Agreement No._____

AGREEMENT BETWEEN THE COUNTY OF SAN MATEO

AND HORIZON SERVICES, INC.

This Agreement is entered into this _____ day of _____ , 2025, by and between the County of San Mateo, a political subdivision of the state of California, hereinafter called "County," and Horizon Services, Inc., hereinafter called "Contractor."

* * *

Whereas, pursuant to Section 31000 of the California Government Code, County may contract with independent contractors for the furnishing of such services to or for County or any Department thereof; and

Whereas, it is necessary and desirable that Contractor be retained for the purpose of professional services.

Now, therefore, it is agreed by the parties to this Agreement as follows:

1. Exhibits and Attachments

The following exhibits and attachments are attached to this Agreement and incorporated into this Agreement by this reference:

Exhibit A—Services
Exhibit B—Payments and Rates
Exhibit C—CalAIM – Contractor Outpatient Rates
Exhibit D—San Mateo County Preliminary Fee-for-Service Rate Schedule 24-hour SUD Services
Attachment I—§ 504 Compliance
Attachment L—DHCS Legal and Regulatory Requirements

2. Services to be performed by Contractor

In consideration of the payments set forth in this Agreement and in Exhibit B, Contractor shall perform services for County in accordance with the terms, conditions, and specifications set forth in this Agreement and in Exhibit A.

3. Payments

In consideration of the services provided by Contractor in accordance with all terms, conditions, and specifications set forth in this Agreement and in Exhibit A, County shall make payment to Contractor based on the rates and in the manner specified in Exhibit B. County reserves the right to withhold payment if County determines that the quantity or quality of the work performed

is unacceptable. In no event shall County's total fiscal obligation under this Agreement exceed **EIGHT MILLION FOUR HUNDRED THIRTY EIGHT THOUSAND SEVENTY EIGHT DOLLARS ($8,438,078).** In the event that the County makes any advance payments, Contractor agrees to refund any amounts in excess of the amount owed by the County at the time of contract termination or expiration. Contractor is not entitled to payment for work not performed as required by this agreement.

4. Term

Subject to compliance with all terms and conditions, the term of this Agreement shall be from June 1, 2025, through June 30, 2027.

5. Termination

This Agreement may be terminated by Contractor or by the Chief of San Mateo County Health or his/her designee at any time without a requirement of good cause upon thirty (30) days' advance written notice to the other party. Subject to availability of funding, Contractor shall be entitled to receive payment for work/services provided prior to termination of the Agreement. Such payment shall be that prorated portion of the full payment determined by comparing the work/services actually completed to the work/services required by the Agreement.

County may terminate this Agreement or a portion of the services referenced in the Attachments and Exhibits based upon the unavailability of Federal, State, or County funds by providing written notice to Contractor as soon as is reasonably possible after County learns of said unavailability of outside funding.

County may terminate this Agreement for cause. In order to terminate for cause, County must first give Contractor notice of the alleged breach. Contractor shall have five business days after receipt of such notice to respond and a total of ten calendar days after receipt of such notice to cure the alleged breach. If Contractor fails to cure the breach within this period, County may immediately terminate this Agreement without further action. The option available in this paragraph is separate from the ability to terminate without cause with appropriate notice described above. In the event that County provides notice of an alleged breach pursuant to this section, County may, in extreme circumstances, immediately suspend performance of services and payment under this Agreement pending the resolution of the process described in this paragraph. County has sole discretion to determine what constitutes an extreme circumstance for purposes of this paragraph, and County shall use reasonable judgment in making that determination.

6. Contract Materials

At the end of this Agreement, or in the event of termination, all finished or unfinished documents, data, studies, maps, photographs, reports, and other written materials (collectively referred to as "contract materials") prepared by Contractor under this Agreement shall become the property of County and shall be promptly delivered to County. Upon termination, Contractor may make and retain a copy of such contract materials if permitted by law.

7. Relationship of Parties

Contractor agrees and understands that the work/services performed under this Agreement are performed as an independent contractor and not as an employee of County and that neither Contractor nor its employees acquire any of the rights, privileges, powers, or advantages of County employees.

8. Hold Harmless

a. General Hold Harmless

Contractor shall indemnify and save harmless County and its officers, agents, employees, and servants from all claims, suits, or actions of every name, kind, and description resulting from this Agreement, the performance of any work or services required of Contractor under this Agreement, or payments made pursuant to this Agreement brought for, or on account of, any of the following:

(A) injuries to or death of any person, including Contractor or its employees/officers/agents;

(B) damage to any property of any kind whatsoever and to whomsoever belonging;

(C) any sanctions, penalties, or claims of damages resulting from Contractor's failure to comply, if applicable, with the requirements set forth in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all Federal regulations promulgated thereunder, as amended; or

(D) any other loss or cost, including but not limited to that caused by the concurrent active or passive negligence of County and/or its officers, agents, employees, or servants. However, Contractor's duty to indemnify and save harmless under this Section shall not apply to injuries or damage for which County has been found in a court of competent jurisdiction to be solely liable by reason of its own negligence or willful misconduct.

The duty of Contractor to indemnify and save harmless as set forth by this Section shall include the duty to defend as set forth in Section 2778 of the California Civil Code.

b. Intellectual Property Indemnification

Contractor hereby certifies that it owns, controls, and/or licenses and retains all right, title, and/or interest in and to any intellectual property it uses in relation to this Agreement, including the design, look, feel, features, source code, content, and/or other technology relating to any part of the services it provides under this Agreement and including all related patents, inventions, trademarks, and copyrights, all applications therefor, and all trade names, service marks, know how, and trade secrets (collectively referred to as "IP Rights") except as otherwise noted by this Agreement.

Contractor warrants that the services it provides under this Agreement do not infringe, violate, trespass, or constitute the unauthorized use or misappropriation of any IP Rights of any third party. Contractor shall defend, indemnify, and hold harmless County from and against all liabilities, costs, damages, losses, and expenses (including reasonable attorney fees) arising out of or related to any claim by a third party that the services provided under this Agreement infringe or violate any third-party's IP Rights provided any such right is enforceable in the United States. Contractor's duty to defend, indemnify, and hold harmless under this Section applies only provided that: (a) County notifies Contractor promptly in writing of any notice of any such third-party claim; (b) County cooperates with Contractor, at Contractor's expense, in all reasonable respects in connection with the investigation and defense of any such third-party claim; (c) Contractor retains sole control of the defense of any action on any such claim and all negotiations for its settlement or compromise (provided Contractor shall not have the right to settle any criminal action, suit, or proceeding without County's prior written consent, not to be unreasonably withheld, and provided further that any settlement permitted under this Section shall not impose any financial or other obligation on County, impair any right of County, or contain any stipulation, admission, or acknowledgement of wrongdoing on the part of County without County's prior written consent, not to be unreasonably withheld); and (d) should services under this Agreement become, or in Contractor's opinion be likely to become, the subject of such a claim, or in the event such a third party claim or threatened claim causes County's reasonable use of the services under this Agreement to be seriously endangered or disrupted, Contractor shall, at Contractor's option and expense, either: (i) procure for County the right to continue using the services without infringement or (ii) replace or modify the services so that they become non-infringing but remain functionally equivalent.

Notwithstanding anything in this Section to the contrary, Contractor will have no obligation or liability to County under this Section to the extent any otherwise covered claim is based upon: (a) any aspects of the services under this Agreement which have been modified by or for County (other than modification performed by, or at the direction of, Contractor) in such a way as to cause the alleged infringement at issue; and/or (b) any aspects of the services under this Agreement which have been used by County in a manner prohibited by this Agreement.

The duty of Contractor to indemnify and save harmless as set forth by this Section shall include the duty to defend as set forth in Section 2778 of the California Civil Code.

9. Assignability and Subcontracting

Contractor shall not assign this Agreement or any portion of it to a third party or subcontract with a third party to provide services required by Contractor under this Agreement without the prior written consent of County. Any such assignment or subcontract without County's prior written consent shall give County the right to automatically and immediately terminate this Agreement without penalty or advance notice.

10. Insurance

a. General Requirements

Contractor shall not commence work or be required to commence work under this Agreement unless and until all insurance required under this Section has been obtained and such insurance has been approved by County's Risk Management, and Contractor shall use diligence to obtain such insurance and to obtain such approval. Contractor shall furnish County with certificates of insurance evidencing the required coverage, and there shall be a specific contractual liability endorsement extending Contractor's coverage to include the contractual liability assumed by Contractor pursuant to this Agreement. These certificates shall specify or be endorsed to provide that thirty (30) days' notice must be given, in writing, to County of any pending change in the limits of liability or of any cancellation or modification of the policy.

b. Workers' Compensation and Employer's Liability Insurance

Contractor shall have in effect during the entire term of this Agreement workers' compensation and employer's liability insurance providing full statutory coverage. In signing this Agreement, Contractor certifies, as required by Section 1861 of the California Labor Code, that (a) it is aware of the provisions of Section 3700 of the California Labor Code, which require every employer to be insured against liability for workers' compensation or to undertake self-insurance in accordance with the provisions of the Labor Code, and (b) it will comply with such provisions before commencing the performance of work under this Agreement.

c. Liability Insurance

Contractor shall take out and maintain during the term of this Agreement such bodily injury liability and property damage liability insurance as shall protect Contractor and all of its employees/officers/agents while performing work covered by this Agreement from any and all claims for damages for bodily injury, including accidental death, as well as any and all claims for property damage which may arise from Contractor's operations under this Agreement, whether such operations be by Contractor, any subcontractor, anyone directly or indirectly employed by either of them, or an agent of either of them. Such insurance shall be combined single limit bodily injury and property damage for each occurrence and shall not be less than the amounts specified below:

(a) Comprehensive General Liability……$1,000,000

(b) Motor Vehicle Liability Insurance……$1,000,000

(c) Professional Liability……$1,000,000

County and its officers, agents, employees, and servants shall be named as additional insured on any such policies of insurance, which shall also contain a provision that (a) the insurance afforded thereby to County and its officers, agents, employees, and servants shall be primary insurance to the full limits of liability of the policy and (b) if the County or its officers, agents, employees, and servants have other insurance against the loss covered by such a policy, such other insurance shall be excess insurance only.

In the event of the breach of any provision of this Section, or in the event any notice is received which indicates any required insurance coverage will be diminished or canceled, County, at its option, may, notwithstanding any other provision of this Agreement to the contrary, immediately declare a material breach of this Agreement and suspend all further work and payment pursuant to this Agreement.

11. Compliance With Laws

All services to be performed by Contractor pursuant to this Agreement shall be performed in accordance with all applicable Federal, State, County, and municipal laws, ordinances, regulations, and executive orders, including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Federal Regulations promulgated thereunder, as amended (if applicable), the Business Associate requirements set forth in Attachment H (if attached), the Americans with Disabilities Act of 1990, as amended, and Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination on the basis of disability in programs and activities receiving any Federal or County financial assistance, as well as any required economic or other sanctions imposed by the United States government or under state law in effect during the term of the Agreement. Such services shall also be performed in accordance with all applicable ordinances and regulations, including but not limited to appropriate licensure, certification regulations, provisions pertaining to confidentiality of records, and applicable quality assurance regulations. In the event of a conflict between the terms of this Agreement and any applicable State, Federal, County, or municipal law, regulation, or executive order, the requirements of the applicable law, regulation, or executive order will take precedence over the requirements set forth in this Agreement.

Further, Contractor certifies that it and all of its subcontractors will adhere to all applicable provisions of Chapter 4.107 of the San Mateo County Ordinance Code, which regulates the use of disposable food service ware. Accordingly, Contractor shall not use any non-recyclable plastic disposable food service ware when providing prepared food on property owned or leased by the County and instead shall use biodegradable, compostable, reusable, or recyclable plastic food service ware on property owned or leased by the County. (This paragraph may be deleted without County Attorney Review if not relevant to this agreement)

Contractor will timely and accurately complete, sign, and submit all necessary documentation of compliance.

12. Non-Discrimination and Other Requirements

a. General Non-discrimination

No person shall be denied any services provided pursuant to this Agreement (except as limited by the scope of services) on the grounds of race, color, national origin, ancestry, age, disability (physical or mental), sex, sexual orientation, gender identity, marital or domestic partner status, religion, political beliefs or affiliation, familial or parental status (including pregnancy), medical condition (cancer-related), military service, or genetic information.

b. Equal Employment Opportunity

Contractor shall ensure equal employment opportunity based on objective standards of recruitment, classification, selection, promotion, compensation, performance evaluation, and management relations for all employees under this Agreement. Contractor's equal employment policies shall be made available to County upon request.

c. Section 504 of the Rehabilitation Act of 1973

Contractor shall comply with Section 504 of the Rehabilitation Act of 1973, as amended, which provides that no otherwise qualified individual with a disability shall, solely by reason of a disability, be excluded from the participation in, be denied the benefits of, or be subjected to discrimination in the performance of any services this Agreement. This Section applies only to contractors who are providing services to members of the public under this Agreement.

d. Compliance with County's Equal Benefits Ordinance

Contractor shall comply with all laws relating to the provision of benefits to its employees and their spouses or domestic partners, including, but not limited to, such laws prohibiting discrimination in the provision of such benefits on the basis that the spouse or domestic partner of the Contractor's employee is of the same or opposite sex as the employee.

e. Discrimination Against Individuals with Disabilities

The nondiscrimination requirements of 41 C.F.R. 60-741.5(a) are incorporated into this Agreement as if fully set forth here, and Contractor and any subcontractor shall abide by the requirements of 41 C.F.R. 60–741.5(a). This regulation prohibits discrimination against qualified individuals on the basis of disability and requires affirmative action by covered prime contractors and subcontractors to employ and advance in employment qualified individuals with disabilities.

f. History of Discrimination

Contractor certifies that no finding of discrimination has been issued in the past 365 days against Contractor by the Equal Employment Opportunity Commission, the California Department of Fair Employment and Housing, or any other investigative entity. If any finding(s) of discrimination have been issued against Contractor within the past 365 days by the Equal Employment Opportunity Commission, the California Department of Fair Employment and Housing, or other investigative entity, Contractor shall provide County with a written explanation of the outcome(s) or remedy for the discrimination prior to execution of this Agreement. Failure to comply with this Section shall constitute a material breach of this Agreement and subjects the Agreement to immediate termination at the sole option of the County.

g. Reporting; Violation of Non-discrimination Provisions

Contractor shall report to the County Executive Officer the filing in any court or with any administrative agency of any complaint or allegation of discrimination on any of the bases prohibited by this Section of the Agreement or the Section titled "Compliance with Laws". Such

duty shall include reporting of the filing of any and all charges with the Equal Employment Opportunity Commission, the California Department of Fair Employment and Housing, or any other entity charged with the investigation or adjudication of allegations covered by this subsection within 30 days of such filing, provided that within such 30 days such entity has not notified Contractor that such charges are dismissed or otherwise unfounded. Such notification shall include a general description of the circumstances involved and a general description of the kind of discrimination alleged (for example, gender-, sexual orientation-, religion-, or race-based discrimination).

Violation of the non-discrimination provisions of this Agreement shall be considered a breach of this Agreement and subject the Contractor to penalties, to be determined by the County Executive Officer, including but not limited to the following:

i. termination of this Agreement;
ii. disqualification of the Contractor from being considered for or being awarded a County contract for a period of up to 3 years;
iii. liquidated damages of $2,500 per violation; and/or
iv. imposition of other appropriate contractual and civil remedies and sanctions, as determined by the County Executive Officer.

To effectuate the provisions of this Section, the County Executive Officer shall have the authority to offset all or any portion of the amount described in this Section against amounts due to Contractor under this Agreement or any other agreement between Contractor and County.

h. Compliance with Living Wage Ordinance

As required by Chapter 2.88 of the San Mateo County Ordinance Code, Contractor certifies all contractor(s) and subcontractor(s) obligated under this contract shall fully comply with the provisions of the County of San Mateo Living Wage Ordinance, including, but not limited to, paying all Covered Employees the current Living Wage and providing notice to all Covered Employees and Subcontractors as required under the Ordinance.

13. Anti-Harassment Clause

Employees of Contractor and County shall not harass (sexually or otherwise) or bully or discriminate against each other's employee on the grounds of race, color, national origin, ancestry, age, disability (physical or mental), sex, sexual orientation, gender identity, marital or domestic partner status, religion, political beliefs or affiliation, familial or parental status (including pregnancy), medical condition (cancer-related), military service, or genetic information. Any misconduct by Contractor's employees towards County employees may be grounds for termination of the Contract. Contractor shall timely address any allegations of their employee's misconduct by a County employee including immediately removing that employee from work on the Contract.

14. Compliance with County Employee Jury Service Ordinance

Contractor shall comply with Chapter 2.85 of the County's Ordinance Code, which states that Contractor shall have and adhere to a written policy providing that its employees, to the extent

they are full-time employees and live in San Mateo County, shall receive from the Contractor, on an annual basis, no fewer than five days of regular pay for jury service in San Mateo County, with jury pay being provided only for each day of actual jury service. The policy may provide that such employees deposit any fees received for such jury service with Contractor or that the Contractor may deduct from an employee's regular pay the fees received for jury service in San Mateo County. By signing this Agreement, Contractor certifies that it has and adheres to a policy consistent with Chapter 2.85. For purposes of this Section, if Contractor has no employees in San Mateo County, it is sufficient for Contractor to provide the following written statement to County: "For purposes of San Mateo County's jury service ordinance, Contractor certifies that it has no full-time employees who live in San Mateo County. To the extent that it hires any such employees during the term of its Agreement with San Mateo County, Contractor shall adopt a policy that complies with Chapter 2.85 of the County's Ordinance Code." The requirements of Chapter 2.85 do not apply unless this Agreement's total value listed in the Section titled "Payments", exceeds two-hundred thousand dollars ($200,000); Contractor acknowledges that Chapter 2.85's requirements will apply if this Agreement is amended such that its total value exceeds that threshold amount.

15. Retention of Records; Right to Monitor and Audit

(a) Contractor shall maintain all required records relating to services provided under this Agreement for three (3) years after County makes final payment and all other pending matters are closed, and Contractor shall be subject to the examination and/or audit by County, a Federal grantor agency, and the State of California.

(b) Contractor shall comply with all program and fiscal reporting requirements set forth by applicable Federal, State, and local agencies and as required by County.

(c) Contractor agrees upon reasonable notice to provide to County, to any Federal or State department having monitoring or review authority, to County's authorized representative, and/or to any of their respective audit agencies access to and the right to examine all records and documents necessary to determine compliance with relevant Federal, State, and local statutes, rules, and regulations, to determine compliance with this Agreement, and to evaluate the quality, appropriateness, and timeliness of services performed.

16. Merger Clause; Amendments

This Agreement, including the Exhibits and Attachments attached to this Agreement and incorporated by reference, constitutes the sole Agreement of the parties to this Agreement and correctly states the rights, duties, and obligations of each party as of this document's date. In the event that any term, condition, provision, requirement, or specification set forth in the body of this Agreement conflicts with or is inconsistent with any term, condition, provision, requirement, or specification in any Exhibit and/or Attachment to this Agreement, the provisions of the body of the Agreement shall prevail. Any prior agreement, promises, negotiations, or representations between the parties not expressly stated in this document are not binding. All subsequent modifications or amendments shall be in writing and signed by the parties.

17. Controlling Law; Venue

The validity of this Agreement and of its terms, the rights and duties of the parties under this Agreement, the interpretation of this Agreement, the performance of this Agreement, and any other dispute of any nature arising out of this Agreement shall be governed by the laws of the State of California without regard to its choice of law or conflict of law rules. Any dispute arising out of this Agreement shall be venued either in the San Mateo County Superior Court or in the United States District Court for the Northern District of California.

18. Notices

Any notice, request, demand, or other communication required or permitted under this Agreement shall be deemed to be properly given when both: (1) transmitted via facsimile to the telephone number listed below or transmitted via email to the email address listed below; and (2) sent to the physical address listed below by either being deposited in the United States mail, postage prepaid, or deposited for overnight delivery, charges prepaid, with an established overnight courier that provides a tracking number showing confirmation of receipt.

In the case of County, to:

Name/Title:	Sheryl Uyan/Health Services Manager
Address:	310 Harbor Blvd., Building E. Belmont, CA 94002
Telephone:	650-802-5016
Email:	suyan@smcgov.org

In the case of Contractor, to:

Name/Title:	Jaime Campos/Executive Director
Address:	P.O. Box 4217 Hayward, CA 94540
Telephone:	510-581-2100
Facsimile:	510-582-1221
Email:	jaime.campos@hsimail.org

19. Electronic Signature

Both County and Contractor wish to permit this Agreement and future documents relating to this Agreement to be digitally signed in accordance with California law and County's Electronic Signature Administrative Memo. Any party to this Agreement may revoke such agreement to permit electronic signatures at any time in relation to all future documents by providing notice pursuant to this Agreement.

20. Payment of Permits/Licenses

Contractor bears responsibility to obtain any license, permit, or approval required from any agency for work/services to be performed under this Agreement at Contractor's own expense prior to commencement of said work/services. Failure to do so will result in forfeit of any right to compensation under this Agreement.

* * *

In witness of and in agreement with this Agreement's terms, the parties, by their duly authorized representatives, affix their respective signatures:

For Contractor: Horizon Services, Inc.

Signed by: Jaime Campos 4A579CCD8E1449C...	3/19/25	Jaime Campos, CEO
Contractor Signature	Date	Contractor Name (please print)

COUNTY OF SAN MATEO

By:

President, Board of Supervisors, San Mateo County

Date:

ATTEST:

By:

Clerk of Said Board

EXHIBIT A – SERVICES
HORIZON SERVICES, INC.
FY 2025-2027

Behavioral Health and Recovery Services (BHRS) provides a continuum of comprehensive services to meet the complex needs of our clients and is designed to promote healthy behavior and lifestyles (a primary driver of positive health outcomes). A full range of high-quality services is necessary to meet the various needs of the diverse population residing in San Mateo County (SMC). As financing, program structure and redesign changes occur, the services within this agreement may fluctuate, be further clarified, or discontinued.

In consideration of the payments set forth in Exhibit B, Contractor shall provide the following services:

I. DESCRIPTION OF SERVICES TO BE PERFORMED BY CONTRACTOR

In providing its services and operations, Contractor shall maintain compliance with requirements listed in the Alcohol and Other Drug (AOD) Policy and Procedure Manual including additions and revisions, incorporated by reference herein and within Behavioral Health and Recovery Services (BHRS) Forms and Policies. As referenced in the Department of Health Care Services (DHCS) Intergovernmental Agreement for substance use disorder (SUD) services, General Definitions and Definitions specific to Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements may be found on DHCS BHIN 24-001. Reimbursement is contingent upon client eligibility, compliance with referral and authorization process and procedures, and documentation requirements as outlined below. All Contractors shall adhere to all requirements found in BHIN 23-068.

Please keep in mind that the State sets the minimum requirements through BHIN's. If the State releases an updated or new version of a BHIN, the County and Contractors shall adhere to any new requirements. Where there is no explicit guidance from the State or the State is silent, the County can impose standards based on the information available with consideration of internal program requirements. This contract is based on the current understanding of the State regulations as well as the County's agreement with the State on what will be provided.

Definitions

AUD	Alcohol Use Disorder
CC	Care Coordination (formerly known as Case Management)
C-Consult	Clinical Consultation
CM-RI	Contingency Management / Recovery Incentives Program

FQHC	Federally Qualified Health Center
IMS	Incidental Medical Services
MAT	Medications for Addiction Treatment
NTP/ OTP	Narcotic Treatment Program / Opioid Treatment Program
PERI	Perinatal Services
OUD	Opioid Use Disorder
PSS	Medi-Cal Peer Support Services
R&B	Room and Board
RR	Recovery Residence
RS	Recovery Services
SLE	Sober Living Environment
SUBG	Substance Use Block Grant
WM	Withdrawal Management (formerly known as Detoxification)

Agency	**ASAM Level of Care**	**Other DMC-ODS Services**	**Other SUD Services**
Horizon Services, Inc.	ASAM 3.2 WM with IMS ASAM 3.5 - pending DHCS licensure approval	CC C-Consult IMS MAT PSS RS	R&B

A. Drug Medi-Cal Organized Delivery System SUD Treatment Services

Contractor shall provide treatment services described herein as part of the SMC Drug Medi-Cal Organized Delivery System (DMC-ODS). Contractor shall work with other ODS providers to ensure a seamless service delivery system to clients needing levels of care not provided by the Contractor. The description of all levels of care and Evidence-based Practices (EBPs) provided by SMC DMC-ODS are contained in the DHCS BHIN 24-001 and adhering to **BHIN 23-058 and BHIN 22-013.**

All program staff providing services to San Mateo County residents shall be certified or registered as defined in Title 9, CCR, Division 4, Chapter 8. SUD programs and facilities shall be licensed or certified by the DHCS Licensing and Certification Division. Contractors not in compliance with these requirements shall be subject to corrective action, up to and including fees, withheld payments, or termination of this Agreement.

Services will include the following:

1. Residential Treatment Services

a. ASAM 3.5

Residential services shall be provided in a DHCS licensed residential facility that is also DMC certified and designated by DHCS or CARF as capable of delivering care consistent with ASAM Level 3.5 treatment criteria.

CONTRACTOR will not be able to provide ASAM Level 3.5 treatment until DHCS licensure and DMC certification is approved.

Residential services shall be authorized in advance. Any services provided without prior authorization shall not be reimbursed.

Residential Treatment Services require a clearly established site for services and in-person contact with a member in order to be claimed. A client receiving Residential Services pursuant to DMC-ODS, regardless of the length of stay, is a "short-term resident" of the residential or inpatient facility in which they are receiving the services.

Each member shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems.

i. Lengths of stay, Treatment Plans, and services offered shall be individualized according to the client's DSM-V diagnosis, medical necessity, and individual needs.

ii. Residential services shall be trauma-informed, co-occurring enhanced and capable of meeting clients' complex needs.

iii. Residential services shall provide services twenty-four (24) hours/seven (7) days per week in a structured treatment support setting to clients, with clinical care and trained counselors, available to clients twenty-four (24) hours a day.

iv. Residential services shall be provided to adults eighteen (18) and over who are at imminent risk as defined by the ASAM criteria.

v. Contractor shall provide at least one (1) of the following treatment services daily in order to bill DMC for a residential SUD treatment day: Assessment, Counseling (individual and group), Family Therapy, Medication Services, Patient Education, SUD Crisis Intervention Services. Contractor shall document the service provided in the client's chart.

Residential treatment day services does not include the following, which shall be documented and billed separately: Care Coordination, Recovery Services, and all MAT for OUD, MAT for AUD and other non-opioid SUDs, and Peer Support Service..

Avatar service codes for each ASAM 3.5 residential service are:

ASAM 3.5 Service	Service Code(s)
ODS 3.5 Residential service day less than or equal to 30 days	AD351ODS
ODS 3.5 PERI Residential service day less than or equal to 30 days	AD351ODSPERI
ODS 3.5 Residential service day greater than or equal to 31 days	AD352ODS

ODS 3.5 Residential service day greater than or equal to 31 days	AD352ODSPERI
ODS 3.5 Care Coordination service, Residential Services	AD3513ODSCM_CA
ODS 3.5 Care Coordination service, Residential Services	AD3513ODSCMPERI_
ODS 3.5 Medication Assisted Treatment	AD35601ODS_CA
ODS 3.5 PERI Medication Assisted Treatment	AD35601ODSPERI_CA
ODS 3.5 MD Clinician Consultation	AD3599367CA
ODS 3.5 Peer Support Prevention Ed Group	AD35H0025CA
ODS 3.5 PERI Peer Support Prevention Ed Group	AD35H0025PERICA
ODS 3.5 Peer Support Self	AD35H0038CA

Help Engage Therapy	
ODS 3.5 PERI Peer Support Self Help Engage Therapy	AD35H0038PERICA
ODS 3.5 Peer Support Prevention Ed Group	AD35H0025CA
ODS 3.5 Peer Support Self Help Engage Therapy	AD35H0038CA
ODS 3.5 PERI Peer Support Self Help Engage Therapy	AD35H0038PERICA

vi. Contractor shall not claim a DMC billable treatment service on a day that the above stated services is/are not provided. The Avatar service codes for days upon which a treatment service is not provided are:

ASAM 3.5 Service	Service Code
Non-Billable Residential Day	AD58
Client Absent from Residential program	AD998

vii. Contractor shall consult with the client's assigned RTX case manager to complete the course of treatment prior to discharge.

1) The consultation request shall be made through Avatar and by telephone.

2) The consultation request shall occur immediately upon the Contractor's knowledge of the client's potential for early discharge or AWOL.

3) Contractor and the RTX case manager will make every effort to maintain the client in treatment and not discharge the client unsuccessfully prior to completion of treatment.

4) Contractor may bypass the consultation request and discharge a client that is an imminent threat to the safety of staff or other clients. Contractor shall notify the RTX case manager immediately upon the discharge of a client due to imminent threat.

d. Prior-Authorization of Residential Services

i. Contractor shall obtain prior authorization from the BHRS Residential Authorization Team (RTX), Pathways, Service Connect, or Primary Care Interface for client admission to a residential treatment program, pursuant to 42 CFR 438.210(b).

ii. Contractor shall establish and follow written policies and procedures that comply with BHRS RTX requirements for initial and continuing authorization requests, including but not limited to the Residential Denial Protocol, Waitlist Management Protocol, One-Time Extension requests. A timely submission is submitted at least once a week (seven calendar days) prior to the last authorized day of the client's residential stay.

iii. Failure to comply with the BHRS RTX requirements for initial and continuing authorization requests will result in an authorization denial, and Contractor shall be financially responsible for the unauthorized treatment service. Contractor shall not penalize the client in any way for unauthorized requests due to Contractor's failure to adhere to the BHRS RTX requirements for initial and continuing authorization requests.

e. Lengths of Stay for Residential Services

i. Contractor shall comply with the following time restrictions.

1) The statewide goal for the average length of stay for Residential Treatment Services is 30 days. The goal for a statewide average length of stay for residential services of 30 days is not a quantitative treatment limitation or hard "cap" on individual stays; lengths of stay in residential treatment settings shall be determined by individualized clinical need. However, DMC-ODS plans shall ensure that members receiving residential treatment are transitioned to another level of care.

2) Those receiving residential treatment shall be stabilized as soon as possible and moved to a less restrictive level of treatment.

a) Members under age twenty-one (21) are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, Members under age twenty-one (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.

b) The DMC-ODS shall not override any EPSDT requirements.

3) Residential, Intensive Outpatient and Outpatient treatment services for adolescents shall comply with Federal, State and Local regulations and with the Youth Treatment Guidelines set forth and as amended by the DHCS located at:

DHCS Adolescent Substance Use Disorder Best Practices Guides October 2020

4) DMC Perinatal clients may receive a longer length of stay than those described above. If medically necessary and authorized by the RTX team, DMC Perinatal clients are eligible for medically necessary services through the postpartum period, defined as the last day of the calendar month on the 365th-day beginning on the last day of pregnancy.

5) Adult clients involved in the criminal justice system may receive a longer length of stay than those described above. If medically necessary and authorized by the RTX team or Service Connect, clients involved in the criminal justice system may receive up to six (6) months of residential services, plus a one-time extension of up to thirty (30) days.

   a) Up to ninety (90) days of the six (6) month stay may be funded by DMC, if medically necessary. Additional lengths of stay may be funded by alternative sources, if medically necessary and authorized by the RTX team, Pathways or Service Connect.

   b) Medi-Cal-eligible youth and adults in state prisons, county jails, and youth correctional facilities shall receive DMC-ODS covered services for up to 90 days prior to their release (collectively referred to as “pre-release services) to stabilize their health conditions and establish a plan for their community-based care Pre-release services are the responsibility of the correctional facilities, and not part of DMC-ODS plans’ contractual coverage obligations. Correctional facilities may choose to deliver pre-release services and/or enter into contracts for pre-

release services with DMC-ODS plans or community-based SUD treatment providers.

To ensure seamless continuity of care following re-entry into the community, justice involved members shall be promptly connected to appropriate community-based services, including mental health and substance use treatment through coordinated behavioral health links (BH Links). As part of BH Links, Contractors, within 14 days prior to release (if known), and in coordination with the prerelease care manager, shall ensure processes are in place for a BH Link between the correctional behavioral health provider, a Contractor, and the member. Contractors Shall implement all components of BH Links, including ability to receive referrals from correctional facilities in all counties, by October 1, 2024.

2. Care Coordination

Care Coordination consists of activities and medical care, and to support the member with linkages to services and supports designed to restore the member to their best possible functional level. Care coordination shall be provided to a member in conjunction with all levels of treatment. It may also be delivered and claimed as a standalone service. DMC-ODS plans, through executed memoranda of understanding, shall implement care coordination services with other SUD, physical, and/or mental health services in order to ensure a client-centered and whole-person approach to wellness.

a. Care Coordination services shall be provided face-to-face, by telephone, or by telehealth and may be provided in any appropriate setting in the community. If services are provided in the community, Contractor shall maintain confidentiality requirements/guidelines.

b. Care Coordination services shall include one or more of the following components:

(1) Coordinating with medical and mental health care providers to monitor and support comorbid health conditions.
(2) Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to

mental health providers, and referrals to primary or specialty medical providers.

(3) Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups.

(4) For guidance on claiming for care coordination within a level of care or as a standalone service, please refer to the most current DMC-ODS Billing Manual.

(5) Care Coordination shall be consistent with and shall not violate the confidentiality of SUD members as set forth in 42 CFR Part 2, and California Law

3. Clinician Consultation

Clinician Consultation consists of DMC-ODS Contractor who are qualified to perform assessments, as described in California's Medicaid State Plan, consulting with providers, such as addiction medicine physicians, addiction psychiatrists, or licensed clinicians to support the provision of care.

Clinician Consultation is not a direct service provided to DMC-ODS members. Rather, Clinician Consultation is designed to support DMC-ODS licensed clinicians with complex cases and may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. It includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific DMC-ODS members.

4. Mobile Crisis Services

Mobile Crisis Services provide rapid response, individual assessment, and community-based stabilization to Medi-Cal members who are experiencing a behavioral health crisis. Mobile crisis services are designed to provide relief to members experiencing a behavioral health crisis, including through de-

escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; and avoid unnecessary emergency department care,

Consistent with existing guidance and given the unique nature of behavioral health crises, mobile crisis services are covered and reimbursable prior to determination of a mental health or SUD diagnosis, or a determination that the member meets access criteria for SMHS, DMC and/or DMC-ODS services.

For additional guidance regarding Mobile Services, please refer to BHIN 23-025.

5. Medications for Addiction Treatment (MAT)

a. MAT includes all FDA-approved medications and biological products to treat AUD, OUD, and any SUD. MAT may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered as part of a level of care listed in this "Covered DMC-ODS Services" section.

b. MAT may be provided with the following service components:
(1) Assessment
(2) Care Coordination
(3) Counseling (individual and group)
(4) Family Therapy
(5) Medication Services
(6) Patient Education
(7) Recovery Services
(8) SUD Crisis Intervention Services
(9) Withdrawal Management Services

c. Contractor shall either offer MAT services directly, or have an effective referral process in place to the most clinically appropriate MAT services, pursuant to the requirements set forth in BHIN 23-054.

(a) Outpatient Treatment Services
(b) Intensive Outpatient Treatment Services
(c) Partial Hospitalization Services
(d) Residential Treatment Services
(e) Inpatient Services
(f) Withdrawal Management Services

d. An effective referral process shall include an established relationship with a MAT provider and transportation to appointments for MAT. Providing contact information for a MAT provider does not meet the requirement of an effective referral. An appropriate facilitated referral to any Medi-Cal provider rendering MAT to the member is compliant whether that provider seeks reimbursement through DMC-ODS.

e. The County shall monitor the referral process or provision of MAT services. Contractors are required to comply with DHCS' MAT access policy, which applies to all licensed and/or certified SUD programs and is described in BHIN 23-054.

f. For additional guidance regarding MAT requirements, please refer to BHIN 23-054.

6. Medi-Cal Peer Support Services

Medi-Cal Peer Support Services Medi-Cal Peer Support Services are defined as "culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower Medi-Cal members through strength-based coaching, support linkages to community resources, and educate members and their families about their conditions and the process of recovery."

Medi-Cal Peer Support Services may be provided with the member or significant support person(s) and may be provided in a clinical or nonclinical setting. Medi-Cal Peer Support Services can be delivered and claimed as a standalone service or provided in conjunction with other DMC-ODS services or levels of care described in BHIN 24-001, including residential services. Peer Support Services are based on an approved plan of care and are delivered and claimed as a standalone service. Beneficiaries may concurrently receive Peer Support Services and services from other levels of care. For additional information, please follow the link to the State website page for Medi-Cal Peer Support Services.

Peer Support Services must be claimed separately. For guidance on claiming Medi-Cal Peer Support Services, please refer to the most current DMC-ODS Billing Manual.

7. Withdrawal Management

a. Withdrawal Management Services are provided to members experiencing withdrawal in the following outpatient and residential settings:

(1) Level 1-WM: Ambulatory withdrawal management without extended on-site monitoring (Mild withdrawal with daily or less than daily outpatient supervision)
(2) Level 2-WM: Ambulatory withdrawal management with extended on-site monitoring (Moderate withdrawal with daytime withdrawal management and support and supervision in a non-residential setting)
(3) Level 3.2-WM: Clinically managed residential withdrawal management (24- hour support for moderate withdrawal symptoms that are not manageable in outpatient setting)

Please refer to BHIN 21-001 and attachments for Level of Care Certification/Designation requirements applicable to Withdrawal Management delivered in residential settings.

b. Withdrawal Management Services are urgent and provided on a short-term basis. When provided as part of Withdrawal Management Services, service activities, such as the assessment, focus on the stabilization and management of psychological and physiological symptoms associated with withdrawal, engagement in care and effective transitions to a level of care where comprehensive treatment services are provided.

c. A full ASAM Criteria assessment shall not be required as a condition of admission to a facility providing Withdrawal Management. To facilitate an appropriate care transition, a full ASAM assessment, brief screening, or other tool to support referral to additional services is appropriate.

d. Withdrawal Management Services may be provided in an outpatient, residential or inpatient setting. If a member is receiving Withdrawal Management in a residential setting, each member shall reside at the facility. All members receiving Withdrawal Management services, regardless in which type of setting, shall be monitored during the withdrawal management process.

e. Withdrawal Management Services include the following service components:

(1) Assessment
(2) Care Coordination
(3) Medication Services
(4) MAT for OUD
(5) MAT for AUD and other non-opioid SUDs
(6) Observation
(7) Recovery Services

f. ASAM 3.2-WM

Contractor shall ensure that clients receiving both residential services and WM services are monitored during the detoxification process. Withdrawal management services include the following:

Contractor shall provide Withdrawal Management (WM) services according to the ASAM Criteria, when medically necessary, in accordance with the client's individualized treatment plan.

Contractor shall ensure that clients receiving both residential services and WM services are monitored during the detoxification process. Client safety is of the highest priority, Withdrawal management services include the following:

Clinically managed residential withdrawal management. For clients in moderate withdrawal but need twenty-four (24) hour support to complete withdrawal management and increase their likelihood of continuing treatment or recovery.

Residential Withdrawal Management services shall be provided in a DHCS or DSS licensed residential facility that is also DMC certified and designated by DHCS as capable of delivering care consistent with ASAM 3.2 treatment criteria.

i. Lengths of stay, Treatment Plans, Problems Lists, and services offered shall be guided by medically necessity, and be trauma-informed and individualized according to client's ASAM-based needs assessment, DSM-5 diagnosis, and individual clinical needs.

ii. Residential Withdrawal Management services shall be co-occurring integrated, and trauma informed.

iii. Residential Withdrawal Management services shall be provided twenty-four (24) hours/seven (7) days per week in a structured treatment support setting to clients, with counselors trained in withdrawal management.

iv. Residential withdrawal management services shall be provided to adults eighteen (18) and over who are at imminent risk as defined by the ASAM criteria.

v. Contractor shall closely observe and physically check each client receiving residential withdrawal management services at least every thirty (30) minutes during the first seventy-two (72) hours following admission, or with the current protocol established by DHCS for residential withdrawal management, whichever is stricter. Physical checks must be face-to-face.

1) After twenty-four (24) hours, close observations and physical checks may be discontinued or reduced based upon a determination by a staff member trained in providing withdrawal management services. Documentation of the information that supports a decrease in close observation and physical checks shall be recorded in the client's file.

2) Documentation of observations and physical checks shall be recorded and signed by program staff.

3) Only program staff that have been trained in the provisions of detoxification services may conduct observations and physical checks of clients receiving withdrawal management services. Training shall include information on withdrawal medications, and signs and symptoms that require referral to a higher level of care. Training shall also include first aid and cardiopulmonary resuscitation. Copies of

detoxification training records shall be kept in personnel files.

vi. During the provision of detoxification services, the minimum staffing or volunteer ratios and health-related requirements shall be as follows:

1) In a program with fifteen (15) or fewer clients who are receiving detoxification services, there shall be at least two (2) staff members on duty and awake at all times with a current cardiopulmonary resuscitation certificate and current first aid training.

2) In a program with more than fifteen (15) clients who are receiving detoxification services, there shall be at least three (3) staff members per every fifteen (15) clients, on duty and awake at all times, one of whom shall have a current cardiopulmonary resuscitation certificate and current first aid training.

3) Clients shall not be used to fulfill this requirement.

vii. In addition to daily room and board, Contractor shall provide at least one (1) of the following treatment services daily: intake, individual counseling, including client observations, group counseling, patient education, collateral services, crisis intervention services, treatment planning, case management or care coordination, transportation services (provision of or arrangement for transportation to and from medically necessary treatment) or discharge services. Contractor shall document the service provided in the client's chart. Avatar service codes for each ASAM 3.2 Residential Withdrawal Management services are:

ASAM 3.2 Service	Service Code(s)
Residential Withdrawal Management service day	AD321ODS
Residential Withdrawal Management service day w/ IMS Certification	AD321IMS

ODS 3.2 CARE COORDINATION	AD3213ODSCM_CA
ODS 3.2 PERI CARE COORDINATION	AD3213ODSPERICM_CA
ODS 3.2 MEDICATION ASSISTED TREATMENT	AD32601ODS_CA
ODS 3.2 PERI MEDICATION ASSISTED TREATMENT	AD32601ODSPERI_CA
ODS 3.2 MD CLINICIAN CONSULTATION	AD3599367CA
ODS 3.2 PERI MD CLINICIAN CONSULTATION	AD3299367PERI_CA
ODS 3.2 NON-MD CLINICIAN CONSULTATION	AD329968_CA
ODS 3.2 PERI NON-MD CLINICIAN CONSULTATION	AD3299368PERI_CA
ODS 3.2 PEER SUPPORT PREVENTION ED GROUP	AD32H0025_CA
ODS 3.2 PERI PEER SUPPORT PREVENTION ED GROUP	AD32H0025PERI_CA
ODS 3.2 PEER SUPPORT SELF HELP ENGAGE THEORY	AD32H0038_CA
3.2 PERI PEER SUPPORT SELF HELP ENGAGE THEORY	AD32H0038PERI_CA

viii. Contractor shall not claim a DMC billable treatment service on a day that the above stated service is/are

not provided. Avatar service codes for days upon which a treatment service is not provided are:

ASAM 3.2 Service	Service Code
Room and Board	AD58
Room and Board Peri	AD58 PERI

Length of stay for some clients may periodically extend beyond that which is medically necessary when a client is pending transition to another level of care. Contractor shall receive prior authorization from the RTX team for the extended length of stay. Contractor shall use service code AD58 in Avatar for non-medically necessary withdrawal management service days.

ix. Incidental Medical Services (IMS)

Contractor shall provide IMS services at a facility by a health care practitioner, or staff under the supervision of a health care practitioner, to address medical issues associated with detoxification, treatment, or recovery services.

IMS must be provided at the facility in compliance with the community standard of practice. IMS shall be an additional service to all residents. IMS cannot be limited to specific residents. Residential facility's HCP must ensure that IMS is appropriate for all residents. If IMS is not appropriate for a resident (as determined by a HCP), then the licensed residential facility must immediately refer the resident for placement in an appropriate level of care.

The following IMS must be provided:

i. Obtaining medical histories

ii. Monitoring health status

iii. Testing associated with detoxification from alcohol or drugs

iv. Providing alcoholism or drug abuse recovery or treatment services

v. Overseeing patient self-administered medications

vi. Treating substance abuse disorders, including detoxification.

8. Telehealth

Contractor shall comply with BHRS Policy 22-07, BHRS Policy 22-06, and DHCS BHIN 23-018 Updated Telehealth Guidance for Substance Use Disorder Treatment Services in Medi-Cal.

Telehealth means contact with a member beneficiary via synchronous audio and video by an LPHA, Peer Support Specialist, or registered or certified counselor and may be done in the community or the home. Telephone means contact with a member beneficiary via synchronous, real-time audio-only telecommunications systems. Telehealth does not include asynchronous store and forward communications or remote patient monitoring.

Contractor may utilize telehealth when providing treatment services only when the following criteria are met:

a. All covered DMC-ODS services delivered via telehealth shall be provided in compliance with the privacy and security requirements contained in the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996 found in Parts 160 and 164 of Title 45 of the Code of Federal Regulations, Part 2 of Title 42 of the Code of Federal Regulations, the Medicaid State Plan, and any other applicable state and federal statutes and regulations. Specific guidance for providers regarding HIPAA and telehealth is available from the external resources listed on DHCS' Telehealth Resources page.

b. Providers that offer telehealth services to Medi-Cal members must meet all applicable Medi-Cal licensure and program enrollment requirements. If the provider is not located in California, they must be licensed in California, enrolled as a Medi-Cal rendering provider, and affiliated with a Medi-Cal enrolled provider group in California or a border community,

as outlined in DHCS' Telehealth Policy Paper and the Medi-Cal Provider Manual.

c. All providers furnishing applicable covered services via synchronous audio-only interaction must also offer those same services via synchronous video interaction to preserve member choice. To preserve a member's right to access covered services in person, a provider furnishing services through telehealth must do one of the following:

i. Offer those same services via in-person, face-to-face contact; or

ii. Arrange for a referral to, and a facilitation of, in-person care that does not require a member to independently contact a different provider to arrange for that care.

iii. Non-medical transportation benefits are available for in-person visits.

iv. Any potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable.

9. Prior to initial delivery of covered services via telehealth, providers are required to obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering services, and must explain the following to beneficiaries:

i. The member has a right to access covered services in person.

ii. Use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time without affecting themember's ability to access Medi-Cal covered services in the future.

iii. Providers must document the member's verbal or written consent to receive covered services via telehealth prior to the initial delivery of the services. The members' consent must be documented in their medical record and made available to BHRS or DHCS upon request.

iv. A provider may utilize a general consent agreement to meet this documentation requirement if that general consent agreement:

1. specifically mentions the use of telehealth delivery of covered services;

2. includes the information described above;

3. is completed prior to initial delivery of services; and

4. is included in the member's record.

10. DMC-ODS providers shall comply with all applicable federal and state laws, regulations, bulletins/information notices, and guidance when establishing a new patient relationship via telehealth.

11. The initial clinical assessment and establishment of a new patient relationship, including any determination of diagnosis, medical necessity, and/or level of care may be delivered through synchronous video interaction. The professional establishing a new client relationship shall evaluate each member's assessment and intake information using the American Society of Addiction Medicine Criteria. If completed by a counselor through a face-to-face review or telehealth with the counselor to establish a member meets the medical necessity criteria.

    DMC-ODS providers may establish a relationship with new patients via synchronous audio-only interaction in the following instances:

    i. When the visit is related to sensitive services as defined in subsection (n) of Section 56.06 of the Civil Code. This includes all covered DMC-ODS services.

    ii. When the patient requests that the provider utilizes synchronous audio-only interactions or attests they do not have access to video.

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

    a. Services must be identified if provided in-person, by telephone, or by telehealth.

    b. If services were provided in the community, identify the location and how the provider ensured confidentiality.

13. Additional DMC-ODS Services Required

The following services are also included in the DMC-ODS continuum of care, although they are not reimbursable by DMC. Contractor may provide the following services; however, Contractor shall refer clients to these services based upon client need, medical necessity, and client eligibility. Avatar service codes for additional DMC-ODS required services are:

Service Description	Service Code
Unclaimable Services	AD80

14. DMC-ODS Contractor Requirements

a. Licensure/Agency

Contractor shall be licensed, registered, and DMC certified in accordance with applicable laws and regulations. Contractor shall comply with the following regulations and guidelines. In the event of a conflict between regulatory requirements, the more stringent provisions shall prevail.

i. Title 21, CFR Part 1300, et seq.,

ii. Title 42, CFR, Part 8;

iii. Drug Medi-Cal Organized Delivery System BHIN 24-001

iv. Title 22, CCR, Sections 51341.1, 51490.1, and 51516.1;

v. DHCS Alcohol and/or Other Drug Program Certification Standards;

vi. Title 9, CCR, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq.; and

vii. Title 22, CCR, Division 3, Chapter 3, sections 51000 et. seq.

b. Staffing Requirements

Contractor shall employ licensed or certified/registered counselors in accordance with Title 9, CCR, Division 4,

Chapter 8 and DHCS BHIN 24-001 to provide covered services.

i. Professional staff must be licensed, registered, certified or recognized under California scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. A Licensed Practitioner of the Healing Arts (LPHA) includes the following:

   1) Physician

   2) Nurse Practitioners

   3) Physician Assistants

   4) Registered Nurses

   5) Licensed Clinical Psychologists

   6) Licensed Clinical Social Worker

   7) Licensed Professional Clinical Counselor

   8) Licensed Marriage and Family Therapists

   9) License Eligible Practitioners working under the supervision of Licensed Clinicians

ii. Non-Professional staff shall receive appropriate onsite orientation and training prior to performing assigned duties. Non-professional staff shall be supervised by professional and/or administrative staff.

iii. Professional and Non-Professional staff shall have appropriate experience and all necessary training at the time of hiring.

iv. Registered and certified SUD counselors providing treatment services shall adhere to all certification requirements in the CCR Title 9, Division 4, Chapter 8 and HSC Section 11833 (b)(1).

v. Prior to the delivery of services under this Agreement, Contractor shall employ a Medical Director enrolled with DHCS under applicable state regulations, screened as a limited categorical risk within one (1) year prior to serving as Medical Director in accordance with 42CFR455.50(a), and has signed a Medicaid provider agreement with DHCS as required by 42 CFR 431.107.

vi. All staff of Contractor shall undergo fingerprint background checks prior to hiring or service delivery, whichever comes first in accordance with CFR 455.34.

vii. Prior to the delivery of services, Contractor shall ensure all treatment staff shall be trained in ASAM criteria.

c. Other Requirements

Contractor is required to inform BHRS QM and BHRS Program Analyst within forty-eight (48) hours after an occurrence, of the following:

i. Leadership or staffing changes.

ii. Organizational and/or corporate structure changes (example: conversion to non-profit status).

iii. Changes in the type of services being provided at that location; day treatment or medication support services when medications are administered or dispensed from the provider site.

iv. Significant changes in the physical plant of the provider site (some physical plant changes could require a new fire or zoning clearance).

v. Change of ownership or location.

vi. Complaints regarding the provider

15. Client Eligibility

a. Clients are eligible to receive DMC-ODS services if they: (a) are receiving San Mateo County Medi-Cal benefits or are eligible to receive San Mateo County Medi-Cal benefits; (b) are not currently institutionalized; (c) have a substance use disorder per the most current published edition of the Diagnostic and Statistical Manual (DSM-5) and meet ASAM medical necessity criteria; and (d) are a San Mateo County resident.

b. Clients may also be eligible to receive treatment and recovery services under San Mateo County's DMC-ODS network of care using non-Medi-Cal funding if they: (a) do not have health care coverage; (b) are not currently institutionalized; (c) have a substance use disorder per the most current published edition of the Diagnostic and Statistical Manual (DSM-5) and meet ASAM medical necessity criteria; and (d) are a San Mateo County resident.

c. Contractor Responsibilities

   i. Contractor shall verify the client's residency status to ensure they are a San Mateo County resident. Clients experiencing homelessness shall be transient or homeless in San Mateo County. A statement of verification shall be kept in the client's file.

   ii. Contractor shall verify the client's Medi-Cal eligibility status on a monthly basis. Verification of Medi-Cal eligibility shall be kept in the client's file.

d. Medical Necessity

   i. Medical necessity shall be determined by the Medical Director or LPHA. After establishing a DSM-5 diagnosis, the diagnosing professional shall apply ASAM criteria to determine the appropriate level of care for placement.

   ii. Medical necessity for adults age twenty-one (21) and over is determined by the following:

      1) The individual has at least one (1) substance-related diagnosis from the DSM-5, excluding tobacco-related disorders.

2) The individual meets the ASAM Criteria definition of medical necessity to receive services.

iii. Medical necessity for youth and adults under the age of twenty-one (21) is determined by the following:

1) The individual is assessed to be at risk for developing a substance use disorder, and

2) The individual meets the ASAM Criteria definition of medical necessity for adolescent services.

iv. Medical necessity shall be re-evaluated and re-determined at each Treatment Plan update, each Level of Care change, and at least once every six (6) months for the duration of treatment services.

1) Narcotic Treatment Programs/Opioid Treatment Programs shall re-evaluate and re-determine medical necessity at least annually for the duration of treatment services.

16. Timely Access to Service

a. Contractor shall deliver the client's first appointment for outpatient, intensive outpatient, or residential services within ten (10) calendar days of the initial request, presuming the client meets medical necessity criteria.

i. Interim services shall be provided to injection drug using and perinatal services-eligible clients when services are not immediately available, including outpatient or intensive outpatient services.

b. Contractor shall deliver the client's first appointment for urgent services within seventy-two (72) hours of the initial request, presuming the client meets medical necessity criteria.

i. Services are defined by DHCS as urgent when themember's condition is such that they face an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other

major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize their ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours.

ii. Interim services shall be provided to injection drug using and perinatal services-eligible clients when services are not immediately available, including outpatient or intensive outpatient services.

c. Contractor shall deliver the client's first appointment for NTP or MAT services within twenty-four (24) hours of the initial request, presuming the client meets medical necessity criteria.

d. Contractor shall ensure that a client experiencing a medical or psychiatric emergency will be transported to the nearest hospital for treatment.

e. Contractor shall advise clients in the program of the County's twenty-four (24) hour on-call Access Call Center. Contractor shall advise clients how to receive treatment or other covered services after hours, weekends and holidays.

f. Contractor's hours of operation shall be no less than the hours of operation to non-Medi-Cal clients.

17. Coordination of Care

Contractor shall provide coordination of client care. Initial care coordination may be provided by the BHRS Residential Treatment Authorization Team (RTX), Service Connect, Pathways, Primary Care Interface (PCI), or Integrated Medication Assisted Treatment Team (IMAT). Once a client is enrolled in and connected to the SUD treatment program, care coordination may be transferred to the Contractor. The Contractor shall continue to coordinate care with any assigned BHRS Case Manager or Counselor/Clinician. Care

coordination responsibilities will comply with those identified in the BHRS DMC-ODS Implementation Plan.

a. The Residential Contractor shall contact the RTX case manager and prior to discharge coordinate a consultation with the referred client, except when the client poses an imminent threat to the safety of them self or someone else.

b. Contractor shall ensure coordination and continuity of care within the standards in accordance with 42 CFR 438.208.

c. Contractor shall ensure that in the course of coordinating care, the client's privacy is protected in accordance with all Federal and State privacy laws, including but not limited to 45 CFR 160 and 164, to the extent that such provisions are applicable.

d. Contractor shall ensure that female and transgender male clients have direct access to a women's health specialist, to provide routine and preventive health care services necessary, within the network for covered care. This is in addition to the clients designated source of primary care if that source is not a women's health specialist, pursuant to 42 CFR 438.206(b)(2).

e. Contractor shall provide treatment services to clients receiving Medication Assisted Treatment. Contractor shall communicate regularly with the prescribing physician(s) of clients prescribed medications unless the client refuses to consent to sign a 42 CFR part 2 compliant Release of Information for this purpose.

18. Sharing Information with Clients

Contractor shall not prohibit or restrict any licensed, registered, or certified professional staff, acting within their scope of practice, from advising or advocating on behalf of a client, for whom the Contractor is providing SUD treatment from any of the following:

a. The client’s health status, medical care or treatment options including any alternative treatment that may be self-administered.

b. Any information the client needs in order to decide among all relevant treatment options,

c. The risks, benefits and consequences of treatment or non-treatment,

d. The clients' right to participate in decisions regarding his/her healthcare including the right to refuse treatment and to express preference regarding future treatment decisions.

19. Laboratory Requirements – applies to all doing drug testing

Contractor shall use testing services of laboratories that are certified and in good standing to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA) unless exempt from CLIA or are SAMHSA certified.

1. Urinalysis Testing

Urinalysis (UA) Testing is a therapeutic intervention when deemed medically appropriate and is used to determine appropriate levels of client care. A positive UA test result may indicate a client's current level of care is not adequate and/or that the client treatment plan should be adjusted.

Contractor shall establish procedures which protect against falsification and/or contamination of any urine sample, and must document urinalysis results in the client's file.

C. Priority Populations

Through the Substance Use Prevention, Treatment, and Recovery Services Substance Use Block Grant (SUBG), BHRS is required to serve priority population clients. Contractor shall establish partnerships for the provision of referral to interim or treatment services when capacity is not available and a client cannot be admitted to treatment within 48 hours of request, as described in the AOD Policy and Procedure Manual. Contractor shall give priority admission to the following populations, provided they are residents of San Mateo County and do not have health care coverage:

1. Pregnant females who use drugs by injection;

2. Pregnant females who use substances;

3. Other persons who use drugs by injection; and

4. As Funding is Available – all other clients with a SUD, regardless of gender or route of use, without insurance or for whom coverage is terminated for short periods of time.

D. Health Order Compliance

1. Health Order Compliance Requirements

Comply with employer requirements established by Cal-OSHA through the COVID -19 Prevention Non-Emergency Regulations which are chaptered in the California Code of Regulations, Title 8-Cal/OSHA, Chapter 4 Division of Industrial Safety, Subchapter 7 General Industry Safety Orders, Section 3205 COVID-19 Prevention.

This section applies to all employees and places of employment with the exception of locations with one employee that does not have contact with other persons, employees working from home, or employees teleworking from a location of the employee's choice, which is not under the control of the employer.

Employers can comply with this section by either maintaining a COVID-19 Plan that was required by previous contract conditions or as part of the required Injury and Illness Prevention Program required by Section 3203.

Employers are required to comply with COVID-19 Prevention requirements of Cal/OSHA.

More information, including access to the text of the regulations, COVID-19 Prevention Plan Templates, Frequently Asked Questions, and Fact Sheets can be found at https://www.dir.ca.gov/dosh/coronavirus/Non_Emergency_Regulations/.

II. ADMINISTRATIVE REQUIREMENTS

In providing its services and operations, Contractor shall maintain compliance with requirements of theCounty , including additions and revisions, which are incorporated by reference herein.

A. Disaster and Emergency Response Plans

CONTRACTOR will develop and maintain a Disaster and Emergency Response Plan ("Emergency Plan") that includes all of the elements set forth in this Section, as well as any additional elements reasonably requested by the County. The Emergency Plan will also include site-Specific emergency response plan(s) for each of the sites at which CONTRACTOR provides services pursuant to this Agreement ("Site Plans"). The Emergency Plan and associated Site Plans will address CONTRACTOR preparations to effectively respond in the immediate aftermath of a national, state or local disaster or emergency ("Emergency Response") and plans for the ongoing continuation of Services under the Agreement during and after a disaster or emergency ("Continuity of Operations").

CONTRACTOR shall submit the Emergency Plan to the Countydue upon request of identified due date from the County. . The Emergency Plan will follow the template provided in Attachment T: Sample Template for Disaster and Emergency Response Plan as a guide when developing the plan, adding any categories or items as needed for the Contractor's unique situation. The submitted Emergency Plan will be subject to the reasonable approval of the County. CONTRACTOR shall respond reasonably promptly to any comments or requests for revisions that the County provides to CONTRACTOR regarding the Emergency Plan. CONTRACTOR will update the Emergency Plan and associated Site Plans as circumstances warrant and shall provide County with copies of such updated plans. CONTRACTOR shall train employees on the Emergency Plan and the Emergency Plan will include a description of how employees will be trained.

The Emergency Plan will indicate, in as much detail as reasonably possible, the categories of additional staff, supplies, and services that CONTRACTOR projects would be necessary for effective Emergency Response and Continuity of Operations and the costs that the CONTRACTOR projects it would incur for such additional staff, supplies and services. CONTRACTOR shall recognize and adhere to the disaster medical health emergency operations structure, including cooperating with, and following direction provided by, the County's Medical Health Operational Area Coordinator (MHOAC). In the event that the CONTRACTOR is required to implement the Emergency Plan during the term of the Agreement, the parties will confer in good faith regarding the additional staff, supplies and services needed to ensure Emergency Response and/or Continuity of Operations owing to the particular nature of the emergency, as well as whether the circumstances warrant additional compensation by the County for additional staff, supplies and services needed for such Emergency Response and/or Continuity of Operations.

CONTRACTOR shall reasonably cooperate with the County in complying with processes and requirements that may be imposed by State and Federal agencies (including, but not limited to the California Governor's Office of Emergency Services and the Federal Emergency Management Agency) in connection with reimbursement for emergency/disaster related expenditures.

In a declared national, state or local disaster or emergency, CONTRACTOR and its employees will be expected to perform services as set forth in the Agreement, including in the area of Emergency Response and Continuity of Operations, as set forth in the Emergency Plan and each Site Plan. CONTRACTOR shall ensure that all of its employees are notified, in writing, that they will be expected to perform services consistent with the Emergency Plan and each Site Plan.

B. System-Wide Improvements

The County has identified issues which require a collaborative and comprehensive approach in order to enhance the system-wide effectiveness and efficiency. Contractor shall implement the following:

1. External Quality Reviews

DHCS has contracted with an External Quality Review Organization (EQRO) to conduct a review of the overall quality of services, service accessibility, and availability provided under the ODS. The EQRO also requires annual Performance Improvement Projects (PIP) that improve both clinical and administrative performance of the ODS.

a. Contractor shall participate in EQRO focus groups, surveys, and other performance measurement and data collection activities.

b. Contractor shall participate in all PIPs implemented by BHRS as part of the EQRO process.

2.. DMC Claim Documentation Quality

Contractor's denied claims shall not exceed five percent (5%) of the total DMC claims submitted per month. Should the denied claims exceed five percent (5%) in any given month, Contractor shall submit a corrective action plan to improve documentation and reduce denials. Corrective action may include, but is not limited to:

additional training, additional monitoring controls of data submission, non-compliance penalty fees, or withheld payments.

C. Qualified Service Organization

1. As a qualified service organization, BHRS agrees to provide the following services to Contractor:

   a. Centralized screening, assessment, and treatment referrals;

   b. Billing supports and services;

   c. Data gathering and submission in compliance with Federal, State, and local requirements;

   d. Policies and procedures related to the service provision, documentation, and billing;

   e. Quality Management and utilization review, including problem resolution;

   f. Education, training and technical assistance as needed.

2. As a qualified service organization, BHRS and Contractor agree to the following:

   a. Acknowledge that in receiving, storing, processing, or otherwise dealing with any information from the Program about the clients in the Program, it is fully bound by the provisions of the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 C.F.R. Part 2;

   b. Undertake to resist in judicial proceedings any effort to obtain access to information pertaining to clients otherwise than as expressly provided for in the Federal Confidentiality Regulations, 42 C.F.R. Part 2; and

   c. Acknowledge that Contractor and any subcontractor or legal representative are or will be fully bound by the provisions of 42 C.F.R. Part 2 upon receipt of the patient identifying data received pursuant to a patient consenting to disclosure of their records under 42 C.F.R. Part 2, § 2.31 for payment and/or health care operation activities, and, as such that each disclosure shall be accompanied by the notice required under § 2.32.

D. No Unlawful Use or Unlawful Use Messages Regarding Drugs

Contractor agrees that no aspect of its substance use treatment program services shall include any messaging in the responsible use, if the use is unlawful, of drugs or alcohol. This is including but not limited to: program standards, curricula, materials, and teachings. These materials and programs may include information on the health hazards of use of illegal drugs and alcohol, concepts promoting the well-being of the whole person, risk reduction, the addictive personality, development of positive self-esteem, productive decision-making skills, and other preventive concepts consistent with the "no unlawful use" of drugs and alcohol message. This does not apply to any program receiving state SUBG/NRC funding that provides education and prevention outreach to intravenous drug users with AIDS or AIDS-related conditions, or persons at risk of HIV-infection through intravenous drug use. (Health and Safety Code Sections 11999-11999.3).

E. Limitation on Use of Funds for Promotion of Legalization of Controlled Substances

None of the federal 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).

F. Restriction on Distribution of Sterile Needles

Contractor shall not use any SUBG Block Grant funds made available through this agreement to carry out any program that includes the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug.

G. AVATAR Electronic Health Record

1. Contractor shall enter referral data into Avatar for calls inquiring about services that includes but is not limited to: date and time of call, caller/referral data, service type inquiry, screening data and referrals made.

2. Contractor shall enter client data into Avatar for services provided that includes but is not limited to: date of service, service type, service units, service duration, screening and assessment data, diagnosis, treatment plans, progress notes, discharge plan and discharge summary.

3. Contractor shall maintain compliance with all documentation, reporting, billing and all other data requirements as required in the BHRS Documentation Manual, San Mateo County Intergovernmental Agreement, Title 22, DMC-ODS STCs, the DHCS AOD Program Certification Standards, CalOMS Tx Data Collection Guide, DMC Billing Manual, Youth Treatment Guidelines, Perinatal Practice Guidelines and the AOD Policy and Procedure Manual, including additions and revisions.

4. Contractor shall submit electronically treatment capacity and waiting list data to DHCS via DATAR no later than the 7th of the month following the report activity. Contractor shall also comply with all BHRS tracking methods for client waitlist times and capacity. This information shall be used to determine unmet treatment needs and wait times to enter treatment.

5. Contractor shall participate in Avatar trainings and in monthly Avatar User Group (AUG) meetings to ensure data quality and integrity and provide input into system improvements to enhance the system.

H. Quality Management and Compliance

1. Clinical Standards of Care and Evidenced-Based Practices

All services provided under this agreement shall be safe, effective, patient centered, timely, culturally competent, efficient and equitable, as defined by the Institute of Medicine.

a. In providing its services and operations, Contractor shall maintain full compliance with the San Mateo County BHRS Standards of Care, Best Practice Guidelines for Working with Limited English Proficiency and LGBTQ Clients, Federal Cultural and Linguistic Access Standards (CLAS) requirements. Contractor shall comply with at least two (2) of the five (5) DMC-ODS Evidenced-Based Practices. Annually, Contractor shall provide a written report on the status of compliance with the following:

i. Standards of Care

ii. Best Practice Guidelines for Working with Limited English Proficiency and LGBTQ Clients

iii. At least two (2) of the DMC-ODS Evidenced-Based Practices. The DMC-ODS Evidenced-Based Practices include: Motivational Interviewing, Cognitive-Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psycho-Education.

iv. Federal CLAS requirements: Contractor shall demonstrate how they have interpreted and complied with all 15 of the federal CLAS standards.

2. Complex Clients and Co-occurring Disorders

a. Contractors providing SUD Treatment and/or Recovery Services shall implement co-occurring capable policies, procedures, assessments, treatment planning, program content, and discharge planning practices that integrate co-occurring services to meet the client's complex needs. Contractor shall coordinate and collaborate with behavioral and physical health services, and: initiate and coordinate with mental health services when appropriate, provide medication monitoring, coordinate with primary health services, and addiction and psychological assessment and consultation. Contractor shall incorporate mental health symptom management groups and motivational enhancement therapies specifically designed for individuals with co-occurring substance use and mental health disorders.

b. Contractor shall not exclude from treatment, persons who require high risk, specialized services or special health needs. Contractor shall work with the health care providers of clients with special health care needs. Contractor shall collaborate with BHRS and other service providers to meet the identified needs of such clients. Contractor shall not arbitrarily deny or reduce the amount, duration, or scope of services solely because of the client's diagnosis, type of illness, or condition of the client.

i. Contractor shall seek ongoing training and support for staff to stay current with best practices for serving individuals with co-occurring disorders.

ii. A Contractor that provides SUBG Block Grant Perinatal services to pregnant, postpartum and women with children aged 17 and under shall be properly certified to provide these services and comply with the

requirements contained in Title 22, Section 51341.1, Services for Pregnant and Postpartum Women, and with the Perinatal Practice Guidelines.

iii. Medi-Cal members who are pregnant or up to 365 days postpartum are eligible to receive DMC-ODS Perinatal services. Postpartum, as defined for DMC purposes, means the 365-day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility for perinatal services shall end on the last day of the calendar month in which the 365th day occurs.

iv. A Contractor that provides adolescent treatment services shall comply with the Youth Treatment Services Guidelines. Assessments and services for adolescents shall follow the ASAM Adolescent Treatment Criteria.

3. Quality Management Program and Quality Improvement Plan

Contractor must have a Quality Management Program and submit a Quality Improvement Plan to Behavioral Health and Recovery Services (BHRS) Quality Management (QM) annually upon the County's requested due date.. The Quality Improvement Plan should address 1) how the Contractor will comply with all elements of this Agreement, 2) the Contractor will maintain an audit disallowance rate of less than five percent (5%), and 3) first appointment will be within ten (10) days of initial request for service for outpatient and non-urgent residential treatment; seventy-two (72) hours for urgent residential treatment; and twenty-four (24) hours for NTP/OTP programs.

BHRS QM will provide feedback if the plan submitted is missing critical components related to San Mateo County requirements. Additional feedback may be available if requested prior to the submission date.

a. Contractor shall have an established Quality Improvement (QI) plan and committee.

b. The QI committee shall include staff from all levels of the Agency and will guide the development and implementation of the annual QI plan. The QI committee shall review quarterly utilization and service quality, performance data, compliance

with BHRS SOC, co-occurring and complex client capability, and client feedback.

c. Contractor shall establish and/or maintain mechanisms whereby processes and practices at the organizational level; which create inefficiencies and/or present barriers to client engagement, enrollment and retention in treatment, will be identified and addressed. An analysis of policies and practices which create barriers for complex clients shall be included.

4. Grievance Process

Contractor shall notify members of their right to the following:

b. a state fair hearing, how to obtain a hearing and representation rules at the hearing;

c. file grievances and appeals, and the requirements and timeframes for filing;

i. members may file a grievance, either orally or in writing, either with DHCS, the County, or the Contractor
ii. members may request assistance with filing grievances and appeals

i. If the member is grieving or appealing the termination, denial, or a change in type or frequency of services, the member may request services be continued during the appeal or state fair hearing filing although the member may be liable for the cost of any continued benefits if the action is upheld.

b. give written consent to allow a provider, acting on behalf of the member, to file an appeal.

5. Referring Individuals to Psychiatrist

Contractor shall have written procedures for referring individuals to a psychiatrist or physician when necessary, if a psychiatrist is not available.

6. Medication Storage and Monitoring

For Contractors that provide or store medications: Contractor shall store and monitor medications in compliance with all pertinent state and federal standards. Policies and procedures must be in place for monitoring, and storing medications consistent with BHRS Policy 99-03, Medication Room Management and BHRS Policy 04-08 Medication Monitoring In particular:

a. Medications are logged in, verified, counted and added to inventory sheets.

b. All medications obtained by prescription are labeled in compliance with federal and state laws. Prescription labels are altered only by persons legally authorized to do so.

c. Medications intended for external use only are stored separately from medications intended for internal use; food and blood samples are stored in separate refrigerators.

d. All medications are stored at proper temperatures: room temperature drugs at 59-86 degrees Fahrenheit and refrigerated drugs at 36-46 degrees Fahrenheit.

e. Medications are stored in a locked area with access limited to staff authorized to monitor medication.

f. Medications are disposed of after the expiration date and recorded.

g. Injectable multi-dose vials are dated and initialed when opened.

h. A medications log is maintained to ensure that expired, contaminated, deteriorated and abandoned medications are disposed in a manner consistent with state and federal laws.

i. Over the counter medications that are not prescribed by the client's physician may not be used (for example, Tylenol).

7. Timely Access to Services

The Contractor shall ensure compliance with the timely access requirements as referenced in 42 C.F.R. § 438.206(c)(1)(iv).

a. Contractor shall offer a first appointment with a client within ten (10) calendar days of the initial request for an services, if

non-urgent. Urgent requests shall be offered a first appointment within seventy-two (72) hours of the initial request. Requests for OTP services shall be offered an initial appointment within twenty-four (24) hours of the initial request.

i. Urgent requests are defined by DHCS as when the member's condition is such that they faces an imminent and serious threat to their health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life or health or could jeopardize their ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to enrollees, shall be made in a timely fashion appropriate for the nature of the enrollee's condition, not to exceed 72 hours.

ii Contractor shall offer interim services to all clients who do not receive a first appointment offer within 48 hours. Interim services may include referrals to a lower level of care, TB or HIV education, physical or mental health providers, or community resources appropriate to meet the client's immediate needs. Interim services offered shall be documented in Avatar via a SUD Progress Note with face-to-face form, or in the contractor's electronic health record.

b. The County shall monitor Contractor regularly to determine compliance with timely access requirements. (42 C.F.R. § 438.206(c)(1)(v).

c. The County shall work with the Contractor to improve timely access and/or take corrective action if there is a failure to comply with timely access requirements. (42 C.F.R. § 438.206(c)(1)(vi).

8. Record Retention

Section 14 of the Agreement notwithstanding, Contractor shall maintain medical records required by the California Code of Regulations. Notwithstanding the foregoing, Contractor shall

maintain member medical and/or clinical records for a period of ten (10) years, except the records of persons under age eighteen (18) at the time of treatment shall be maintained: a) until ten (10) years beyond the person's eighteenth (18th) birthday or b) for a period of ten (10) years beyond the date of discharge, whichever is later. This rule does not supersede professional standards. Contractor may maintain records for a longer period of time if required by other regulations or licenses. The Contractor shall keep and maintain records for each service rendered, to whom it was rendered, and the date of service, pursuant to W&I Code section 14124.1 and 42 CFR 438.3(h) and 438.3(u).

9. Documentation of Services

Contractor shall provide all pertinent documentation required for state and federal reimbursement including but not limited to Consent Forms, assessments, treatment plans, and progress notes. Contractor agencies must submit, via fax to Quality Management at 650-525-1762, their version of these forms for approval before the forms are to be used. Special attention must be paid to documentation requirements for residential treatment facilities. Documentation shall be completed in compliance with the BHRS Policies & Documentation Manuals. Contractor agencies are required to provide and maintain record of regular documentation training to staff providing direct services. Proof of trainings including attendance by staff may be requested at any time during the term of this Agreement.

System of Care (SOC) Short-Doyle MediCal Mental Health Providers shall document in accordance with the BHRS Documentation Manual located online at: https://www.smchealth.org/sites/main/files/file-attachments/bhrsdocmanual.pdf

SOC contractor will utilize either documentation forms located on http://smchealth.org/SOCMHContractors or contractor's own forms that have been pre-approved.

Substance Use provider services shall be in compliance with DHCS BHIN 23-068

10. Cooperation with Audits

a. 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 program, fiscal, electronic access, or chart reviews and/or audits.

b. In addition, Contractor shall comply with all requests for any documentation or files including, but not limited to, client and personnel files.

c. 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.

d. Contractor shall allow inspection, evaluation and audit of its records, documents and facilities for ten 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 438.230I(3)(i-iii).

e. Behavioral Health and Recovery Services QM and/or BHRS analyst will conduct regular chart audits of Contractors. Contractor is required to provide either the original or copies of charts, including all documentation upon request. The DHCS and other regulatory agencies conduct regular audits of the clinical services provided by BHRS and Contractors requiring submission of charts as requested. Contractor is required to provide all necessary documentation for external audits and reviews within the stated timeline.

   Contractor shall accommodate and cooperate with unannounced chart audits, chart reviews, site visits, and grievance/complaint investigations by BHRS staff with or without advance notice. BHRS has the right to audit, evaluate, inspect any books, records, charts, contracts, computer or other electronic systems of the Contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under this

Agreement at any time. Contractor shall make available, for purposes of an audit, evaluation, or inspection, its premises, physical facilities, equipment, books, records, charts, contracts, computer or other electronic systems related to DMC, SAPT, or any Services funded by this contract.

If deficiencies are found during an audit or utilization review of Contractor's services, Contractor shall develop a Corrective Action Plan (CAP) to include the following:

a. Address each demand for recovery of payment and/or programmatic deficiency;

b. Provide a specific description of how the deficiency will be corrected;

c. Specify the date of implementation of the corrective action; and

d. Identify who will be responsible for ongoing compliance.

BHRS will review and approve or require additional changes to the CAP. Contractor failure to submit a CAP within the required timeframe and failure to complete, fully implement, or sustain a CAP over time may result in withheld or denied payments, penalty fees, or termination of this agreement.

11. Client Rights and Satisfaction Surveys

a. Administering Satisfaction Surveys

i. Contractor agrees to administer/utilize any and all survey instruments as directed by BHRS, including outcomes and satisfaction measurement instruments.

ii. Contractor shall actively participate in Treatment Perception Survey collection processes in all SUD program areas. Treatment Perception Surveys collect client satisfaction data. Contractor may solicit additional feedback from service recipients and family members. All feedback surveys shall be incorporated into Contractor quality improvement processes and plans.

iii. In addition to the Treatment Perception Surveys, Contractor shall develop and administer client and family satisfaction surveys on an annual basis for quality improvement and quality assurance purposes.

b. Client/Patient's Rights

Contractor will comply with County policies and procedures relating to member /patient's rights and responsibilities as referenced in the Agreement.

c. Advance Directives

Contractor will comply with County policies and procedures relating to advance directives.

12. Member Brochure and Provider Lists

Contractor must provide Medi-Cal members new to BHRS with a member brochure at the time of their first service from the Contractor. Contractors are required to be aware of and make available to BHRS Medi-Cal clients all mandatory postings listed at this website http://www.smchealth.org/bhrs/providers/mandpost.

13. Notice of Adverse Benefit Determination

a. Contractor shall issue Medi-Cal members a written Notice of Adverse Benefit Determination (NOABD) each time the member's service is denied, delayed, terminated, or there is a change in the amount, scope, or duration of the treatment service from what was requested by the member. Contractor shall use the appropriate BHRS-provided templates when issuing a NOABD. The NOABD shall meet the requirements of 42 CFR 438.404.

b. BHRS will conduct random reviews of the Contractor to ensure compliance with NOABD requirements.

14. Certification and Licensing

a. SUD Treatment Services

i. Contractors providing SUD treatment services to San Mateo County residents shall be certified and/or licensed by DHCS Licensing and Certification Division.

Contractor shall maintain all applicable certifications through San Mateo County and/or DHCS to provide any of the following reimbursable services: Substance Use Prevention, Treatment and Recovery Services Block Grant Services, and Drug Medi-Cal Organized Delivery System reimbursed services.

ii. Contractor shall submit a copy of any licensing complaint, deficiency findings, or corrective action report issued by a licensing agency to BHRS QM and the AOD Administrator or their designee, within two (2) business days of Contractor's receipt of any such licensing report.

iii. Should Contractor cease to offer a DMC-ODS service, Contractor will work with BHRS to ensure participating clients are successfully transferred to another DMC-ODS provider.

iv. Contractor shall provide written notification to the AOD Administrator of any changes in DMC-ODS offered services at least ninety (90) days prior to implementing the changes in services.

b. DMC-ODS SUD Treatment Services

i. If at any time, Contractor's license, registration, certification, or approval to operate a substance use disorder program or provide a DMC-ODS covered service is revoked, suspended, modified, or not renewed outside of DHCS, the Contractor shall notify DHCS Fiscal Management & Accountability Branch by e-mail at DHCSMPF@dhcs.ca.gov and the BHRS Program Analyst within two (2) business days of knowledge of such change.

ii. Contractor's certification to participate in the DMC program shall automatically terminate in the event the Contractor or its owners, officers or directors are convicted of Medi-Cal fraud, abuse or malfeasance. For purposes of this section, a conviction shall include a plea of guilty or nolo contendere.

iii. If Contractor is under investigation by DHCS or any other state, local or federal law enforcement agency for

fraud or abuse, DHCS may temporarily suspend the Contractor from the DMC program, pursuant to W&I Code, Section 14043.36(a). Information about Contractor's administrative sanction status is confidential until such time as the action is either completed or resolved. The DHCS may also issue a Payment Suspension to Contractor pursuant to W&I Code, Section 14107.11 and Code of Federal Regulations, Title 42, section 455.23. DHCS will authorize BHRS to withhold payments from the DMC Contractor during the time a Payment Suspension is in effect.

15. Licensing Reports

Contractor shall submit a copy of any licensing complaint or corrective report issued by a licensing agency to BHRS Quality Management and Manager of SUD Services or their designee, within ten (10) business days of Contractor's receipt of any such licensing report.

16. Compliance with HIPAA, Confidentiality Laws, and PHI Security

a. Contractor must implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Protected Health Information (PHI), including electronic PHI that it creates, receives, maintains, uses or transmits, in compliance with 45 C.F.R and to prevent use or disclosure of PHI other than as provided for by this Agreement. Contractor shall implement reasonable and appropriate policies and procedures to comply with the standards. Contractor is required to report any security incident or breach of confidential PHI to BHRS Quality Management within twenty–four (24) hours.

b. Contractor will develop and maintain a written Privacy and Security Program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities.

i. On an annual basis, Contractor shall require all staff accessing client PHI or PI to sign a confidentiality statement that includes, as a minimum, General Use,

Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies.

c. Contractor shall install and actively use comprehensive antivirus software on all workstations, laptops and other systems that process and/or store PHI or PI. The antivirus software solution must have automatic updates scheduled at least daily.

d. All workstations, laptops and other systems that process and/or store PHI or PI shall have critical security patches applied, with system reboot if necessary. Contractor shall document the patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within thirty (30) days of vendor release. Applications and systems that cannot be patched within this timeframe due to significant operational reasons must have compensatory controls implemented to minimize risk until the patches can be installed. Applications and systems that cannot be patched must have compensatory controls implemented to minimize risk, where possible.

e. Contractor agrees to comply with the provisions of 42 C.F.R. Part 2 as described below if records contain or contract possesses any PHI covered under 42 C.F.R Part 2:

   i. Acknowledge that in receiving, storing, processing, or otherwise using any information from BHRS about the clients in the program, it is fully bound by the provisions of the federal regulations governing Confidentiality of Behavioral Health and Recovery Services Patient Records, 42 C.F.R. Part 2;

   ii. Undertake to resist in judicial proceedings any effort to obtain access to information pertaining to clients otherwise than as expressly provided for in the federal confidentiality regulations, 42 C.F.R. Part 2; and

   iii. Agree to use appropriate safeguards to prevent the unauthorized use or disclosure of the protected information.

f. Confidentiality Training

Contractor is required to conduct, complete and maintain record of annual confidentiality training by all staff serving or accessing PHI of BHRS clients. Contractor may utilize BHRS Confidentiality trainings located at http://smchealth.org/bhrs/providers/ontrain.

17. Other Required Training

Contractor will complete and maintain a record of annual required trainings. The following trainings must be completed on an initial and then annual basis:

a. Confidentiality & HIPAA for BHRS Mental Health and AOD:
b. Compliance Training
c. Fraud, Waste, & Abuse Training
d. AB 210 Brief Overview
e. Critical Incident Management
e. Cultural Humility
f. Interpreter training (if using interpreter services)
g. ASAM certification training: All New Staff (SUD contractors only)
h. At least 5 hours annually of addiction medicine training for all LPHA employees (SUD contractors only)
i. At least 6 hours annually of the Evidenced-Based Practices utilized at the agency (SUD contractors only)
j. Human Trafficking and compliance with the Human Trafficking Victims Protection Act of 2000 (SUD contractors only)
k. DMC-ODS Documentation Requirements (SUD contractors only)
l. Infectious Disease
m. Elder and Child abuse training

Trainings may be offered through the County's Learning Management System (LMS) located at: https://sanmateocounty.csod.com/LMS/catalog/Welcome.aspx?tab_page_id=-67.
Contractor must register on the LMS site to access the training modules. The link to register for a LMS new account is: https://sanmateocounty.csod.com/selfreg/register.aspx?c=bhrscp01

Proof of training, such as certificate of completion, may be requested at any time during the term of this Agreement.

18. Critical Incident Reporting

Contractor is required to submit Critical Incident reports to BHRS Quality Management on the same day of the incident or within 24 hours when there are unusual events, accidents, errors, violence or significant injuries requiring medical treatment for clients, staff or members of the community. (Policy #93-11 and 45 C.F.R. § 164, subpart C, in compliance with 45 C.F.R. § 164.316.)

The incident reports are confidential however discussion may occur with the Contractor regarding future prevention efforts to reduce the likelihood of recurrence. Contractor is required to participate in all activities related to the resolution of critical incidents, including but not limited to participation in quality improvement meetings, provision of all information requested by the County relevant to the incident, and Contractor staff cooperation.

19. Ineligible Employees

Behavioral Health and Recovery Services (BHRS) requires that contractors comply with Federal requirements as outlined in 42 CFR (438.608) Managed Care Regulations. Contractors must identify the eligibility of employees, interns, or volunteers prior to hiring and on a monthly basis thereafter. Results of the eligibility screenings are to be maintained in the employee files. This process is meant to ensure that any person delivering services to clients of BHRS are not currently excluded, suspended, debarred or have been convicted of a criminal offense as described below. The Contractor must notify BHRS Quality Management (by completing the BHRS Critical Incident Reporting Form, Policy 93-11) should a current employee, intern, or volunteer be identified as ineligible. Contractors are required to screen for ineligible employees, interns, and volunteers by following procedures included in BHRS Policy 19-08, which can be found online at: https://www.smchealth.org/bhrs-policies/credentialing-and-re-credentialing-providers-19-08. BHRS Quality Management must be notified within twenty-four (24) hours of any violations. Contractor must notify BHRS Quality Management if an employee's license is not current or is not in good standing and must submit a plan to correct to address the matter.

a. Credentialing Check – Initial

During the initial contract process, BHRS will send a packet of contract documents that are to be completed by the Contractor and returned to BHRS. Attachment A –

Agency/Group Credentialing Information will be included in the contract packet. Contractor must complete Attachment A and return it along with all other contract forms.

b. Credentialing Check – Monthly

Contractor will complete Attachment A – Agency/Group Credentialing Information each month and submit the completed form to BHRS Quality Management via email at: HS_BHRS_QM@smcgov.org or via a secure electronic format.

20. Compliance Plan and Code of Conduct

Contractor will annually read and be knowledgeable of the compliance principles contained in the BHRS Compliance Plan and Code of Conduct located at http://smchealth.org/bhrs-documents. In addition, Contractor will assure that Contractor's workforce is aware of compliance mandates and informed of the existence and use of the BHRS Compliance Improvement Hotline (650) 573-2695.

Contractor is required to conduct, complete and maintain record of annual compliance training by all staff serving or accessing PHI of BHRS clients. Contractor may utilize BHRS Confidentiality trainings located at http://smchealth.org/bhrs/providers/ontrain.

21. Fingerprint Compliance

Contractor certifies that, if its contracted program(s) are identified as being a 'high' categorical risk level as per 42 CFR 455.434 and Welfare and Institutions (W&I) Code Section 14043.38, that its employees, trainees, and/or its subcontractors, assignees, volunteers, and any other persons who provide services under this agreement, who have direct contact with any client will be fingerprinted in order to determine whether they have a criminal history which would compromise the safety of individuals with whom the Contractor's employees, trainees and/or its subcontractors, assignees, or volunteers have contact. Contractor shall have a screening process in place to ensure that employees who have positive fingerprints shall:

a. Adhere to CCR Title 9 Section 13060 (Code of Conduct) when providing services to individuals with whom they have contact as a part of their employment with the contractor; OR

b. Obtain an exemption from Community Care Licensing allowing the employee to provide services to individuals with whom they have contact as a part of their employment with the contractor.

A certificate of fingerprinting certification is attached hereto and incorporated by reference herein as Attachment E.

22. Staff Termination

Contractor shall inform BHRS, within two (2) business days, when staff have been terminated. BHRS Quality Management and BHRS Management Information System requires prompt notification to be able to terminate computer access and to safeguard access to electronic medical records by completing the BHRS Contractor Termination Form.

23. Minimum Staffing Requirements

Contractor shall have on file 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. Contractor agrees to submit any material changes in such duties or minimum qualifications to County prior to implementing such changes or employing persons who do not meet the minimum qualifications currently on file. Contractor service personnel shall be direct employees, contractors, volunteers, or training status persons.

24. Provider Application and Validation for Enrollment (PAVE) Enrollment

Contractor shall be enrolled in the PAVE program or in the process of becoming enrolled. https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx
Contractor will keep BHRS informed on their enrollment status and submit proof of PAVE enrollment to HS_BHRS_PAVE@smcgov.org

I. Cultural Competency

Implementations of these guidelines are based on the National Culturally and Linguistically Accessible Services (CLAS) Standards issued by the Department of Health and Human Services. For more information about these standards, please contact the Office of Diversity & Equity (ODE) at 650- 573-2714 or ode@smcgov.org.

1. Contractor will submit an annual cultural competence plan that details on-going and future efforts to address the diverse needs of clients, families and the workforce. This plan will be submitted to the BHRS Analyst/Program Manager and the Office of Diversity & Equity (ODE) by September 30th of the fiscal year.

   The annual cultural competence plan will include, but is not limited to the following:

   a. Implementation of policies and practices that are related to promoting diversity and cultural competence, such as ongoing organizational assessments on disparities and needs, client's rights to receive language assistance.

   b. Contractor forum for discussing relevant and appropriate cultural competence-related issues (such as a cultural competence committee, grievance, or conflict resolution committee).

   c. Ongoing collection of client cultural demographic information, including race, ethnicity, primary language, gender and sexual orientation in health records to improve service provision and help in planning and implementing CLAS standards.

   d. Staffing objectives that reflect the cultural and linguistic diversity of the clients. (Contractor will recruit, hire and retain clinical staff members who can provide services in a culturally and linguistically appropriate manner.).

   e. Contractor will ensure that all program staff receive at least 8 hours of external training per year (i.e. sponsored by BHRS or other agencies) on how to provide culturally and linguistically appropriate services including the CLAS and use of interpreters.

2. Contractor will actively participate in at least one cultural competence effort within BHRS and/or to send a representative to attend a Health Equity Initiative (HEI), including but not limited to the Diversity & Equity Council (DEC), for the term of the Agreement. Participation in an HEI/DEC allows for the dissemination of CLAS as well as ongoing collaborations with diverse stakeholders. Contractor shall submit to BHRS Office of Diversity and Equity (ODE) by March 31st, a list of staff who have participated in these efforts. For more information

about the HEI/DEC, and other cultural competence efforts within BHRS, contact ODE or visit https://www.smchealth.org/health-equity-initiatives.

3. Contractor will establish the appropriate infrastructure to provide services in County identified threshold languages. Currently the threshold languages are: Spanish, Tagalog and Chinese (Mandarin and Cantonese). If Contractor is unable to provide services in those languages, Contractor is expected to contact their BHRS Analyst/Program Manager for consultation. If additional language resources are needed, please contact ODE.

4. Contractor will translate relevant and appropriate behavioral health-related materials (such as forms, signage, etc.) in County identified threshold languages in a culturally and linguistically appropriate manner. BHRS strongly encourages its contractors to use BHRS-sponsored forms in an effort to create uniformity within the system of care. Contractor shall submit to ODE by March 31st, copies of Contractor's health-related materials in English and as translated.

5. Should Contractor be unable to comply with the cultural competence requirements, Contractor will meet with the BHRS Analyst/Program Manager and ODE (ode@smcgov.org) to plan for appropriate technical assistance.

J. Availability and Accessibility of Service

Contractor shall offer hours of operation that are no less than the hours of operation offered to commercial enrollees, if the Contractor also serves enrollees of a commercial plan, or that are comparable to the hours the Contractor makes available for Medi-Cal services that are not covered by the County or another Mental Health Plan, if the Contractor serves only Medi-Cal clients.

K. Surety Bond

Contractor shall retain and show proof of a bond issued by a surety company in accordance with Community Care Licensing's regulations for a licensee who may be entrusted with care and/or control of client's cash resources.

L. Control Requirements

Contractor shall be familiar and implement the laws, regulations, codes and guidelines listed in Attachment L. Contractor shall assure that its Subcontractors are also familiar with such requirements.

Contractor shall establish written policies and procedures consistent with the requirements identified in Attachment L. Contractor shall be held accountable for audit exceptions taken by the State for any failure to comply with these requirements.

DMC Contractor will fulfill the requirements of 42 CFR Part 438 et seq (managed care) that are appropriate to the service or activity covered under this contract.

Attachment L is subject to modifications by federal, state and local regulations that are applicable to the Intergovernmental Agreement.

M. 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(g)) as amended by section 1702: http://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title22-section7104d&num=0&edition=prelim.

N. Hatch Act

Contractor 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. County-Owned Facility

Contractor agrees to the terms and conditions as specified in Schedule C attached hereto.

P. Capacity Management

Capacity management systems track and manage the flow of clients with SUDs entering treatment. These systems serve to ensure timely placement into the appropriate level of care.

When Contractor cannot admit a pregnant or parenting woman or an intravenous substance user because of insufficient capacity, the Contractor shall:

1. Provide or arrange for interim services within forty-eight (48) hours of the service request, including a referral for prenatal care.

2. Refer the individual to DHCS through its capacity management program.

3. When Contractor reaches or exceeds ninety percent (90%) of its treatment capacity, the provider must report this information to the Drug and Alcohol treatment Access Report (DATAR) on a monthly basis.

4. Contractor shall also notify the County and DHCS seven (7) days upon reaching or exceeding 90 percent of its treatment capacity by emailing the designated County staff and DHCS at DHCSPerinatal@dhcs.ca.gov. The subject line in the email must read "Capacity Management."

Q. Substance Use Block Grant (SUBG) Specifications

1. Debarment and Suspension

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.

Contractor 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 the 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).

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

All work performed under this Contract is subject to HIPAA, County shall perform the work in compliance with all applicable provisions of HIPAA. As identified in Exhibit E, DHCS and County shall cooperate to assure mutual agreement as to those transactions between them, to which this provision applies. Refer to Exhibit E for additional information.

a. Trading Partner Requirements

i. No Changes. Contractor 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)).

ii. No Additions. Contractor 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)).

iii. No Unauthorized Uses. 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. Contractor 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)).

3. Concurrence for Test Modifications to HHS Transaction Standards

Contractor 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.

4. Adequate Testing

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

5. Deficiencies

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

6. 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.

7. 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.

8. Nondiscrimination and Institutional Safeguards for Religious Providers

Contractor 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.

9. Counselor Certification

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

10. Cultural and Linguistic Proficiency

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://thinkculturalh ealth.hhs.gov/clas/standards

11. Intravenous Drug Use (IVDU) Treatment

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)).

12. Tuberculosis Treatment

Contractor shall ensure the following related to Tuberculosis (TB):

a. Routinely make available TB services to individuals receiving treatment.

b. Reduce barriers to patients' accepting TB treatment.

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

13. Trafficking Victims Protection Act of 2000

Contractor 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.

14. Tribal Communities and Organizations

Contractor 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.

15. Marijuana Restriction

Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 CFR. § 75.300(a) (requiring HHS to “ensure that Federal funding

is expended . . . in full accordance with U.S. statutory . . . requirements."); 21 USC § 812(c) (10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the 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.

16. 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.

17. Adolescent Best Practices Guidelines

Contractor must utilize DHCS guidelines in developing and implementing youth treatment programs funded under this Enclosure The Adolescent Best Practices Guidelines can be found at:
DHCS Adolescent Substance Use Disorder Best Practices Guides October 2020

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

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

19. Nondiscrimination in Employment and Services

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

20. 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).

21. 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 Contractor or its subcontractors for sectarian worship, instruction, or proselytization. No federal funds shall be used by the Contractor or its subcontractors to provide direct, immediate, or substantial support to any religious activity.

22. 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.

23. Information Access for Individuals with Limited English Proficiency

a. 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. 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.

III. PERFORMANCE STANDARDS/GOALS AND OBJECTIVES

Contractor shall ensure that the following outcome objectives are pursued throughout the term of this Agreement:

PERFORMANCE STANDARDS

A. Timely Access to Care: Contractor shall track and document timely access data, including the date of initial contact, the date of first offered appointment, and the date of first actual appointment, in Avatar using the IPS episode.

1. For non-urgent requests, the first appointment shall occur no later than ten (10) days after the initial request for services.

2. For urgent requests, the first appointment shall occur no later than seventy-two (72) hours after the referral was received, if the Contractor has capacity to admit the client. If the Contractor does not have capacity to admit the client, the Contractor shall either refer the client to interim services or to another clinically and culturally appropriate provider with capacity.

3. For NTP/OTP and Residential Withdrawal Management, the first appointment shall occur within twenty-four (24) hours of the initial request for services.

B. Transitions Between Levels of Care: Both the admitting and discharging Contractors shall be responsible for facilitating the client's transition between levels of care, including assisting the client in scheduling their first appointment and ensuring a minimal delay between discharge and admission at the next level of care, providing or arranging for transportation as appropriate, and documenting the transition in the client's chart.

1. Transitions between levels of care shall occur within seven (7) calendar days from the time of the SUD Reassessment indicating the need for a different level of care.

2. At least fifty percent (50%) of clients discharged from Residential Treatment are subsequently admitted to another level of care (IOP, OP or Recovery Services) within seven (7) calendar days from the date of discharge.

3. At least seventy-five percent (75%) of clients discharged from Residential Withdrawal Management care are subsequently admitted to another level of care within seven (7) calendar days from the date of discharge.

4. At least thirty percent (30%) of clients discharged from Intensive Outpatient or Outpatient Treatment are subsequently admitted to another level of care (including Recovery Services) within seven (7) calendar days from the date of discharge.

C. Care Coordination: Contractor shall ensure 42 CFR compliant releases are in place for all clients in order to coordinate care. The Contractor shall screen for and link clients with mental health and primary care, as indicated.

1. One hundred percent (100%) of clients retained in treatment for at least thirty (30) days are screened for mental health and primary health care needs.

2. At least seventy percent (70%) of clients who screen positive for mental health disorders and were retained in treatment for at least thirty (30) days have documentation of referrals to and coordination with mental health providers.

3. At least eighty percent (80%) of clients who screen positive for primary health care needs and were retained in care for at least thirty

(30) days have documentation of referrals to and/or coordination with primary care providers.

D. Medication Assisted Treatment: Contractor shall have procedures for referrals to and integration of medication assisted treatment for substance use disorders. Contractor staff shall regularly communicate with physicians of clients prescribed these medications unless the client refuses to sign a Release of Information.

1. One hundred percent (100%) of clients with a primary opioid or alcohol use disorder will be offered a referral for a MAT assessment and/or MAT services.

E. Culturally Competent Services: Contractor shall be responsible for providing culturally competent and linguistically appropriate services. Translation and interpretation services shall be available to all clients, as needed and at no cost to the client.

1. One hundred percent (100%) of clients who speak a threshold language are provided services in their preferred language via a licensed, credentialed, or registered staff person, or a subcontracted interpreter service.

2. One hundred percent (100%) of clients who read a threshold language are provided written treatment materials in their preferred language, or a subcontracted translation service.

GOALS AND OBJECTIVES

Contractor shall ensure that the following outcome objectives are pursued throughout the term of this Agreement:

GOAL: Program participants will achieve a successful treatment discharge.

OBJECTIVE: No less than eighty-five percent (85%) of participants will have a successful treatment discharge. Successful treatment discharge occurs when a program participant completes their treatment/recovery plan or is transferred for continued treatment.

*** END OF EXHIBIT A ***

EXHIBIT B – PAYMENTS AND RATES
HORIZON SERVICES, INC.
FY 2025-2027

In consideration of the services provided by Contractor in Exhibit A, County shall pay Contractor based on the following fee schedule:

I. PAYMENTS

In full consideration of the services provided by Contractor under this Agreement and subject to the provisions of Section 3 of this Agreement, County shall pay Contractor in the manner described below:

A. Maximum Obligation

The maximum amount that County shall be obligated to pay for all services provided under this Agreement shall not exceed the amount stated in Section 3 of this Agreement. Furthermore, County shall not pay or be obligated to pay more than the amounts listed below for each component of service required under this Agreement.

In any event, the maximum amount county shall be obligated to pay for all services rendered under this contract shall not exceed **EIGHT MILLION FOUR HUNDRED THIRTY-EIGHT THOUSAND SEVENTY-EIGHT DOLLARS ($8,438,078).**

The county will review cumulative fee for service payments for the period of July – March each fiscal year and amend the contract obligations if necessary to reflect actual services paid for on a fee for services basis.

B. One Time 3- Month Advance Payment Option

1. Not later than April 22, 2025, Contractor may request in writing a one-time advance payment of up to three (3) months of the maximum obligation of this contract. These advance payments will be reconciled on or before November 2025 against the actual services provided for all services currently paid using fee for service methodology. This advance payment will be made in June 2025.All payments other than this advance payment will be made in arrears.

2. In the event that the County makes any advance payments, Contractor agrees to refund any amounts in excess of the amount owed to by the County or credit a portion of such advance payments to the County. Contractor is only entitled to payment for work pursuant to this Agreement.

3. Within 30 days of November 30, 2025, Contractor must submit an invoice for amounts owed by the County or a refund to the County for any advance funds in excess of actual costs. In no event, however, shall County's annual fiscal obligation under this Agreement exceed the amounts noted in Exhibit B Section C and Section D. Fiscal Year and Amount.

4. Advance payments will only be made in FY 2025-26. There will be no advance payments in future years.

C. Drug MediCal Organized Delivery System SUD Treatment Services

1. Payments for Services Provided in FY24-25

The County shall pay a maximum amount of **THREE HUNDRED ELEVEN THOUSAND SIX HUNDRED THIRTY-SIX DOLLARS ($311,636)** for services provided during FY 2024-25.

a. 1/12th payment for June FY 2024-25 shall be **THREE HUNDRED ELEVEN THOUSAND SIX HUNDRED THIRTY-SIX DOLLARS ($311,636).**

b. Invoice for this payment must be submitted to BHRS fiscal unit no later than May 15, 2025.

Reconciliations to actual claimed services for FY 2024-25 and related 1/12th payments will be conducted quarterly.

2. July 1, 2025 – June 30, 2026

The maximum amount County shall be obligated to pay for DMC-ODS services shall not exceed **FOUR MILLION ONE THOUSAND FOUR HUNDRED DOLLARS ($4,001,400)**.

Subject to the maximum amount stated above and the terms and conditions of this Agreement, Contractor shall be reimbursed the Fee for Services rates per schedule in the Exhibit C and of providing services described in Section I of Exhibit A.

3. July 1, 2026 – June 30, 2027

The maximum amount County shall be obligated to pay for DMC-ODS services shall not exceed **FOUR MILLION ONE HUNDRED**

TWENTY-FIVE THOUSAND FORTY-THREE DOLLARS ($4,125,043).

Subject to the maximum amount stated above and the terms and conditions of this Agreement, Contractor shall be reimbursed the Fee for Services rates per schedule in the Exhibit C and of providing services described in Section I of Exhibit A.

4. INVOICING

a. Contractor shall submit monthly invoices for payment Invoice amount shall be submitted by Contractor for an advanced payment. Contractor will submit invoices on forms in a manner prescribed by the County.

b. Invoices shall be provided to County within 15 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 30 days.

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 C. Any Exhibit CPT, HCPCS code or rate updates will be made available to the Contractor on-line and/or via an Executive Letter by the County.

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 or the reasons for recoupment set forth in, Section 4.

e. Due to the County Controller's Office yearly "Black-Out Period" there will be no payments made in July or August. Payments for these months will be issued once the Controller's Office has reopened in September. This pertains to all fiscal years.

5. REASONS FOR RECOUPMENT

a. In addition to the reconciliation process noted in section 4, 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.

b. Such audits may result in requirements for Contractor to reimburse County for services previously paid in the following circumstances:
   I. Identification of Fraud, Waste or Abuse as defined in federal regulation
   II. Fraud and abuse are defined in C.F.R. Title 42, § 455.2 and W&I Code, section 14107.11, subdivision (d).
   III. Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual available at www.cms.gov/Regulation-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf
   IV. Overpayment of Contractor by County due to errors in claiming or documentation.
   V. Other reasons specified in the SMHS Reasons for Recoupment document released annually by DHCS and posted on the DHCS BHIN website.

c. 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 Country or state or federal agency. The Contractor shall notify the County within 60 days in writing of any identified overpayments and the reason. Notification shall be emailed to the AOD reporting mailbox at HS_BHRS_AOD_Reporting@smcgov.org and cc BHRS Analyst. The Contractor shall return the overpayment to the County within 60 calendar days after the date on which the overpayment was identified or BHRS may offset the amount disallowed from any payment due to the Contractor under the Contract Agreement.

6. ADDITIONAL FINANCIAL REQUIREMENTS

a. County has the right to monitor the performance of this Agreement to ensure the accuracy of claims for reimbursement and compliance with all applicable laws and regulations.

b. 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.

c. 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.

d. Federal Financial Participation is not available for any amount furnished to an Excluded individual or entity, or at the direction of a physician during the period of exclusion when the person providing the service knew or had reason to know of the exclusion, or to an individual or entity when the County failed to suspend payments during an investigation of a credible allegation of fraud [42 U.S.C. section 1396b(i)(2)].

7. CONTRACTOR PROHIBITED FROM REDIRECTION OF CONTRACTED FUNDS

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

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8. Billing for DMC Services

a. Contractor shall bill BHRS for services provided to Medi-Cal clients, covered under the DMC-ODS.

b. Contractor must follow the process established under DHCS ADP Bulletin 11-01, for clients that have other healthcare coverage (OHC) in addition to Medi-Cal including future DHCS process updates for DMC claims for clients with OHC: http://www.dhcs.ca.gov/services/MH/MHSUD/Documents/ADP_Bulletins/ADP_11-01.pdf.

c. Services covered through another healthcare provider shall not be reimbursed through the County. Contractor shall bill the other healthcare coverage for which the client is a

member. If Contractor is not a member of the provider network for that healthcare coverage, Contractor shall then refer client to the healthcare provider network.

9. DMC-ODS Administrative Requirements

a. Contractor may not use allocated DMC State General Funds to pay for any non-DMC services. In accordance with W&IC Sections 14132.44 and 14132.47, funds allocated to the Contractor for DMC services, including funding for alcohol and other drug services for pregnant and postpartum women pursuant to Title 22, Section 51341.1(c), may not be used as match for targeted case management services or for MediCal Administrative Activities (MAA).

b. DMC rates are contingent upon legislative action of the annual State Budget and/or the approval of the DMC-ODS plan. All claims must be documented in accordance with DHCS DMC Provider Billing Manual, DMC rules, guidelines, timelines, and must be provided by staff who are lawfully authorized to provide, prescribe and/or order these services within the scope of their practice and/or licensure.

c. Contractor shall prepare and retain for DHCS review as needed the following forms: a) multiple billing overrider certification (MC 6700), document 2K; b) Good Cause Certification (6065A) document 2L(a); and Good Cause Certification (6065B) Document 2LB. In the absence of good cause documented on the GCC 6065 a or b form, claims that are not submitted within thirty (30) days of the end of the month of service will be denied.

d. The existence of good cause shall be determined by DHCS in accordance with Title 22, CCR, Sections 51008 and 51008.5.

e. DMC services are jointly funded by Federal Financial Participation (FFP) and matching State and local dollars. FFP is the Federal share of reimbursement for eligible services delivered to MediCal clients as defined by CCR Title 9, Section 1840.1000. Contractor will meet the FFP eligibility criteria.

D. All Services

1. Contractor will be responsible for all expenses incurred during the performance of services rendered under this Agreement.

2. Modifications to the allocations in Section A of this Exhibit B may be approved by the Chief of San Mateo County Health or designee, subject to the maximum amount set forth in Section 3 of this Agreement.

3. The Chief of San Mateo County Health or designee is authorized to execute contract amendments which modify the County's maximum fiscal obligation by no more than $25,000 (in aggregate), and/or modify the contract term and/or services so long as the modified term or services is/are within the current or revised fiscal provisions.

4. In the event that funds provided under this Agreement are expended prior to the end of the contract period, Contractor shall provide ongoing services not unit based, rate services under the terms of this Agreement through the end of the contract period without further payment from County.

5. In the event this Agreement is terminated prior to June 30, 2027, Contractor shall be paid on a prorated basis for only that portion of the contract term during which Contractor provided services pursuant to this Agreement. Such billing shall be subject to the approval of the Chief of San Mateo County Health or designee.

6. Disallowances that are attributable to an error or omission on the part of County shall be the responsibility of County. This shall include but not be limited to quality assurance (QA) audit disallowances as a result of QA Plan error or format problems with County-designed service documents.

7. The contracting parties shall be subject to the examination and audit of the Department of Auditor General for a period of three years after final payment under contract (Government Code, Section 8546.7).

8. Contractor shall set and collect client fees from non-Medi-Cal members based on the client's ability to pay. The fee requirement shall not apply to prevention and early intervention services. Contractor shall identify in its annual cost report the types and amounts of revenues collected.

9. County anticipates revenues from various sources to be used to fund services provided by Contractor through this Agreement. Should actual revenues be less than the amounts anticipated for any period

of this Agreement, the maximum payment obligation and/or payment obligations for specific services may be reduced at the discretion of the Chief of San Mateo County Health or designee.

10. Adjustments may be made to the total of the Agreement and amounts may be withheld from payments otherwise due to the Contractor for nonperformance to the extent that nonperformance involves fraud, abuse, or failure to achieve the objectives of the provisions of Exhibit A.

11. In the event Contractor claims or receives payment from County for a service, reimbursement for which is later disallowed by County or the State of California or the United States Government, then Contractor shall promptly refund the disallowed amount to County upon request, or, at its option, County may offset the amount disallowed from any payment due or become due to Contractor under this Agreement or any other agreement.

12. Contractor shall provide all pertinent documentation required for Medi-Cal, Medicare, and any other federal and state regulation applicable to reimbursement including assessment and service plans, and progress notes. The County may withhold payment for any and all services for which the required documentation is not provided, or if the documentation provided does not meet professional standards as determined by the San Mateo County BHRS Quality Improvement Manager.

    Contractor shall maintain for review and audit and supply to County and/or DHCS upon request, adequate documentation of all expenses claimed pursuant to this Intergovernmental Agreement to permit a determination of expense allowability.

    If the allowability or appropriateness of an expense cannot be determined by County or DHCS because invoice detail, fiscal records, or backup documentation is nonexistent or inadequate according to generally accepted accounting principles and generally accepted governmental audit standards, all questionable costs may be disallowed by County or DHCS. Upon receipt of adequate documentation supporting a disallowed or questionable expense, reimbursement may be made for the amount substantiated and deemed allowable. Invoices, received from a Contractor and accepted and/or submitted for payment by County, shall not be deemed evidence of allowable Intergovernmental Agreement costs.

    It is understood and agreed that failure by the County or Contractor

to comply with applicable federal and state requirements in rendering covered services shall be sufficient cause for the State to deny payments to and/or recover payments from the County and/or terminate the Contractor from DMC program participation. If the State or the Department of Health Care Services (DHCS) disallows or denies payments for any claim, County shall repay to the State the federal Medicaid funds and/or State General Funds it received for all claims so disallowed or denied. The overpayment shall be recovered by any of the methods allowed in Title 22, CCR, Sections 51047(a) and (b).

Before such denial, recoupment, or disallowances are made, State shall provide the Contractor with written notice of its proposed action. Such notice shall include the reason for the proposed action and shall allow the Contractor sixty (60) days to submit additional information before the proposed action is taken, as required in Title 22, CCR, Section 51047(a).

Reimbursement for covered services, other than NTP services, shall be limited to the lower of:

a. Contractor's usual and customary charges to the general public for the same or similar services;

b. Contractor's actual allowable costs.

13. Substance Use Prevention and Treatment, and Recovery Services Block Grant Funding

Contractor shall comply with the Substance Use Block Grant (SUBG) financial management standards contained in Title 45, CFR, Part 74, Sections 74.21(b)(1) through (4) and (b)(7), and Part 96, Section 96.30.

Pursuant to 42 U.S.C. 300x-31, Contractor shall not use SUBG Block Grant funds provided by the Intergovernmental Agreement on the following activities:

a. Provide inpatient services;

b. Make cash payment to intended recipients of health services;

c. Purchase or improve land, purchase, construct or permanently improve (other than minor remodeling) any building or other facility or purchase major medical equipment;

d. Satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds;

f. Provide financial assistance to any entity other than a public or nonprofit private entity;

g. 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;

h. Purchase treatment services in penal or correctional institutions of this State of California; and

i. Supplant state funding of programs to prevent and treat substance abuse and related activities.

14. County May Withhold Payment

Contractor shall provide all pertinent documentation required for Medi-Cal, Medicare, and any other federal and state regulation applicable to reimbursement including assessment and service plans, and progress notes. The County may withhold payment for any and all services for which the required documentation is not provided, or if the documentation provided does not meet professional standards as determined by the BHRS Quality Improvement Manager. Contractor shall meet quarterly with County contract monitor, as designated by the BHRS Deputy Director, Adult and Older Adults, to review documentation and billing reports, and to take appropriate corrective action, as needed, to resolve any identified discrepancies.

15. Inadequate Performance

If County or Contractor finds that performance is inadequate, at the County's discretion, a meeting may be called to discuss the causes for the performance problem, to review documentation, billing and/or other reports, and to take appropriate corrective action, as needed, to resolve any identified discrepancies. This Agreement may be renegotiated, allowed to continue to end of term, or terminated pursuant to Section 5 of this Agreement. Any unspent monies due to performance failure may reduce the following year's agreement, if any.

16. Member Billing

Contractor shall not submit a claim to, demand or otherwise collect reimbursement from, the member or persons acting on behalf of the member for any specialty mental health or related administrative services provided under this contract except to collect other health insurance coverage, share of cost and co-payments. The Contractor shall not hold members liable for debts in the event that the County becomes insolvent, for costs of covered services for which the State does not pay the County, for costs of covered services for which the State or the County does not pay the Contractor, for costs of covered services provided under this or other contracts, referral or other arrangement rather than from the County, or for payment of subsequent screening and treatment needed to diagnose the specific condition of or stabilize a member with an emergency psychiatric condition.

17. Claims Certification and Program Integrity

a. Contractor shall comply with all state and federal statutory and regulatory requirements for certification of claims, including Title 42, Code of Federal Regulations (CFR) Part 438, Sections 438.604, 438.606, and, as effective August 13, 2003, Section 438.608, as published in the June 14, 2002 Federal Register (Vol. 67, No. 115, Page 41112), which are hereby incorporated by reference.

b. Anytime Contractor submits a claim to the County for reimbursement for services provided under Exhibit A of this Agreement, Contractor shall certify by signature that the claim is true and accurate by stating the claim is submitted under the penalty of perjury under the laws of the State of California.

The claim must include the following language and signature line at the bottom of the form(s) and/or cover letter used to report the claim.

"Under the penalty of perjury under the laws of the State of California, I hereby certify that this claim for services complies with all terms and conditions referenced in the Agreement with San Mateo County.

Executed at _____California, on _____20___

Signed _____ Title_____

Agency _____ ”

c. The certification shall attest to the following for each member with services included in the claim:

i. An assessment of the member was conducted in compliance with the requirements established in this agreement.

ii. The member was eligible to receive services described in Exhibit A of this Agreement at the time the services were provided to the member.

iii. The services included in the claim were actually provided to the member.

iv. Medical necessity was established for the member as defined under California Code of Regulations, Title 9, Division 1, Chapter 11, for the service or services provided, for the timeframe in which the services were provided.

v. A client plan was developed and maintained for the member that met all client plan requirements established in this agreement.

vi. For each member with specialty mental health services included in the claim, all requirements for Contractor payment authorization for specialty mental health services were met, and any reviews for such service or services were conducted prior to the initial authorization and any re-authorization periods as established in this agreement.

vii. Services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability.

d. Except as provided in Paragraph V.A. of Exhibit A relative to medical records, Contractor agrees to keep for a minimum period of three years from the date of service a printed representation of all records which are necessary to disclose

fully the extent of services furnished to the client. Contractor agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California, to the California Department of Health Services; the Medi-Cal Fraud Unit; California Department of Mental Health; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services, Managed Risk Medical Insurance Board or their duly authorized representatives, and/or the County.

18. Audit Requirements

All expenditures of County realignment funds, state and federal funds furnished to the Contractor are subject to audit by the State. Such audits shall consider and build upon external independent audits performed pursuant to audit requirements of the Office of Management and Budget (OMB) 2 CFR 200 and/or any independent Contractor audits or reviews.

In addition to requirements below, Contractor shall be in compliance with federal Single Audit requirements as a designated sub-recipient of federal funding. Contractor agrees to amend this agreement during the contract term to add federal Uniform Guidance compliance requirements.

Objectives of audits may include, but not limited to, the following:

a. To determine whether units of service claimed/reported are properly documented by service records and accurately accumulated for claiming/reporting;

b. To validate data reported by the Contractor for prospective Intergovernmental Agreement negotiations;

c. To provide technical assistance in addressing current year activities and providing recommendation on internal controls, accounting procedures, financial records, and compliance with laws and regulations;

d. To determine the cost of services, net of related patient and participant fees, third- party payments, and other related revenues and funds;

e. To determine that expenditures are made in accordance with

applicable state and federal laws and regulations and State Agreement with the State requirements, and/or;

f. To determine the facts in relation to analysis of data, complaints, or allegations, which may be indicative of fraud, abuse, willful misrepresentation.

Unannounced visits may be made at the discretion of the State and/or County.

The refusal of the Contractor to permit access to and inspection of electronic or print books and records, physical facilities, and/or refusal to permit interviews with employees, as described in this part constitutes an express and immediate material breach of this Agreement and will be sufficient basis to terminate the Agreement for cause or default.

County shall monitor the activities of Contractor to ensure that:

a. Contractor is complying with program requirements and achieving performance goals; and

b. Contractor is complying with fiscal requirements, such as having appropriate fiscal controls in place, and using awards for authorized purposes.

Contractor shall be responsible for any disallowance taken by the Federal Government, the State, or the California State Auditor, as a result of any audit exception that is related to the Contractor's responsibilities herein.

Pursuant to OMB Circular A-133, State may impose sanctions against the Contractor for not submitting single or program-specific audit reports, or failure to comply with all other audit requirements. Should such sanctions be due to noncompliance by the Contractor, such sanctions will be passed on to the Contractor by the County. The sanctions may include:

a. Withholding a percentage of federal awards until the audit is completed satisfactorily;

b. Withhold or disallowing overhead costs;

c. Suspending federal awards until the audit is conducted; or

d. Terminating the federal award.

19. Drug Medi-Cal Financial Audit Requirements

In addition to the audit requirements, the State may also conduct financial audits of DMC programs, exclusive of NTP services, to accomplish any of, but not limited to, the following audit objectives:

a. To review reported costs for validity, appropriate allocation methodology, and compliance with Medicaid laws and regulations;

b. To ensure that only the cost of allowable DMC activities are included in reported costs;

c. To determine the provider's usual and customary charge to the general public in accordance with CMS (The Medicare Provider Reimbursement Manual) (CMS- Pub.15), which can be obtained from the Centers for Medicare & Medicaid Services, Baltimore, Maryland, or www.cms.hhs.gov for comparison to the DMC cost per unit;

d. To review documentation of units of service and determine the final number of approved units of service;

e. To determine the amount of clients' third-party revenue and MediCal share of cost to offset allowable DMC reimbursement; and

f. To compute final settlement based on the lower of actual allowable cost, the usual and customary charge, or the maximum allowance, in accordance with Title 22, Section 51516.1.

20. Contractor shall be responsible for any disallowances taken by the Federal Government, the State, or the Bureau of State Audits as a result of any audit exception that is related to its responsibilities. Contractor shall not use funds administered by the State to repay one federal funding source with funds provided by another federal funding source, or to repay federal funds with state funds, or to repay state funds with federal funds.

Contractor agrees to promptly develop and implement any corrective action plans in a manner acceptable to the State in order to comply with recommendations contained in any audit report. Such corrective

action plans shall include time-specific objectives to allow for measurement of progress and are subject to verification by the State within six (6) months from the date of the plan.

21. DMC Record Keeping

Contractor shall maintain sufficient books, records, documents, and other evidence necessary for the State to audit Intergovernmental Agreement performance and Intergovernmental Agreement compliance. Contractor shall make these records available to the State, upon request, to evaluate the quality and quantity of services, accessibility and appropriateness of services, and to ensure fiscal accountability. Regardless of the location or ownership of such records, they shall be sufficient to determine if costs incurred by Contractor are reasonable, allowable and allocated appropriately. All records must be capable of verification by qualified auditors.

a. Contractor shall include in any Agreement with an audit firm a clause to permit access by the State to the working papers of the external independent auditor, and require that copies of the working papers shall be made for the State at its request.

b. Contractor shall keep adequate and sufficient financial records and statistical data to support the year-end documents filed with the State. All records must be capable of verification by qualified auditors.

c. Accounting records and supporting documents shall be retained for a ten (10) year period from the date the year-end cost settlement report was approved by the State for interim settlement. When an audit by the Federal Government, the State, or the California State Auditor has been started before the expiration of the ten (10) year period, the records shall be retained until completion of the audit and final resolution of all issues that arise in the audit.

d. 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. All records must be capable of verification by qualified auditors.

e. Should Contractor discontinue its contractual agreement with

the County, or cease to conduct business in its entirety, Contractor shall provide fiscal and program records for the Agreement period to the County. Records shall be provided in compliance with the State Administrative Manual (SAM), located at http://sam.dgs.ca.gov/TOC/1600.aspx.

The Contractor shall retain all records required by Welfare and Institutions Code section 14124.1, 42 CFR 433.32, and California Code of Regulations, Title 22, Section 51341.1 et seq. for reimbursement of services and financial audit purposes.

f. In the expenditure of funds hereunder, and as required by 45 CFR Part 96, Contractor shall comply with the requirements of SAM and the laws and procedures applicable to the obligation and expenditure of federal and state funds.

g. Contractor shall retain records of utilization review activities required for a minimum of ten (10) years.

In addition, Contractor shall, upon request, make available to the County and/or the State their fiscal and other records to assure that Contractor has adequate recordkeeping capability and to assure that reimbursement for covered DMC services is made in accordance with Title 22, CCR, Section 51516.1. These records include, but are not limited to, matters pertaining to:

- Provider ownership, organization, and operation;
- Fiscal, medical, and other recordkeeping systems;
- Federal income tax status;
- Asset acquisition, lease, sale, or other action;
- Franchise or management arrangements;
- Patient service charge schedules;
- Costs of operation;
- Cost allocation methodology;
- Amounts of income received by source and purpose; and
- Flow of funds and working capital.

22. Dispute Resolution Process

a. 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. Contractor must file such an appeal of State audit findings with the County. The appeal must be in writing and sent to the County AOD Administrator within thirty (30) days of receipt of the audit findings.

b. When a financial audit is conducted by the County with Contractor, and if the Contractor disagrees with audit disallowances related to its programs, claims or services, the Contractor may file a written appeal by email or facsimile with the Director of Behavioral Health and Recovery Services. The appeal must be sent within thirty (30) days of receipt of the audit findings from the County.

The County will respond to an appeal within ten (10) business days of receiving it, and the County may, at its election, set up a meeting with the Contractor to discuss the concerns raised by the appeal. The decision of the County will be final. The appeal letter must be sent as follows:

Director, Behavioral Health and Recovery Services

*** END OF EXHIBIT B ***

Exhibit C: San Mateo County AOD CalAIM Outpatient Rates FY 2024-25

CalAIM Service Code	CalAIM Service Description	CPT / HCPCS Code	Time Associated with Code (Mins) for Purposes of Rate	MD	Physicians Assistant	Nurse Practitioner	RN	LVN	LPT	Psychologist / Pre-licensed Psychologist	LPCC / MFT / LCSW	Alcohol and Drug Counselor	Peer Support Specialist
		PROVIDER TYPE HOURLY RATE		$ 1,448.48	$ 649.63	$ 720.29	$ 588.35	$ 309.08	$ 264.97	$ 582.53	$ 376.97	$ 312.68	$ 297.80
AD101ODS_CA	AD101 ODS OP ASSESSMENT	H0001	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD101ODSPERI_CA	AD101 ODS PERI OP ASSESSMENT	H0001	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD102ODS_CA	AD102 ODS OP INDIVIDUAL COUNSELING	H0004	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09			$ 145.63	$ 94.24	$ 78.17	
AD102ODSPERI_CA	AD102 ODS PERI OP INDIVIDUAL COUNSELING	H0004	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09			$ 145.63	$ 94.24	$ 78.17	
AD103ODS_CA	AD103 ODS OP GROUP COUNSELING	H0005	15	$ 80.47	$ 36.09	$ 40.02	$ 32.69			$ 32.36	$ 20.94	$ 17.37	
AD103ODSPERI_CA	AD103 ODS PERI OP GROUP COUNSELING	H0005	15	$ 80.47	$ 36.09	$ 40.02	$ 32.69			$ 32.36	$ 20.94	$ 17.37	
AD104ODS_CA	AD104 ODS OP PATIENT EDUCATION INDIVIDUAL	H2027	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD104ODSPERI_CA	AD104 ODS PERI OP PATIENT EDUCATION IND	H2027	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD105ODS_CA	AD105 ODS OP PATIENT EDUCATION GROUP	H2014	15	$ 80.47	$ 36.09	$ 40.02	$ 32.69	$ 17.17	$ 14.72	$ 32.36	$ 20.94	$ 17.37	
AD105ODSPERI_CA	AD105 ODS PERI OP PATIENT EDUCATION GROUP	H2014	15	$ 80.47	$ 36.09	$ 40.02	$ 32.69	$ 17.17	$ 14.72	$ 32.36	$ 20.94	$ 17.37	
AD107ODS_CA	AD107 ODS OP CRISIS INTERVENTION	H0007	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD107ODSPERI_CA	AD107 ODS PERI OP CRISIS INTERVENTION	H0007	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD108ODS_CA	AD108 ODS OP TX PLANNING	H2014	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD108ODSPERI_CA	AD108 ODS PERI OP TX PLANNING	H2014	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD109ODS_CA	AD109 ODS OP DISCHARGE SERVICES	T1007	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD109ODSPERI_CA	AD109 ODS PERI OP DISCHARGE SERVICES	T1007	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD110ODS_CA	AD110 ODS OP FAMILY COUNSELING	T1006	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09			$ 145.63	$ 94.24	$ 78.17	
AD110ODSPERI_CA	AD110 ODS PERI OP FAMILY COUNSELING	T1006	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09			$ 145.63	$ 94.24	$ 78.17	
AD113ODSCM_CA	AD113 ODS OP CARE COORDINATION	T1017	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD113ODSPERICM_CA	AD113 ODS PERI OP CARE COORDINATION	T1017	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD1501ODS_CA	AD1501 ODS OP RS INDIVIDUAL COUNSELING	H2017	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD1502ODS_CA	AD1502 ODS OP RS GROUP COUNSELING	H2017	15	$ 80.47	$ 36.09	$ 40.02	$ 32.69	$ 17.17	$ 14.72	$ 32.36	$ 20.94	$ 17.37	
AD1504ODSRM_CA	AD1504 ODS OP RS RECOVERY MONITORING	H2015	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD1601ODS_CA	AD1601 ODS OP MAT (NON-NTP)	H0033	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24				
AD1601ODSPERI_CA	AD1601 ODS PERI OP MAT (NON-NTP)	H0033	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24				
AD175ODS_CA	AD175 ODS OP URINALYSIS TESTING	H0049	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD175ODSPERI_CA	AD175 ODS PERI OP URINALYSIS TESTING	H0049	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD199367CA	AD199367 OP MD CLIN CONSULT CLT/FAM NOT PRESENT 30+ MIN	99367	60	$ 1,448.48									
AD199367PERICA	AD199367 PERI OP MD CLIN CONSULT CLT/FAM NOT PRESENT 30+ MIN	99367	60	$ 1,448.48									
AD199368CA	AD199368 OP NON MD CLIN CONSULT CLT NOT PRESENT 30+ MIN	99368	60		$ 649.63	$ 720.29	$ 588.35			$ 582.53	$ 376.97		
AD199368PERICA	AD199368 PERI OP NON MD CLIN CONSULT CLT NOT PRESENT 30+ MIN	99368	60		$ 649.63	$ 720.29	$ 588.35			$ 582.53	$ 376.97		
AD1H0025CA	AD1H0025 OP PEER SUPPORT PREVENTION ED GROUP	H0025	15										$ 16.54
AD1H0025PERICA	AD1H0025 PERI OP PEER SUPPORT PREVENTION ED GROUP	H0025	15										$ 16.54
AD1H0038CA	AD1H0025 OP SUPPORT SELF HELP ENGAGE THEORY	H0038	15										$ 74.45
AD1H0038PERICA	AD1H0025 PERI OP PEER SUPPORT SELF HELP ENGAGE THEORY	H0038	15										$ 74.45

Updated
9/25/24

Exhibit C: San Mateo County AOD CalAIM Outpatient Rates FY 2024-25

CalAIM Service Code	CalAIM Service Description	CPT / HCPCS Code	Time Associated with Code (Mins) for Purposes of Rate	MD	Physicians Assistant	Nurse Practitioner	RN	LVN	LPT	Psychologist / Pre-licensed Psychologist	LPCC / MFT / LCSW	Alcohol and Drug Counselor	Peer Support Specialist
		PROVIDER TYPE HOURLY RATE		$ 1,448.48	$ 649.63	$ 720.29	$ 588.35	$ 309.08	$ 264.97	$ 582.53	$ 376.97	$ 312.68	$ 297.80
AD1H0050CA	AD1H0050 OP CONTINGENCY MANAGEMENT	H0050	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	$ 74.45
AD1H0050PERICA	AD1H0050 PERI OP CONTINGENCY MANAGEMENT	H0050	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	$ 74.45
AD201ODS_CA	AD201 ODS IOP ASSESSMENT	H0001	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD201ODSPERI_CA	AD201 ODS PERI IOP ASSESSMENT	H0001	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD202ODS_CA	AD202 ODS IOP INDIVIDUAL COUNSELING	H0004	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09			$ 145.63	$ 94.24	$ 78.17	
AD202ODSPERI_CA	AD202 ODS PERI IOP INDIVIDUAL COUNSELING	H0004	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09			$ 145.63	$ 94.24	$ 78.17	
AD203ODS_CA	AD203 ODS IOP GROUP COUNSELING	H0005	15	$ 80.47	$ 36.09	$ 40.02	$ 32.69			$ 32.36	$ 20.94	$ 17.37	
AD203ODSPERI_CA	AD203 ODS PERI IOP GROUP COUNSELING	H0005	15	$ 80.47	$ 36.09	$ 40.02	$ 32.69			$ 32.36	$ 20.94	$ 17.37	
AD204ODS_CA	AD204 ODS IOP PATIENT EDUCATION IND	H2027	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD204ODSPERI_CA	AD204 ODS PERI IOP PATIENT EDUCATION IND	H2027	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD205ODS_CA	AD205 ODS IOP PATIENT EDUCATION GROUP	H2014	15	$ 80.47	$ 36.09	$ 40.02	$ 32.69	$ 17.17	$ 14.72	$ 32.36	$ 20.94	$ 17.37	
AD205ODSPERI_CA	AD205 ODS PERI IOP PATIENT EDUCATION GROUP	H2014	15	$ 80.47	$ 36.09	$ 40.02	$ 32.69	$ 17.17	$ 14.72	$ 32.36	$ 20.94	$ 17.37	
AD207ODS_CA	AD207 ODS IOP CRISIS INTERVENTION	H0007	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD207ODSPERI_CA	AD207 ODS PERI IOP CRISIS INTERVENTION	H0007	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD208ODS_CA	AD208 ODS IOP TX PLANNING	H2014	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD208ODSPERI_CA	AD208 ODS PERI IOP TX PLANNING	H2014	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD209ODS_CA	AD209 ODS IOP DISCHARGE SERVICES	T1007	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD209ODSPERI_CA	AD209 ODS PERI IOP DISCHARGE SERVICES	T1007	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD210ODS_CA	AD210 ODS IOP FAMILY COUNSELING	T1006	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09			$ 145.63	$ 94.24	$ 78.17	
AD210ODSPERI_CA	AD210 ODS PERI IOP FAMILY COUNSELING	T1006	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09			$ 145.63	$ 94.24	$ 78.17	
AD213ODSCM_CA	AD213 ODS IOP CARE COORDINATION	T1017	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD213ODSPERICM_CA	AD213 ODS IOP PERI CARE COORDINATION	T1017	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD2501ODS_CA	AD2501 ODS IOP RS INDIVIDUAL COUNSELING	H2017	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD2502ODS_CA	AD2502 ODS IOP RS GROUP COUNSELING	H2017	15	$ 80.47	$ 36.09	$ 40.02	$ 32.69	$ 17.17	$ 14.72	$ 32.36	$ 20.94	$ 17.37	
AD2504ODSRM_CA	AD2504 ODS IOP RS RECOVERY MONITORING	H2015	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD2601ODS_CA	AD2601 ODS IOP MAT (NON-NTP)	H0033	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24				
AD2601ODSPERI_CA	AD2601 ODS IOP PERI MAT (NON-NTP)	H0033	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24				
AD275ODS_CA	AD275 ODS IOP URINALYSIS TESTING	H0049	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD275ODSPERICA	AD275 ODS PERI IOP URINALYSIS TESTING	H0049	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD299367CA	AD299367 IOP MD CLIN CONSULT CLT/FAM NOT PRESENT 30+ MIN	99367	60	$ 1,448.48									
AD299367PERICA	AD299367 IOP PERI MD CLIN CONSULT CLT/FAM NOT PRESENT 30+ MIN	99367	60	$ 1,448.48									
AD299368CA	AD299368 IOP NON MD CLIN CONSULT CLT NOT PRESENT 30+ MIN	99368	60		$ 649.63	$ 720.29	$ 588.35			$ 582.53	$ 376.97		
AD299368PERICA	AD299368 IOP PERI NON MD CLIN CONSULT CLT NOT PRESENT 30+ MIN	99368	60		$ 649.63	$ 720.29	$ 588.35			$ 582.53	$ 376.97		
AD2H0025CA	AD2H0025 IOP PEER SUPPORT PREVENTION ED GROUP	H0025	15										$ 16.54

Updated
9/25/24

Exhibit C: San Mateo County AOD CalAIM Outpatient Rates FY 2024-25

CalAIM Service Code	CalAIM Service Description	CPT / HCPCS Code	Time Associated with Code (Mins) for Purposes of Rate	MD	Physicians Assistant	Nurse Practitioner	RN	LVN	LPT	Psychologist / Pre-licensed Psychologist	LPCC / MFT / LCSW	Alcohol and Drug Counselor	Peer Support Specialist
		PROVIDER TYPE HOURLY RATE		$ 1,448.48	$ 649.63	$ 720.29	$ 588.35	$ 309.08	$ 264.97	$ 582.53	$ 376.97	$ 312.68	$ 297.80
AD2H0025PERICA	AD2H0025 PERI IOP PEER SUPPORT PREVENTION ED GROUP	H0025	15										$ 16.54
AD2H0038CA	AD2H0025 IOP PEER SUPPORT SELF HELP ENGAGE THEORY	H0038	15										$ 74.45
AD2H0038PERICA	AD2H0025 PERI IOP PEER SUPPORT SELF HELP ENGAGE THEORY	H0038	15										$ 74.45
AD2H0050CA	AD2H0050 IOP CONTINGENCY MANAGEMENT	H0050	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	$ 74.45
AD2H0050PERICA	AD2H0050 IOP PERI CONTINGENCY MANAGEMENT	H0050	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	$ 74.45
AD3113ODSCM_CA	AD3113 ODS 3.1 CARE COORDINATION	T1017	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD3113ODSPERICM_CA	AD3113 ODS 3.1 PERI CARE COORDINATION	T1017	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD31501ODS_CA	AD31501 ODS 3.1 RS INDIVIDUAL COUNSELING	H2017	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD31502ODS_CA	AD31502 ODS 3.1 RS GROUP COUNSELING	H2017	15	$ 80.47	$ 36.09	$ 40.02	$ 32.69	$ 17.17	$ 14.72	$ 32.36	$ 20.94	$ 17.37	
AD31504ODSRM_CA	AD31504 ODS 3.1 RS RECOVERY MONITORING	H2015	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD31601ODS_CA	AD31601 ODS 3.1 MAT RES	H0033	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24				
AD31601ODSPERI_CA	AD31601 ODS 3.1 PERI MAT RES	H0033	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24				
AD3199367CA	AD3199367 3.1 MD CLIN CONSULT CLT/FAM NOT PRESENT 30+ MIN	99367	60	$ 1,448.48									
AD3199367PERICA	AD3199367 3.1 PERI MD CLIN CONSULT CLT/FAM NOT PRESENT 30+ MIN	99367	60	$ 1,448.48									
AD3199368CA	AD3199368 3.1 NON MD CLIN CONSULT CLT NOT PRESENT 30+ MIN	99368	60		$ 649.63	$ 720.29	$ 588.35			$ 582.53	$ 376.97		
AD3199368PERICA	AD3199368 3.1 PERI NON MD CLIN CONSULT CLT NOT PRESENT 30+ MIN	99368	60		$ 649.63	$ 720.29	$ 588.35			$ 582.53	$ 376.97		
AD31H0025CA	AD31H0025 3.1 PEER SUPPORT PREVENTION ED GROUP	H0025	15										$ 16.54
AD31H0025PERICA	AD31H0025 3.1 PERI PEER SUPPORT PREVENTION ED GROUP	H0025	15										$ 16.54
AD31H0038CA	AD31H0025 3.1 PEER SUPPORT SELF HELP ENGAGE THEORY	H0038	15										$ 74.45
AD31H0038PERICA	AD31H0025 3.1 PERI PEER SUPPORT SELF HELP ENGAGE THEORY	H0038	15										$ 74.45
AD3213ODSCM_CA	AD3213 ODS 3.2 CARE COORDINATION	T1017	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD3213ODSPERICM_CA	AD3213 ODS 3.2 PERI CARE COORDINATION	T1017	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD32601ODS_CA	AD32601 ODS 3.2 MAT (NON-NTP)	H0033	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24				
AD32601ODSPERI_CA	AD32601 ODS 3.2 PERI MAT (NON-NTP)	H0033	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24				
AD3299367CA	AD3299367 3.2 MD CLIN CONSULT CLT/FAM NOT PRESENT 30+ MIN	99367	60	$ 1,448.48									

Updated
9/25/24

Exhibit C1: San Mateo County AOD CalAIM Outpatient Rates FY 2024-25

CalAIM Service Code	CalAIM Service Description	CPT / HCPCS Code	Time Associated with Code (Mins) for Purposes of Rate	MD	Physicians Assistant	Nurse Practitioner	RN	LVN	LPT	Psychologist / Pre-licensed Psychologist	LPCC / MFT / LCSW	Alcohol and Drug Counselor	Peer Support Specialist
		PROVIDER TYPE HOURLY RATE		$ 1,448.48	$ 649.63	$ 720.29	$ 588.35	$ 309.08	$ 264.97	$ 582.53	$ 376.97	$ 312.68	$ 297.80
AD3299367PERICA	AD3299367 3.2 PERI MD CLIN CONSULT CLT/FAM NOT PRESENT 30+ MIN	99367	60	$ 1,448.48									
AD3299368CA	AD3299368 3.2 NON MD CLIN CONSULT CLT NOT PRESENT 30+ MIN	99368	60		$ 649.63	$ 720.29	$ 588.35			$ 582.53	$ 376.97		
AD3299368PERICA	AD3299368 3.2 PERI NON MD CLIN CONSULT CLT NOT PRESENT 30+ MIN	99368	60		$ 649.63	$ 720.29	$ 588.35			$ 582.53	$ 376.97		
AD32H0025CA	AD32H0025 3.2 PEER SUPPORT PREVENTION ED GROUP	H0025	15										$ 16.54
AD32H0025PERICA	AD32H0025 3.2 PERI PEER SUPPORT PREVENTION ED GROUP	H0025	15										$ 16.54
AD32H0038CA	AD32H0025 3.2 PEER SUPPORT SELF HELP ENGAGE THEORY	H0038	15										$ 74.45
AD32H0038PERICA	AD32H0025 3.2 PERI PEER SUPPORT SELF HELP ENGAGE THEORY	H0038	15										$ 74.45
AD3313ODSCM_CA	AD3313 ODS 3.3 CARE COORDINATION	T1017	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD3313ODSPERICM_CA	AD3313 ODS 3.3 PERI CARE COORDINATION	T1017	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD33601ODS_CA	AD33601 ODS 3.3 MAT (NON-NTP)	H0033	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24				
AD3399367CA	AD3399367 3.3 MD CLIN CONSULT CLT/FAM NOT PRESENT 30+ MIN	99367	60	$ 1,448.48									
AD3399367PERICA	AD3399367 3.3 PERI MD CLIN CONSULT CLT/FAM NOT PRESENT 30+ MIN	99367	60	$ 1,448.48									
AD3399368CA	AD3399368 3.3 NON MD CLIN CONSULT CLT NOT PRESENT 30+ MIN	99368	60		$ 649.63	$ 720.29	$ 588.35			$ 582.53	$ 376.97		
AD3399368PERICA	AD3399368 3.3 PERI NON MD CLIN CONSULT CLT NOT PRESENT 30+ MIN	99368	60		$ 649.63	$ 720.29	$ 588.35			$ 582.53	$ 376.97		
AD33H0025CA	AD33H0025 3.3 PEER SUPPORT PREVENTION ED GROUP	H0025	15										$ 16.54
AD33H0025PERICA	AD33H0025 3.3 PERI PEER SUPPORT PREVENTION ED GROUP	H0025	15										$ 16.54
AD33H0038CA	AD33H0025 3.3 PEER SUPPORT SELF HELP ENGAGE THEORY	H0038	15										$ 74.45
AD33H0038PERICA	AD33H0025 3.3 PERI PEER SUPPORT SELF HELP ENGAGE THEORY	H0038	15										$ 74.45
AD3513ODSCM_CA	AD3513 ODS 3.5 CARE COORDINATION	T1017	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD3513ODSPERICM_CA	AD3513 ODS 3.5 PERI CARE COORDINATION	T1017	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD35601ODS_CA	AD35601 ODS 3.5 MAT RES	H0033	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24				
AD35601ODSPERI_CA	AD35601 ODS PERI 3.5 MAT RES	H0033	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24				
AD3599367CA	AD3599367 3.5 MD CLIN CONSULT CLT/FAM NOT PRESENT 30+ MIN	99367	60	$ 1,448.48									
AD3599367PERICA	AD3599367 3.5 PERI MD CLIN CONSULT CLT/FAM NOT PRESENT 30+ MIN	99367	60	$ 1,448.48									
AD3599368CA	AD3599368 3.5 NON MD CLIN CONSULT CLT NOT PRESENT 30+ MIN	99368	60		$ 649.63	$ 720.29	$ 588.35			$ 582.53	$ 376.97		

Updated
9/25/24

Exhibit C1: San Mateo County AOD CalAIM Outpatient Rates FY 2024-25

CalAIM Service Code	CalAIM Service Description	CPT / HCPCS Code	Time Associated with Code (Mins) for Purposes of Rate	MD	Physicians Assistant	Nurse Practitioner	RN	LVN	LPT	Psychologist / Pre-licensed Psychologist	LPCC / MFT / LCSW	Alcohol and Drug Counselor	Peer Support Specialist
		PROVIDER TYPE HOURLY RATE		$ 1,448.48	$ 649.63	$ 720.29	$ 588.35	$ 309.08	$ 264.97	$ 582.53	$ 376.97	$ 312.68	$ 297.80
AD3599368PERICA	AD3599368 3.5 PERI NON MD CLIN CONSULT CLT NOT PRESENT 30+ MIN	99368	60		$ 649.63	$ 720.29	$ 588.35			$ 582.53	$ 376.97		
AD35H0025CA	AD35H0025 3.5 PEER SUPPORT PREVENTION ED GROUP	H0025	15										$ 16.54
AD35H0025PERICA	AD35H0025 3.5 PERI PEER SUPPORT PREVENTION ED GROUP	H0025	15										$ 16.54
AD35H0038CA	AD35H0025 3.5 PEER SUPPORT SELF HELP ENGAGE THEORY	H0038	15										$ 74.45
AD35H0038PERICA	AD35H0025 3.5 PERI PEER SUPPORT SELF HELP ENGAGE THEORY	H0038	15										$ 74.45
AD402ODS_CA	AD402 ODS NTP INDIVIDUAL COUNSELING	H0004	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09			$ 145.63	$ 94.24	$ 78.17	
AD402ODSPERI_CA	AD402 ODS NTP PERI INDIVIDUAL COUNSELING	H0004	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09			$ 145.63	$ 94.24	$ 78.17	
AD403ODS_CA	AD403 ODS NTP GROUP COUNSELING	H0005	15	$ 80.47	$ 36.09	$ 40.02	$ 32.69			$ 32.36	$ 20.94	$ 17.37	
AD403ODSPERI_CA	AD403 ODS NTP PERI GROUP COUNSELING	H0005	15	$ 80.47	$ 36.09	$ 40.02	$ 32.69			$ 32.36	$ 20.94	$ 17.37	
AD413ODSCMCA	AD413 ODS NTP CARE COORDINATION	T1017	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD413ODSPERICMCA	AD413 ODS NTP PERI CARE COORDINATION	T1017	15	$ 362.12	$ 162.41	$ 180.07	$ 147.09	$ 77.27	$ 66.24	$ 145.63	$ 94.24	$ 78.17	
AD499367CA	AD499367 NTP MD CLIN CONSULT CLT/FAM NOT PRESENT 30+ MIN	99367	60	$ 1,448.48									
AD499367PERICA	AD499367 NTP PERI MD CLIN CONSULT CLT/FAM NOT PRESENT 30+ MIN	99367	60	$ 1,448.48									
AD499368CA	AD499368 NTP NON MD CLIN CONSULT CLT NOT PRESENT 30+ MIN	99368	60		$ 649.63	$ 720.29	$ 588.35			$ 582.53	$ 376.97		
AD499368PERICA	AD499368 NTP PERI NON MD CLIN CONSULT CLT NOT PRESENT 30+ MIN	99368	60		$ 649.63	$ 720.29	$ 588.35			$ 582.53	$ 376.97		
AD4H0025CA	AD4H0025 NTP PEER SUPPORT PREVENTION ED GROUP	H0025	15										$ 16.54
AD4H0025PERICA	AD4H0025 NTP PERI PEER SUPPORT PREVENTION ED GROUP	H0025	15										$ 16.54
AD4H0038CA	AD4H0025 NTP PEER SUPPORT SELF HELP ENGAGE THEORY	H0038	15										$ 74.45
AD4H0038PERICA	AD4H0025 NTP PERI PEER SUPPORT SELF HELP ENGAGE THEORY	H0038	15										$ 74.45

Updated
9/25/24

Revised Exhibit D - AOD Residential Services Rates Table

San Mateo County Preliminary FY 2024-25 Fee-for-Service Rate Schedule
24-hour SUD Services 6/13/2024 - update

Description

24-hour Service Type	Unit of Service	FY 24/25 Rate
ASAM 3.1 Residential	Treatment Day	$ 229.19
ASAM 3.2 Residential	Treatment Day	$ 365.83
ASAM 3.2 Residential - with IMS Certification	Treatment Day	$ 443.03
ASAM 3.3 Residential	Treatment Day	$ 189.61
ASAM 3.5 Residential	Treatment Day	$ 281.74
Adult Residential Room and Board (all ASAM levels)	Bed Day	$ 134.29
Recovery Residence - Single Adult	Bed Day	$ 113.78
Recovery Residence - Perinatal (parent and child billed separately)	Bed Day	$ 151.86

ATTACHMENT I

Assurance of Compliance with Section 504 of the Rehabilitation Act of 1973, as Amended

The undersigned (hereinafter called "Contractor(s)") hereby agrees that it will comply with Section 504 of the Rehabilitation Act of 1973, as amended, all requirements imposed by the applicable DHHS regulation, and all guidelines and interpretations issued pursuant thereto.

The Contractor(s) gives/give this assurance in consideration of for the purpose of obtaining contracts after the date of this assurance. The Contractor(s) recognizes/recognize and agrees/agree that contracts will be extended in reliance on the representations and agreements made in this assurance. This assurance is binding on the Contractor(s), its successors, transferees, and assignees, and the person or persons whose signatures appear below are authorized to sign this assurance on behalf of the Contractor(s).

The Contractor(s): (Check a, b, or c)

- ☐ a. Has no employees
- ☐ b. Employs fewer than 15 persons
- ☒ c. Employs 15 or more persons and, pursuant to section 84.7 (a) of the regulation (45 C.F.R. 84.7 (a), has designated the following person(s) to coordinate its efforts to comply with the DHHS regulation.

Name of 504 Person:	Lisa Valdez
Name of Contractor(s):	Horizon Services
Street Address or P.O. Box:	PO Box 4217
City, State, Zip Code:	Hayward CA 94540

I certify that the above information is complete and correct to the best of my knowledge

Signature:	Signed by: Jaime Campos 4A570CCD8E1449C...
Title of Authorized Official:	CEO
Date:	3/19/25

*Exception: DHHS regulations state that: "If a recipient with fewer than 15 employees finds that, after consultation with a disabled person seeking its services, there is no method of complying with (the facility accessibility regulations) other than making a significant alteration in its existing facilities, the recipient may, as an alternative, refer the handicapped person to other providers of those services that are accessible."

ATTACHMENT L – DHCS LEGAL AND REGULATORY REQUIREMENTS

Contractor and staff are required to know and implement all federal, state and local legal and regulatory requirements that pertain to the provision of DHCS services.

42 CFR		PUBLIC HEALTH
	Part 431 (Single state agency	A single state agency will be assigned to manage this contract. For California it is DHCS.
	431.107 (record keeping)	Provider Agreement required. Provide the fraud control unit any information regarding payments claimed by the provider for furnishing services.
	438	MANAGED CARE
Not applicable to the DMC-ODS waiver	438.104	Marketing activities
	438.114	Emergency post stabilization services
	438.116	Solvency standards
	438.206(b)(2)	Women's Health Services
	438.208(c)(1)	Individuals with special health care needs
	438.6(i)	Advanced directives
	438.210 (Managed care definitions) Covered services	Managed Care (Managed Care Organization, Prepaid Inpatient Health Plan, & Prepaid Ambulatory Health Plans) must specify the amount, duration, and scope of each service to assure that that the services are set reasonably to achieve the purpose for which services are furnished. May not arbitrarily reduce or deny services solely because of diagnosis, type of illness, or condition of a beneficiary. *1
	455 (Program Integrity: Medicaid)	Disclosure of Information by Providers and Fiscal Agents.
	455.101	Definitions of Agent, hospital, MediCare Intermediary, carrier, Health Insuring Organization, Managed Care Entity (MCE),MCO, PIHP, FPHP, PCCM and HIO's; ownership, controlling interest, indirect ownership, subcontractor, supplier, termination, & fraud.
	455.104	Disclosure by Medicaid providers and fiscal agents: of information on ownership and control, the means of providing identifications (SSN, DOB, address, etc..); relationships; when disclosures are due: application, renewal, upon investigation, etc....
	455.23	Suspension of payments in case of fraud. Payments can be suspended upon the initiation of a fraud investigation.
	455.34	
	455.450(c) program integrity)	Provide screening levels for Medicaid Providers and conduct screening at the level of assessed risk. Limited, moderate, or high.
	Part 8 (Medicated	Accreditation, responsibilities, evaluation, and withdrawal of accreditation. Certification and treatment standards.

ATTACHMENT L – DHCS LEGAL AND REGULATORY REQUIREMENTS

Contractor and staff are required to know and implement all federal, state and local legal and regulatory requirements that pertain to the provision of DHCS services.

	assisted treatment for opioid use disorder)	Procedures for review of suspension or proposed revocation of OTP certification, and of adverse action regarding withdrawal of approval of an accreditation body. Authorization to increase patient limit to 275.
	Part 2	Confidentiality of alcohol and drug abuse patient records.
CFR Title 21		Food and drug administration, Department of Health and Human services
	1300 et seg	Drug Enforcement Administration, Department of Justice. Quotas, records and reports of registrants, schedule I and II controlled substances, prescriptions, administrative functions, practices, and procedures.
W& I		WELFARE AND INSTITUTIONS CODE
	Chapter 7	BASIC HEALTH CARE
	14000 et seq	General provisions. The purpose of this chapter is to afford to qualifying individuals health care and related remedial or preventive services, including related social services which are necessary for those receiving health care under this chapter.
	14021.51-.53 14043.1	The department shall establish a NRT dosing fee for methadone and LAAM. Only covered services are eligible for reimbursement. Financial evaluation form instructions.
	14043.27	Termination of provisional provider status and preferred provisional provider status.
	14043.36	The department shall not enroll any applicant that has been convicted of any felony or misdemeanor involving fraud or abuse in any government program.
	14043.6	The department shall automatically suspend any entity upon the loss, revocation, suspension of their license or certificate.
	14043.61	A provider shall be subject to suspension if claims are submitted by entities listed on the suspended and ineligible provider list or any list published by the Federal Office of Inspector General.
	14100.2	California Privacy Law.
	14107.11	Upon receipt of a credible allegation of fraud for which an investigation is pending the provider shall be temporarily placed under payment suspension unless there is a good cause exception.
	14124.20-.25	The department may enter into a DMC Treatment

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		Program contract with each county for the provision of AOD services within the county service area or the department can enter into contracts with individual providers. Defines reimbursable services including NTP and Perinatal Services. Goes into FFP and county funding, cost reports, criminal investigations, fair hearings, DMC's toll free number.
H& S		Health and Safety
	11848.5 a &b	(a) Once the negotiated rate with service providers has been approved by the county, all participating governmental funding sources, except the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), shall be bound to that rate as the cost of providing all or part of the total county alcohol and other drug program as described in the county contract for each fiscal year to the extent that the governmental funding sources participate in funding the county alcohol and other drug program. Where the State Department of Health Services adopts regulations for determining reimbursement of alcohol and other drug program services formerly allowable under the Short-Doyle program and reimbursed under the Medi-Cal Act, those regulations shall be controlling only as to the rates for reimbursement of alcohol and other drug program services allowable under the Medi-Cal program and rendered to Medi-Cal beneficiaries. Providers under this section shall report to the department and the county any information required by the department in accordance with the procedures established by the director of the department. (b) The Legislature recognizes that alcohol and other drug abuse services differ from mental health services provided through the State Department of Health Care Services and therefore should not necessarily be bound by rate determination methodology used for reimbursement of those services formerly provided under the Short-Doyle program and reimbursed under the Medi-Cal Act.
CCR		California Code of Regulations
	Title 22	Social Security
	Division 3,	Health Care Services

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Chapter 51000 et seq	Counselor Certifications and allowed activities.
51341.1	Description of SUD Services
51490.1	Description of SUD Claim Submission
51516.1	Reimbursement rate methodology and baseline rates
Title 9	Rehabilitation and Developmental Services
Division 4	Department of Alcohol and Drug Programs

*1 - 438.210 (Managed Care definitions) Covered services§438.210 Coverage and authorization of services.

(a) *Coverage.* Each contract between a State and an MCO, PIHP, or PAHP must do the following:

(1) Identify, define, and specify the amount, duration, and scope of each service that the MCO, PIHP, or PAHP is required to offer.

(2) Require that the services identified in paragraph (a)(1) of this section be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished

to beneficiaries under FFS Medicaid, as set forth in §440.230 of this chapter, and for enrollees under the age of 21, as set forth in subpart B of part 440 of this chapter.

(3) Provide that the MCO, PIHP, or PAHP—

(i) Must ensure that the services are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.

(ii) May not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.

(4) Permit an MCO, PIHP, or PAHP to place appropriate limits on a service—

(i) On the basis of criteria applied under the State plan, such as medical necessity; or

(ii) For the purpose of utilization control, provided that—

(A) The services furnished can reasonably achieve their purpose, as required in paragraph (a)(3)(i) of this section;

(B) The services supporting individuals with ongoing or chronic conditions or who require long-term services and supports are authorized in a manner that reflects the enrollee's ongoing need for such services and supports; and

(C) Family planning services are provided in a manner that protects and enables the enrollee's freedom to choose the method of family planning to be used consistent with §441.20 of this chapter.

(5) Specify what constitutes “medically necessary services” in a manner that—

(i) Is no more restrictive than that used in the State Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State statutes and regulations, the State Plan, and other State policy and procedures; and

(ii) Addresses the extent to which the MCO, PIHP, or PAHP is responsible for covering services that address:

(A) The prevention, diagnosis, and treatment of an enrollee's disease, condition, and/or disorder that results in health impairments and/or disability.

(B) The ability for an enrollee to achieve age-appropriate growth and development.

(C) The ability for an enrollee to attain, maintain, or regain functional capacity.

(D) The opportunity for an enrollee receiving long-term services and supports to have access to the benefits of community living, to achieve person-centered goals, and live and work in the setting of their choice.

(b) *Authorization of services.* For the processing of requests for initial and continuing authorizations of services, each contract must require—

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(1) That the MCO, PIHP, or PAHP and its subcontractors have in place, and follow, written policies and procedures.

(2) That the MCO, PIHP, or PAHP—

(i) Have in effect mechanisms to ensure consistent application of review criteria for authorization decisions.

(ii) Consult with the requesting provider for medical services when appropriate.

(iii) Authorize LTSS based on an enrollee's current needs assessment and consistent with the person-centered service plan.

(3) That any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by an individual who has appropriate expertise in addressing the enrollee's medical, behavioral health, or long-term services and supports needs.

(c) *Notice of adverse benefit determination.* Each contract must provide for the MCO, PIHP, or PAHP to notify the requesting provider, and give the enrollee written notice of any decision by the MCO, PIHP, or PAHP to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested. For MCOs, PIHPs, and PAHPs, the enrollee's notice must meet the requirements of §438.404.

(d) *Timeframe for decisions.* Each MCO, PIHP, or PAHP contract must provide for the following decisions and notices:

(1) *Standard authorization decisions.* For standard authorization decisions, provide notice as expeditiously as the enrollee's condition requires and within State-established timeframes that may not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days, if—

(i) The enrollee, or the provider, requests extension; or

(ii) The MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(2) *Expedited authorization decisions.* (i) For cases in which a provider indicates, or the MCO, PIHP, or PAHP determines, that following the standard timeframe could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO, PIHP, or PAHP must make an expedited authorization decision and provide notice as expeditiously as the enrollee's health condition requires and no later than 72 hours after receipt of the request for service.

(ii) The MCO, PIHP, or PAHP may extend the 72 hour time period by up to 14 calendar days if the enrollee requests an extension, or if the MCO, PIHP, or PAHP justifies (to the State agency upon request) a need for additional information and how the extension is in the enrollee's interest.

(3) *Covered outpatient drug decisions.* For all covered outpatient drug authorization decisions, provide notice as described in section 1927(d)(5)(A) of the Act.

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(e) *Compensation for utilization management activities.* Each contract between a State and MCO, PIHP, or PAHP must provide that, consistent with §438.3(i), and §422.208 of this chapter, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any enrollee.

(f) *Applicability date.* This section applies to the rating period for contracts with MCOs, PIHPs, and PAHPs beginning on or after July 1, 2017. Until that applicability date, states are required to continue to comply with §438.210 contained in the 42 CFR parts 430 to 481, edition revised as of October 1, 2015.