

AGREEMENT FOR SERVICES #7107
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 Recover Medical Group P.C., a California Professional Corporation, duly qualified to conduct business in the State of California, whose principal place of business is 120 Birmingham Drive, Suite 240A, Cardiff-by-the-Sea, California 92007 (hereinafter referred to as "Provider");

RECITALS

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

WHEREAS, Provider responded to a Request for Proposal #22-952-009, wherein Provider represented to County that it is specially trained, experienced, expert, and competent to perform the special services described in **ARTICLE I, Responsibilities and Services**; that it is an independent and bona fide business operation, advertises and holds itself as such, is in possession of a valid business license, and is customarily engaged in an independently established business that provides similar services to others; and County relies upon those representations;

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

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

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

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Exhibits

HHS Behavioral Health Program contracts use several numbered exhibits.

As some vendors have multiple contracts, for consistency, the numbers by which the exhibits are defined are not changed. Only those listed here apply to this agreement.

- 1. Intergovernmental Agreement (IGA) # 21-10027**
- 2. N/A**
- 3. Care Coordination**
- 4. Intensive Outpatient Services Level 2.1**
- 5. N/A**
- 6. Outpatient Services Level 1.0.**
- 7-13. N/A**
- 14. HIPAA Business Associate Agreement**
- 15. Vendor Assurance of Compliance with the County of El Dorado Health and Human Services Agency Nondiscrimination in State and Federally Assisted Programs**
- 16. California Levine Act Statement.**

ARTICLE I – Responsibilities and Services

1. County Responsibilities:

County shall be responsible for the following:

- A. Annual site inspection of all Provider-operated or Provider-contracted sites located within El Dorado County to evaluate the work performed or being performed hereunder, including subcontracted supported activities and the premises in which it is being performed. For Provider-operated or Provider-contracted sites located outside El Dorado County, the County may accept the annual site inspection documentation prepared by the host county if all El Dorado County Compliance Monitoring requirements are contained within.
 - B. Monitoring of invoices and services to verify adherence to the funding requirements.
 - C. Monitoring of program to verify adherence to terms and conditions pursuant to this Agreement.
2. **Scope of Services:** Provider agrees to furnish the personnel and equipment necessary to provide services as defined in the Intergovernmental Agreement #21-10027 (Exhibit 1), or as may be amended or replaced, and the included Exhibits numbered 3, 4, and 6, as applicable, all of which are attached hereto and incorporated by reference herein, as well as client progress reports. To the extent that the terms and conditions of the Intergovernmental Agreement conflict, the terms and conditions of the Agreement with the most stringent provisions shall prevail.

In addition, all services provided pursuant to this Agreement shall be performed in accordance with the following requirements, or as may be amended, all of which constitute part of this Agreement, available at https://www.edcgov.us/Government/hhsa/Pages/hhsa_contractor_resources.aspx

- A. Alcohol and/or Other Drug Program Certification Standards
- B. Drug Medi-Cal Billing Manual
- C. El Dorado County DMC-ODS Practice Guidelines
- D. Minimum Quality Drug Treatment Standards – DMC
- E. DHCS Adolescent Substance Use Disorder Best Practices Guide
- F. El Dorado County Policy and Procedure N-SUDS-005: Drug Medi-Cal Organized Delivery System Requirements for the Period of 2022-2026
- G. El Dorado County Policy and Procedure BH-182: Documentation Requirements For All Specialty Mental Health Services, and Drug Medi-Cal Organized Delivery System Services

3. Provision of Services:

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

- A. Professional staff shall be licensed, registered, certified, or recognized under California scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioners of the Healing Arts (LPHA) include:
 1. Physician
 2. Nurse Practitioners

3. Physician Assistants
 4. Registered Nurses
 5. Registered Pharmacists
 6. Licensed Clinical Psychologists
 7. Licensed Clinical Social Worker
 8. Licensed Professional Clinical Counselor
 9. Licensed Marriage and Family Therapists
 10. Licensed Eligible Practitioners working under the supervision of Licensed Clinicians
- B. Non-professional staff shall receive appropriate onsite orientation and training prior to performing assigned duties. A professional and/or administrative staff shall supervise non-professional staff.
 - C. Professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring. Documentation of trainings, certifications, and licensure shall be contained in personnel files.
 - D. Physicians shall receive a minimum of five hours of continuing medical education related to addiction medicine each year.
 - E. Professional staff (LPHAs) shall receive a minimum of five hours of continuing education related to addiction medicine each year.
 - F. Registered and certified Substance Use Disorder (SUD) counselors shall adhere to all requirements in Title 9, Chapter 8.
4. **Services for Adolescents and Youth:** Assessment and services for adolescents will follow the American Society of Additive Medicine (ASAM) adolescent treatment criteria.
 5. **Confidentiality:** All SUD treatment services shall be provided in a confidential setting in compliance with 42 Code of Federal Regulations (CFR), Part 2 requirements.
 6. **Substance Use Disorder Medical Director:**
 - A. The SUD Medical Director's responsibilities shall, at a minimum, include all of the following:
 1. Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
 2. Ensure that physicians do not delegate their duties to non-physician personnel
 3. Develop and implement written medical policies and standards for the Provider.
 4. Ensure that physicians, registered nurse practitioners, and physician assistants follow the Provider's medical policies and standards.
 5. Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
 6. Ensure that Provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries and to determine the medical necessity of treatment for beneficiaries.
 7. Ensure that Provider's physicians are adequately trained to perform other physician duties, as outlined in this section.
 - B. The SUD Medical Director may delegate his/her responsibilities to a physician consistent with the Provider's medical policies and standards; however, the SUD Medical Director shall remain responsible for ensuring all delegated duties are properly performed.

7. Provider Personnel:

- A. Personnel files shall be maintained on all employees and volunteers/interns and shall contain the following:
 - 1. Application for employment and/or resume
 - 2. Signed employment confirmation statement/duty statement
 - 3. Job description
 - 4. Performance evaluations
 - 5. Health records/status as required by the Provider, Alcohol and Other Drug (AOD) Certification or Title 9
 - 6. Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries)
 - 7. Training documentation relative to substance use disorders and treatment
 - 8. Current registration, certification, intern status, or licensure
 - 9. Proof of continuing education required by licensing or certifying agency and program
 - 10. Provider's Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying/licensing body's code of conduct as well
- B. Job descriptions shall be developed, revised as needed, and approved by the Provider's governing body. The job descriptions shall include:
 - 1. Position title and classification
 - 2. Duties and responsibilities
 - 3. Lines of supervision
 - 4. Education, training, work experience, and other qualifications for the position
- C. Written Provider code of conduct for employees and volunteers/interns shall be established which addresses at least the following:
 - 1. Use of drugs and/or alcohol
 - 2. Prohibition of social/business relationship with beneficiaries or their family members for personal gain
 - 3. Prohibition of sexual contact with beneficiaries
 - 4. Conflict of interest
 - 5. Providing services beyond scope
 - 6. Discrimination against beneficiaries or staff
 - 7. Verbally, physically, or sexually harassing, threatening or abusing beneficiaries, family members or other staff
 - 8. Protection of beneficiary confidentiality
 - 9. Cooperate with complaint investigations
- D. If a Provider utilizes the services of volunteers and/or interns, written procedures shall be implemented which address:
 - 1. Recruitment
 - 2. Screening and Selection
 - 3. Training and orientation
 - 4. Duties and assignments
 - 5. Scope of practice
 - 6. Supervision
 - 7. Evaluation

- 8. Protection of beneficiary confidentiality
- E. Written roles and responsibilities and a code of conduct for the Medical Director shall be clearly documented, signed and dated by a Provider representative and the physician.

8. Beneficiary Eligibility:

- A. All beneficiaries shall meet the following medical necessity criteria:
 - 1. The individual shall have received a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders or be assessed to be at risk for developing substance use disorder (for youth under 21).
 - 2. The individual shall meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.
- B. In addition, the initial medical necessity determination, for an individual to receive a DMC-ODS benefit, shall be performed by a Medical Director or an LPHA. The Medical Director or LPHA shall evaluate each beneficiary's assessment and intake information if completed by a counselor through a face-to-face review or telehealth with the counselor to establish a beneficiary meets medical necessity criteria. After establishing a diagnosis and documenting the basis for diagnosis, the ASAM Criteria shall be applied to determine placement into the level of assessed services.
- C. For an individual to receive ongoing DMC-ODS services, the Medical Director or LPHA shall reevaluate that individual's medical necessity qualification at least every six months through the reauthorization process and document their determination that those services are still clinically appropriate for that individual.
- D. Provider shall be responsible for verifying the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for DMC services to that beneficiary for that month. Medi-Cal eligibility verification should be performed prior to rendering service, in accordance with and as described in the DHCS DMC Provider Billing Manual. Options for verifying the eligibility of a Medi-Cal beneficiary are described in the Department of Health Care Services DMC Provider Billing Manual.

9. Beneficiary Admission:

- A. Each provider shall include in its policies, procedures, and practice, written admission and readmission criteria for determining beneficiary's eligibility and the medical necessity for treatment. These criteria shall include, at a minimum:
 - 1. Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis
 - 2. Use of alcohol/drugs of abuse
 - 3. Physical health status
 - 4. Documentation of social and psychological problems.

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- B. If a potential beneficiary does not meet the admission criteria, the beneficiary shall be referred to an appropriate service provider.
- C. If a beneficiary is admitted to treatment, the beneficiary shall sign a consent to treatment form.
- D. The Medical Director or Licensed Practitioner of Healing Arts (LPHA) shall document the basis for the diagnosis in the beneficiary record.
- E. All referrals made by the provider staff shall be documented in the beneficiary record.
- F. Copies of the following documents shall be provided to the beneficiary upon admission:
 - 1. Beneficiary rights, share of cost if applicable, notification of Drug Medi-Cal (DMC) funding accepted as payment in full, and consent to treatment.
- G. Copies of the following shall be provided to the beneficiary:
 - 1. A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay.
 - 2. Complaint process and grievance procedures.
 - 3. Appeal process for involuntary discharge.
 - 4. Program rules and expectations.
- H. Where drug screening by urinalysis is deemed medically appropriate the program shall:
 - 1. Establish written procedures, which protect against the falsification and/or contamination of any urine sample.
 - 2. Document urinalysis results in the beneficiary's file.

10. Assessment:

- A. The provider shall ensure a counselor or LPHA completes a personal, medical, and substance use history for each beneficiary upon admission to treatment.
 - 1. Assessment for all beneficiaries shall include at a minimum:
 - a. Drug/Alcohol use history
 - b. Medical history
 - c. Family history
 - d. Psychiatric/psychological history
 - e. Social/recreational history
 - f. Financial status/history
 - g. Educational history
 - h. Employment history
 - i. Criminal history
 - j. Legal status
 - k. Previous SUD treatment history
- B. The Medical Director or LPHA shall review each beneficiary's personal, medical, and substance use history if completed by a counselor within thirty (30) calendar days of each beneficiary's admission to treatment date.

11. Beneficiary Record

- A. In addition to the requirements of 22 California Code of Regulations (CCR) § 51476(a), the provider shall:
 - 1. Establish, maintain, and update as necessary, an individual beneficiary record for each beneficiary admitted to treatment and receiving services.

2. Each beneficiary's individual beneficiary record shall include documentation of personal information.
 3. Documentation of personal information shall include all of the following:
 4. Information specifying the beneficiary's identifier (i.e., name, number).
 5. Date of beneficiary's birth, the beneficiary's sex, race and/or ethnic background, beneficiary's address and telephone number, and beneficiary's next of kin or emergency contact.
- B. Documentation of treatment episode information shall include documentation of all activities, services, sessions, and assessments, including, but not limited to all of the following:
1. Intake and admission data including, a physical examination, if applicable.
 2. Treatment plans.
 3. Progress notes.
 4. Continuing services justifications.
 5. Laboratory test orders and results.
 6. Referrals.
 7. Discharge plan.
 8. Discharge summary.
 9. County authorizations for Residential Services.
 10. Any other information relating to the treatment services rendered to the beneficiary.

12. Diagnosis Requirements.

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

13. Physical Examination Requirements:

- A. If a beneficiary had a physical examination within the twelve-month period prior to the beneficiary's admission to treatment date, the physician or registered nurse practitioner or physician's assistant (physician extenders) shall review documentation of the beneficiary's most recent physical examination within thirty (30) calendar days of the beneficiary's admission to treatment date.
1. If a provider is unable to obtain documentation of a beneficiary's most recent physical examination, the provider shall describe the efforts made to obtain this documentation in the beneficiary's individual patient record.

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

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

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

- A. The initial treatment plan and updated treatment plans shall include all of the following:
 - 1. A statement of problems identified through the ASAM, other assessment tool(s) or intake documentation.
 - 2. Goals to be reached which address each problem.
 - 3. Action steps that will be taken by the provider and/or beneficiary to accomplish identified goals.
 - 4. Target dates for the accomplishment of action steps and goals.
 - 5. A description of the services, including the type of counseling, to be provided and the frequency thereof.
 - 6. The assignment of a primary therapist or counselor.
 - 7. The beneficiary's diagnosis as documented by the Medical Director or LPHA.
 - 8. If a beneficiary has not had a physical examination within the 12-month period prior to the beneficiary's admission to treatment date, a goal that the beneficiary have a physical examination.
 - 9. If documentation of a beneficiary's physical examination, which was performed during the prior 12 months, indicates a beneficiary has a significant medical illness, a goal that the beneficiary obtain appropriate treatment for the illness.
- B. The provider shall ensure that the initial treatment plan meets all of the following requirements:
 - 1. The LPHA or counselor shall complete, type or legibly print their name, and sign and date the initial treatment plan within thirty (30) calendar days of the admission to treatment date. The signature shall be adjacent to the typed or legibly printed name.
 - 2. The beneficiary shall review, approve, type, or legibly print their name, sign and date the initial treatment plan, indicating whether the beneficiary participated in preparation of the plan, within thirty (30) calendar days of the admission to treatment date.

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

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15. Sign-In Sheet: Establish and maintain a sign-in sheet for every group counseling session, which shall include all of the following:

- A. The LPHA(s) and/or counselor(s) conducting the counseling session shall type or legibly print their name(s), sign, and date the sign-in sheet on the same day of the session. The signature(s) must be adjacent to the typed or legibly printed name(s). By signing the sign-in sheet, the LPHA(s) and/or counselor(s) attest that the sign-in sheet is accurate and complete.
- B. The date of the counseling session.
- C. The topic of the counseling session.
- D. The start and end time of the counseling session.
- E. A typed or legibly printed list of the participants' names and the signature of each participant that attended the counseling session. The participants shall sign the sign-in sheet at the start of or during the counseling session.

16. Progress Notes:

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

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

17. Continuing Services:

- A. Continuing services shall be justified as shown below:
- 1. For outpatient services, intensive outpatient services, Naltrexone treatment, and case management:
 - a. For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the LPHA or counselor shall review the beneficiary's progress and eligibility to continue to receive treatment services and recommend whether the beneficiary should or should not continue to receive treatment services at the same level of care.
 - b. For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the Medical Director or LPHA shall determine medical necessity for continued services for the beneficiary. The determination of medical necessity shall be documented by the Medical Director

or LPHA in the beneficiary's individual patient record and shall include documentation that all of the following have been considered:

- i. The beneficiary's personal, medical and substance use history.
 - ii. Documentation of the beneficiary's most recent physical examination.
 - iii. The beneficiary's progress notes and treatment plan goals.
 - iv. The LPHA's or counselor's recommendation pursuant to Paragraph (i) above.
 - v. The beneficiary's prognosis.
 - vi. The Medical Director or LPHA shall type or legibly print their name, and sign and date the continuing services information when completed. The signature shall be adjacent to the typed or legibly printed name.
2. If the Medical Director or LPHA determines that continuing treatment services for the beneficiary is not medically necessary, the Provider shall discharge the beneficiary from the current Level of Care (LOC) and transfer to the appropriate services.
- B. Residential services length of stay shall be in accordance with County procedures for request of authorized residential services and the Intergovernmental Agreement #21-10027.

18. Discharge:

- A. Discharge of a beneficiary from treatment may occur on a voluntary or involuntary basis. For outpatient services, intensive outpatient services and residential services, in addition to the requirements of this subsection, an involuntary discharge is subject to the requirements set forth in Health and Human Services Agency Policy N-SUDS-003 DMC-ODS Grievances, Appeals & Fair Hearing, which constitutes part of this Agreement, available at https://www.edcgov.us/Government/hhsa/Pages/hhsa_contractor_resources.aspx
- B. An LPHA or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom the provider loses contact.
1. The discharge plan shall include, but not be limited to, all of the following:
 - a. A description of each of the beneficiary's relapse triggers.
 - b. A plan to assist the beneficiary to avoid relapse when confronted with each trigger.
 - c. A support plan.
 2. The discharge plan shall be prepared within thirty (30) calendar days prior to the scheduled date of the last face-to-face treatment with the beneficiary.
 - a. If a beneficiary is transferred to a higher or lower level of care based on ASAM criteria within the same DMC certified program, they are not required to be discharged unless there has been more than a thirty (30) calendar day lapse in treatment services.
 3. During the LPHA's or counselor's last face-to-face or telehealth treatment with the beneficiary, the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. The signatures shall be adjacent to the typed or legibly printed name. A copy of the discharge plan shall be provided to the beneficiary and documented in the beneficiary record.
- C. The LPHA or counselor shall complete a discharge summary, for any beneficiary with whom the provider lost contact, in accordance with all of the following requirements:
1. The LPHA or counselor shall complete the discharge summary within thirty (30) calendar days of the date of the last face-to-face or telehealth treatment contact with the beneficiary.

2. The discharge summary shall include all of the following:
 - a. The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment.
 - b. The reason for discharge.
 - c. A narrative summary of the treatment episode.
 - d. The beneficiary's prognosis.

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

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

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

self-awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

22. Program Integrity:

- A. Requirements of a Compliance Program are set forth in 42 Code of Federal Regulations Sections 455.1 and 438.608. Further requirements for Program Integrity, which includes the Compliance Program, are established pursuant to the DMC-ODS Intergovernmental Agreement between the State of California Department of Health Care Services (DHCS) and El Dorado County HHSA, as well as through Information Notices issued by DHCS.
- B. The requirements of the Compliance Program apply to all individuals who provide services, including billing or coding functions, in support the DMC-ODS operated by or through the County, including employees, volunteers, interns, and others working on behalf of the County in the provision of DMC-ODS Services. These individuals are generally referred to within this document as the “County workforce” or “County workforce members”. In addition, the law specifies contractors that furnish, or authorize the furnishing of, Medi-Cal services, perform billing or coding functions, or are involved in the monitoring of services provided by the County, are covered under DMC-ODS Compliance Program. This includes contracted providers, contracted psychiatrists, and other network and organizational providers.
- C. Suspected Medi-Cal fraud, waste, or abuse must be reported to: DHCS Medi-Cal Fraud: (800) 822-6222 or Fraud@dhcs.ca.gov

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

Providers shall adhere to the El Dorado County DMC-ODS Annual Training Plan requirements

The Provider shall ensure that all residential service providers meet the established ASAM criteria for each level of residential care they provide and receive an ASAM Designation prior to providing DMC-ODS services.

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

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25. Drug and Alcohol Treatment Access Report (DATAR):

- A. All treatment providers shall be enrolled in DATAR.
- B. County shall be responsible for ensuring that treatment services and all treatment providers submit a monthly DATAR report in an electronic copy format as provided by California Department of Health Care Services (DHCS) and according to the DATAR Web Manual, which constitutes part of this Agreement, available at https://www.edc.gov.us/Government/hhsa/Pages/hhsa_contractor_resources.aspx
- C. Reports shall be submitted by the 10th of the month following the report activity month.

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

Any Provider staff that enter CalOMS data shall participate in annual CalOMS training.

ARTICLE II – Term

This Agreement shall become effective upon final execution by both parties hereto and shall continue for two (2) years.

ARTICLE III – Funding Categories

Funding sources include but may not be limited to DMC-ODS, Federal Financial Participation (FFP) or Federal match on DMC-ODS.

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- A. State General Fund and 2011 Realignment DMC-ODS: DMC-ODS is a treatment program as defined in Intergovernmental Agreement 21-10027, or as may be amended. Effective July 1, 2011, Local Realignment Revenues are used to fund DMC services to DMC beneficiaries, including Minor Consent Services. As of June 1, 2019, revenues are used to fund DMC-ODS services to DMC-ODS El Dorado County beneficiaries, including minor consent services.
 - 1. Federal Financial Participation (FFP) or Federal match on DMC-ODS: This funding is the Federal share of the DMC Program. The match, which varies by year, is usually at or near fifty percent (50%).
 - 2. DMC Eligibility Accepted as Payment in Full: Except where a share of cost, as defined in Intergovernmental Agreement 21-10027, or as may be amended, is applicable, Providers shall accept proof of eligibility for DMC as payment in full for treatment services rendered. Providers shall not charge fees to beneficiaries for access to DMC substance abuse services or for admission to a DMC treatment slot.

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ARTICLE IV – Compensation for Services

Rates for face-to-face and telehealth services provided herein shall be in accordance with the following:

Rates			
Description	Units of Service	Rate Amount Per Unit	Rate Amount Per Minute
Outpatient Services – Individual Counseling	Per 15 minutes	\$44.85	\$2.99
Outpatient Services – Group Counseling	Per 15 minutes	\$44.85	\$2.99
Intensive Outpatient – Individual Counseling	Per 15 minutes	\$45.04	\$3.00
Intensive Outpatient – Group Counseling	Per 15 minutes	\$45.04	\$3.00
Intensive Outpatient – Patient Education	Per 15 Minutes	\$45.04	\$3.00
Care Coordination – All levels of care	Per 15 minutes	\$45.04	\$3.00

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE V – Maximum Obligation

The total Maximum Contractual Obligation for services provided as stated herein is \$300,000, inclusive of all costs and expenses for the term of the Agreement.

ARTICLE VI – Federal Funding Notification

An award/subaward or contract associated with a covered transaction may not be made to a subrecipient or contractor who has been identified as suspended or debarred from receiving federal funds. Additionally, counties must annually verify that the subrecipient and/or contractor remains in good standing with the federal government throughout the life of the agreement/contract.

Pursuant to 2 CFR 180.300(a), counties are required to fulfill their above-mentioned verification responsibilities 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 contractor is listed on the federal SAM excluded list and thus suspended or debarred from receiving federal funds.

- A. System for Award Management: Contractor is required to obtain and maintain an active registration in the System for Award Management (SAM.gov). 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(s) titled "Fiscal Considerations" or "Default, Termination, and Cancellation."
 1. The Contractor must register and maintain an "Active" status within SAM at <https://sam.gov/content/home>.
 2. If County cannot access or verify "Active" status, the Contractor must immediately update the information as required.
- B. Catalog of Federal Domestic Assistance: Pursuant to the Office of Management and Budget (OMB) Uniform Grants Guidance, all recipients and sub-recipients of federal funds must be provided the Catalog of Federal Domestic Assistance (CFDA) number at the time the

contract is awarded. The following are CFDA numbers, award specific information, and program titles for programs administered by the County on behalf of California Department of Health Care Services that may apply to this contract:

Federal Funding Subrecipient Information			
Provider:	Recover Medical Group, P.C.	UEI #: GURNB1K9H5F7	
Award Term:	Upon execution – for 2 years.	EIN #: 87-0895890	
Total Federal Funds Obligated: Up to \$300,000			
Federal Award Information			
CFDA Number	Federal Award ID Number (FAIN)	Federal Award Date / Amount	Program Title
93.778		06/01/2019	Drug Medi-Cal Organized Delivery System Services (DMC-ODS)
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 <input checked="" type="checkbox"/>
Yes <input type="checkbox"/>	No <input checked="" type="checkbox"/>	Award is for Research and development.	

ARTICLE VII – Cost Report

- A. Provider shall submit a State DMC-ODS Cost Report to HHSa on or before September 15 for each year of this Agreement, covering all expenditures for services provided herein.
- B. Provider shall prepare the Cost Report in accordance with all federal, state, and County requirements and generally accepted accounting principles (GAAP). Provider shall allocate direct and indirect costs to, and between, programs, cost centers, services, and funding sources in accordance with such requirements and consistent with prudent business practice. Such costs and allocations shall be supported by source documentation maintained by Provider and available at any time to Contract Administrator upon reasonable notice.
- C. Provider shall document that costs are reasonable and allowable, and directly or indirectly related to the services provided hereunder. The Provider Cost Report shall be the final financial record of services rendered under this Agreement for subsequent audits, if any.
- D. If the Provider Cost Report shows the actual and reimbursable cost of services provided pursuant to this Agreement is lower than the aggregate of monthly payments to Provider, Provider shall remit 90 percent of the difference to County. Such reimbursement shall be repaid by Provider to County in cash within forty-five (45) days of submission of the Provider Cost Report.

- E. Initial Cost Report Settlement between Provider and County shall be based upon the actual and reimbursable costs for services hereunder. Provider shall not claim expenditures to County that are not reimbursable pursuant to applicable federal, state, and County laws, regulations, and requirements. Any payment made by County to Provider, which is subsequently determined to have been for a non-reimbursable expenditure or service, shall be repaid by Provider to County in cash within forty-five (45) days of submission of the Provider Cost Report or post payment settlement review.
- F. When the State reconciliation of costs occurs, if the State settlement shows that the aggregate of monthly payments to Provider for covered services provided under this agreement exceeds Provider's allowable cost, in accordance with Title 22 CCR Section 51516.1, Provider shall remit the difference to County. Provider shall pay County the difference within forty-five (45) days after the date of settlement or the completion of an Appeal Process through County, whichever comes first. The amount due to County will be inclusive of any amount initially paid to County with the submission of the Cost Report. Amount due to County for the Fiscal Year will be finalized upon the State settlement of the Cost Report. If the State settlement identifies payment due to Provider, for costs reported in accordance with the terms and conditions of the contract in which State funding was received, funding will be passed to Provider through County after finalization of the settlement with the State. In the event of a State cost report audit and/or program audit, both Local Realignment Revenue and Federal Medicaid portions of all Provider disallowances shall be reimbursed to County within forty-five (45) days of the final audit report or of completion of an appeal process following receipt of a final Audit Report or the completion of an Appeal Process through County, whichever comes first. Any amounts due County that remain unpaid by the forty-five (45) days will be paid through a 50 percent offset of current invoices, that are pending payment to Provider, until paid in full.
- G. In the event of an appeal from Provider to County, Provider shall, within thirty (30) days, submit the appeal in writing identifying the reason for the appeal, detailed account of discrepancies, and supporting documentation. County shall respond within thirty (30) days following receipt of a completed appeal. Final determination, if necessary, is dependent on the State.

ARTICLE VIII – Record Retention

- A. Provider shall retain beneficiary records for a minimum of 10 years, in accordance with 42 CFR 438.3(h), from the finalized cost settlement process with the Department. When an audit by the Federal Government or DHCS has been started before the expiration of the 10-year period, the beneficiary records shall be maintained until completion of the audit and the final resolution of all issues.
- B. Provider shall comply with, and include in any subcontract with providers, the mandate to keep and maintain records for each service rendered, to whom it was rendered, and the date of service, pursuant to Welfare and Institutions Code 14124.1 and 42 CFR 438.3(h) and 438.3(u).
- C. County shall ensure that any Provider sites authorized shall keep a record of the beneficiaries/patients being treated at that location.

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

- A. If any of the work performed under this Agreement is subject to the HIPAA, Provider shall perform the work in compliance with all applicable provisions of HIPAA. By signing this Agreement, Provider agrees to the terms and conditions of the HIPAA Business Associate Agreement, **attached hereto as Exhibit 14**, and incorporated by reference herein.
- B. For medical records and any other health and enrollment information that identifies a particular beneficiary, the Provider shall use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E and 42 CFR Part 2, to the extent that these requirements are applicable.

ARTICLE X – Taxes

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

ARTICLE XI – Changes to Agreement

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

ARTICLE XII – Provider to County

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

ARTICLE XIII – Assignment and Delegation

Provider is engaged by County for its unique qualifications and skills as well as those of its personnel. Provider shall not subcontract, delegate or assign services to be provided, in whole or in part, to any other person or entity.

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

ARTICLE XIV – Independent Contractor

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

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

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

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

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

ARTICLE XV – Fiscal Considerations

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

Notwithstanding any other provision of this Agreement to the contrary, County shall give notice of cancellation of this Agreement in the event of adoption of a proposed budget that does not provide for funds for the services, products or equipment subject herein. Such notice shall become effective upon the adoption of a final budget which does not provide funding for this Agreement. Upon the

effective date of such notice, this Agreement shall be automatically terminated and County released from any further liability hereunder.

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

ARTICLE XVI – Training for Provider

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

ARTICLE XVII – Audits, Compliance, and Monitoring

- A. **Program Integrity Safeguards:** Consistent with 42 CFR Section 438.66, the County shall monitor the Provider’s compliance, as applicable, with 42 CFR Sections 438.604, 438.606, 438.608, 438.620, 438.230, 438.808, 438.900 et seq
- B. County is also required to monitor the Provider compliance pursuant to Agreement 21-10027, Exhibit A, Attachment I, Article III “Program Specifications,” AA “Subcontracts,” and
 1. Provider shall provide a copy of any Audit to County within thirty (30) days of completion of said audit, consistent with 45 CFR Subpart F, as applicable.
 2. Audits or monitoring by the County may be performed by way of annual Contract Monitoring Surveys. Provider receiving a Contract Monitoring Survey shall, within sixty (60) days of receipt, complete and return the survey along with all documentation, details, and supporting materials required by the survey or otherwise necessary for the County to verify compliance with the terms and conditions of the Agreement. Failure to return the survey within the specified time period may result in the withholding of payment from the Provider until such time as compliance with the terms of the Agreement can be verified. Verifying compliance may necessitate additional on-site reviews should information submitted by the Provider be deemed insufficient or inaccurate.
- C. **State Audits:** Provider acknowledges that if total compensation under this agreement is greater than \$10,000.00, this Agreement is subject to examination and audit by the California State Auditor for a period of three (3) years, or for any longer period required by law, after final payment under this Agreement, pursuant to California Government Code §8546.7. In order to facilitate these potential examinations and audits, Provider shall maintain, for a period of at least three (3) years, or for any longer period required by law, after final payment under the contract, all books, records and documentation necessary to demonstrate performance under the Agreement.
- D. The State, CMS, the Office of the Inspector General, the Comptroller General, the County, and their designees may, at any time, inspect and audit any records or documents of the County, or its Providers, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted. The right to

audit under this section exists for 10 years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.

- E. The State, CMS, the Health and Human Services (HHS) Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the Provider, that pertain to any aspect of services and activities performed, or determination of amounts payable under this Agreement at any time;
- F. The Provider will make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid beneficiaries;
- G. The State, CMS, the HHS Inspector General, the Comptroller General, or their designees' right to audit the Provider will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
- H. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the Provider at any time.
- I. Upon notification of an exception or finding of non-compliance, the Provider shall submit evidence of Corrective Action within thirty (30) days, or as otherwise specified in the notice of required corrective action provided by the County. Continued non-compliance beyond due date for submission of Corrective Action may lead to termination of this Agreement in accordance with the Article titled **Default, Termination, and Cancellation**.
- J. Failure by County to notify or require Corrective Action does not constitute acceptance of the practice of waiver of the County's right to enforce.
- K. Provider shall be held accountable for audit exceptions taken by DHCS against the Provider and its subcontractors for any failure to comply with these requirements:
 - i. Health and Safety Code (HSC), Division 10.5, commencing with Section 11760
 - ii. Title 9, Division 4, Chapter 8, commencing with Section 13000
 - iii. Government Code Section 16367.8
 - iv. Title 42, CFR, Sections 8.1 through 8.6
 - v. Title 21, CFR, Sections 1301.01 through 1301.93, Department of Justice, Controlled Substances
 - vi. State Administrative Manual (SAM), Chapter 7200 (General Outline of Procedures)
- L. Provider shall be familiar with the above laws, regulations, and guidelines and shall ensure that its subcontractors are also familiar with such requirements.

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ARTICLE XVIII – 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.
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 Contractor 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 Contractor, the excess costs to procure from an alternate source.
2. County shall pay Contractor the sum due to Contractor 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 Contractor under this Agreement and the balance, if any, shall be paid to Contractor upon demand.
3. County may require Contractor to transfer title and deliver to County any completed work under the Agreement.

The following shall 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 Contractor in this Agreement proves to have been false or misleading in any respect.
3. Contractor 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 Contractor.

- C. **Ceasing Performance:** County may terminate this Agreement immediately in the event Contractor 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:** Either Party ~~County~~ may terminate this Agreement, in whole or in part, for convenience upon thirty (30) calendar days' written Notice of Termination. 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 Contractor or County, and for any other services that County and Contractor 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, Contractor shall promptly discontinue all services affected, as of the effective date of termination set forth in such Notice of Termination, unless the Notice directs otherwise.

ARTICLE XIX – Notice to Parties

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

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

or to such other location as the County directs.

with a copy to

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

Notices to Provider shall be addressed as follows:

Recover Medical Group P.C.,
120 Birmingham Drive, Suite 240A,
Cardiff-by-the-Sea, CA 92007
ATTN: Nick Gulino
nick@letsrecover.com

or to such other location as the Provider directs.

ARTICLE XX – Change of Address

In the event of a change in address for Provider's principal place of business, Provider's Agent for Service of Process, or Notices to Provider, Provider shall notify County in writing pursuant to the provisions contained in this Agreement under 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.

ARTICLE XXI – Indemnity

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

ARTICLE XXII – Insurance

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

- A. Full Worker's Compensation and Employer's Liability Insurance covering all employees of Provider as required by law in the State of California.
- B. Commercial General Liability Insurance of not less than \$1,000,000.00 combined single limit per occurrence for bodily injury and property damage and a \$2,000,000.00 aggregate limit.
- C. Automobile Liability Insurance of not less than \$1,000,000.00 is required in the event motor vehicles are used by the Provider in the performance of the Agreement.
- D. In the event Provider is a licensed professional or professional consultant, and is performing professional services under this Agreement, professional liability is required with a limit of liability of not less than \$1,000,000.00 per occurrence.
- E. Provider shall furnish a certificate of insurance satisfactory to the County of El Dorado Risk Manager as evidence that the insurance required above is being maintained.

- F. The insurance will be issued by an insurance company acceptable to Risk Management, or be provided through partial or total self-insurance likewise acceptable to Risk Management.
- G. Provider agrees that the insurance required above shall be in effect at all times during the term of this Agreement. In the event said insurance coverage expires at any time or times during the term of this Agreement, Provider agrees to provide at least thirty (30) days prior to said expiration date, a new certificate of insurance evidencing insurance coverage as provided for herein for not less than the remainder of term of the Agreement, or for a period of not less than one (1) year. New certificates of insurance are subject to the approval of Risk Management and Provider agrees that no work or services shall be performed prior to the giving of such approval. In the event the Provider fails to keep in effect at all times insurance coverage as herein provided, County may, in addition to any other remedies it may have, terminate this Agreement upon the occurrence of such event.
- H. The certificate of insurance must include the following provisions stating that:
 - 1. The insurer will not cancel the insured's coverage without prior written notice to County, and;
 - 2. The County of El Dorado, its officers, officials, employees and volunteers are included as additional insured on an additional insured endorsement, but only insofar as the operations under this Agreement are concerned. This provision shall apply to the general liability policy.
- I. The Provider's insurance coverage shall be primary insurance as respects the County, its officers, officials, employees and volunteers. Any insurance or self-insurance maintained by the County, its officers, officials, employees or volunteers shall be in excess of the Provider's insurance and shall not contribute with it.
- J. Any deductibles or self-insured retentions must be declared to and approved by the County, either: the insurer shall reduce or eliminate such deductibles or self-insured retentions as respects the County, its officers, officials, employees and volunteers; or the Provider shall procure a bond guaranteeing payment of losses and related investigations, claim administration and defense expenses.
- K. Any failure to comply with the reporting provisions of the policies shall not affect coverage provided to the County, its officers, officials, employees or volunteers.
- L. The insurance companies shall have no recourse against the County of El Dorado, its officers and employees or any of them for payment of any premiums or assessments under any policy issued by any insurance company.
- M. Provider's obligations shall not be limited by the foregoing insurance requirements and shall survive expiration of this Agreement.
- N. In the event Provider cannot provide an occurrence policy, Provider shall provide insurance covering claims made as a result of performance of this Agreement for not less than three (3) years following completion of performance of this Agreement.
- O. Certificate of insurance shall meet such additional standards as may be determined by the contracting County Department either independently or in consultation with Risk Management, as essential for protection of the County.

ARTICLE XXIII – Conflict of Interest

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 Contractor and performing work for County and who are considered to be a Consultant within the meaning of Title 2, California Code of Regulations, 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.

Contractor covenants that during the term of this Agreement neither it, or any officer or employee of the Contractor, 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 Contractor becomes aware of a conflict of interest related to this Agreement, Contractor 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), Contractor shall complete and sign the attached **Exhibit 16**, marked “California Levine Act Statement,” incorporated herein and made by reference a part hereof, regarding campaign contributions by Contractor, if any, to any officer of County.

ARTICLE XXIV – Nondiscrimination:

- A. By signing this Agreement, Provider certifies that under the laws of the United States and the State of California, incorporated into this Agreement by reference and made a part hereof as if set forth in full, Provider shall not unlawfully discriminate against any person.
- B. County may require Provider’s services on projects involving funding from various state and/or federal agencies, and as a consequence, Provider shall comply with all applicable nondiscrimination statutes and regulations during the performance of this Agreement including but not limited to the following: Provider and its employees and representatives shall not unlawfully discriminate against any employee or applicant for employment because of race, religion, color, national origin, ancestry, physical handicap,

medical condition, marital status, age, or sex; Provider shall, unless exempt, comply with the applicable provisions of the Fair Employment and Housing Act (Government Code, Sections 12900 et seq.) and applicable regulations promulgated thereunder (California Code of Regulations, Title 2, Sections 7285.0 et seq.); the applicable regulations of the Fair Employment and Housing Commission implementing Government Code, Section 12990, set forth in Chapter 5 of Division 4 of Title 2 of the California Code of Regulations incorporated into this Agreement by reference and made a part hereof as if set forth in full; and Title VI of the Civil Rights Act of 1964, as amended, the California Family Rights Act (Government Code Section 12945.2), the Unruh Civil Rights Act (California Civil Code, Division I, Part 2, Section 51, et seq), the Ralph Civil Rights Act (California Civil Code, Division I, Part 2, Section 51.7), the California Trafficking Victims Protection Act (California Civil Code, Division I, Part 2, Section 52.5), the Disabled Persons Act (California Civil Code, Division I, Part 2.5), and as applicable, Section 11135 et. seq., of the California Government Code, prohibiting discrimination in all state-funded programs. Provider and its employees and representatives shall give written notice of their obligations under this clause as required by law.

- C. Where applicable, Provider shall include these nondiscrimination and compliance provisions in any of its agreements that affect or are related to the services performed herein.
- D. Provider's signature shall provide any certifications necessary under the federal laws, the laws of the State of California, including but not limited to Government Code Section 12990 and Title 2, California Code of Regulations, Section 11102.
- E. By signing this Agreement, Provider certifies that under the laws of the United States and the State of California, incorporated into this Agreement by reference and made a part hereof as if set forth in full, Provider shall not unlawfully discriminate against any person.
- F. Contractor shall comply with **Exhibit 15**, "Vendor Assurance of Compliance with the County of El Dorado Health and Human Services Agency Nondiscrimination in State and Federally Assisted Programs," attached hereto, incorporated by reference herein, and thus made a part hereof. Contractor shall acknowledge compliance by signing and returning **Exhibit 15** upon request by County.

ARTICLE XXV – California Residency (Form 590)

If Provider is a California resident, Providers must file a State of California Form 590, certifying its California residency or, in the case of a corporation, certifying that it has a permanent place of business in California. The Provider will be required to submit a Form 590 prior to execution of an Agreement or County shall withhold seven (7) percent of each payment made to the Provider during term of the Agreement. This requirement applies to any agreement/contract exceeding \$1,500.00.

ARTICLE XXVI – County Payee Data Record Form

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

ARTICLE XXVII – County Business License

It is unlawful for any person to furnish supplies or services or transact any kind of business in the unincorporated territory of El Dorado County without possessing a County business license unless exempt under County Code Section 5.08.070.

ARTICLE XXVIII – Licenses

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

ARTICLE XXIX – Administrator

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

ARTICLE XXX – Authorized Signatures

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

ARTICLE XXXI - 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 XXXII – Partial Liability

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

ARTICLE XXXIII – California Forum and Law

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

ARTICLE XXXIV – 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 XXXV – Additional Terms and Conditions

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

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

- A. Licenses: Provider shall comply with the following:
 - 1. Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8
 - 2. Title 22, Sections 51490.1(a)
 - 3. Agreement 21-10027, Exhibit A, Attachment I, Article III. – PP “Requirements for Services.”
 - 4. Title 9, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq
 - 5. Title 22, Division 3, Chapter 3, sections 51000 et. seq
- B. Hatch Act: Provider agrees to comply with the provisions of the Hatch Act (Title 5 USC, Sections 1501-1508), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.
- C. No Unlawful Use or Unlawful Use Messages Regarding Drugs: Provider agrees that information produced through these funds, and which pertains to drug and alcohol related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug or alcohol related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (HSC Section 11999-11999.3). By signing this Agreement, Provider agrees that it shall enforce, these requirements.
- D. Drug-Free Workplace: Provider agrees to maintain a drug-free workplace and remain in compliance with the Federal Drug-Free Workplace Act of 1988 (41 U.S.C. Chapter 10) and the California Drug-Free Workplace Act of 1990 (Government Code Section 8350 et seq.) and any subsequent amendments to either Act thereto. A “drug free workplace” means the site(s) for the performance of work done by Provider at which Provider and employees of the Provider are prohibited from engaging in the unlawful manufacture, distribution, dispensing, possession, or use of any controlled substance. A list of controlled substances can be found in

Schedules I through V of Section 202 of the Controlled Substances Act (21 U.S.C. 812) and as further defined in Regulation 21 CFR 1308.11 – 1308.15. Provider will comply with the requirements of the Drug-Free Workplace Act of 1990 and will provide a drug-free workplace by taking the following actions:

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

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

E. Recordkeeping Requirements:

1. The Provider shall retain, as applicable, the following information: beneficiary grievance and appeal records in 42 CFR §438.416, and the data, information, and documentation specified in 42 CFR §§438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.
2. Provider shall ensure that all Provider sites shall keep a record of the beneficiaries/patients being treated at that location. Provider shall retain beneficiary records for a minimum of 10 years, in accordance with 438.3(h), from the finalized cost settlement process with the Department. When an audit by the Federal Government or DHCS has been started before the expiration of the 10-year period, the beneficiary records shall be maintained until completion of the audit and the final resolution of all issues.

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

G. Federal Law Requirements:

1. Title VI of the Civil Rights Act of 1964, Section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in federally funded programs.
2. Title IX of the education amendments of 1972 (regarding education and programs and activities), if applicable. iii. Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et

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

H. State Law Requirements:

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

I. Trading Partner Requirements:

1. No Changes. Provider hereby agrees that for the personal health information (Information), it shall not change any definition, data condition or use of a data element or segment as proscribed in the federal HHS Transaction Standard Regulation. (45 CFR Part 162.915 (a))
2. No Additions. Provider hereby agrees that for the Information, it shall not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation. (45 CFR Part 162.915 (b))
3. No Unauthorized Uses. Provider hereby agrees that for the Information, it shall not use any code or data elements that either are marked “not used” in the HHS Transaction’s Implementation specification or are not in the HHS Transaction Standard’s implementation specifications. (45 CFR Part 162.915 (c))

4. No Changes to Meaning or Intent. Provider hereby agrees that for the Information, it shall not change the meaning or intent of any of the HHS Transaction Standard's implementation specification. (45 CFR Part 162.915 (d))
- J. Confidentiality (42 CFR §438.224): For medical records and any other health and enrollment information that identifies a particular beneficiary, the Provider shall use and disclose such individually identifiable health information in accordance with the privacy requirements in 45 CFR parts 160 and 164, subparts A and E and 42 CFR Part 2, to the extent that these requirements are applicable.
- K. Trafficking Victims Protection Act of 2000: Provider shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 (22 U.S.C. 7104(g)) as amended by section 1702.
- L. National Labor Relations Board Certification: Provider certifies that no more than one (1) final un-appealable finding of contempt of court by a Federal court has been issued against Provider within the immediately preceding two-year period because of Provider's failure to comply with an order of a Federal court, which orders Provider to comply with an order of the National Labor Relations Board (Public Contract Code Section 10296).
- M. Domestic Partners: For contracts of \$100,000 or more, Provider certifies that Provider is in compliance with Public Contract Code Section 10295.3.
- N. Gender Identity: For contracts of \$100,000 or more, Provider certifies that Provider is in compliance with Public Contract Code Section 10295.35.
- O. Americans with Disabilities Act: Provider assures that it complies with the Americans with Disability Act (ADA) of 1990, which prohibits discrimination on the basis of disability, as well as all applicable regulations and guidelines issued pursuant to the ADA (42 U.S.C. 12101 et seq).
- P. Prohibited Affiliations (42 CFR Section 438.610): The Provider shall not knowingly have a relationship of the type described in paragraph (iii) of this subsection with the following:
1. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.
 2. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in paragraph (a)(1) of this section.
 - a. The Provider shall not have a relationship with an individual or entity that is excluded from participation in any Federal Health Care Program under section 1128 or 1128A of the Act.
 - b. The relationships described in paragraph (i) of this section, are as follows:
 - i. A director, officer, or partner of the Provider.
 - ii. A subcontractor (Provider) of the County, as governed by 42 CFR §438.230.
 - iii. A person with beneficial ownership of five percent or more of the Provider's equity.
 - iv. A network provider or person with an employment, consulting, or other arrangement with the Provider for the provision of items and services that are significant and material to the Provider's obligations under this Agreement.

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


ARTICLE XXXVI – Counterparts

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


ARTICLE XXXVII – Entire Agreement

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

Requesting Contract Administrator Concurrence:

By:  Dated: 02/03/2023
Salina Drennan
Alcohol and Drug Programs Division Manager
Health and Human Services Agency

Requesting Department Head Concurrence:

By:  Dated: 02/03/2023
Olivia Byron-Cooper, Interim Director
Health and Human Services Agency

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

-- COUNTY OF EL DORADO --

Dated: 2/21/23

By: Wendy Thomas
Wendy Thomas, Chair
Board of Supervisors
"County"

ATTEST:
Kim Dawson
Clerk of the Board of Supervisors

By: Thya Schaffenberg
Deputy Clerk

Dated: 2/21/23

-- PROVIDER --

RECOVER MEDICAL GROUP, P.C.
A California Corporation

By: Daniel Duel
Daniel Duel (Feb 3, 2023 10:52 PST)
Daniel Duel, M.D.
Chief Executive Officer
"Contractor"

Dated: 02/03/2023

By: Daniel Duel
Daniel Duel (Feb 3, 2023 10:52 PST)
Daniel Duel, M.D.
Corporate Secretary

Dated: 02/03/2023