Agreement No. 081104-A3

THIRD AMENDMENT TO AGREEMENT BETWEEN THE COUNTY OF SAN MATEO AND OUR COMMON GROUND, INC.

THIS AMENDMENT TO THE AGREEMENT, entered into this _____ day of March 2026, by and between the COUNTY OF SAN MATEO, hereinafter called "County," and Our Common Ground, Inc., hereinafter called "Contractor";

W I T N E S S E T H:

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

WHEREAS, the parties entered into an Agreement for the purpose of providing professional service, for the term of June 1, 2025 through June 30, 2027, for a total amount not to exceed $18,552,817; and

WHEREAS, on September 1, 2025 the parties entered into an Amendment to the Agreement increasing the maximum amount by $437,064 for a total amount not to exceed $18,989,881 with no change to the agreement term; and

WHEREAS, on September 10, 2025 the parties entered into an Amendment by Executive Letter to revise billing rates for FY 2025-26 with Exhibit C – CalAIM Outpatient Rates for FY 2024-25 being replaced by Exhibit H – CalAIM Outpatient Rates for FY 2025-26, and Exhibit D – CalAIM 24-Hour SUD Rates being replaced by Exhibit F - CalAIM 24-Hour SUD Rates for FY 2025-26, with no change to the terms or the total amount of the Agreement; and

WHEREAS, the parties wish to amend the Agreement to increase the maximum amount by $4,548,763 for a total amount not to exceed $23,538,644, with no change to the agreement terms.

NOW, THEREFORE, IT IS HEREBY AGREED BY THE PARTIES HERETO AS FOLLOWS:

1. Section 4 of the agreement is amended to read as follows:

In consideration of the services provided by Contractor in accordance with all terms, conditions and specifications set forth herein and in Exhibit A-2, County shall make payment to Contractor based on the rates and in the manner specified in Exhibit B-

2. 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 TWENTY-THREE MILLION FIVE HUNDRED THIRTY-EIGHT THOUSAND SIX HUNDRED FORTY-FOUR DOLLARS ($23,538,644).

County reserves the right to refuse payment to Contractor or disallow costs for any expenditure, as determined by County to be in conflict with the terms and conditions of this Agreement, outside the scope of work of this Agreement, when adequate supporting documentation is not presented or where prior approval was required but was either not requested or not granted.

The Contractor will submit invoices and monthly program reports to Behavioral Health and Recovery Services (BHRS) by the tenth (10th) of each month. Program performance data will be submitted in a timely, complete, accurate, and verifiable manner using the BHRS approved reporting procedures. Invoices must reflect the provision of services and the usage of funds each month throughout the entire contract period. Refer to Exhibit B-2 for specific fiscal requirements. Upon notification from BHRS, the Contractor must correct inaccurate invoices and corresponding reports in order to receive reimbursement. Corrections must be made within five (5) working days. Invoices submitted more than two (2) months past the month of service may not be reimbursed.

2. Exhibit A is hereby replaced with Exhibit A-2 attached hereto.

3. Exhibit B is hereby replaced with Exhibit B-2 attached hereto.

4. All other terms and conditions of the agreement as amended September 10, 2025, between the County and Contractor shall remain in full force and effect.

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

For Contractor: Our Common Ground, Inc.

DocuSigned by:
Orville Roache
261F0F165FB749D...

Contractor Signature	Date	Contractor Name (please print)
	01/29/2026	Orville Roache

For County:

COUNTY OF SAN MATEO

By:
President, Board of Supervisors, San Mateo County

Date:

ATTEST:

By:
Clerk of Said Board

EXHIBIT A-2 – SERVICES
OUR COMMON GROUND
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-2, 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 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**
Our Common Ground	ASAM 0.5 ASAM 1.0 ASAM 2.1 ASAM 3.1 ASAM 3.3 ASAM 3.5 ASAM 3.2	CC C-Consult IMS CM/RI PSS RS	R& B RR SLE

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. Early Intervention Services (ASAM Level 0.5)

Early intervention services are covered DMC-ODS services for members under the age of 21. Any member under the age of 21 who is screened and determined to be at risk of developing an SUD may receive any service component covered under the outpatient level of care as early intervention services. An SUD diagnosis is not required for early intervention services. A full assessment utilizing the ASAM criteria is not required for a DMC member under the age of 21 to receive early intervention services; an abbreviated ASAM screening tool may be used in lieu of a full ASAM for purposes of assessing for SBIRT or Early Intervention Services.

A full ASAM assessment shall be performed, and the member under the age of 21 shall receive a referral to the appropriate level of care indicated by the assessment if the member's conditions or symptoms constitute diagnostic criteria for SUD.

Early intervention services are provided under the outpatient treatment modality and must be available as needed based on individual clinical need, even if the member under age 21 is not participating in the full array of outpatient treatment services.

2. Outpatient Services (OP) – ASAM 1.0

OP services shall be provided by a DHCS certified program that is also DMC certified and designated by DHCS or CARF as capable of delivering care consistent with ASAM Level 1.0 treatment criteria.

a. Outpatient services up to nine (9) hours per week for adults, and less than six (6) hours a week for adolescents as determined to be medically necessary by a Medical Director or LPHA.

b. 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

c. Outpatient services shall have of a minimum of two (2) group counseling sessions per month, and at least one (1) hour of individual counseling sessions per month.

d. Outpatient services shall include Assessment, Care Coordination, Counseling (individual and group), family therapy, medication Services, MAT for Opioid Use Disorder (OUD), MAT for Alcohol Used Disorder (AUD) and other non-opioid SUDS, patient education, recovery services and SUD Crisis Intervention Services. Avatar service codes for each outpatient service are:

CalAIM Service Description	Service Code(s)
ODS OP ASSESSMENT	AD101ODS_CA
ODS OP PERI ASSESSMENT	AD101ODSPERI_CA
ODS OP INDIVIDUAL COUNSELING	AD102ODS_CA
ODS OP PERI INDIVIDUAL COUNSELING	AD102ODSPERI_CA
ODS OP GROUP COUNSELING	AD103ODS_CA
ODS OP PERI GROUP COUNSELING	AD103ODSPERI-CA
ODS OP INDIVIDUAL PATIENT EDUCATION	AD104ODS_CA
ODS OP PERI INDIVIDUAL PATIENT EDUCATION	AD104ODSPERI_CA
ODS OP GROUP PATIENT EDUCATION	AD105ODS_CA
ODS OP PERI GROUP PATIENT EDUCATION	AD105ODSPERI_CA
ODS OP CRISIS INTERVENTION	AD107ODS_CA
ODS OP PERI CRISIS INTERVENTION	AD107ODSPERI-CA
ODS OP TREATMENT PLANNING	AD109ODS_CA
ODS OP PERI TREATMENT PLANNING	AD109ODSPERI_CA
ODS OP DISCHARGE PLANNING	AD109ODS_CA
ODS OP PERI DISCHARGE PLANNING	AD109ODSPERI_CA
ODS OP FAMILY COUNSELING	AD110ODS_CA
ODS OP PERI FAMILY COUNSELING	AD110ODSPERI _CA
ODS OP CARE COORDINATION	AD113ODSCM-CA

ODS OP PERI CARE COORDICATION	AD113ODSPERIMCM-CA
ODS OP RECOVERY SERVICES INDIVIDUAL COUNSELING	AD1501ODS_CA
ODS OP RECOVERY SERVICES GROUP COUNSELING	AD1502ODS_CA
ODS OP RECOVERY SERVICES RECOVERY MONITORING	AD1504ODSRM)CA
ODS OP MEDICATION ASSISTED TREATMENT (NON-NTP)	AD1601ODS_CA
ODS OP PERI MEDICATION ASSISTED TREATMENT (NON-NTP)	AD601ODSPERI_CA
ODS OP MD CLINICIAN CONSULTATION	AD199367CA
ODS OP PERI MD CLINICIAN CONSULTATION	AD199367PERI_CA
ODS OP NON-MD CLINICIAN CONSULTATION	AD199368_CA
ODS OP PERI NON-MD CLINICIAN CONSULTATION	AD199368PERI_CA
ODS OP URINALYSIS TESTING	AD175ODS_CA
ODS OP PERI URINALYSIS TESTING	AD175ODSPERI_CA
ODS OP PEER SUPPORT PREVENTION ED GROUP	AD1H0025_CA
ODS OP PERI PEER SUPPORT PREVENTION ED GROUP	AD1H0025PERI_CA
ODS OP PEER SUPPORT SELF HELP ENGAGE THEORY	AD1H0038_CA
ODS OP PERI PEER SUPPORT SELF HELP ENGAGE THEORY	AD1H0038PERI_CA

e. Services may be provided in-person, or by telephone or telehealth, in any appropriate setting in the community.

2. Intensive Outpatient (IOP) Services – ASAM 2.1

IOP services shall be provided by a DHCS certified program that is also DMC certified and designated by DHCS or CARF

as capable of delivering care consistent with ASAM Level 2.1 treatment criteria.

a. Intensive outpatient provides structured programming to clients as medically necessary for a minimum of nine (9) hours per week and a maximum of nineteen (19) hours per week for adult perinatal and non-perinatal clients. Adolescents are provided a minimum of six (6) hours and a maximum of nineteen (19) hours per week.

Intensive 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

b. Intensive outpatient services shall have a minimum of one (1) hour of individual counseling session per week.

c. Intensive outpatient services shall include: Assessment, Care Coordination, Counseling (individual and group), Family Therapy, Medication Services, MAT for OUD, MAT for AUD and other non-opioid SUDS, Patient Education, Recovery Services, SUD Crisis Intervention Services. Avatar service codes for each intensive outpatient service are:

CalAIM Service Description	Service Code(s)
ODS IOP ASSESSMENT	AD201ODS_CA
ODS IOP PERI ASSESSMENT	AD201PERI_CA
ODS IOP INDIVIDUAL COUNSELING	AD202ODS_CA
ODS IOP PERI INDIVIDUAL COUNSELING	AD202ODSPERI_CA
ODS IOP GROUP COUNSELING	AD203ODS_CA
ODS IOP PERI GROUP COUNSELING	AD203ODSPERI_CA
ODS IOP INDIVIDUAL PATIENT EDUCATION	AD204ODS_CA
ODS IOP PERI INDIVIDUAL PATIENT EDUCATION	AD204ODSPERI_CA

ODS IOP GROUP PATIENT EDUCATION	AD205ODS_CA
ODS IOP PERI GROUP PATIENT EDUCATION	AD205ODSPERI_CA
ODS IOP CRISIS INTERVENTION	AD207ODS_CA
ODS IOP PERI CRISIS INTERVENTION	AD207ODSPERI_CA
ODS IOP TREATMENT PLANNING	AD208ODS_CA
ODS IOP PERI TREATMENT PLANNING	AD208ODSPERI_CA
ODS IOP DISCHARGE PLANNING	AD209ODS_CA
ODS IOP PERI DISCHARGE PLANNING	AD209ODSPERI_CA
ODS IOP FAMILY COUNSELING	AD210ODS_CA
ODS IOP PERI FAMILY COUNSELING	AD210ODSPERI_CA
ODS IOP CARE COORDINATION	AD213ODSCM_CA
ODS IOP PERI CARE COORDICATION	AD213ODSCMPERI_CA
ODS IOP RECOVERY SERVICES INDIVIDUAL COUNSELING	AD2501ODS_CA
ODS IOP RECOVERY SERVICES GROUP COUNSELING	AD2502ODS_CA
ODS IOP RECOVERY SERVICES RECOVERY MONITORING	AD2504ODSRM)CA
ODS IOP MEDICATION ASSISTED TREATMENT (NON-NTP)	AD2601ODS_CA
ODS IOP PERI MEDICATION ASSISTED TREATMENT (NON-NTP)	AD2601ODSPERI_CA
ODS IOP MD CLINICIAN CONSULTATION	AD299368_CA
ODS IOP PERI MD CLINICIAN CONSULTATION	AD299368PERI_CA
ODS IOP Urinalysis Testing	AD275ODS_CA

IOP PEER SUPPORT PREVENTION ED GROUP	AD2H0025_CA
PERI IOP PEER SUPPORT PREVENTION ED GROUP	AD2H0025PERI_CA
IOP PEER SUPPORT SELF HELP ENGAGE THEORY	AD2H0038_CA
PERI IOP PEER SUPPORT SELF HELP ENGAGE THEORY	AD2H0038PERI_CA

d. Services may be provided in-person, by telephone or telehealth, in any appropriate setting in the community.

3. Residential Treatment Services

a. ASAM 3.1

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 3.1 treatment criteria.

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

i. Contractor shall provide a minimum of twenty (20) hours per week of structured activities in accordance with the client’s treatment plan. At least five (5) of these twenty (20) structured hours shall be clinical in nature.

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

iii. Contractor shall provide at least one (1) of the following treatment services daily 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 Avatar chart.

Residential treatment day services do 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 3.1 residential service are:

CalAIM ASAM 3.1 Service	Service Code(s)
ODS 3.1 Residential service day less than or equal to 30 days	AD311ODS
ODS 3.1 PERI Residential service day less than or equal to 30 days	AD311ODSPERI
ODS 3.1 Residential service day greater than or equal to 31 days	AD312ODS
ODS 3.1 PERI Residential service day greater than or equal to 31 days	AD312ODSPERI
ODS 3.1 Care Coordination	AD3113ODSCM_CA
ODS 3.1 PERI Care Coordination	AD313ODSCMPERI_CA

ODS 3.1 Recovery Services Individual Counseling	AD31501ODS_CA
ODS 3.1 Recovery Services Group Counseling	AD31502ODS_CA
ODS 3.1 Recovery Services Recovery Monitoring	AD31504ODSRM_CA
ODS 3.1 Medication Assisted Treatment	AD31601ODS_CA
ODS 3.1 PERI Medication Assisted Treatment	AD31601ODSPERI_CA
ODS 3.1 MD Clinician Consultation	AD3199367CA
ODS 3.1 PERI MD Clinician Consultation	AD3199367PERI_CA
ODS 3.1 Non-MD Clinician Consultation	AD319968_CA
ODS 3.1 PERI Non-MD Clinician Consultation	AD319968PERI_CA
ODS 3.1 Peer Support Prevention ED Group	AD31H0025_CA
ODS 3.1 PERI Peer Support Prevention ED Group	AD31H0025PERI_CA
ODS 3.1 Peer Support Self Help Engage Theory	AD31H0038_CA
ODS 3.1 PERI Peer Support Self Help Engage Theory	AD31H0038PERI_CA

iv. 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 3.1 Service	Service Code
Non-Billable Residential Day	AD58
Client Absent from Residential program	AD999

v. Contractor shall consult with the client's assigned RTX case manager regarding the course of treatment prior to unplanned discharges.

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

2) The consultation request shall occur immediately upon 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 and shall file an incident report with BHRS.

b. ASAM 3.3

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 3.3 treatment criteria.

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. Residential services shall be provided to adults eighteen (18) and over with cognitive or other impairments that make them unable to participate in a full active milieu or therapeutic community.

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

iii. Residential services shall provide 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. 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 Avatar 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 3.3 service are:

CalAIM ASAM 3.3 Service	Service Code(s)
ODS 3.3 Residential service day less than or equal to 30 days	AD331ODS
ODS 3.3 PERI Residential service day less than or equal to 30 days	AD331ODSPERI

ODS 3.3 Residential service day greater than or equal to 31 days	AD332ODS
ODS 3.3 PERI Residential service day greater than or equal to 31 days	AD332ODSPERI
ODS 3.3 Care Coordination	AD3313ODSCM_CA
ODS 3.3 PERI Care Coordination	AD3313ODSCMPERI-CA
ODS 3.3 Medication Assisted Treatment	AD33601ODS_CA
ODS 3.3 PERI Medication Assisted Treatment	AD33601ODSPERI_CA
ODS 3.3 MD Clinician Consultation	AD3399367CA
ODS 3.3 PERI MD Clinician Consultation	AD339367PERI_CA
ODS 3.3 Non-MD Clinician Consultation	AD339968_CA
ODS 3.3 PERI Non-MD Clinician Consultation	AD339966 PERI_CA
ODS 3.3 Peer Support Prevention ED Group	AD33H0025_CA
ODS 3.3 PERI Peer Support Prevention ED Group	AD33H0025PERI_CA
ODS 3.3 Peer Support Self Help Engage Theory	AD33H0038_CA
ODS 3.3 PERI Peer Support Self Help Engage Theory	AD33H0038PERI_CA

v. 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 3.3 Service	Service Code
Non-Billable Residential Day	AD58
Client Absent from Residential program	AD33999

vi. Contractor shall consult with the client's assigned RTX case manager regarding the course of treatment prior to unplanned 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.

c. 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.

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:

Cal AIM 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 PERI Residential service day greater than or equal to 31 days	AD352ODSPERI
ODS 3.5 Care Coordination	AD3513ODSCM_CA
ODS 3.5 PERI Care Coordination	AD3513ODSCMPERI_CA
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 PERI MD Clinician Consultation	AD3599367PERI_CA
ODS 3.5 Non-MD Clinician Consultation	AD359968_CA
ODS 3.5 PERI Non-MD Clinician Consultation	AD3599368PERI_CA
ODS 3.5 Peer Support Prevention ED Group	AD35H0025_CA
ODS 3.5 PERI Peer Support Prevention ED Group	AD35H0025PERI_CA
ODS 3.5 Peer Support Self Help Engage Theory	AD35H0038_CA
ODS 3.5 PERI Peer Support Self Help Engage Theory	AD35H0038PERI_CA

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.

4. 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

5. 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, 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.

6. Recovery Services

Recovery Services shall be provided to clients following completion of treatment, when medically necessary. Recovery services may be provided face-to-face or by telephone with the client, in any appropriate setting in the community. Recovery Services are designed to support recovery and prevent relapse with the objective of restoring the member to their best possible functional level. Recovery Services emphasize the member's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support to members.

Recovery Services can be delivered and claimed as a standalone service, concurrently with the other levels of care described in this BHIN's "Covered DMC-ODS Services" section, or as a service delivered as part of these levels of care. Recovery Services may be provided in clinical or non-clinical settings (including the community).

Members may receive Recovery Services based on self-assessment or provider assessment of relapse risk. Members do not need to be diagnosed as being in remission to access Recovery Services.

Members may receive Recovery Services while receiving other DMC-ODS services, including MAT services and including NTP services. Members may receive Recovery Services immediately after incarceration with a prior diagnosis of SUD.

Recovery Services include the following service components:
(1) Assessment
(2) Care Coordination
(3) Counseling (individual and group)
(4) Family Therapy
(5) Recovery Monitoring, which includes recovery coaching and monitoring designed for the maximum reduction of the member's SUD
(6) Relapse Prevention, which includes interventions designed to teach members with SUD how to anticipate and cope with the potential for relapse for the maximum reduction of the member's SUD.

For additional guidance regarding Recovery Services, please refer to BHIN 22-005.

a.

Recovery Service	Service Code(s)

ODS 3.1 CARE COORDINATION	AD3113ODSCM_CA
ODS 3.1 RS INDIVIDUAL COUNSELING	AD31501ODS_CA
ODS 3.1 RS GROUP COUNSELING	AD31502ODS_CA
ODS 3.1 RS RECOVERY MONITORING	AD31504ODSRM_CA

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7. 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.

8. 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.

(1) Outpatient Treatment Services
(2) Intensive Outpatient Treatment Services
(3) Partial Hospitalization Services
(4) Residential Treatment Services
(5) Inpatient Services
(6) 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 or not 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.

8. 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.

9. Withdrawal Management

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

      i. Level 1-WM: Ambulatory withdrawal management without extended on-site monitoring (Mild withdrawal with daily or less than daily outpatient supervision)
      ii. 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)
      iii. 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:

i. Assessment
ii. Care Coordination
iii. Medication Services
iv. MAT for OUD
v. MAT for AUD and other non-opioid SUDs
vi. Observation
vii. Recovery Services

f. ASAM 3.2-WM Services

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 Cert	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
ODS 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 an 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:

1) Obtaining medical histories

2) Monitoring health status

3) Testing associated with detoxification from alcohol or drugs

4) Providing alcoholism or drug abuse recovery or treatment services

5) Overseeing patient self-administered medications

6) Treating substance abuse disorders, including detoxification.

10. Contingency Management/Recovery Incentive Program

Contingency Management (CM) is an evidence-based treatment that provides motivational incentives to treat individuals living with stimulant use disorder and support their path to recovery. It recognizes and reinforces individual positive behavioral change, as evidenced by drug tests that are negative for stimulants. CM is the only treatment that has demonstrated robust outcomes for individuals living with stimulant use disorder, including reduction or cessation of drug use and longer retention in treatment.

Contractor shall implement the Contingency Management / Recovery Incentive Program BHIN 23-040 Guidance for the Recovery Incentives Program: California's Contingency Management Benefit.

Eligible Medi-Cal members will participate in a structured 24-week outpatient CM service, followed by six or more months of additional treatment and recovery support services without incentives. The initial 12 weeks of CM consists of a series of incentives for meeting treatment goals, specifically abstinence from stimulants objectively verified by urine drug tests (UDTs) negative for stimulant drugs (e.g., cocaine, amphetamine, and methamphetamine). The incentives

consist of cash-equivalents (e.g., gift cards), consistent with evidence-based clinical research for treating SUD. CM should be offered alongside other therapeutic interventions, such as cognitive behavioral therapy and motivational interviewing that meet the definition of rehabilitative services as defined by 1905(a) of the Social Security Act and CFR 440.130(d).

a. CM services are only available to Medi-Cal beneficiaries who meet the following conditions:
    i. Are enrolled in Medi-Cal and meet access criteria for a comprehensive, individualized course of SUD treatment
    ii. Residing in a participating DMC-ODS county that elects and is approved by DHCS to participate in the Recovery Incentives Program.
    iii. Receiving services in non-residential level of care operated by a DMC-ODS.
b. CM services delivered under the Recovery Incentives Program are only covered when medically necessary and appropriate as determined by an initial substance use disorder assessment consistent with DMC-ODS Intergovernmental Agreement (IA) showing
    i. moderate or severe StimUD as defined by the clinical criteria in the Diagnostic and Statistical Manual (DSM, current edition);
    ii. clinical determination that outpatient treatment is appropriate per the American Society of Addiction Medicine (ASAM) criteria; and
    iii. that the CM benefit is medically necessary and appropriate based on the fidelity of treatment to the evidence-based practice. The presence of additional substance use disorders and/or diagnoses does not disqualify an individual from receiving CM services.
c. The Recovery Incentives Program shall consist of two phases:
    i. Phase 1: CM treatment;
    Phase 1 of CM treatment shall consist of a 24-week outpatient program, during which incentives shall be available for meeting the target behavior of stimulant-non-use. Weeks 1–12 of CM treatment shall serve as the escalation/reset/recovery period, and weeks 13–24 shall serve as the stabilizing period.

    ii. Phase 2: CM continuing care

Phase 2 begins when a member completes the initial 24-weeks of CM treatment. The participating member shall receive CM continuing care of six months or more, with treatment services to support ongoing recovery (e.g., counseling and peer support services). During the period of CM continuing care, participating beneficiaries may receive treatment and recovery-oriented support from DMC-ODS providers, as well as covered DMC-ODS services, including but not limited to Recovery Services.

Service Description	Service Code
ODS OP CONTINGENCY MANAGEMENT	AD1H0050CA
ODS OP PERI CONTINGENCY MANAGEMENT	AD1H0050PERI_CA
ODS IOP CONTINGENCY MANAGEMENT	AD2H0050CA
ODS IOP PERI CONTINGENCY MANAGEMENT	AD2H0050PERI CA

11. 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.

12. 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:

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

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

c. 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.

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

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

ii. includes the information described above;

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

iv. is included in the member's record.

13. 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.

14. 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:

a. 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.

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

15. 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.

16. 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
Recovery Residences	AD96
	AD997 – when client is on a leave of absence
Sober Living Environment	AD95

17. 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

18. 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.

19. 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 the member'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.

20. 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.

21. 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.

22. 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.

B. Non-Drug Medi-Cal Organized Delivery System Services

1. Sober Living Environments

Sober Living Environments (SLEs) are also known as Transitional Housing Units, Transitional Living Centers or Alcohol/Drug Free Housing. SLE programs cannot provide any treatment, recovery, or detoxification services. SLE residents shall also be enrolled and participating in a DHCS certified Outpatient or Intensive Outpatient Treatment program. SLE residents shall be involved in the criminal justice system.

a. Contractor shall provide monthly updates regarding the clients' participation to their Case Manager and/or Probation Officer.

b. The SLE home shall be recovery conducive and space should be adequate to accommodate each individual comfortably and with dignity and respect.

c. Contractor shall establish and maintain a culture and environment that is welcoming and understanding to those they serve.

d. Sleeping rooms shall be adequate to provide a bed and private space for each resident. These areas shall not be used for any other purposes. If more than six people who are not related to each other (not a "family') live together, Contractor shall obtain and maintain the proper permit(s) from its governing district.

e. All residents shall have access to the: kitchen, refrigerator, stove, dining room, laundry facilities, restrooms, and showers to ensure basic needs are met.

f. Staffing is not required. At a minimum, Contractor shall have an individual be responsible for the safety of the facility, be available to maintain records, to collect rent (if applicable), to register and check-out residents, and to maintain rules of the house.

g. Contractor shall provide residents with copies of all policies, procedures, house rules and expectations during the interview process or at the time of admission. One policy shall address the use and possession of alcohol, marijuana, illegal substances and non-prescribed medications (excluding OTC).

h. Contractor shall have a written admission and discharge procedure at each SLE facility.

i. Admission and SLE residency documents shall be kept in a resident's file on the premises at all times.

j. Contractor shall have a written policy regarding the use and storage of residents' prescribed medications.

k. Contractor shall comply with the provision of 42 C.F.R. Part 2.

l. Contractor shall permit and cooperate with BHRS monitoring of its performance and contract compliance.

2. Recovery Residence

A Recovery Residence (RR) provides a safe and healthy living environment to initiate and sustain treatment and recovery from SUDs. A RR may be divided into levels of support based on the type, intensity and duration of support offered.

a. Contractor shall comply with all BHRS RR standards and requirements.

b. Clients may reside at RR for no longer than twenty-four (24) months.

c. Contractor shall maintain all zoning, fire clearance, and previous licensing requirements.

d. Contractor shall employ twenty-four (24) hour staff supervision and resources necessary to provide close and consistent care of residents at the RR.

e. Services provided shall include peer-to-peer recovery support, social and recreational activities, medical and counseling services as medically necessary and appropriate on the client care plan. Services shall not include any treatment at the RR which require a DHCS SUD residential license.

f. Contractor shall assist residents self-administer prescribed medication and secure psychotropic and/or narcotic based medications.

g. Residents shall be enrolled and actively participate in a DHCS certified Outpatient, Intensive Outpatient, Opioid Treatment, Medication Assisted Treatment, or Recovery Support Services program.

i. Contractor shall coordinate services with the SUD treatment provider.

ii. If the Contractor also has SUD Treatment program, the resident shall not be required to attend the Contractor's program as a condition of residing at the RR.

h. Contractor shall assist residents in scheduling health and legal appointments; and, if necessary, provide transportation.

i. Contractor shall provide meals to the residents three (3) times daily and provide personal sundries, towels, linens, and laundry bag, if needed.

j. Contractor shall permit and cooperate with BHRS monitoring of its performance and contract compliance, and shall permit BHRS to review and audit documents.

3. 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 Abuse 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

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 the County , 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”).

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:

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

b. 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

iii. 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.

c. 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 a service, 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 15 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 Abuse Prevention and 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 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.

e. 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.).

f. 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 Exhibit F 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 his/her treatment/recovery plan or is transferred for continued treatment.

*** END OF EXHIBIT A-2 ***

EXHIBIT B-2 – PAYMENTS AND RATES
OUR COMMON GROUND
June 1, 2025 – June 30, 2027

In consideration of the services provided by Contractor in Exhibit A-2, 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 4 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 4 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 TWENTY-THREE MILLION FIVE HUNDRED THIRTY-EIGHT THOUSAND SIX HUNDRED FORTY-FOUR DOLLARS ($23,538,644).

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.

1. FY 2024-2025 Maximum Payment

The County shall pay a maximum amount of ONE MILLION EIGHT HUNDRED THIRTY THOUSAND SEVENTY-EIGHT DOLLARS ($1,830,078) for services provided during FY 2024-2025.

a. 1/12th payment for June FY 2024-2025 shall be FIVE HUNDRED NINETY-ONE THOUSAND FOUR HUNDRED THIRTY-SIX DOLLARS ($591,436).

b. Reconciliations to actual claimed services for FY 2024-2025 and related 1/12th payments will be conducted quarterly. The total reconciliation amount for FY 2024-2025 will be ONE MILLION TWO HUNDRED THIRTY-EIGHT THOUSAND SIX HUNDRED FORTY-TWO DOLLARS ($1,238,642).

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

2. FY 2025-26 Maximum Payment

The County shall pay a maximum reconciled amount of TEN MILLION SIX HUNDRED SIXTY-FIVE THOUSAND NINE HUNDRED SEVENTY-SIX DOLLARS ($10,665,976) for services provided during FY 2025-2026. This includes a reconciliation increase of TWO MILLION TWO HUNDRED EIGHTEEN THOUSAND NINE HUNDRED NINE DOLLARS ($2,218,909).

3. FY 2026-27 Maximum Payment

The County shall pay a maximum amount of ELEVEN MILLION FORTY-TWO THOUSAND FIVE HUNDRED NINETY DOLLARS ($11,042,590) for services provided during FY 2026-2027.

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 payment, 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-2 Section C and Section D. Fiscal Year and Amount.

4. No payments for any services will be made in July or August of FY 2025-26 and any future fiscal year.

5. 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

The maximum amount County shall be obligated to pay for DMC-ODS services shall not exceed EIGHTEEN MILLION THIRTY-THREE THOUSAND EIGHT HUNDRED NINETY-SIX DOLLARS ($18,033,896)

1. Payments for Services Provided in FY 2024-2025

The County shall pay a maximum amount of EIGHT HUNDRED ONE THOUSAND FIVE HUNDRED SEVENTY-EIGHT DOLLARS ($801,578) for reconciled fee for service payments made during FY 2024-2025.

The County shall pay a maximum of FIVE HUNDRED SEVENTY-TWO THOUSAND NINETY-FOUR DOLLARS ($572,094) for June 2025 services upon submission of invoice no later than May 7, 2025.

2. FY 2025-2026

The maximum amount County shall be obligated to pay for DMC-ODS services shall not exceed a reconciled total of TEN MILLION FOUR HUNDRED TWENTY-TWO THOUSAND TWO HUNDRED SEVENTY-NINE DOLLARS ($10,422,279).

Subject to the maximum amount stated above and the terms and conditions of this Agreement, Contractor shall be reimbursed the fee for service rates per Exhibits F and H for the provision of services described in Section I of Exhibit A-2.

3. FY 2026-2027

The maximum amount County shall be obligated to pay for DMC-ODS services shall not exceed TEN MILLION SEVEN HUNDRED EIGHTY-SIX THOUSAND SEVEN HUNDRED EIGHT DOLLARS ($10,786,708).

Subject to the maximum amount stated above and the terms and conditions of this Agreement, Contractor shall be reimbursed the fee for service rates per Exhibits F and H for the provision of services described in Section I of Exhibit A-2.

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, the 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.

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.

C. Non-Drug MediCal SUD Treatment Services

1. Non-Drug Medi-Cal SUD Treatment Services

a. Sober Living Environment

The maximum amount County shall be obligated to pay for a Sober Living Environment shall not exceed NINETY-ONE THOUSAND FIVE HUNDRED EIGHTY-FIVE DOLLARS ($91,585) for the term of the agreement.

i. June 1, 2025 – June 30, 2025

County shall pay contractor at a rate of THIRTY DOLLARS EIGHTY NINE CENTS ($30.89) per client,

per day, on a fee for service basis, not to exceed THREE THOUSAND FOUR HUNDRED FOURTEEN DOLLARS ($3,414) for the period June 1, 2025 through June 30, 2025.

ii. FY 2025-2026

County shall pay contractor at a rate of THIRTY DOLLARS EIGHTY NINE CENTS ($30.89) per client, per day, on a fee for service basis, not to exceed a reconciled total of FORTY-THREE THOUSAND TEN DOLLARS ($43,010) for FY 2025-2026.

iii. FY 2026-2027

County shall pay contractor at a rate of THIRTY DOLLARS EIGHTY NINE CENTS ($30.89) per client, per day, on a fee for service basis, not to exceed FORTY-FIVE THOUSAND ONE HUNDRED SIXTY-ONE DOLLARS ($45,161) for FY 2026-2027.

D. Mental Health Diversion

The maximum payment for alcohol and drug treatment services of non-MediCal clients through the non-Medi Program shall not exceed an aggregate reconciled amount of FOUR HUNDRED TWENTY-SEVEN THOUSAND THREE HUNDRED THIRTY-SIX DOLLARS ($427,336). Subject to the maximum amount stated above and the terms and conditions of this Agreement, Contractor shall be reimbursed the fee for service rates per schedule in the Exhibit C and of providing services described in Section I of Exhibit A-2.

1. Payments for Services Provided in FY 2024-2025

The County shall pay a maximum of FIFTEEN THOUSAND NINE HUNDRED TWENTY-EIGHT DOLLARS ($15,928) for June 2025 services upon submission of invoice no later than May 7, 2025.

2. FY 2025-2026

The maximum amount County shall be obligated to pay for DMC-ODS services shall not exceed a reconciled total of TWO HUNDRED THOUSAND SIX HUNDRED EIGHTY-SEVEN DOLLARS ($200,687).

3. FY 2026-2027

The maximum amount County shall be obligated to pay for DMC-ODS services shall not exceed TWO HUNDRED TEN THOUSAND SEVEN HUNDRED TWENTY-ONE DOLLARS ($210,721).

E. County-Owned Facility

Contractor shall pay County for use of the premises as described in Exhibit A-2., Section I., D., County-Owned Facility Use Requirements. Said charges shall be automatically deducted from Contractor's monthly payments provided under Exhibit B-2, Section I. B. Fixed Rate Payments. This base shall be adjusted annually to reflect the proposed maintenance and operating costs of the premises to County.

1. June 1, 2025 – June 30, 2025

Contractor shall pay County FIVE THOUSAND FIVE HUNDRED EIGHTY-FIVE DOLLARS ($5,585). This amount includes a ten percent (10%) surcharge and property insurance

2. FY 2025-2026

Contractor shall pay County FIVE THOUSAND THREE HUNDRED SIXTY-NINE DOLLARS AND SEVENTY-FIVE CENTS ($5,369.75) per month, for a total of SIXTY-FOUR THOUSAND FOUR HUNDRED THIRTY-SEVEN DOLLARS ($64,437). This amount includes a ten percent (10%) surcharge and property insurance

3. FY 2026-2027

Contractor shall pay County FIVE THOUSAND FIVE HUNDRED THIRTY-EIGHT DOLLARS AND FIFTY CENTS ($5,538.50) per month, for a total of SIXTY-SIX THOUSAND FOUR HUNDRED SIXTY-TWO DOLLARS ($66,462). This amount includes a ten percent (10%) surcharge and property insurance.

F. 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 Paragraph A of this Exhibit B-2 may be approved by the Chief of San Mateo County Health or

designee, subject to the maximum amount set forth in Section 4 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 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-2.

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;

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

f. 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;

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

h. 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-2 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-2 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-2 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
c/o Janet Gard, jgard@smcgov.org

*** END OF EXHIBIT B-2 ***