

COUNTY OF TULARE  
HEALTH & HUMAN SERVICES AGENCY  
SERVICES AGREEMENT FORM  
REVISION APPROVED 07/2021

**COUNTY OF TULARE  
HEALTH & HUMAN SERVICES AGENCY  
SERVICES AGREEMENT**

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**THIS AGREEMENT** ("Agreement") is entered into as of August 27, 2024, between the **COUNTY OF TULARE**, a political subdivision of the State of California ("COUNTY"), and **Central Valley Recovery Services, Inc.**, a California Corporation ("CONTRACTOR"). COUNTY and CONTRACTOR are each a "Party" and together are the "Parties" to this Agreement, which is made with reference to the following:

- A.** COUNTY wishes to retain the services of CONTRACTOR for the provision of substance abuse residential, outpatient, intensive outpatient, and transitional services.
- B.** CONTRACTOR has the experience and qualifications to provide the services COUNTY requires pertaining to the COUNTY'S Alcohol, Drug, and Perinatal Program; and
- C.** CONTRACTOR is willing to enter into this Agreement with COUNTY upon terms and conditions set forth herein.

**THE PARTIES AGREE AS FOLLOWS:**

- 1. TERM:** This Agreement becomes effective retroactive from July 1, 2024, through 11:59 PM on June 30, 2025, unless earlier terminated as provided below, or unless the Parties extend the term by a written amendment to this Agreement.
- 2. SERVICES:** CONTRACTOR shall provide COUNTY with the services shown on the attached **Exhibits A, A-1, and A-2**.
- 3. PAYMENT FOR SERVICES:** As consideration for the services provided by CONTRACTOR hereunder, COUNTY shall pay CONTRACTOR in accordance with the attached **Exhibits B and B-1**.
- 4. INSURANCE:** Before approval of this Agreement by COUNTY, CONTRACTOR must file with the Clerk of the Board of Supervisors evidence of the required insurance as set forth in the attached **Exhibit C**.
- 5. GENERAL AGREEMENT TERMS AND CONDITIONS:** COUNTY'S "General Agreement Terms and Conditions (Form revision approved as of 01/01/2021)" are hereby incorporated by reference and made a part of this Agreement as if fully set forth herein. COUNTY'S "General Agreement Terms and Conditions" can be viewed at <http://tularecountycounsel.org/default/index.cfm/public-information/>
- 6. ADDITIONAL EXHIBITS:** CONTRACTOR shall comply with the terms and conditions of the Exhibits listed below and identified with a checked box, which are by this reference made a part of this Agreement. Complete Exhibits D, E, F, G, G-1, and H can be viewed at <http://tularecountycounsel.org/default/index.cfm/public-information/>

TULARE COUNTY AGREEMENT NO. 318660

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<input checked="" type="checkbox"/>	<b>Exhibit D</b>	Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement
<input checked="" type="checkbox"/>	<b>Exhibit E</b>	Cultural Competence and Diversity
<input checked="" type="checkbox"/>	<b>Exhibit F</b>	Information Confidentiality and Security Requirements
<input checked="" type="checkbox"/>	<b>Exhibit G</b>	Contract Provider Disclosures ( <u>Must be completed by Contractor and submitted to County prior to approval of agreement.</u> )
<input checked="" type="checkbox"/>	<b>Exhibit G1</b>	National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
<input checked="" type="checkbox"/>	<b>Exhibit H</b>	Additional terms and conditions for federally funded contracts
<input checked="" type="checkbox"/>	<b>Exhibit I</b>	Substance Use Disorder Service Provisions

**7. NOTICES:** (a) Except as may be otherwise required by law, any notice to be given must be written and must be either personally delivered, sent by facsimile transmission or sent by first class mail, postage pre-paid and addressed as follows:

**COUNTY:**

TULARE COUNTY HEALTH AND HUMAN SERVICES AGENCY  
CONTRACTS UNIT  
5957 S. Mooney Boulevard  
Visalia, CA 93277  
Phone No.: 559-624-8000  
Fax No.: 559-713-3718

**With a Copy to:**

COUNTY ADMINISTRATIVE OFFICER  
2800 W. Burrel Ave.  
Visalia, CA 93291  
Phone No.: 559-636-5005  
Fax No.: 559- 733-6318

**CONTRACTOR:**

CENTRAL VALLEY RECOVERY SERVICES, INC.  
320 W. Oak Avenue, Suite A.  
Visalia, CA 93291  
Phone No.: 559-625-2995  
Fax No.: 559-625-3808

(b). Notice personally delivered is effective when delivered. Notice sent by facsimile transmission is deemed to be received upon successful transmission. Notice sent by first class mail will be deemed received on the fifth calendar day after the date of mailing. Either Party may change the above address by giving written notice under this section.

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**8. AUTHORITY:** CONTRACTOR represents and warrants to COUNTY that the individual(s) signing this Agreement on its behalf are duly authorized and have legal capacity to sign this Agreement and bind CONTRACTOR to its terms. CONTRACTOR acknowledges that COUNTY has relied upon this representation and warranty in entering into this Agreement.

**9. COUNTERPARTS:** The Parties may sign this Agreement in counterparts, each of which shall be deemed an original and all of which taken together form one and the same agreement. A signed copy or signed counterpart of this Agreement delivered by facsimile, email, or other means of electronic transmission shall be deemed to have the same legal effect as delivery of a signed original or signed copy of this Agreement.

**10. MANUAL OR ELECTRONIC SIGNATURES:** The Parties may sign this Agreement by means of manual or electronic signatures. The Parties agree that the electronic signature of a Party, whether digital or encrypted, is intended to authenticate this Agreement and to have the same force and effect as a manual signature. For purposes of this Agreement, the term "electronic signature" means any electronic sound, symbol, or process attached to or logically associated with this Agreement and executed and adopted by a Party with the intent to sign this Agreement, including facsimile, portable document format, or email electronic signatures, pursuant to the California Uniform Electronic Transactions Act (Cal. Civ. Code §§ 1633.1 to 1633.17), as it may be amended from time to time.

[THIS SPACE LEFT BLANK INTENTIONALLY; SIGNATURES FOLLOW ON NEXT PAGE]

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**THE PARTIES**, having read and considered the above provisions, indicate their agreement by their authorized signatures below.

Date: 7/30/2024

**Central Valley Recovery Services, Inc.**

DocuSigned by:

By Judy A. Silicato

C07BAB27685A4CE...

Print Name Judy A. Silicato

Title TREASURER

Date: 7/24/2024

DocuSigned by:

By Robert Debruin

173CD531055C4ED...

Print Name Robert Debruin

Title Board Chairman

[Pursuant to Corporations Code section 313, County policy requires that contracts with a **Corporation** be signed by both (1) the chairman of the Board of Directors, the president or any vice-president (or another officer having general, operational responsibilities), and (2) the secretary, any assistant secretary, the chief financial officer, or any assistant treasurer (or another officer having recordkeeping or financial responsibilities), unless the contract is accompanied by a certified copy of a resolution of the corporation's Board of Directors authorizing the execution of the contract. Similarly, pursuant to California Corporations Code section 17703.01, County policy requires that contracts with a **Limited Liability Company** be signed by at least two managers, unless the contract is accompanied by a certified copy of the articles of organization stating that the LLC is managed by only one manager.]

**COUNTY OF TULARE**

Date: 8/27/2024

By [Signature]

Chair, Board of Supervisors

ATTEST: JASON T. BRITT  
County Administrative Officer/Clerk of the Board  
of Supervisors of the County of Tulare

By [Signature]  
Deputy Clerk



Approved as to Form  
COUNTY COUNSEL

By Charles W. Felix  
Deputy

Date: 8/9/24

Matter # 2024874



**EXHIBIT A**  
**SCOPE OF SERVICES**  
**CENTRAL VALLEY RECOVERY SERVICES, INC.**  
**JULY 1, 2024 – JUNE 30, 2025**

**Section 1 - Services Provided**

- A. Outpatient Drug Free (ODF) Services (American Society of Addiction Medicine (ASAM) Level 1):** Counseling services are provided to beneficiaries (up to 9 hours a week for adults, and less than six (6) hours a week for adolescents) when determined by a Medical Director or Licensed Practitioner of the Healing Arts (LPHA) to be medically necessary and in accordance with an individualized client plan. Group size is limited to no less than two (2) and no more than twelve (12) beneficiaries.
1. CONTRACTOR providers may provide Drug Medi-Cal (DMC) – Organized Delivery System (DMC-ODS) ODF services in-person or by telephone by a licensed professional or a registered or certified counselor in any appropriate setting in the community, in accordance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA) and 42 Code of Federal Regulations (CFR) Part 2.
- B. Intensive Outpatient Treatment (IOT) Services (ASAM Level 2.1):** Structured programming services provided to beneficiaries a minimum of nine (9) hours with a maximum of nineteen (19) hours a week for adults, and a minimum of six (6) hours with a maximum of nineteen (19) hours a week for adolescents. Group size is limited to no less than two (2) and no more than twelve (12) beneficiaries.
1. CONTRACTOR shall provide IOT services in-person or by telephone by an LPHA or a certified counselor in any appropriate setting in the community in accordance with HIPAA and 42 CFR Part 2.
  2. Adults
    - a) CONTRACTOR may provide more than 19 hours per week to adults when determined by a Medical Director or LPHA to be medically necessary, and in accordance with the individualized treatment plan.
    - b) CONTRACTOR may extend a beneficiary's length of treatment when determined by a Medical Director or LPHA to be medically necessary, and in accordance with the individualized treatment plan.
  3. Adolescents
    - a) CONTRACTOR shall provide more than 19 hours per week to adolescents when determined by a Medical Director or LPHA to be medically necessary, and in accordance with the individualized treatment plan.
    - b) CONTRACTOR may extend a beneficiary's length of treatment when determined by a Medical Director or LPHA to be medically necessary, and in accordance with the individualized treatment plan.
- C. The components of ODF and IOT services include the following services:**
1. **Intake:** The process of determining that a beneficiary meets the medical necessity criteria, and a beneficiary is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders, the diagnosis of substance use disorders, and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
  2. **Individual and/or Group Counseling:** Contacts between a beneficiary and a therapist or counselor.
  3. **Patient Education:** Provide research-based education on addiction, treatment, recovery, and associated health risks.

4. **Family Therapy:** The effects of addiction are far-reaching and the patient's family members and loved ones are also affected by the disorder. By including family members in the treatment process, education about factors that are important to the patient's recovery, as well as their own recovery, can be conveyed. Family members can provide social support to the patient, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.
5. **Medication Services:** The prescription or administration of medication related to substance use treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice or licensure.
6. **Collateral Services:** Sessions with therapists or counselors and significant persons in the life of the beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.
7. **Crisis Intervention Service:** Contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the beneficiary's emergency situation.
8. **Treatment Planning:** The provider shall prepare an individualized written treatment plan, based upon information obtained in the intake and assessment process. The treatment plan shall be completed within the regulatory timeframe then updated every subsequent 90 days unless there is a change in treatment modality or significant event that would then require a new treatment plan.
9. **Discharge Services:** The process to prepare the beneficiary for referral into another Level of Care (LOC), post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing, and human services.
10. **Case Management:** Service to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Case management can be face-to-face or over the telephone and shall be consistent with and shall not violate the confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California law.
  - a) CONTRACTOR shall provide case management services to beneficiaries receiving ODF services and IOT services to coordinate care with ancillary service providers and facilitate transitions between LOC.
  - b) The components of case management include:
    - (i) Comprehensive assessment and periodic reassessment of individual needs to determine the need for the continuation of case management;
    - (ii) Transition to a higher or lower level of Substance Use Disorder (SUD) care;
    - (iii) Development and periodic revision of a client plan that includes service activities;
    - (iv) Communication, coordination, referral, and related activities;
    - (v) Monitoring service delivery to ensure beneficiary access to service and the service delivery system;
    - (vi) Monitoring the beneficiary's progress; and
    - (vii) Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services.

## 11. Recovery Services

CONTRACTOR shall comply with the following CONTRACTOR specific recovery services requirements:

- a) CONTRACTOR shall offer DMC-ODS beneficiaries SUD recovery services when a Medical Director or LPHA has determined that recovery services are medically necessary and after the DMC-ODS beneficiary has been discharged from SUD treatment services.
  - (i) Recovery services shall be made available to DMC-ODS beneficiaries in accordance with their individualized treatment plan.
  - (ii) CONTRACTOR shall not provide a DMC-ODS beneficiary with recovery services while the DMC-ODS beneficiary is receiving SUD treatment services.
- b) The components of recovery services shall include:
  - (i) ODF individual or group counseling (relapse prevention).
  - (ii) Recovery monitoring/coaching (via telephone or the internet).
  - (iii) Peer-to-peer assistance.
  - (iv) Care coordination to services to education services, life skills, employment services, and job training.
- c) Care coordination to childcare, child development, and support services, and marriage/family counseling.
- d) Care coordination to housing assistance, transportation, case management, and individual service coordination.

## 12. Recovery Residences

CONTRACTOR shall comply with the following CONTRACTOR-specific recovery services requirements:

- a) CONTRACTOR shall offer DMC-ODS beneficiaries SUD recovery residence if applicable, when a Medical Director or LPHA has determined that recovery residences are medically necessary and after the DMC-ODS beneficiary has been discharged from SUD treatment services.
  - (i) Recovery residences shall be made available to DMC-ODS beneficiaries in accordance with their individualized treatment plan.
  - (ii) CONTRACTOR shall not provide a DMC-ODS beneficiary with recovery residence while the DMC-ODS beneficiary is receiving SUD treatment services.

\*See Exhibit B for fiscal implications \*

**13. Physician Consultation:** Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are not with DMC-ODS beneficiaries; rather, they are designed to assist DMC physicians with seeking expert advice on designing treatment plans for specific DMC-ODS beneficiaries, and to support DMC providers with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or LOC considerations.

**D. Residential (ASAM Level 3.1):** Clinically Managed Low Intensity – Provides 24-hour structure with available trained personnel; at least 5 hours of clinical service per week and preparation for outpatient treatment.

- E. **Residential (ASAM Level 3.3):** Clinically Managed Population Specific High Intensity – Provides 24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community and prepare for outpatient treatment.
- F. **Residential (ASAM Level 3.5):** Clinically Managed High-Intensity – Provides 24-hour care with trained counselors to stabilize multidimensional imminent danger and preparation for outpatient treatment. Able to tolerate and use the full milieu or therapeutic community.

Residential treatment (ASAM Level 3.1-3.5) is a non-institutional, 24-hour, short-term residential program that provides rehabilitation services to beneficiaries with a substance use disorder diagnosis when determined by a Medical Director or Licensed Practitioner of the Healing Arts as medically necessary and in accordance with the individual treatment plan. Room and Board is not reimbursable through the DMC program.

1. The length of residential services ranges from one to 90 days with a 90-day maximum for adults, unless medical necessity authorizes a one-time extension of up to 30 days on an annual basis.
2. Adolescents under the age of 21, shall receive continuous residential services for a maximum of 30 days. Adolescent beneficiaries may receive a 30-day extension if that extension is determined to be medically necessary. Adolescent beneficiaries are limited to one extension per year.
  - a) Nothing in the DMC-ODS overrides any EPSDT requirements. Adolescent beneficiaries may receive a longer length of stay based on medical necessity.
3. For adult beneficiaries, only two non-continuous 90-day regimens shall be authorized in a one-year period.
4. Pursuant to STC 138 (c), perinatal clients shall receive lengths of stay up to the length of the pregnancy and postpartum period (60 days after the pregnancy ends).
  - a) Medical documentation that substantiates the beneficiary's pregnancy and the last day of pregnancy shall be maintained in the beneficiary record.
  - b) CONTRACTOR shall comply with the perinatal program requirements as outlined in the Perinatal Practice Guidelines.
5. The components of Residential Treatment Services shall include:
  - a) **Intake:** The process of determining that a beneficiary meets the medical necessity criteria and admitting the beneficiary into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
  - b) **Individual and Group Counseling:** Contacts between a beneficiary and a therapist or counselor. Services are provided in-person or by telephone qualify as Medi-Cal reimbursable units of service and are reimbursed without distinction.
  - c) **Patient Education:** Provide research-based education on addiction, treatment, recovery, and associated health risks.
  - d) **Family Therapy:** The effects of addiction are far-reaching and patient's family members and loved ones also are affected by the disorder. By including family members in the treatment process, education about factors that are important to the patient's recovery, as well as their own recovery, can be conveyed. Family members can provide social support to the patient, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.
  - e) **Safeguarding Medications:** Facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.

- f) **Collateral Services:** Sessions with therapists or counselors and significant persons in the life of the beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.
  - g) **Crisis Intervention Services:** Contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the beneficiary's emergency situation.
  - h) **Treatment Planning:** The provider shall prepare an individualized written treatment plan, based upon information obtained in the intake and assessment process. The treatment plan will be completed within regulatory timeframes, reviewed every 30 days, and then updated every 90 days unless there is a change in treatment modality or significant event that would then require a new treatment plan.
  - i) **Transportation Services:** Provision of or arrangement for transportation to and from medically necessary treatment.
  - j) **Discharge Services:** The process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing, and human services.
  - k) **Physician Consultation:** Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are not with DMC-ODS beneficiaries; rather, they are designed to assist DMC physicians with seeking expert advice on designing treatment plans for specific DMC-ODS beneficiaries, and to support DMC providers with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.
6. For beneficiaries in Residential programs, CONTRACTOR shall provide case management services to coordinate care with ancillary service providers and facilitate transitions between LOCs.
- a) **Case Management services are not a component of Residential 3.1, 3.3 or 3.5; therefore, if the only service provided on a specific date, that bed day is not billable.**

**G. Residential Withdrawal Management (ASAM) Level 3.2-WM) – Clinically Managed Residential Withdrawal Management (WM):** WM services are provided when determined medically necessary by a Medical Director or Licensed Practitioner of the Healing Arts (LPHA), and in accordance with an individualized client plan. Medically necessary habilitative and rehabilitative services are provided in accordance with the individualized treatment plan prescribed by a licensed physician or licensed prescriber and approved and authorized according to the state of California requirements. Each beneficiary shall reside at the facility if receiving a residential service and will be monitored during the detoxification process.

- 1. Withdrawal Management services shall be determined by the Medical Director, LPHA, by contracted and licensed physicians, or by nurse practitioners, as medically necessary, and in accordance with an individualized beneficiary's treatment plan.
- 2. For beneficiaries in Withdrawal Management, CONTRACTOR shall provide case management services to coordinate care with ancillary service providers and facilitate transitions between LOCs.
  - a) **Case Management services are not a component of Withdrawal Management; therefore, if the only service provided on a specific date, that bed day is not billable.**
- 3. The components of Withdrawal Management services shall include:
  - a) **Intake:** The process of admitting a beneficiary into a substance use disorder (SUD) treatment program. Intake includes the evaluation or analysis of SUD, the diagnosis of SUD, the assessment

of treatment needs, and may include a physical examination and laboratory testing necessary for SUD treatment.

- b) **Observation:** The process of monitoring the beneficiary's course of withdrawal as frequently as deemed appropriate for the beneficiary. This may include but is not limited to, observation of the beneficiary's health status.
- c) **Medication Services:** The prescription or administration related to SUD treatment services, and/or the assessment of the side effects and results of that medication.
- d) **Care Coordination:** CONTRACTOR shall ensure that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, outpatient) without disruptions to services.
- e) **Discharge Services:** Preparing the beneficiary for referral into another level of care, post treatment return, re-entry into the community, and/or the linkage of the individual to community treatment, housing, and human services.

### **Section 2 - Assessments**

- A. Face-to-Face: Assessments shall be face-to-face and performed by qualified staff. If the face-to-face assessment is provided by a certified counselor, the "face-to-face" interaction must take place, at minimum, between the certified counselor who has completed the assessment for the beneficiary and the Medical Director, licensed physician, or LPHA. This interaction also must be documented appropriately in the medical record to establish the determination of medical necessity for the beneficiary.
- B. Re-Assessments:
  - 1. CONTRACTOR shall reassess all ODF and IOT beneficiaries, at a minimum of every 90 calendar days, unless medical necessity warrants more frequent reassessments as documented in the individualized treatment plan.
  - 2. CONTRACTOR shall reassess beneficiaries initially authorized for residential treatment, at a minimum of every 30 calendar days, unless medical necessity warrants more frequent reassessments as documented in the individualized treatment plan.
- C. ASAM Training: All staff shall complete the required two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and LOC" every two years and for new staff prior to providing any DMC-ODS services. These modules will be sent from the QI Unit for completion. The CONTRACTOR is responsible for notifying the COUNTY of all staff completions and sending ASAM completion certificates to the COUNTY.

### **Section 3 - Program Requirements**

- A. For beneficiaries referred by TulareWORKs, CVRS will provide the following:
  - 1. Upon receipt of the referral, CVRS will contact the client and complete an assessment.
    - a) CVRS will contact the TulareWORKs staff with the outcome of the initial contact within 72 hours from the date CVRS receives the referral.
    - b) CVRS will notify TulareWORKs staff monthly on the status of each beneficiaries' engagement in the program.
    - c) CVRS shall carbon copy (CC) [ICM@tularecounty.ca.gov](mailto:ICM@tularecounty.ca.gov) along with TulareWORKs lead staff, when submitting the initial contact and/or monthly status to TulareWORKs staff.



B. Counselors

1. In accordance with Title IX, at least thirty percent (30%) of staff providing counseling services in all Alcohol and Other Drug (AOD) programs shall be licensed or certified and the remaining seventy percent (70%) may be registered.
2. Best practices for providing SUD services are when staffing is a balance of Registrants and AOD Counselors and LPHAs for continuity of care. It is highly recommended to provide the best possible services to beneficiaries, CONTRACTOR utilize the following ratio:
  - a) At least seventy percent (70%) of staff providing counseling services be licensed or certified and the remaining thirty percent (30%) may be registered.
3. Upon the date of hire, all non-licensed or non-certified individuals in an AOD program shall be registered to obtain certification as an AOD Counselor by an approved certifying organization prior to providing counseling services, in accordance with Title IX regulation.
  - a) Registrants shall complete certification as an AOD counselor within five (5) years of the date of registration.
4. Registrants shall ensure a licensed or certified AOD counselor is on-site when conducting individual counseling sessions, group counseling sessions, face-to-face interviews, or counseling for families, couples, and other individuals significant in the life of the participants, patients, or residents.

C. Volunteers and Interns

1. In the event volunteers and/or interns are used by CONTRACTOR, CONTRACTOR shall meet the following requirements:
  - a) Volunteers/interns shall NOT be currently receiving treatment or recovery services by CONTRACTOR or have received services within six (6) months.
  - b) Volunteers shall NOT have access to beneficiaries' information, to include:
    - (i) Access to Electronic Health Record (EHR) systems;
    - (ii) Personnel files; and
    - (iii) Beneficiaries PII
2. If CONTRACTOR utilizes the services of volunteers and/or interns, it shall develop and implement written policies and procedures, which shall be available for, and reviewed with all volunteers and interns. The policies and procedures shall address all of the following:
  - a) Recruitment;
  - b) Screening;
  - c) Selection;
  - d) Training and orientation;
  - e) Duties and assignments;
  - f) Supervision;
  - g) Protection of beneficiaries' confidentiality; and
  - h) Code of Conduct
3. The program shall maintain personnel files on all volunteers and interns. Each personnel file shall contain:
  - a) Health records including a health screening report or health questionnaire and tuberculosis test result records as required;

- b) Code of Conduct statement;
- c) Protection of confidentiality statement; and
- d) Job description including lines of supervision.
- e) At no time shall a volunteer be alone with beneficiaries during treatment.

#### **Section 4 - Performance Standards**

CONTRACTOR shall be evaluated by the University of California, Los Angeles, Integrated Substance Abuse Programs (UCLA ISAP), to measure and monitor outcomes of DMC-ODS. The evaluation will focus on four areas: (1) access to care, (2) quality of care, (3) cost, and (4) the integration and coordination of SUD care, both within the SUD system and with medical and mental health services. As part of DMC-ODS, CONTRACTOR shall make available, the Treatment Perception Survey (TPS), which can be found at <http://www.uclaisap.org/ca-policy/html/client-treatment-perceptions-survey.html>. The data may also be used by CONTRACTOR to evaluate and improve the quality of care and beneficiary experience.

After the first year of DMC-ODS, COUNTY will review CONTRACTOR'S performance and identify potential patterns and areas that may indicate quality of care issues (e.g., timeliness of placement, effective ASAM assessment, patient-centered focus). After year one of DMC-ODS, COUNTY may implement baselines for CONTRACTOR performance.

#### **A. Access to Care**

1. CONTRACTOR shall accept individuals eligible for enrollment in the order in which they apply without restriction in accordance with this Agreement. CONTRACTOR shall take affirmative action to ensure that beneficiaries are provided covered services and will not discriminate against individuals eligible to enroll under the laws of the United States and the State of California. CONTRACTOR shall not unlawfully discriminate against any person pursuant to:
  - a) Title VI of the Civil Rights Act of 1964.
  - b) Title IX of the Education Amendments of 1972 (regarding education and programs and activities).
  - c) The Age Discrimination Act of 1975.
  - d) The Rehabilitation Act of 1973.
  - e) The Americans with Disabilities Act.
2. DMC-ODS services shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in this opt-in COUNTY. Determination of who may receive the DMC-ODS benefits shall be performed in accordance with DMC-ODS Special Terms and Conditions (STC) 132(d), Article II.E.4 of the State-County Contract, and as follows:
  - a) CONTRACTOR shall verify the Medicaid eligibility determination of an individual. When CONTRACTOR conducts the initial eligibility verification, that verification shall be reviewed and approved by CONTRACTOR prior to payment for services. If the individual is eligible to receive services from tribal health programs operating under the Indian Self-Determination Education Assistance Act (ISDEAA), then the determination shall be conducted as set forth in the Tribal Delivery System - Attachment BB to the STCs.
  - b) All beneficiaries shall meet the following medical necessity criteria:
    - (i) The individual shall have received a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-V) 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).
    - (ii) The individual shall meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.

- (iii) For beneficiaries in treatment prior to implementation of the DMC-ODS, the provider must conduct an ASAM assessment by the due date of the next updated treatment plan or continuing services justification, whichever occurs first.
      - a. If the assessment determines a different level of care, the provider shall refer the beneficiary to the appropriate level of care.
  - c) Adolescents are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under the age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Nothing in the DMC-ODS overrides any EPSDT requirements.
  - d) In addition to Article III.B.2.ii, 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.
  - e) For an individual to receive ongoing DMC-ODS services, the Medical Director or LPHA shall reevaluate that individual's medical necessity qualification at least every six months through the reauthorization process and document their determination that those services are still clinically appropriate for that individual. For an individual to receive ongoing Opioid Treatment Program/Narcotic Treatment Program (OTP/NTP) services, the Medical Director or LPHA shall reevaluate that individual's medical necessity qualification at least annually through the reauthorization process and determine that those services are still clinically appropriate for that individual.
3. Timely access data—including date of initial contact, date of first offered appointment and date of scheduled assessment—shall be entered into the EHR system within seven (7) days of the intake.

Performance Standard:

- a) First face-to-face appointment shall occur within five (5) and no later than 10 business days of initial contact.
  - (i) CONTRACTOR shall allow beneficiaries to appear in person and receive same-day screening, ASAM assessments, and referral, if available.
- b) First face-to-face appointment Medication Assisted Treatment appointment for beneficiaries with alcohol or opioid disorders shall occur within five (5) and no later than 10 business days.
- c) Tulare County strives to ensure the highest quality of care, which includes time and location of services. CONTRACTOR shall provide all beneficiaries the TPS, to guarantee the best possible care is provided.
- d) Timely access data shall be entered in EHR within seven (7) days of first contact for all beneficiaries.

B. Progress Notes

- 1. For ODF 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 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 CONTRACTOR ensured confidentiality.
- 2. For IOT 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.
  - a) CONTRACTOR shall provide progress note for each day a service is rendered to beneficiary.
  - b) 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.
  - c) Weekly Progress notes are individual narrative summaries and shall include all of the following:
    - (i) A description of the beneficiary's progress on the treatment plan, problems, goals, action steps, objectives, and/or referrals.
    - (ii) A record of the beneficiary's attendance at each counseling session including the date, start and end times and topic of the counseling session.
    - (iii) Identify if services were provided in-person, by telephone, or by telehealth.
    - (iv) If services were provided in the community, identify the location and how the provider ensured confidentiality.
- 3. For each beneficiary provided case management services, the LPHA or counselor who provided the treatment service shall record a progress note.
  - a) The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven calendar days of the case management service. The signature shall be adjacent to the typed or legibly printed name.
  - b) Progress notes shall include all of the following:
    - (i) Beneficiary's name.
    - (ii) The purpose of the service.
    - (iii) A description of how the service relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referrals.
    - (iv) Date, start and end times of each service.
    - (v) Identify if services were provided in-person, by telephone, or by telehealth.
    - (vi) If services were provided in the community, identify the location and how the provider ensured confidentiality.
- 4. 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.

- a) The Medical Director or LPHA shall type or legibly print their name, and sign and date the progress note within seven calendar days of the service. The signature shall be adjacent to the typed or legibly printed name.
- b) Progress notes shall include all of the following:
  - (i) Beneficiary's name.
  - (ii) The purpose of the service.
  - (iii) Date, start and end times of each service.
  - (iv) Identify if services were provided face-to-face, by telephone or by telehealth.

C. Continuing Services.

1. Continuing services shall be justified as shown below:

- a) For ODF services, IOT services, and case management:
  - (i) 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.
  - (ii) 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:
    - a. The beneficiary's personal, medical and substance use history.
    - b. Documentation of the beneficiary's most recent physical examination.
    - c. The beneficiary's progress notes and treatment plan goals.
    - d. The LPHA's or counselor's recommendation pursuant to Paragraph (i) above.
    - e. The beneficiary's prognosis.
    - f. 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.
  - (iii) 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 LOC and transfer to the appropriate services.

D. Transitions Between LOCs

- 1. CONTRACTOR shall ensure the transition of the beneficiaries to appropriate LOC. This may include step-up or step-down in SUD treatment services. Case Managers shall provide warm hand-offs and transportation to the new LOC when medically necessary and documented in the individualized treatment plan.
- 2. CONTRACTOR shall ensure transitions to other LOCs will occur within 10 business days from the time of assessment or reassessment with no interruption of current treatment services.
- 3. CONTRACTOR shall follow-up with beneficiaries transitioning from ASAM levels 3.1, 3.2, 3.3 and 3.5

within seven (7) days after discharge to ensure the beneficiaries are referred to appropriate LOC, and must document and track the following outcomes:

- a) Where the beneficiary was referred to.
  - b) Date CONTRACTOR followed-up with beneficiary.
  - c) The number of days to beneficiary's next LOC appointment.
  - d) The outcome
4. CONTRACTOR shall manage a beneficiary's transition of care to a DMC-ODS provider when that beneficiary has received, and no longer requires, inpatient SUD services (ASAM level 3.7 and 4.0 services) in an acute care hospital, or another Fee for Service (FFS) facility.

E. Coordination and Continuity of Care (42 CFR §438.208).

1. CONTRACTOR shall comply with the care and coordination requirements of this section.
2. As all beneficiaries receiving DMC-ODS services shall have special health care needs, CONTRACTOR shall implement mechanisms for identifying, assessing, and producing a treatment plan for all beneficiaries that have been assessed to need a course of treatment, and as specified below.
3. CONTRACTOR shall implement procedures to deliver care to and coordinate services for all of its beneficiaries. These procedures shall meet Department requirements and shall do the following:
  - a) Ensure that each beneficiary has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary. The beneficiary shall be provided with information on how to contact their designated person or entity.
  - b) Coordinate the services the CONTRACTOR furnishes to the beneficiary:
    - (i) Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.
    - (ii) With the services the beneficiary receives from any other managed care organization.
    - (iii) With the services the beneficiary receives in FFS Medicaid.
    - (iv) With the services the beneficiary receives from community and social support providers.
  - c) Make a best effort to conduct an initial screening of each beneficiary's needs, within 90 calendar days of the effective date of enrollment for all new beneficiaries, including subsequent attempts if the initial attempt to contact the beneficiary is unsuccessful.
  - d) Share with the Department or other managed care organizations serving the beneficiary the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities.
  - e) Ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards.
  - f) Ensure that in the process of coordinating care, each beneficiary's privacy is protected 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 they are applicable.
  - g) CONTRACTOR shall implement mechanisms to comprehensively assess each Medicaid beneficiary identified by the Department as having special health care needs to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring. The assessment mechanisms shall use appropriate providers.
  - h) CONTRACTOR shall produce a treatment or service plan meeting the criteria below for beneficiaries with special health care needs that are determined through assessment to need a course



of treatment or regular care monitoring. The treatment or service plan shall be:

- (i) Developed with beneficiary participation, and in consultation with any providers caring for the beneficiary.
- (ii) Developed by a person trained in person-centered planning using a person-centered process and plan, as defined in 42 CFR §441.301(c)(1).
- (iii) Approved by CONTRACTOR in a timely manner, if this approval is required by CONTRACTOR.
- (iv) In accordance with any applicable Department quality assurance and utilization review standards.
- (v) Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the beneficiary's circumstances or needs change significantly, or at the request of the beneficiary per 42 CFR §441.301(c)(3).
- (vi) For beneficiaries with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the CONTRACTOR shall have a mechanism in place to allow beneficiaries to directly access a specialist as appropriate for the beneficiary's condition and identified needs.

F. Care Coordination and Linkage with Ancillary Service

- 1. CONTRACTOR shall adhere to COUNTY'S care coordination plan that provides for seamless transitions of care for beneficiaries with the DMC-ODS system of care. CONTRACTOR is responsible for ensuring that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, ODF) without disruptions to services.
- 2. In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, CONTRACTOR shall ensure that beneficiaries have access to recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.
- 3. CONTRACTOR shall ensure 42 CFR Part 2 compliant releases are in place in order to coordinate care. CONTRACTOR shall screen for and link clients with mental and physical health, as indicated.
- 4. It is required that CONTRACTOR document all interactions with beneficiaries. It is highly recommended CONTRACTOR document if a beneficiary refuses continuity of care services.
- 5. CONTRACTOR shall not be penalized for beneficiaries that refuse services.
- 6. Performance Standard:
  - a) COUNTY strives to ensure Quality of Care, which includes ensuring the coordination of care, as well as linkages with ancillary services. Continuity of care is of the whole person model and performance measures will be measured at the following:
  - b) There is documentation of physical health and mental health screening in all beneficiary records.
  - c) Beneficiaries have 42 CFR compliant releases in place to coordinate care with physical health providers.
  - d) Beneficiary records have documentation of coordination with physical health.
  - e) Beneficiaries engaged in treatment for at least 30 days have an assigned Primary Care Provider
  - f) Beneficiaries who screen positive for mental health disorders have 42 CFR compliant releases in place to coordinate care with mental health providers.
  - g) Beneficiary records for individuals who screen positive for mental health disorders have

documentation of coordination with mental health (e.g. referral for mental health assessment or consultation with existing providers).

G. Narcotic Treatment Programs (NTPs)

1. CONTRACTOR shall have procedures for linkage/integration for beneficiaries requiring NTP services for substance use disorders. CONTRACTOR staff shall regularly communicate with physicians of beneficiaries who are prescribed these medications unless the beneficiary refuses to consent to a 42 CFR, Part 2 compliant release of information for this purpose.
2. It is required that CONTRACTOR document all contact with beneficiaries. It is highly recommended CONTRACTOR document if a beneficiary refuses continuity of care services.
  - a) CONTRACTOR shall not be penalized for beneficiaries that refuse services.
3. Performance Standard:
  - a) CONTRACTOR shall strive to ensure beneficiary records for individuals receiving Medication Assisted Treatment for substance use disorders have 42 CFR compliant releases in place to coordinate care.
  - b) CONTRACTOR shall strive to ensure that beneficiaries with a primary opioid or alcohol use disorder be linked to a Medication Assisted Treatment (MAT) assessment and/or MAT services.

H. Delivery of Individualized and Quality Care

1. Beneficiary Satisfaction: DMC-ODS Providers (serving adults 18+) shall participate in the annual statewide Treatment Perceptions Survey (administration period to be determined by DHCS). Upon review of Provider-specific results, CONTRACTOR shall select a minimum of one quality improvement initiative to implement annually.
2. Evidence-Based Practices (EBPs): CONTRACTOR shall implement, at the least Motivational Interviewing, and two of the following EBPs per service modality: Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment and Psychoeducation.
3. ASAM LOC: All beneficiaries participate in an assessment using ASAM dimensions. The assessed and actual LOC (and justification if the levels differ) shall be recorded in the Electronic Health Record (HER) within seven (7) days of the assessment.
4. Performance Standards:
  - a) Beneficiaries' TPS shall identify overall satisfaction with the program and their individualized treatment plan.
  - b) CONTRACTOR shall implement at least three approved EBPs.
    - (i) CONTRACTOR shall implement Motivational Interviewing as an EBP

I. CONTRACTOR shall ensure beneficiaries participated in an assessment using ASAM dimensions and are provided with a recommendation regarding ASAM LOC.

J. Discharge

1. Discharge of a beneficiary from treatment may occur on a voluntary or involuntary basis. For ODF services and IOT service, in addition to the requirements of this subsection, an involuntary discharge is subject to the requirements set forth in Article II.G.2. of this Agreement.
2. An LPHA or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom CONTRACTOR loses contact.
  - a) The discharge plan shall include, but not be limited to, all of the following:

- (i) A description of each of the beneficiary's relapse triggers.
  - (ii) A plan to assist the beneficiary to avoid relapse when confronted with each trigger.
  - (iii) A support plan.
- 3. The discharge plan shall be prepared within 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 30-calendar day lapse in treatment services.
- 4. During the LPHA's or counselor's last face-to-face treatment with the beneficiary, the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. The signatures shall be adjacent to the typed or legibly printed name. A copy of the discharge plan shall be provided to the beneficiary and documented in the beneficiary record.
- 5. 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:
  - a) The LPHA or counselor shall complete the discharge summary within 30 calendar days of the date of the last face-to-face treatment contact with the beneficiary.
  - b) The discharge summary shall include all of the following:
    - (i) The duration of the beneficiary's treatment is determined by the dates of admission to and discharge from treatment.
    - (ii) The reason for discharge.
    - (iii) A narrative summary of the treatment episode.
    - (iv) The beneficiary's prognosis.

#### K. Culturally Competent Services

CONTRACTORS are responsible for providing culturally competent services. CONTRACTORS must ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations. Translation and oral interpreter services must be available for beneficiaries, as needed and at no cost to the beneficiary.

##### 1. Performance Standard:

- a) COUNTY strives to ensure Quality of Care services are provided, which includes providing culturally competent services to beneficiaries. Performance measures will be measured at the following:
  - (i) CONTRACTOR shall adopt Federal Culturally & Linguistic Appropriate Services (CLAS) standards and develop cultural competence plan with regular updates.
  - (ii) Translation services shall be available for beneficiaries and services will be culturally competent and accessible.
  - (iii) Provide written information in all threshold languages based on COUNTY population.

#### **Section 5 - Outcomes**

- A. In order to assess whether beneficiaries: 1) Reduce substance abuse or achieve a substance-free life; 2) Maximize multiple aspects of life functioning; 3) Prevent or reduce the frequency and severity of relapse; and 4) Improve overall quality of life, the following indicators that shall be evaluated and measured include, but are not limited to:
  - 1. Engagement in the first 30 days of treatment (at least two treatment sessions within 30 days after

- initiating treatment).
- 2. Reduction in substance use.
- 3. Reduction in criminal activity or violations of probation/parole and days in custody.
- 4. Increase in employment or employment (and/or educational) skills.
- 5. Increases in family reunification.
- 6. Increase engagement in social supports.
- 7. Maintenance of stable living environments and reduction in homelessness.
- 8. Improvement in mental and physical health status.
- 9. Beneficiary satisfaction.

#### **Section 6 - Training and Certification**

A. Applicable staff are required to participate in the following training:

- 1. **DMC-ODS IA Training (annually)**
- 2. Information Privacy and Security (At least annually).
- 3. ASAM E-modules 1 and 2 (via Relias) (Prior to Conducting Assessments).
- 4. Cultural Competency (At least annually).
- 5. Oath of Confidentiality (Review and sign at hire and annually thereafter).

B. Program Licensure, Certification and Standards

- 1. CONTRACTOR shall possess valid DHCS Alcohol and Drug Certification and DHCS DMC certification for the contracted LOC.

C. Beneficiary Protections and Beneficiary Informing Materials

- 1. Beneficiary Informing Materials
  - a) CONTRACTOR shall make available at initial contact and shall notify beneficiaries of their right to request and obtain at least once a year and thereafter upon request, the following materials: DMC-ODS Beneficiary Booklet and Provider Directory.
  - b) CONTRACTOR shall also post notices explaining grievance, appeal and expedited appeal processes in all program sites, as well as make available forms and self-addressed envelopes to file grievances, appeals and expedited appeals without having to make a verbal or written request to anyone. COUNTY shall produce required beneficiary informing materials in English and Spanish. CONTRACTOR shall request materials from COUNTY, as needed. Refer to 42 CFR 438.10(g)(2)(xi) for additional information about the grievance and appeal system.

#### **Section 7 – Authorization Process – ASAM Levels 3.1, 3.3 and 3.5**

A. Initial Authorization

Requests for initial authorization are to be submitted to HHSA Access on the Residential Placement Request (RPR) - Initial Authorization form at least 24 hours before the scheduled admission date. A copy of the ASAM Continuum or COUNTY-provided ASAM assessment tool shall be attached to the RPR. Initial authorizations can be granted for up to 30 days for youth and adults. An approved authorization allows for a client to be admitted to treatment within seven (7) calendar days of the approval date. Admissions later than seven (7) calendar days from the authorization date will be considered on a case-by-case basis and will require written approval by the COUNTY.

B. Continuing Authorization

Requests for continuing authorizations are to be submitted to HHSA Access on the RPR – Continuing Authorization form seven (7) calendar days before the expiration date of the current authorization. A copy of the re-assessment (ASAM Continuum or COUNTY-provided ASAM assessment tool) shall be attached to the RPR. For youth, a one-time extension for up to 30 days on an annual basis can be granted. For adults, continuing authorizations can be granted for up to an additional 30 days, for a total length of stay not to exceed 90 days. A one-time extension for up to 30 days on an annual basis can be granted, for a total length of stay not to exceed 120 days. Only two, non-continuous, 90-day regimens will be authorized in a one-year period. Perinatal, EPSDT and criminal justice clients may receive a longer length of stay based on medical necessity.

C. Additional Information - RPRs

For an RPR to be considered eligible for authorization, the individual must be a Tulare County Medi-Cal beneficiary or Tulare County low-income (<138% FPL) uninsured resident and meet medical necessity and the ASAM criteria for the proposed level of care. Payment and submission of claims to Medi-Cal are subject to a beneficiary's eligibility and services being rendered and documented in accordance with Title 22, ASAM diagnostic and dimensional criteria and the DMC-ODS STCs.

**Section 8 - Notice of Adverse Benefit Determination (NOABD)**

A. CONTRACTOR shall have written procedures to ensure compliance with the following:

1. CONTRACTOR shall request consent from beneficiaries for the COUNTY of Tulare to issue a NOABD to the address on record should covered services be reduced, denied, modified, delayed or terminated. If a beneficiary should refuse to consent, it is CONTRACTOR'S responsibility for issuing any applicable NOABD directly to the beneficiary.
  - a) CONTRACTOR shall immediately notify COUNTY in writing of any actions that may require a NOABD be issued, including, but not limited to 1) not meeting timely access standards; 2) not meeting medical necessity for any substance use disorder treatment services; and 3) terminating or reducing authorized covered services.

**Section 8 - Locations**

**Administrative**

320 W. Oak Ave. Suite A  
Visalia, CA 93291

**New Heights**

1731 W Walnut Ave.  
Visalia, CA 93277

**New Hope**

212 N. Stevenson  
Visalia, CA 93291

**New Visions**

1425 W. School Ave.  
Visalia, CA 93292

**Pine Recovery**

120 W. School Ave.  
Visalia, CA 93291

**Mothering Heights**

705 S. Court St.  
Visalia, CA 93277

**Robertson Recovery**  
3107 E. Kaweah Ave.  
Visalia, CA 93292

**Section 9 – Additional Contract Information**

- A. If significant changes are expected, you must submit a request in writing to the contract manager. You must receive written approval prior to any changes being implemented and/or reimbursed. Significant changes include, but are not limited to:
1. Scope of Work
    - a) Proposing to re-distribute units of service between existing service codes by more than 20%.
    - b) Proposing to add or remove a service modality.
    - c) Proposing to transfer substantive programmatic work to a subcontractor.
    - d) Proposing to provide any services by telephone or field-based.
  2. Budget
    - a) Proposing to re-distribute more than 20% between budget categories.
    - b) Proposing to increase or decrease Full Time Equivalent (FTE).
    - c) Proposing to increase the contract maximum.
- B. CONTRACTOR shall also report any other key changes per the timelines and processes outlined in applicable Policies and Procedures, including, but not limited to 1) Staff Updates; 2) Facility alterations/renovations; 3) Unusual occurrences or incidents; 4) Reduction in DMC services; and 5) Not accepting beneficiaries (facility at capacity).
- C. CONTRACTOR will comply with the Code of Federal Regulations (42 C.F.R. § 455.434(a)) which requires that providers who are enrolled in the State of California Medi-Cal/Medicaid program, including subcontracted providers are required to consent to criminal background checks including fingerprinting when required to do so by the California Department of Healthcare Services or by the level of screening based on risk of fraud, waste or abuse as determined for that category of provider.



**EXHIBIT A-1**  
**TULARE COUNTY DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS),**  
**QUALITY MANAGEMENT STANDARDS**

The Tulare County Drug Medi-Cal Organized Delivery System (DMC-ODS) has established standards for all organizational, individual, and group providers furnishing Substance Use Disorder (SUD) Services. CONTRACTOR shall adhere to all current DMC-ODS policies and procedures (P&P's) in addition to the following standards. In the event of conflicting requirements, current P&P's will supersede the below standards. P&P's may be updated from time to time, and when an update occurs COUNTY shall notify and provide CONTRACTOR with the revised P&P's. Copies of all current P&P's are available by contacting the Tulare County Alcohol and Other Drugs (AOD) Managed Care Quality Improvement (QI) Unit at (559) 624-8000.

**Section 1. SERVICES AND ACCESS PROVISIONS**

**1. CERTIFICATION OF ELIGIBILITY**

CONTRACTOR will, in cooperation with COUNTY, comply with 42 C.F.R. § 455.1(a)(2) and BHIN 23-001, to obtain a certification of a client's eligibility for SUD services under Medi-Cal.

**2. ACCESS TO SUBSTANCE USE DISORDER SERVICES**

A. In collaboration with the COUNTY, CONTRACTOR will work to ensure that individuals to whom the CONTRACTOR provides SUD services meet access criteria and medical necessity requirements, as per DHCS guidance specified in BHIN 23-001. Specifically, the CONTRACTOR will ensure that the clinical record for each client includes information as a whole indicating that client's presentation and needs are aligned with the criteria applicable to their age at the time of service provision as specified below.

B. CONTRACTOR shall have written admission criteria for determining the client's eligibility and suitability for treatment and services. All clients admitted shall meet the admission criteria and this shall be documented in the client's record.

C. Programs shall ensure that their policies, procedures, practices, and rules and regulations do not discriminate against the above special populations. Whenever the needs of the client cannot be reasonably accommodated, efforts shall be made to make referral(s) to appropriate programs.

D. CONTRACTOR should recognize and educate staff and collaborative partners that Parole and Probation status is not a barrier to SUD services.

E. CONTRACTOR will ensure that the clinical record for each client includes information as a whole indicating that client's presentation and needs are aligned with the criteria applicable to their age at the time-of-service provision as outlined in this Agreement.

F. The initial assessment shall be performed face-to-face, by telehealth or by telephone by an Licensed Practitioner of the Healing Arts (LPHA) or a registered or certified counselor and may be done in the community or the home, except for residential treatment services and narcotic treatment programs (NTPs). If the assessment of the client is completed by a registered or certified counselor, then an LPHA shall evaluate that assessment with the counselor and the LPHA shall make the final diagnosis. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.

G. CONTRACTOR shall comply with beneficiaries' access criteria and services provided during the initial assessment process requirements, which include the following:

I. For beneficiaries 21 years of age and older, a full assessment using the American Society of Addiction Medicine (ASAM) Criteria shall be completed within 30 days of the beneficiary's first visit with an LPHA or a registered or certified counselor, or Peer Support Specialist (except for residential treatment services).

II. For beneficiaries under the age of 21, a full assessment using the ASAM Criteria shall be completed within 60 days of the beneficiary's first visit with an LPHA or registered or certified counselor (except for residential treatment services).

III. For beneficiaries experiencing homelessness and where the provider documents that due to homelessness additional time is required to complete the assessment, a full assessment using the ASAM Criteria shall be completed within 60 days of the beneficiary's first visit with an LPHA or a registered or certified counselor (except for residential treatment services).

IV. If a client withdraws from treatment prior to completion of the assessment or prior to establishing a DSM diagnosis for Substance-Related and Addictive Disorder, and later returns, the 30-day or 60-day time period starts over.

H. CONTRACTOR shall comply with beneficiaries' access criteria after initial assessment requirements, which include the following:

I. Beneficiaries 21 years of age and older, to qualify for DMC-ODS services after the initial assessment, must meet one of the following criteria:

- a. Have at least one diagnosis from the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders for Substance-Related and Addictive Disorders, except for Tobacco-Related Disorders and Non-Substance-Related Disorders, OR
- b. Have had at least one diagnosis from the most current edition of the DSM for Substance-Related and Addictive Disorders, except for Tobacco-Related Disorders and Non-Substance-Related Disorders, prior to being incarcerated or during incarceration, determined by substance use history.

II. Beneficiaries under the age of 21, qualify for DMC-ODS medically necessary services after the initial assessment, in the following circumstances:

- a. All services that are Medi-Cal-coverable, appropriate, and medically necessary, needed to correct and ameliorate health conditions shall be provided, as per federal Early & Periodic Screening, Diagnostic and Treatment (EPSDT) statutes and regulations.
- b. Services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and SUDs, consistent with federal guidance.
- c. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

### 3. ASAM LEVEL OF CARE DETERMINATION

A. CONTRACTOR shall use the ASAM Criteria to determine placement into the appropriate level of care (LOC) for all beneficiaries, which is separate and distinct from determining medical necessity. LOC determinations shall ensure that beneficiaries are able to receive care in the least restrictive LOC that is clinically appropriate to treat their condition.

B. A full ASAM Criteria assessment and an SUD diagnosis is not required to deliver prevention and early intervention services for beneficiaries under the age of 21; a brief screening ASAM Criteria tool is sufficient for these services.

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

D. A full ASAM Criteria assessment, or brief screening ASAM Criteria tool for preliminary LOC recommendations, shall not be required to begin receiving DMC-ODS services.

E. A full ASAM Criteria assessment does not need to be repeated unless the client's condition changes.

F. Requirements for ASAM LOC assessments apply to NTP clients and settings.

#### 4. MEDICAL NECESSITY

A. Pursuant to BHIN 23-001 and consistent with Welfare & Institutions Code § 14059.5, DMC-ODS services must be medically necessary.

B. For beneficiaries 21 years of age and older, a service is “medically necessary” or a “medical necessity” when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

C. For beneficiaries under the age of 21, a service is “medically necessary” or a “medical necessity” if the service is necessary to correct or ameliorate screened health conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

#### 5. ADDITIONAL COVERAGE REQUIREMENTS AND CLARIFICATIONS

A. The target population for DMC-ODS SUD services includes clients who are enrolled in Medi-Cal, reside in the COUNTY, and meet the criteria for DMC-ODS services as per established requirements above.

B. Consistent with Welfare & Institutions Code § 14184.402(f), covered SUD prevention, screening, assessment, treatment, and recovery services are reimbursable Medi-Cal services in the following circumstances:

I. Services are provided prior to the completion of an assessment or prior to the determination of whether DMC-ODS access criteria are met, or prior to the determination of a diagnosis.

a. Clinically appropriate and covered DMC-ODS services provided to clients over the age of 21 are reimbursable during the assessment process. Similarly, if the assessment determines that the client does not meet the DMC-ODS access criteria after initial assessment, those clinically appropriate and covered DMC-ODS services provided are reimbursable.

b. All Medi-Cal claims shall include a current Centers for Medicare & Medicaid Services (CMS) approved International Classification of Diseases (ICD) diagnosis code. In cases where services are provided due to a suspected SUD that has not yet been diagnosed, options are available in the CMS approved ICD-10 code list, for example, codes for “Other

specified” and “Unspecified” disorders, or “Factors influencing health status and contact with health services”.

II. Prevention, screening, assessment, treatment, or recovery services were not included in an individual treatment plan, or if the client signature was absent from the treatment plan.

a. While most DMC-ODS providers are expected to adopt problem lists as specified in BHIN 22-019, treatment plans continue to be required for some services in accordance with federal law.

b. Treatment plans are required by federal law for:

i. Narcotic Treatment Programs (NTPs)

ii. Peer Support Services

III. The beneficiary has a co-occurring mental health condition.

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

C. Intravenous substance abuse

I. Capacity of treatment programs

a. Notification of reaching capacity

A funding agreement for a grant under section 300x–21 of this title is that the State involved will, in the case of programs of treatment for intravenous drug abuse, require that any such program receiving amounts from the grant, upon reaching 90 percent of its capacity to admit individuals to the program, provide to the State a notification of such fact.

b. Provision of treatment

A funding agreement for a grant under section 300x–21 of this title is that the State involved will, with respect to notifications under paragraph (1), ensure that each individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment not later than:

i. 14 days after making the request for admission to such a program; or

ii. 120 days after the date of such request, if no such program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not later than 48 hours after such request.

iii. Outreach to persons who inject drugs

A funding agreement for a grant under section 300x–21 of this title is that the State involved, in providing amounts from the grant to any entity for treatment services for persons who inject drugs, will require the entity to carry out activities to encourage individuals in need of such treatment to undergo treatment. (July 1, 1944, ch. 373, title XIX, §1923, as added Pub. L. 102–321, title II, §202, July 10, 1992, 106 Stat. 390 ; amended Pub. L. 114–255, div. B, title VIII, §8002(b), Dec. 13, 2016, 130 Stat. 1229 .)

## 6. DIAGNOSIS DURING INITIAL ASSESSMENT

A. CONTRACTOR may use the following options during the assessment phase of client's treatment when a diagnosis has yet to be established as specified in BHIN 22-013:

I. ICD-10 codes Z55-Z65 Potential health hazards related to socioeconomic and psychological circumstances: may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision, of, an LPHA.

II. ICD-10 code Z03.89 Encounter for observation for other suspected diseases and conditions ruled out: may be used by an LPHA during the assessment phase of a client's treatment when a diagnosis has yet to be established.

III. CMS approved diagnosis code on the ICD 10 tabular, available in the CMS 2022 ICD-10-CM page at: <https://www.cms.gov/medicare/icd-10/2022-icd-10-cm>, which may include Z codes. LPHAs may use any clinically appropriate ICD-10 code, for example, codes for "Other specified" and "Unspecified" disorders, or "Factors influencing health status and contact with health services."

## 7. COORDINATION AND CONTINUITY OF CARE

A. CONTRACTOR shall comply with the care and coordination requirements established by the COUNTY and per 42 C.F.R. § 438.208.

B. CONTRACTOR shall ensure that all care, treatment, and services provided pursuant to this Agreement are coordinated among all providers who are serving the client. Coordination and continuity of care procedures shall meet the following requirements:

I. Ensure that each client has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the client. The client shall be provided information on how to contact their designated person or entity.

II. All services provided to clients shall be coordinated:

a. Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.

b. With the services the client receives from any other managed care organization.

c. With the services the client receives in FFS Medi-Cal.

d. With the services the client receives from community and social support providers.

III. Share with other providers serving the client, as allowed by regulations, the results of any identification and assessment of that client's needs to prevent duplication of those activities.

IV. Ensure that each provider furnishing services to clients maintains and shares, as appropriate, a client health record in accordance with professional standards.

V. Ensure that in the process of coordinating care, each client's privacy is protected in accordance with the privacy requirements in 45 C.F.R. Parts 160 and 164 subparts A and E and 42 C.F.R. Part 2, to the extent that they are applicable.

C. CONTRACTOR shall engage in care coordination activities beginning at intake and throughout the treatment and discharge planning processes.

D. To facilitate care coordination, CONTRACTOR will request a client authorization that complies with Health Insurance Portability and Accountability Act (HIPAA) and California law to share client information with and among all other providers involved in the client's care, in satisfaction of state, and federal privacy laws and regulations.

#### 8. SITE LICENSES, CERTIFICATIONS, PERMITS REQUIREMENTS

A. As specified in BHIN 21-001 and in accordance with Health and Safety Code § 11834.015, DHCS adopted the ASAM treatment criteria as the minimum standard of care for licensed AOD facilities. All licensed AOD facilities shall obtain at least one DHCS LOC Designation and/or at least one residential ASAM LOC Certification consistent with all of its program services. If an AOD facility opts to obtain an ASAM LOC Certification, then that facility will not be required to obtain a DHCS LOC Designation. However, nothing precludes a facility from obtaining both a DHCS LOC Designation and ASAM LOC Certification.

B. CONTRACTOR shall obtain and comply with DMC site certification and ASAM designation or DHCS LOC Designation for each type of contracted service being delivered, as well as any additional licensure, registration or accreditation required by regulations for the contracted service being delivered.

C. CONTRACTOR shall obtain and maintain all appropriate licenses, permits, and certificates required by all applicable federal, state, and county and/or municipal laws, regulations, guidelines, and/or directives.

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

#### 9. MEDICATIONS

A. If CONTRACTOR provides or stores medications, the CONTRACTOR shall store and monitor medications in compliance with all pertinent statutes and federal standards.

B. CONTRACTOR shall have written policies and procedures regarding the use of prescribed medications by clients, and for monitoring and storing of medications.

C. Prescription and over the counter medications which expire and other bio-hazardous pharmaceuticals including used syringes or medications which are not removed by the client upon termination of services shall be disposed of by the program director or a designated substitute, and one other adult who is not a client. Both shall sign a record, to be retained for at least one year.

D. CONTRACTOR shall have at least one program staff on duty at all times trained to adequately monitor clients for signs and symptoms of their possible misuse of prescribed medications, adverse medication reactions and related medical complications.

#### 10. ALCOHOL AND/OR DRUG-FREE ENVIRONMENT

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

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



## 11. ASSESSMENT OF TOBACCO USE DISORDER

A. As required by Assembly Bill (AB) 541 and BHIN 22-024, all licensed and/or certified SUD recovery or treatment facilities shall conduct an assessment of tobacco use at the time of the client's initial intake. The assessment shall include questions recommended in the most recent version of Diagnostic and Statistical Manual of Mental Disorders (DSM) under Tobacco Use Disorder, or COUNTY's evidence-based guidance, for determining whether a client has a tobacco use disorder.

B. The licensed and/or certified SUD recovery or treatment facility shall do the following:

I. Provide information to the client on how continued use of tobacco products could affect their long-term success in recovery from SUD.

II. Recommend treatment for tobacco use disorder in the treatment plan.

III. Offer either treatment, subject to the limitation of the license or certification issued by DHCS, or a referral for treatment for tobacco use disorder.

C. Licensed and/or certified SUD recovery or treatment facilities can also adopt tobacco free campus policies, to change the social norm of tobacco use, promote wellness, and reduce exposure to secondhand smoke.

## 12. NALOXONE REQUIREMENTS

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

I. Maintain, at all times, at least 2 unexpired doses of naloxone, or any other opioid antagonist medication that is approved by the FDA for the treatment of an opioid overdose, on the premises of the licensed SUD recovery or treatment facility.

II. Have at least one staff member, at all times, on the premises who knows the specific location of the naloxone, or other FDA-approved opioid antagonist medication, and who has been trained in its administration. Training shall include review of online resources and the National Harm Reduction Coalition's Opioid Overdose Basics website to respond effectively to an opioid-associated overdose emergency. Staff shall certify that they have reviewed and undergone training in opioid overdose prevention and treatment.

III. The proof of completion of such training shall be documented in the staff member's individual personnel file, in accordance with California Code of Regulations (CCR), Title 9, § 10564(k).

## 13. SERVICES REQUIREMENTS

A. Services and work provided by CONTRACTOR at the COUNTY's request under this Agreement will be performed in a timely manner, and in accordance with applicable federal and state statutes and regulations, including, but not limited to, sections 96.126, 96.127, 96.128, 96.131 and 96.132, and all references therefrom, of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reauthorization Act, Public Law 106-310, the State of California Alcohol and/or Other Drug Program Certification Standards (2017 version), Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8; Drug Medi-Cal Certification Standards for Substance Abuse Clinics; Title 22, CCR, Sections 51341.1, 51490.1, and 51516.1; Title 9, CCR, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq.; Title 22, CCR, Division 3, Chapter 3, sections 51000 et. seq. and any and all guidelines promulgated by the State Department of Health Care Services' (DHCS) Alcohol

and Drug Programs and the Tulare COUNTY Department of Health and Human Services to serve special populations and groups, as applicable; COUNTY laws, ordinances, regulations and resolutions; and in a manner in accordance with the standards and obligations of CONTRACTOR's profession. CONTRACTOR shall devote such time to the performance of services pursuant to this Agreement as may be reasonably necessary for the satisfactory performance of CONTRACTOR's obligations. The COUNTY shall maintain copies of above-mentioned statutes, regulations, and guidelines for CONTRACTOR's use. Copies of Substance Use Disorder Service Programs Policies and Procedures are sent to CONTRACTORS, as applicable, and can be resubmitted on request. CONTRACTOR shall adhere to the applicable provisions of the Multi- Year State-COUNTY Agreement referenced below in their entirety.

B. Counselor Certification: Any registered or certified counselor 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.

C. Re-Certification Events: CONTRACTOR shall notify DHCS and the COUNTY Alcohol and Drug Administrator within the timeframes noted in the State Agreement, in addition to applicable federal, state and local regulations and policies of any triggering recertification events, such as change in ownership, change in scope of services, remodeling of facility, or change in location.

D. Cultural and Linguistic Proficiency: To ensure access to quality care by diverse populations, each service provider receiving funds from the State-COUNTY Agreement shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Services (CLAS) national standards (2016 version).

E. Perinatal Services Network Guidelines: Perinatal programs shall comply with the Perinatal Services Network Guidelines FY 2016-17 until such time new Perinatal Services Network Guidelines are established and adopted.

F. Charitable Choice Requirements: CONTRACTORS shall not use funds provided through this Agreement for inherently religious activities, such as worship, religious instruction, or proselytization. CONTRACTORS that are religious organizations shall establish a referral process to a reasonably accessible program for clients who may object to the religious nature of the CONTRACTOR's program and CONTRACTORS shall be required to notify clients of their rights prohibiting discrimination and to be referred to another program if they object to the religious nature of the program at intake. Referrals that were made due to the religious nature of the CONTRACTOR's program shall be submitted annually to the COUNTY Alcohol and Drug Administrator by June 30 for referrals made during the fiscal year.

G. Trafficking Victims Protection Act of 2000: CONTRACTOR shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 as amended (22 U.S.C. 7104). The COUNTY is authorized to terminate the Agreement, without penalty, if the CONTRACTOR: (a) Engages in severe forms of trafficking in persons during the period of time that the award is in effect; (b) Procures a commercial sex act during the period of time that the award is in effect; or (c) Uses forced labor in the performance of the award or subawards under the award.

H. Beneficiary Informational Materials: CONTRACTOR shall make available at initial contact, and shall notify beneficiaries of their right to request and obtain the following information at least once a year and thereafter upon request: DMC-ODS Beneficiary

Booklet and Provider Directory. CONTRACTOR shall also post notices explaining grievance, appeal and expedited appeal processes in all program sites, as well as make available forms and self-addressed envelopes to file grievances, appeals and expedited appeals without having to make a verbal or written request to anyone. The COUNTY will produce required beneficiary informational materials in English and Spanish. CONTRACTOR shall request materials from the COUNTY, as needed

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

J. Restriction on Distribution of Sterile Needles: No Substance Abuse Prevention and Treatment (SAPT) Block Grant funds made available through this Agreement shall be used to carry out any program that includes the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug unless the State chooses to implement a demonstration syringe services program for injecting drug users.

K. 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).

L. CONTRACTOR shall notify the COUNTY Alcohol and Drug Administrator within two business days of receipt of any DHCS report identifying non-compliance services or processes requiring a Corrective Action Plan (CAP). CONTRACTOR shall submit the CAP to DHCS with the designated timeframe specified by DHCS and shall concurrently send a copy to the COUNTY Alcohol and Drug Administrator.

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

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

O. Debarment and Suspension. COUNTY shall not subcontract with or employ any party listed on the government wide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines at 2 CFR 180 that implement Executive Orders 12549 (3 CFR part 1986 Comp. p. 189) and 12689 (3 CFR part 1989., p. 235), "Debarment and Suspension." SAM exclusions contain the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549. The COUNTY shall advise all subcontractors of their obligation to comply with applicable federal debarment and suspension regulations, in addition to the requirements set forth in 42 CFR Part 1001. If a County subcontracts or employs an excluded party, DHCS has the right to withhold payments, disallow costs, or issue a CAP, as appropriate, pursuant to HSC Code 11817.8(h).

P. All work performed under this Contract is subject to HIPAA, COUNTY shall perform the work in compliance with all applicable provisions of HIPAA.

#### I. Trading Partner Requirements

a. No Changes. COUNTY hereby agrees that for the personal health information (Information), it will not change any definition, data condition or use of a data element or segment as proscribed in the Federal Health and Human Services (HHS) Transaction Standard Regulation (45 CFR 162.915 (a)).

b. No Additions. COUNTY hereby agrees that for the Information, it will not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation (45 CFR 162.915 (b)).

c. No Unauthorized Uses. COUNTY hereby agrees that for the Information, it will not use any code or data elements that either are marked "not used" in the HHS Transaction's Implementation specification or are not in the HHS Transaction Standard's implementation specifications (45 CFR 162.915 (c)).

d. No Changes to Meaning or Intent. COUNTY hereby agrees that for the Information, it will not change the meaning or intent of any of the HHS Transaction Standard's implementation specification (45 CFR 162.915 (d)).

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

#### III. Adequate Testing

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

#### IV. Deficiencies

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

#### V. Code Set Retention

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

#### VI. Data Transmission Log

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

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

R. Intravenous Drug Use (IVDU) Treatment

COUNTY shall ensure that individuals in need of IVDU treatment shall be encouraged to undergo AOD treatment (42 USC 300x-23 (45 CFR 96.126(e)). CONTRACTOR will be responsible for selecting, training and supervision of outreach workers; Contacting, communicating and following-up with high risk substance abusers, their associates, and neighborhood residents, within the constraints of Federal and State confidentiality requirements, including 42 CFR part 2. Also, promoting awareness among injecting drug abusers about the relationship between injecting drug abuse and communicable diseases such as HIV; recommend steps that can be taken to ensure that HIV transmission does not occur; and encouraging entry into treatment.

S. Tuberculosis Treatment COUNTY shall ensure the following related to Tuberculosis (TB):

- I. Routinely make available TB services to each individual receiving treatment for AOD use and/or abuse.
- II. Reduce barriers to patients' accepting TB treatment.
- III. Develop strategies to improve follow-up monitoring, particularly after patients leave treatment, by disseminating information through educational bulletins and technical assistance

T. Tribal Communities and Organizations

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

U. Participation of County Behavioral Health Director's Association of California

The COUNTY AOD Program Administrator shall participate and represent the COUNTY in meetings of the County Behavioral Health Director's Association of California for the purposes of representing the counties in their relationship with DHCS with respect to policies, standards, and administration for AOD abuse services. The COUNTY AOD Program Administrator shall attend any special meetings called by the Director of DHCS. Participation and representation shall also be provided by the County Behavioral Health Director's Association of California.

#### V. Youth Treatment Guidelines

COUNTY must comply with DHCS guidelines in developing and implementing youth treatment programs funded under this Enclosure, until new Youth Treatment Guidelines are established and adopted. Youth Treatment Guidelines are posted online at: <https://www.dhcs.ca.gov/provgovpart/Pages/Youth-Services.asp>

#### W. Nondiscrimination in Employment and Services

COUNTY certifies that under the laws of the United States and the State of California, COUNTY will not unlawfully discriminate against any person.

### 14. RECORDS

A. CONTRACTOR and the COUNTY mutually agree to maintain the confidentiality of CONTRACTOR's participant records, including billings, pursuant to Sections 11812(c) and 11879, Health & Safety Code and Federal Regulations for Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2, dated June 9, 1987), HIPAA, and all other applicable State and Federal laws and any amendments. CONTRACTOR shall inform all its officers, employees, and agents of the confidentiality provisions of said regulations, and provide all necessary policies and procedures and training to ensure compliance. CONTRACTOR shall ensure staff participate in information privacy and security training at least annually, and prior to accessing Protected Health Information (PHI) or Personally Identifiable Information (PII), sign a confidentiality statement that includes, at a minimum, General use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The statement must be renewed annually and shall be retained for a period of six (6) years following termination of this Agreement.

B. Where Agreements exceed \$10,000 of state funding – the CONTRACTOR shall be subject to examination and audit of the Department of Auditor General for a period of three (3) years after final payment under this Agreement (Government Code § 8546.7).

C. CONTRACTOR shall allow DHCS, US HHS, the Comptroller General of the US and other authorized federal and state agencies, or their duly authorized representatives to inspect books, records and facilities, as permitted by law.

D. The CONTRACTOR, if applicable, shall maintain medical records required by Title 22 of the California Code of Regulations, and other records showing a Medi-Cal beneficiary's eligibility for services, the service(s) rendered, the Medi-Cal beneficiary to whom the service was rendered, the date of the services, the medical necessity of the service and the quality of care provided. Records shall be maintained in accordance with Title 22 California Code of Regulations.

E. CONTRACTOR is responsible for the repayment of all exceptions and disallowances taken by local, State and Federal agencies, related to activities conducted by CONTRACTOR under the Agreement. Where unallowable costs have been claimed and reimbursed, they will be refunded to COUNTY. When a financial audit is conducted by

the Federal Government, the State, or the California State Auditor directly with CONTRACTOR, and if the CONTRACTOR disagrees with audit disallowances related to its programs, claims or services, COUNTY shall, at the CONTRACTOR's request, request an appeal to the State via the COUNTY.

F. Financial records shall be kept so that they clearly reflect the source of funding for each type of service for which reimbursement is claimed. These documents include, but are not limited to, all ledgers, books, vouchers, time sheets, payrolls, appointment schedules, client data cards, and schedules for allocating costs. Fiscal records shall contain sufficient data to enable auditors to perform a complete audit and shall be maintained in conformance with the procedures and accounting principles set forth in the State Department of Health Care Services' Cost Reporting/Data Collection Systems

15. UNUSUAL OCCURRENCES AND INCIDENT REPORTING

A. CONTRACTOR shall report unusual occurrences to the COUNTY of Tulare Substance Use Services' Program Manager or designee. An unusual occurrence is any event which jeopardizes the health and/or safety of clients, staff and/or members of the community, including but not limited to physical injury and death.

B. Unusual occurrences are to be reported to the COUNTY within five (5) calendar days of the event or as soon as possible after becoming aware of the unusual event. Reports are to include the following elements:

C. Complete written description of event including outcome;

D. Written report of CONTRACTOR's investigation and conclusions;

E. List of persons directly involved and/or with direct knowledge of the event.

F. The COUNTY and DHCS retain the right to independently investigate unusual occurrences and CONTRACTOR will cooperate in the conduct of such independent investigations.

G. Residential substance use treatment facilities licensed by DHCS shall also comply with reporting unusual incidents as outlined in Title 9 CCR, Chapter 5, Subchapter 3, Article 1. CONTRACTOR shall notify the COUNTY Alcohol and Drug Administrator concurrently, which is a telephonic report within one (1) working day of the event, followed by a copy of the written report submitted to DHCS within seven (7) days of the event.

16. REQUIRED PROGRAM SUBMISSIONS

A. CONTRACTOR agrees to maintain, and provide to COUNTY upon request, job descriptions, including minimum qualifications for employment and duties performed, for all personnel whose salaries, wages, and benefits are reimbursable in whole or in part under this Agreement.

B. CONTRACTOR agrees to maintain, and to provide to COUNTY upon request, an organizational chart that reflects the CONTRACTOR's current operating structure.

C. CONTRACTOR shall maintain, and provide to COUNTY upon request, the complaint procedure to be utilized in the event that there is a complaint regarding services provided under this Agreement. CONTRACTOR shall ensure that recipients of service under this Agreement have access to and are informed of CONTRACTOR's complaint procedure.



D. Upon CONTRACTOR's completion of services under this Agreement to COUNTY's satisfaction, payment to CONTRACTOR shall be made monthly in accordance with the procedures set forth in Exhibit B. All billings and reports shall clearly reflect and in reasonable detail give information regarding the services for which the claim is being made. It is understood and agreed that COUNTY may withhold payment until receipt of billings and reports in the prescribed detail and format. Billings and reports shall be made and forwarded to COUNTY of Tulare Health & Human Services Division of Behavioral Health and Recovery Services (BHRS) promptly at the end of each calendar month; no later than the 10th day of the month following the month in which the services, for which billing is made, were rendered. Payments received after that date may result in a delay in payment until the next monthly billing cycle. The payment for the month of September may be withheld pending receipt of the preceding year's Cost Report on continuing services Agreements.

E. CONTRACTOR shall provide COUNTY with an annual Cost Report no later than sixty (60) days after the termination of this agreement. In addition to the annual Cost Report, CONTRACTOR shall furnish COUNTY, within one hundred and eighty (180) days of close of CONTRACTOR fiscal year, a certified copy of an Audit Report from an independent Certified Public Accountant (CPA) firm. This Audit Report shall cover CONTRACTOR's fiscal year which most nearly coincides with COUNTY's fiscal year. CONTRACTORS receiving federal funds shall comply with Office of Management and Budget (OMB) Circular Number A-133, Uniform administrative Requirements for Grants and Other Agreements with Institutions of Higher Education, Hospitals, and other Nonprofit Organizations. Cost Report settlements shall be made when a proper Cost Report has been submitted to the COUNTY. The findings of the annual Cost Report shall be subject to an audit by COUNTY and State. The State of California may make such audits as it deems necessary for the purpose of determining reimbursement due to the COUNTY.

F. CONTRACTOR will have an MOU in place with all approved Sub-CONTRACTORS that defines the services to be provided by the Sub-CONTRACTORS and is consistent with and fully reflects the services and conditions described in this Agreement. Such MOUs will be made available to COUNTY within a reasonable time upon request.

G. CONTRACTOR will report all data and outcomes, such as CalOMS and DATAR, as required by state or COUNTY and as required by the State-COUNTY Agreement.

17. CONTRACTOR'S COMPLIANCE WITH PROVISIONS OF STATE AGREEMENT

A. The COUNTY receives funding from DHCS pursuant to an annual CONTRACTING arrangement (hereinafter "State Agreement"). The State Agreement contains certain requirements pertaining to the privacy and security of PII and/or PHI and requires that COUNTY CONTRACTUALLY obligate any of its Sub-CONTRACTORS to also comply with these requirements. CONTRACTOR hereby agrees to be bound by, and comply with, any and all terms and conditions of the State Agreement pertaining to the privacy and/or security of PII and/or PHI, a hard copy of which COUNTY will provide to the CONTRACTOR upon request, and an electronic copy of which can be found on the DHCS website at <http://www.dhcs.ca.gov/Pages/DMC-ODS-Executed-Agreements.aspx>.

B. Additionally, in the event the State Agreement requires the COUNTY to notify the State of a breach of privacy and/or security of PII and/or PHI, CONTRACTOR shall, immediately upon discovery of a breach of privacy and/or security of PII and/or PHI by CONTRACTOR, notify COUNTY of such breach by telephone and email or facsimile to the following contact: Compliance Officer – Ph: (559) 624-7465, e-mail:



ComplianceOfficer@tularecounty.ca.gov. CONTRACTOR further agrees that it shall notify COUNTY of any such breaches prior to the time the COUNTY is required to notify the State pursuant to the State CONTRACT.

C. In the event the State Agreement requires the COUNTY to pay any costs associated with a breach of privacy and/or security of PII and/or PHI, including but not limited to the costs of notification, CONTRACTOR shall pay on COUNTY's behalf any and all such costs arising out of a breach of privacy and/or security of PII and/or PHI by CONTRACTOR.

18. COMPLIANCE WITH ANTI-KICKBACK STATUTE

A. CONTRACTOR shall comply with the provisions of the "Anti-Kickback Statute" (42 U.S.C. § 1320a-7b) as they pertain to Federal healthcare programs.

19. DAVIS-BACON ACT

A. CONTRACTOR must comply with the provisions of the Davis-Bacon Act, as amended (40 U.S.C. § 3141 et seq.). When required by Federal Medicaid Program legislation, all Agreements awarded by the CONTRACTOR and its Sub-CONTRACTORS of more than \$2,000 must include a provision for compliance with the Davis-Bacon Act (40 U.S.C. § 3141 et seq.) as supplemented by Department of Labor regulations (Title 29, CFR Part 5, "Labor Standards Provisions Applicable to Agreements Governing Federally Financed and Assisted Construction").

20. CONDITIONS FOR FEDERAL FINANCIAL PARTICIPATION

A. CONTRACTOR shall meet all conditions for Federal Financial Participation, consistent with 42 CFR 438.802, 42 CFR 438.804, 42 CFR 438.806, 42 CFR 438.808, 42 CFR 438.810, 42 CFR 438.812.

B. Pursuant to 42 CFR 438.808, Federal Financial Participation (FFP) is not available to the CONTRACTOR if the CONTRACTOR:

C. Is an entity that could be excluded under section 1128(b)(8) as being controlled by a sanctioned individual;

D. Is an entity that has a substantial CONTRACTUAL relationship as defined in section 431.55(h)(3), either directly or indirectly, with an individual convicted of certain crimes described in section 1128(8)(B); or

E. Is an entity that employs or Agreements, directly or indirectly, for the furnishing of health care utilization review, medical social work, or administrative services, with one of the following:

F. Any individual or entity excluded from participation in federal health care programs under section 1128 or section 1126A; or

G. An entity that would provide those services through an excluded individual or entity.

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

A. Federal and State Excluded, Suspension and Debarment List: The COUNTY and the CONTRACTOR shall comply with the provisions of Title 42 § 438.610 and Executive Orders 12549 and 12689, "Debarment and Suspension," which excludes parties listed on the General Services Administration (GSA) list of parties excluded from federal

procurement or non-procurement programs from having a relationship with the COUNTY or CONTRACTOR.

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

C. CONTRACTOR shall certify, prior to the execution of the Agreement, that the CONTRACTOR does not employ staff or Sub-CONTRACTORS who are excluded from participation in federally funded health care programs. CONTRACTOR shall conduct initial and monthly Exclusion & Suspension searches of the following databases and provide evidence of these completed searches when requested by COUNTY, CA Department of Health Care Services or the US Department of Health & Human Services.

C1 [www.oig.hhs.gov/exclusions](http://www.oig.hhs.gov/exclusions) - LEIE Federal Exclusions

C2 [www.sam.gov/portal/SAM](http://www.sam.gov/portal/SAM) - GSA Exclusions Extract

C3 [www.Medi-Cal.ca.gov](http://www.Medi-Cal.ca.gov) – Suspended & Ineligible Provider List

D. CONTRACTOR shall certify, prior to the execution of the Agreement that the CONTRACTOR does not employ staff or Sub-CONTRACTORS that are on the Social Security Administration's Death Master File. CONTRACTOR shall check the following database prior to employing staff or Sub-CONTRACTORS and provide evidence of these completed searches when requested by COUNTY, CA Department of Health Care Services, or the US Department of Health & Human Services.

E. <https://www.ssdmf.com/> - Social Security Death Master File

F. CONTRACTOR is required to notify COUNTY immediately if they become aware of any information that may indicate their (including employees and Sub-CONTRACTORS) potential placement on an exclusions list.

## **Section 2. AUTHORIZATION AND DOCUMENTATION PROVISIONS**

### **1. SERVICE AUTHORIZATION**

A. CONTRACTOR will collaborate with COUNTY to complete authorization requests in line with COUNTY and DHCS policy.

B. CONTRACTOR shall respond to County in a timely manner when consultation is necessary for COUNTY to make appropriate authorization determinations.

C. COUNTY shall provide CONTRACTOR with written notice of authorization determinations within the timeframes set forth in BHIN 23-001, or any subsequent DHCS notices.

D. For SUD Non-Residential and Non-Inpatient Levels of Care service authorization:

I. CONTRACTOR shall follow COUNTY's policies and procedures around non-residential/non-inpatient levels of care according to BHIN 23-001.

II. CONTRACTOR is not required to obtain service authorization for non-residential/non-inpatient levels of care. Prior authorization is prohibited for non-residential DMC-ODS services.

E. For SUD Residential and Inpatient Levels of Care service authorization:

I. CONTRACTOR shall have in place, and follow, COUNTY written authorization policies and procedures for processing requests for initial and continuing authorization, or prior authorization, for residential treatment services, including inpatient services, but excluding withdrawal management services.

II. COUNTY will review the DSM and ASAM Criteria to ensure that the beneficiary meets the requirements for the service.

Prior authorization for residential and inpatient services (excluding withdrawal management services) shall be made within 24 hours of the prior authorization request being submitted by the provider.

- a. COUNTY will ensure that prior authorization processes are completed in a manner that assures the provision of a covered SUD service to a client in a timely manner appropriate for the client's condition.

IV. CONTRACTOR shall alert COUNTY when an expediated service authorization decision is necessary due to a client's specific needs and circumstances that could seriously jeopardize the client's life or health, or ability to attain, maintain, or regain maximum function. Expediated service authorizations shall not exceed 72 hours after receipt of the request for service, with a possible extension of up to 14 calendar days if the client or provider requests an extension.

V. CONTRACTOR shall alert COUNTY when a standard authorization decision is necessary. Standard service authorizations shall not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days if the client or provider requests an extension.

F. CONTRACTOR, if applicable, shall ensure that length of stay (LOS) in residential program complies with the following:

I. LOS shall be determined by individualized clinical need (statewide LOS goal is 30 days). LOS for clients shall be determined by an LPHA and authorized by the COUNTY as medically necessary.

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

III. Perinatal clients may receive a longer LOS than those described above, if determined to be medically necessary.

IV. Nothing in this section overrides any EPSDT requirements. EPSDT clients may receive a longer length of stay based on medical necessity.

## 2. DOCUMENTATION REQUIREMENTS

A. CONTRACTOR agrees to comply with documentation requirements for non-hospital services as specified in Article 4.2-4.9 inclusive in compliance with federal, state and COUNTY requirements.

B. All CONTRACTOR documentation shall be accurate, complete, legible, and shall list each date of service. CONTRACTOR shall document the face-to-face duration of the service, including travel and documentation time for each service. Services must be identified as provided in-person, by telephone, or by telehealth.

C. All services shall be documented utilizing COUNTY-approved templates and contain all required elements. CONTRACTOR agrees to satisfy the chart documentation requirements set forth in BHIN 22-019 and the contract between COUNTY and DHCS.

Failure to comply with documentation standards specified in this Article require corrective action plans.

3. ASSESSMENT

A. CONTRACTOR shall use the ASAM Criteria assessment for DMC-ODS clients to determine the appropriate level of SUD care.

B. The assessment shall include a typed or legibly printed name, signature of the service provider and date of signature. Assessment shall include the provider's LOC determination and recommendation for services. If the assessment of the client is completed by a registered or certified counselor, then the LPHA shall evaluate that assessment with the counselor and the LPHA shall make the initial diagnosis. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.

C. The problem list and progress note requirements shall support the medically necessary services or medical necessity of each service provided.

D. Assessments shall be updated as clinically appropriate when the beneficiary's condition changes. Additional information on assessment requirements can be found in Article 3 Section 2 Access to Substance Use Disorder Services or BHIN 23-001.

4. ICD-10

A. CONTRACTOR shall use the criteria set forth in the current edition of the DSM as the clinical tool to make diagnostic determinations.

B. Once a DSM diagnosis is determined, the CONTRACTOR shall determine the corresponding diagnosis in the current edition of ICD. CONTRACTOR shall use the ICD diagnosis code(s) to submit a claim for SUD services to receive reimbursement from COUNTY.

C. Under the EPSDT mandate, for youth under the age of 21, a diagnosis from the ICD-10 for Substance-Related and Addictive Disorders is not required for early intervention services.

D. The ICD Tabular List of Diseases and Injuries is maintained by CMS and may be updated during the term of this Agreement. Changes to the lists of ICD diagnoses do not require an amendment to this Agreement, and COUNTY may implement these changes as provided by DHCS.

5. PROBLEM LIST

A. CONTRACTOR will create and maintain a Problem List for each client served under this Agreement. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.

B. CONTRACTOR must document a problem list that adheres to industry standards utilizing at minimum SNOMED International, Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®). U.S. Edition, March 2021 Release, and ICD-10-CM 2023.

C. A problem identified during a service encounter may be addressed by the service provider (within their scope of practice) during that service encounter and subsequently added to the problem list.

- D. The problem list shall be updated on an ongoing basis to reflect the current presentation of the client.
- E. The problem list shall include, but is not limited to the following:
  - I. Diagnoses identified by a provider acting within their scope of practice, if any. Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable.
  - II. Problems identified by a provider acting within their scope of practice, if any.
  - III. Problems or illnesses identified by the client and/or significant support person, if any.
  - IV. The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.
- F. CONTRACTOR shall add to or remove problems from the problem list when there is a relevant change to a beneficiary's condition.
- G. COUNTY does not require the problem list to be updated within a specific timeframe or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, CONTRACTOR shall update the problem list within a reasonable time such that the problem list reflects the current issues facing the client, in accordance with generally accepted standards of practice and in specific circumstances specified in BHIN 22-019.

6. PROGRESS NOTES

- A. CONTRACTOR shall create progress notes for the provision of all DMC-ODS services provided under this Agreement.
- B. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.
- C. Progress notes shall include all elements specified in BHIN 22-019, whether the note be for an individual or group service, and shall include:
  - I. The type of service rendered
  - II. A narrative describing the service, including how the service addressed the client's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors)
  - III. The date that the service was provided to the beneficiary
  - IV. Duration of the service, including travel and documentation time
  - V. Location of the client at the time of receiving the service
  - VI. A typed or legibly printed name, signature of the service provider and date of signature
  - VII. ICD-10 code
  - VIII. Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code

IX. Next steps, including, but not limited to, planned action steps by the provider or by the client, collaboration with the client, collaboration with other provider(s) and any update to the problem list as appropriate.

D. CONTRACTOR shall complete progress notes within three business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.

E. CONTRACTOR shall complete a daily progress note for services that are billed on a daily basis, such as residential and inpatient services, if applicable.

F. When a group service is rendered by the CONTRACTOR, the following conditions shall be met:

I. A list of participants is required to be documented and maintained by the CONTRACTOR.

II. If more than one provider renders a group service, one progress note may be completed for a group session and signed by one provider. CONTRACTOR shall ensure that in this case, the progress note clearly documents the specific involvement and the specific amount of time of involvement of each provider during the group activity, including documentation time.

## 7. PLAN OF CARE

A. As specified in BHIN 22-019, when a plan of care is required, CONTRACTOR shall follow the DHCS requirements outlined in the Alcohol and/or Other Drug Program Certification Standards document, available in the DHCS Facility Certification page at: <https://www.dhcs.ca.gov/provgovpart/Pages/Licensing-and-Certification-Facility-Certification.aspx>

B. CONTRACTOR shall develop plans of care for all clients, when required, and these plans of care shall include the following:

I. Statement of problems experienced by the client to be addressed.

II. Statement of objectives to be reached that address each problem.

III. Statement of actions that will be taken by the program and/or client to accomplish the identified objectives.

IV. Target date(s) for accomplishment of actions and objectives.

C. CONTRACTOR shall develop the plan of care with participation from the client in accordance with the timeframes specified below:

I. For outpatient programs, the plan of care shall be developed within 30 calendar days from the date of the client's admission. The client's progress shall be reviewed and documented within 30 calendar days after signing the plan of care and not later than every 30 calendar days thereafter.

II. For residential programs, the plan of care shall be developed within 10 calendar days from the date of the client's admission.

III. An LPHA, registered or certified counselor shall ensure and document, that together with the client, the plan of care is reviewed and updated, as necessary, when a change in problem identification or focus of treatment occurs, or no later than 90 calendar days after signing the plan of care and no later than every 90 calendar days thereafter, whichever comes first.

D. CONTRACTOR is not required to complete a plan of care for clients under this Agreement, except in the below circumstances:

I. Peer Support Services require a specific care plan based on an approved plan of care. The plan of care shall be documented within the progress notes in the client's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services.

II. Narcotic Treatment Programs (NTP) are required to create a plan of care for clients as per federal law. This requirement is not impacted by the documentation requirements in BHIN 22-019. NTPs shall continue to comply with federal and state regulations regarding plans of care and documentation requirements.

#### 8. TELEHEALTH

A. CONTRACTOR may use telehealth, when it deems clinically appropriate, as a mode of delivering behavioral health services in accordance with all applicable COUNTY, state, and federal requirements, including those related to privacy/security, efficiency, and standards of care. Such services will conform to the definitions and meet the requirements included in the Medi-Cal Provider Manual: Telehealth, available in the DHCS Telehealth Resources page at: <https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx>.

B. All telehealth equipment and service locations must ensure that client confidentiality is maintained.

C. Licensed providers and staff may provide services via telephone and telehealth as long as the service is within their scope of practice.

D. Medical records for clients served by CONTRACTOR under this Agreement must include documentation of written or verbal consent for telehealth or telephone services if such services are provided by CONTRACTOR. Such consent must be obtained at least once prior to initiating applicable health care services and consent must include all elements as specified in BHIN 22-019.

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

#### 9. DISCHARGE PLANNING

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

I. Written criteria for discharge defining:

- a. Successful completion of program;
- b. Administrative discharge;
- c. Involuntary discharge;
- d. Transfers and referrals.

II. A discharge summary that includes:

- a. Reason for discharge, including whether the discharge was voluntary or involuntary and whether the client successfully completed the program;
- b. Description of treatment episodes;
- c. Description of recovery services completed;
- d. Current alcohol and/or other drug usage;
- e. Vocational and educational achievements;
- f. Client's continuing recovery or discharge plan signed by an LPHA, or registered or certified counselor and client;
- g. Transfers and referrals; and
- h. Client's comments.

### **Section 3. CHART AUDITING AND REASONS FOR RECOUPMENT**

#### **1. MAINTENANCE OF RECORDS**

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

#### **2. ACCESS TO RECORDS**

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

#### **3. FEDERAL, STATE AND COUNTY AUDITS**

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

#### **4. INTERNAL AUDITING**

A. CONTRACTORS of sufficient size as determined by COUNTY shall institute and conduct a Quality Assurance Process for all services provided hereunder. Said process shall include at a minimum a system for verifying that all services provided and claimed for reimbursement shall meet DMC-ODS definitions and be documented accurately.

B. COUNTY staff shall have the right to monitor, assess, and evaluate the CONTRACTOR's performance pursuant to this Agreement. Said monitoring, assessment,



and evaluation may include, but is not limited to, audits, inspections of project premises, and interviews of project staff and participants. The fiscal audit shall be:

- I. Performed timely - The audit is required to be completed not later than nine (9) months after the end of the CONTRACTOR'S fiscal year. The audit report is due no later than thirty (30) days after the completion of the audit.
  - II. Performed in accordance with Government Auditing Standards- shall be performed by an independent audit and be organization-wide.
  - III. All inclusive- includes an audit of the financial statements; an assessment of internal controls, includes tests of transactions; and a determination of compliance with laws and regulations of all major programs and selected non-major program transactions. Programs which may be reviewed include, but are not limited to:
- C. Drug Medi-Cal (DMC) Programs
- I. Narcotic Treatment Programs (NTP)
  - II. Outpatient Drug-Free (ODF)
  - III. Perinatal Services
  - IV. Residential Services
  - V. Youth Treatment Services
- D. Substance Abuse and Prevention Programs (SAPT)
- H. Non-Perinatal Services
- I. Perinatal Services
  - II. Primary Prevention
  - III. Residential Services
  - IV. Youth Treatment Services
- E. Driving Under the Influence (DUI) Programs
- F. The COUNTY shall prepare a summary worksheet of results from the audit resolutions performed for all CONTRACTORS. The summary worksheet shall include, but not be limited to, contract amount; amount resolved; variances; whether an audit was relied upon, or the CONTRACTOR performed an independent expense verification review of the CONTRACTOR in making the determination; whether audit findings were issued, and if applicable, date of management letter.
- G. Audits to be performed shall be, minimally, financial and compliance audits, and may include economy and efficiency and/or program results audits.
- H. Audits may be conducted by an independent, third party, including either a private professional or a separate governmental agency or office. The audit will be conducted at a time specified by the COUNTY.
- I. State/Federal Audits
- I. Upon an audit by the State of California or Federal agency, CONTRACTOR shall:

II. Immediately notify the Tulare County Alcohol & Other Drug Administrator

III. Provide copies of all "Corrective Action Plans" to the Tulare County Alcohol & Other Drug Administrator

IV. Provide copies of all correspondence with the auditing agency to the Tulare County Alcohol & Other Drug Administrator

J. CONTRACTOR shall provide COUNTY with notification and a summary of any internal audit exceptions, and the specific corrective actions taken to sufficiently reduce the errors that are discovered through CONTRACTOR's internal audit process. CONTRACTOR shall provide this notification and summary COUNTY in a timely manner.

K. CONFIDENTIALITY IN AUDIT PROCESS

I. CONTRACTOR and COUNTY mutually agree to maintain the confidentiality of CONTRACTOR's client records and information, in compliance with all applicable state and federal statutes and regulations, including but not limited to HIPAA, 42 CFR Part 2, and California Welfare and Institutions Code, § 5328, to the extent that these requirements are applicable. CONTRACTOR shall inform all of its officers, employees and agents of the confidentiality provisions of all applicable statutes.

II. CONTRACTOR's fiscal records shall contain sufficient data to enable auditors to perform a complete audit and shall be maintained in conformance with standard procedures and accounting principles.

III. CONTRACTOR's records shall be maintained as required by the Director and DHCS on forms furnished by DHCS or the COUNTY. All statistical data or information requested by the Director shall be provided by the CONTRACTOR in a complete and timely manner.

L. REASONS FOR RECOUPMENT

I. COUNTY will conduct periodic audits of CONTRACTOR files to ensure appropriate clinical documentation, high quality service provision and compliance with applicable federal, state and COUNTY regulations.

II. Such audits may result in requirements for CONTRACTOR to reimburse COUNTY for services previously paid in the following circumstances:

a. Identification of Fraud, Waste or Abuse as defined in federal regulation.

i. Fraud and abuse are defined in Code of Federal Regulations, Title 42, § 455.2 and Welfare & Institutions Code, § 14107.11, subdivision (d).

ii. Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual available at [www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf](http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf).

- III. Overpayment of CONTRACTOR by COUNTY due to errors in claiming or documentation.
- M. CONTRACTOR shall reimburse COUNTY for all overpayments identified by CONTRACTOR, COUNTY and/or state or federal oversight agencies as an audit exception within the timeframes required by law or COUNTY or state or federal agency.
- N. COOPERATION WITH AUDITS
  - I. CONTRACTOR shall cooperate with COUNTY in any review and/or audit initiated by COUNTY, DHCS, or any other applicable regulatory body. This cooperation may include such activities as onsite programs, fiscal, or chart reviews and/or audits.
  - II. In addition, CONTRACTOR shall comply with all requests for any documentation or files including, but not limited to, client and personnel files.
  - III. CONTRACTOR shall notify the COUNTY of any scheduled or unscheduled external evaluation or site visits when it becomes aware of such visit. COUNTY shall reserve the right to attend any or all parts of external review processes.
  - IV. CONTRACTOR shall allow inspection, evaluation and audit of its records, documents and facilities for 10 years from the term end date of this Agreement or in the event CONTRACTOR has been notified that an audit or investigation of this Agreement has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later pursuant to 42 C.F.R. §§ 438.3(h) and 438.230(c)(3)(i-iii).

#### **Section 4. CLIENT PROTECTIONS**

- 1. GRIEVANCES, APPEALS AND NOTICES OF ADVERSE BENEFIT DETERMINATION
  - A. All grievances (as defined by 42 C.F.R. § 438.400) and complaints received by CONTRACTOR must be immediately forwarded to the COUNTY's Quality Management Department or other designated persons via a secure method (e.g., encrypted email or by fax) to allow ample time for the Quality Management staff to acknowledge receipt of the grievance and complaints and issue appropriate responses.
  - B. CONTRACTOR shall not discourage the filing of grievances and clients do not need to use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance.
  - C. Aligned with MHSUDS 18-010E and 42 C.F.R. § 438.404, the appropriate and delegated Notice of Adverse Benefit Determination (NOABD) must be issued by CONTRACTORS within the specified timeframes using the template provided by the COUNTY.
  - D. NOABDs must be issued to clients anytime the CONTRACTOR has made or intends to make an adverse benefit determination that includes the reduction, suspension, or termination of a previously authorized service and/or the failure to provide services in a timely manner. The notice must have a clear and concise explanation of the reason(s) for

the decision as established by DHCS and the COUNTY. The CONTRACTOR must inform the COUNTY immediately after issuing a NOABD.

E. Procedures and timeframes for responding to grievances, issuing, and responding to adverse benefit determinations, appeals, and state hearings must be followed as per 42 C.F.R., Part 438, Subpart F (42 C.F.R. §§ 438.400 – 438.424).

F. CONTRACTOR must provide clients with any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal such as auxiliary aids and interpreter services.

G. CONTRACTOR must maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures. The record must be accurately maintained in a manner accessible to the COUNTY and available upon request to DHCS.

## 2. ADVANCED DIRECTIVES

CONTRACTOR must comply with all COUNTY policies and procedures regarding Advanced Directives in compliance with the requirements of 42 C.F.R. §§ 422.128 and 438.6(i) (1), (3) and (4).

## 3. TRANSITION OF CARE

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

B. Clients shall be allowed to continue receiving covered DMC-ODS services with an out-of-network provider when their assessment determines that, in the absence of continued services, the client would suffer serious detriment to their health or be at risk of hospitalization or institutionalization. DMC-ODS treatment services with the existing provider (out-of-network) provider shall continue for a period of no more than 90 days unless medical necessity requires the services to continue for a longer period of time, not exceeding 12 months. Specific criteria must be met.

## 4. ADVERTISING REQUIREMENTS

A. CONTRACTOR, to protect the health, safety, and welfare of clients with a SUD, shall not use false or misleading advertisement for their medical treatment or medical services as per SB 434 Health and Safety Code § 11831.9 and BHIN 22-022.

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

I. Make a false or misleading statement or provide false or misleading information about the entity's products, goods, services, or geographical locations in its marketing, advertising materials, or media, or on its internet website or on a third-party internet website.

II. Include on its internet website a picture, description, staff information, or the location of an entity, along with false contact information that surreptitiously directs the reader to a business that does not have a contract with the entity.

III. Include on its internet website false information or an electronic link that provides false information or surreptitiously directs the reader to another internet website.

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

## **Section 5. PROGRAM INTEGRITY**

### **1. GENERAL**

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

### **2. ASAM STANDARDS OF CARE**

A. In accordance with Health and Safety Code section 111834.015, DHCS has adopted the ASAM treatment criteria, or other equivalent evidenced based criteria as the minimum standard of care for AOD facilities.

B. For this Agreement and subsequential services, CONTRACTOR shall adopt ASAM as the evidenced based practice standard for LOC.

C. CONTRACTOR shall ensure treatment staff of all SUD treatment programs receive adequate training in ASAM criteria prior to providing services that includes but is not limited to in person or e-training modules:

I. ASAM Module I- Multidimensional Assessment

II. ASAM Module II- From Assessment to Service Planning and Level of Care

III. ASAM Module III-Introduction to the ASAM Criteria

### **3. CREDENTIALING AND RE-CREDENTIALING OF PROVIDERS**

A. CONTRACTORS must follow the uniform process for credentialing and recredentialing of network providers established by COUNTY, including disciplinary actions such as reducing, suspending, or terminating provider's privileges. Failure to comply with specified requirements can result in suspension or termination of a provider.

B. Upon request, the CONTRACTOR must demonstrate to the COUNTY that each of its providers are qualified in accordance with current legal, professional, and technical standards, and that they are appropriately licensed, registered, waived, and/or certified.

C. CONTRACTOR must not employ or subcontract with providers debarred, suspended, or otherwise excluded (individually, and collectively referred to as "Excluded") from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. § 438.610. See relevant section below regarding specific requirements for exclusion monitoring.

D. CONTRACTORS shall ensure that all of their network providers, delivering covered services, sign and date an attestation statement on a form provided by COUNTY, in which each provider attests to the following:

I. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;

II. A history of loss of license or felony convictions;

III. A history of loss or limitation of privileges or disciplinary activity;

IV. A lack of present illegal drug use; and

V. The application's accuracy and completeness

E. CONTRACTOR must file and keep track of attestation statements for all of their providers and must make those available to the COUNTY upon request at any time.

F. CONTRACTOR is required to sign an annual attestation statement at the time of Agreement renewal in which they will attest that they will follow COUNTY's Credentialing Policy and MHSUDS IN 18-019 and ensure that all of their rendering providers are credentialed as per established guidelines.

G. CONTRACTOR is required to verify and document at a minimum every three years that each network provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements as per the COUNTY's uniform process for credentialing and recredentialing. If any of the requirements are not up-to-date, updated information should be obtained from network providers to complete the re-credentialing process.

4. SCREENING AND ENROLLMENT REQUIREMENTS

A. COUNTY shall ensure that all CONTRACTOR providers are enrolled with the state as Medi-Cal providers consistent with the provider disclosure, screening, and enrollment requirements of 42 C.F.R. Part 455, subparts B and E. (42 C.F.R. § 438.608(b)).

B. COUNTY may execute this Agreement, pending the outcome of screening, enrollment, and revalidation of CONTRACTOR, of up to 120 days but must terminate this Agreement immediately upon determination that CONTRACTOR cannot be enrolled, or the expiration of one 120-day period without enrollment of the CONTRACTOR, and notify affected clients (42 C.F.R. § 438.602(b)(2)).

C. CONTRACTOR shall ensure that all Providers and/or subcontracted Providers consent to a criminal background check, including fingerprinting to the extent required under state law and 42 C.F.R. § 455.434(a). CONTRACTOR shall provide evidence of completed consents when requested by the COUNTY, DHCS or the US Department of Health & Human Services (US DHHS).

5. PROVIDER APPLICATION AND VALIDATION FOR ENROLLMENT (PAVE)

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

6. COMPLIANCE PROGRAM, INCLUDING FRAUD PREVENTION AND OVERPAYMENTS

A. CONTRACTOR shall have in place a compliance program designed to detect and prevent fraud, waste and abuse, as per 42 C.F.R. § 438.608 (a)(1), that must include:

- I. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Agreement, and all applicable federal and state requirements.
- II. A Compliance Office (CO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Agreement and who reports directly to the CEO and the Board of Directors.

- III. A Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Agreement.
  - IV. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the Agreement.
  - V. Effective lines of communication between the Compliance Officer and the organization's employees.
  - VI. Enforcement of standards through well-publicized disciplinary guidelines.
  - VII. The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, corrections of such problems promptly and thoroughly to reduce the potential for recurrence, and ongoing compliance with the requirements under the Agreement.
  - VIII. The requirement for prompt reporting and repayment of any overpayments identified.
- B. CONTRACTOR must have administrative and management arrangements or procedures designed to detect and prevent fraud, waste, and abuse of federal or state health care funding. CONTRACTOR must report fraud and abuse information to the COUNTY including but not limited to:
- I. Any potential fraud, waste, or abuse as per 42 C.F.R. § 438.608(a), (a)(7),
  - II. All overpayments identified or recovered, specifying the overpayment due to potential fraud as per 42C.F.R. § 438.608(a), (a)(2).
  - III. Information about change in a client's circumstances that may affect the client's eligibility including changes in the client's residence or the death of the client as per 42 C.F.R. § 438.608(a)(3).
  - IV. Information about a change in the CONTRACTOR's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of this Agreement with the CONTRACTOR as per 42 C.F.R. § 438.608 (a)(6).
- C. CONTRACTOR shall implement written policies that provide detailed information about the False Claims Act ("Act") and other federal and state laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.
- D. CONTRACTOR shall make prompt referral of any potential fraud, waste, or abuse to the COUNTY or potential fraud directly to the State Medicaid Fraud Control Unit.
- E. COUNTY may suspend payments to CONTRACTOR if DHCS or COUNTY determine that there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23. (42 C.F.R. § 438.608 (a)(8)).
- F. CONTRACTOR shall report to the COUNTY all identified overpayments and reason for the overpayment, including overpayments due to potential fraud.

CONTRACTOR shall return any overpayments to the COUNTY within 60 calendar days after the date on which the overpayment was identified. (42 C.F.R. § 438.608 (a)(2), (c)(3)).

7. INTEGRITY DISCLOSURES

A. CONTRACTOR shall provide information on ownership and controlling interests, disclosures related to business transactions, and disclosures related to persons convicted of crimes in the form and manner requested by the COUNTY, by the Effective Date, each time the Agreement is renewed and within 35 days of any change in ownership or controlling interest of CONTRACTOR. (42 C.F.R. §§ 455.104, 455.105, and 455.106)

B. Upon the execution of this Agreement, CONTRACTOR shall furnish COUNTY a Provider Disclosure Statement, which, upon receipt by COUNTY, shall be kept on file with COUNTY and may be disclosed to DHCS. If there are any changes to the information disclosed in the Provider Disclosure Statement, an updated statement should be completed and submitted to the COUNTY within 35 days of the change. (42 C.F.R. § 455.104).

C. CONTRACTOR must disclose the following information as requested in the Provider Disclosure Statement:

I. Disclosure of 5% or More Ownership Interest:

- a. In the case of corporate entities with an ownership or control interest in the disclosing entity, the primary business address as well as every business location and P.O. Box address must be disclosed. In the case of an individual, the date of birth and Social Security Number must be disclosed.
- b. In the case of a corporation with ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five percent (5%) or more interest, the corporation tax identification number must be disclosed.
- c. For individuals or corporations with ownership or control interest in any subcontractor in which the disclosing entity has a five percent (5%) or more interest, the disclosure of familial relationship is required.
- d. For individuals with five percent (5%) or more direct or indirect ownership interest of a disclosing entity, the individual shall provide evidence of completion of a criminal background check, including fingerprinting, if required by law, prior to execution of Agreement. (42 C.F.R. § 455.434)

II. Disclosures Related to Business Transactions:

- a. The ownership of any subcontractor with whom CONTRACTOR has had business transactions totaling more than \$25,000 during the 12-month period ending on the date of the request.
- b. Any significant business transactions between CONTRACTOR and any wholly owned supplier, or between CONTRACTOR and any subcontractor, during the 5-year period ending on the date of the request. (42 C.F.R. § 455.105(b).)

III. Disclosures Related to Persons Convicted of Crimes:



- a. The identity of any person who has an ownership or control interest in the CONTRACTOR or is an agent or managing employee of the CONTRACTOR who has been convicted of a criminal offense related to that person's involvement in any program under the Medicare, Medicaid, or the Title XXI services program since the inception of those programs. (42 C.F.R. § 455.106.)
- b. COUNTY shall terminate the enrollment of CONTRACTOR if any person with five percent (5%) or greater direct or indirect ownership interest in the disclosing entity has been convicted of a criminal offense related to the person's involvement with Medicare, Medicaid, or Title XXI program in the last 10 years.

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

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

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

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

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

- I. [www.oig.hhs.gov/exclusions](http://www.oig.hhs.gov/exclusions) - LEIE Federal Exclusions
- II. [www.sam.gov/portal/SAM](http://www.sam.gov/portal/SAM) - GSA Exclusions Extract
- III. [www.Medi-Cal.ca.gov](http://www.Medi-Cal.ca.gov) - Suspended & Ineligible Provider List
- IV. <https://nppes.cms.hhs.gov/#/> - National Plan and Provider Enumeration System (NPPES)
- V. any other database required by DHCS or DHHS.

C. CONTRACTOR shall certify, prior to the execution of the Agreement, that CONTRACTOR does not employ staff or individual contractors/vendors that are on the Social Security Administration's Death Master File. CONTRACTOR shall check the following database prior to employing staff or individual contractors/vendors and provide evidence of these completed searches when requested by the COUNTY, DHCS or the US DHHS.

I. <https://www.ssdmf.com/> - Social Security Death Master File

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

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

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

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

## **Section 6. QUALITY IMPROVEMENT PROGRAM**

### **1. QUALITY IMPROVEMENT ACTIVITIES AND PARTICIPATION**

A. CONTRACTOR shall comply with the COUNTY's ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) Program (42 C.F.R. § 438.330(a)) and work with the COUNTY to improve established outcomes by following structural and operational processes and activities that are consistent with current practice standards.

B. CONTRACTOR shall participate in quality improvement (QI) activities, including clinical and non-clinical performance improvement projects (PIPs), as requested by the COUNTY in relation to state and federal requirements and responsibilities, to improve health outcomes and clients' satisfaction over time. Other QI activities include quality assurance, collection and submission of performance measures specified by the COUNTY, mechanisms to detect both underutilization and overutilization of services, client and system outcomes, utilization management, utilization review, provider appeals, provider credentialing and re-credentialing, and client grievances. CONTRACTOR shall measure, monitor, and annually report to the COUNTY its performance.

C. CONTRACTOR shall implement mechanisms to assess client/family satisfaction based on COUNTY's guidance. The CONTRACTOR shall assess client/family satisfaction by:

I. Surveying client/family satisfaction with the CONTRACTOR's services at least annually.

- II. Evaluating client grievances, appeals and State Hearings at least annually.
  - III. Evaluating requests to change persons providing services at least annually.
  - IV. Informing the COUNTY and clients of the results of client/family satisfaction activities.
- D. CONTRACTOR, if applicable, shall implement mechanisms to monitor the safety and effectiveness of medication practices. This mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs, at least annually.
- E. CONTRACTOR shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The CONTRACTOR shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the CONTRACTOR at least annually and shared with the COUNTY.
- F. CONTRACTOR shall collaborate with COUNTY to create a QI Work Plan with documented annual evaluations and documented revisions as needed. The QI Work Plan shall evaluate the impact and effectiveness of its quality assessment and performance improvement program.
- G. CONTRACTOR shall attend and participate in the COUNTY's Quality Improvement Committee (QIC) to recommend policy decisions, review, and evaluate results of QI activities, including PIPs, institute needed QI actions, and ensure follow-up of QI processes. CONTRACTOR shall ensure that there is active participation by the CONTRACTOR's practitioners and providers in the QIC.
- H. CONTRACTOR shall assist COUNTY, as needed, with the development and implementation of Corrective Action Plans.
- I. CONTRACTOR shall participate, as required, in annual, independent external quality reviews (EQR) of the quality, timeliness, and access to the services covered under this Contract, which are conducted pursuant to Subpart E of Part 438 of the Code of Federal Regulations. (42 C.F.R. §§ 438.350(a) and 438.320)
2. NETWORK ADEQUACY
- A. CONTRACTOR shall ensure that all services covered under this Agreement are available and accessible to clients in a timely manner and in accordance with the network adequacy standards required by regulation. (42 C.F.R. § 438.206 (a), (c)).
- B. CONTRACTOR shall submit, when requested by COUNTY and in a manner and format determined by the COUNTY, network adequacy certification information to COUNTY, utilizing a provided template or other designated format.
- C. CONTRACTOR shall submit updated network adequacy information to the COUNTY any time there has been a significant change that would affect the adequacy and capacity of services. Significant changes include, but are not limited to, changes in services or providers available to clients, and changes in geographic service area.
3. TIMELY ACCESS
- A. CONTRACTOR shall comply with the requirements set forth in CCR, Title 9, § 1810.405, including meeting COUNTY and State Contract standards for timely access to care and services, considering the urgency of the need for services. COUNTY shall monitor

CONTRACTOR to determine compliance with timely access requirements and shall take corrective action in the event of noncompliance.

B. Timely access standards include:

- I. CONTRACTORS must have hours of operation during which services are provided to Medi-Cal clients that are no less than the hours of operation during which the CONTRACTOR offers services to non-Medi-Cal clients. If the CONTRACTOR's provider only serves Medi-Cal clients, the provider must provide hours of operation comparable to the hours the CONTRACTOR makes available for Medi-Cal services that are not covered by the Agreement or another COUNTY.
- II. Appointments data, including wait times for requested services, must be recorded and tracked by CONTRACTOR, and submitted to the COUNTY on a monthly basis in a format specified by the COUNTY. Appointments' data should be submitted to the COUNTY's Quality Management department or other designated persons.
- III. CONTRACTOR shall ensure that all clients seeking NTP services are provided with an appointment within three business days of a service request.
- IV. CONTRACTOR shall ensure that all clients seeking outpatient and intensive outpatient (non-NTP) services are provided with an appointment within 10 business days of a non-NTP service request.
- V. CONTRACTOR shall ensure that all clients seeking non-urgent appointments with a non-physician SUD provider are provided within 10 business days of the request for the appointment. Similarly, CONTRACTOR shall ensure that all clients seeking non-urgent follow-up appointments with a non-physician SUD provider are provided within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing SUD condition. These timely standards must be followed, except in the following circumstances:
  - a. The referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, has determined and noted that in the relevant record that a longer waiting time will not have a detrimental impact on the client's health.
  - b. Preventive care services and periodic follow-up care, including office visits for SUD conditions, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice.
- VI. CONTRACTOR shall ensure that, if necessary for a client or a provider to reschedule an appointment, the appointment is promptly rescheduled in a manner that is appropriate for the client's health care needs and ensures continuity of care consistent with good professional practice.
- VII. CONTRACTOR shall ensure that during normal business hours, the waiting time for a client to speak by telephone with staff knowledgeable

and competent regarding the client's questions and concerns does not exceed 10 minutes.

4. DATA REPORTING REQUIREMENTS

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

B. CONTRACTOR shall ensure that all data stored or submitted to the COUNTY, DHCS or other data collection sites is accurate and complete.

I. California Outcomes Measurement System Treatment (CalOMS Tx)

a. CalOMS Tx data shall be submitted by CONTRACTOR to DHCS via electronic submission within 45 days from the end of the last day of the report month. This data shall be submitted during this time frame.

II. Drug and Alcohol Treatment Access Report (DATAR)

a. DATAR data shall be submitted by CONTRACTOR as specified by COUNTY, either directly to DHCS or by other means established by COUNTY, by the 10th of the month following the report activity month.

III. Substance Abuse and Prevention Treatment Block Grant (SABG) Funding reporting

a. CONTRACTORs providing services to beneficiaries in counties using SABG funds will collect and report performance data to COUNTY monthly.

5. TREATMENT PERCEPTION SURVEY (TPS)

CONTRACTOR shall conduct the annual Treatment Perception Survey (TPS) consistent with DMC-ODS requirements and under the direction of COUNTY.

6. PRACTICE GUIDELINES

A. CONTRACTOR shall adopt practice guidelines (or adopt COUNTY's practice guidelines) that meet the following requirements as per 42 C.F.R. § 438.236:

I. Are based on valid and reliable clinical evidence or a consensus of providers in the field.

II. Consider the needs of the CONTRACTOR's clients

III. Are adopted in consultation with network providers

IV. Are reviewed and updated periodically as appropriate

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

7. EVIDENCE-BASED PRACTICES (EBPs)

A. CONTRACTORs will comply with COUNTY and DHCS standards related to Evidenced Based Practices (EBPs).

B. CONTRACTOR will implement at least two of the following EBP to fidelity per provider, per service modality:

- I. Motivational Interviewing
- II. Cognitive-Behavioral Services
- III. Relapse Prevention
- IV. Trauma-Informed Treatment
- V. Psychoeducation

8. PHYSICIAN INCENTIVE PLAN

If CONTRACTOR wants to institute a Physician Incentive Plan, CONTRACTOR shall submit the proposed plan to the COUNTY which will in turn submit the Plan to the State for approval, in accordance with the provisions of 42 C.F.R. § 438.6(c).

9. REPORTING UNUSUAL OCCURRENCES

A. CONTRACTOR shall report unusual occurrences to the Director. An unusual occurrence is any event which jeopardizes the health and/or safety of clients, staff and/or members of the community, including, but not limited to, physical injury and death.

B. Unusual occurrences are to be reported to the COUNTY within timelines specified in COUNTY policy after becoming aware of the unusual event. Reports are to include the following elements:

- I. Complete written description of event including outcome;
- II. Written report of CONTRACTOR's investigation and conclusions;
- III. List of persons directly involved and/or with direct knowledge of the event.

C. COUNTY and DHCS retain the right to independently investigate unusual occurrences and the CONTRACTOR will cooperate in the conduct of such independent investigations.

**Section 7. ADDITIONAL FINAL RULE PROVISIONS**

1. NON-DISCRIMINATION

A. CONTRACTOR shall not discriminate against Medi-Cal eligible individuals in its COUNTY who require an assessment or meet medical necessity criteria for DMC-ODS in the provision of SUD services because of race, color, religion, ancestry, marital status, national origin, ethnic group identification, sex, sexual orientation, gender, gender identity, age, medical condition, genetic information, health status or need for health care services, or mental or physical disability as consistent with the requirements of applicable federal law, such as 42 C.F.R. § 438.3(d)(3) and (4), BHIN 22-060 Enclosure 4 and state law, Age Discrimination in Employment Act (29 CFR Part 1625). Age Discrimination Act of 1975 (45 CFR Part 90), as amended 42 USC Sections 6101 – 6107), which prohibits discrimination on the basis of age.

B. CONTRACTOR shall take affirmative action to ensure that services to intended Medi-Cal clients are provided without use of any policy or practice that has the effect of discriminating on the basis of race, color, religion, ancestry, marital status, national origin, ethnic group identification, sex, sexual orientation, gender, gender identity, age, medical condition, genetic information, health status or need for health care services, or mental or physical disability.

2. PHYSICAL ACCESSIBILITY

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

3. APPLICABLE FEES

A. CONTRACTOR shall not charge any clients or third-party payers any fee for service unless directed to do so by the Director at the time the client is referred for services. When directed to charge for services, CONTRACTOR shall use the uniform billing and collection guidelines prescribed by DHCS.

B. CONTRACTOR will perform eligibility and financial determinations for each beneficiary prior to rendering services in accordance with the Drug Medi-Cal Billing Manual, unless directed otherwise by the Director.

C. CONTRACTOR shall not submit a claim to, or demand or otherwise collect reimbursement from, the client or persons acting on behalf of the client for any SUD or related administrative services provided under this Agreement, except to collect other health insurance coverage, share of cost, and co-payments (California Code of Regulations, tit. 9, § 1810.365(c)).

D. The CONTRACTOR must not bill clients, for covered services, any amount greater than would be owed if the COUNTY provided the services directly as per and otherwise not bill client as set forth in 42 C.F.R. § 438.106.

4. CULTURAL COMPETENCE

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

5. CLIENT INFORMING MATERIALS

A. Basic Information Requirements

I. CONTRACTOR shall provide information in a manner and format that is easily understood and readily accessible to clients. (42 C.F.R. § 438.10(c)(1)). CONTRACTOR shall provide all written materials for clients in easily understood language, format, and alternative formats that take into consideration the special needs of clients in compliance with 42 C.F.R. § 438.10(d)(6). CONTRACTOR shall inform clients that information is available in alternate formats and how to access those formats in compliance with 42 C.F.R. § 438.10.

II. CONTRACTOR shall provide the required information in this section to each client receiving SUD services under this Agreement and upon request.

III. CONTRACTOR shall utilize the COUNTY's website that provides the content required in this section and 42 C.F.R. § 438.10 and complies with all the requirements regarding the same set forth in 42 C.F.R. § 438.10.

- IV. CONTRACTOR shall use DHCS/COUNTY developed model beneficiary handbook and client notices. (42 C.F.R. §§ 438.10(c)(4)(ii), 438.62(b)(3)).
- V. Client information required in this section may only be provided electronically by the CONTRACTOR if all of the following conditions are met:
  - a. The format is readily accessible;
  - b. The information is placed in a location on the CONTRACTOR's website that is prominent and readily accessible;
  - c. The information is provided in an electronic form which can be electronically retained and printed;
  - d. The information is consistent with the content and language requirements of this Agreement;
  - e. The client is informed that the information is available in paper form without charge upon request and the CONTRACTOR provides it upon request within five business days. (42 C.F.R. § 438.10(c)(6)).

B. Language and Format

- I. CONTRACTOR shall provide all written materials for potential clients and clients in a font size no smaller than 12 points. (42 C.F.R. § 438.10(d)(6)(ii).)
- II. CONTRACTOR shall ensure its written materials that are critical to obtaining services are available in alternative formats, upon request of the client or potential client at no cost.
- III. CONTRACTOR shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, beneficiary handbook, appeal and grievance notices, denial and termination notices, and the CONTRACTOR's SUD health education materials, available in the prevalent non-English languages in the COUNTY. (42 C.F.R. § 438.10(d)(3).)
  - a. CONTRACTOR shall notify clients, prospective clients, and members of the public that written translation is available in prevalent languages free of cost and how to access those materials. (42 C.F.R. § 438.10(d)(5)(i), (iii); Welfare & Institutions Code § 14727(a)(1); California Code of Regulations, tit. 9 § 1810.410, subd. (e), para. (4))
- IV. CONTRACTOR shall make auxiliary aids and services available upon request and free of charge to each client. (42 C.F.R. § 438.10(d)(3)-(4).)
- V. CONTRACTOR shall make oral interpretation and auxiliary aids, such as Teletypewriter Telephone/Text Telephone (TTY/TDY) and American Sign Language (ASL), available and free of charge for any language in compliance with 42 C.F.R. § 438.10(d)(2), (4)-(5).
- VI. Taglines for written materials critical to obtaining services must be printed in a conspicuously visible font size.



C. Beneficiary Informing Materials

- I. Each client must receive and have access to the beneficiary informing materials upon request by the client and when first receiving SUD services. Beneficiary informing materials include but are not limited to:
  - a. COUNTY DMC-ODS Beneficiary Handbook (BHIN 22-060)
  - b. Provider Directory
  - c. DMC-ODS Formulary
  - d. Advance Health Care Directive Form (required for adult clients only)
  - e. Notice of Language Assistance Services available upon request at no cost to the client
  - f. Language Taglines
  - g. Grievance/Appeal Process and Form
  - h. Notice of Privacy Practices
  - i. EPSDT poster (if serving clients under the age of 21)
- II. CONTRACTOR shall provide each client with a beneficiary handbook at the time the client first accesses services. The beneficiary handbook shall be provided to beneficiaries within 14 business days after receiving notice of enrollment.
- III. CONTRACTOR shall give each client notice of any significant change to the information contained in the beneficiary handbook at least 30 days before the intended effective date of change as per BHIN 22-060.
- IV. Required informing materials must be electronically available on the CONTRACTOR's website and must be physically available at the CONTRACTOR agency facility lobby for clients' access.
- V. Informing materials must be made available upon request, at no cost, in alternate formats (i.e., Braille or Audio) and Auxiliary Aids (i.e., California Relay Service (CRS) 711 and American Sign Language) and must be provided to clients within five business days. Large print materials shall be in a minimum 18-point font size.
- VI. Informing materials will be considered provided to the client if CONTRACTOR does one or more of the following:
  - a. Mails a printed copy of the information to the client's mailing address before the client first receives a SUD service;
  - b. Mails a printed copy of the information upon the client's request to the client's mailing address;
  - c. Provides the information by email after obtaining the client's agreement to receive the information by email;
  - d. Posts the information on the CONTRACTOR's website and advises the client in paper or electronic form that the information is available on the internet and includes

applicable internet addresses, provided that clients with disabilities who cannot access this information online are provided auxiliary aids and services upon request and at no cost; or,

- e. Provides the information by any other method that can reasonably be expected to result in the client receiving that information. If the CONTRACTOR provides informing materials in person, when the client first receives SUD services, the date and method of delivery shall be documented in the client's file.

D. Provider Directory

- I. CONTRACTOR must follow the COUNTY's provider directory policy, in compliance with MHSUDS IN 18-020.
- II. CONTRACTOR must make available to clients, in paper form upon request and electronic form, specified information about its provider network as per 42 C.F.R. § 438.10(h). The most current provider directory is electronically available on the COUNTY website and is updated by the COUNTY no later than 30 calendar days after information is received to update provider information. A paper provider directory must be updated as set forth in 42 C.F.R. § 438.10(h)(3)(i).
- III. Any changes to information published in the provider directory must be reported to the COUNTY within two weeks of the change.
- IV. CONTRACTOR will only need to report changes/updates to the provider directory for each licensed SUD service provider.

E. Medication Formulary

- I. CONTRACTOR shall make available in electronic or paper form, the following information about the COUNTY's formulary as outlined in 42 C.F.R. § 438.10(i):
  - a. Which medications are covered (for both generic and name brand).
  - b. What tier each medication resides on.
- II. CONTRACTOR shall inform clients about COUNTY's formulary drug lists availability in a machine-readable file and format on the COUNTY's website.

**Section 8. DATA, PRIVACY AND SECURITY REQUIREMENTS**

1. CONFIDENTIALITY AND SECURE COMMUNICATIONS

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

B. CONTRACTOR will comply with all COUNTY policies and procedures related to confidentiality, privacy, and secure communications.

C. CONTRACTOR shall have all employees acknowledge an Oath of Confidentiality mirroring that of County, including confidentiality and disclosure requirements, as well as sanctions related to non-compliance.

D. CONTRACTOR shall not use or disclose PHI or PII other than as permitted or required by law.

2. ELECTRONIC PRIVACY AND SECURITY

A. CONTRACTOR shall have a secure email system and send any email containing PII or PHI in a secure and encrypted manner. CONTRACTOR's email transmissions shall display a warning banner stating that data is confidential, systems activities are monitored and logged for administrative and security purposes, systems use is for authorized users only, and that users are directed to log off the system if they do not agree with these requirements.

B. CONTRACTOR shall institute compliant password management policies and procedures, which shall include but are not limited to procedures for creating, changing, and safeguarding passwords. CONTRACTOR shall establish guidelines for creating passwords and ensuring that passwords expire and are changed at least once every 90 days.

C. Any Electronic Health Records (EHRs) maintained by CONTRACTOR that contain any PHI or PII for clients served through this Agreement shall contain a warning banner regarding the PHI or PII contained within the EHR. CONTRACTORS that utilize an EHR shall maintain all parts of the clinical record that are not stored in the EHR, including but not limited to the following examples of client signed documents: discharge plans, informing materials, and health questionnaire.

D. CONTRACTOR entering data into any COUNTY electronic systems shall ensure that staff are trained to enter and maintain data within this system.

3. BUSINESS ASSOCIATE AGREEMENT (BAA)

A. CONTRACTOR may perform or assist COUNTY in the performance of certain health care administrative duties that involve the use and/or disclosure of client identifying information as defined by HIPAA. For these duties, the CONTRACTOR shall be a Business Associate of the COUNTY and shall comply with the applicable provisions set forth in the signed HIPAA BAA, which must be signed and attached as an exhibit to this Agreement. Reference Exhibit D HIPAA Business Associate Agreement.

B. CONTRACTOR shall follow all requirements listed within the BAA and shall comply with all applicable COUNTY policies, state laws and regulations and federal laws pertaining to breaches of confidentiality. CONTRACTOR agrees to hold the COUNTY harmless for any breaches or violations.

**Section 9. CLIENT RIGHTS**

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

**Section 10. RIGHT TO MONITOR**

1. COUNTY or any subdivision or appointee thereof, and the State of California or any subdivision or appointee thereof, including the Auditor General, shall have absolute right to review

and audit all records, books, papers, documents, corporate minutes, financial records, staff information, client records, other pertinent items as requested, and shall have absolute right to monitor the performance of CONTRACTOR in the delivery of services provided under this Agreement. Full cooperation shall be given by the CONTRACTOR in any auditing or monitoring conducted, according to this Agreement.

2. CONTRACTOR shall make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to Medi-Cal enrollees, Medi-Cal-related activities, services, and activities furnished under the terms of this Agreement, or determinations of amounts payable available at any time for inspection, examination, or copying by COUNTY, the State of California or any subdivision or appointee thereof, CMS, U.S. Department of Health and Human Services (HHS) Office of Inspector General, the United States Comptroller General or their designees, and other authorized federal and state agencies. This audit right will exist for at least 10 years from the final date of the Agreement period or in the event the CONTRACTOR has been notified that an audit or investigation of this Agreement has commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later (42 CFR § 438.230(c)(3)(I)-(ii)).

3. The COUNTY, DHCS, CMS, or the HHS Office of Inspector General may inspect, evaluate, and audit the CONTRACTOR at any time if there is a reasonable possibility of fraud or similar risk. The Department's inspection shall occur at the CONTRACTOR's place of business, premises or physical facilities (42 CFR § 438.230(c)(3)(iv)).

4. CONTRACTOR shall cooperate with the COUNTY in the implementation, monitoring and evaluation of this Agreement and comply with any and all reporting requirements established by the COUNTY. Should the COUNTY identify an issue or receive notification of a complaint or potential/actual/suspected violation of requirements, the COUNTY may audit, monitor, and/or request information from the CONTRACTOR to ensure compliance with laws, regulations, and requirements, as applicable.

5. COUNTY reserves the right to place CONTRACTOR on probationary status, , should CONTRACTOR fail to meet performance requirements; including, but not limited to violations such as high disallowance rates, failure to report incidents and changes as contractually required, failure to correct issues, inappropriate invoicing, untimely and inaccurate data entry, not meeting performance outcomes expectations, and violations issued directly from the State. Additionally, CONTRACTOR may be subject to Probationary Status or termination if contract monitoring and auditing corrective actions are not resolved within specified timeframes.

6. CONTRACTOR shall retain all records and documents originated or prepared pursuant to CONTRACTOR's performance under this Agreement, including client grievance and appeal records, and the data, information and documentation specified in 42 C.F.R. parts §§ 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years from the term end date of this Agreement or until such time as the matter under audit or investigation has been resolved. Records and documents include but are not limited to all physical and electronic records and documents originated or prepared pursuant to CONTRACTOR's or subcontractor's performance under this Agreement including working papers, reports, financial records and documents of account, client records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for clients.

7. CONTRACTOR shall maintain all records and management books pertaining to service delivery and demonstrate accountability for contract performance and maintain all fiscal, statistical, and management books and records pertaining to the program. Records should include, but are not limited to, monthly summary sheets, sign-in sheets, and other primary source documents. Fiscal

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

8. All records shall be complete and current and comply with all Agreement requirements. Failure to maintain acceptable records per the preceding requirements shall be considered grounds for withholding of payments for billings submitted and for termination of Agreement.

9. CONTRACTOR shall maintain client and community service records in compliance with all regulations set forth by local, state, and federal requirements, laws and regulations, and provide access to clinical records by COUNTY staff.

10. CONTRACTOR shall comply with Medical Records/Protected Health Information Article regarding relinquishing or maintaining medical records.

11. CONTRACTOR shall agree to maintain and retain all appropriate service and financial records for a period of at least 10 years from the date of final payment, the final date of the contract period, final settlement, or until audit findings are resolved, whichever is later.

12. CONTRACTOR shall submit audited financial reports on an annual basis to the COUNTY. The audit shall be conducted in accordance with generally accepted accounting principles and generally accepted auditing standards.

13. In the event the Agreement is terminated, ends its designated term or CONTRACTOR ceases operation of its business, CONTRACTOR shall deliver or make available to COUNTY all financial records that may have been accumulated by CONTRACTOR or subcontractor under this Agreement, whether completed, partially completed or in progress within seven calendar days of said termination/end date.

14. CONTRACTOR shall provide all reasonable facilities and assistance for the safety and convenience of the COUNTY's representatives in the performance of their duties. All inspections and evaluations shall be performed in such a manner that will not unduly delay the work of CONTRACTOR.

15. COUNTY has the discretion to revoke full or partial provisions of the Agreement, delegated activities or obligations, or application of other remedies permitted by state or federal law when the COUNTY or DHCS determines CONTRACTOR has not performed satisfactorily.

#### **Section 11. SITE INSPECTION**

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

**EXHIBIT A-2**  
**TRANSLATION SERVICES**

CONTRACTOR agrees to provide translation services such as, but not limited to, interpreting and sign language to consumers for the provision of services under this Agreement at CONTRACTOR'S sole cost.

Services provided may include:

- AT&T Language Line
- American Sign Language Translation Services, including TeleTYpewriter (TTY)/  
Telecommunication device for the Deaf (TDD) California Relay Services
- Orchid Interpreting
- Other interpreting services as deemed necessary to provide the consumer with linguistically and culturally appropriate services

CONTRACTOR will not be allowed to use COUNTY'S language and translation services' providers' accounts. Separate accounts will need to be arranged at CONTRACTOR'S discretion.

If COUNTY at any given time receives charges for CONTRACTOR'S language and translation services, CONTRACTOR will receive an invoice for such charge(s).

**EXHIBIT B**  
**FINANCIAL TERMS**  
**CENTRAL VALLEY RECOVERY SERVICES, INC.**  
**JULY 1, 2024 – JUNE 30, 2025**

**1. COMPENSATION**

- A. COUNTY agrees to compensate CONTRACTOR for allowed costs. The maximum contract amount shall not exceed SIX MILLION FOUR HUNDRED EIGHTY-NINE THOUSAND TWO HUNDRED NINETY-NINE DOLLARS \$6,489,299 for Fiscal Year 2024/2025.

I. Maximum compensation by Program Service and Funding Source:

	<b>CVRS</b>
	Maximum
DMC-ODS Funded Services	\$4,800,000.00
SUBG Funded Services	\$1,600,000.00
Recovery Residence - ARPA Funded Services	\$89,299.00
Contract Maximum	\$6,489,299.00

- B. Notwithstanding any other provision of this Agreement, in no event shall COUNTY pay CONTRACTOR more than the maximum contract amount for CONTRACTOR's performance hereunder without a properly executed amendment. Notwithstanding any other provisions of this Agreement, in no event may CONTRACTOR request a rate that exceeds the contracted rates in Exhibit B-1.
- C. If CONTRACTOR is going to exceed the maximum contract amount due to additional expenses, it is the responsibility of the CONTRACTOR to request the amendment and provide all supporting documentation that substantiates the increase. No amendments can be requested after April 1, 2025.
- D. CONTRACTOR agrees to comply with Medi-Cal requirements as set forth in Behavioral Health Information Notices found on the MedCCC library (<https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx>) as well as all applicable Tulare County Policy and Procedures (P&Ps) related to the

delivery of DMC-ODS services. To receive a full list of current P&Ps related to the delivery of DMC-ODS services, contact Tulare County Mental Health Managed Care/Quality Improvement Division at (559) 624-8000.

- E. CONTRACTOR shall be responsible for verifying the Consumer's Medi-Cal eligibility status and will take steps as described in the applicable Tulare County P&P to reactivate or establish eligibility where none exists. To receive a copy of the latest P&P related to the activation of a consumer's Medi-Cal insurance, please contact Tulare County Mental Health Managed Care/Quality Improvement Division at (559)624-8000.
- F. CONTRACTOR shall certify that all Units of Service (UOS) listed on the invoice submitted by the CONTRACTOR for any payor sources covered by this Agreement are true and accurate to the best of the CONTRACTOR'S knowledge.
- G. CONTRACTOR shall use funds provided by COUNTY exclusively for the purposes of performing the services described in the Scope of Services exhibit of this Agreement.

## 2. CLAIMING

- A. Claimed services under this agreement must be rendered only to Tulare County DMC beneficiaries and low-income [ $< 138\%$  Federal Poverty Line (FPL)] uninsured Tulare County residents.
- I. CONTRACTOR shall not request reimbursement from COUNTY for beneficiaries that are residents of another COUNTY.
  - a. In the event a beneficiary has Out-of-COUNTY Medi-Cal, but resides permanently in Tulare County, CONTRACTOR may include the services provided only when the following have been met:
    - i. CONTRACTOR has ensured the beneficiary has reported the address change,
    - ii. CONTRACTOR provides supporting documentation as required in the applicable P&P to verify the address change has been requested. To receive a copy of the current P&P related to updating consumer Medi-Cal insurance, contact Tulare County Mental



Health Managed Care/Quality Improvement Division at (559)624-8000.

- B. CONTRACTOR shall use Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, as provided in the Department of Health Care Services (DHCS) Billing Manual, currently available at <https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx>.
- C. CONTRACTOR shall enter claims data into the COUNTY's billing and transactional database system within ten (10) days following the close of the month in which services were rendered. If CONTRACTOR does not have access to COUNTY's billing and transactional system, claims data and all required documentation will be forwarded to COUNTY in a format that is reviewed and approved by COUNTY within ten (10) days following the close of the month in which services were rendered.
  - I. Prior to submitting Drug Medi-Cal claims to the Department of Health Care Services (DHCS), COUNTY will perform a utilization review of the DMC services and related documentation as described in the applicable Tulare County P&P. To receive a copy of the latest P&P related to the Utilization Review process, please contact Tulare County Mental Health Managed Care/Quality Improvement Division at (559)624-8000.
- D. Claims shall be complete and accurate and must include all required information regarding the claimed services per the Drug Medi-Cal ODS – Medi-Cal Billing Manual and all applicable Tulare County P&Ps. To Receive a copy of the latest P&P regarding documentation requirements, please contact Tulare County Mental Health Managed Care/Quality Improvement Division at (559)624-8000.
- E. CONTRACTOR shall maximize the Federal Financial Participation (FFP) reimbursement by claiming all eligible Drug/Medi-Cal services and coordinating with COUNTY to correct denied service claims for resubmission.

- F. CONTRACTOR must submit within thirty (30) days of the expiration or termination date of this agreement (whichever comes first), all final claims in order to receive reimbursement.
- G. 6-month billing limit: Unless otherwise determined by State or Federal regulations. All original (or initial) claims for eligible individual persons under this Agreement must be received by COUNTY within six (6) months from the month of service to avoid denial for late billing.
- H. Claims for Physician Consultation services can only be billed by the eligible DMC provider receiving Physician Consultation services.
  - I. CONTRACTOR is responsible for submitting claims for any Physician Consultation services provided by COUNTY to the CONTRACTOR.
  - II. COUNTY will retain all records related to Physician Consultation services provided by COUNTY to the CONTRACTOR in accordance with applicable Federal and State regulations regarding retention of such records.

### 3. INVOICING

- A. CONTRACTOR shall invoice COUNTY for services monthly, in arrears, in a format that is reviewed and approved by COUNTY. Invoices shall be based on claims entered into COUNTY's billing and transactional database system for the prior month.
- B. Invoices shall be provided to COUNTY within ten (10) days after the close of the month in which services were rendered. Following receipt and provisional approval of a monthly invoice, COUNTY shall make payment within thirty (30) days.
  - I. For residential program invoices, CONTRACTOR shall submit a Residential Worksheet in a format that is approved by COUNTY and additional supporting documentation as required.
  - II. Invoices may be submitted via mail to:
    - Tulare County HHSA
    - 5957 Mooney Blvd

Visalia, CA 93277

ATTN: Mental Health Department

III. Invoices may be submitted electronically to

[TulareMHP@tularecounty.ca.gov](mailto:TulareMHP@tularecounty.ca.gov)

a. CONTRACTOR will ensure that invoice documentation containing sensitive patient data shall be encrypted prior to electronic transmission in accordance with local, State, and Federal regulations.

C. Monthly payments for claimed services shall be based on the units of time assigned to each CPT or HCPCS code entered in the COUNTY's billing and transactional database multiplied by the service rates in Exhibit B-1.

I. The CPT or HCPCS II codes available on Exhibit B-1 are subject to change. COUNTY reserves the right to activate and deactivate codes in the electronic health record (EHR) system.

D. COUNTY's payments to CONTRACTOR for performance of claimed services are provisional and subject to adjustment until the completion of all settlement activities. COUNTY's adjustments to provisional payments for claimed services shall be based on the terms, conditions, and limitations of this agreement.

#### 4. MONITORING AND REPORTING

A. All beneficiaries whose treatment is paid for by COUNTY using funding from the State Department of Health Care Services (DHCS) Substance Use Drug (SUD) Programs must have received a Health & Human Services Agency (HHSA) authorization through Placement Orientation Services (POS).

I. No payments will be made for client services provided prior to the authorization date.

II. CONTRACTOR shall enter all relevant information into COUNTY's electronic health record system no later than 5 business days after the date of admission.

- B. California Outcomes Measurement System (CalOMS) client data must be entered within 48 business hours of admittance to and discharge from the treatment program.
    - I. CONTRACTOR must correct CalOMS data within 2 business days after notification from POS of all errors.
  - C. Online Drug and Alcohol Treatment Access Report (DATAR) entries shall be made no later than the 10th day of each month.
  - D. If CONTRACTOR fails to meet the monitoring and reporting requirements described in the applicable P&P, COUNTY may withhold future payments until CONTRACTOR is compliant with applicable monitoring and reporting requirements. To Receive a copy of the latest P&P regarding monitoring and reporting requirements, please contact Tulare County Mental Health Managed Care/Quality Improvement Division at (559)624-8000.
  - E. COUNTY has the right to monitor the performance of this agreement to ensure the accuracy of claims for reimbursement and compliance with all applicable laws and regulations.
5. FINANCIAL SETTLEMENT FOR DRUG/MEDI-CAL BILLABLE SERVICES
- A. CONTRACTOR shall be required to reimburse COUNTY for 100 percent (100%) of the provisional payments made by COUNTY to CONTRACTOR for units of service that have been denied by Medi-Cal when:
    - I. Claims are denied as the result of CONTRACTOR failing to ensure its rendering providers meet Medi-Cal claiming requirements and/or claim documentation provided by CONTRACTOR fails to meet Medi-Cal claiming requirements, and
    - II. CONTRACTOR fails to make a good faith effort to coordinate with COUNTY to submit replacement claims for denied services.
  - B. For additional reasons for recoupment for claimed services provided under this agreement, see section 7. FINANCIAL AUDIT REPORT REQUIREMENTS AND REASONS FOR RECOUPMENT of this exhibit.
6. ADDITIONAL FINANCIAL REQUIREMENTS

- A. CONTRACTOR shall NOT charge a DMC client a fee for services other than a share of cost, pursuant to Article 12 (commencing with Section 50651), Chapter 2, Division 3, Title 22, CCR.
- B. CONTRACTOR shall comply with 45 CFR 162.410(a)(1) for any subpart that would be a covered health care provider if it were a separate legal entity. For purposes of this paragraph, a covered health care provider shall have the same definition as set forth in 45 CFR 160.103.
- C. CONTRACTOR shall maintain internal financial controls, which adequately ensure proper billing and collection procedures. CONTRACTOR shall pursue payment from all potential sources in sequential order, with Medi-Cal as payor of last resort. All fees paid by or on behalf of the consumer receiving services under this Agreement shall be utilized by CONTRACTOR only for the delivery of mental health service units as specified in this Agreement.
- D. COUNTY shall not furnish any payments to the CONTRACTOR if that individual/entity is under investigation by any Federal, State, or other public agency for any fraudulent activity. Payments in this manner will be prohibited until such investigations are completed by COUNTY or State.
- E. CONTRACTOR must comply with the False Claims Act employee training and policy requirements set forth in 42 U.S.C. 1396a(a)(68) and as the Secretary of the United States Department of Health and Human Services may specify.
- F. CONTRACTOR agrees that no part of any federal funds provided under this Agreement shall be used to pay the salary of an individual per fiscal year at a rate in excess of Level 1 of the Executive Schedule at <https://www.opm.gov/> (U.S. Office of Personnel Management), as from time to time amended.
- G. Federal Financial Participation is not available for any amount furnished to an Excluded individual or entity, or at the direction of a physician during the period of exclusion when the person providing the service knew or had reason to know of the exclusion, or to an individual or entity when the COUNTY failed to suspend payments during an investigation of a credible allegation of fraud [42 U.S.C. section 1396b(i)(2)].

H. CONTRACTOR must keep records of services rendered to Medi-Cal beneficiaries for ten years or until the final cost report settlement, Per Welfare & Institutions Code section 14124.1.

7. CONTRACTOR PROHIBITED FROM REDIRECTION OF CONTRACTED FUNDS [IF APPLICABLE]

A. Funds paid to CONTRACTOR for services rendered under this agreement, may not be redirected or transferred to support another program operated by CONTRACTOR except through a duly executed amendment to this Agreement.

8. FINANCIAL AUDIT REPORT REQUIREMENTS AND REASONS FOR RECOUPMENT

A. COUNTY, its agents, officers, or employees, may conduct financial program audits at any time to ensure provisional payments made to CONTRACTOR are used as described in the terms of this agreement.

B. The CONTRACTOR shall submit any documentation requested by COUNTY or State in accordance with audit requirements and needs. Requested documentation must be supplied within a reasonable amount of time.

C. The audit shall be conducted by utilizing generally accepted accounting principles and generally accepted auditing standards.

D. COUNTY will involve the CONTRACTOR in developing responses to any draft federal or State audit reports that directly impact COUNTY.

E. In the event of overpayments and prohibited payments:

I. CONTRACTOR shall report to COUNTY within sixty (60) calendar days of payments in excess of amounts specified by contract standards.

II. COUNTY may offset the amount of any overpayment for any fiscal year against subsequent claims from the Contractor.

III. Offsets may be done at any time after COUNTY has invoiced or otherwise notified the CONTRACTOR about the overpayment. COUNTY shall determine the amount that may be withheld from each payment to the CONTRACTOR.

- IV. CONTRACTOR shall retain documentation, policies, and treatment of recoveries of overpayments due to fraud, waste, or abuse. Such documentation should include timeframes, processes, documentation, and reporting.

F. For pass-through entities:

- I. If COUNTY determines that CONTRACTOR is a “subrecipient” (also known as a “pass-through entity”) as defined in 2 C.F.R. § 200 et seq., CONTRACTOR agrees that it will comply with the applicable cost principles and administrative requirements including claims for payment or reimbursement by COUNTY as set forth in 2 C.F.R. § 200 et seq., as may be amended from time to time. CONTRACTOR shall observe and comply with all applicable financial audit report requirements and standards.
  - II. Financial audit reports must contain a separate schedule that identifies all funds included in the audit that are received from or passed through the COUNTY. COUNTY programs must be identified by Agreement number, Agreement amount, Agreement period, and the amount expended during the fiscal year by funding source.
  - III. CONTRACTOR will provide a financial audit report including all attachments to the report and the management letter and corresponding response within six months of the end of the audit year to the County Mental Health Director. The Director is responsible for providing the audit report to the COUNTY Auditor.
  - IV. CONTRACTOR must submit any required corrective action plan (CAP) to the COUNTY simultaneously with the audit report or as soon thereafter as it is available. The COUNTY shall monitor implementation of the corrective action plan as it pertains to services provided pursuant to this Agreement.
9. Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) FUNDING PROVISIONS [IF APPLICABLE]
- A. The non-DMC reimbursement for this agreement shall NOT exceed the amount listed in 1.A.I. of this exhibit. There shall be no opportunity to exchange money between sources or programs within this Agreement unless

both parties agree to such an exchange in writing and is agreed by both parties.

- B. Prior to expending SUBG funding, every reasonable effort should be made to establish systems for eligibility determination, billing, and collection:
  - I. Collect reimbursement of the costs of providing such services to persons who are entitled to insurance benefits under the Social Security Act, including programs under Title XVIII and Title XIX, any State compensation program, any other public assistance program for medical expenses, any grant program, any private health insurance, or any other benefit program; and
  - II. Secure from beneficiary payments for services in accordance with their ability to pay.
- C. Pursuant to 45 CFR Section 75.371 and HSC Section 11817.8, COUNTY may withhold SUBG payments if CONTRACTOR fails to:
  - I. Submit any forms and/or reports to COUNTY by each due date.
  - II. Complete CAP items within the timeframe agreed upon by COUNTY and CONTRACTOR.
- D. CONTRACTOR shall comply with the financial management standards contained in 45 CFR Sections 75.302(b)(1) through (6), and 45 CFR Section 96.30.
  - I. CONTRACTOR shall comply with the financial management standards contained in 45 CFR Section 75.302(b)(1) through (4) and (b)(7), and 45 CFR Section 96.30.
- E. CONTRACTOR shall not use SUBG funds provided by COUNTY on the following activities:
  - I. Provide inpatient services.
  - II. Make cash payments to intended recipients of behavioral health services.
  - III. Purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility or purchase major medical equipment.



- IV. Satisfy any requirement for the expenditure of SUBG funds as a condition for the receipt of federal funds.
- V. Provide financial assistance to any entity other than a public or nonprofit private entity.
- VI. Pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of level I of the Executive Salary Schedule for the award year: see [http://grants.nih.gov/grants/policy/salcap\\_summary.htm](http://grants.nih.gov/grants/policy/salcap_summary.htm).
- VII. Purchase treatment services in penal or correctional institutions of the State of California.
- VIII. Supplant state funding of programs to prevent and treat substance abuse and related activities.
- IX. Provide services reimbursable by DMC:
  - a. CONTRACTOR shall not utilize SUBG funds to pay for a service that is reimbursable by DMC.
  - b. CONTRACTOR may utilize SUBG funds to pay for a service included in DMC-ODS, but which is not reimbursable by DMC.
  - c. If CONTRACTOR utilizes SUBG funds to pay for a service that is included in DMC-ODS, CONTRACTOR shall maintain documentation sufficient to demonstrate that DMC reimbursement was not available.
    - i. If CONTRACTOR is unable to provide adequate documentation, those funds shall be recuperated by COUNTY.
- F. SUBG regulations require that the following provisions be included in any agreement funded by SUBG:
  - I. Additional Restrictions
    - a. This Contract is subject to any additional restrictions, limitations, or conditions enacted by Congress, or any statute enacted by Congress, which may affect the provisions, terms, or funding of this Contract in any manner.
  - II. Hatch Act

- a. COUNTY and CONTRACTOR agree to comply with the provisions of the Hatch Act (USC, Title 5, Part III, Subpart F., Chapter 73, Subchapter III), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.
- III. No Unlawful Use or Unlawful Use Messages Regarding Drugs
  - a. COUNTY and CONTRACTOR agree that information produced through these funds, and which pertains to drugs and alcohol-related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program.
  - b. 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, Division 10.7, Chapter 1429, Sections 11999-11999.3). By signing this Enclosure, COUNTY and CONTRACTOR agree that it will enforce, and will require its subcontractors to enforce, these requirements.
- IV. Limitation on Use of Funds for Promotion of Legalization of Controlled Substances
  - a. None of the funds made available through this Contract 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).
- V. Debarment and Suspension
  - a. COUNTY and CONTRACTOR shall not subcontract with or employ any party listed on the government wide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines at 2 CFR 180 that implement Executive Orders 12549 (3 CFR part 1986 Comp. p. 189) and 12689 (3 CFR part 1989., p. 235), "Debarment and Suspension." SAM exclusions contain the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than

Executive Order 12549.

- b. COUNTY shall advise all subcontractors of their obligation to comply with applicable federal debarment and suspension regulations, in addition to the requirements set forth in 42 CFR Part 1001.
- c. If COUNTY or CONTRACTOR subcontracts or employs an excluded party, DHCS has the right to withhold payments, disallow costs, or issue a CAP, as appropriate, pursuant to HSC Code 11817.8(h).

VI. Restriction on Distribution of Sterile Needles

- a. No SUBG funds made available through this Contract shall be used to carry out any program that includes the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug unless DHCS chooses to implement a demonstration syringe services program for injecting drug users.

VII. Health Insurance Portability and Accountability Act (HIPAA) of 1996

- a. All work performed under this Contract is subject to HIPAA, COUNTY and CONTRACTOR shall perform the work in compliance with all applicable provisions of HIPAA. DHCS, COUNTY, and CONTRACTOR shall cooperate to assure mutual agreement as to those transactions between them to which this provision applies.
- b. Trading Partner Requirements:
  - i. No Changes. COUNTY and CONTRACTOR hereby agree that for the personal health information (Information), it will not change any definition, data condition, or use of a data element or segment as proscribed in the Federal Health and Human Services (HHS) Transaction Standard Regulation (45 CFR 162.915 (a)).
  - ii. No Additions. COUNTY and CONTRACTOR hereby agree that for the Information, it will not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation (45 CFR 162.915 (b)).
  - iii. No Unauthorized Uses. COUNTY and CONTRACTOR hereby agrees that for the Information, it will not use any code or data

elements that either are marked “not used” in the HHS Transaction’s Implementation specification or are not in the HHS Transaction Standard’s implementation specifications (45 CFR 162.915 (c)).

- iv. No Changes to Meaning or Intent. COUNTY and CONTRACTOR hereby agree that for the Information, it will not change the meaning or intent of any of the HHS Transaction Standard’s implementation specifications (45 CFR 162.915 (d)).
- c. Concurrence for Test Modifications to HHS Transaction Standards
  - i. COUNTY and CONTRACTOR agree and understand that there exists the possibility that DHCS or others may request an extension from the use of a standard in the HHS Transaction Standards. If this occurs, COUNTY and CONTRACTOR agree that it will participate in such test modifications.
- d. Adequate Testing
  - i. COUNTY and CONTRACTOR are responsible to adequately test all business rules appropriate to their types and specialties. If the COUNTY and CONTRACTOR is acting as a clearinghouse for enrolled providers, COUNTY and CONTRACTOR has obligations to adequately test all business rules appropriate to each and every provider type and specialty for which they provide clearinghouse services.
- e. Deficiencies
  - i. COUNTY and CONTRACTOR agrees to correct transactions, errors, or deficiencies identified by DHCS, and transactions errors or deficiencies identified by an enrolled provider if the COUNTY and CONTRACTOR are acting as a clearinghouse for that provider. When COUNTY and CONTRACTOR is a clearinghouse, COUNTY and CONTRACTOR agrees to properly communicate deficiencies and other pertinent information regarding electronic transactions to enrolled providers for which they provide clearinghouse services.

f. Code Set Retention

- i. Both parties understand and agree to keep open code sets being processed or used in this Contract for at least the current billing period or any appeal period, whichever is longer.

g. Data Transmission Log

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

VIII. Nondiscrimination and Institutional Safeguards for Religious Providers

- a. COUNTY shall establish such processes and procedures as necessary to comply with the provisions of USC, Title 42, Section 300x-65 and CFR, Title 42, Part 54

IX. Counselor Certification

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

X. Cultural and Linguistic Proficiency

- a. To ensure equal access to quality care by diverse populations, each service provider receiving funds from this Contract shall adopt the Federal Office of Minority Health Culturally and Linguistically

Appropriate Service (CLAS) national standards as outlined online at:  
<https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53https://thinkculturalhealth.hhs.gov/clas/standards>.

- XI. Intravenous Drug Use (IVDU) Treatment
  - a. COUNTY and CONTRACTOR shall ensure that individuals in need of IVDU treatment shall be encouraged to undergo AOD treatment (42 USC 300x-23 (45 CFR 96.126(e))).
- XII. Tuberculosis Treatment
  - a. COUNTY and CONTRACTOR shall ensure the following related to Tuberculosis (TB):
    - i. Routinely make available TB services to individuals receiving treatment.
    - ii. Reduce barriers to patients' accepting TB treatment.
    - iii. Develop strategies to improve follow-up monitoring, particularly after patients leave treatment, by disseminating information through educational bulletins and technical assistance.
- XIII. Trafficking Victims Protection Act of 2000
  - a. COUNTY and its subcontractors that provide services covered by this Contract shall comply with the Trafficking Victims Protection Act of 2000 (USC, Title 22, Chapter 78, Section 7104) as amended by section 1702 of Pub. L. 112-239.
- XIV. Tribal Communities and Organizations
  - a. COUNTY shall regularly review population information available through Census, compare to information obtained in the California Outcome Measurement System for Treatment (CalOMS-Tx) to determine whether the population is being reached, and survey Tribal representatives for insight in potential barriers to the substance use service needs of the American Indian/Alaskan Native (AI/AN) population within the County geographic area. CONTRACTOR shall also engage in regular and meaningful consultation and collaboration with elected officials of the tribe, Rancheria, or their designee for the

purpose of identifying issues/barriers to service delivery and improvement of the quality, effectiveness, and accessibility of services available to AI/AN communities within the County.

XV. Marijuana Restriction

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

XVI. Participation of County Behavioral Health Director’s Association of California

- a. COUNTY Alcohol and/or Other Drug (AOD) Program Administrator shall participate and represent the COUNTY in meetings of the County Behavioral Health Director’s Association of California for the purposes of representing the counties in their relationship with DHCS with respect to policies, standards, and administration for AOD abuse services.
- b. COUNTY AOD Program Administrator shall attend any special meetings called by the Director of DHCS. Participation and representation shall also be provided by the County Behavioral Health Director’s Association of California.

XVII. Adolescent Best Practices Guidelines

- a. COUNTY must utilize DHCS guidelines in developing and implementing youth treatment programs funded under this agreement. The Adolescent Best Practices Guidelines can be found at:  
[https://www.dhcs.ca.gov/Documents/CSD\\_CMHCS/Adol%20Best%20Practices%20Guide/AdolBestPracGuideOCTOBER2020.pdf](https://www.dhcs.ca.gov/Documents/CSD_CMHCS/Adol%20Best%20Practices%20Guide/AdolBestPracGuideOCTOBER2020.pdf)

XVIII. Byrd Anti-Lobbying Amendment (31 USC 1352)

- a. COUNTY and CONTRACTOR certifies that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 USC 1352. COUNTY and CONTRACTOR shall also disclose to DHCS any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award.

XIX. Nondiscrimination in Employment and Services

- a. COUNTY and CONTRACTOR certifies that under the laws of the United States and the State of California, COUNTY and CONTRACTOR will not unlawfully discriminate against any person.

XX. Federal Law Requirements:

- a. Title VI of the Civil Rights Act of 1964, Section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in federally funded programs.
- b. Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.
- c. Age Discrimination Act of 1975 (45 CFR Part 90), as amended 42 USC Sections 6101 – 6107), which prohibits discrimination on the basis of age.



- d. Age Discrimination in Employment Act (29 CFR Part 1625).
- e. Title I of the Americans with Disabilities Act (29 CFR Part 1630) prohibiting discrimination against the disabled in employment.
- f. Title II of the Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities.
- g. Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.
- h. Section 504 of the Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.
- i. Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than \$10,000 funded by federal financial assistance.
- j. Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.
- k. The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.
- l. Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2, Subparts A – E).

XXI. State Law Requirements:

- a. Fair Employment and Housing Act (Government Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (2 CCR 7285.0 et seq.).
- b. Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135.
- c. Title 9, Division 4, Chapter 8 of the CCR, commencing with Section 13000.
- d. No federal funds shall be used by the COUNTY and CONTRACTOR or its subcontractors for sectarian worship, instruction, or proselytization. No federal funds shall be used by the COUNTY and CONTRACTOR or

its subcontractors to provide direct, immediate, or substantial support to any religious activity.

XXII. Additional Contract Restrictions

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

XXIII. Information Access for Individuals with Limited English Proficiency

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

**EXHIBIT B-1**  
**RATES**  
**CENTRAL VALLEY RECOVERY SERVICES, INC.**  
**JULY 1, 2024 – JUNE 30, 2025**

Code	Time Associated with Code (Mins) for Purposes of Rate	Physicians Assistant	Nurse Practitioner	RN	Pharmacist	MD	Psychologist/Pre-licensed Psychologist	LPHA	LCSW	Alcohol and Drug Counselor	Peer Recovery Specialist
<b>PROVIDER TYPE HOURLY RATE:</b>		\$ 581.46	\$ 644.71	\$ 526.61	\$ 620.59	\$ 974.26	\$ 521.40	\$ 337.41	\$ 337.41	\$ 266.55	\$ 253.85
90785	15	\$ 145.37	\$ 161.18	\$ 131.65	\$ 155.15	\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35	\$ 66.64	
90791	15	\$ 145.37	\$ 161.18			\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35		
90792	15	\$ 145.37	\$ 161.18			\$ 243.56					
90846	50	\$ 484.55	\$ 537.26			\$ 811.88	\$ 434.50	\$ 281.18	\$ 281.18		
90847	50	\$ 484.55	\$ 537.26			\$ 811.88	\$ 434.50	\$ 281.18	\$ 281.18		
90849	15	\$ 145.37	\$ 161.18			\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35		
90865	15	\$ 145.37	\$ 161.18			\$ 243.56					
90882	15	\$ 145.37	\$ 161.18	\$ 131.65		\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35	\$ 66.64	
90885	15	\$ 145.37	\$ 161.18			\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35		
90887	15	\$ 145.37	\$ 161.18		\$ 155.15	\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35		
90889	15	\$ 145.37	\$ 161.18	\$ 131.65		\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35		
96130	60	\$ 581.46	\$ 644.71			\$ 974.26	\$ 521.40				
96131	60	\$ 581.46	\$ 644.71			\$ 974.26	\$ 521.40				
96160	15	\$ 145.37	\$ 161.18	\$ 131.65		\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35		
96170	30	\$ 290.73	\$ 322.35	\$ 263.31		\$ 487.13	\$ 260.70	\$ 168.71	\$ 168.71		
96171	15	\$ 145.37	\$ 161.18	\$ 131.65		\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35		
98966	8	\$ 77.53	\$ 85.96				\$ 69.52	\$ 44.99	\$ 44.99		
98967	16	\$ 155.06	\$ 171.92				\$ 139.04	\$ 89.98	\$ 89.98		
98968	26	\$ 251.97	\$ 279.37				\$ 225.94	\$ 146.21	\$ 146.21		
99202	22	\$ 213.20	\$ 236.39			\$ 357.23					
99203	37	\$ 358.57	\$ 397.57			\$ 600.79					
99204	52	\$ 503.94	\$ 558.75			\$ 844.36					
99205	67	\$ 649.30	\$ 719.92			\$ 1,087.92					
99212	15	\$ 145.37	\$ 161.18			\$ 243.56					
99213	25	\$ 242.28	\$ 268.63			\$ 405.94					
99214	35	\$ 339.19	\$ 376.08			\$ 568.32					
99215	47	\$ 455.48	\$ 505.02			\$ 763.17					
99217	15	\$ 145.37	\$ 161.18			\$ 243.56					
99234	40	\$ 387.64	\$ 429.80			\$ 649.51					
99235	49	\$ 474.86	\$ 526.51			\$ 795.64					
99236	57	\$ 552.39	\$ 612.47			\$ 925.55					
99304	23	\$ 222.89	\$ 247.14			\$ 373.47					
99305	35	\$ 339.19	\$ 376.08			\$ 568.32					
99306	50	\$ 484.55	\$ 537.26			\$ 811.88					

Note: Not all CPT/HCPCS II codes listed on this rates exhibit may be available for CONTRACTOR to select and claim in the COUNTY's electronic health record (EHR) system. COUNTY reserves the right to activate and deactivate codes in the EHR. Additional codes may also be made available as needed and will be paid at the provider rate listed above.

Code	Time Associated with Code (Mins) for Purposes of Rate	Physicians Assistant	Nurse Practitioner	RN	Pharmacist	MD	Psychologist/Pre-licensed Psychologist	LPHA	LCSW	Alcohol and Drug Counselor	Peer Recovery Specialist
<b>PROVIDER TYPE HOURLY RATE:</b>		\$ 581.46	\$ 644.71	\$ 526.61	\$ 620.59	\$ 974.26	\$ 521.40	\$ 337.41	\$ 337.41	\$ 266.55	\$ 253.85
99307	7	\$ 67.84	\$ 75.22			\$ 113.66					
99308	16	\$ 155.06	\$ 171.92			\$ 259.80					
99309	25	\$ 242.28	\$ 268.63			\$ 405.94					
99310	35	\$ 339.19	\$ 376.08			\$ 568.32					
99324	20	\$ 193.82	\$ 214.90			\$ 324.75					
99325	31	\$ 300.42	\$ 333.10			\$ 503.37					
99326	43	\$ 416.72	\$ 462.04			\$ 698.22					
99327	58	\$ 562.08	\$ 623.22			\$ 941.78					
99328	73	\$ 707.45	\$ 784.39			\$ 1,185.35					
99334	15	\$ 145.37	\$ 161.18			\$ 243.56					
99335	28	\$ 271.35	\$ 300.86			\$ 454.65					
99336	43	\$ 416.72	\$ 462.04			\$ 698.22					
99337	61	\$ 591.15	\$ 655.45			\$ 990.50					
99339	22	\$ 213.20	\$ 236.39			\$ 357.23					
99340	30	\$ 290.73	\$ 322.35			\$ 487.13					
99341	20	\$ 193.82	\$ 214.90			\$ 324.75					
99342	31	\$ 300.42	\$ 333.10			\$ 503.37					
99343	43	\$ 416.72	\$ 462.04			\$ 698.22					
99344	58	\$ 562.08	\$ 623.22			\$ 941.78					
99345	73	\$ 707.45	\$ 784.39			\$ 1,185.35					
99347	15	\$ 145.37	\$ 161.18			\$ 243.56					
99348	28	\$ 271.35	\$ 300.86			\$ 454.65					
99349	43	\$ 416.72	\$ 462.04			\$ 698.22					
99350	61	\$ 591.15	\$ 655.45			\$ 990.50					
99367	30					\$ 487.13					
99368	30	\$ 290.73	\$ 322.35	\$ 263.31	\$ 310.30		\$ 260.70	\$ 168.71	\$ 168.71		
99408	23	\$ 222.89	\$ 247.14			\$ 373.47					
99409	30	\$ 290.73	\$ 322.35			\$ 487.13					
99441	8	\$ 77.53	\$ 85.96			\$ 129.90					
99442	16	\$ 155.06	\$ 171.92			\$ 259.80					
99443	26	\$ 251.97	\$ 279.37			\$ 422.18					
99451	10					\$ 162.38					
99495	15	\$ 145.37	\$ 161.18			\$ 243.56					

Code	Time Associated with Code (Mins) for Purposes of Rate	Physicians Assistant	Nurse Practitioner	RN	Pharmacist	MD	Psychologist/Pre-licensed Psychologist	LPHA	LCSW	Alcohol and Drug Counselor	Peer Recovery Specialist
<b>PROVIDER TYPE</b>	<b>HOURLY RATE:</b>	\$ 581.46	\$ 644.71	\$ 526.61	\$ 620.59	\$ 974.26	\$ 521.40	\$ 337.41	\$ 337.41	\$ 266.55	\$ 253.85
99496	15	\$ 145.37	\$ 161.18			\$ 243.56					
G0396	23	\$ 222.89	\$ 247.14	\$ 201.87	\$ 237.89	\$ 373.47	\$ 199.87	\$ 129.34	\$ 129.34	\$ 102.18	
G0397	30	\$ 290.73	\$ 322.35	\$ 263.31	\$ 310.30	\$ 487.13	\$ 260.70	\$ 168.71	\$ 168.71	\$ 133.27	
G2011	10	\$ 96.91	\$ 107.45	\$ 87.77	\$ 103.43	\$ 162.38	\$ 86.90	\$ 56.24	\$ 56.24	\$ 44.42	
G2212	15	\$ 145.37	\$ 161.18			\$ 243.56					
H0001	15	\$ 145.37	\$ 161.18	\$ 131.65		\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35	\$ 66.64	
H0003	15	\$ 145.37	\$ 161.18	\$ 131.65	\$ 155.15	\$ 243.56	\$ 130.35				
H0004	15	\$ 145.37	\$ 161.18	\$ 131.65		\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35	\$ 66.64	
H0005	15	\$ 145.37	\$ 161.18	\$ 131.65		\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35	\$ 66.64	
H0007	15	\$ 145.37	\$ 161.18	\$ 131.65		\$ 243.56	\$ 130.35	\$ 84.35			
H0008	15	\$ 145.37	\$ 161.18		\$ 155.15	\$ 243.56					
H0009	15	\$ 145.37	\$ 161.18		\$ 155.15	\$ 243.56					
H0025	15										\$ 63.46
H0033	15	\$ 145.37	\$ 161.18	\$ 131.65	\$ 155.15	\$ 243.56					
H0034	15	\$ 145.37	\$ 161.18	\$ 131.65	\$ 155.15	\$ 243.56					
H0038	15										\$ 63.46
H0048	15	\$ 145.37	\$ 161.18	\$ 131.65	\$ 155.15	\$ 243.56					
H0049	15	\$ 145.37	\$ 161.18	\$ 131.65	\$ 155.15	\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35	\$ 66.64	
H0050	15	\$ 145.37	\$ 161.18	\$ 131.65		\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35	\$ 66.64	\$ 63.46
H1000	15	\$ 145.37	\$ 161.18	\$ 131.65		\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35	\$ 66.64	
H2011	15	\$ 145.37	\$ 161.18	\$ 131.65		\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35	\$ 66.64	\$ 63.46
H2014	15	\$ 145.37	\$ 161.18	\$ 131.65		\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35	\$ 66.64	
H2015	15	\$ 145.37	\$ 161.18	\$ 131.65		\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35	\$ 66.64	
H2017	15	\$ 145.37	\$ 161.18	\$ 131.65	\$ 155.15	\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35	\$ 66.64	
H2021	15	\$ 145.37	\$ 161.18	\$ 131.65	\$ 155.15	\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35	\$ 66.64	
H2027	15	\$ 145.37	\$ 161.18	\$ 131.65		\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35	\$ 66.64	
H2035	60	\$ 581.46	\$ 644.71	\$ 526.61	\$ 620.59	\$ 974.26	\$ 521.40	\$ 337.41	\$ 337.41	\$ 266.55	
T1006	15	\$ 145.37	\$ 161.18	\$ 131.65		\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35	\$ 66.64	
T1007	15	\$ 145.37	\$ 161.18	\$ 131.65		\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35	\$ 66.64	
T1013	15	\$ 145.37	\$ 161.18	\$ 131.65		\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35	\$ 66.64	
T1017	15	\$ 145.37	\$ 161.18	\$ 131.65	\$ 155.15	\$ 243.56	\$ 130.35	\$ 84.35	\$ 84.35	\$ 66.64	

Day Services		
Code	Unit	Rate
Level 3.2 – Withdrawal Management	Per Day	\$ 156.30
Level 3.1 – Residential	Per Day	\$ 122.07
Level 3.3 – Residential	Per Day	\$ 208.47
Level 3.5 – Residential	Per Day	\$ 141.86

\*Rates are unbundled. Outpatient services to be billed separately

Room & Board Day Rate		
Service	Unit	Rate
Room & Board	Per Day	\$ 46.83

\*Room & Board rate is for food and lodging expenses only, covered by SUBG Funding



## **EXHIBIT I**

### **SUBSTANCE USE DISORDER SERVICE PROGRAMS**

#### **1. Services**

Services and work provided by CONTRACTOR at the COUNTY'S request under this Agreement will be performed in a timely manner, and in accordance with applicable federal and state statutes and regulations, including, but not limited to, sections 96.126, 96.127, 96.128, 96.131 and 96.132, and all references therefrom, of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reauthorization Act, Public Law 106-310, the State of California Alcohol and/or Other Drug Program Certification Standards (2017 version), Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8; Drug Medi-Cal Certification Standards for Substance Abuse Clinics; Title 22, CCR, Sections 51341.1, 51490.1, and 51516.1; Title 9, CCR, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq.; Title 22, CCR, Division 3, Chapter 3, sections 51000 et. seq. and any and all guidelines promulgated by the State Department of Health Care Services' (DHCS) Alcohol and Drug Programs and the Tulare COUNTY Department of Health and Human Services to serve special populations and groups, as applicable; COUNTY laws, ordinances, regulations and resolutions; and in a manner in accordance with the standards and obligations of CONTRACTOR'S profession. CONTRACTOR shall devote such time to the performance of services pursuant to this Agreement as may be reasonably necessary for the satisfactory performance of CONTRACTOR'S obligations. The COUNTY shall maintain copies of above-mentioned statutes, regulations, and guidelines for CONTRACTOR'S use. Copies of Substance Use Disorder Service Programs Policies and Procedures are sent to CONTRACTORS, as applicable, and can be resubmitted on request. CONTRACTOR shall adhere to the applicable provisions of the Multi- Year State-COUNTY Agreement referenced below in their entirety.

1.1 Counselor Certification: Any registered or certified counselor 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. [State-COUNTY Agreement, Exhibit A, Attachment I, Part I]

1.2 Re-Certification Events: CONTRACTOR shall notify DHCS and the COUNTY Alcohol and Drug Administrator within the timeframes noted in the State Agreement, in addition to applicable federal, state, and local regulations and policies of any triggering recertification events, such as change in ownership, change in scope of services, remodeling of facility, or change in location. [State-COUNTY Agreement, Exhibit A, Attachment I]

1.3 Cultural and Linguistic Proficiency: To ensure access to quality care by diverse populations, each service provider receiving funds from the State-COUNTY Agreement shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Services (CLAS) national standards (2016 version). [State-COUNTY Agreement, Exhibit A, Attachment I, Part I; 42 CFR 438.206(c)(2)]

1.4 Perinatal Services Network Guidelines: Perinatal programs shall comply with the Perinatal Services Network Guidelines FY 2016-17 until such time new Perinatal Services Network Guidelines are established and adopted. [State-COUNTY Agreement, Exhibit A, Attachment I, Part IV]

1.5 Charitable Choice Requirements: CONTRACTORS shall not use funds provided through this Agreement for inherently religious activities, such as worship, religious instruction, or proselytization. CONTRACTORS that are religious organizations shall establish a referral process to a reasonably accessible program for clients who may object to the religious nature of the CONTRACTOR'S program and CONTRACTORS shall be required to notify clients of their rights prohibiting discrimination and to be referred to another program if they object to the religious nature of the program at intake. Referrals that were made due to the religious nature of the CONTRACTOR'S program shall be submitted annually to the COUNTY Alcohol and Drug Administrator by June 30 for referrals made during the fiscal year. [State-COUNTY Agreement, Exhibit A, Attachment I, Part III]

1.6 Trafficking Victims Protection Act of 2000: CONTRACTOR shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 as amended (22 U.S.C. 7104). The COUNTY is

authorized to terminate the Agreement, without penalty, if the CONTRACTOR: (a) Engages in severe forms of trafficking in persons during the period of time that the award is in effect; (b) Procures a commercial sex act during the period of time that the award is in effect; or (c) Uses forced labor in the performance of the award or subawards under the award. [State-COUNTY Agreement, Exhibit A, Attachment I, Part I]

1.7 Access to Drug/Medi-Cal Services: When a request for covered services is made by a beneficiary, services shall be initiated within 10 business days of the CONTRACTOR'S receipt of the request. CONTRACTOR shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop regarding waiting times and appointments. CONTRACTOR shall also have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the provider offers services to non-Medi-Cal beneficiaries [State-COUNTY Agreement, Exhibit A, Attachment I, Part V; State-COUNTY Intergovernmental Agreement, Exhibit A, Attachment I]

1.8 CONTRACTORS that are Drug/Medi-Cal certified shall also comply with the applicable 42 CFR 438 Managed Care requirements, including, but not limited to the following [State-COUNTY Intergovernmental Agreement, Exhibit A, Attachment I]:

1.8.1 Culturally Competent Services: CONTRACTORS are responsible for providing culturally competent services. CONTRACTORS must ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations. Translation and oral interpreter services must be available for beneficiaries, as needed and at no cost to the beneficiary.

1.8.2 Medication Assisted Treatment: CONTRACTORS will have procedures for linkage/integration for beneficiaries requiring medication assisted treatment. CONTRACTOR staff will regularly communicate with physicians of beneficiaries who are prescribed these medications unless the beneficiary refuses to consent to a 42 CFR, Part 2 compliant release of information for this purpose.

1.8.3 Evidence-Based Practices (EBPs): CONTRACTORS will implement at least two of the following EBPs per service modality: Motivational Interviewing, Cognitive-Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment and Psychoeducation.

1.8.4 Beneficiary Informational Materials: CONTRACTOR shall make available at initial contact and shall notify beneficiaries of their right to request and obtain the following information at least once a year and thereafter upon request: DMC-ODS Beneficiary Booklet and Provider Directory. CONTRACTOR shall also post notices explaining grievance, appeal, and expedited appeal processes in all program sites, as well as make available forms and self-addressed envelopes to file grievances, appeals and expedited appeals without having to make a verbal or written request to anyone. The COUNTY will produce required beneficiary informational materials in English and Spanish. CONTRACTOR shall request materials from the COUNTY, as needed.

1.8.5 Notice of Adverse Benefit Determination (NOABD): CONTRACTOR shall immediately notify BHRS of any action that may require a NOABD be issued to a beneficiary, including, but not limited to failing to provide the beneficiary with an initial face-to-face assessment appointment within 10 business days of the request; or determining that a beneficiary does not meet medical necessity for any substance use disorder treatment services.

1.8.6 Verifying Medi-Cal Eligibility: CONTRACTOR shall verify the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for Drug/Medi-Cal 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's DMC Provider Billing Manual. [State-COUNTY Intergovernmental Agreement, Exhibit A, Attachment I]



1.8.7 American Society of Addiction Medicine (ASAM) Criteria: CONTRACTOR shall be trained in the ASAM Criteria prior to providing services. At a minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care". [State-COUNTY Intergovernmental Agreement, Exhibit A, Attachment I]

1.9 No Unlawful Use or Unlawful Use Messages Regarding Drugs: CONTRACTOR agrees that information produced through these funds, and which pertains to drugs and alcohol - related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug or alcohol - related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (HSC Section 11999-11999.3). By signing this Agreement, CONTRACTOR agrees that it will enforce, and will require its Sub-CONTRACTORS to enforce, these requirements. [State COUNTY Agreement, Exhibit A, Attachment I, Part I]

1.10 Restriction on Distribution of Sterile Needles: No Substance Abuse Prevention and Treatment (SAPT) Block Grant funds made available through this Agreement shall be used to carry out any program that includes the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug unless the State chooses to implement a demonstration syringe services program for injecting drug users. [State COUNTY Agreement, Exhibit A, Attachment I, Part I]

1.11 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). [State-COUNTY Agreement, Exhibit A, Attachment I]

## **2. Program Evaluation**

2.1 CONTRACTOR shall maintain books, records, files, documents, and evidence directly pertinent to work under this Agreement in sufficient detail to make possible an evaluation of services provided and compliance with DHCS regulations, as applicable, and in accordance with accepted professional practice and accounting procedures for a minimum of five (5) years after the termination of the Agreement. CONTRACTOR agrees to extend to DHCS and to the COUNTY and their designees the right to review and investigate records, programs, and procedures, as well as overall operation of CONTRACTOR'S program with reasonable notice.

2.2 Formal evaluation of the program shall be made annually through a Provider Self-Audit and on-site visit. This evaluation shall result in a written report to the CONTRACTOR within fifteen (15) working days of the site visit. Any report that results from a site visit shall be submitted to the CONTRACTOR within fifteen (15) working days. CONTRACTOR shall submit a written response within the timeframe outlined in the site visit report, and such response shall be part of the official written report provided for in this section.

2.3 CONTRACTOR shall meet the requirements of and participate in the management information system of BHRS, and maintain fiscal, administrative, and programmatic records and such other data as may be required by the COUNTY Alcohol and Drug Administrator for program and research requirements.

2.4 CONTRACTOR shall notify the COUNTY Alcohol and Drug Administrator within two business days of receipt of any DHCS report identifying non-compliance services or processes requiring a Corrective Action Plan (CAP). CONTRACTOR shall submit the CAP to DHCS with the designated timeframe specified by DHCS and shall concurrently send a copy to the COUNTY Alcohol and Drug Administrator.

## **3. Records**

3.1 CONTRACTOR and the COUNTY mutually agree to maintain the confidentiality of CONTRACTOR'S participant records, including billings, pursuant to Sections 11812(c) and 11879, Health & Safety Code and Federal Regulations for Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2, dated June 9, 1987), the Federal Health Insurance Portability and Accountability Act (HIPAA) and all other applicable State and Federal laws and any amendments. CONTRACTOR shall inform all its officers, employees, and agents of the confidentiality provisions of said regulations, and provide all necessary

policies and procedures and training to ensure compliance. CONTRACTOR shall ensure staff participate in information privacy and security training at least annually, and prior to accessing PHI or PI, sign a confidentiality statement that includes, at a minimum, General use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The statement must be renewed annually and shall be retained for a period of six (6) years following termination of this Agreement. [State-COUNTY Agreement, Exhibit F, Attachment I]

3.2 Where Agreements exceed \$10,000 of state funding – the CONTRACTOR shall be subject to examination and audit of the Department of Auditor General for a period of three (3) years after final payment under Agreement (Government Code § 8546.7).

3.3 CONTRACTOR shall allow DHCS, US HHS, the Comptroller General of the US and other authorized federal and state agencies, or their duly authorized representatives to inspect books, records and facilities, as permitted by law.

3.4 The CONTRACTOR, if applicable, shall maintain medical records required by Title 22 of the California Code of Regulations, and other records showing a Medi-Cal beneficiary's eligibility for services, the service(s) rendered, the Medi-Cal beneficiary to whom the service was rendered, the date of the services, the medical necessity of the service and the quality of care provided. Records shall be maintained in accordance with Title 22 California Code of Regulations.

3.5 CONTRACTOR is responsible for the repayment of all exceptions and disallowances taken by local, State and Federal agencies, related to activities conducted by CONTRACTOR under the Agreement. Where unallowable costs have been claimed and reimbursed, they will be refunded to COUNTY. When a financial audit is conducted by the Federal Government, the State, or the California State Auditor directly with CONTRACTOR, and if the CONTRACTOR disagrees with audit disallowances related to its programs, claims or services, COUNTY shall, at the CONTRACTOR'S request, request an appeal to the State via the COUNTY. [State-COUNTY Intergovernmental Agreement, Exhibit B]

3.6 Financial records shall be kept so that they clearly reflect the source of funding for each type of service for which reimbursement is claimed. These documents include, but are not limited to, all ledgers, books, vouchers, time sheets, payrolls, appointment schedules, client data cards, and schedules for allocating costs. Fiscal records shall contain sufficient data to enable auditors to perform a complete audit and shall be maintained in conformance with the procedures and accounting principles set forth in the State Department of Health Care Services' Cost Reporting/Data Collection Systems.

#### **4. Unusual Occurrence and Incident Reporting**

4.1 CONTRACTOR shall report unusual occurrences to the COUNTY of Tulare Substance Use Services' Program Manager or designee. An unusual occurrence is any event which jeopardizes the health and/or safety of clients, staff and/or members of the community, including but not limited to physical injury and death.

4.2 Unusual occurrences are to be reported to the COUNTY within five (5) calendar days of the event or as soon as possible after becoming aware of the unusual event. Reports are to include the following elements:

- 4.2.1 Complete written description of event including outcome;
- 4.2.2 Written report of CONTRACTOR'S investigation and conclusions;
- 4.2.3 List of persons directly involved and/or with direct knowledge of the event.

4.3 The COUNTY and DHCS retain the right to independently investigate unusual occurrences and CONTRACTOR will cooperate in the conduct of such independent investigations.

4.4 Residential substance use treatment facilities licensed by DHCS shall also comply with reporting unusual incidents as outlined in Title 9 CCR, Chapter 5, Subchapter 3, Article 1. CONTRACTOR shall notify the COUNTY Alcohol and Drug Administrator concurrently, which is a telephonic report within one (1) working day of the event, followed by a copy of the written report submitted to DHCS within seven (7) days of the event.

**5. Applicable Fee(s)**

5.1 CONTRACTOR shall charge participant fees. No one shall be denied services based solely on ability or inability to pay.

5.2 CONTRACTOR shall perform eligibility and financial determinations in accordance with a fee schedule approved by the Chief of Alcohol and Drug Programs for this purpose. Individual income, expenses, and number of dependents shall be considered in formulating the fee schedule and in its utilization.

5.3 CONTRACTOR agrees to have on file with the COUNTY a schedule of CONTRACTOR'S published charges, if applicable.

5.4 CONTRACTOR shall conduct community-centered fundraising activities, as appropriate.

**6. Non-Discrimination**

6.1 CONTRACTOR shall develop and implement policies and procedures that ensure: non-discrimination in the provision of services based on a diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Complex (ARC), or upon testing positive for Human Immunodeficiency Virus (HIV); the prohibition of the use of HIV antibody testing as a screening criterion for program participation; training of all staff and all participants regarding high-risk behaviors, safer sex practices, and perinatal transmission of HIV infection ; and development of procedures for addressing the special needs and problems of those individuals who test positive for antibodies to HIV. No individual shall be required to disclose his or her HIV status.

6.2 The CONTRACTOR and/or any permitted Sub-CONTRACTOR shall not discriminate in the provision of services because of race, color, religion, national origin, sex, sexual orientation, age or mental or physical handicap as provided by State and Federal law. For the purpose of this Agreement, distinctions on the grounds of race, color, religion, national origin, age or mental or physical handicap include but are not limited to the following: denying a Medi-Cal beneficiary any service or benefit which is different, or is provided in a different way manner or at a different time from that provided to other beneficiaries under this Agreement; subjecting a beneficiary to segregation or separate treatment in any matter related to receipt of any service; restricting a beneficiary in any way in the enjoyment, advantage or privilege enjoyed by others receiving ant service or benefit; treating a beneficiary differently from others in determining whether the beneficiary satisfied any admission, eligibility, other requirement or condition which individuals must meet in order to be provided any benefit; the assignment of times or places for the provision of services on a basis of the race, color, religion, national origin, sexual orientation, age or mental or physical handicap of the beneficiaries to be served.

6.3 The CONTRACTOR shall take affirmative action to ensure that services to intended Medi-Cal beneficiaries are provided without regard to race, color, religion, national origin, sex, sexual orientation, age or mental or physical handicap.

**7. Required Program Submissions**

7.1 CONTRACTOR agrees to maintain, and provide to COUNTY upon request, job descriptions, including minimum qualifications for employment and duties performed, for all personnel whose salaries, wages, and benefits are reimbursable in whole or in part under this Agreement.

7.2 CONTRACTOR agrees to maintain, and to provide to COUNTY upon request, an organizational chart that reflects the CONTRACTOR'S current operating structure.

7.3 CONTRACTOR shall maintain, and provide to COUNTY upon request, the complaint procedure to be utilized in the event that there is a complaint regarding services provided under this Agreement. CONTRACTOR shall ensure that recipients of service under this Agreement have access to and are informed of CONTRACTOR'S complaint procedure.

7.4 Upon CONTRACTOR'S completion of services under this Agreement to COUNTY'S satisfaction, payment to CONTRACTOR shall be made monthly in accordance with the procedures set forth in Exhibit B. All billings and reports shall clearly reflect and in reasonable detail give information regarding the services for which the claim is being made. It is understood and agreed that COUNTY may withhold payment until receipt of billings and reports in the prescribed detail and format. Billings and reports shall be made and forwarded to COUNTY of Tulare Health & Human Services Division of BHRS promptly at the end of each calendar month; no later than the 10<sup>th</sup> day of the month following the month in which the services, for which billing is made, were rendered. Payments received after that date may result in a delay in payment until the next monthly billing cycle. The payment for the month of September may be withheld pending receipt of the preceding year's Cost Report on continuing services Agreements.

7.5 CONTRACTOR shall provide COUNTY with an annual Cost Report no later than sixty (60) days after the termination of this agreement. In addition to the annual Cost Report, CONTRACTOR shall furnish COUNTY, within one hundred and eighty (180) days of close of CONTRACTOR fiscal year, a certified copy of an Audit Report from an independent CPA firm. This Audit Report shall cover CONTRACTOR'S fiscal year which most nearly coincides with COUNTY'S fiscal year. CONTRACTORS receiving federal funds shall comply with Office of Management and Budget (OMB) Circular Number A-133, Uniform administrative Requirements for Grants and Other Agreements with Institutions of Higher Education, Hospitals, and other Nonprofit Organizations. Cost Report settlements shall be made when a proper Cost Report has been submitted to the COUNTY. The findings of the annual Cost Report shall be subject to an audit by COUNTY and State. The State of California may make such audits as it deems necessary for the purpose of determining reimbursement due to the COUNTY.

7.6 CONTRACTOR will have an MOU in place with all approved Sub-CONTRACTORS that defines the services to be provided by the Sub-CONTRACTORS and is consistent with and fully reflects the services and conditions described in this Agreement. Such MOUs will be made available to COUNTY within a reasonable time upon request.

7.7 CONTRACTOR will report all data and outcomes, such as CalOMS and DATAR, as required by state or COUNTY and as required by the State-COUNTY Agreement.

#### **8. CONTRACTOR'S Compliance with Provisions of State Agreement**

8.1 The COUNTY receives funding from DHCS pursuant to an annual CONTRACTING arrangement (hereinafter "State Agreement"). The State Agreement contains certain requirements pertaining to the privacy and security of personally identifiable information (hereinafter "PII") and/or protected health information (hereinafter "PHI") and requires that COUNTY CONTRACTUALLY obligate any of its Sub-CONTRACTORS to also comply with these requirements. CONTRACTOR hereby agrees to be bound by, and comply with, any and all terms and conditions of the State Agreement pertaining to the privacy and/or security of PII and/or PHI, a hard copy of which COUNTY will provide to the CONTRACTOR upon request, and an electronic copy of which can be found on the DHCS website at <http://www.dhcs.ca.gov/Pages/DMC-ODS-Executed-Agreements.aspx>.

8.2 Additionally, in the event the State Agreement requires the COUNTY to notify the State of a breach of privacy and/or security of PII and/or PHI, CONTRACTOR shall, immediately upon discovery of a breach of privacy and/or security of PII and/or PHI by CONTRACTOR, notify COUNTY of such breach by telephone and email or facsimile to the following contact: Privacy Officer – Ph: (559) 624-7465, e-mail: [privacyofficer@tularehhsa.org](mailto:privacyofficer@tularehhsa.org). CONTRACTOR further agrees that it shall notify COUNTY of any such breaches prior to the time the COUNTY is required to notify the State pursuant to the State CONTRACT.

8.3 In the event the State Agreement requires the COUNTY to pay any costs associated with a breach of privacy and/or security of PII and/or PHI, including but not limited to the costs of notification, CONTRACTOR shall pay on COUNTY'S behalf any and all such costs arising out of a breach of privacy and/or security of PII and/or PHI by CONTRACTOR.

#### **9. Electronic Signature**

If CONTRACTOR uses electronic medical records, the CONTRACTOR agrees to use a system that is consistent with DHCS requirements.

If CONTRACTOR uses electronic medical records, the CONTRACTOR agrees to submit staff updates, including changes in roles or new or separated staff, to the Electronic Health Record system administrator within the timeframes outlined in the HHSA Policy 30-02 Electronic Health Record (EHR) Privacy and Security. The notification shall include submission of the EHR Electronic Signature Agreement and EHR User Request/Change Form, as applicable. If a user suspects that their electronic signature may be comprised, CONTRACTOR shall notify the EHR system administrator within the timeframes outlined in the HHSA Policy.

**10. Compliance with Anti-Kickback Statute**

CONTRACTOR shall comply with the provisions of the “Anti-Kickback Statute” (42 U.S.C. § 1320a-7b) as they pertain to Federal healthcare programs.

**11. Davis-Bacon Act**

CONTRACTOR must comply with the provisions of the Davis-Bacon Act, as amended (40 U.S.C. § 3141 et seq.). When required by Federal Medicaid Program legislation, all Agreements awarded by the CONTRACTOR and its Sub-CONTRACTORS of more than \$2,000 must include a provision for compliance with the Davis-Bacon Act (40 U.S.C. § 3141 et seq.) as supplemented by Department of Labor regulations (Title 29, CFR Part 5, “Labor Standards Provisions Applicable to Agreements Governing Federally Financed and Assisted Construction”).

**12. Conditions for Federal Financial Participation**

12.1 CONTRACTOR shall meet all conditions for Federal Financial Participation, consistent with 42 CFR 438.802, 42 CFR 438.804, 42 CFR 438.806, 42 CFR 438.808, 42 CFR 438.810, 42 CFR 438.812.

12.2 Pursuant to 42 CFR 438.808, Federal Financial Participation (FFP) is not available to the CONTRACTOR if the CONTRACTOR:

12.2.1 Is an entity that could be excluded under section 1128(b)(8) as being controlled by a sanctioned individual;

12.2.2 Is an entity that has a substantial CONTRACTUAL relationship as defined in section 431.55(h)(3), either directly or indirectly, with an individual convicted of certain crimes described in section 1128(8)(B); or

12.2.3 Is an entity that employs or Agreements, directly or indirectly, for the furnishing of health care utilization review, medical social work, or administrative services, with one of the following:

- i. Any individual or entity excluded from participation in federal health care programs under section 1128 or section 1126A; or
- ii. An entity that would provide those services through an excluded individual or entity.

**13. Certification of Non-Exclusion or Suspension from Participation in Federal Health Care Program**

13.1 Federal and State Excluded, Suspension and Debarment List: The COUNTY and the CONTRACTOR shall comply with the provisions of Title 42 § 438.610 and Executive Orders 12549 and 12689, “Debarment and Suspension,” which excludes parties listed on the General Services Administration (GSA) list of parties excluded from federal procurement or non-procurement programs from having a relationship with the COUNTY or CONTRACTOR.

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

13.3 CONTRACTOR shall certify, prior to the execution of the Agreement, that the CONTRACTOR does not employ staff or Sub-CONTRACTORS who are excluded from participation in

federally funded health care programs. CONTRACTOR shall conduct initial and monthly Exclusion & Suspension searches of the following databases and provide evidence of these completed searches when requested by COUNTY, CA Department of Health Care Services or the US Department of Health & Human Services.

13.3.1 [www.oig.hhs.gov/exclusions](http://www.oig.hhs.gov/exclusions) - LEIE Federal Exclusions

13.3.2 [www.sam.gov/portal/SAM](http://www.sam.gov/portal/SAM) - GSA Exclusions Extract

13.3.3 [www.Medi-Cal.ca.gov](http://www.Medi-Cal.ca.gov) – Suspended & Ineligible Provider List

13.4 CONTRACTOR shall certify, prior to the execution of the Agreement that the CONTRACTOR does not employ staff or Sub-CONTRACTORS that are on the Social Security Administration's Death Master File. CONTRACTOR shall check the following database prior to employing staff or Sub-CONTRACTORS and provide evidence of these completed searches when requested by COUNTY, CA Department of Health Care Services, or the US Department of Health & Human Services.

13.4.1 <https://www.ssdmf.com/> - Social Security Death Master File

13.5 CONTRACTOR is required to notify COUNTY immediately if they become aware of any information that may indicate their (including employees and Sub-CONTRACTORS) potential placement on an exclusions list.

#### **14. License Verification**

CONTRACTOR shall ensure that all staff and Sub-CONTRACTORS providing services will have all necessary and valid professional certification(s) or license(s) to practice the CONTRACTED services. This includes implementing procedures of professional license checks, credentialing and re-credentialing, monitoring limitations and expiration of licenses, and ensuring that all providers have a current National Provider Identifier (NPI) through the National Plan and Provider Enumeration System (NPPES). CONTRACTOR shall provide evidence of these completed verifications when requested by COUNTY, DHCS or the US Department of Health & Human Services.

## EXHIBIT C

### **PROFESSIONAL SERVICES CONTRACTS** **INSURANCE REQUIREMENTS**

CONTRACTOR shall provide and maintain insurance for the duration of this Agreement against claims for injuries to persons and damage to property which may arise from, or in connection with, performance under the Agreement by the CONTRACTOR, his agents, representatives, employees and subcontractors, if applicable.

#### A. Minimum Scope & Limits of Insurance

1. Coverage at least as broad as Commercial General Liability, insurance Services Office Commercial General Liability coverage occurrence form GC 00 01, with limits no less than \$1,000,000 per occurrence including products and completed operations, property damage, bodily injury and personal & advertising injury. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location (ISO CG 25 03 or 25 04) or the general aggregate limit shall be twice the required occurrence limit.
2. Insurance Services Office Form Number CA 00 01 covering Automobile Liability of \$1,000,000 per occurrence including any auto or, if the CONTRACTOR has no owned autos, hired and non-owned auto coverage. If an annual aggregate applies it must be no less than \$2,000,000.
3. Workers' Compensation insurance as required by the State of California, with Statutory Limits, and Employer's Liability Insurance with limit of no less than \$1,000,000 per accident for bodily injury or disease.
4. Professional Liability (Errors and Omissions) insurance appropriate to the CONTRACTOR's profession, with limit no less than \$1,000,000 per occurrence or claim, \$2,000,000 aggregate.

#### B. Specific Provisions of the Certificate

1. If the required insurance is written on a claims made form, the retroactive date must be before the date of the contract or the beginning of the contract work and must be maintained and evidence of insurance must be provided for at least three (3) years after completion of the contract work.
2. CONTRACTOR must submit endorsements to the General Liability reflecting the following provisions:
  - a. *The COUNTY, its officers, agents, officials, employees and volunteers are to be covered as additional insureds as respects; liability arising out of work or operations performed by or on behalf of the CONTRACTOR including material, parts, or equipment furnished in connection with such work or operations.*
  - b. *For any claims related to this project, the CONTRACTOR's insurance coverage shall be primary insurance as respects the COUNTY, its officers, agents, officials, employees and volunteers. Any insurance or self-insurance maintained by the COUNTY, its officers, agents, officials, employees or volunteers shall be excess of the CONTRACTOR's insurance and shall not contribute with it.*
  - c. *CONTRACTOR hereby grants to COUNTY a waiver of any right to subrogation which any insurer of CONTRACTOR may acquire against the county by virtue of the payment of any loss under such insurance. CONTRACTOR agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the COUNTY has received a waiver of subrogation endorsement from the insurer.*



*d. Each insurance policy required by this agreement shall be endorsed to state that coverage shall not be canceled, except after written notice has been provided to the COUNTY.*

3. The Workers' Compensation policy shall be endorsed with a waiver of subrogation in favor of the COUNTY for all work performed by the CONTRACTOR, its employees, agents and subcontractors. CONTRACTOR waives all rights against the COUNTY and its officers, agents, officials, employees and volunteers for recovery of damages to the extent these damages are covered by the workers compensation and employers liability.

C. Deductibles and Self-Insured Retentions

Deductibles and Self-insured retentions must be declared and any deductible or self-insured retention that exceeds \$100,000 will be reviewed by the COUNTY Risk Manager for approval.

D. Acceptability of Insurance

Insurance must be placed with insurers with a current rating given by A.M. Best and Company of no less than A-:VII and a Standard & Poor's Rating (if rated) of at least BBB and from a company approved by the Department of Insurance to conduct business in California. Any waiver of these standards is subject to approval by the County Risk Manager.

E. Verification of Coverage

Prior to approval of this Agreement by the COUNTY, the CONTRACTOR shall file with the submitting department, certificates of insurance with original endorsements effecting coverage in a form acceptable to the COUNTY. Endorsements must be signed by persons authorized to bind coverage on behalf of the insurer. The COUNTY reserves the right to require certified copies of all required insurance policies at any time.

WAIVERS:

I represent and attest that I am a person authorized to make representations on behalf of the CONTRACTOR, and represent the following:

(mark X if applicable)

☐ Automobile Exemption: I certify that <sup>0</sup>\_\_\_\_\_ does not own nor use vehicles in the performance of the agreement for which this insurance requirement is attached.

☐ Workers' Compensation Exemption: I certify that <sup>0</sup>\_\_\_\_\_ is not required to carry workers' compensation coverage or has filed an exemption with the State of California as required by law.

I acknowledge and represent that we have met the insurance requirements listed above.

Print Name Judy A. Silicato Date: 7/30/2024

Contractor Name CENTRAL VALLEY RECOVERY SERVICES

Signature Judy A. Silicato  
C07B8B27685A4CE...