by regulations for the contracted service being delivered.
C. Provider shall obtain and maintain all appropriate licenses, permits, and certificates required by all applicable federal, state, and county and/or municipal laws, regulations, guidelines, and/or directives.
D. Provider shall have and maintain a valid fire clearance at the specified service delivery sites where direct services are provided to clients.

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

ARTICLE XXXI
Alcohol and/or Drug-Free Environment:
A. Provider shall provide an alcohol and/or drug-free environment for clients. The use of medications for the treatment of SUD, mental illness, or physical conditions, shall be allowed and controlled as per Provider's written policies and procedures.

B. Provider shall have written policies regarding service delivery for when clients experience relapse episodes. These policies shall be supportive of and consistent with the alcohol and/or drug-free environment of the program.

ARTICLE XXXII
Assessment of Tobacco Use Disorder:

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

ARTICLE XXXIII
Naloxone Requirements:

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

ARTICLE XXXIV
Authorization Provisions:

A. Service Authorization: Contracted services funded by the follow funding streams, as applicable, may only be provided if County refers a client to Provider via County's written treatment authorization:
   (Non-applicable services may be removed per provider specifications in final contract)
   1. SUBG Funding
   2. Opioid Treatment Settlement Funds (OSF)

B. Provider shall collaborate with County to complete authorization requests in line with County and DHCS policy.
C. Provider shall respond to County in a timely manner when consultation is necessary for County to make appropriate authorization determinations.
D. County shall provide Provider with written notice of authorization determinations within the timeframes set forth in BHIN 24-001, or any subsequent DHCS notices.
E. For SUD Non-Residential and Non-Inpatient Levels of Care service authorization:
    1. Provider shall follow County's policies and procedures around non-residential/non-inpatient levels of care according to BHIN 24-001.
    2. Provider is not required to obtain service authorization for non-residential/non-inpatient levels of care. Prior authorization is prohibited for non-residential DMC-ODS services.
F. For SUD Residential and Inpatient Levels of Care service authorization:
    1. Provider shall have in place, and follow, County written authorization policies and procedures for processing requests for initial and continuing authorization, or prior authorization, for residential treatment services, including inpatient services, but excluding withdrawal management services.
    2. County will review the DSM and ASAM Criteria to ensure that the beneficiary meets the requirements for the service.
    3. Prior authorization for residential and inpatient services (excluding withdrawal management services) shall be made within 24 hours of the prior authorization request being submitted by Provider.
        a. County will ensure that prior authorization processes are completed in a manner that assures the provision of a covered SUD service to a client in a timely manner appropriate for the client's condition.
    4. Provider shall alert County when an expediated service authorization decision is necessary due to a client's specific needs and circumstances that could seriously jeopardize the client's life or health, or ability to attain, maintain, or regain maximum function. Expediated service authorizations shall not exceed 72 hours after receipt of the request for service, with a possible extension of up to 14 calendar days if the client or provider requests an extension.
    5. Provider shall alert County when a standard authorization decision is necessary. Standard service authorizations shall not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days if the client or provider requests an extension.
G. Provider, if applicable, shall ensure that length of stay (LOS) in residential program complies with the following:
    1. LOS shall be determined by individualized clinical need (statewide LOS goal is 30 days). LOS for clients shall be determined by an LPHA and authorized by the County as medically necessary.
    2. Clients receiving residential treatment must be transitioned to another LOC when clinically appropriate based on treatment progress.
    3. Perinatal clients may receive a longer LOS than those described above, if determined to be medically necessary.
    4. Nothing in this section overrides any EPSDT requirements. EPSDT clients may receive a longer length of stay based on medical necessity.

ARTICLE XXXV
Documentation Requirements:

A. Provider agrees to comply with documentation requirements for non-hospital services as specified herein in ARTICLES XXXV through XLII inclusive in compliance with federal, state and County requirements.
B. All Provider documentation shall be accurate, complete, legible, and shall list each date of service. Provider shall document the face-to-face duration of the service, including travel and documentation time for each service. Services must be identified as provided in-person, by telephone, or by telehealth.
C. All services shall be documented utilizing County-approved templates and contain all required elements. Provider agrees to satisfy the chart documentation requirements set forth in BHIN 23-068 and the contract between County and DHCS. Failure to comply with documentation standards specified in this Article require corrective action plans.

ARTICLE XXXVI
Assessment:

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

ARTICLE XXXVII
ICD-10:

A. Provider shall use the criteria set forth in the current edition of the DSM as the clinical tool to make diagnostic determinations.
B. Once a DSM diagnosis is determined, the Provider shall determine the corresponding diagnosis in the current edition of ICD. Provider shall use the ICD diagnosis code(s) to submit a claim for SUD services to receive reimbursement from County.
C. Under the EPSDT mandate, for youth under the age of 21, a diagnosis from the ICD-10 for Substance-Related and Addictive Disorders is not required for early intervention services.
D. The ICD Tabular List of Diseases and Injuries is maintained by CMS and may be updated during the term of this Agreement. Changes to the lists of ICD diagnoses do not require an amendment to this Agreement, and County may implement these changes as provided by DHCS.

ARTICLE XXXVIII
Physical Examination Requirements:

A. If a beneficiary had a physical examination within the twelve-month period prior to the beneficiary's admission to treatment date, the physician or registered nurse practitioner or

physician's assistant (physician extenders) shall review documentation of the beneficiary's most recent physical examination within thirty (30) calendar days of the beneficiary's admission to treatment date.

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

ARTICLE XXXIX
Problem List:

A. Provider will create and maintain a Problem List for each client served under this Agreement. The problem list is a list of symptoms, conditions, diagnoses, or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.
B. Provider must document a problem list that adheres to industry standards utilizing at minimum SNOMED International, Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) U.S. Edition, March 2021 Release, and ICD-10-CM 2023.
C. A problem identified during a service encounter may be addressed by the service provider (within their scope of practice) during that service encounter and subsequently added to the problem list.
D. The problem list shall be updated on an ongoing basis to reflect the current presentation of the client.
E. The problem list shall include, but is not limited to the following:
    1. Diagnoses identified by a provider acting within their scope of practice, if any. Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable.
    2. Problems identified by a provider acting within their scope of practice, if any.
    3. Problems or illnesses identified by the client and/or significant support person, if any.
    4. The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.
F. Provider shall add to or remove problems from the problem list when there is a relevant change to a beneficiary's condition.
G. County does not require the problem list to be updated within a specific timeframe or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, Provider shall update the problem list within a reasonable time such that the problem list reflects the current issues facing the client, in accordance with

generally accepted standards of practice and in specific circumstances specified in BHIN 23-068.

ARTICLE XL
Progress Notes:

A. Provider shall create progress notes for the provision of all DMC-ODS services provided under this Agreement.
B. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.
C. Progress notes shall include all elements specified in BHIN 23-068, whether the note be for an individual or group service, and shall include:
    1. The type of service rendered
    2. A narrative describing the service, including how the service addressed the client's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors)
    3. The date that the service was provided to the beneficiary
    4. Duration of the service, including travel and documentation time
    5. Location of the client at the time of receiving the service
    6. A typed or legibly printed name, signature of the service provider and date of signature
    7. ICD-10 code
    8. Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code
    9. Next steps, including, but not limited to, planned action steps by the provider or by the client, collaboration with the client, collaboration with other provider(s) and any update to the problem list as appropriate.
D. Provider shall complete progress notes within three business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.
E. Provider shall complete a daily progress note for services that are billed on a daily basis, such as residential and inpatient services, if applicable.
F. When a group service is rendered by the Provider, the following conditions shall be met:
    1. A list of participants is required to be documented and maintained by the Provider.
    2. If more than one provider renders a group service, one progress note may be completed for a group session and signed by one provider. Provider shall ensure that in this case, the progress note clearly documents the specific involvement and the specific amount of time of involvement of each provider during the group activity, including documentation time.

ARTICLE XLI
Plan of Care:

A. As specified in BHIN 23-068, when a plan of care is required, Provider shall follow the DHCS requirements outlined in the Alcohol and/or Other Drug Program Certification Standards document, available in the DHCS Facility Certification page at: https://www.dhcs.ca.gov/provgovpart/Pages/Licensing-and-Certification-Facility-Certification.aspx
B. Provider shall develop plans of care for all clients, when required, and these plans of care shall include the following:
    1. Statement of problems experienced by the client to be addressed.
    2. Statement of objectives to be reached that address each problem.

3. Statement of actions that will be taken by the program and/or client to accomplish the identified objectives.
4. Target date(s) for accomplishment of actions and objectives.

C. Provider shall develop the plan of care with participation from the client in accordance with the timeframes specified below:
   1. For outpatient programs, the plan of care shall be developed within 30 calendar days from the date of the client's admission. The client's progress shall be reviewed and documented within 30 calendar days after signing the plan of care and not later than every 30 calendar days thereafter.
   2. For residential programs, the plan of care shall be developed within 10 calendar days from the date of the client's admission.
   3. An LPHA, registered or certified counselor shall ensure and document, that together with the client, the plan of care is reviewed and updated, as necessary, when a change in problem identification or focus of treatment occurs, or no later than 90 calendar days after signing the plan of care and no later than every 90 calendar days thereafter, whichever comes first.

D. Provider is not required to complete a plan of care for clients under this Agreement, except in the below circumstances:
   1. Peer Support Services require a specific care plan based on an approved Plan of Care. The plan of care shall be documented within the progress notes in the client's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services.
   2. Narcotic Treatment Programs (NTP) are required to create a plan of care for clients as per federal law. This requirement is not impacted by the documentation requirements in BHIN 23-068. NTPs shall continue to comply with federal and state regulations regarding plans of care and documentation requirements.

ARTICLE XLII
Telehealth:

A. Provider may use telehealth, when it deems clinically appropriate, as a mode of delivering behavioral health services in accordance with all applicable County, state, and federal requirements, including those related to privacy/security, efficiency, and standards of care. Such services will conform to the definitions and meet the requirements included in the Medi-Cal Provider Manual: Telehealth, available in the DHCS Telehealth Resources page at: https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx.
B. All telehealth equipment and service locations must ensure that client confidentiality is maintained.
C. Licensed providers and staff may provide services via telephone and telehealth as long as the service is within their scope of practice.
D. Medical records for clients served by Provider under this Agreement must include documentation of written or verbal consent for telehealth or telephone services if such services are provided by Provider. Such consent must be obtained at least once prior to initiating applicable health care services and consent must include all elements as specified in BHIN 23-068.
E. County may at any time audit Provider's telehealth practices, and Provider must allow access to all materials needed to adequately monitor Provider's adherence to telehealth standards and requirements.

ARTICLE XLIII

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

A. Written criteria for discharge defining:
   1. Successful completion of program;
   2. Administrative discharge;
   3. Involuntary discharge;
   4. Transfers and referrals.

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

ARTICLE XLIV

Chart Auditing And Reasons For Recoupment:

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

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

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

D. Internal Auditing, Compliance, and Monitoring
   1. Providers of sufficient size as determined by County shall institute and conduct a Quality Assurance Process for all services provided hereunder. Said process shall include at a

minimum a system for verifying that all services provided and claimed for reimbursement shall meet DMC-ODS definitions and be documented accurately.

2. Provider shall provide County with notification and a summary of any internal audit within thirty (30) days of completion of said audit, consistent with 2 CFR 200.501, including any exceptions and the specific corrective actions taken to sufficiently reduce the errors that are discovered through Provider's internal audit process as applicable.
3. 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.
4. 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.
5. The State, Center for Medicare and Medicaid Services (CMS), the Health and Human Services (HHS) Office of the Inspector General, the Comptroller General, the County, and their designees may, at any time, inspect and audit any records or documents of the County, or its Providers, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted. The right to audit under this section exists for 10 years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.
6. 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.
7. 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.
8. 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.
9. Upon notification of an exception or finding of non-compliance, 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 the Article titled :Default, Termination, and Cancellation."
10. 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.

11. 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:
    a. Title 9, CCR, Division 4, Chapter 8, commencing with Section 13000, Certification of Alcohol and Other Drug Counselors
    b. Title 42, CFR, Sections 8.1 through 8.6, Medication Assisted Treatment for Opioid Use Disorders
    c. Title 21, CFR, Sections 1301.01 through 1301.93, Department of Justice, Controlled Substances
    d. State Administrative Manual (SAM), Chapter 7200 (General Outline of Procedures)
12. Provider shall be familiar with the above laws, regulations, and guidelines and shall ensure that its subcontractors are also familiar with such requirements.

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

F. Reasons for Recoupment
1. County will conduct periodic audits of Provider files to ensure appropriate clinical documentation, high quality service provision and compliance with applicable federal, state and county regulations.
2. Such audits may result in requirements for Provider to reimburse County for services previously paid in the following circumstances:
    a. Identification of Fraud, Waste or Abuse as defined in federal regulation.
        i. Fraud and abuse are defined in Code of Federal Regulations, Title 42, §455.2 and Welfare & Institutions Code, §14107.11, subdivision (d).
        ii. Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf.
    b. Overpayment of Provider by County due to errors in claiming or documentation.
        i. Provider shall reimburse County for all overpayments identified by Provider, County and/or state or federal oversight agencies as an audit exception within the timeframes required by law or Country or state or federal agency.

G. Cooperation with Audits
1. Provider shall cooperate with County in any review and/or audit initiated by County, DHCS, or any other applicable regulatory body. This cooperation may include such activities as onsite program, fiscal, or chart reviews and/or audits.
2. In addition, Provider shall comply with all requests for any documentation or files including, but not limited to, client and personnel files.

3. Provider shall notify the County of any scheduled or unscheduled external evaluation or site visits when it becomes aware of such visit. County shall reserve the right to attend any or all parts of external review processes.
4. Provider shall allow inspection, evaluation and audit of its records, documents and facilities for 10 years from the term end date of this Agreement or in the event Provider has been notified that an audit or investigation of this Agreement has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later pursuant to 42 C.F.R. §§ 438.3(h) and 438.230(c)(3)(i-iii).

ARTICLE XLV

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

ARTICLE XLVI

Client Protections:

A. Grievances, Appeals and Notices of Adverse Benefit Determination
   1. All grievances (as defined by 42 C.F.R. §438.400) and complaints received by Provider must be immediately forwarded to the County's Quality Management Department or other designated persons via a secure method (e.g., encrypted email or by fax) to allow ample time for the Quality Management staff to acknowledge receipt of the grievance and complaints and issue appropriate responses.
   2. Provider shall not discourage the filing of grievances and clients do not need to use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance.
   3. Aligned with MHSUDS 18-010E and 42 C.F.R. §438.404, the appropriate and delegated Notice of Adverse Benefit Determination (NOABD) must be issued by Providers within the specified timeframes using the template provided by the County.
   4. All NOABDs are issued by County. Providers are required to submit a completed Exhibit D, marked "Notice of Adverse Benefit Determination (NOABD) Form," incorporated herein and made by reference a part hereof, securely to email: SUDSQualityAssurance@edcgov.us or Fax to 530-295-2596 to notify County of need for NOABD.
   5. NOABDs must be issued to clients anytime the Provider has made or intends to make an adverse benefit determination that includes the reduction, suspension, or termination of a previously authorized service and/or the failure to provide services in a timely manner. The notice must have a clear and concise explanation of the reason(s) for the decision as

established by DHCS and the County. The Provider must inform the County immediately after issuing a NOABD.

6. Procedures and timeframes for responding to grievances, issuing, and responding to adverse benefit determinations, appeals, and state hearings must be followed as per 42 C.F.R., Part 438, Subpart F (42 C.F.R. §§ 438.400 – 438.424).
7. Provider must provide clients with any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal such as auxiliary aids and interpreter services.
8. Provider must maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures. The record must be accurately maintained in a manner accessible to the County and available upon request to DHCS.

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

C. Transition of Care:

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

ARTICLE XLVII

Advertising Requirements:

A. Provider shall protect the health, safety, and welfare of clients with a SUD, shall not use false or misleading advertisement for their medical treatment or medical services as per Health and Safety Code §11831.9 and BHIN 22-022.

B. Licensed SUD recovery or treatment facilities and certified alcohol or other drug programs shall not do any of the following:

1. Make a false or misleading statement or provide false or misleading information about the entity's products, goods, services, or geographical locations in its marketing, advertising materials, or media, or on its internet website or on a third-party internet website.
2. Include on its internet website a picture, description, staff information, or the location of an entity, along with false contact information that surreptitiously directs the reader to a business that does not have a contract with the entity.
3. Include on its internet website false information or an electronic link that provides false information or surreptitiously directs the reader to another internet website.

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

ARTICLE XLVIII

Program Integrity:

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

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

C. Credentialing and Re-Credentialing of Providers
   1. Providers must follow the uniform process for credentialing and recredentialing of network providers established by County, including disciplinary actions such reducing, suspending, or terminating provider's privileges. Failure to comply with specified requirements can result in suspension or termination of a provider.
   2. Upon request, the Provider must demonstrate to the County that each of its providers are qualified in accordance with current legal, professional, and technical standards, and that they are appropriately licensed, registered, waivered, and/or certified.
   3. Provider must not employ or subcontract with providers debarred, suspended or otherwise excluded (individually, and collectively referred to as "Excluded") from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. §438.610. See relevant section below regarding specific requirements for exclusion monitoring.
   4. Providers shall ensure that all of their network providers, delivering covered services, sign and date an attestation statement on a form provided by County, in which each provider attests to the following:
      a. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
      b. A history of loss of license or felony convictions;
      c. A history of loss or limitation of privileges or disciplinary activity;
      d. A lack of present illegal drug use; and
      e. The application's accuracy and completeness
   5. Provider must file and keep track of attestation statements for all of their providers and must make those available to the County upon request at any time.
   6. Provider is required to sign an annual attestation statement at the time of Agreement renewal in which they will attest that they will follow County's Credentialing Policy and MHSUDS IN 18-019 and ensure that all of their rendering providers are credentialed as per established guidelines.
   7. Provider is required to verify and document at a minimum every three years that each network provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements as per the County's

uniform process for credentialing and recredentialing. If any of the requirements are not up-to-date, updated information should be obtained from network providers to complete the re-credentialing process.

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

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

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

9. Provider must have administrative and management arrangements or procedures designed to detect and prevent fraud, waste and abuse of federal or state health care funding. Provider must report fraud and abuse information to the County including but not limited to:
    a. Any potential fraud, waste, or abuse as per 42 C.F.R. §438.608(a), (a)(7),
    b. All overpayments identified or recovered, specifying the overpayment due to potential fraud as per 42 C.F.R. §438.608(a), (a)(2).
    c. Information about change in a client's circumstances that may affect the client's eligibility including changes in the client's residence or the death of the client as per 42 C.F.R. §438.608(a)(3).
    d. Information about a change in the Provider's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of this Agreement with the Provider as per 42 C.F.R. §438.608 (a)(6).
10. Provider shall implement written policies that provide detailed information about the False Claims Act ("Act") and other federal and state Laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.
11. Provider shall make prompt referral of any potential fraud, waste or abuse to County or potential fraud directly to the State Medicaid Fraud Control Unit.
12. County may suspend payments to Provider if DHCS or County determine that there is a credible allegation of fraud in accordance with 42 C.F.R. §455.23. (42 C.F.R. §438.608 (a)(8)).
13. Provider shall report to the County all identified overpayments and reason for the overpayment, including overpayments due to potential fraud. Provider shall return any overpayments to the County within 60 calendar days after the date on which the overpayment was identified. (42 C.F.R. §438.608 (a)(2), (c)(3)).

G. Integrity Disclosures
1. Provider shall provide information on ownership and controlling interests, disclosures related to business transactions, and disclosures related to persons convicted of crimes in the form and manner requested by the County, by the Effective Date, each time the Agreement is renewed and within 35 days of any change in ownership or controlling interest of Provider. (42 C.F.R. §§ 455.104, 455.105, and 455.106)
2. Upon the execution of this Agreement, Provider shall furnish County a Provider Disclosure Statement, which, upon receipt by County, shall be kept on file with County and may be disclosed to DHCS. If there are any changes to the information disclosed in the Provider Disclosure Statement, an updated statement should be completed and submitted to the County within 35 days of the change. (42 C.F.R. §455.104).
3. Provider must disclose the following information as requested in the Provider Disclosure Statement:
    a. Disclosure of 5% or More Ownership Interest:
        i. In the case of corporate entities with an ownership or control interest in the disclosing entity, the primary business address as well as every business location and P.O. Box address must be disclosed. In the case of an individual, the date of birth and Social Security Number must be disclosed.
        ii. In the case of a corporation with ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five percent (5%) or more interest, the corporation tax identification number must be disclosed.

iii. For individuals or corporations with ownership or control interest in any subcontractor in which the disclosing entity has a five percent (5%) or more interest, the disclosure of familial relationship is required.

iv. For individuals with five percent (5%) or more direct or indirect ownership interest of a disclosing entity, the individual shall provide evidence of completion of a criminal background check, including fingerprinting, if required by law, prior to execution of Agreement. (42 C.F.R. §455.434)

b. Disclosures Related to Business Transactions:

i. The ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.

ii. Any significant business transactions between Provider and any wholly owned supplier, or between Provider and any subcontractor, during the 5-year period ending on the date of the request. (42 C.F.R. §455.105(b).)

c. Disclosures Related to Persons Convicted of Crimes:

i. The identity of any person who has an ownership or control interest in the Provider or is an agent or managing employee of the Provider who has been convicted of a criminal offense related to that person's involvement in any program under the Medicare, Medicaid, or the Title XXI services program since the inception of those programs. (42 C.F.R. §455.106.)

ii. County shall terminate the enrollment of Provider if any person with five percent (5%) or greater direct or indirect ownership interest in the disclosing entity has been convicted of a criminal offense related to the person's involvement with Medicare, Medicaid, or Title XXI program in the last 10 years.

d. Provider must provide disclosure upon execution of Contract, extension for renewal, and within 35 days after any change in Provider ownership or upon request of County. County may refuse to enter into an Agreement or terminate an existing Agreement with a Provider if the Provider fails to disclose ownership and control interest information, information related to business transactions and information on persons convicted of crimes, or if the Provider did not fully and accurately make the disclosure as required.

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

H. Certification of Non-Exclusion or Suspension from Participation in a Federal Health Care Program:

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

2. Provider shall certify, prior to the execution of this Agreement, that Provider does not employ or subcontract with providers or have other relationships with providers Excluded from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. §438.610. Provider shall conduct initial and monthly Exclusion & Suspension searches of the following databases and provide evidence of these completed searches when requested by County, DHCS or the US DHHS:

a. www.oig.hhs.gov/exclusions – LEIE Federal Exclusions
b. www.sam.gov/portal/SAM – GSA Exclusions Extract
c. www.Medi-Cal.ca.gov – Suspended & Ineligible Provider List
d. https://nppes.cms.hhs.gov/#/ - National Plan and Provider Enumeration System (NPPES)
e. any other database required by DHCS or DHHS.

3. Provider shall certify, prior to the execution of this Agreement, that Provider does not employ staff or individual Providers/vendors that are on the Social Security Administration's Death Master File. Provider shall check the following database prior to employing staff or individual Providers/vendors and provide evidence of these completed searches when requested by the County, DHCS or the US DHHS. (https://www.ssdmf.com/ - Social Security Death Master File)
4. Provider is required to notify County immediately if Provider becomes aware of any information that may indicate their (including employees/staff and individual Providers/vendors) potential placement on an exclusions list.
5. Provider shall screen and periodically revalidate all network providers in accordance with the requirements of 42 C.F.R., Part 455, Subparts B and E.
6. Provider must confirm the identity and determine the exclusion status of all its providers, as well as any person with an ownership or control interest, or who is an agent or managing employee of the contracted agency through routine checks of federal and state databases. This includes the Social Security Administration's Death Master File, NPPES, the Office of Inspector General's List of Excluded Individuals/Entities (LEIE), the Medi-Cal Suspended and Ineligible Provider List (S&I List) as consistent with the requirements of 42 C.F.R. §455.436.
7. If Provider finds that any of its providers are Excluded, it must promptly notify the County as per 42 C.F.R. §438.608(a)(2), (4). Provider shall not certify or pay any Excluded provider with Medi-Cal funds, must treat any payments made to an Excluded provider as an overpayment, and any such inappropriate payments may be subject to recovery.
8. Provider shall sign Exhibit E, marked "Certification Of Non-Exclusion Or Suspension from Participation in a Federal Health Care Program" incorporated herein and made by reference a part hereof, attesting to the certifications listed above (numbers 1-7) and agreeing to comply with these requirements.

ARTICLE XLIX

Quality Improvement Program and Participation:

A. Provider shall comply with the County's ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program (42 C.F.R. §438.330(a)) and work with the County to improve established outcomes by following structural and operational processes and activities that are consistent with current practice standards.
B. Provider shall participate in quality improvement (QI) activities, including clinical and non-clinical performance improvement projects (PIPs), as requested by the County in relation to state and federal requirements and responsibilities, to improve health outcomes and clients' satisfaction over time. Other QI activities include quality assurance, collection and submission of performance measures specified by the County, mechanisms to detect both underutilization and overutilization of services, client and system outcomes, utilization management, utilization review, provider appeals, provider credentialing and re-credentialing, and client grievances. Provider shall measure, monitor, and annually report to the County its performance.

C. Provider shall implement mechanisms to assess client/family satisfaction based on County's guidance. Provider shall assess client/family satisfaction by:
   1. Surveying client/family satisfaction with the Provider's services at least annually.
   2. Evaluating client grievances, appeals and State Hearings at least annually.
   3. Evaluating requests to change persons providing services at least annually.
   4. Informing the County and clients of the results of client/family satisfaction activities.

D. Provider, if applicable, shall implement mechanisms to monitor the safety and effectiveness of medication practices. This mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs, at least annually.

E. Provider shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The Provider shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the Provider at least annually and shared with the County.

F. Provider shall collaborate with County to create a QI Work Plan with documented annual evaluations and documented revisions as needed. The QI Work Plan shall evaluate the impact and effectiveness of its quality assessment and performance improvement program.

G. Provider shall attend and participate in the County's Quality Improvement Committee (QIC) to recommend policy decisions, review and evaluate results of QI activities, including PIPs, institute needed QI actions, and ensure follow-up of QI processes. Provider shall ensure that there is active participation by the Provider's practitioners and providers in the QIC.

H. Provider shall assist County, as needed, with the development and implementation of Corrective Action Plans.

I. Provider shall participate, as required, in annual, independent external quality reviews (EQR) of the quality, Reporting, and access to the services covered under this Agreement, which are conducted pursuant to Subpart E of Part 438 of the Code of Federal Regulations. (42 C.F.R. §§ 438.350(a) and 438.320)

ARTICLE L

Network Adequacy:

A. Provider shall ensure that all services covered under this Agreement are available and accessible to clients in a timely manner and in accordance with the network adequacy standards required by regulation. (42 C.F.R. §438.206 (a),(c)).

B. Provider shall submit, when requested by County and in a manner and format determined by the County, network adequacy certification information to County, utilizing a provided template or other designated format.

C. Provider shall submit updated network adequacy information to the County any time there has been a significant change that would affect the adequacy and capacity of services. Significant changes include, but are not limited to, changes in services or providers available to clients, and changes in geographic service area.

ARTICLE LI

Timely Access: Provider shall comply with the requirements set forth in CCR, Title 9, §1810.405, including meeting County and State Contract standards for timely access to care and services, taking into account the urgency of the need for services. County shall monitor Provider to determine compliance with timely access requirements and shall take corrective action in the event of noncompliance.

A. Timely access standards include:
   1. Providers must have hours of operation during which services are provided to Medi-Cal clients that are no less than the hours of operation during which the Provider offers services to non-Medi-Cal clients. If the Provider's provider only serves Medi-Cal clients, the provider must provide hours of operation comparable to the hours the Provider makes available for Medi-Cal services that are not covered by the Agreement or another County.
   2. Appointment data, including wait times for requested services, must be recorded and tracked by Provider, and submitted to the County on a monthly basis in a format specified by the County. Appointments' data should be submitted to the County's Quality Management department or other designated persons.
   3. Provider shall ensure that all clients seeking NTP services are provided with an appointment within three (3) business days of a service request.
   4. Provider shall ensure that all clients seeking outpatient and intensive outpatient (non-NTP) services are provided with an appointment within ten (10) business days of a non-NTP service request.
   5. Provider shall ensure that all clients seeking non-urgent appointments with a non-physician SUD provider are provided within ten (10) business days of the request for the appointment. Similarly, Provider shall ensure that all clients seeking non-urgent follow-up appointments with a non-physician SUD provider are provided within ten (10) business days of the prior appointment for those undergoing a course of treatment for an ongoing SUD condition. These timely standards must be followed, except in the following circumstances:
      a. The referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, has determined and noted that in the relevant record that a longer waiting time will not have a detrimental impact on the client's health.
      b. Preventive care services and periodic follow-up care, including office visits for SUD conditions, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice.

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

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

ARTICLE LII

Data Reporting Requirements:

A. Provider shall comply with data reporting compliance standards as established by DHCS and/or SAMHSA depending on the specific source of funding.

B. Provider shall ensure that all data stored or submitted to the County, DHCS or other data collection sites is accurate and complete.
   (Non-applicable services may be removed from the below per Provider specifications in final contract)
   1. California Outcomes Measurement System Treatment (CalOMS Tx): CalOMS Tx data shall be submitted by Provider to DHCS via electronic submission within forty-five (45)

days from the end of the last day of the report month. This data shall be submitted during this time frame.

2. Drug and Alcohol Treatment Access Report (DATAR): DATAR data shall be submitted by Provider as specified by County, either directly to DHCS or by other means established by County, by the tenth (10^{th}) of the month following the report activity month.
3. Substance Use and Prevention Treatment Block Grant (SUBG) funding reporting: Provider using SUBG funds to serve beneficiaries in El Dorado County shall collect and report performance data to County monthly.

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

ARTICLE LIII
Practice Guidelines:

A. Provider shall adopt practice guidelines (or adopt County's practice guidelines) that meet the following requirements as per 42 C.F.R. §438.236:
   1. Are based on valid and reliable clinical evidence or a consensus of providers in the field;
   2. Consider the needs of Provider's clients;
   3. Are adopted in consultation with network providers; and
   4. Are reviewed and updated periodically as appropriate.

B. Provider shall disseminate the guidelines to all affected providers and, upon request, to clients and potential clients.

C. Evidence-Based Practices (EBPs): Providers will comply with County and DHCS standards related to EBPs. Provider shall implement at least two of the following EBP to fidelity per provider, per service modality:
   1. Motivational Interviewing;
   2. Cognitive-Behavioral Services;
   3. Relapse Prevention;
   4. Trauma-Informed Treatment; and/or
   5. Psycho-Education.

D. Reporting Unusual Occurrences: Provider shall report unusual occurrences to the Director. An unusual occurrence is any event which jeopardizes the health and/or safety of clients, staff and/or members of the community, including, but not limited to, physical injury and death. Unusual occurrences are to be reported to the County within timelines specified in County policy after becoming aware of the unusual event. Reports are to include the following elements:
   1. Complete written description of event including outcome;
   2. Written report of Provider's investigation and conclusions; and
   3. List of persons directly involved and/or with direct knowledge of the event.

   County and DHCS retain the right to independently investigate unusual occurrences, and Provider shall cooperate in the conduct of such independent investigations.

ARTICLE LIV
Financial Terms:

A. <u>Claiming</u>
   1. Provider shall enter claims data into the County's billing and transactional database system within the timeframes established by County. Provider shall use Current Procedural

Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, as provided in the DHCS Billing Manual available at https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx, as from time to time amended.

2. Claims shall be complete and accurate and must include all required information regarding the claimed services.
3. Provider shall maximize the Federal Financial Participation (FFP) reimbursement by claiming all possible Medi-Cal services and correcting denied services for resubmission in a timely manner as needed.

B. Additional Financial Requirements

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

ARTICLE LV

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

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

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

ARTICLE LVI

Provider Prohibited From Redirection of Contracted Funds [If Applicable]:

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

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

ARTICLE LVII

Financial Audit Report Requirements for Pass-Through Entities:

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

B. Financial audit reports must contain a separate schedule that identifies all funds included in the audit that are received from or passed through the County. County programs must be identified by Agreement number, Agreement amount, Agreement period, and the amount expended during the fiscal year by funding source.

C. Provider shall provide a financial audit report including all attachments to the report and the management letter and corresponding response within six (6) months of the end of the audit year to the County. The Director is responsible for providing the audit report to the County Auditor.

D. Provider must submit any required corrective action plan to the County simultaneously with the audit report or as soon thereafter as it is available. County shall monitor implementation of the corrective action plan as it pertains to services provided pursuant to this Agreement.

ARTICLE LVIII

Additional Provisions:

A. Non-Discrimination

1. Provider shall not discriminate against Medi-Cal eligible individuals who require an assessment or meet medical necessity criteria for DMC-ODS in the provision of SUD services because of race, color, religion, ancestry, marital status, national origin, ethnic group identification, sex, sexual orientation, gender, gender identity, age, medical condition, genetic information, health status or need for health care services, or mental or physical disability as consistent with the requirements of applicable federal law, such as 42 C.F.R. §438.3(d)(3) and (4), BHIN 22-060 Enclosure 4 and state law.
2. Provider shall take affirmative action to ensure that services to intended Medi-Cal clients are provided without use of any policy or practice that has the effect of discriminating on the basis of race, color, religion, ancestry, marital status, national origin, ethnic group identification, sex, sexual orientation, gender, gender identity, age, medical condition, genetic information, health status or need for health care services, or mental or physical disability.
3. 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.

4. County may require Provider's services on projects involving funding from various state and/or federal agencies, and as a consequence, Provider shall comply with all applicable nondiscrimination statutes and regulations during the performance of this Agreement including but not limited to the following: Provider and its employees and representatives shall not unlawfully discriminate against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical handicap, medical condition, marital status, age, or sex; Provider shall, unless exempt, comply with the applicable provisions of the Fair Employment and Housing Act (Government Code, Sections 12900 et seq.) and applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Sections 11000 et seq.); the applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Subchapter 5 of Chapter 5 of Division 4.1 of Title 2 of the California Code of Regulations incorporated into this Agreement by reference and made a part hereof as if set forth in full; and Title VI of the Civil Rights Act of 1964, as amended, the California Family Rights Act (Government Code Section 12945.2), the Unruh Civil Rights Act (California Civil Code, Division I, Part 2, Section 51, et seq), the Ralph Civil Rights Act (California Civil Code, Division I, Part 2, Section 51.7), the California Trafficking Victims Protection Act (California Civil Code, Division I, Part 2, Section 52.5), the Disabled Persons Act (California Civil Code, Division I, Part 2.5), and as applicable, Section 11135 et. seq., of the California Government Code, prohibiting discrimination in all state-funded programs. Provider and its employees and representatives shall give written notice of their obligations under this clause as required by law.
5. 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.
6. Provider's signature shall provide any certifications necessary under the federal laws, the laws of the State of California, including but not limited to Government Code Section 12990 and Title 2, California Code of Regulations, Section 11102.
7. 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.
8. Provider shall comply with Exhibit F, marked "Provider Assurance of Compliance with Nondiscrimination in State and Federally Assisted Programs," incorporated herein and made by reference a part hereof. Provider shall acknowledge compliance by signing and returning Exhibit F upon request by County.

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

C. Applicable Fees:
1. Provider shall not charge any clients or third-party payers any fee for service unless directed to do so by the Director at the time the client is referred for services. When directed to charge for services, Provider shall use the uniform billing and collection guidelines prescribed by DHCS.
2. Provider will perform eligibility and financial determinations for each beneficiary prior to rendering services in accordance with the Drug Medi-Cal Billing Manual, unless directed otherwise by the Director.

3. Provider shall not submit a claim to, or demand or otherwise collect reimbursement from, the client or persons acting on behalf of the client for any SUD or related administrative services provided under this Agreement, except to collect other health insurance coverage, share of cost, and co-payments (California Code of Regulations, tit. 9, §1810.365(c)).
4. The Provider must not bill clients, for covered services, any amount greater than would be owed if the County provided the services directly as per and otherwise not bill client as set forth in 42 C.F.R. §438.106.

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

E. Client Informing Materials:
1. Basic Information Requirements
   a. Provider shall provide information in a manner and format that is easily understood and readily accessible to clients. (42 C.F.R. §438.10(c)(1)). Provider shall provide all written materials for clients in easily understood language, format, and alternative formats that take into consideration the special needs of clients in compliance with 42 C.F.R. §438.10(d)(6). Provider shall inform clients that information is available in alternate formats and how to access those formats in compliance with 42 C.F.R. §438.10.
   b. Provider shall provide the required information in this section to each client receiving SUD services under this Agreement and upon request.
   c. Provider shall utilize the County's website that provides the content required in this section and 42 C.F.R. §438.10 and complies with all the requirements regarding the same set forth in 42 C.F.R. §438.10.
   d. Provider shall use DHCS/County developed model beneficiary handbook and client notices. (42 C.F.R. §§ 438.10(c)(4)(ii), 438.62(b)(3)).
   e. Client information required in this section may only be provided electronically by the Provider if all of the following conditions are met:
      i. The format is readily accessible;
      ii. The information is placed in a location on the Provider's website that is prominent and readily accessible;
      iii. The information is provided in an electronic form which can be electronically retained and printed;
      iv. The information is consistent with the content and language requirements of this Agreement; and
      v. The client is informed that the information is available in paper form without charge upon request and the Provider provides it upon request within five business days. (42 C.F.R. §438.10(c)(6)).
2. Language and Format
   a. Provider shall provide all written materials for potential clients and clients in a font size no smaller than 12-point font. (42 C.F.R. §438.10(d)(6)(ii).)
   b. Provider shall ensure its written materials that are critical to obtaining services are available in alternative formats, upon request of the client or potential client at no cost.

c. Provider shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, beneficiary handbook, appeal and grievance notices, denial and termination notices, and the Provider's SUD health education materials, available in the prevalent non-English languages in the County. (42 C.F.R. §438.10(d)(3).)
    i. Provider shall notify clients, prospective clients, and members of the public that written translation is available in prevalent languages free of cost and how to access those materials. (42 C.F.R. §438.10(d)(5)(i), (iii); Welfare & Institutions Code §14727(a)(1); California Code of Regulations. tit. 9 §1810.410, subd. (e), para. (4))
d. Provider shall make auxiliary aids and services available upon request and free of charge to each client. (42 C.F.R. §438.10(d)(3)- (4).)
e. Provider shall make oral interpretation and auxiliary aids, such as Teletypewriter Telephone/Text Telephone (TTY/TDY) and American Sign Language (ASL), available and free of charge for any language in compliance with 42 C.F.R. §438.10(d)(2), (4)-(5).
f. Taglines for written materials critical to obtaining services must be printed in a conspicuously visible font size.

3. Beneficiary Informing Materials
    a. Each client must receive and have access to the beneficiary informing materials upon request by the client and when first receiving SUD services. Beneficiary informing materials include but are not limited to:
        i. County DMC-ODS Beneficiary Handbook (BHIN 22-060)
        ii. Provider Directory
        iii. DMC-ODS Formulary
        iv. Advance Health Care Directive Form (required for adult clients only)
        v. Notice of Language Assistance Services available upon request at no cost to the client
        vi. Language Taglines
        vii. Grievance/Appeal Process and Form
        viii. Notice of Privacy Practices
        ix. EPSDT poster (if serving clients under the age of 21)
    b. Provider shall provide each client with a beneficiary handbook at the time the client first accesses services. The beneficiary handbook shall be provided to beneficiaries within fourteen (14) business days after receiving notice of enrollment.
    c. Provider shall give each client notice of any significant change to the information contained in the beneficiary handbook at least thirty (30) days before the intended effective date of change as per BHIN 22-060.
    d. Required informing materials must be electronically available on the Provider's website and must be physically available at the Provider agency facility lobby for clients' access.
    e. Informing materials must be made available upon request, at no cost, in alternate formats (i.e., Braille or Audio) and Auxiliary Aids (i.e., California Relay Service (CRS) 711 and American Sign Language) and must be provided to clients within five business days. Large print materials shall be in a minimum 18-point font size.
    f. Informing materials will be considered provided to the client if Provider does one or more of the following:

i. Mails a printed copy of the information to the client's mailing address before the client first receives a SUD service;
ii. Mails a printed copy of the information upon the client's request to the client's mailing address;
iii. Provides the information by email after obtaining the client's agreement to receive the information by email;
iv. Posts the information on the Provider's website and advises the client in paper or electronic form that the information is available on the internet and includes applicable internet addresses, provided that clients with disabilities who cannot access this information online are provided auxiliary aids and services upon request and at no cost; or,
v. Provides the information by any other method that can reasonably be expected to result in the client receiving that information. If the Provider provides informing materials in person, when the client first receives SUD services, the date and method of delivery shall be documented in the client's file.

4. Provider Directory
   a. Provider must follow the County's provider directory policy, in compliance with MHSUDS IN 18-020.
   b. Provider must make available to clients, in paper form upon request and electronic form, specified information about its provider network as per 42 C.F.R. §438.10(h). The most current provider directory is electronically available on the County website and is updated by the County no later than 30 calendar days after information is received to update provider information. A paper provider directory must be updated as set forth in 42 C.F.R. §438.10(h)(3)(i).
   c. Any changes to information published in the provider directory must be reported to the County within two weeks of the change.
   d. Provider will only need to report changes/updates to the provider directory for each licensed SUD service provider.
5. Medication Formulary
   a. Provider shall make available in electronic or paper form, the following information about the County's formulary as outlined in 42 C.F.R. §438.10(i):
      i. Which medications are covered (for both generic and name brand).
      ii. What tier each medication resides on.
   b. Provider shall inform clients about County's formulary drug lists availability in a machine-readable file and format on the County's website.

ARTICLE LIX
Data, Privacy And Security Requirements:

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

2. Provider will comply with all County policies and procedures related to confidentiality, privacy, and secure communications.
3. Provider shall have all employees acknowledge an Oath of Confidentiality mirroring that of County, including confidentiality and disclosure requirements, as well as sanctions related to non-compliance.
4. Provider shall not use or disclose PHI or PII other than as permitted or required by law.

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

ARTICLE LX

Health Insurance Portability And Accountability Act (HIPAA) Compliance Business Associate Agreement (BAA):

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

ARTICLE LXI

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

ARTICLE LXII

Right To Monitor:

A. County or any subdivision or appointee thereof, and the State of California or any subdivision or appointee thereof, including the Auditor General, shall have absolute right to review and audit all records, books, papers, documents, corporate minutes, financial records, staff

information, client records, other pertinent items as requested, and shall have absolute right to monitor the performance of Provider in the delivery of services provided under this Agreement. Full cooperation shall be given by the Provider in any auditing or monitoring conducted, according to this Agreement.

B. Provider shall make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to Medi-Cal enrollees, Medi-Cal-related activities, services, and activities furnished under the terms of this Agreement, or determinations of amounts payable available at any time for inspection, examination, or copying by County, the State of California or any subdivision or appointee thereof, CMS, U.S. Department of Health and Human Services (HHS) Office of Inspector General, the United States Comptroller General or their designees, and other authorized federal and state agencies. This audit right will exist for at least 10 years from the final date of the Agreement period or in the event the Provider has been notified that an audit or investigation of this Agreement has commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later (42 CFR §438.230(c)(3)(I)-(ii)).
C. County, DHCS, CMS, or the HHS Office of Inspector General may inspect, evaluate, and audit the Provider at any time if there is a reasonable possibility of fraud or similar risk. The Department's inspection shall occur at the Provider's place of business, premises or physical facilities (42 CFR §438.230(c)(3)(iv)).
D. Provider shall cooperate with County in the implementation, monitoring and evaluation of this Agreement and comply with any and all reporting requirements established by the County. Should the County identify an issue or receive notification of a complaint or potential/actual/suspected violation of requirements, the County may audit, monitor, and/or request information from the Provider to ensure compliance with laws, regulations, and requirements, as applicable.
E. County reserves the right to place Provider on probationary status, as referenced in the Probationary Status Article, should Provider fail to meet performance requirements; including, but not limited to violations such as high disallowance rates, failure to report incidents and changes as contractually required, failure to correct issues, inappropriate invoicing, untimely and inaccurate data entry, not meeting performance outcomes expectations, and violations issued directly from the State. Additionally, Provider may be subject to Probationary Status or termination if contract monitoring and auditing corrective actions are not resolved within specified timeframes.
F. Provider shall retain all records and documents originated or prepared pursuant to Provider's performance under this Agreement, including client grievance and appeal records, and the data, information and documentation specified in 42 C.F.R. parts §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years from the term end date of this Agreement or until such time as the matter under audit or investigation has been resolved. Records and documents include but are not limited to all physical and electronic records and documents originated or prepared pursuant to Provider's or subcontractor's performance under this Agreement including working papers, reports, financial records and documents of account, client records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for clients.
G. Provider shall maintain all records and management books pertaining to service delivery and demonstrate accountability for contract performance and maintain all fiscal, statistical, and management books and records pertaining to the program. Records should include, but are not

limited to, monthly summary sheets, sign-in sheets, and other primary source documents. Fiscal records shall be kept in accordance with Generally Accepted Accounting Principles and must account for all funds, tangible assets, revenue and expenditures. Fiscal records must also comply with the Code of Federal Regulations (CFR), Title II, Subtitle A, Chapter 11, Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

H. All records shall be complete and current and comply with all Agreement requirements. Failure to maintain acceptable records per the preceding requirements shall be considered grounds for withholding of payments for billings submitted and for termination of Agreement.
I. Provider shall maintain client and community service records in compliance with all regulations set forth by local, state, and federal requirements, laws and regulations, and provide access to clinical records by County staff.
J. Provider shall comply with Medical Records/Protected Health Information Article regarding relinquishing or maintaining medical records.
K. Provider shall agree to maintain and retain all appropriate service and financial records for a period of at least 10 years from the date of final payment, the final date of the contract period, final settlement, or until audit findings are resolved, whichever is later.
L. Provider shall submit audited financial reports on an annual basis to the County. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.
M. In the event the Agreement is terminated, ends its designated term or Provider ceases operation of its business, Provider shall deliver or make available to County all financial records that may have been accumulated by Provider or subcontractor under this Agreement, whether completed, partially completed or in progress within seven calendar days of said termination/end date.
N. Provider shall provide all reasonable facilities and assistance for the safety and convenience of the County's representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner that will not unduly delay the work of Provider.
O. County has the discretion to revoke full or partial provisions of the Agreement, delegated activities or obligations, or application of other remedies permitted by state or federal law when the County or DHCS determines Provider has not performed satisfactorily.

ARTICLE LXIII

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

ARTICLE LXIV

Executive Order N-6-22 – Russia Sanctions: On March 4, 2022, Governor Gavin Newsom issued Executive Order N-6-22 (the EO) regarding Economic Sanctions against Russia and Russian entities and individuals. “Economic Sanctions” refers to sanctions imposed by the U.S. government in response to Russia’s actions in Ukraine, as well as any sanctions imposed under state law. The EO directs state agencies to terminate contracts with, and to refrain from entering

any new contracts with, individuals or entities that are determined to be a target of Economic Sanctions. Accordingly, if this Agreement is funded by state funds and County determines Provider is a target of Economic Sanctions or is conducting prohibited transactions with sanctioned individuals or entities, that shall be grounds for termination of this agreement. The County shall provide Provider advance written notice of such termination, allowing Provider at least thirty (30) calendar days to provide a written response. Termination shall be at the sole discretion of the County.

ARTICLE LXV

Contract Administrator: The County Officer or employee with responsibility for administering this Agreement is Shaun O'Malley, Alcohol and Drug Division Manager, Behavioral Health Division, Health and Human Services Agency (HHSA), or successor. In the instance where the named Contract Administrator no longer holds this title with County and a successor is pending, or HHSA has to temporarily delegate this authority, County Contract Administrator's Supervisor shall designate a representative to temporarily act as the primary Contract Administrator of this Agreement and HHSA Administration shall provide the Provider with the name, title and email for this designee via notification in accordance with the Article titled "Notice to Parties" herein.

ARTICLE LXVI

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

ARTICLE LXVII

Partial Invalidity: 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 LXVIII

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.

(Non-applicable services may be removed in the below ARTICLE LXIX per Provider specifications in final contract)

ARTICLE LXIX

Additional Terms and Conditions: In accordance with the DHCS Substance Use Prevention, Treatment and Recovery Services Block Grant (SUBG) requirements as set forth in DHCS Substance Use Block Grant (SUBG) Application #8797 and Enclosures for 2024-2026, or as amended or replaced, which can be viewed at County's Contractor Resources (under the category titled Behavioral Health Funding and/or Governing Agreements) online at https://www.eldoradocounty.ca.gov/Health-Well-Being/Health-and-Human-Services/HHSA-

Contractor-Resources, provider, p shall comply with the following SUBG Enclosure 2, sections 2 additional terms and conditions:

A. General Provisions

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

2. Hatch Act: Provider agrees to comply with the provisions of the Hatch Act United States Code (USC), Title 5, Part III, Subpart F., Chapter 73, Subchapter III), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.

3. No Unlawful Use or Unlawful Use Messages Regarding Drugs: Provider agrees that information produced through these funds, and which pertains to drugs 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 (California Health and Safety Code (HSC), Division 10.7, Chapter 1429, Sections 11999-11999.3). By signing this Agreement, Provider agrees that it will enforce, and will require its subcontractors to enforce, these requirements (DHCS Substance Use Block Grant (SUBG) Application #8797 and Enclosures for 2024-2026, or as amended or replaced, which can be viewed at County's Contractor Resources (under the category titled Behavioral Health Funding and/or Governing Agreements) online at https://www.eldoradocounty.ca.gov/Health-Well-Being/Health-and-Human-Services/HHSA-Contractor-Resources).

4. 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).

5. Debarment and Suspension: Provider shall not subcontract with or employ any party listed on the government wide exclusions in the System for Award Management (SAM), in accordance with the Office of Management and Budget (OMB) guidelines at 2 California Code of Federal Regulations (CFR) 180 that implement Executive Orders 12549 (3 CFR part 1986 Comp. p. 189) and 12689 (3 CFR part 1989., p. 235), "Debarment and Suspension." SAM exclusions contain the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549. Provider shall advise all subcontractors of their obligation to comply with applicable federal debarment and suspension regulations, in addition to the requirements set forth in 42 CFR Part 1001.

   If a county subcontracts or employs an excluded party, DHCS has the right to withhold payments, disallow costs, or issue a Corrective Action Plan (CAP), as appropriate, pursuant to HSC Code 11817.8(h).

6. Restriction on Purchase of Sterile Needles: No SUBG funds made available through this Agreement shall be used to purchase sterile needles or syringes for the hypodermic

injection of any illegal drug. DHCS has allowed SUBG funds to support existing Syringe Services Programs (SSP) or to establish new SSPs; reference Enclosure 5 (included in DHCS Substance Use Block Grant (SUBG) Application #8797 and Enclosures for 2024-2026, or as amended or replaced, which can be viewed at County's Contractor Resources (under the category titled Behavioral Health Funding and/or Governing Agreements) online at https://www.eldoradocounty.ca.gov/Health-Well-Being/Health-and-Human-Services/HHSA-Contractor-Resources) for allowable costs related to SSP. **No federal funds can be used to purchase sterile needles or syringes.**

7. Health Insurance Portability and Accountability Act (HIPAA) of 1996: All work performed by Provider under this Agreement is subject to HIPAA. Provider shall perform the work in compliance with all applicable provisions of HIPAA and in accordance with the HIPAA requirements identified in the County's fully executed Performance Agreement, including any amendments or renewals thereto, with DHCS (DHCS Agreement #21-10079/County Agreement #5819), which can be viewed at County's Contractor Resources (under the category titled Behavioral Health Funding and/or Governing Agreements) online at https://www.eldoradocounty.ca.gov/Health-Well-Being/Health-and-Human-Services/HHSA-Contractor-Resources, to include the HIPAA provisions included in the following DHCS Exhibits:
   a. DHCS Exhibit E (Privacy and Information Security Requirements)
   b. DHCS Exhibit E-1 (HIPAA Business Addendum);
   c. DHCS Exhibit E-2 (Privacy and Security of Personal Information and Personally Identifiable Information Not Subject to HIPAA); and
   d. DHCS Exhibit E-3 (Miscellaneous Provisions).

8. Trading Partner Requirements:
   a. Provider hereby agrees that for the personal health information (Information), it will not change any definition, data condition, or use of a data element or segment as proscribed in the federal Department of Health and Human Services (HHS) Transaction Standard Regulation (45 CFR 162.915 (a)).
   b. No Additions. Provider hereby agrees that for the Information, it will not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation (45 CFR 162.915 (b)).
   c. No Unauthorized Uses. Provider hereby agrees that for the Information, it will 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 162.915 (c)).
   d. No Changes to Meaning or Intent. Provider hereby agrees that for the Information, it will not change the meaning or intent of any of the HHS Transaction Standard's implementation specification (45 CFR 162.915 (d)).

9. Concurrence for Test Modifications to HHS Transaction Standards: Provider agrees and understands that there exists the possibility that DHCS or others may request an extension from the uses of a standard in the HHS Transaction Standards. If this occurs, Provider agrees that it will participate in such test modifications.

10. Adequate Testing: Provider is responsible to adequately test all business rules appropriate to their types and specialties. If the contractor is acting as a clearinghouse for enrolled providers, contractor has obligations to adequately test all business rules appropriate to each and every provider type and specialty for which they provide clearinghouse services.

11. Deficiencies: Provider agrees to correct transactions, errors, or deficiencies identified by DHCS, and transactions errors or deficiencies identified by an enrolled provider if the county is acting as a clearinghouse for that provider. When county is a clearinghouse, county agrees to properly communicate deficiencies and other pertinent information regarding electronic transactions to enrolled providers for which they provide clearinghouse services.

12. Code Set Retention: Both parties understand and agree to keep open code sets being processed or used in this Agreement for at least the current billing period or any appeal period, whichever is longer.

13. Data Transmission Log: Both parties shall establish and maintain a Data Transmission Log which shall record any and all Data Transmissions taking place between the Parties during the term of this Agreement. Each party will take necessary and reasonable steps to ensure that such Data Transmission Logs constitute a current, accurate, complete, and unaltered record of any and all Data Transmissions between the parties, and shall be retained by each Party for no less than twenty-four (24) months following the date of the Data Transmission. The Data Transmission Log may be maintained on computer media or other suitable means provided that, if it is necessary to do so, the information contained in the Data Transmission Log may be retrieved in a timely manner and presented in readable form.

14. Nondiscrimination and Institutional Safeguards for Religious Providers: Provider shall establish such processes and procedures as necessary to comply with the provisions of USC, Title 42, Section 300x-65 and CFR, Title 42, Part 54.

15. Counselor Certification: 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 registered or certified as defined in California Code of Regulations (CCR), Title 9, Division 4, Chapter 8.

16. Cultural and Linguistic Proficiency: To ensure equal access to quality care by diverse populations, Provider, receiving funds from this Agreement, shall adopt the Federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards as outlined online at: https://thinkculturalhealth.hhs.gov/clas/standards.

17. Intravenous Drug Use (IVDU) Treatment: Provider shall ensure that individuals in need of IVDU treatment shall be encouraged to undergo AOD treatment (42 USC 300x-23 (45 CFR 96.126(e)).

18. Tuberculosis Treatment: Provider shall ensure the following related to Tuberculosis (TB):
    a. Routinely make available TB services to individuals receiving treatment.

b. Reduce barriers to patients' accepting TB treatment.
c. Develop strategies to improve follow-up monitoring, particularly after patients leave treatment, by disseminating information through educational bulletins and technical assistance.

19. Trafficking Victims Protection Act of 2000: Provider and its subcontractors that provide services covered by this Agreement shall comply with the Trafficking Victims Protection Act of 2000 (USC, Title 22, Chapter 78, Section 7104) as amended by section 1702 of Pub. L. 112-239.

20. Tribal Communities and Organizations: Provider shall regularly review population information available through Census, compare to information obtained in the California Outcome Measurement System for Treatment (CalOMS-Tx) to determine whether the population is being reached, and survey Tribal representatives for insight in potential barriers to the substance use service needs of the American Indian/Alaskan Native (AI/AN) population within the county geographic area. County shall also engage in regular and meaningful consultation and collaboration with elected officials of the tribe, Rancheria, or their designee for the purpose of identifying issues/barriers to service delivery and improvement of the quality, effectiveness, and accessibility of services available to AI/AN communities within El Dorado County.

21. Marijuana Restriction: Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 CFR. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements."); 21 USC § 812(c) (10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the Drug Enforcement Administration (DEA) and under the Food and Drug Administration (FDA)-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under federal law.

22. Adolescent Best Practices Guidelines: Provider must utilize DHCS guidelines in developing and implementing youth treatment programs funded under this Enclosure (DHCS Substance Use Block Grant (SUBG) Application #8797 and Enclosures for 2024-2026, or as amended or replaced) The Adolescent Best Practices Guidelines can be found at: https://www.dhcs.ca.gov/Documents/CSD_CMHCS/Adol%20Best%20Practices%20Guide/AdolBestPracGuideOCTOBER2020.pdf

23. Byrd Anti-Lobbying Amendment (31 USC 1352): Provider certifies that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 USC 1352.

Provider shall also disclose to DHCS any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award.

24. Nondiscrimination in Employment and Services: Provider certifies that under the laws of the United States and the State of California, Provider will not unlawfully discriminate against any person.

25. Federal Law Requirements: Provider agrees to abide by the following federal requirements/laws:
    a. 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.
    b. 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.
    c. Age Discrimination Act of 1975 (45 CFR Part 90), as amended 42 USC Sections 6101 – 6107), which prohibits discrimination on the basis of age.
    d. Age Discrimination in Employment Act (29 CFR Part 1625).
    e. Title I of the Americans with Disabilities Act (29 CFR Part 1630) prohibiting discrimination against the disabled in employment.
    f. Title II of the Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities.
    g. Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.
    h. Section 504 of the Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.
    i. 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.
    j. Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.
    k. The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.
    l. Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2, Subparts A – E).

26. State Law Requirements: Provider agrees to abide by the following state requirements/laws:
    a. Fair Employment and Housing Act (Government Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (2 CCR 7285.0 et seq.).
    b. Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135.
    c. Title 9, Division 4, Chapter 8 of the CCR, commencing with Section 13000.
    d. No federal funds shall be used by the county or its subcontractors for sectarian worship, instruction, or proselytization. No federal funds shall be used by the county or its subcontractors to provide direct, immediate, or substantial support to any religious activity.

27. Additional Restrictions:
    a. Noncompliance with the requirements of nondiscrimination in services shall constitute grounds for DHCS to withhold payments under this Agreement or terminate all, or any type, of funding provided hereunder.
    b. This Agreement is subject to any additional restrictions, limitations, or conditions enacted by the federal or state governments that affect the provisions, terms, or funding of this Agreement in any manner.

28. Information Access for Individuals with Limited English Proficiency:
    a. Provider shall comply with all applicable provisions of the Dymally-Alatorre Bilingual Services Act (Government Code sections 7290-7299.8) regarding access to materials that explain services available to the public as well as providing language interpretation services.
    b. Provider shall comply with the applicable provisions of Section 1557 of the Affordable Care Act (45 CFR Part 92), including, but not limited to, 45 CFR 92.201, when providing access to: (a) materials explaining services available to the public, (b) language assistance, (c) language interpreter and translation services, or (d) video remote language interpreting services.

29. Subcontract Provisions: Provider shall include all of the foregoing Part II general provisions in all of its subcontracts. These requirements must be included verbatim in contracts with subcontractors/subrecipients and not through documents incorporated by reference.

ARTICLE LXX

Generative Artificial Intelligence: For the purposes of this provision, "Generative AI (GenAI)" means an artificial intelligence system that can generate derived synthetic content, including text, images, video, and audio that emulates the structure and characteristics of the system's training data. (Gov. Code § 11549.64.)

A. Provider shall immediately notify County in writing if it: (1) intends to provide GenAI as a deliverable to the County; or (2), intends to utilize GenAI, including GenAI from third parties, to complete all or a portion of any deliverable that materially impacts: (i) functionality of a State or County system ("System"), (ii) risk to the State or County, or (iii) performance of this Agreement. For avoidance of doubt, the term "materially impacts" shall have the meaning set forth in State Administrative Manual (SAM) § 4986.2 Definitions for GenAI.
B. Notification shall be provided to the County's Contract Administrator identified in this Agreement.
C. At the direction of County, Provider shall discontinue the provision to County of any previously unreported GenAI that results in a material impact to the functionality of a System, risk to the State or County, or performance of this Agreement, as determined by County.
D. If the use of previously undisclosed GenAI is approved by County, the Parties will amend the Agreement accordingly, which may include updating the description of deliverables and incorporating GenAI Special Provisions into the Agreement, at no additional cost to the County.
E. County, at its sole discretion, may consider Provider's failure to disclose or discontinue the provision or use of GenAI as described above, to constitute a material breach of this Agreement when such failure results in a material impact to the functionality of the System, risk to the

State or County, or performance of this Agreement. County is entitled to seek any and all remedies available to it under law as a result of such breach, including but not limited to termination of the Agreement.

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

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

Requesting Contract Administrator Concurrence:

By: _____ Dated: _____
Shaun O'Malley, MPH
Alcohol and Drug Division Manager
Behavioral Health Division
Health and Human Services Agency

Requesting Department Head Concurrence:

By: _____ Dated: _____
Olivia Byron-Cooper, MPH
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 --

By: _____ Dated: _____
Purchasing Agent
Chief Administrative Office
"County"

OR

-- COUNTY OF EL DORADO --

Dated: _____

By: _____
Chair
Board of Supervisors
"County"

ATTEST:
Kim Dawson
Clerk of the Board of Supervisors

By: _____ Dated: _____
Deputy Clerk

-- PROVIDER --

By: _____ Dated: _____
Name
Chief Executive Officer
"Provider"

By: _____ Dated: _____
Corporate Secretary

Provider Name
Exhibit A
Scope Of Work

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

2. **TARGET POPULATION**
   Provider shall provide services to the following populations:
   A. The target population for DMC-ODS SUD services includes clients who are enrolled in Medi-Cal, reside in the County, and meet the criteria for DMC-ODS services as per established requirements above.
   B. Clients referred by, and who have written prior authorization from the County of El Dorado, Substance Use Disorder Division

3. **SERVICES TO BE PROVIDED**
   A. Provider shall provide services in accordance with the requirements included in the below County agreements, available online through the County's Contractor Resources site (under the category labeled Behavioral Health Funding and/or Governing Agreements) at: https://www.eldoradocounty.ca.gov/Health-Well-Being/Health-and-Human-Services/HHSA-Contractor-Resources

   (Non-applicable services may be removed per provider specifications in final contract)
      i. DHCS Drug Medical Organized Delivery System Agreement #25-50096 (County Agreement 9726), or as may be amended or replaced;
      ii. County's DHCS Performance Agreement, inclusive of Substance Use Prevention and Treatment Block Grant (SUBG) #21-10079, inclusive of its First and Second Amendments (County Agreement #5819, #5819 A1 and #5819 A2), or as may be amended or replaced; and
      iii. County's Substance Use Prevention and Treatment Block Grant (SUBG) program requirements which are included in Enclosures #2, #3, and #4.
   B. Provider shall also adhere to the program requirements below, included in the Drug Medi-Cal Billing Manual available in the Department of Health Care Services (DHCS) County Claims Customer Services Library page available at https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx, or subsequent updates to this billing manual, to clients who meet access criteria for receiving SUD services.
   C. Provider shall also adhere to the program requirements below which are available on the County's Behavioral Health Division SUDS resources page at:

https://www.eldoradocounty.ca.gov/Health-Well-Being/Behavioral-Health/Substance-Use-Disorder-Services-SUDS:

(Non-applicable services may be removed per provider specifications in final contract)

i. El Dorado County DMC-ODS Practice Guidelines
ii. Minimum Quality Drug Treatment Standards – DMC
iii. Minimum Quality Drug Treatment Standards – SUBG
iv. SUBG Policy Manual
v. Perinatal Practice Guidelines
vi. Adolescent Substance Use Disorder Best Practices Guide
vii. El Dorado County SUD Compliance Plan
viii. El Dorado County SUD DMC-ODS Training Plan

4. **ALLOWABLE SERVICES UNDER CONTRACT**

(Non-applicable services may be removed per provider specifications in final contract)

A. ASAM Level 0.5 - Screening, Brief Intervention, Referral to Treatment and Early Intervention Services
   i. Early intervention services are covered for beneficiaries under the age of 21. Any beneficiary under age 21 who is screened and determined to be at risk of developing a SUD may receive any service component covered under the outpatient level of care as early intervention services. Early intervention services are provided under the outpatient treatment modality and must be available as needed based on individual clinical need, even if the beneficiary under age 21 is not participating in the full array of outpatient treatment services.
   ii. A SUD diagnosis is not required for early intervention services.
   iii. A full assessment utilizing the ASAM Criteria© is not required for a beneficiary under the age of 21 to receive early intervention services; an abbreviated ASAM screening tool may be used.
      a. If the beneficiary under 21 meets diagnostic criteria for SUD, a full ASAM assessment shall be performed, and the beneficiary shall receive a referral to the appropriate level of care indicated by the assessment. IV. Services may be delivered in a wide variety of settings, and can be provided in person, by telehealth, or by telephone. Nothing in this section limits or modifies the scope of the EPSDT mandate.
   iv. Additional clarification:
      a. Alcohol and Drug Screening, Assessment, Brief Intervention, and Referral to Treatment (SABIRT), commonly known as Brief Intervention, and Referral and Treatment (SBIRT) is not a DMC-ODS benefit. It is a benefit in Medi-Cal Fee for- Service (FFS) and Medi-Cal managed care delivery system for beneficiaries aged 11 years and older.
      b. An abbreviated ASAM screening tool may be used for initial screening, referral, and access to clinically appropriate services. Please note that no preliminary level of care recommendation or screening tool is a substitute for a comprehensive ASAM Criteria© assessment.

B. ASAM Level 1.0 - Outpatient Treatment Services (often referred to as Outpatient Drug Free/ODF)
   i. Outpatient treatment services include the following:

a. Assessment
b. Care Coordination
c. Counseling (individual and group)
d. Family Therapy
e. Medication Services
f. MAT for Opioid Use Disorder (OUD)
g. MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
h. Patient Education
i. Recovery Services
j. SUD Crisis Intervention Services

ii. Service hours:
a. Beneficiaries aged 21 years and older: Up to none (9) hours a week
b. Beneficiary under the age of 21: Up to six (6) hours a week
c. Services may exceed the maximum based on individual medical necessity.
d. Services may be provided in person, by telehealth, or by telephone.

iii. Medication Assisted Treatment (MAT)
a. County is required to either offer medications for addiction treatment directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving outpatient treatment services if not provided on-site (Providing a beneficiary the contact information for a treatment program is insufficient).
b. County shall monitor the referral process or provision of MAT services.

C. ASAM Level 2.1 – Intensive Outpatient Treatment Services
i. Intensive Outpatient Services are provided in a structured programming environment.
a. Intensive outpatient treatment services include the following:
1. Assessment
2. Care Coordination
3. Counseling (individual and group)
4. Family Therapy
5. Medication Services
6. MAT for Opioid Use Disorder (OUD)
7. MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs
8. Patient Education
9. Recovery Services
10. SUD Crisis Intervention Services

ii. Service hours:
a. Beneficiaries aged 21 years and older: Minimum of nine (9) hours with a maximum of 19 hours a week.
b. Beneficiary under the age of 21: Minimum of six (6) hours with a maximum of 19 hours a week.
c. Services may exceed the maximum based on individual medical necessity.

iii. Services may be provided in person, by telehealth, or by telephone.
iv. Medication Assisted Treatment (MAT)

a. Provider is required to either offer medications for addiction treatment directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving outpatient treatment services if not provided on-site. Effective referral mechanism is defined as facilitating access to MAT off-site for beneficiaries if not provide on-site). Providing a beneficiary, the contact information for a treatment program, is considered insufficient.
b. County shall monitor the referral process or provision of MAT services.

D. Recovery Services
   i. Recovery services are designed to support recovery and prevent relapse with the objective of restoring the beneficiary to their best possible functional level with emphasis on the beneficiary as the central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management.
      a. Service components:
         1. Assessment
         2. Care Coordination
         3. Counseling (individual and group)
         4. Family Therapy
         5. Recovery Monitoring, which includes recovery coaching and monitoring designed for the maximum reduction of the beneficiary's SUD.
         6. Relapse Prevention, which includes interventions designed to teach beneficiaries with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the beneficiary's SUD.
      b. Services may be provided based on the beneficiary's self-assessment or provider assessment of relapse risk.
      c. Diagnosis of "remission" is not required to receive Recovery Services.
      d. Services may be provided concurrently with MAT services, including NTP services.
      e. Services may be provided immediately after incarceration with a prior diagnosis of SUD.
      f. Services may be provided in person, by telehealth, or by telephone.
      g. Recovery Services can be delivered and claimed as a standalone service, concurrently with the other levels of care described.

E. Care Coordination
   i. Care coordination was previously referred to as "case management" for the years 2015-2021.
   ii. Care coordination shall be provided in conjunction with all levels of treatment.
      a. Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level.
      b. Service components include one of more of the following:
         1. Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.

2. Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers.
3. Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports, including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.

iii. Care Coordination may also be delivered and claimed as a standalone service in a DMC-ODS County.
   a. Services can be provided in clinical or non-clinical settings, including the community.
   b. Services may be provided in-person, by telehealth, or by telephone.
   c. Care coordination services shall be provided with other SUD, physical, and/or mental health services in order to ensure a client-centered and whole-person approach to wellness.

F. ASAM Levels 3.1, 3.3, 3.5 - Residential Treatment
   i. Residential Treatment Services are provided in a short-term residential program through one of the following levels:
      a. Level 3.1 - Clinically Managed Low-Intensity Residential Services
      b. Level 3.3 - Clinically Managed Population Specific High Intensity Residential Services
      c. Level 3.5 - Clinically Managed High Intensity Residential Services
   ii. Service components:
      a. Assessment
      b. Care Coordination
      c. Counseling (individual and group)
      d. Family Therapy
      e. Medication Services
      f. MAT for OUD
      g. MAT for AUD and other non-opioid SUDs
      h. Patient Education
      i. Recovery Services
      j. SUD Crisis Intervention Services
   iii. Services shall address functional deficits documented in the ASAM Criteria©: Services shall be aimed to restore, maintain, and apply interpersonal and independent living skills and access community support systems.
   iv. A beneficiary shall live on the premises and be considered a "short-term resident" of the residential facility where the beneficiary receives services under this DMC-ODS level of care.
   v. Services may be provided in facilities of any size.
   vi. Services are driven by the beneficiary's care needs and shall be transitioned to other levels of care when clinically appropriate and served in the least restrictive setting.

vii. Residential treatment services for adults under these levels are provided by DMC-certified providers who must be licensed and enrolled in accordance with all applicable state and federal laws and regulations. This includes residential facilities licensed by DHCS, residential facilities licensed by the Department of Social Services, Chemical Dependency Recovery Hospitals (CDRHs) licensed by the Department of Public Health or freestanding Acute Psychiatric Hospitals (FAPHs) licensed by Department of Public Health (DPH).

viii. Residential providers licensed by a state agency other than DHCS must be DMC Certified.

ix. DHCS Level of Care designation and/or ASAM Level of Care Certification:
   a. All facilities delivering Residential Treatment services under DMCODS must also be designated as capable of delivering care consistent with the ASAM Criteria.
   b. Designation is required for facilities offering ASAM levels 3.1, 3.3 and/or 3.5.
   c. All counties with residential facilities offering levels 3.1. 3.3 and/or 3.5, licensed by a state agency other than DHCS, shall have an ASAM Level of Care Certification for each of the levels of care provided at the facility under the DMCS-ODS program by January 1, 2024.

x. Services may be provided in person, by telehealth, or by telephone
   a. Most services shall be in person.
   b. Telehealth and telephone services shall be used to supplement, not replace, the in-person services and in-person treatment milieu.

xi. Medication Assisted Treatment (MAT): Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving partial hospitalization services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient). County shall monitor the referral process or provision of MAT services.

xii. Length of Stay
   a. The average statewide length of stay goal is 30 days; however, this is not a quantitative treatment limitation and there is no hard "cap" on individual length of stays. Lengths of stay shall be determined by individualized clinical need. Beneficiaries shall be transitioned to appropriate levels of care as medically necessary.
   b. County shall adhere to length of stay monitoring requirements established by DHCS and the external quality review organization.

G. Withdrawal Management (WM) Services – Level 3.2 WM
   i. WM services are provided as a part of a continuum of care to beneficiaries experiencing withdrawal in the following outpatient, residential, and inpatient settings. Beneficiary shall be monitored during the detoxification process. Services are urgent and provided on a short-term basis.
   ii. A full ASAM Criteria© assessment shall not be required as a condition of admission to a facility providing WM. Service activities focus on the stabilization and management of psychological and physiological symptoms associated with

withdrawal, engagement in care and effective transitions to a level of care where beneficiary can receive comprehensive treatment services.

a. Level 3.2-WM: Clinically managed residential withdrawal management (24-hour support for moderate withdrawal symptoms that are not manageable in outpatient setting).
    1. This is considered a residential level of care and therefore requires the facility to be designated as capable of delivering care consistent with ASAM Criteria©.
    2. A DHCS level of care designation and/or an ASAM Level of Care Certification is required.

iii. Service components for residential, settings:
    a. Assessment
    b. Care Coordination
    c. Medication Services
    d. MAT for OUD
    e. MAT for AUD and other non-opioid SUDs
    f. Observation
    g. Recovery Services

iv. Care transitions to facilitate additional services or transition to a comprehensive treatment program.
    a. WM services are urgent and provided on a short-term basis.
    b. Practitioner shall conduct a full ASAM Criteria© assessment, brief screening, or other tools to support referral to additional services as appropriate.
    c. If a full ASAM Criteria© assessment was not completed as part of the withdrawal management service episode.
        1. Receiving program shall adhere to initial assessment timeliness requirements.

v. Level 3.2 WM services may be provided in a residential setting. For residential settings, each beneficiary shall reside at the facility.

H. Medication Assisted Treatment (MAT): Providers must offer MAT directly or have effective referral mechanisms in place to the most clinically appropriate MAT services (defined as facilitating access to MAT off-site for beneficiaries while they are receiving partial hospitalization services if not provided on-site. Providing a beneficiary the contact information for a treatment program is insufficient).

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

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

to the California Code of Regulations, title 9, Chapter 4, and Title 42 of the Code of Federal Regulations (CFR).

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

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

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

J. Medi-Cal Peer Support Services:

i. Medi-Cal Peer Support Services are defined as "culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower Medi-Cal members through strength-based coaching, support linkages to community resources, and educate members and their families about their conditions and the process of recovery." Medi-Cal Peer Support Services may be provided with the member or significant support person(s) and may be provided in a clinical or non-clinical setting.

5. **PROVISION OF SERVICES**

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

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

B. Professional staff means any of the following:
   i. Licensed Practitioners of the Healing Arts (LPHA) include:
   ii. Physician
   iii. Nurse Practitioners
   iv. Physician Assistants
   v. Registered Nurses
   vi. Registered Pharmacists
   vii. Licensed Clinical Psychologists
   viii. Licensed Clinical Social Worker
   ix. Licensed Professional Clinical Counselor
   x. Licensed Marriage and Family Therapists
   xi. Licensed Eligible Practitioners registered with the Board of Psychology or Behavioral Science Board working under the supervision of a licensed clinician
   xii. An Alcohol or other drug (AOD) counselor that is 1) either certified or registered by an organization that is recognized by the Department of Health Care Services and accredited with the National Commission for Certifying Agencies (NCCA), and 2) meets all California State education, training, and work experience requirements set forth in the Counselor Certification Regulations, Cal. Code Regs., tit. 9, Div. 4, chapter 8.
   xiii. Medical Director of a Narcotic Treatment Program who is a licensed physician in the State of California.

C. Additional Staffing Requirements:
   i. 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.
   ii. 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.
   iii. Physicians shall receive a minimum of five (5) hours of continuing medical education related to addiction medicine each year.
   iv. Professional staff (LPHAs) shall receive a minimum of five (5) hours of continuing education related to addiction medicine each year.
   v. Registered and certified Substance Use Disorder (SUD) counselors shall adhere to all requirements in California Code of Regulations (CCR), Title 9, Chapter 8, Certification of Alcohol and Other Drug Counselors.

D. Confidentiality**:** All SUD treatment services shall be provided in a confidential setting in compliance with 42 Code of Federal Regulations (CFR), Part 2 requirements.
E. Substance Use Disorder (SUD) Medical Director: The SUD Medical Director's responsibilities shall, at a minimum, include all of the following:
    i. Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
    ii. Ensure that physicians do not delegate their duties to non-physician personnel
    iii. Develop and implement written medical policies and standards for the Provider.
    iv. Ensure that physicians, registered nurse practitioners, and physician assistants follow the Provider's medical policies and standards.
    v. Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
    vi. 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.
    vii. Ensure that Provider's physicians are adequately trained to perform other physician duties, as outlined in this section.
    viii. The SUD Medical Director may delegate his/her responsibilities to a physician consistent with the Provider's medical policies and standards; however, the SUD Medical Director shall remain responsible for ensuring all delegated duties are properly performed.

6. **PROVIDER PERSONNEL**

Personnel files shall be maintained on all employees and volunteers/interns and shall contain the following:

A. Application for employment and/or resume
B. Signed employment confirmation statement/duty statement
C. Job description
D. Performance evaluations
E. Health records/status as required by the Provider, Alcohol and Other Drug (AOD) Certification or Title 9
F. Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries)
G. Training documentation relative to substance use disorders and treatment
H. Current registration, certification, intern status, or licensure
I. Proof of continuing education required by licensing or certifying agency and program
J. Provider's Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying/licensing body's code of conduct as well.
K. Job descriptions shall be developed, revised as needed, and approved by the Provider's governing body. The job descriptions shall include:
    i. Position title and classification;
    ii. Duties and responsibilities;
    iii. Lines of supervision; and
    iv. Education, training, work experience, and other qualifications for the position.
L. Written Provider code of conduct for employees and volunteers/interns shall be established which addresses at least the following:

i. Use of drugs and/or alcohol;
ii. Prohibition of social/business relationship with beneficiaries or their family members for personal gain;
iii. Prohibition of sexual contact with beneficiaries;
iv. Conflict of interest;
v. Providing services beyond scope;
vi. Discrimination against beneficiaries or staff;
vii. Verbally, physically, or sexually harassing, threatening or abusing beneficiaries, family members or other staff;
viii. Protection of beneficiary confidentiality; and
ix. Cooperation with complaint investigations.

M. If a Provider utilizes the services of volunteers and/or interns, written procedures shall be implemented which address:
i. Recruitment;
ii. Screening and Selection;
iii. Training and orientation;
iv. Duties and assignments;
v. Scope of practice;
vi. Supervision;
vii. Evaluation; and
viii. Protection of beneficiary confidentiality.

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

7. **DISCHARGE CRITERIA AND PROCESS**

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

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

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

8. **PROGRAM OR SERVICE SPECIFIC AUTHORIZATION REQUIREMENTS**

A. The following services, as applicable, may only be provided if County refers a client to Provider via County's written treatment authorization form:

(Non-applicable services may be removed per provider specifications in final contract)

i. SUBG Funded Treatment Services;
ii. Residential Treatment Services – Levels 3.1, 3.3 and 3.5;
iii. Recovery Residences Services; and
iv. Room and Board Services.

9. **CONTRACT DELIVERABLES, OBJECTIVES AND OUTCOMES**

A. Provider shall comply with all requests regarding local, state, and federal performance outcomes measurement requirements and participate in the outcomes measurement processes as requested.
B. Provider shall work collaboratively with County to develop process benchmarks and monitor progress in the following areas:
    i. Productivity: Provider shall ensure that staff maintain a productivity level of at least 50% and will report staff productivity levels on a quarterly basis to: SUDSQualityassurance@edcgov.us. Incentive shall be authorized when Provider reports staff productivity level of at least 60% for two consecutive quarters of a fiscal year.
    ii. Access: First face-to-face appointment shall occur within ten (10) business days of initial contact.
        a. Incentive shall be authorized when at least 75% of first face-to-face appointment occurs within five (5) business days of initial contact.

OR

    ii. Access: First face-to-face appointment shall occur within 3 business days of initial contact for licensed Opioid Treatment Providers (OTPs).
        a. Incentive shall be authorized when at least 75% of first face-to-face appointment occurs within five (5) business days of initial contact.
C. Provider will collaborate with the County in the collection and reporting of performance outcomes data, including data relevant to Healthcare Effectiveness Data and Information Set (HEDIS®) measures, as required by DHCS. Measures relevant to this Agreement are indicated below (check all that apply):
    i. Follow up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA);
    ii. Use of Pharmacotherapy for Opioid Use Disorder (POD) In accordance with agreed upon processes detailed in the applicable POD performance improvement plan between the provider and the County;
    iii. Pharmacotherapy of Opioid Use Disorder; and
    iv. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment.

10. **REPORTING AND EVALUATION REQUIREMENTS**
A. Provider shall complete all reporting and evaluation activities as required by the County and described herein.
    i. Productivity Reporting
    ii. Monthly Attestation of Compliance Due by the 10th of the month
    iii. Level of Care Reporting Due by the 10th of the month
    iv. Timeliness Reporting Due by the 10th of the month

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

B. County will provide the Provider with all applicable standards for the delivery and accurate documentation of services.
C. County will make ongoing technical assistance available in the form of direct consultation to Provider upon Provider's request to the extent that County has capacity and capability to provide this assistance. In doing so, the County is not relieving Provider of its duty to provide training and supervision to its staff or to ensure that its activities comply with applicable regulations and other requirements included in the terms and conditions of this Agreement.
D. Any requests for technical assistance by Provider regarding any part of this Agreement shall be directed to the County's designated contract monitor.
E. Provider shall require all new employees in positions designated as "covered individuals" to complete compliance training within the first 30 days of their first day of work. Provider shall require all covered individuals to attend, at minimum, one compliance training annually.
    i. These trainings shall be conducted by County or, at County's discretion, by Provider staff, or both, and may address any standards contained in this Agreement.
    ii. Covered individuals who are subject to this training are any Provider staff who have or will have responsibility for, or who supervises any staff who have responsibility for, ordering, prescribing, providing, or documenting client care or medical items or services.
F. Provider shall require that physicians receive a minimum of five hours of continuing medical education related to addiction medicine each year.
G. Provider shall require that professional staff (LPHAs) receive a minimum of five (5) hours of continuing education related to addiction medicine each year.
H. Additional Requirements: Provider shall adhere to the Substance Use Disorder Services Training Plan most current version, which can be found online at: https://www.eldoradocounty.ca.gov/files/assets/county/v/1/documents/health-amp-wellbeing/mental-health/sud/edc-dmc-ods-fiscal-year-2025-2026-training-plan.pdf.

Provider Name
Exhibit B
Provider Rates

A. Rates: Provider shall observe and comply with all provisions, including lockout and non-reimbursable service rules, as outlined in the DHCS Drug Medi-Cal ODS Billing Manual or as otherwise amended or superseded. Use of the following Provider Types shall be in accordance with BHIN 24-023 titled "Standards for Specific Behavioral Health Provider Types and Services" or as otherwise amended or superseded.

Table 1: Provider Type Rates

Provider Type	15 minutes per unit (Individual Client Rate)	15 minutes per unit (Group Rate)
Certified Alcohol and Other Drug (AOD) Counselor		
Licensed, Waived or Intern Practitioner of the Healing Arts (LPHA/PHA): Clinical Social Worker (LCSW/CSW), Marriage and Family Therapist (LMFT/MFT), Professional Clinical Counselor (LPCC/PCC)		
Licensed Physician (MD)		
Registered Nurse (RN)		
Nurse Practitioner (NP)		
Physicians Assistant (PA)		
Occupational Therapist (OT)		
Psychologist (Licensed or Waivered)		
Licensed Psychiatric Technician (LPT)		
Licensed Vocational Nurse (LVN)		
Medical Assistant		
Other Qualified Practitioner		
Peer Support Specialist		
Registered Pharmacist		

Subject to the written approval of the County Contract Administrator, County may amend the following Table 2 Rates, Description thereof, or Duration, in accordance and to align with updates to the DHCS Drug Medi-Cal ODS Billing Manual as well as DHCS Service Tables and Fee Schedules at rates proportional to the previously negotiated Provider Type Rate detailed in Table 1. County shall issue written notice of amended Table 2 in accordance with the Article in the Agreement titled "Notice to Parties," at least 30-days in advance of the rate change.

Table 2: Other Rates

Provider Type	15 minutes (Individual)	15 minutes (2-4 patients)	15 minutes (5-8 patients)
Community Health Worker			

AND/OR

Medication Rates	One (1) unit (standard)	One (1) unit (perinatal)
NTP-Methadone		
NTP-Buprenorphine Mono		
NTP-Combination Product Film		
NTP-Combination Product Tablets		
NTP-Disulfiram		
Buprenorphine Injectable (Monthly)		
Naltrexone Injectable (Monthly)		
Naltrexone HCL generic (As Needed)		
Naltrexone HCL Narcan (As Needed)		
Naltrexone (Per Visit)		

AND/OR

Provider Type - Assessment	(5-14 minutes)	(15-30 minutes)	(30+ minutes)
Certified Alcohol and Other Drug (AOD) Counselor			
Licensed, Waived or Intern Practitioner of the Healing Arts (LPHA/PHA): Clinical Social Worker (LCSW/CSW), Marriage and Family Therapist (LMFT/MFT), Professional Clinical Counselor (LPCC/PCC)			
Licensed Physician (MD)			
Registered Nurse (RN)			
Nurse Practitioner (NP)			
Physicians Assistant (PA)			
Occupational Therapist (OT)			
Psychologist (Licensed or Waivered)			
Community Health Worker			
Licensed Psychiatric Technician (LPT)			
Licensed Vocational Nurse (LVN)			
Medical Assistant			

Provider Type - Assessment	(5-14 minutes)	(15-30 minutes)	(30+ minutes)
Other Qualified Practitioner			
Peer Support Specialist			
Registered Pharmacist			

AND/OR

Residential Services	1 Unit per day
SUDs Residential 3.1 (including Perinatal)	
SUDs Residential 3.2 Withdrawal Management	
SUDs Residential 3.5 (including Perinatal)	
Residential Treatment Room and Board	
Residential Treatment - Accompanying Child #1	
Residential Treatment - Accompanying Child #2	
Recovery Residences Room and Board	

AND/OR

Provider Type - Medical Team Conference	30 Units	60 Units
Licensed Physician (MD)		

AND/OR

Supplemental Services Description	Duration	Rate
Interpretation services	1 unit	31.88

AND/OR

CPT Code	Description	Duration (Minutes)	MD	NP	PA
99212	Medication Assisted Treatment (MAT) Services - Assessment	10-19			
99213		20-29			
99214		30-39			

Provider Name
Exhibit C
California Levine Act Statement

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

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

_____YES _____NO
If yes, please identify the person(s) by name:
If no, please type N/A.

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

_____YES _____NO
If yes, please identify the person(s) by name:
If no, please type N/A.

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

Date	Signature of authorized individual
Type or write name of company	Type or write name of authorized individual

Provider Name
Exhibit D
Notice of Adverse Benefit Determination (NOABD) Form

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

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

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

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

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

Provider Name
Exhibit E
Certification Of Non-Exclusion Or Suspension from Participation in a Federal Health Care Program

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

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

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

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

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

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

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

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

_____ _____

Provider Name Date

_____

Provider Signature

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

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PROVIDER 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; Fair Employment and Housing Act (Gov. Code §12900 et seq.), the regulations promulgated thereunder (Cal. Code Regs., tit. 2, §11000 et seq.), and including 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, physical disability, mental health disability, medical condition, national origin, race, ancestry, marital status, religion, religious creed, political affiliation, sexual orientation, gender identity, gender expression, genetic information, military and veteran status, or other applicable protected basis 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 PROVIDER HEREBY GIVES ASSURANCE THAT administrative methods/procedures which have the effect of subjecting individuals to discrimination or defeating the objectives of the California Department of Social Services (CDSS) Manual of Policies and Procedures (MPP) Chapter 21, will be prohibited.

BY ACCEPTING THIS ASSURANCE, the Provider/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.

BY ACCEPTING THIS ASSURANCE, the Provider agrees to give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement.

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

_____ _____

Date Provider Signature

_____

Address of Provider

Provider Name
Exhibit G
HIPAA Business Associate Agreement

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

R E C I T A L S

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

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

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

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

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

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

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

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

I. Definitions. Unless otherwise provided in this Business Associate Agreement, capitalized terms shall have the same meanings as set forth in the Privacy Rule, as may be amended from time to time.

II. Scope of Use and Disclosure by BA of County Disclosed PHI

A. BA shall not disclose PHI except for the purposes of performing BA's obligations under the Underlying Agreement. Further, BA shall not use PHI in any manner that would constitute a violation of the minimum necessary policies and procedures of the County, Privacy Rule, Security Rule, or the HITECH Act.

B. Unless otherwise limited herein, in addition to any other uses and/or disclosures permitted or authorized by this Business Associate Agreement or required by law, BA may:

1. Use the PHI in its possession for its proper management and administration and to fulfill any legal obligations.
2. disclose the PHI in its possession to a third party for the purpose of BA's proper management and administration or to fulfill any legal responsibilities of BA, or as required by law
3. Disclose PHI as necessary for BA's operations only if:
   a) Prior to making a disclosure to a third party, BA will obtain written assurances from such third party including:
      (1) To hold such PHI in confidence and use or further disclose it only for the purpose of which BA disclosed it to the third party, or as required by law; and
      (2) The third party will immediately notify BA of any breaches of confidentiality of PHI to the extent it has obtained knowledge of such breach.
4. Aggregate the PHI and/or aggregate the PHI with that of other data for the purpose of providing County with data analyses related to the Underlying Agreement, or any other purpose, financial or otherwise, as requested by County.
5. Not disclose PHI disclosed to BA by County not authorized by the Underlying Agreement or this Business Associate Agreement without patient authorization or de-identification of the PHI as authorized in writing by County.
6. De-identify any and all PHI of County received by BA under this Business Associate Agreement provided that the de-identification conforms to the requirements of the Privacy Rule, 45 CFR and does not preclude timely payment and/or claims processing and receipt.

C. BA agrees that it will neither use nor disclose PHI it receives from County, or from another business associate of County, except as permitted or required by this Business Associate Agreement, or as required by law, or as otherwise permitted by law.

III. Obligations of BA. In connection with its use of PHI disclosed by County to BA, BA agrees to:

A. Implement appropriate administrative, technical, and physical safeguards as are necessary to prevent use or disclosure of PHI other than as permitted by the Agreement that reasonably and appropriately protects the confidentiality, integrity, and availability of the PHI in accordance with Title 45 of the Code of Federal Regulations, Part 160 and Part 164, Subparts A and C (the "HIPAA Privacy Rule" and the "HIPAA Security Rule") in effect or as may be amended, including but not limited to 45 CFR 164.308,

164.310, 164.312, and 164.504(e)(2). BA shall comply with the policies, procedures, and documentation requirements of the HIPAA Security Rule.

B. Report to County within 24 hours of any suspected or actual breach of security, intrusion, or unauthorized use or disclosure of PHI of which BA becomes aware and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations. BA shall take prompt corrective action to cure any such deficiencies and any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.

C. Report to County in writing of any access, use, or disclosure of PHI not permitted by the Underlying Agreement and this Business Associate Agreement, and any Breach of Unsecured PHI of which it becomes aware without unreasonable delay and in no case later than five (5) days. To the extent the Breach is solely a result of BA's failure to implement reasonable and appropriate safeguards as required by law, and not due in whole or part to the acts or omissions of the County, BA may be required to reimburse the County for notifications required under 45 CFR 164.404 and CFR 164.406.

D. BA shall not use or disclose PHI for fundraising or marketing purposes. BA shall not disclose PHI to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates. BA shall not directly or indirectly receive remuneration in exchange of PHI, except with the prior written consent of the County and as permitted by the HITECH Act, 42 USC Section 17935(d)(2); however, this prohibition shall not affect payment by County to BA for services provided pursuant to the Agreement.

IV. PHI Access, Amendment, and Disclosure Accounting. BA agrees to:

A. Provide access, at the request of County, within five (5) days, to PHI in a Designated Record Set, to the County, or to an Individual as directed by the County. If BA maintains an Electronic Health Record, BA shall provide such information in electronic format to enable County to fulfill its obligations under the HITECH Act, including, but not limited to, 42 USC Section 17935(e).

B. Within ten (10) days of receipt of a request from County, incorporate any amendments or corrections to the PHI in accordance with the Privacy Rule in the event that the PHI in BA's possession constitutes a Designated Record Set.

C. To assist the County in meeting its disclosure accounting under HIPAA:

1. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents or subcontractors for at least six (6) years prior to the request. However, accounting of disclosure from Electronic Health Record for treatment, payment, or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent that BA maintains an electronic health record and is subject to this requirement. At the minimum, the information collected shall include: (i) the date of disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) a brief description of PHI disclosed and; (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure.

2. Within in 30 days of notice by the County, BA agrees to provide to County information collected in accordance with this section to permit the County to respond to a request by an Individual for an accounting of disclosures of PHI.

D. Make available to the County, or to the Secretary of Health and Human Services (the "Secretary"), BA's internal practices, books and records relating to the use of and disclosure of PHI for purposes of determining BA's compliance with the Privacy Rule, subject to any applicable legal restrictions. BA shall provide County a copy of any PHI that BA provides to the Secretary concurrently with providing such information to the Secretary.

V. Obligations of County.

A. County agrees that it will promptly notify BA in writing of any restrictions on the use and disclosure of PHI agreed to by County that may affect BA's ability to perform its obligations under the Underlying Agreement, or this Business Associate Agreement.

B. County agrees that it will promptly notify BA in writing of any changes in, or revocation of, permission by any Individual to use or disclose PHI, if such changes or revocation may affect BA's ability to perform its obligations under the Underlying Agreement, or this Business Associate Agreement.

C. County agrees that it will promptly notify BA in writing of any known limitation(s) in its notice of privacy practices to the extent that such limitation may affect BA's use of disclosure of PHI.

D. County shall not request BA to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by County, except as may be expressly permitted by the Privacy Rule.

E. County will obtain any authorizations necessary for the use or disclosure of PHI, so that BA can perform its obligations under this Business Associate Agreement and/or the Underlying Agreement.

VI. Term and Termination.

A. Term. This Business Associate Agreement shall commence upon the Effective Date and terminate upon the termination of the Underlying Agreement, as provided therein when all PHI provided by the County to BA, or created or received by BA on behalf of the County, is destroyed or returned to the County, or, or if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

B. Termination for Cause. Upon the County's knowledge of a material breach by the BA, the County shall either:

1. Provide an opportunity for the BA to cure the breach or end the violation and terminate this Agreement if the BA does not cure the breach or end the violation within the time specified by the County.
2. Immediately terminate this Agreement if the BA has breached a material term of this Agreement and cure is not possible; or
3. If neither termination nor cures are feasible, the County shall report the violation to the Secretary.

C. Effect of Termination.

1. Except as provided in paragraph (2) of this section, upon termination of this Agreement, for any reason, the BA shall, at the option of County, return or destroy

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

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

VII. Indemnity

A. BA shall indemnify and hold harmless all Agencies, Districts, Special Districts and Departments of the County, their respective directors, officers, Board of Supervisors, elected and appointed officials, employees, agents and representatives (collectively "County") from any liability whatsoever, based or asserted upon any services of BA, its officers, employees, subcontractors, agents or representatives arising out of or in any way relating to BA's performance under this Business Associate Agreement, including but not limited to property damage, bodily injury, or death or any other element of any kind or nature whatsoever including fines, penalties or any other costs and resulting from any reason whatsoever to the extent arising from the performance of BA, its officers, agents, employees, subcontractors, agents or representatives under this Business Associate Agreement. BA shall defend, at its sole expense, all costs and fees including but not limited to attorney fees, cost of investigation, defense and settlements or awards against the County in any claim or action based upon such alleged acts or omissions.

B. With respect to any action or claim subject to indemnification herein by BA, BA shall, at its sole cost, have the right to use counsel of its choice, subject to the approval of County, which shall not be unreasonably withheld, and shall have the right to adjust, settle, or compromise any such action or claim without the prior consent of County; provided, however, that any such adjustment, settlement or compromise in no manner whatsoever limits or circumscribes BA's indemnification of County as set forth herein. BA's obligation to defend, indemnify and hold harmless County shall be subject to County having given BA written notice within a reasonable period of time of the claim or of the commencement of the related action, as the case may be, and information and reasonable assistance, at BA's expense, for the defense or settlement thereof. BA's obligation hereunder shall be satisfied when BA has provided to County the appropriate form of dismissal relieving County from any liability for the action or claim involved.

C. The specified insurance limits required in the Underlying Agreement of this Business Associate Agreement shall in no way limit or circumscribe BA's obligations to indemnify and hold harmless the County herein from third party claims arising from the issues of this Business Associate Agreement.

D. In the event there is conflict between this clause and California Civil Code Section 2782, this clause shall be interpreted to comply with Civil Code Section 2782. Such interpretation shall not relieve the BA from indemnifying the County to the fullest extent allowed by law.

E. In the event there is a conflict between this indemnification clause and an indemnification clause contained in the Underlying Agreement of this Business

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

VIII. Amendment. The parties agree to take such action as is necessary to amend this Business Associate Agreement from time to time as is necessary for County to comply with the Privacy Rule, 45 CFR, and HIPAA generally.

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

X. Regulatory References. A reference in this Business Associate Agreement to a section in the Privacy Rule means the section as in effect or as amended.

XI. Conflicts. Any ambiguity in this Business Associate Agreement and the Underlying Agreement shall be resolved to permit County to comply with the Privacy Rule, 45 CFR, and HIPAA generally.

Approval and Signatures

By: _____ Dated: _____

Name
Title
Entity Name
"BA Representative"

By: _____ Dated: _____

Name
Title
El Dorado County Health and Human Services Agency (HHSA)
"HHSA Representative"