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SAN BERNARDINO COUNTY

Contract Number

SAP Number
4400014179

Department of Behavioral Health

Department Contract Representative	Jose Sandoval
Telephone Number	(909)383-3978
Contractor	High Desert Child, Adolescent and Family Services Center, Inc.
Contractor Representative	Shannon Baird
Telephone Number	(760)243-7151
Contract Term	July 1, 2020 through September 30, 2024
Total Contract Amount	$1,657,559
Cost Center	1018511000

THIS CONTRACT is entered into in the State of California by and between the County of San Bernardino, hereinafter called the County, and High Desert Child, Adolescent and Family Services Center, Inc. referenced above, hereinafter called Contractor.

IT IS HEREBY AGREED AS FOLLOWS*:*

WITNESSETH:

WHEREAS, the County desires to purchase and Contractor desires to provide **Non-Residential Drug Court Services**, and,

WHEREAS, this Agreement is authorized by law,

NOW, THEREFORE, the parties hereto do mutually agree to terms and conditions as follows:

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I. Definition of Terminology

A. Wherever in this document and in any attachments hereto, the terms "Contract" and/or "Agreement" are used to describe the conditions and covenants incumbent upon the parties hereto, these terms are interchangeable.

B. The terms beneficiary, client, consumer, customer, participant, or patient are used interchangeably throughout this document and refers to the individual(s) receiving services.

C. Definition of May, Shall and Should. Whenever in this document the words "may," "shall" and "should" are used, the following definitions shall apply: "may" is permissive; "shall" is mandatory; and "should" means desirable.

D. The term “Contractor” means a person or company that undertakes a contract to provide materials or labor to perform a service or do a job.

E. The term County refers to San Bernardino County in which the Contractor physically provides covered substance use disorder treatment services.

F. The term “County’s billing and transactional database system” refers to the centralized data entry system used by the Department of Behavioral Health (DBH) for client and billing information.

G. The term Department of Behavioral Health refers to the department under state law that provides mental health and/or substance use disorder treatment and prevention services to San Bernardino County residents. In order to maintain a continuum of care, DBH operates or contracts for the provision of 24-hour residential treatment, withdrawal management (detoxification) services, Outpatient Treatment services, Intensive Outpatient Treatment (IOT), care coordination, recovery services, crisis and referral services. Community services are provided in all major County metropolitan areas and are readily accessible to County residents.

H. The term “Director,” unless otherwise stated, refers to the Director of DBH for San Bernardino County.

I. The “State and/or applicable State agency” as referenced in this Contract may include the Department of Health Care Services (DHCS), the Department of State Hospitals (DSH), the Department of Social Services (DSS), the Mental Health Services Oversight and Accountability Commission (MHSOAC), the Department of Public Health (CDPH), and the Office of Statewide Health Planning and Development (OSHPD).

J. The term "SUDRS" refers to the San Bernardino County Department of Behavioral Health, Substance Use Disorder and Recovery Services.

K. The term “unit of service” refers to:

1. For case management, intensive outpatient treatment, outpatient services, Naltrexone treatment services, and recovery services contact with a client in 15-minute increments on a calendar day.

2. For additional medication assisted treatment, physician services that includes ordering, prescribing, administering, and monitoring of all medications for substance use disorders per visit or in 15-minute increments.

3. For narcotic treatment program services, a calendar month of treatment services provided pursuant to this section and Chapter 4 commencing with 9 CCR § 10000.

4. For physician consultation services, consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists in 15-minute increments.

5. For residential services, providing 24-hour daily service, per client, per bed rate.

6. For withdrawal management per client per visit/daily unit of service.

L. With respect to substance use disorder treatment services, a unit of service includes staff time spent conducting client visits, collateral visits, and group treatment sessions. Other services, including time spent staffing client charts and documenting treatment sessions in the charts, should be included in the Contractor's cost of the unit of service.

M. The term "group counseling session," per Medi-Cal regulations, means face-to-face contacts in which one or more therapists or counselors treat two (2) or more clients at the same time with a maximum of twelve (12) in the group, lasting 90 minutes focusing on the needs of the individuals served. Group counseling sessions are for treatment. Charting the group session is not included in the 90 minute group counseling session. A beneficiary that is 17 years of age or younger shall not participate in group counseling with any participants who are 18 years of age or older. However, a beneficiary who is 17 years of age or younger may participate in group counseling with participants who are 18 years of age or older when the counseling is at a provider's certified school site.

N. The term "individual counseling session" means a face-to-face meeting with a therapist or counselor with one (1) client. Individual counseling sessions are for treatment. Time spent charting is not included within the individual counseling session. Services provided in-person, by telephone, or by telehealth qualify as Medi-Cal reimbursable units of service and are reimbursed without distinction.

II. Contract Supervision

A. The Director or designee shall be the County employee authorized to represent the interests of the County in carrying out the terms and conditions of this Contract. The Contractor shall provide, in writing, the names of the persons who are authorized to represent the Contractor in this Contract.

B. Contractor will designate an individual to serve as the primary point of contact for this Contract. Contractor shall not change the primary contact without written notification and acceptance of the County. Contractor shall notify DBH when the primary contact will be unavailable/out of the office for one (1) or more workdays and will also designate a back-up point of contact in the event the primary contact is not available. Contractor or designee must respond to DBH inquiries within two (2) business days.

C. Contractor shall provide the DBH with contact information, specifically, name, phone number and email address of Contractor's staff member who is responsible for the

following processes: Business regarding administrative issues, Technical regarding data issues, Clinical regarding program issues; and Facility.

III. Performance

A. Drug Court Districts identify and then refer adult defendants with non-violent, felony drug violations and juvenile offenders to the County's comprehensive non-residential Drug Court Program, which provides a highly structured and strictly monitored treatment alternative to prosecution. Program staffing should be multi-disciplinary and reflect the cultural, linguistic, ethnic, age, gender, sexual orientation and other social characteristics of the community which the program serves. Families, caregivers, human service agency personnel and other significant support persons should be encouraged to participate in the planning and implementation process in responding to the individual's needs and desires, and in facilitating the individual's choices and responsibilities. Recovery programs by design may employ credentialed personnel and/or others with expert knowledge and experience in the substance use disorder treatment and recovery field.

B. Under this Agreement, the Contractor shall provide those services, which are dictated by attached Addenda, Schedules and/or Attachments. The Contractor agrees to be knowledgeable in and apply all pertinent local, State and Federal laws and regulations; including, but not limited to those referenced in the body of this Agreement, and all memos, letters, or instruction given by the Director and/or designee in the provision of any and all Substance Use Disorder programs. In the event information in the Addenda, Schedules and/or Attachments conflicts with the basic Agreement, then information in the Addenda, Schedules and/or Attachments shall take precedence to the extent permitted by law.

C. Data Collection and Performance Outcome Requirements

Contractor shall comply with all local, State and Federal regulations regarding local, State and Federal Performance Outcomes measurement requirements and participate in the outcomes measurement process, as required by the State and/or DBH and as outlined in the California Outcomes Measurement System (CalOMS). For Mental Health Services Act (MHSA) programs, Contractor agrees to meet the goals and intention of the program as indicated in the related MHSA Component Plan and most recent update.

Contractor shall comply with all requests regarding local, State and Federal Performance Outcomes measurement requirements and participate in the outcomes measurement processes as requested.

MHSOAC, DHCS, OSHPD, DBH and other oversight agencies or their representatives have specific accountability and outcome requirements. Timely reporting is essential for meeting those expectations.

1. Contractor must collect, manage, maintain and update client, service and episode data as well as staffing data required for local, State and Federal reporting.

2. Contractor shall provide information by entering or uploading required data into:

a. County's billing and transactional database system.

b. DBH's client information system and, when available, its electronic health record system.

c. Individualized data collection applications as specified by DBH.

d. Any other data or information collection system identified by DBH, the MHSOAC, OSHPD or DHCS.

3. Contractor shall comply with all requirements regarding paper or online forms:

a) Contractor shall collect consumer perception data for clients served by the programs. The data to be collected includes, but not limited to, the client's perceptions of the quality and results of services provided by the Contractor.

b) For MH Services - Bi-Annual Client Perception Surveys (paper-based): twice annually, or as designated by DHCS.

c) For SUD Services – Annual Treatment Perception Survey (paper-based): once annually, or as designated by DHCS.

d) Client preferred language survey (paper-based), if requested by DBH.

e) Intermittent services outcomes surveys.

f) Surveys associated with services and/or evidence-based practices and programs intended to measure strategy program, component, or system level outcomes and/or implementation fidelity.

4. Data must be entered, submitted and/or updated in a timely manner for:

a. All FSP and non-FSP clients: this typically means that client, episode and service-related data shall be entered into the County's billing and transactional database system.

b. All service, program, and survey data will be provided in accordance with all DBH established timelines.

5. Contractor will ensure that data are consistent with DBH's specified operational definitions, that data are in the required format, that data is correct and complete at time of data entry, and that databases are updated when information changes.

6. Data collection requirements may be modified or expanded according to local, State, and/or Federal requirements.

7. Contractor shall submit, monthly, its own analyses of the data collected for the prior month, demonstrating how well the contracted services or functions provided satisfied the intent of the Contract, and indicating, where appropriate, changes in operations that will improve adherence to the intent of the Contract. The format for this reporting will be provided by DBH.

8. Independent research involving clients shall not be conducted without the prior written approval of the Director of DBH. Any approved research must follow the guidelines in the DBH Research Policy.

   Note: Independent research means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalized knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.

D. Right to Monitor and Audit Performance and Records

1. Right to Monitor

County or any subdivision or appointee thereof, and the State of California or any subdivision or appointee thereof, including the Auditor General, shall have absolute right to review and audit all records, books, papers, documents, corporate minutes, financial records, staff information, patient records other pertinent items as requested, and shall have absolute right to monitor the performance of Contractor in the delivery of services provided under this Contract. Full cooperation shall be given by Contractor in any auditing or monitoring conducted, according to this agreement and per 42 C.F.R. § 2.53 Audit and Evaluation.

Contractor shall make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to Drug Medi-Cal enrollees, Drug Medi-Cal-related activities, services, and activities furnished under the terms of this Contract, or determinations of amounts payable available at any time for inspection, examination, or copying by DBH, the State of California or any subdivision or appointee thereof, Centers for Medicare and Medicaid Services (CMS), U.S. Department of Health and Human Services (HHS) Office of Inspector General, the United States Comptroller General or their designees, and other authorized Federal and State agencies. This audit right will exist for at least ten (10) years from the final date of the contract period or in the event the Contractor has been notified that an audit or investigation of this Contract has commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies. Records and documents include, but are not limited to all physical and electronic records.

Contractor shall cooperate with the County in the implementation, monitoring and evaluation of this Agreement and comply with any and all reporting requirements established by the County.

County reserves the right to place the Contractor on probationary status, as referenced in the Probationary Status Article, should the Contractor fail to meet performance requirements; including, but not limited to violations such as high disallowance rates, failure to report incidents and changes as contractually required, failure to correct issues, inappropriate invoicing, timely and accurate data

entry, meeting performance outcomes expectations, and violations issued directly from the State. Additionally, Contractor may be subject to Probationary Status or termination if contract monitoring and auditing corrective actions are not resolved within specified timeframes.

2. Availability of Records

Contractor and subcontractors, shall retain, all records and documents originated or prepared pursuant to Contractor's or subcontractor's performance under this Contract, including beneficiary grievance and appeal records as indicated in 42 Code of Federal Regulations (CFR) section 438.416, and the data, information and documentation specified in 42 CFR sections 438.604, 438.606, 438.608, and 438.610 for a period of no less than ten (10) years from the term end date of this Contract or until such time as the matter under audit or investigation has been resolved. Records and documents include, but are not limited to all physical and electronic records and documents originated or prepared pursuant to Contractor's or subcontractor's performance under this Contract including working papers, reports, financial records and documents of account, beneficiary records, prescription files, subcontracts, and any other documentation pertaining to covered services and other related services for beneficiaries.

Contractor shall maintain all records and management books pertaining to local service delivery and demonstrate accountability for contract performance and maintain all fiscal, statistical, and management books and records pertaining to the program. Contractor shall ensure and oversee the existence of reasonable internal control over fiscal records and financial reporting.

Records, should include, but are not limited to, monthly summary sheets, sign-in sheets, and other primary source documents.

Contractor shall permit DBH and the State access and inspection of electronic or print books and records, access to physical facilities, and access and ability to interview employees. Failure to permit access for inspection and/or ability to interview is a breach of this Contract and sufficient basis to terminate for cause or default.

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

Contractor shall maintain client and community service records in compliance with all regulations set forth by local, State, and Federal requirements, laws and regulations, and provide access to clinical records by DBH staff.

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

Contractor shall agree to maintain and retain all appropriate service and financial records for a period of at least ten (10) years from the date of final payment, the

final date of the contract period, final settlement, or until audit findings are resolved, whichever is later.

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

In the event the Contract is terminated, ends its designated term or the Contractor ceases operation of its business, Contractor shall deliver or make available to DBH all financial records that may have been accumulated by Contractor or Subcontractor under this Contract, whether completed, partially completed or in progress within seven (7) calendar days of said termination/end date.

3. Assistance by Contractor

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

E. Notwithstanding any other provision of this Agreement, the County may withhold all payments due to the Contractor, if the Contractor has been given at least thirty (30) days notice of any deficiency(ies) and has failed to correct such deficiency(ies). Such deficiency(ies) may include, but are not limited to: failure to provide services described in this Agreement; Federal, State, and County audit exceptions resulting from noncompliance, violations of pertinent Federal and State laws and regulations, and significant performance problems as determined by the Director or designee from monitoring visits.

F. County has the discretion to revoke full or partial provisions of the Contract, delegated activities or obligations, or application of other remedies permitted by State or Federal law when the County or DHCS determines Contractor has not performed satisfactorily.

G. Cultural Competency

The State mandates counties to develop and implement a Cultural Competency Plan (CCP). This Plan applies to all DBH services. Policies and procedures and all services must be culturally and linguistically appropriate. Contract agencies are included in the implementation process of the most recent State approved CCP for the County of San Bernardino and shall adhere to all cultural competency standards and requirements. Contractor shall participate in the County’s efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation or gender identity. In addition, contract agencies will maintain a copy of the current DBH CCP.

1. Cultural and Linguistic Competency

Cultural competence is defined as a set of congruent practice skills, knowledge, behaviors, attitudes, and policies that come together in a system, agency, or

among consumer providers and professionals that enables that system, agency, or those professionals and consumer providers to work effectively in cross-cultural situations.

a. To ensure equal access to quality care for diverse populations, Contractor shall adopt the federal Office of Minority Health Cultural and Linguistically Appropriate Service (CLAS) national standards.

b. Contractor shall be required to assess the demographic make-up and population trends of its service area to identify the cultural and linguistic needs of the eligible beneficiary population. Such studies are critical to designing and planning for providing appropriate and effective mental health and substance use disorder treatment services.

c. Upon request provide DBH with cultural specific service options available to be provided by Contractor.

d. DBH recognizes that cultural competence is a goal toward which professionals, agencies, and systems should strive. Becoming culturally competent is a developmental process and incorporates at all levels the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs. Providing medically necessary specialty mental health and substance use disorder treatment services in a culturally appropriate and responsive manner is fundamental in any effort to ensure success of high quality and cost-effective behavioral health services. Offering those services in a manner that fails to achieve its intended result due to cultural and linguistic barriers does not reflect high quality of care and is not cost-effective.

e. To assist the Contractor's efforts towards cultural and linguistic competency, DBH shall provide the following:

    i. Technical assistance to the Contractor regarding cultural competency implementation.

    ii. Demographic information to the Contractor on service area for service(s) planning.

    iii. Cultural competency training for DBH and Contractor personnel.

    NOTE: Contractor staff is required to attend cultural competency trainings. Staff who do not have direct contact providing services to clients/consumers shall complete a minimum of two (2) hours of cultural competency training, and direct service clinical staff shall complete a minimum of four (4) hours of cultural competency training each calendar year. Contractor shall upon request from the County, provide information and/or reports as to whether its provider staff completed cultural competency training.

iv. Interpreter training for DBH and Contractor personnel, when available.

v. Technical assistance for the Contractor in translating mental health and substance use disorder services information to DBH's threshold language (Spanish). Technical assistance will consist of final review and field testing of all translated materials as needed.

vi. Monitoring activities administered by DBH to demonstrate documented capacity to offer services in threshold language or contracted interpretation and translation.

vii. Contractor's written organizational procedures must be in place to determine multilingual and competency level(s).

viii. The Office of Cultural Competence and Ethnic Services (OCCES) may be contacted for technical assistance and training offerings at culturalcompetency@dbh.sbcounty.gov or by phone at (909) 386-8223.

f. Contractor agrees to provide culturally competent services. Contractor shall ensue its policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations. Contractor shall ensure translation services are available for beneficiaries, as needed.

H. Access by Public Transportation

Contractor shall ensure that services provided are accessible by transportation.

I. Site Inspection

Contractor shall permit authorized County, State, and/or Federal Agency(ies), through any authorized representative, the right to inspect or otherwise evaluate the work performed or being performed hereunder including subcontract support activities and the premises which it is being performed. The Contractor shall provide all reasonable assistance for the safety and convenience of the authorized representative in the performance of their duties. All inspections and evaluations shall be made in a manner that will not unduly delay the work.

J. Disaster Response

1. In the event that a local, State, or Federal emergency is proclaimed within San Bernardino County, Contractor shall cooperate with the County in the implementation of the DBH Disaster Response Plan. This may include deployment of Contractor staff to provide services in the community, in and around county areas under mutual aid contracts, in shelters and/or other designated areas.

2. Contractor shall provide the DBH Disaster Coordinator with a roster of key administrative and response personnel including after-hours phone numbers, pagers, and/or cell phone numbers to be used in the event of a regional

emergency or local disaster. These numbers will be kept current by quarterly reports to the County by Contractor. The County shall keep such information confidential and not release other than to authorized County personnel or as otherwise required by law.

3. Contractor shall ensure that, within three months from the Contract effective date, at least twenty-five percent (25%) of Contractor's permanent direct service staff participates in a disaster response orientation and training provided by the County or County's designee.

4. Said twenty-five percent (25%) of designated Contractor permanent direct service staff shall complete the following disaster trainings as prerequisites to the DBH-live trainings held annually, which are available online on the Federal Emergency Management Agency (FEMA) website at https://training.fema.gov/is/crslist.aspx:

   a. IS: 100

   b. IS: 200

   c. IS: 700

   d. IS: 800

5. The County agrees to reimburse Contractor for all necessary and reasonable expenses incurred as a result of participating in the County's disaster response at the request of County. Any reasonable and allowable expenses above the Contract maximum will be subject to negotiations.

6. Contractor shall provide DBH with the key administrative and response personnel including after-hours phone numbers, pagers, and/or cell phone numbers to be used in the event of a regional emergency or local disaster. Updated reports are due fourteen (14) days after the close of each quarter. Please send updated reports to:

Office of Disaster and Safety

303 E. Vanderbilt Way

San Bernardino, CA 92415

safety@dbh.sbcounty.gov

K. Collections Costs

Should the Contractor owe monies to the County for reasons including, but not limited to, Quality Management review, cost-settlement, and/or fiscal audit, and the Contractor has failed to pay the balance in full or remit mutually agreed upon payment, the County may refer the debt for collection. Collection costs incurred by the County shall be recouped from the Contractor. Collection costs charged to the Contractor are not a reimbursable expenditure under the Contract.

L. Internal Control

Contractor must establish and maintain effective internal control over the County Fund to provide reasonable assurance that the Contractor manages the County Fund in

compliance with Federal, State and County statutes, regulations, and terms and conditions of the Contract.

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

M. 2-1-1 Registration

Contractor shall submit request to register with 2-1-1 San Bernardino County Inland Empire United Way within thirty (30) days of Contract effective date and follow necessary procedures to be included in the 2-1-1 database. The Contractor shall notify the 2-1-1 San Bernardino County Inland Empire United Way of any changes in program services, location, or contact information within ten (10) days of the change. Services performed as a result of being included in the 2-1-1 database are separate and apart from the services being performed under this Contract and payment for such services will not be the responsibility of the County.

N. Damage to County Property, Facilities, Buildings, or Grounds (If Applicable)

Contractor shall repair, or cause to be repaired, at its own cost, all damage to County vehicles, facilities, buildings or grounds caused by the willful or negligent acts of Contractor or employees or agents of the Contractor. Contractor shall notify DBH within two (2) business days when such damage has occurred. All repairs or replacements must be approved by the County in writing, prior to the Contractor's commencement of repairs or replacement of reported damaged items. Such repairs shall be made as soon as possible after Contractor receives written approval from DBH but no later than thirty (30) days after the DBH approval.

O. If the Contractor fails to make timely repairs, the County may make any necessary repairs. The Contractor, as determined by the County, for such repairs shall repay all costs incurred by the County, by cash payment upon demand, or County may deduct such costs from any amounts due to the Contractor from the County.

P. Damage to County Issued/Loaned Equipment (if Applicable)

1. Contractor shall repair, at its own cost, all damage to County equipment issued/loaned to Contractor for use in performance of this Contract. Such repairs shall be made immediately after Contractor becomes aware of such damage, but in no event later than thirty (30) days after the occurrence.

2. If the Contractor fails to make timely repairs, the County may make any necessary repairs. The Contractor shall repay all costs incurred by the County, by cash payment upon demand, or County may deduct such costs from any amounts due to the Contractor from the County.

3. If a virtual private network (VPN) token is lost or damaged, Contractor must contact DBH immediately and provide the user name assigned to the VPN

Token. DBH will obtain a replacement token and assign it to the user account. Contractor will be responsible for the VPN token replacement fee.

Q. All services performed by the Contractor, regardless of funding, shall be entered into the County's billing and transactional database system no later than the seventh (7^{th}) day of the following month. Reports will be run by DBH Fiscal after this date and the reports will be used for payment of services.

R. Drug and Treatment Access Report

Contractor shall comply with all State regulations regarding the Drug and Treatment Access Report (DATAR) requirements and participate in the DATAR process, as required by the State, which includes, but is not limited to, enrollment in DHCS's web-based DATAR program for submission of data, accessible on the DHCS website upon execution of this contract.

Contractor shall complete the monthly DATAR reporting requirements, in an electronic copy format, no later than the fifth (5th) day of the following month for the prior month's services and demographic information.

Should the Contractor experience system or service failure or other extraordinary circumstances that affect its ability to timely submit a monthly DATAR report, Contractor shall immediately, but no later than three (3) days before the submission deadline, report the problem to DBH in writing. Contractor shall include in the notice a corrective action plan that is subject to review and approval by DBH and DHCS. Contractor acknowledges if the problem is not resolved in the determined grace period, which cannot exceed sixty (60) days, non-DMC payments may be withheld. Contractor acknowledges the State may assess penalties to the County or directly to the Contractor to which the Contractor is responsible for payment if the County or Contractor is found to be non-compliant with DATAR requirements.

IV. Funding

A. This Agreement is contingent upon sufficient funds being made available by Federal, State, and/or County governments for the term of the Agreement. Funding is by fiscal year period July 1 through June 30. Costs and services are accounted for by fiscal year. Any unspent fiscal year allocation may not roll over and may not be available in future years. Any unspent allocation by Fiscal Year may, upon County review and approval, be available within the contract term. Each fiscal year period is settled to Federal and/or State cost reporting accountability.

B. The maximum financial obligation of the County under this Agreement shall not exceed the sum referenced in the Schedules A and B. The maximum financial obligation is further limited by fiscal year, funding source and service modalities as delineated on the Schedules A and B. Contractor may not transfer funds between funding sources or modes of services, or go over 15% of a budgeted line item without the prior written approval from DBH. Budget line items applicable to the 15% rule are: (1) Total Salaries & Benefits and (2) Individual Operating Expense items. The County has the sole discretion of transferring funds between funding sources or modes of services.

1. It is understood between the parties that the Schedules A and B are budgetary guidelines. Contractor must adhere to the budget by categorical funding outlined in the Schedule A of the Contract as well as track year-to-date expenditures. Contractor understands that costs incurred for services not listed or in excess of categorical funding in the Schedule A shall result in non-payment to Contractor for these costs.

C. Contractor agrees to renegotiate the dollar value of this Contract, at the option of the County, if the annualized projected units of service (minutes/hours of time) for any mode of service based on claims submitted for the operative fiscal year, is less than the target percentage of the projected minutes/hours of time for the modes of service as reported in Schedules A and B.

D. If the annualized projected units of service (minutes/hours of time) for any mode of service, based on claims submitted for the operative fiscal year, is greater than/or equal to 110% of the projected units (minutes/hours of time) reported in the Schedules A and B, the County and Contractor agree to meet to discuss the feasibility of renegotiating this Agreement. Contractor must timely notify the County of Contractor's desire to meet.

E. County will take into consideration requests for changes to Contract funding, within the existing contracted amount. All requests must be submitted in writing by Contractor to DBH Fiscal no later than March 1 for the operative fiscal year.

F. A portion of the funding for these services includes Federal Funds. The Federal CFDA numbers are 93.959 and 93.778.

G. In the event of a reduction of the County's allocation of Federal, State or County funding for substance use disorder programs, the Contractor agrees to accept a reduction in funding under this Contract to be determined by the County.

H. Contractor shall maximize the Federal Financial Participation (FFP) reimbursement by claiming all possible Medi-Cal services. Therefore, Contractor must determine on a monthly basis, client eligibility for or entitlement to any and all of the funding used by the County for services to pay for services under the terms and conditions of this Contract. Contractor shall then bill County for those services based on client eligibility or entitlement. Failure to verify eligibility or comply with all program and funding requirements will result in non-payment of services.

1. The County may not be responsible for beneficiaries that do not reside within County boundaries and do not meet eligibility.

I. If client eligibility for a categorical funding is found by the County to be different than eligibility determined by Contractor, County's determination of eligibility will be used to reimburse Contractor for said services. Additionally, no payment will be made for identified services if it is determined that Contractor is out of compliance with program and funding requirements.

J. Contractor Prohibited From Redirections of Contracted Funds:

1. Funds under this Agreement are provided for the delivery of SUD services to eligible beneficiaries under each of the funded programs identified in the Scope

of Work. Each funded program has been established in accordance with the requirements imposed by each respective County, State and/or Federal payer source contributing to the funded program.

2. Contractor may not redirect funds from one funded program to another funded program, except through a duly executed amendment to this Agreement.

K. The maximum financial obligation under this contract shall not exceed $1,657,559 for the contract term.

L. The Schedules A and B will be submitted to, and approved by, the Director or designee at a later date.

V. Limitation on Use of Funds

A. Contractor agrees that no part of any federal funds provided under this Contract shall be used to support lobbying activities to influence proposed or pending Federal or State legislation or appropriations.

B. Contractor shall not use any state or federal funds to provide direct, immediate or substantial support to any religious activity.

C. No funds made available through this Contract shall be used to carry out any program of distributing sterile needles or syringes for the hypodermic injection of any illegal drug.

D. None of the funds made available through this Contract may be used for any activity that promotes the legalization of any drug or other substance included in Schedule I of Section 202 of the Controlled Substance Act (21USC 812).

VI. Provisional Payment

A. During the term of this Agreement, the County shall reimburse Contractor in arrears for eligible expenditures provided under this Agreement and in accordance with the terms. County reimbursements to Contractor for performance of eligible expenditures hereunder are provisional until the completion of all settlement activities.

B. County's adjustments to reimbursements to Contractor will be based upon State adjudication of Medi-Cal claims, contractual limitations of this Agreement, annual cost report, application of various County, State and/or Federal reimbursement limitations, application of any County, State and/or Federal policies, procedures and regulations and/or County, State or Federal audits, all of which take precedence over monthly claim reimbursement.

C. After fiscal review and approval of the billing or invoice, County shall reimburse Contractor, subject to the limitations and conditions specified in this Agreement, in accordance with the following:

1. The County will reimburse Contractor based upon Contractor's submitted and approved claims for rendered services/activities subject to claim adjustments.

2. Reimbursement for SUD services claimed and billed through the DBH treatment claims processing information system will utilize provisional rates to be settled based on actual cost.

3. County will provide Contractor a year-to-date Medi-Cal denied claims report on a monthly basis. It is the responsibility of Contractor to make any necessary corrections to the denied services and notify the County. The County will resubmit the corrected services to DHCS for adjudication.

4. In the event that the denied claims cannot be corrected, and therefore the State DHCS will not approve the denied claims, the County may recover the paid funds from Contractor's current invoice payment.

D. Contractor shall bill the County monthly in arrears for services provided by Contractor on claim forms provided by DBH. All claims submitted shall clearly reflect all required information specified regarding the services for which claims are made. Contractor shall submit the organizations' Profit and Loss Statement with each monthly claim. Each claim shall reflect any and all payments made to Contractor by, or on behalf of patients. Claims for reimbursement shall be completed and forwarded to DBH within ten (10) days after the close of the month in which services were rendered. Following receipt of a complete and correct monthly claim, the County shall make payment within a reasonable period. Payment, for any mode of service covered hereunder, shall be limited as noted.

E. If applicable, no single monthly payment shall exceed one-twelfth (1/12) of the maximum allocations for the mode of service unless there have been payments of less than one-twelfth (1/12) of such amount for any prior month of the Agreement. To the extent that there have been such lesser payments, then the remaining amount(s) may be used to pay monthly services claims which exceed one-twelfth (1/12) of the maximum for that mode of service.

F. In order for the County to properly report accurate expenditures to the State at the end of the fiscal year, Contractor must have the final Claim for Reimbursement Report to the County within 30 (thirty) days following the end of the fiscal year.

G. Contractor shall make its best effort to ensure that the proposed interim reimbursement rates do not exceed the Contractor's actual cost.

H. Reportable revenues are fees paid by persons receiving services or fees paid on behalf of such persons by the Federal Government, by the California Medical Assistance Program (set forth commencing with Section 14000 of the Welfare and Institutions Code) and by other public or private sources.

I. Total revenue collected pursuant to this Agreement from fees collected for services rendered and/or claims for reimbursement from the County shall not exceed the cost of services delivered by the Contractor. In no instance will the Contractor be reimbursed more than the actual net cost of delivering services under this Contract.

J. Contractor shall input Charge Data Invoices (CDI's) into the County's billing and transactional database system by the seventh (7th) day of the month for the previous month's services. Contractor will be paid based on Drug Medi-Cal claimed services in the County's billing and transactional database system for the previous month. Services cannot be billed by the County to the State until they are input into the County's billing and transactional database system.

1. In order to properly reimburse Contractor for eligible monthly services, service data entry must be entered in the month of service. Failure to enter current data may result in delay of payment or non-payment.

K. Contractor shall accept all payments from the County via electronic funds transfer (EFT) directly deposited into the Contractor's designated checking or other bank account. Contractor shall promptly comply with directions and accurately complete forms provided by the County required to process EFT payments.

L. Contractor shall be in compliance with the Deficit Reduction Act of 2005, Section 6032 Implementation. As a condition of payment for services, goods, supplies and merchandise provided to beneficiaries in the Medical Assistance Program ("Medi-Cal"), providers must comply with the False Claims Act employee training and policy requirements in 1902(a) of the Social Security Act [42 USC 1396(a) (68)], set forth in that subsection and as the federal Secretary of the United States Department of Health and Human Services may specify.

M. Contractor agrees that no part of any federal funds provided under this Contract 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 http://www.opm.gov/oca (U.S. Office of Personnel Management).

N. County is exempt from Federal excise taxes and no payment shall be made for any personal property taxes levied on Contractor or any taxes levied on employee wages. The County shall only pay for any State or local sales or use taxes on the services rendered or equipment and/or parts supplied to the County pursuant to the Contract.

O. Contractor shall have a written policy and procedures which outline the allocation of direct and indirect costs. These policies and procedures should follow the guidelines set forth in the Uniform Grant Guidance, Cost Principles and Audit Requirements for Federal Awards. Calculation of allocation rates must be based on actual data (total direct cost, labor costs, labor hours, etc.) from current fiscal year. If current data is not available, the most recent data may be used. Contractor shall acquire actual data necessary for indirect costs allocation purpose. Estimated costs must be reconciled to actual cost and contractor must notify DBH in writing if the indirect cost rate changes.

P. As applicable, for Federal Funded Programs, Contractor shall charge the County program a de Minimis ten percent (10%) of the Modified Total Direct Cost (MTDC) as indirect cost unless Contractor has obtained a "Negotiated Indirect Cost Rates Agreement" from a cognizant agency responsible for negotiating and approving indirect cost rate for non-profit organizations on behalf of all Federal agencies.

For non-Federal funded programs, the County will take into consideration the program requirements and contractor's documented Indirect Cost-Rate as applicable.

The total cost of the program must be composed of the total allowable direct cost and allocable indirect cost less applicable credits. Cost must be consistently charged as either indirect or direct costs but, may not be double charged or inconsistently charged as both, reference Title II Code of Federal Regulations (CFR) §200.414 Indirect (F&A) costs. All costs must be based on actual instead of estimated costs.

Q. Contractor shall not request additional payments and acknowledges payment for services covered under this contract can only be made to the Contractor, no other network provider or agency.

VII. Electronic Signatures

A. The State has established the requirements for electronic signatures in electronic health record systems. DBH has sole discretion to authorize contractors to use e-signatures as applicable. If a contractor desires to use e-signatures in the performance of this Contract, the Contractor shall:

1. Submit the request in writing to the DBH Office of Compliance (Compliance) along with the E-Signature Checklist and requested policies to the Compliance general email inbox at compliance_questions@dbh.sbcounty.gov
2. Compliance will review the request and forward the submitted checklist and policies to the DBH Information Technology (IT) for review. This review period will be based on the completeness of the material submitted.
3. Contractor will receive a formal letter with tentative approval and the E-Signature Agreement. Contractor shall obtain all signatures for staff participating in E-Signature and submit the Agreement with signatures, as directed in the formal letter.
4. Once final, the DBH Compliance will send a second formal letter with the DBH Director's approval and a copy of fully executed E-Signature Agreement will be sent to the Contractor.
5. DBH reserves the right to change or update the e-signature requirements as the governing State Agenc(ies) modifies requirements.
6. DBH reserves the right to terminate e-signature authorization at will and/or should the contract agency fail to uphold the requirements.

B. DBH reserves the right to change or update the e-signature requirements as the governing State agency(ies) modifies requirements.

C. DBH reserves the right to terminate e-signature authorization at will and/or should the contract agency fail to uphold the requirements.

VIII. Cost Report Settlement

A. Section 14124.24 (g) of the Welfare and Institutions Code (WIC) and Section 11852.5 (e) of the Health and Safety Code (HSC) requires contractors to submit accurate and complete cost reports for the previous fiscal year. Contractor shall provide DBH with a complete and correct statement of annual costs in order for the County to complete State Cost Report not later than forty-five (45) days at the end of each fiscal year and not later than forty-five (45) days after the expiration date or termination of this Contract, unless otherwise notified by the County.

B. The Cost Report is a multiyear process consisting of a preliminary, interim, and final settlement, and is subject to audit by DHCS.

C. These cost reports shall be the basis upon which the County reports to the State costs for all services provided.

1. Contractor is required to identify where the cost was incurred by expenditure for the fiscal year.

2. The total costs reported on the cost report must match the total of all the claims submitted to DBH by Contractor as of the end of the fiscal year which includes revised and/or final claims. Any variances between the total costs reported in the cost report and the fiscal year claimed costs must be justified, by contractor, during the cost report process. Approval will be at the discretion of the County.

D. Notwithstanding Final Settlement: Audit Article, Paragraph F, the County shall have the option:

1. To withhold payment, or any portion thereof, pending outcome of a termination audit to be conducted by the County;

2. To withhold any sums due Contractor as a result of a termination audit or similar determination regarding Contractor's indebtedness to the County and to offset such withholdings as to any indebtedness to the County.

E. Preliminary and Final Cost Settlement: The cost of services rendered shall be adjusted to the lowest of the following:

1. Actual net costs for direct prevention and/or treatment services; or

2. Maximum Contract amount.

F. In the event Contractor fails to complete the cost report(s) when due, the County may, at its option, withhold current payments or any monetary settlements due Contractor until the cost report(s) is (are) complete.

G. Only the Director or designee may make exception to the requirement set forth in Cost Report Settlement Article, Paragraph A above, by providing Contractor written notice of the extension of the due date.

H. If Contractor does not submit the required cost report(s) when due and therefore no costs have been reported, the County may, at its option, request full payment of all funds paid Contractor under Payment Article of this Agreement. Contractor shall reimburse the full amount of all payments made by the County to Contractor within a period of time to be determined by the Director or designee.

I. The Final Claim for Reimbursement is due 30 days from end of fiscal year (refer to Payment Article, Paragraph C). Therefore, no claim for reimbursement will be accepted by the County thereafter and should not be included in the cost report.

IX. Fiscal Award Monitoring

A. County has the right to monitor the Contract during the award period to ensure accuracy of claim for reimbursement and compliance with applicable laws and regulations.

B. Contractor agrees to furnish duly authorized representatives from the County and the State access to patient/client records, in accordance with 42 CFR §2.53 and per CFR

Part 200 Title 2, Subpart F § 200.508, and to disclose to State and County representatives all financial records necessary to review or audit Contract services and to evaluate the cost, quality, appropriateness and timeliness of services. Contractor shall ensure County or State representative signs an Oath of Confidentiality/confidentiality statement when requesting access to any patient records. Contractor will retain said statement for its records.

C. If the appropriate agency of the State of California, or the County, determines that all, or any part of, the payments made by the County to Contractor pursuant hereto are not reimbursable in accordance with this Agreement, said payments will be repaid by Contractor to the County. In the event such payment is not made on demand, the County may withhold monthly payment on Contractor's claims until such disallowances are paid by Contractor.

X. Final Settlement: Audit

A. Contractor agrees to maintain and retain all appropriate service and financial records for a period of at least ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later. This is not to be construed to relieve Contractor of the obligations concerning retention of medical records as set forth in Medical Records/Protected Health Information Article.

B. Contractor agrees to furnish duly authorized representatives from the County and the State access to patient/client records and to disclose to State and County representatives all financial records necessary to review or audit Contract services and to evaluate the cost, quality, appropriateness and timeliness of services. Contractor shall attain a signed confidentiality statement from said County or State representative when access to any patient record is being requested for research and/or auditing purposes. Contractor will retain the confidentiality statement for its records.

C. If the appropriate agency of the State of California, or the County, determines that all, or any part of, the payments made by the County to Contractor pursuant hereto are not reimbursable in accordance with this Agreement, said payments will be repaid by Contractor to the County. In the event such payment is not made on demand, the County may withhold monthly payment on Contractor's claims until such disallowances are paid by Contractor, may refer for collections, and/or the County may terminate and/or indefinitely suspend this Agreement immediately upon serving written notice to the Contractor.

D. The eligibility determination and the fees charged to, and collected from, patients whose treatment is provided for hereunder may be audited periodically by the County, DBH and the State.

E. Contractor expressly acknowledges and will comply with all audit requirements contained in the Contract documents. These requirements include, but are not limited to, the agreement that the County or its designated representative shall have the right to audit, to review, and to copy any records and supporting documentation, pertaining to the performance of this Agreement. The Contractor shall have fourteen (14) days to provide a response and additional supporting documentation upon receipt of the draft

post Contract audit report. DBH – Administration Audits will review the response(s) and supporting documentation for reasonableness and consider updating the audit information. After said time, the post Contract audit report will be final.

F. In the event, a post Contract audit finds that Contractor is out of compliance in supporting client eligibility requirements for any categorical funding, including Drug Medi-Cal, the services will be deemed unallowable.

G. If a post Contract audit finds that funds reimbursed to Contractor under this Agreement were in excess of actual costs or in excess of claimed costs (depending upon State of California reimbursement/audit policies) of furnishing the services, the difference shall be reimbursed on demand by Contractor to the County using one of the following methods, which shall be at the election of the County:

1. Payment of total.

2. Payment on a monthly schedule of reimbursement agreed upon by both the Contractor and the County.

H. If there is a conflict between a State of California audit of this Agreement and a County audit of this Agreement, the State audit shall take precedence.

I. In the event this Agreement is terminated, the last reimbursement claim shall be submitted within sixty (60) days after the Contractor discontinues operating under the terms of this Agreement. When such termination occurs, the County shall conduct a final audit of the Contractor within the ninety (90) day period following the termination date, and final reimbursement to the Contractor by the County shall not be made until audit results are known and all accounts are reconciled. No claims for reimbursement shall be accepted after the sixtieth (60th) day following the date of contract termination.

XI. Single Audit Requirement

A. Pursuant to CFR, Title II, Subtitle A, Chapter II, Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards, Contractors expending the threshold amount or more in Federal funds within the Contractor's fiscal year must have a single or program-specific audit performed in accordance with Subpart F, Audit Requirements. The audit shall comply with the following requirements:

1. The audit shall be performed by a licensed Certified Public Accountant (CPA).

2. The audit shall be conducted in accordance with generally accepted auditing standards and Government Auditing Standards, latest revision, issued by the Comptroller General of the United States.

3. At the completion of the audit, the Contractor must prepare, in a separate document from the auditor's findings, a corrective action plan to address each audit finding included in the auditor's report(s). The corrective action plan must provide the name(s) of the contact person(s) responsible for corrective action, the corrective action planned, and the anticipated completion date. If Contractor does not agree with the audit findings or believes corrective action is not required, then the corrective action plan must include an explanation and specific reasons.

4. Contractor is responsible for follow-up on all audit findings. As part of this responsibility, the Contractor must prepare a summary schedule of prior audit findings. The summary schedule of prior audit findings must report the status of all audit findings included in the prior audit's schedule of findings and questioned costs. When audit findings were fully corrected, the summary schedule need only list the audit findings and state that corrective action was taken.

5. Contractor must electronically submit within thirty (30) calendar days after receipt of the auditor's report(s), but no later than nine (9) months following the end of the Contractor's fiscal year, to the Federal Audit Clearinghouse (FAC) the Data Collection Form SF-SAC (available on the FAC Web site) and the reporting package which must include the following:

   a. Financial statements and schedule of expenditures of Federal awards.

   b. Summary schedule of prior audit findings.

   c. Auditor's report(s).

   d. Corrective action plan.

   Contractor must keep one copy of the data collection form and one copy of the reporting package described above on file for ten (10) years from the date of submission to the FAC or from the date of completion of any audit, whichever is later.

6. The cost of the audit made in accordance with the provisions of Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards can be charged to applicable Federal awards. However, the following audit costs are unallowable:

   a. Any costs when audits required by the Single Audit Act that have not been conducted or have been conducted but not in accordance with the Single Audit requirement.

   b. Any costs of auditing that is exempted from having an audit conducted under the Single Audit Act and Subpart F – Audit Requirements because its expenditures under Federal awards are less than the threshold amount during the Contractor's fiscal year.

   Where apportionment of the audit is necessary, such apportionment shall be made in accordance with generally accepted accounting principles, but shall not exceed the proportionate amount that the Federal funds represent of the Contractor's total revenue.

   The costs of a financial statement audit of Contractor's that do not have a Federal award may be included in the indirect cost pool for a cost allocation plan or indirect cost proposal.

7. Contractor must prepare appropriate financial statements, including Schedule of Expenditures for Federal Awards (SEFA), if applicable.

8. The work papers and the audit reports shall be retained for a minimum of ten (10) years from the date of the final audit report, and longer if the independent auditor is notified in writing by the County to extend the retention period.

9. Audit work papers shall be made available upon request to the County and/or the State, and copies shall be made as reasonable and necessary.

XII. Special Reports

Contractor agrees to submit reports as stipulated by the Director or designee to the address listed below:

Department of Behavioral Health
Substance Use Disorder and Recovery Services Administration
621 E. Carnegie Drive, #210
San Bernardino, CA 92415

XIII. Contract Performance Notification

A. In the event of a problem or potential problem that will impact the quality or quantity of work or the level of performance under this Contract, Contractor shall provide notification within one (1) working day, in writing and by telephone, to DBH.

B. Contractor shall notify DBH in writing of any change in mailing address within ten (10) calendar days of the address change.

C. DBH will notify the Contractor within 30 days in the event of any new and/or changes to laws and/or regulations. The Contract Agreement will remain in effect for the duration of this Agreement unless modified through a written notification from the County.

XIV. Probationary Status

A. In accordance with the Performance Article of this Agreement, the County may place Contractor on probationary status in an effort to allow the Contractor to correct deficiencies, improve practices, and receive technical assistance from the County.

B. County shall give notice to Contractor of change to probationary status. The effective date of probationary status shall be five (5) business days from date of notice.

C. The duration of probationary status is determined by the Director or designee(s).

D. Contractor shall develop and implement a corrective action plan, to be approved by DBH, no later than ten (10) business days from date of notice to become compliant.

E. Should the Contractor refuse to be placed on probationary status or comply with the corrective action plan within the designated timeframe, the County reserves the right to terminate this Agreement as outlined in the Duration and Termination Article.

F. Placement on probationary status requires the Contractor disclose probationary status on any Request for Proposal responses to the County.

G. County reserves the right to place Contractor on probationary status or to terminate this Agreement as outlined in the Duration and Termination Article.

XV. Duration and Termination

A. The term of this Agreement shall be from July 1, 2020 through September 30, 2024 inclusive.

B. This Agreement may be terminated immediately by the Director at any time if:

1. The appropriate office of the State of California indicates that this Agreement is not subject to reimbursement under law; or

2. There are insufficient funds available to the County; or

3. There is evidence of fraud or misuse of funds by Contractor; or

4. There is an immediate threat to the health and safety of Medi-Cal beneficiaries; or

5. Contractor is found not to be in compliance with any or all of the terms of the herein incorporated Articles of this Agreement or any other material terms of the Contract, including the corrective action plan.

6. During the course of the administration of this Agreement, the County determines that the Contractor has made a material misstatement or misrepresentation or that materially inaccurate information has been provided to the County, this Contract may be immediately terminated. If this Contract is terminated according to this provision, the County is entitled to pursue any available legal remedies.

C. Either the Contractor or Director may terminate this Agreement at any time for any reason or no reason by serving thirty (30) days written notice upon the other party.

D. This Agreement may be terminated at any time by the mutual written concurrence of both the Contractor and the Director.

E. Contractor must immediately notify DBH when a facility operated by Contractor as part of this Agreement is sold or leased to another party. In the event a facility operated by Contractor as part of this Agreement is sold or leased to another party, the Director has the option to terminate this Agreement immediately.

XVI. Accountability: Revenue

A. Total revenue collected pursuant to this Agreement from fees collected for services rendered and/or claims for reimbursement from the County cannot exceed the cost of services delivered by the Contractor. In no event shall the amount reimbursed exceed the cost of delivering services.

B. Charges for services to either patients or other responsible persons shall be at actual costs.

XVII. State Monitoring

A. Contractor agrees and acknowledges that DHCS shall conduct Postservice Postpayment and Postservice Prepayment (PSPP) Utilization Reviews of DMC Contractors to determine whether the DMC services were provided in accordance with this agreement. DHCS shall issue the PSPP report to DBH with a copy to DMC Contractor.

B. DHCS shall recover payments made if subsequent investigation uncovers evidence that the claim(s) should not have been paid, DMC-ODS services have been improperly utilized, and requirements were not met.

C. All deficiencies identified by PSPP reports, whether or not a recovery of funds results, shall be corrected and the subcontractor that provided the services shall submit a DBH-approved corrective action plan (CAP) to DBH within 60 days of the date of the PSPP report.

XVIII. Patient/Client Billing

Contractor shall exercise diligence in billing and collecting fees, including the billing of other health insurance if applicable, from patients for services under this Agreement prior to utilizing County funding. Contractor agrees to cure transaction errors or deficiencies identified by the State or County.

A. Substance Use Disorder Programs

Client fees shall be charged for treatment services provided under the provisions of this Agreement based upon the client's financial ability to pay for service. Fees charged shall approximate estimated actual cost of providing services, and no person shall be excluded from receiving services based solely on lack of financial ability to make payment toward the cost of providing services.

B. Fees

The Director or designee shall approve the Contractor's fee assessment system, which shall describe how the Contractor charges fees and which must take into consideration the client's income and expenses. The fee system shall be in writing and shall be a matter of public record. In establishing fees to clients, a fee system shall be used which conforms to the following guidelines and criteria as prescribed in Section 11852.5 of the California Health and Safety Code:

1. The fee system shall be equitable.
2. The fee charged shall not exceed the actual cost of providing services.
3. The fee system shall consider the client's income and expenses.
4. The fee system shall be approved by the Director or designee.
5. To ensure an audit trail, Contractor shall maintain the following records:
    a. Fee assessment schedules and collection records.
    b. Documents in each client's file showing client's income and expenses, and how each was considered in determining fees.

C. Other Insurance Billing

Contractor must bill other health insurance companies and collect share of cost if client has been identified as having such in accordance with the State DMC billing manual and other applicable regulations, policies and procedures. Failure to follow said policies and procedures for billing may result in non-payment of services.

D. Liability for Payment

Contractor shall not hold beneficiaries liable for any of the following:

1. Contractor's debt, in the event of the entity's insolvency.
2. Covered services provided to the beneficiary, for which:
    a. The Contractor is not reimbursed for services or
    b. The Contractor does not pay an individual health care provider or health care agency for services furnished pursuant to a contractual, referral or other arrangement.

E. Cost Sharing

Any cost sharing imposed on the beneficiaries shall be in accordance with Chapter 42 of the Code of Federal Regulations, Sections 447.50 through 447.82.

XIX. Personnel

A. Contractor shall furnish such qualified professional personnel prescribed by Title 9 of the California Code of Regulations as are required for the types of services Contractor shall perform, which services are described in such Addenda as may be attached hereto and/or in all memos, letters, or instruction given by the Director or designee in the provision of any and all Substance Use Disorder programs. This includes 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. Contractor shall ensure requirements set forth in DHCS' Certification Standards, including Personnel Practices, are followed.

B. Contractor shall ensure the Staff Master is updated regularly for each service provider with the current employment and license/certification/registration status in order to bill for services and determine provider network capacity. Updates to the Staff Master shall be completed, including, but not limited to, the following events: new registration number obtained, licensure obtained, licensure renewed, and employment terminated. When updating the Staff Master, provider information shall include, but not limited to, the following: employee name; professional discipline; license, registration or certification number; National Provider Identifier (NPI) number and NPI taxonomy code; County's billing and transactional database system number; date of hire; and date of termination (when applicable).

C. Contractor agrees to provide or has already provided information on former County of San Bernardino administrative officials (as defined below) who are employed by or represent Contractor. The information provided includes a list of former County administrative officials who terminated County employment within the last five years and who are now officers, principals, partners, associates or members of the business. The information also includes the employment with or representation of Contractor. For purposes of this provision, "County administrative official" is defined as a member of the Board of Supervisors or such officer's staff, Chief Executive Officer or member of such officer's staff, County department or group head, assistant department or group head, or any employee in the Exempt Group, Management Unit or Safety Management Unit.

D. Contractor shall comply with DBH's request(s) for provider information that is not readily available on the Staff Master form or the Management Information System as DBH is required by Federal regulation to update its paper and electronic provider directory, which includes detailed information regarding its contract agencies and behavioral health care providers, at least monthly.

E. Contractor shall ensure its staff and contracted employees are not located outside of the United States when rendering services (telehealth or telephone) as neither the County nor State will reimburse for services.

F. Contractor shall work collaboratively with the County to ensure all network providers are enrolled with DHCS as Medi-Cal providers.

G. Statements of Disclosure

1. Contractor shall submit a statement of disclosure of ownership, control and relationship information regarding its providers, managing employees, including agents and managing agents as required in Title 42 of the CA Code of Federal Regulations, Sections 455.104 and 455.105 for those having five percent (5%) or more ownership or control interest. This statement relates to the provision of information about provider business transactions and provider ownership and control and must be completed prior to entering into a contract, during certification or re-certification of the provider; within thirty-five (35) days after any change in ownership; annually; and/or upon request of the County. The disclosures to provide are as follows:

    a. Name and address of any person (individual or corporation) with an ownership or control interest in Contractor's agency. The address for corporate entities shall include, as applicable, a primary business address, every business location and a P.O. Box address;

    b. Date of birth and Social Security Number (if an individual);

    c. Other tax identification number (if a corporation or other entity);

    d. Whether the person (individual or corporation) with an ownership or control interest in the Contractor's agency is related to another person with ownership or control in the same or any other network provider of the Contractor as a spouse, parent, child or sibling;

    e. The name of any other disclosing entity in which the Contractor has an ownership or control interest; and

    f. The name, address, date of birth and Social Security Number of any managing employee of the Contractor.

2. Contractor shall also submit disclosures related to business transactions as follows:

    a. Ownership of any subcontractor with whom the Contractor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

b. Any significant business transactions between the Contractor and any wholly owned supplier, or between the Contractor and any subcontractor, during the five (5) year period ending on the date of a request by County.

3. Contractor shall submit disclosures related to persons convicted of crimes regarding the Contractor's management as follows:

a. The identity of any person who is a managing employee, owner or person with controlling interest of the Contractor who has been convicted of a crime related to federal health care programs;

b. The identity of any person who is an agent of the Contractor who has been convicted of a crime related to federal health care programs. Agent is described in 42 C.F.R. §455.101; and

c. The Contractor shall supply the disclosures before entering into a contract and at any time upon the County's request.

H. Contractor shall confirm the identity of its providers, employees, DBH-funded network providers, contractors and any person with an ownership or controlling interest, or who is an agent or managing employee by developing and implementing a process to conduct a review of applicable federal databases in accordance with Title 42 of the Code of Federal Regulations, Section 455.436. In addition to any background check or Department of Justice clearance, the Contractor shall review and verify the following databases:

1. Social Security Administration's Death Master File to ensure new and current providers are not listed. Contractor shall conduct the review prior to hire and upon contract renewal (for contractor employees not hired at the time of contract commencement).

2. National Plan and Provider Enumeration System (NPPES) to ensure the provider has a NPI number, confirm the NPI number belongs to the provider, verify the accuracy of the providers' information and confirm the taxonomy code selected is correct for the discipline of the provider.

3. List of Excluded Individuals/Entities and General Services Administration's System for Award Management (SAM) to ensure providers and Contractor administrative staff are not excluded and confirm provider eligibility. See the Licensing and Certification section of this Contract regarding exclusion checks requirements.

I. Contractor shall obtain records from the Department of Justice of all convictions of persons offered employment or volunteers and any subcontractors (and their staff) as specified in Penal Code Section 11105.3.

J. Contractor shall inform DBH within twenty-four (24) hours or next business day of any allegations of sexual harassment, physical abuse, etc., committed by Contractor's employees against clients served under this Contract. Contractor shall report incident as outlined in Notification of Unusual Occurrences or Incident/Injury Reports paragraph in the Administrative Procedures Article.

K. Iran Contracting Act of 2010

In accordance with Public Contract Code Section 2204(a), the Contractor certifies that at the time the Contract is signed, the Contractor signing the Contract is not identified on a list created pursuant to subdivision (b) of Public Contract Code Section 2203 (http://www.dgs.ca.gov/pd/Resources/PDLegislation.aspx) as a person [as defined in Public Contract Code Section 2202(e)] engaging in investment activities in Iran described in subdivision (a) of Public Contract Code Section 2202.5, or as a person described in subdivision (b) of Public Contract Code Section 2202.5, as applicable.

Contractors are cautioned that making a false certification may subject the Contractor to civil penalties, termination of existing contract, and ineligibility to bid on a contract for a period of three (3) years in accordance with Public Contract Code Section 2205.

L. Trafficking Victims Protection Act of 2000

In accordance with the Trafficking Victims Protection Act (TVPA) of 2000, the Contractor certifies that at the time the Contract is signed, the Contractor will remain in compliance with Section 106(g) of the Trafficking Victims Protection Act of 2000 as amended (22 U.S.C. 7104). For access to the full text of the award term, go to: http://www.samhsa.gov/grants/grants-management/policies-regulations/additional-directives.

The TVPA strictly prohibits any Contractor or Contractor employee from:

1. Engaging in severe forms of trafficking in persons during the duration of the Contract;
2. Procuring a commercial sex act during the duration of the Contract; and
3. Using forced labor in the performance of the Contract.

Any violation of the TVPA may result in payment withholding and/or a unilateral termination of this Contract without penalty in accordance with 2 CFR Part 175. The TVPA applies to Contractor and Contractor's employees and/or agents.

XX. Prohibited Affiliations

A. Contractor shall not knowingly have any prohibited type of relationship with the following:

1. An individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549 [42 C.F.R. § 438.610(a)(1)].
2. An individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described in this section [42 C.F.R. § 438.610(a)(2)].

B. Contractor shall not have a prohibited type of relationship by employing or contracting with providers or other individuals and entities excluded from participation in Federal health care programs (as defined in section 1128B(f) of the Social Security Act) under

either Section 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act [42 C.F.R. §§ 438.214(d)(1), 438.610(b); 42 U.S.C. § 1320c-5].

C. Contractor shall not have any types of relationships prohibited by this section with an excluded, debarred, or suspended individual, provider, or entity as follows:

1. A director, officer, agent, managing employee, or partner of the Contractor [42 U.S.C. § 1320a-7(b)(8)(A)(ii); 42 C.F.R. § 438.610(c)(1)].

2. A subcontractor of the Contractor, as governed by 42 C.F.R. § 438.230. [42 C.F.R. § 438.610(c)(2)].

3. A person with beneficial ownership of 5 percent (5%) or more of the Contractor's equity [(42 C.F.R. § 438.610(c)(3)].

4. An individual convicted of crimes described in section 1128(b)(8)(B) of the Act [42 C.F.R. § 438.808(b)(2)].

5. A network provider or person with an employment, consulting, or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under this Contract [42 C.F.R. § 438.610(c)(4)].

6. Contractor shall not employ or contract with, directly or indirectly, such individuals or entities for the furnishing of health care, utilization review, medical social work, administrative services, management, or provision of medical services, or the establishment of policies or provision of operational support for such services [42 C.F.R. § 438.808(b)(3)].

D. Non-compliance with this section of the contract by the Contractor requires DBH evaluate the current contract and may affect renewals or extensions.

E. Contractor shall provide the County with written disclosure of any prohibited affiliation under this section of the contract by the Contractor or any of its subcontractors.

F. Conflict of Interest

1. Contractor shall comply with the conflict of interest safeguards described in 42 Code of Federal Regulations part 438.58 and the prohibitions described in section 1902(a)(4)(C) of the Act [42 C.F.R. § 438.3(f)(2)].

2. Contractor shall not utilize in the performance of this Contract any County officer or employee or other appointed County official unless the employment, activity, or enterprise is required as a condition of the officer's or employee's regular County employment [Pub. Con. Code § 10410; 42 C.F.R. § 438.3(f)(2)].

a. Contractor shall submit documentation to the County of current and former County employees who may present a conflict of interest.

XXI. Licensing, Certification and Accreditation

A. Contractor shall operate continuously throughout the term of this Agreement with all licenses, certifications and/or permits as are necessary to the performance hereunder.

Failure to maintain a required license, certification, and/or permit may result in immediate termination of this Contract.

B. Contractor shall inform DBH whether it has been accredited by a private independent accrediting entity [42 C.F.R. 438.332(a)]. If Contractor has received accreditation by a private independent accrediting entity, Contractor shall authorize the private independent accrediting entity to provide the County a copy of its most recent accreditation review, including:

1. Its accreditation status, survey type, and level (as applicable); and

2. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings; and

3. The expiration date of the accreditation [42 C.F.R. § 438.332(b)].

C. Contractor shall ensure all service providers apply for, obtain and maintain the appropriate certification, licensure, registration or waiver prior to rendering services. Service providers must work within their scope of practice and may not render and/or claim services without a valid certification, licensure, registration or waiver. Contractor shall develop and implement a policy and procedure for all applicable staff to notify Contractor of a change in licensure/certification/waiver status, and Contractor is responsible for notifying DBH of such change.

D. Contractor shall comply with applicable provisions of the:

1. California Code of Regulations, Title 9, Division 4, Chapter 8 and Title 22, Sections 51341.1, 51490.1, 51516.1 and 51000 et. seq.;

2. California Business and Professions Code, Division 2;

3. California Health and Safety Code, Division 10.5, Part 2, Chapter 7.5;

4. Code of Federal Regulations, Title 21, Part 1300, et. seq. and Title 42, Part 8;

5. Drug Medi-Cal Certification Standards for Substance Abuse Clinics;

6. Standards for Drug Treatment Programs.

E. Contractor shall comply with the United States Department of Health and Human Services, Office of Inspector General (OIG) requirements related to eligibility for participation in Federal and State health care programs as set forth in Executive Order 12549; Social Security Act, 42 U.S. Code, Section 1128 and 1320 a-7; Title 42 CFR, Parts 1001 and 1002, et al; and Welfare and Institutions Code, Section 14043.6 and 14123.

1. Ineligible Persons may include both entities and individuals and are defined as any individual or entity who:

a. Is currently excluded, suspended, debarred or otherwise ineligible to participate in the Federal and State health care programs; or

b. Has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in the Federal and State health care programs after a period of exclusion, suspension,

debarment, or ineligibility.

2. Contractor shall review the organization and all its employees, subcontractors, agents, and physicians for eligibility against the United States General Services Administration's System for Award Management (SAM) and the OIG's List of Excluded Individuals/Entities (LEIE) respectively to ensure that Ineligible Persons are not employed or retained to provide services related to this Contract. Contractor shall conduct these reviews before hire of contract start date and then no less than once a month thereafter.

   a. SAM can be accessed at https://www.sam.gov/SAM/

   b. LEIE can be accessed at http://oig.hhs.gov/exclusions/index.asp

3. If the Contractor receives Drug Medi-Cal reimbursement, Contractor shall review the organization and all its employees, subcontractors, agents and physicians for eligibility against the California Department of Health Care Services Suspended and Ineligible Provider (S&I) List to ensure that Ineligible Persons are not employed or retained to provide services related to this Contract. Contractor shall conduct this review before hire or contract start date and then no less than once a month thereafter.

   a. S&I List can be accessed at: http://files.medi-cal.ca.gov/pubsdoco/sandilanding.asp

4. Contractor shall certify or attest that no staff member, officer, director, partner or principal, or sub-contractor is "excluded" or "suspended" from any federal health care program, federally funded contract, state health care program or state funded contract. This certification shall be documented by completing the Attestation Regarding Ineligible/Excluded Persons (**ATTACHMENT II**) at time of the initial contract execution and annually thereafter. Contractor shall not certify or attest any excluded person working/contracting for its agency and acknowledges that the County shall not pay the Contractor for any excluded person. The Attestation Regarding Ineligible/Excluded Persons shall be submitted to the following program and address:

   DBH Office of Compliance
   303 East Vanderbilt Way
   San Bernardino, CA 92415-0026

   Or send via email to: Compliance_Questions@dbh.sbcounty.gov

5. Contractor acknowledges that Ineligible Persons are precluded from employment and from providing Federal and State funded health care services by contract with the County.

6. Contractor shall have a policy regarding prohibition of employment of sanctioned or excluded employees that includes the requirement for employees to notify the Contractor should the employee become sanctioned or excluded by the OIG, General Services Administration (GSA), and/or the DHCS.

7. Contractor acknowledges any payment received for an excluded person may be

subject to recovery and/or considered an overpayment by DBH/DHCS and/or be the basis for other sanctions by DHCS.

8. Contractor shall immediately notify DBH should an employee become sanctioned or excluded by the OIG, GSA, and/or the DHCS.

9. If a contractor subcontracts or employs an excluded party, DBH has the right to withhold payments, disallow costs, or issue a CAP, as appropriate pursuant to HSC Code 11817.8(h).

XXII. Health Information System

A. Should Contractor have a health information system, it shall maintain a system that collects, analyzes, integrates, and reports data (42 C.F.R. § 438.242(a); Cal. Code Regs., tit. 9, § 1810.376.) The system shall provide information on areas including, but not limited to, utilization, claims, grievances, and appeals [42 C.F.R. § 438.242(a)]. Contractor shall comply with Section 6504(a) of the Affordable Care Act [42 C.F.R. § 438.242(b)(1)].

B. Contractor's health information system shall, at a minimum:

1. Collect data on beneficiary and Contractor characteristics as specified by the County, and on services furnished to beneficiaries as specified by the County; [42 C.F.R. § 438.242(b)(2)].

2. Ensure that data received is accurate and complete by:

a. Verifying the accuracy and timeliness of reported data.

b. Screening the data for completeness, logic, and consistency.

c. Collecting service information in standardized formats to the extent feasible and appropriate.

C. Collect and maintain sufficient beneficiary encounter data to identify the rendering provider, the service and beneficiary.

D. Contractor shall make all collected data, such as beneficiary encounter data available to DBH and, upon request, to DHCS and/or CMS [42 C.F.R. § 438.242(b)(4)] in a HIPAA compliant and standardized format as instructed by DBH.

XXIII. Administrative Procedures

A. Contractor agrees to adhere to all applicable provisions of:

1. State Notices, and;

2. County DBH Standard Practice Manual (SPM). Both the State Notices and the DBH SPM are included as a part of this Contract by reference.

B. Contractor shall have a current administrative manual which includes: personnel policies and procedures, general operating procedures, service delivery policies, any required State or Federal notices (Deficit Reduction Act), and procedures for reporting unusual occurrences relating to health and safety issues.

C. All written materials for potential beneficiaries and beneficiaries with disabilities must utilize easily understood language and a format which is typically at 5th or 6th grade reading level, in a font size no smaller than 12 point, be available in alternative formats and through the provision of auxiliary aids and services, in an appropriate manner that takes into consideration the special needs of potential beneficiaries or beneficiaries with disabilities or limited English proficiency and include a large print tagline and information on how to request auxiliary aids and services, including the provision of the materials in alternative formats [42 C.F.R. 438.10(d)(6)(ii)]. The aforementioned written materials may only be provided electronically by the Contractor if all of the following conditions are met:

1. The format is readily accessible;
2. The information is placed in a location on the Contractor's website that is prominent and readily accessible;
3. The information is provided in an electronic form which can be electronically retained and printed;
4. The information is consistent with the content and language requirements of this Attachment; and
5. The beneficiary is informed that the information is available in paper form without charge upon request and Contractor provides it upon request within five (5) business days [42 C.F.R. 438.10(c)(6)].

D. Contractor shall ensure its written materials are available in alternative formats, including large print, upon request of the potential beneficiary or beneficiary with disabilities at no cost. Large print means printed in a font size no smaller than 18 point [42 C.F.R. § 438.10(d)(3)].

E. Beneficiary Handbook

The Contractor shall utilize the DBH beneficiary handbook, and shall provide each beneficiary the DBH beneficiary handbook, within a reasonable time after receiving notice of the beneficiary's enrollment. The handbook serves as the summary of benefits and coverage described in 45 CFR § 147.200(a). Contractor shall provide the required information in this section to each beneficiary when first required to enroll in the Contractor's SUD program.

F. Consistency

For consistency in the information provided to beneficiaries, the Contractor shall use:

1. State and County developed definitions for managed care terminology, including appeal, emergency medical condition, emergency services, excluded services, grievance, health insurance, hospitalization, medically necessary, network, non-participating provider, physician services, plan, preauthorization, participating provider, prescription drugs, primary care physician, primary care provider, provider, rehabilitation services, and urgent care.
2. State and County developed beneficiary handbooks and beneficiary notices.

G. Credentialing and Re-Credentialing

Contractor shall adhere to DBH's credentialing and re-credentialing policy that addresses behavioral and substance use disorders.

H. Provider Directory

Contractor shall ensure that staff is knowledgeable of and compliant with State and DBH policy/procedure regarding DBH Provider Directories. Contractor agrees to demonstrate staff know how to access the DBH Provider Directory.

I. Beneficiary Rights and Protections

1. Contractor shall ensure staff is knowledgeable of and compliant with applicable federal and state laws and DBH policy/procedure pertaining to beneficiary rights by ensuring its employees and contracted providers observe and protect those rights, which include the following:
    a. Receive information regarding DBH's PIHP and plan in accordance with 42 CFR §438.10.
    b. Be treated with respect and with due consideration for his or her dignity and privacy.
    c. Receive information on available treatment options and alternatives, presented in a manner appropriate to the beneficiary's condition and ability to understand.
    d. Participate in decisions regarding his or her health care, including the right to refuse treatment.
    e. Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation, as specified in other Federal regulations on the use of restraints and seclusion.
    f. If the privacy rule, as set forth in 45 CFR parts 160 and 164 subparts A and E, applies, request and receive a copy of his or her medical records, and request that they be amended or corrected, as specified in 45 CFR § 164.524 and 164.526.
2. The Contractor shall ensure that its beneficiaries have the right to be furnished health care services in accordance with 42 CFR §§438.206 through 438.210.
3. The Contractor shall ensure that each beneficiary is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way DBH and its network providers treat the beneficiary.

J. Provider-Beneficiary Communications

Contractor acting within the lawful scope of practice may advise or advocate on behalf of a beneficiary who is his or her patient, for the following:

1. The beneficiary's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
2. Any information the beneficiary needs to decide among all relevant treatment options.
3. The risks, benefits, and consequences of treatment or non- treatment.
4. The beneficiary's right to participate in decisions regarding his or her health

care, including the right to refuse treatment.

5. To express preferences about future treatment decisions.

K. Grievance and Appeals System

Contractor shall ensure staff is knowledgeable of and compliant with State law and DBH policy/procedure regarding beneficiary problem resolution, the grievance and appeal system, including timing, procedures, handling, resolution and notification, expedited resolution, recordkeeping, reversed appeal resolutions and continued benefits while appeals and state fair hearings are pending, in accordance with 42 CFR §§438.228, 438.402, 438.406, 438.408, 438.410, 438.416, 438.420, and 438.424.

L. Notice of Adverse Benefit Determination Procedures

Contractor shall ensure staff is knowledgeable of and compliant with State law and DBH policy/procedure regarding timely and adequate Notice of Adverse Benefit Determination (NOABD) as outlined in 42 CFR §§438.10, 438.210, 438.402, 438.404, 438.406.

M. If a dispute arises between the parties to this Agreement concerning the interpretation of any State Notice or a policy/procedure within the DBH SPM, the parties agree to meet with the Director to attempt to resolve the dispute.

N. State Notices shall take precedence in the event of conflict with the terms and conditions of this Agreement.

O. If a dispute arises between the parties concerning the performance of this Agreement, DBH and Contractor agree to meet informally to attempt to reach a just and equitable solution.

P. Network Adequacy Standards

Effective July 1, 2018, Contractor shall submit to DBH documentation verifying it has the capacity to serve the expected enrollment in its service area in accordance with the network adequacy standards developed by DHCS. Documentation shall be submitted no less frequently than the following:

1. At the time it enters into this Contract with the County;

2. On an annual basis; and

3. At any time there has been a significant change, as defined by DBH, in the Contractor's operations that would affect the adequacy capacity of services, including the following:

    a. A decrease of twenty-five percent (25%) or more in services or providers available to beneficiaries;

    b. Changes in geographic service area; and

    c. Details regarding the change and Contractor's plans to ensure beneficiaries continue to have access to adequate services and providers.

Q. Notification of Unusual Occurrences or Incident/Injury Reports

1. Contractor shall notify DBH, within twenty-four (24) hours or next business day, of any unusual incident(s) or event(s) that occur while providing services under this Contract, which may result in reputational harm to either the Contractor or the County. Notice shall be made to the assigned contract oversight DBH Program Manager with a follow-up call to the applicable Deputy Director.

2. Contractor shall submit a written report to DBH within three (3) business days of occurrence on DBH Unusual Occurrence/Incident Report form or on Contractor's own form preapproved by DBH Program Manager or designee.

3. If Contractor is required to report occurrences, incidents or injuries as part of licensing requirements, Contractor shall provide DBH Program Manager or designee with a copy of report submitted to applicable State agency.

4. Written reports shall not be made via email unless encryption is used.

R. Copyright

County shall have a royalty-free, non-exclusive and irrevocable license to publish, disclose, copy, translate, and otherwise use, copyright or patent, now and hereafter, all reports, studies, information, data, statistics, forms, designs, plans, procedures, systems, and any other materials or properties developed under this Contract including those covered by copyright, and reserves the right to authorize others to use or reproduce such material. All such materials developed under the terms of this Contract shall acknowledge the County of San Bernardino Department of Behavioral Health as the funding agency and Contractor as the creator of the publication. No such materials or properties produced in whole or in part under this Contract shall be subject to private use, copyright or patent right by Contractor in the United States or in any other country without the express written consent of the County. Copies of all educational and training materials, curricula, audio/visual aids, printed material, and periodicals, assembled pursuant to this Contract must be filed with and approved by the County prior to publication. Contractor shall receive written permission from DBH prior to publication of said training materials.

S. Release of Information

No news releases, advertisements, public announcements or photographs arising out of this Contract or Contractor's relationship with the County may be made or used without prior written approval of DBH.

T. Ownership of Documents

All documents, data, products, graphics, computer programs and reports prepared by Contractor or subcontractors pursuant to the Agreement shall be considered property of the County upon payment for services. All such items shall be delivered to DBH at the completion of work under the Agreement. Unless otherwise directed by DBH, Contractor may retain copies of such items.

U. Equipment and Other Property

All equipment, materials, supplies or property of any kind (including vehicles, publications, copyrights, etc.) purchased with funds received under the terms of this Agreement which has a life expectancy of one (1) year or more shall be the property of

DBH, unless mandated otherwise by Funding Source, and shall be subject to the provisions of this paragraph. The disposition of equipment or property of any kind shall be determined by DBH when the Agreement is terminated. Additional terms are as follows:

1. The purchase of any furniture or equipment which was not included in Contractor's approved budget, shall require the prior written approval of DBH, and shall fulfill the provisions of this Agreement which are appropriate and directly related to Contractor's services or activities under the terms of the Agreement. DBH may refuse reimbursement for any cost resulting from such items purchased, which are incurred by Contractor, if prior written approval has not been obtained from DBH.

2. Before equipment purchases made by Contractor are reimbursed by DBH, Contractor must submit paid vendor receipts identifying the purchase price, description of the item, serial numbers, model number and location where equipment will be used during the term of this Agreement.

3. All equipment purchased/reimbursed with funds from this Agreement shall only be used for performance of this Agreement.

4. Assets purchased with Medi-Cal Federal Financial Participation (FFP) funds shall be capitalized and expensed according to Medi-Cal (Centers for Medicare and Medicaid Services) regulation.

5. Contractor shall submit an inventory of equipment purchased under the terms of this Agreement as part of the monthly activity report for the month in which the equipment is purchased. Contractor must also maintain an inventory of equipment purchased that, at a minimum, includes the description of the property, serial number or other identification number, source of funding, title holder, acquisition date, cost of the equipment, location, use and condition of the property, and ultimate disposition data. A physical inventory of the property must be reconciled annually. Equipment should be adequately maintained and a control system in place to prevent loss, damage, or theft. Equipment with cost exceeding County's capitalization threshold of $5,000 must be depreciated.

6. Upon termination of this Agreement, Contractor will provide a final inventory to DBH and shall at that time query DBH as to requirements, including the manner and method in returning equipment to DBH. Final disposition of such equipment shall be in accordance with instructions from DBH.

V. SUDRS Information and Guidelines

1. Contractor agrees to adhere to all memos, letters, or instruction given by the Director, or designee(s) in the provision of any and all Substance Use Disorder programs. Contractor acknowledges full understanding of the provisions referenced in any memos, letters, or instruction given and agrees to operate the respective substance use disorder programs in accordance with the provisions of such information and the provisions of this Contract. At the option of the County, changes

may be made during the Contract period. Such changes, when made, will be binding on the Contractor.

2. Applicable references, websites, guidelines, definitions, and processes from the State can be found in **EXHIBIT A – DHCS ODS-WAIVER SUPPLEMENTAL GUIDANCE.**

W. Contractor agrees to and shall comply with all requirements and procedures established by the State, County, and Federal Governments, including those pertaining to Quality Management Program and Quality Assessment and Performance Improvement Program regarding ongoing quality assessment and performance improvement, standard performance measures, performance improvement projects, monitoring activities, continuity and coordination of care, under/overutilization of services, beneficiary satisfaction and Quality Management Work Plan, which may require submission of periodic reports to DBH for coordination, contract compliance, and quality assurance as well as participation in reviews conducted by DHCS of DBH and its SUDRS contract agencies.

X. Travel

Contractor shall adhere to the County's Travel Management Policy (8-02) when travel is pursuant to this Agreement and for which reimbursement is sought from the County. In addition, Contractor shall, to the fullest extent practicable, utilize local transportation services, including but not limited to Ontario Airport, for all such travel.

XXIV. Laws and Regulations

A. Contractor agrees to comply with all relevant Federal and State laws and regulations, including, but not limited to those listed below, inclusive of future revisions, and comply with all applicable provisions of:

1. Code of Federal Regulations, Title 21, Sections 1301.01-1301.93
2. Code of Federal Regulations, Title 42, Part 2
3. Code of Federal Regulations, Title 45, Sections 96.30-96.33 and 96.120-96.137
4. California Code of Regulations, Title 9
5. California Code of Regulations, Title 22
6. California Health and Safety Code, Division 10.5
7. Government Code, Section 16367.8
8. Government Code, Article 7, Chapter 1, Division 2, Title 5
9. State Administrative Manual, Chapter 7200 and
10. DHCS or applicable State agency(ies) Negotiated Net Amount and Drug Medi-Cal Contract.
11. United States Code, Title 5, Sections 1501-1508, also known as the Hatch Act
12. Section 1557 of the Patient Protection and Affordable Care Act

B. Health and Safety

Contractor shall comply with all applicable State and local health and safety requirements and clearances, for each site where program services are provided under the terms of the Contract.

1. Any space owned, leased or operated by the Contractor and used for services or staff must meet local fire codes.

2. The physical plant of any site owned, leased or operated by the Contractor and used for services or staff is clean, sanitary and in good repair.

3. Contractor shall establish and implement maintenance policies for any site owned, leased or operated that is used for services or staff to ensure the safety and well-being of clients and staff.

C. Pro-Children Act of 1994

Contractor will comply with Public Law 103-227, Part C - Environmental Tobacco Smoke, also known as the Pro-Children Act of 1994.

D. Drug and Alcohol-Free Workplace

In recognition of individual rights to work in a safe, healthful and productive work place, as a material condition of this Contract, Contractor agrees that Contractor and Contractor's employees, while performing service for the County, on County property, or while using County equipment:

1. Shall not be in any way impaired because of being under the influence of alcohol or a drug.

2. Shall not possess an open container of alcohol or consume alcohol or possess or be under the influence of any substance.

3. Shall not sell, offer, or provide alcohol or a drug to another person. This shall not be applicable to Contractor or Contractor's employees who, as part of the performance of normal job duties and responsibilities, prescribes or administers medically prescribed drugs.

4. Contractor shall inform all employees that are performing service for the County on County property, or using County equipment, of the County's objective of a safe, healthful and productive work place and the prohibition of drug or alcohol use or impairment from same while performing such service for the County.

5. The County may terminate for default or breach of this Contract and any other contract Contractor has with County, if Contractor or Contractor's employees are determined by the County not to be in compliance with above.

E. Privacy and Security

1. Contractor shall comply with all applicable State and Federal regulations pertaining to privacy and security of client information including but not limited to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Health Information Technology for Economic and Clinical Health Act (HITECH), as incorporated in the American Recovery and Reinvestment Act of 2009 (ARRA), and Code of Federal Regulations, Title 42, Part 2. Regulations have

been promulgated governing the privacy and security of Individually Identifiable Health Information (IIHI) and/or Protected Health Information (PHI) or electronic Protected Health Information (ePHI).

2. In addition to the aforementioned protection of IIHI, PHI and e-PHI, the County requires Contractor to adhere to the Protection Of Personally Identifiable Information (PII) and Medi-Cal PII, and in accordance with 42 C.F.R. §2.13 Confidentiality Restrictions and Safeguards and HIPAA Privacy and Security rules. PII includes any information that can be used to search for or identify individuals such as but not limited to name, social security number or date of birth. Whereas Medi-Cal PII is the information that is directly obtained in the course of performing an administrative function on behalf of Medi-Cal, such as determining or verifying eligibility that can be used alone or in conjunction with any other information to identify an individual.

3. Disclosure of PHI, including acknowledgement of participation or referral to/from Part 2 services is prohibited unless a valid client authorization (also referred to as "consent" of disclosure) per 42 CFR §2.31. Contractor shall ensure disclosure without client authorization/consent occurs only for medical emergencies, research, and/or audit and evaluation, as specified under 42 CFR §2.51, §2.52. §2.53, respectively.

4. Contractor shall comply with 42 C.F.R. §2.13 Confidentiality Restrictions and Safeguards and §2.16 Security for Records and the HIPAA Privacy and Security Rules, which includes but is not limited to implementing administrative, physical and technical safeguards that reasonably protect the confidentiality, integrity and availability of PHI, PII, IIHI, and e-PHI; implementing and providing a copy to DBH of reasonable and appropriate written policies and procedures to comply with the standards; conducting a risk analysis regarding the potential risks and vulnerabilities of the confidentiality, integrity and availability of PHI, PII, IIHI, and e-PHI, conducting privacy and security awareness and training at least annually and retain training records for six (6) years, and limiting access to those persons, who have a business need. Any disclosure made under 42 C.F.R. Part 2 must be limited to that information which is necessary to carry out the purpose of the disclosure.

5. Violations of privacy and security requirements as specified under 42 CFR Part 2 may be subject to criminal penalty under 42 U.S.C. 290 dd-2(f) and may be subject to fines in accordance with Title 18 of the U.S.C.

6. Contractor shall comply with the data security requirements set forth by the County as referenced in **Attachment III**.

7. Reporting of Improper Access, Use or Disclosure or Breach

   Contractor shall report to DBH Office of Compliance any unauthorized use, access or disclosure of unsecured Protected Health Information or any other security incident with respect to Protected Health Information no later than one (1) business day upon the discovery of a potential breach consistent with the

regulations promulgated under HITECH by the United States Department of Health and Human Services, 45 CFR Part 164, Subpart D. Upon discovery of the potential breach, the Contractor shall complete the following actions:

a. Provide DBH Office of Compliance with the following information to include but not limited to:

   i. Date the potential breach occurred;

   ii. Date the potential breach was discovered;

   iii. Number of staff, employees, subcontractors, agents or other third parties and the titles of each person allegedly involved;

   iv. Number of potentially affected patients/clients; and

   v. Description of how the potential breach allegedly occurred.

b. Provide an update of applicable information to the extent known at that time without reasonable delay and in no case later than three (3) calendar days of discovery of the potential breach.

c. Provide completed risk assessment and investigation documentation to the DBH Office of Compliance within ten (10) calendar days of discovery of the potential breach with decision whether a breach has occurred, including the following information:

   i. The nature and extent of the PHI involved, including the types of identifiers and likelihood of re-identification;

   ii. The unauthorized person who used PHI or to whom it was made;

   iii. Whether the PHI was actually acquired or viewed; and

   iv. The extent to which the risk to PHI has been mitigated.

d. Contractor is responsible for notifying the client and for any associated costs that are not reimbursable under this Contract, if a breach has occurred. Contractor must provide the client notification letter to DBH for review and approval prior to sending to the affected client(s).

e. Make available to the County and governing State and Federal agencies in a time and manner designated by the County or governing State and Federal agencies, any policies, procedures, internal practices and records relating to a potential breach for the purposes of audit or should the County reserve the right to conduct its own investigation and analysis.

F. Program Integrity Requirements

1. General Requirement

Pursuant to Title 42 C.F.R. Section 438.608, Contractor must have administrative and management arrangements or procedures, including a mandatory compliance plan, that are designed to guard against fraud and abuse.

a. If Contractor identifies an issue or receives notification of a complaint concerning an incident of possible fraud or abuse, the Contractor shall conduct an internal investigation to determine the validity of the

issue/complaint and develop and implement corrective action if needed.

b. If Contractor's internal investigation concludes that fraud or abuse has occurred or is suspected, the issue, if egregious, or beyond the scope of the Contractor's ability to pursue, the Contractor shall immediately report to the DBH Office of Compliance for investigation, review and/or disposition.

c. Contractor shall develop a method to verify whether services were actually furnished to beneficiaries and demonstrate the results to DBH.

d. Contractor acknowledges the County may suspend payments, at the direction of DHCS, if DHCS determines there is a credible allegation of fraud in accordance with 42 CFR 455.23.

2. Compliance Program

DBH has established an Office of Compliance for purposes of ensuring adherence to all standards, rules and regulations related to the provision of services and expenditure of funds in Federal and State health care programs. Contractor shall either adopt DBH's Compliance Plan/Program or establish its own Compliance/Program and provide documentation to DBH to evaluate whether the Program is consistent with the elements of a Compliance Program as recommended by the United States Department of Health and Human Services, Office of Inspector General.

Contractor's Compliance Program must include the following elements:

a. Designation of a compliance officer who reports directly to the Chief Executive Officer and the Contactor's Board of Directors and compliance committee comprised of senior management who are charged with overseeing the Contractor's compliance program and compliance with the requirements of this account. The committee shall be accountable to the Contractor's Board of Directors.

b. Policies and Procedures

Written policies and procedures that articulate the Contractor's commitment to comply with all applicable Federal and State standards. Contractor shall adhere to applicable DBH Policies and Procedures relating to the Compliance Program or develop its own compliance related policies and procedures.

i. Contractor shall maintain documentation, verification or acknowledgement that the Contractor's employees, subcontractors, interns, volunteers, and members of Board of Directors are aware of these Policies and Procedures and the Compliance Program.

ii. Contractor shall have a Compliance Plan demonstrating the seven (7) elements of a Compliance Plan. Contractor has the option to develop its own or adopt DBH's Compliance Plan. Should

Contractor develop its own Plan, Contractor shall submit the Plan prior to implementation for review and approval to:

DBH Office of Compliance
303 East Vanderbilt Way
San Bernardino, CA 92415-0026

Or send via email to: Compliance_Questions@dbh.sbcounty.gov.

c. Code of Conduct

Contractor shall either adopt the DBH Code of Conduct or develop its own Code of Conduct.

i. Should the Contractor develop its own Code of Conduct, Contractor shall submit the Code prior to implementation to the following DBH Program for review and approval:

DBH Office of Compliance
303 East Vanderbilt Way
San Bernardino, CA 92415-0026

Or send via email to: Compliance_Questions@dbh.sbcounty.gov.

ii. Contractor shall distribute the Code of Conduct annually. The code of conduct shall be signed by both the contractor representative, and all employees, subcontractors, interns, volunteers, physicians and members of Board of Directors indicating such persons have received, read, understand and will abide by said Code.

d. Excluded/Ineligible Persons

Contractor shall comply with Licensing, Certification and Accreditation Article in this Contract related to excluded and ineligible status in Federal and State health care programs.

e. Contractor shall ensure all workforce members adhere to code of conduct requirements as specified under CCR Title 9 Section 9846 and 13060; DHCS Certification Standards 1320 – Program Code of Conduct; and DBH Code of Professional Conduct Policy (ADS060202).

f. Internal Monitoring and Auditing

Contractor shall be responsible for conducting internal monitoring and auditing of its agency. Internal monitoring and auditing include, but are not limited to billing and coding practices, licensure/credential/registration/waiver verification and adherence to County, State and Federal regulations.

i. Contractor shall take reasonable precaution to ensure that the coding of health care claims and billing for same are prepared and submitted in an accurate and timely manner and are consistent with Federal, State and County laws and regulations as well as DBH's policies and/or agreements with third party payers. This includes compliance with Federal and State health care program

regulations and procedures or instructions otherwise communicated by regulatory agencies including the Centers for Medicare and Medicaid Services or its agents.

ii. Contractor shall not submit false, fraudulent, inaccurate or fictitious claims for payment or reimbursement of any kind.

iii. Contractor shall bill only for those eligible services actually rendered which are also fully documented. When such services are coded, Contractor shall use only correct billing codes that accurately describe the services provided.

iv. Contractor shall act promptly to investigate and correct any problems or errors in coding of claims and billing, if and when, any such problems or errors are identified by the County, Contractor, outside auditors, etc.

v. Contractor shall ensure all employees/service providers maintain current licensure/credential/registration status as required by the respective licensing Board or certifying organization and Title 9 of the California Code of Regulations.

g. Response to Detected Offenses

Contractor shall respond to and correct detected healthcare program offenses relating to this Contract promptly. Contractor shall be responsible for developing corrective action initiatives for offenses to mitigate the potential for recurrence.

h. Training

i. Compliance

Contractor is responsible for ensuring its Compliance Officer attends effective training and education related to compliance, including but not limited to, seven elements of a compliance program and fraud, waste and abuse. Contractor is responsible for conducting and tracking Compliance Training for its agency staff. Contractor is encouraged to attend DBH Compliance trainings, as offered and available.

ii. Drug Medi-Cal (DMC)

Contractor shall attend training DBH provides regarding Title 22 regulations and DMC requirements at least once annually. Attendance at any of the annual trainings offered by DHCS satisfies the DMC requirement.

i. Enforcement of Standards

Contractor shall enforce compliance standards uniformly and through well-publicized disciplinary guidelines. If Contractor does not have its own standards, the County requires the Contractor utilize DBH policies

and procedures as guidelines when enforcing compliance standards.

j. Communication

Contractor shall establish and maintain effective lines of communication between its Compliance Program and DBH's Compliance Officer. Contractor's employees may use Contractor's approved Compliance Hotline or DBH's Compliance Hotline (800) 398-9736 to report fraud, waste, abuse or unethical practices.

k. Subpoena

In the event that a subpoena or other legal process commenced by a third party in any way concerning the Services provided under this Contract is served upon Contractor or County, such party agrees to notify the other party in the most expeditious fashion possible following receipt of such subpoena or other legal process. Contractor and County further agree to cooperate with the other party in any lawful effort by such other party to contest the legal validity of such subpoena or other legal process commenced by a third party as may be reasonably required and at the expense of the party to whom the legal process is directed, except as otherwise provided herein in connection with defense obligations by Contractor for County.

l. Overpayment

Contractor shall adhere to DBH's policy/procedure regarding the immediate reporting, return within 60 calendar days and timely notification of the reason for an overpayment.

m. In accordance with the Termination paragraph of this Agreement, the County may terminate this Agreement upon thirty (30) days written notice if Contractor fails to perform any of the terms of this Compliance paragraph. At the County's sole discretion, Contractor may be allowed up to thirty (30) days for corrective action.

XXV. Patients' Rights

Contractor shall take all appropriate steps to fully protect patients' rights, as specified in Welfare and Institutions Code Sections 5325 et. seq.; Title 9 California Code of Regulations (CCR), Sections 861, 862, 883, 884; and Title 22 CCR, Sections 72453 and 72527.

XXVI. Confidentiality

Contractor agrees to comply with confidentiality requirements contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), commencing with Subchapter C; 42 Code of Federal Regulations Part 2; and all State and Federal statutes and regulations regarding confidentiality, including but not limited to applicable provisions of Welfare and Institutions Code Sections 5328 et. seq. and 14100.2; Section 11812 of the Health and Safety Code; and Title 22, California Code of Regulations Section 51009. Contractor is aware that criminal penalties may be imposed for a violation of these confidentiality requirements.

A. Contractor and its employees, agents or subcontractors shall protect from unauthorized disclosure of PII or PHI concerning persons receiving services or being referred for services related to this agreement.

B. Contractor shall have all employees acknowledge an Oath of Confidentiality mirroring that of DBH's, including confidentiality and disclosure requirements, as well as sanctions related to non-compliance. Contractor shall have all employees sign acknowledgement of the Oath on an annual basis. Said confidentiality statements must be kept for inspection for a period of six (6) years following contract termination.

C. Contractor shall not use or disclose PHI other than as permitted or required by law.

D. Contractor shall provide patients with a notice of Federal confidentiality requirements, as specified under Admission Policies, Paragraph C.

XXVII. Admission Policies

A. Contractor shall develop patient/client admission policies, which are in writing and available to the public.

B. Contractor's admission policies shall adhere to policies that are compatible with Department of Behavioral Health service priorities, and Contractor shall admit clients according to procedures and time frames established by DBH.

C. Contractor is prohibited from enrollment discrimination and shall adhere to the following:

1. accept individuals eligible for enrollment,
2. enrollment is mandatory,
3. shall not, based on health status or need for health care services, discriminate against individuals eligible to enroll,
4. shall not discriminate against individuals eligible to enroll based on race, color, national origin, sex, sexual orientation, gender identity, or disability.

D. If Contractor is found not to be in compliance with the terms of Admission Policies Article, this Agreement may be subject to termination.

XXVIII. Choice of Network Provider

DBH and Contractor shall allow each beneficiary to choose his or her network provider to the extent possible and appropriate.

XXIX. Medical Records/Protected Health Information

A. Contractor agrees to maintain and retain medical records according to the following:

1. The minimum maintenance requirement of medical records is:

a. The information contained in the medical record shall be confidential and shall be disclosed only to authorized persons in accordance to local, State and Federal laws.

b. Documents contained in the medical record shall be written legibly in ink or typewritten, be capable of being photocopied and shall be kept for all clients accepted for care or admitted, if applicable.

c. If the medical record is electronic, the Contractor shall make the computerized records accessible for the County's review.

2. The minimum legal requirement for the retention of medical records is:

a. For adults and emancipated minors, ten (10) years following discharge (last date of service), contract end date or completion date of any audit, whichever is later);

b. For unemancipated minors, a minimum of seven (7) years after they have attained the age of 18, but in no event less than ten (10) years following discharge (last date of service), contract end date or completion date of any audit, whichever is later).

c. County shall be informed within three (3) business days, in writing, if client medical records are defaced or destroyed prior to the expiration of the required retention period.

B. Should patient/client records be misplaced and cannot be located after the Contractor has performed due diligence, the Contractor shall report to DBH as a possible breach of PHI in violation of HIPAA and 42 CFR Part 2. Should the County and Contractor determine the chart cannot be located, all billable services shall be disallowed/rejected.

C. Contractor shall ensure that all patient/client records are stored in a secure manner and access to records is limited to those employees of Contractor who have a business need. Security and access of records shall occur at all times, during and after business hours.

D. Contractor agrees to furnish duly authorized representatives from the County and the State access to patient/client records.

E. The IIHI or PHI under this Contract shall be and remain the property of the County. The Contractor agrees that it acquires no title or rights to any of the types of client information.

F. The County shall store the medical records for all the Contractor's County funded clients when a Contract ends its designated term, a Contract is terminated, a Contractor relinquishes its contracts or if the Contractor ceases operations.

1. Contractor shall deliver to DBH all data, reports, records and other such information and materials (in electronic or hard copy format) pertaining to the medical records that may have been accumulated by Contractor or Subcontractor under this Contract, whether completed, partially completed or in progress within seven (7) calendar days of said termination/end date.

2. Contractor shall be responsible for the boxing, indexing and delivery of any and all records that will be stored by DBH Medical Records Unit. Contractor shall arrange for delivery of any and all records to DBH Medical Records Unit within seven (7) calendar days (this may be extended to thirty (30) calendar days with approval of DBH) of cessation of business operations.

3. Should the Contractor fail to relinquish the medical records to the County, the County shall report the Contractor and its qualified professional personnel to the applicable licensing or certifying board(s).

4. Contractor shall maintain responsibility for the medical records of non-county funded clients.

XXX. Transfer of Care

A. Prior to the termination or expiration of this Contract, and upon request by the County, the Contractor shall assist the County in the orderly transfer of behavioral health care for beneficiaries in San Bernardino County. In doing this, the Contractor shall make available to DBH copies of medical records and any other pertinent information, including information maintained by any subcontractor that is necessary for efficient case management of beneficiaries. Under no circumstances will the costs for reproduction of records to the County from the Contractor be the responsibility of the client.

B. Transfer of care includes continued services to beneficiaries (42 CFR §438.62).

C. The State shall arrange for Medicaid services to be provided without delay to any Medicaid beneficiary of DBH, if the Agreement between State and DBH is terminated.

D. Contractor shall adhere to the County's transition of care policy (once in effect) to ensure continued access to services during a transition from fee-for-service (FFS) to Contractor or transition from one Contractor to another when a beneficiary, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

E. The State shall make its transition of care policy publicly available and provide instructions on how beneficiaries and potential beneficiaries access continued services upon transition. At a minimum, DBH and Contractor shall provide the transition of care policy to beneficiaries and potential beneficiaries in the beneficiary handbook and notices.

XXXI. Quality Assurance/Utilization Review

A. Contractor agrees for the County to have a monitoring system in effect to evaluate the performance of the Contractor.

B. Contractor agrees to be in compliance with the Laws and Regulations Article of this Contract.

C. Contractor agrees to implement a Quality Improvement Program as part of program operations. This program will be responsible for monitoring documentation, quality improvement and quality care issues. Contractor will submit its quality improvement plan to DBH SUDRS Administration on an annual basis, and any tools/documents used to evaluate Contractor's documentation, quality of care and the quality improvement process.

D. When quality of care documentation or issues are found to exist by DBH, Contractor shall submit a plan of correction to be approved by DBH SUDRS Administration.

E. Contractor agrees to be part of the County Quality Improvement planning process through the annual submission of Quality Improvement Outcomes in County identified areas.

F. County shall establish standards and implement processes for Contractor that will support understanding of, compliance with, documentation standards set forth by the State. The County has the right to monitor performance so that the documentation of care provided will satisfy the requirements set forth. The documentation standards for beneficiary care are minimum standards to support claims for the delivery of behavioral health services. All documentation shall be addressed in the beneficiary record.

XXXII. Independent Contractor Status

Contractor understands and agrees that the services performed hereunder by its officers, agents, employees, or contracting persons or entities are performed in an independent capacity and not in the capacity of officers, agents or employees of the County.

All personnel, supplies, equipment, furniture, quarters, and operating expenses of any kind required for the performance of this Contract shall be provided by Contractor.

XXXIII. Subcontractor Status

A. If Contractor intends to subcontract any part of the services provided under this Contract to a separate and independent agency or agencies, Contractor must submit a written Memorandum of Understanding (MOU) with that agency or agencies with original signatures to DBH. The MOU must clearly define the following:

1. The name of the subcontracting agency.
2. The amount (units, minutes, etc.) and types of services to be rendered under the MOU.
3. The amount of funding to be paid to the subcontracting agency.
4. The subcontracting agency's role and responsibilities as it relates to this Contract.
5. A detailed description of the methods by which the Contractor will insure that all subcontracting agencies meet the monitoring requirements associated with funding regulations.
6. A budget sheet outlining how the subcontracting agency will spend the allocation.

B. Any subcontracting agency must be approved in writing by DBH and shall be subject to all applicable provisions of this Contract. The Contractor will be fully responsible for any performance of a subcontracting agency. DBH will not reimburse Contractor or Subcontractor for any expenses rendered by a subcontractor NOT approved in writing by DBH.

C. Ineligible Persons

Contractor shall adhere to Licensing and Certification Article, Subsection D regarding Ineligible Persons or Excluded Parties for its subcontractors.

D. All subcontractors shall fulfill the requirements the service or activity delegated under the subcontract, and shall fulfill the requirements outlined in this contract, to which the Contractor shall oversee and be held accountable for the performance, any functions, responsibilities and adherence that the Contractor delegates and contracts to its subcontractor.

E. The Contractor shall require subcontractors not bill beneficiaries for covered services under a contractual, referral, or other arrangement with DBH in excess of the amount that would be owed by the individual if the Contractor had directly provided the services.

XXXIV. Attorney Costs and Fees

If any legal action is instituted to enforce any party's rights hereunder, each party shall bear its own costs and attorneys' fees, regardless of who is the prevailing party. This paragraph shall not apply to those costs and attorney fees directly arising from a third-party legal action against a party hereto and payable under Indemnification and Insurance Article, Part A.

XXXV. Indemnification and Insurance

A. Indemnification

Contractor agrees to indemnify, defend (with counsel reasonably approved by the County) and hold harmless the County and its authorized officers, employees, agents and volunteers from any and all claims, actions, losses, damages, and/or liability arising out of this Contract from any cause whatsoever, including the acts, errors or omissions of any person and for any costs or expenses incurred by the County on account of any claim except where such indemnification is prohibited by law. This indemnification provision shall apply regardless of the existence or degree of fault of indemnitees. The Contractor's indemnification obligation applies to the County's "active" as well as "passive" negligence but does not apply to the County's "sole negligence" or "willful misconduct" within the meaning of Civil Code Section 2782.

B. Additional Insured

All policies, except for the Workers' Compensation, Errors and Omissions and Professional Liability policies shall contain endorsements naming the County and its officers, employees, agents and volunteers as additional insured with respect to liabilities arising out of the performance of services hereunder. The additional insured endorsements shall not limit the scope of coverage for the County to vicarious liability but shall allow coverage for the County to the full extent provided by the policy. Such additional insured coverage shall be at least as broad as Additional Insured (Form B) endorsement form ISO, CG 2010.11 85.

C. Waiver of Subrogation Rights

Contractor shall require the carriers of required coverages to waive all rights of subrogation against the County, its officers, employees, agents, volunteers, contractors, and subcontractors. All general or auto liability insurance coverage provided shall not prohibit the Contractor and Contractor's employees or agents from waiving the right of subrogation prior to a loss or claim. The Contractor hereby waives all rights of subrogation against the County.

D. Policies Primary and Non-Contributory

All policies required herein are to be primary and non-contributory with any insurance or self-insurance programs carried or administered by the County.

E. Severability of Interests

Contractor agrees to ensure that coverage provided to meet these requirements is applicable separately to each insured and there will be no cross liability exclusions that preclude coverage for suits between the Contractor and the County or between the County and any other insured or additional insured under the policy.

F. Proof of Coverage

Contractor shall furnish Certificates of Insurance to the County Department administering the Contract evidencing the insurance coverage at the time the contract is executed. Additional endorsements, as required, shall be provided prior to the commencement of performance of services hereunder, which certificates shall provide that such insurance shall not be terminated or expire without thirty (30) days written notice to the Department and Contractor shall maintain such insurance from the time Contractor commences performance of services hereunder until the completion of such services. Within fifteen (15) days of the commencement of this Contract, the Contractor shall furnish a copy of the Declaration page for all applicable policies and will provide complete certified copies of the policies and all endorsements immediately upon request.

G. Acceptability of Insurance Carrier

Unless otherwise approved by Risk Management, insurance shall be written by insurers authorized to do business in the State of California and with a minimum “Best” Insurance Guide rating of “A-VII”.

H. Deductibles and Self-Insured Retention

Any and all deductibles or self-insured retentions in excess of $10,000 shall be declared to and approved by Risk Management.

I. Failure to Procure Coverage

In the event that any policy of insurance required under this Contract does not comply with the requirements, is not procured, or is canceled and not replaced, the County has the right but not the obligation or duty to cancel the Contract or obtain insurance if it deems necessary and any premiums paid by the County will be promptly reimbursed by the Contractor or County payments to the Contractor will be reduced to pay for County purchased insurance.

J. Insurance Review

Insurance requirements are subject to periodic review by the County. The Director of Risk Management or designee is authorized, but not required, to reduce, waive or suspend any insurance requirements whenever Risk Management determines that any of the required insurance is not available, is unreasonably priced, or is not needed to protect the interests of the County. In addition, if the Department of Risk Management determines that heretofore unreasonably priced or unavailable types of insurance

coverage or coverage limits become reasonably priced or available, the Director of Risk Management or designee is authorized, but not required, to change the above insurance requirements to require additional types of insurance coverage or higher coverage limits, provided that any such change is reasonable in light of past claims against the County, inflation, or any other item reasonably related to the County's risk.

Any change requiring additional types of insurance coverage or higher coverage limits must be made by amendment to this Contract. Contractor agrees to execute any such amendment within thirty (30) days of receipt.

Any failure, actual or alleged, on the part of the County to monitor or enforce compliance with any of the insurance and indemnification requirements will not be deemed as a waiver of any rights on the part of the County.

K. Insurance Specifications

Contractor agrees to provide insurance set forth in accordance with the requirements herein. If the Contractor uses existing coverage to comply with these requirements and that coverage does not meet the specified requirements, the Contractor agrees to amend, supplement or endorse the existing coverage to do so. The type(s) of insurance required is determined by the scope of the contract services.

Without in anyway affecting the indemnity herein provided and in addition thereto, the Contractor shall secure and maintain throughout the contract term the following types of insurance with limits as shown:

1. Workers' Compensation/Employers Liability

   A program of Workers' Compensation insurance or a State-approved, Self-Insurance Program in an amount and form to meet all applicable requirements of the Labor Code of the State of California, including Employer's Liability with $250,000 limits, covering all persons including volunteers providing services on behalf of the Contractor and all risks to such persons under this Contract.

   If Contractor has no employees, it may certify or warrant to the County that it does not currently have any employees or individuals who are defined as "employees" under the Labor Code and the requirement for Workers' Compensation coverage will be waived by the County's Director of Risk Management.

   With respect to Contractors that are non-profit corporations organized under California or Federal law, volunteers for such entities are required to be covered by Workers' Compensation insurance.

2. Commercial/General Liability Insurance

   Contractor shall carry General Liability Insurance covering all operations performed by or on behalf of the Contractor providing coverage for bodily injury and property damage with a combined single limit of not less than one million dollars ($1,000,000), per occurrence. The policy coverage shall include:

   a. Premises operations and mobile equipment.

b. Products and completed operations.

c. Broad form property damage (including completed operations).

d. Explosion, collapse and underground hazards.

e. Personal Injury.

f. Contractual liability.

g. $2,000,000 general aggregate limit.

3. Automobile Liability Insurance

Primary insurance coverage shall be written on ISO Business Auto coverage form for all owned, hired and non-owned automobiles or symbol 1 (any auto). The policy shall have a combined single limit of not less than one million dollars ($1,000,000) for bodily injury and property damage, per occurrence.

If the Contractor is transporting one or more non-employee passengers in performance of contract services, the automobile liability policy shall have a combined single limit of two million dollars ($2,000,000) for bodily injury and property damage per occurrence.

If the Contractor owns no autos, a non-owned auto endorsement to the General Liability policy described above is acceptable.

4. Umbrella Liability Insurance

An umbrella (over primary) or excess policy may be used to comply with limits or other primary coverage requirements. When used, the umbrella policy shall apply to bodily injury/property damage, personal injury/advertising injury and shall include a “dropdown” provision providing primary coverage for any liability not covered by the primary policy. The coverage shall also apply to automobile liability.

5. Cyber Liability Insurance

Cyber Liability Insurance with limits of not less than $1,000,000 for each occurrence or event with an annual aggregate of $5,000,000 covering claims involving privacy violations, information theft, damage to or destruction of electronic information, intentional and/or unintentional release of private information, alteration of electronic information, extortion and network security. The policy shall protect the involved County entities and cover breach response cost as well as regulatory fines and penalties.

L. Professional Services Requirements

1. Professional Liability Insurance with limits of not less than one million ($1,000,000) per claim or occurrence and two million ($2,000,000) aggregate.

or

Errors and Omissions Liability Insurance with limits of not less than one million ($1,000,000) per occurrence and two million ($2,000,000) aggregate.

or

Directors and Officers Insurance coverage with limits of not less than one million ($1,000,000) shall be required for contracts with charter labor committees or other not-for-profit organizations advising or acting on behalf of the County.

2. Abuse/Molestation Insurance – The Contractor shall have abuse or molestation insurance providing coverage for all employees for the actual or threatened abuse or molestation by anyone of any person in the care, custody, or control of any insured, including negligent employment, investigation, and supervision. The policy shall provide coverage for both defense and indemnity with liability limits of not less than one million dollars ($1,000,000) per occurrence and two million dollars ($2,000,000) aggregate.

3. If insurance coverage is provided on a "claims made" policy, the "retroactive date" shall be shown and must be before the date of the start of the contract work. The "claims made" insurance shall be maintained or "tail" coverage provided for a minimum of five (5) years after contract completion.

XXXVI. Nondiscrimination

A. General

Contractor agrees to serve all clients without regard to race, color, gender, gender identity, religion, marital status, national origin, age, sexual orientation, or mental or physical handicap or disability pursuant to the Civil Rights Act of 1964, as amended (42 U.S.C., Section 2000d), Executive Order No. 11246, September 24, 1965, as amended, Title IX of the Education Amendments of 1972, and Age Discrimination Act of 1975.

Contractor shall not engage in any unlawful discriminatory practices in the admission of beneficiaries, assignments of accommodations, treatment, evaluation, employment of personnel, or in any other respect on the basis of race, color, gender, gender identity, religion, marital status, national origin, age, sexual orientation, or mental or physical handicap or disability.

B. Individuals with Disabilities

Contractor agrees to comply with Titles I, II, and III of the Americans with Disabilities Act (ADA) which prohibits discrimination on the basis of disability in employment, by public entities, and regarding access, as well as all applicable Federal and State laws and regulations, guidelines and interpretations issued pursuant thereto.

Contractor agrees to comply with the Rehabilitation Act of 1973, which prohibits discrimination on the basis of individuals with disabilities.

C. Employment and Civil Rights

Contractor agrees to and shall comply with the County's Equal Employment Opportunity Program and Civil Rights Compliance requirements:

1. Equal Employment Opportunity Program

Contractor agrees to comply with the provisions of the Equal Employment Opportunity Program of the County of San Bernardino and rules and regulations adopted pursuant thereto: Executive Orders 11246, 11375, 11625, 12138,

12432, 12250, and 13672; Title VII of the Civil Rights Act of 1964 (and Division 21 of the California Department of Social Services Manual of Policies and Procedures and California Welfare and Institutions Code, Section 10000); the California Fair Employment and Housing Act; and other applicable Federal, State, and County laws, regulations and policies relating to equal employment or social services to welfare recipients, including laws and regulations hereafter enacted.

During the term of the Contract, Contractor shall not discriminate against any employee, applicant for employment, or service recipient on the basis of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, sexual orientation, age, political affiliation or military and veteran status.

2. Civil Rights Compliance

a. Contractor shall develop and maintain internal policies and procedures to assure compliance with each factor outlined by State regulation. Consistent with the requirements of applicable Federal or State law, the Contractor shall not engage in any unlawful discriminatory practices in the admission of beneficiaries, assignments of accommodations, treatment, evaluation, employment of personnel or in any other respect on the basis of race, color, gender, religion, marital status, national origin, age, sexual preference or mental or physical disabilities. The Contractor shall comply with the provisions of Section 504 of the Rehabilitation Act of 1973, as amended, pertaining to the prohibition of discrimination against qualified individuals with disabilities in all federally assisted programs or activities, as detailed in regulations signed by the Secretary of the United States Department of Health and Human Services, effective June 2, 1977, and found in the Federal Register, Volume 42, No. 86, dated May 4, 1977. The Contractor shall include the nondiscrimination and compliance provisions of this Contract in all subcontracts to perform work under this Contract. Notwithstanding other provisions of this section, the Contractor may require a determination of medical necessity pursuant to Title 9, CCR, Section 1820.205, Section 1830.205 or Section 1830.210, prior to providing covered services to a beneficiary.

b. Contractor shall prohibit discrimination on the basis of race, color, national origin, sex, gender identity, age, disability, or limited English proficiency (LEP) in accordance with Section 1557 of the Affordable Care Act (ACA), appropriate notices, publications, and DBH Non-Discrimination-Section 1557 of the Affordable Care Act Policy (COM0953).

D. Sexual Harassment

Contractor agrees that clients have the right to be free from sexual harassment and sexual contact by all staff members and other professional affiliates.

E. Charitable Choice Policy

Contractor shall comply with all Federal, State and County rules and regulations that are required for compliance under: Title 42 of the Code of Federal Regulations, Part 54 – Charitable Choice Regulations and DBH's Standard Practice Manual Charitable Choice Policy.

F. ADA Plan

Contractor shall comply with all Federal, State and County rules and regulations that are required for compliance under:

1. Americans with Disability Act (ADA);
2. Section 504 of the Rehabilitation Act of 1973;
3. 45 Code of Federal Regulations (CFR), Part 84, Non-discrimination on the Basis of Handicap in Programs or Activities Receiving Federal Financial Assistance;
4. Title 24, California Code of Regulations (CCR), Part 2, Activities Receiving Federal Financial Assistance and;
5. Unruh Civil Rights Act California Civil Code (CCC) Sections 51 through 51.3 and all applicable laws related to services and access to services for persons with disabilities (PWD).

G. Contractor shall not discriminate against beneficiaries on the basis of health status or need for health care services, pursuant to 42 C.F.R. Section 438.6(d)(3).

H. Policy Prohibiting Discrimination, Harassment, and Retaliation

1. Contractor shall adhere to the County's Policy Prohibiting Discrimination, Harassment and Retaliation (07-01). This policy prohibits discrimination, harassment, and retaliation by all persons involved in or related to the County's business operations.

   The County prohibits discrimination, harassment, and/or retaliation on the basis of Race, Religion, Color, National Origin, Ancestry, Disability, Sex/Gender, Gender Identity/Gender Expression/Sex Stereotype/Transgender, Sexual Orientation, Age, Military and Veteran Status. These classes and/or categories are Covered Classes covered under this policy; more information is available at www.dfeh.ca.gov/employment.

   The County prohibits discrimination against any employee, job applicant, unpaid intern in hiring, promotions, assignments, termination, or any other term, condition, or privilege of employment on the basis of a Protected Class. The County prohibits verbal harassment, physical harassment, visual harassment, and sexual harassment directed to a Protected Class.

2. Contractor shall comply with 45 C.F.R. § 160.316 to refrain from intimidation or retaliation. Contractors may not threaten, intimidate, coerce, harass, discriminate

against, or take any other retaliatory action against any individual or other person for:

a. Filing of a complaint

b. Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing

c. Opposing any unlawful act of practice, provided the individual or person has a good faith belief that the practice opposed is unlawful, and the manner of opposition is reasonable and does not involve a disclosure of protected health information.

XXXVII. DBH Notice of Personal/Civil Rights

Contractor shall ensure that staff are knowledgeable on the County DBH Notice of Personal/Civil Rights (designated as **ATTACHMENT I**).

XXXVIII. Drug-Free Workplace

By signing this Contract the Contractor certifies under penalty of perjury under the laws of the State of California that the Contractor shall comply with the requirements of the Drug-Free Workplace Act of 1990 (Government Code § 8350 et. seq.), and the Pro-Children Act of 1994, and shall provide a drug-free workplace by taking the following actions:

A. Publish a statement notifying employees that the unlawful manufacture, distribution, dispensation, possession, or use of a controlled substance is prohibited in the person's or organization's workplace and specifying the actions that shall be taken against employees for violations of the prohibitions as required by Government Code § 8355 (a).

B. Establish a drug-free awareness program as required by Government Code § 8355 (b) to inform employees about all of the following:

1. The dangers of drug abuse in the workplace;

2. The person's or organization's policy of maintaining a drug-free workplace;

3. Any available drug counseling, rehabilitation, and employee assistance programs; and

4. The penalties that may be imposed upon employees for drug abuse violations.

C. Provide, as required by Government Code § 8355 (c), that every employee engaged in performing of the Contract shall:

1. Be given a copy of the Contractor's drug-free policy statement; and

2. As a condition of employment on the Contract, agree to abide by the terms of the statement.

D. Failure to comply with these requirements may result in suspension of payments under the Contract or termination of the Contract or both, and the Contractor may be ineligible for future County or State contracts if the County or State determines that any of the following has occurred:

1. Contractor has made false certification; and/or

2. Contractor has violated the certification by failing to carry out the requirements as noted above.

XXXIX. Contract Amendments

Contractor agrees that any alterations, variations, modifications, or waivers of the provisions of the Contract shall be valid only when they have been reduced to writing, duly signed by both parties and attached to the original of the Contract and approved by the required persons and organizations.

XL. Assignment

A. This Agreement shall not be assigned by Contractor, either in whole or in part, without the prior written consent of the Director.

B. This Contract and all terms, conditions and covenants hereto shall inure to the benefit of, and binding upon, the successors and assigns of the parties hereto.

C. If the ownership of the Contractor changes, both the licensee and the applicant for the new license shall, prior to the change of ownership, provide the State and DBH with written documentation stating:

1. The organizational change in the Contractor's name or ownership, including Articles of Incorporation or Partnership Agreements, and business licenses, fictitious name permits, and such other information and documentation that may be requested by the State;

2. That the new licensee shall have custody of the clients' records and that these records or copies shall be available to the former licensee, the new licensee and the County; or

3. That arrangements have been made by the licensee for the safe preservation and the location of the clients' records, and that they are available to both the new and former licensees and the County; or

4. The reason for the unavailability of such records.

XLI. Severability

The provisions of this Contract are specifically made severable. If any clause, provision, right and/or remedy provided herein are unenforceable or inoperative, the remainder of this Contract shall be enforced as if such clause, provision, right and/or remedy were not contained herein.

XLII. Improper Consideration

Contractor shall not offer (either directly or through an intermediary) any improper consideration such as, but not limited to, cash, discounts, service, the provision of travel or entertainment, or any items of value to any officer, employee or agent of the County in an attempt to secure favorable treatment regarding this Contract.

The County, by written notice, may immediately terminate any Contract if it determines that any improper consideration as described in the preceding paragraph was offered to any officer, employee or agent of the County with respect to the proposal and award process or any solicitation

for consideration was not reported. This prohibition shall apply to any amendment, extension or evaluation process once a Contract has been awarded.

Contractor shall immediately report any attempt by a County officer, employee or agent to solicit (either directly or through an intermediary) improper consideration from Contractor. The report shall be made to the supervisor or manager charged with supervision of the employee or to the County Administrative Office. In the event of a termination under this provision, the County is entitled to pursue any available legal remedies.

XLIII. Venue

The venue of any action or claim brought by any party to the Contract will be the Superior Court of California, County of San Bernardino, San Bernardino District. Each party hereby waives any law or rule of the court, which would allow them to request or demand a change of venue. If any action or claim concerning the Contract is brought by any third-party and filed in another venue, the parties hereto agree to use their best efforts to obtain a change of venue to the Superior Court of California, County of San Bernardino, San Bernardino District.

XLIV. Conclusion

A. This Agreement consisting of sixty-three (63) pages, Schedules, Addenda, and Attachments inclusive is the full and complete document describing the services to be rendered by Contractor to the County, including all covenants, conditions and benefits.

B. IN WITNESS WHEREOF, the Board of Supervisors of the County of San Bernardino has caused this Agreement to be subscribed by the Clerk thereof, and Contractor has caused this Agreement to be subscribed on its behalf by its duly authorized officers, the day, month, and year first above written.

This Agreement may be executed in any number of counterparts, each of which so executed shall be deemed to be an original, and such counterparts shall together constitute one and the same Agreement. The parties shall be entitled to sign and transmit an electronic signature of this Agreement (whether by facsimile, PDF or other email transmission), which signature shall be binding on the party whose name is contained therein. Each party providing an electronic signature agrees to promptly execute and deliver to the other party an original signed Agreement upon request.

COUNTY OF SAN BERNARDINO

► _____
Curt Hagman, Chairman, Board of Supervisors

Dated: _____

SIGNED AND CERTIFIED THAT A COPY OF THIS DOCUMENT HAS BEEN DELIVERED TO THE CHAIRMAN OF THE BOARD
Lynna Monell
Clerk of the Board of Supervisors
of the County of San Bernardino

By _____
Deputy

High Desert Child, Adolescent and Family Services Center, Inc.
(Print or type name of corporation, company, contractor, etc.)

By ► _____
(Authorized signature - sign in blue ink)

Name _____
(*Print or type name of person signing contract)*

Title _____
(Print or Type)

Dated: _____

Address _____

Approved as to Legal Form	Reviewed by Contract Compliance	Presented to BOS for Signature
►	►	►
Dawn Martin, Deputy County Counsel	Natalie Kessee, Contracts Manager	Veronica Kelley, Director
Date	Date	Date

AGREEMENT FOR FEDERAL BLOCK GRANT

CONTRACTOR NAME: High Desert Child, Adolescent and Family Services Center, Inc.

SPECIAL PROVISIONS FOR FEDERAL FUNDED PROGRAMS

1. Financial records shall be kept that 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.

2. Substance use disorder treatment service agencies which serve intravenous drug users (IDU's) shall do outreach activities for the purpose of encouraging individuals in need of treatment for substance use disorders to undergo such treatment.

3. Programs receiving funds under this grant are required to notify the State, within seven (7) days, or reaching ninety percent (90%) capacity to admit individuals.

4. Any treatment services provided with SABG funds must follow the treatment preferences established in 45 CFR 96.131:

   a) Pregnant Intravenous Drug Users (IVDU);

   b) Pregnant substance abusers;

   c) IVDUs

   d) All other eligible individuals

5. The Contractor agrees to give preferences in admission for treatment to pregnant women seeking, or referred for, services and who would benefit from them. In the event of insufficient capacity in a facility, the Contractor shall: refer pregnant women to another program with an available treatment slot; or, provide interim services within 48 hours of initial request until treatment becomes available.

6. The Contractor agrees to ensure that, to the maximum extent practicable, each individual who requests and is in need of treatment for a substance use disorder is admitted to a program within 14 days after making the request. If placement cannot occur within 14 days of the request, the Contractor agrees to ensure that interim services will be made available within 48 hours of the request and placement will occur within 120 days of the request.

7. The Contractor agrees to ensure that directly, or through arrangement with another Contractor, routine tuberculosis services are made available to each individual receiving treatment. If an individual is denied admission due to lack of capacity, the individual will be referred to another provider of tuberculosis services. Tuberculosis services consist of counseling, testing, and treatment.

8. The Contractor agrees that data will be maintained regarding interim services, Tuberculosis, pre/post test results, and HIV services. A report, which will include aggregate data, will be filed with the County SUDRS and the State Department of Health Care Services (DHCS) or applicable State agency(ies) monthly.

9. The Contractor agrees to report information regarding program capacity and waiting list by submitting a Drug Abuse Treatment Access Report (DATAR) to DHCS or applicable State agency(ies) and the County SUDRS monthly. DATAR shall be submitted by the 5th of the month for the previous month of services.

10. The Contractor agrees to comply with all County SUDRS Provider Block Grant Re-authorization Guidelines.

11. Contractor must verify client eligibility for other categorical funding, including, but not limited to Drug Medi-Cal, prior to utilizing Block Grant funds. Failure to verify eligibility for other funding may result in non-payment for services. Also, if audit findings reveal Contractor failed to fulfill requirements for categorical funding, funding source will not revert to Block Grant. Contractor will be required to reimburse funds to the County.

12. Contractor shall input client information and data into the County's billing and transactional database system. All clients and client services shall be entered into the system regardless of funding. The system will feed into the California Outcomes Measurement System (CalOMS). CalOMS is a statewide client-based data collection and outcomes measurement system. CalOMS will allow the State DHCS or applicable State agency(ies) to effectively manage and improve the provision of substance use disorders services at the State, County, and Provider levels.

---END OF ADDENDUM---

AGREEMENT FOR THE PROVISION OF SUBSTANCE USE DISORDER SERVICES NON-RESIDENTIAL DRUG COURT SERVICES

CONTRACTOR NAME: High Desert Child, Adolescent and Family Services Center, Inc.

A. Contractor shall provide Non-Residential Drug Court services as defined herein to San Bernardino County residents.

B. FACILITY LOCATIONS:

Contractor shall provide the above services in and from the following address(es):

High Desert Child, Adolescent and Family Services Center

16248 Victor St.

Victorville, CA. 92395

C. SERVICE DESCRIPTION:

Contractor shall provide Substance Use Disorder Services Non-Residential Drug Court services in accordance with the following description:

1. The San Bernardino County Department of Behavioral Health (DBH), Substance Use Disorder and Recovery Services (SUDRS) have implemented a coordinated network of substance use disorder prevention, treatment and recovery services which are provided through contractors and County clinics. Each Contractor agrees that every effort shall be made to make all services available through the coordinated network including its various levels of care: prevention, residential treatment, withdrawal management (detoxification), outpatient, intensive outpatient treatment, and medication assisted treatment.
2. Each Contractor agrees to provide all potential clients access to this network of services and system of care through a consistent evaluation process to determine the appropriate ASAM Criteria level of care.

D. SPECIFIC RESPONSIBILITIES:

1. Program Description
    a. General Program Information, Guidelines, and Requirements - Adult and Juvenile Drug Court Programs
        1) Program General Description, Responsibilities and Qualifications – Adult and Juvenile Drug Court Programs

The Contractor shall provide Outpatient and Intensive Outpatient Substance Use Disorder Treatment Drug Court services in accordance with the following description:

a) The County of San Bernardino Department of Behavioral Health, Substance Use Disorder and Recovery Services is in search of providers in San Bernardino County with extensive experience in providing substance use disorder treatment to Drug Court clients and also offers integrated co-occurring disorder treatment. At a minimum, providers must have the ability to identify underlying co-occurring disorders as well as targeted substance use disorder symptoms and treatment. The importance of combining strategies from the fields of psychiatry and addiction therapies is that the combined strategies can assist in lowering relapse rates, reduce recidivism and foster long-term abstinence.

b) The DBH-SUDRS provides a coordinated network of substance use prevention, treatment and recovery services which are provided through subcontractors and county clinics. Each Contractor agrees that every effort shall be made to make all services available through the coordinated network including its various levels of care: prevention, residential treatment, withdrawal management (detoxification), outpatient, intensive outpatient, community-based recovery centers, and Narcotic Treatment Programs.

c) Eligible clients will have consented to therapeutic treatment as an alternative approach to incarceration for non-violent criminal offenses. It is estimated clients will need approximately 18-20 months of treatment for adults an at minimum eight (8) months for juveniles. Services will include treatment recommendations made to the Court; substance use disorder treatment services including services and interventions for co-occurring clients. Providers will provide evidence-based services, fostering recovery and resiliency for adults with mental co-occurring disorders.

d) A minimum of two evidence-based, age appropriate models (with supporting evidenced-based curriculum) will be used by all Drug Court programs and program staff shall be adequately trained in the curriculum being utilized at the treatment facility. The evidence-based model is a comprehensive approach integrating therapeutic components of Cognitive Behavioral Therapy, Motivational

Interviewing, Marriage and Family Therapy, Contingency Managements, individual and group psycho educational components. In addition self-help groups or other recovery-conducive groups, and social support are also encouraged program considerations. The integration of all components, as applicable, results in a multi-format program that covers individual and conjoint therapy, early recovery skills, and relapse prevention, family education, social support, and clinical utilization of drug testing. For example; the Matrix Model is an evidence-based treatment model for stimulant drug use disorders. It has been widely used for clients with cocaine and methamphetamine substance use disorders. The Matrix Model is recognized by SAMHSA, the Center for Substance Abuse Treatment (CSAT), National Institute on Drug Abuse (NIDA), and the Office of National Drug Control Policy and Department of Justice (National Synthetic Action Plan).

e) The Program Scope of Services must be based on Units of Service. Contractors must indicate the Units of Service it intends to provide and the cost per unit. In addition, Contractors are to indicate the cost per individual treatment episode. At a minimum, services for Outpatient and Intensive Outpatient Treatment Drug Court shall include:

- Intake
- Individual Counseling
- Group Counseling
- Family Therapy
- Client Education
- Medication Services
- Collateral Services
- Crisis Intervention Services
- Individual Treatment Planning
- Discharge Services
- Health Services
- Independent Living Skills / Transitional Aged Life Skills
- Drug Testing

- Referrals to outside agencies as needed for co-occurring disorders and medical care
- Consideration for MAT as recommended

f) Treatment shall be individualized for each client, therefore; culture, ethnicity, age and gender information gathered through the comprehensive assessment process play an important role in developing the Individualized Treatment Plan (ITP) and each client's treatment goals.

g) Specific group topics including violence prevention, anger management, victimization issues, and values/moral decision-making skills will be incorporated into the program as needed, adding gender and cultural perspectives, when relevant. These groups will be provided by qualified staff.

h) Additional group topics such as independent living skills can be provided by qualified staff, community member or other outside resources coordinated by the Contractor.

i) The Contractor will work closely with the Treatment Court Coordinator to incorporate specific relevant topics into the treatment curriculum.

2) Program Staff Requirements

a) Staffing levels and qualifications shall be appropriate to meet the needs of the clients. Professional staff shall be licensed, registered, certified or recognized under California scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioners of the Healing Arts (LPHA) include:

- Physicians,
- Nurse Practitioners,
- Physician Assistants,
- Registered Nurses,
- Registered Pharmacists,
- Licensed Clinical Psychologist (LCP),
- Licensed Clinical Social Worker (LCSW),
- Licensed Professional Clinical Counselor (LPCC),
- Licensed Marriage and Family Therapist (LMFT)

- Licensed-eligible practitioners working under the supervision of licensed clinicians

b) Program staffing levels must meet current requirements of the State. Program staff must also meet the current State certification/licensing requirements.

c) All staff providing treatment services will be regular paid employees, interns or volunteers. Interns and volunteers must be supervised by regular staff. Participants of the program may not substitute for regular staff, interns or volunteers.

d) A minimum of one (1) on-site staff member will be certified in cardiopulmonary resuscitation (CPR) and Basic First Aid to provide coverage at all times clinics are open for services.

e) Staff shall have specific training and/or expertise in Substance Use Disorder (SUD) treatment in accordance with state requirements. Primary service delivery staff must be registered/certified by a State approved organization.

f) Staff shall be trained to provide assessment and evaluations; shall be familiar with and trained in ASAM criteria, Outpatient and IOT services, referral services; and shall have the expertise in crisis intervention, psychosocial assessment, and treatment planning, if required, based on their staff position.

g) At a minimum, all Selected Contractors management and staff conducting assessments shall complete two (2) ASAM e-Training modules:

   i. ASAM Multidimensional Assessment

   ii. From Assessment to Service Planning and Level of Care

   A third module is recommended, but shall not be mandatory:

   iii. Introduction to the ASAM criteria

h) At least thirty (30) percent of staff providing counseling services must be licensed or certified pursuant to Title 9, Section 13010 of the California Code of Regulations (CCR) and all other counseling staff shall be registered pursuant to Section 13035.

i) All licensed, certified or registered counseling staff shall enter their registration or certification information in the DBH

Staff Master which is accessible at:

http://www.sbcounty.gov/dbh/Staffmaster%20Worksheet/Default.aspx

Contractors shall update registration or certification via the DBH Staff Master Update at:

http://www.sbcounty.gov/dbh/Staffmaster/Default.aspx

j) A written Code of Conduct must be established for all employees, volunteers, interns and the Board of Directors which shall include, but not be limited to, an oath of confidentiality; standards related to the use of drugs and/or alcohol; staff-client relationships; prohibition of sexual conduct with clients; and conflict of interest. A copy of the Code of Conduct will be provided to each client upon admission to treatment and to each employee, and will be posted in the facility.

3) Collateral Activities and Services – Adult and Juvenile Drug Court Programs

As part of the Drug Court Key Components, the Contractor will participate in the following services which relate to specific elements of the Drug Court Key Components:

a) Educational/Vocational Services (Drug Count Key Component #10)

i. For Adult Drug Courts, The Contractor, will secure the assistance of community resources such as community colleges and Adult Learning Centers to provide literacy classes, GED classes, Certificates of Completion, ESL classes and a High School Diploma Program for those who have not completed high school. (approximately 65% projected).

ii. For Juvenile Drug Courts, the Contractor will secure the assistance of community resources and if available, School Resource Officers, School Probation Officers and assigned Juvenile Drug Court Probation Officer to obtain youth's educational records and history of behavior that has affected the youth's ability to function and be successful at school. This should include any available records that show the youth having or needing an IEP (Individualized Education Plan).

iii. Through a signed authorization (Release of Information), the care coordinator (case manager) will track the client's attendance and participation in educational activities. This information will be passed on to the Drug Court Team (DCT) at the case conference hearings at the court.

iv. Education is a high priority with the Drug Court Program. Under the guidance of the Drug Court Judges and with the recommendations from the DCT, every effort is made to assist clients in seeking and receiving resources to help fund educational expenses.

- During Phase I, the case manager will identify client's educational needs utilizing a biopsychosocial multidimensional assessment. Educational goals will be identified on the ITP.
- Each Drug Court will provide assistance to clients with seeking resources to obtain funds necessary to help fund educational expenses to assist in achieving educational goals.
- Care coordinators (Case managers) will provide referrals to local community programs which may assist the client in achieving educational goals, such as local libraries for computer skills courses, tutoring services, ESL courses if needed.
- The care coordinator (case manager) will assist the client in enrolling in the appropriate level of education.

b) Collateral Services

i. The care coordinator (case manager) will be responsible for working with the clients to identify their collateral service needs and will ensure that they are met. Use of community services, such as sober living (aka; transitional housing or recovery homes) housing and public transportation, is encouraged.

ii. The Contractor will assist the client in accessing all the primary and ancillary services needed during the Drug Court Program tenure. As needs emerge, clients will be promptly referred for medical care,

psychiatric evaluation and therapy, job training, employment, education, legal assistance, transportation and childcare. Referrals will be made and service use coordinated by the Contractor, care coordinator (case managers), counselors and Probation Officers.

iii. For pregnant and parenting clients, access to public housing, transportation, childcare, community service and other collateral services will be assessed and referrals to appropriate Public Health and Community Service agencies will be made.

c) Case Management (Drug Court Key Component #8)

i. Care Coordination (case management) will be provided by the Contractor to insure continuity of care, transitions of care and consistency throughout the program.

ii. The care coordinators (case managers) will provide the initial assessment, coordinate the development of the clients' individual treatment plan and meet weekly with clients in Phase I of the program. Monitoring of the individual treatment plan and client progress will be done on an ongoing basis (every 30 days) and includes the entire Drug Court Team at regular intervals.

iii. The care coordinator (case manager), counselors, and collateral staff will meet weekly to discuss client progress and will monitor reviews. Typically, each care coordinator (case manager) will be responsible for 25-30 clients.

iv. The care coordinator (case manager) will be responsible for ensuring that collateral services are provided as needed and that clients attend specialized groups or individual counseling sessions.

v. The care coordinator (case manager) will also ensure that all progress reports are maintained and provided to the DCT on a weekly basis.

d) Judicial Supervision (Drug Courts Key Component #7)

i. Through a regularly scheduled Court Calendar and trained Drug Court Judge, judicial supervision begins

at the arraignment and continues throughout the program. The DCT will meet for Drug Court Status Hearings (depends on the District- some courts do not meet on a weekly basis). Prior to each hearing, the Drug Court team will hold case conferences to review each client scheduled to appear that day. Progress reports generated by the treatment Provider will provide the DCT with the updated progress of the client.

ii. Clients typically appear before the Judge weekly (depending on Jurisdiction) during the first 7-10 weeks of the program. Throughout the rest of Phases I and II, judicial appearances will be based upon: 1) client progress; 2) counselor recommendation; 3) level of functioning; 4) court team approval

iii. Court appearances may be reduced to every 3-5 weeks during Phase III. Additional team conferences and client meetings with the DCT will be held when there is a significant change in the client situation. Known obstacles such as positive alcohol/drug test, change in the family status, marital, living or employment situation or some other stressful event could result in a temporary increase in judicial supervision until the client stabilizes. Clients participating in Recovery Services (Aftercare) will be required to attend Court as recommended by the DCT.

iv. The role of the DCT is to fully evaluate the client's progress, examine the need for incentives and sanctions or other treatment interventions, and to come to a consensus and appear as a united front in the courtroom regardless of the personal opinions of individual team members.

v. Others who might participate in the case conferences are Public Health Nurses as requested by the Court or attorney, law enforcement officers dedicated to the Drug Court, employment counselors or others that have a positive vested interest in the case and have a Release of Information signed by the client, as requested by Court.

e) Drug Testing (Drug Courts Key Component #5)

i. Clients once accepted into the program will be tested for substance use frequently at any time and any place either by Probation Officers or Treatment Providers (in treatment) throughout the entirety of the program.

ii. Urine drug testing will be observed by the staff (assigned accordingly by their scope of practice) to ensure freedom from errors.

iii. Contractors will make sure that staff is trained properly in administering and providing adequate information and following the drug testing policy set forth by the agency.

iv. Contractors will make sure that staff is trained in properly documenting the outcomes of these drug tests including any requests for lab verifications

v. Contractors will make sure that staff attending court are trained in proper procedures and protocol to submit such testing results to the Drug Court Team as these results could potentially lead to custody time or a sanction for the client.

vi. Contractors will make sure they have a proper process to request lab tests from a third party agency that will be providing a quick and swift turn-around in order to have that information available for the next court hearing (if possible).

f) Additional Collateral Services -Juvenile Drug Court Program (**Juvenile Program only**)

Phase I: Frequent and observed drug testing (juvenile must attain 30 days of abstinence to be eligible for Phase II)

Phase II: Frequent and observed drug testing (must attain 45 days of consecutive abstinence to be eligible for Phase III)

Phase III: Frequent and observed drug testing (must attain 55 days of consecutive abstinence to be eligible for Phase IV)

Phase IV: Frequent and observed drug testing (must attain 60 days of consecutive abstinence to be eligible for graduation)

Drug tests are administered on-site.

Care coordinators (case managers) and/or drug testing technicians schedule the drug tests and are responsible for observing the tests (85 – 95%). This helps to guard against tampering and adulteration.

Clients call an "800" number daily to see if they are scheduled to provide a drug test. Clients can expect random and for-cause drug tests to be scheduled.

Clients may be randomly selected based on the phase of the program they are participating in and/or based on the counselor's recommendation.

Turnaround time for results is immediate or within 24 hours unless specimen is sent to a lab for confirmation.

Oral, fluid testing, urine analysis presumptive testing and on site lab testing is considered acceptable.

4) Service Coordination and Quality Assurance – Adult and Juvenile Drug Court Programs

Substance Use Disorder and Recovery (SUDRS) shall monitor the progress and quality of care afforded each individual client through a quality improvement process in addition to an analysis of other client information made available through the computerized management information system. The Contractor shall ensure that each client receives service at the appropriate level of care as determined by the clinical application of the ASAM criteria after assessment.

The Contractor shall establish outpatient and/or IOT treatment services according to the most recent version of the Alcohol and/or Other Drug Program Treatment Certification Standards.

5) Court Districts to be served:

Victorville Court District.

6) Operational Guidelines – Contractors shall:

a) Assess the demographic make-up and population trends of the proposed service area(s) to identify cultural and linguistic needs of the target population. Such assessments are critical to designing and planning for the provision of appropriate and effective services.

b) Verify Medi-Cal eligibility for all clients each month the client is enrolled in the program.

c) Establish medical necessity through a comprehensive assessment. The initial medical necessity determination shall be provided through a review by a Medical Director or LPHA who will provide a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders (with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders). After establishing a diagnosis, the ASAM criteria will be applied to determine placement into the appropriate level of care.

- Medical necessity qualification for ongoing services is to be determined at least every six (6) months through the reauthorization process for clients determined by the Medical Director or LPHA to be clinically appropriate.

d) Attend all meetings held by DBH Program staff regarding program updates, progress, and changes.

7) Facility Requirements

a) Provide all facilities, facility management, supplies and other resources necessary to establish and operate the program.

b) Provide prior proper notification to DBH if the facility location will change.

c) Business Hours: The clinic location shall maintain, at minimum, “normal business hours” (8 a.m. to 5 p.m.) to allow for public access and County/State oversight.

- Contractors shall offer clinical services that are sufficient to meet the needs of Drug Court clients enrolled in SUD treatment services.
- Selected Contractors shall be required to provide a copy of their clinic schedule upon request.

d) Contractors shall provide the following for each clinic by the contract start date and maintain these requirements in good standing throughout the term of any contract issued by the County:

- Current Alcohol and Other Drug (AOD) Certification;
- Drug Medi-Cal Certification;
- Business Licenses and/or City/County permits as required; and

- Zoning and Fire clearances as required.

e) Facility shall have sufficient space for services, activities, staff and administrative offices as necessary.

f) Obtain and/or maintain a facility location that will be appropriate and accessible for the selected service regions, readily accessible by public transportation, be easily accessible to community services, educational resources, health care facilities, and employment opportunities, and shall be in compliance with Americans with Disabilities Act (ADA) and California State Administration Code Title 24.

g) First aid supplies shall be maintained and be readily available in the facility.

8) Required Referrals:

a) Contractors shall refer clients to the appropriate level of care for services that are not provided through the Drug Court program.

b) Clients shall be referred promptly for medical and/or psychiatric evaluation when deemed appropriate by staff.

c) Contractors shall provide care coordination (case management) services for Drug Court clients. As documented on the treatment plan, care coordination shall provide advocacy and care coordination to physical health, mental health, and transportation, housing, vocational, educational, and transition services for reintegration into the community.

d) Contractors shall initiate collaborative community partnerships and service systems. Contractors will establish procedures that will ensure strong, reliable linkages with other community service providers and service organizations for the client's support. These collaborative efforts shall be designed to integrate, coordinate and access necessary support services within the community in order to ensure successful treatment and recovery. These efforts shall help achieve mutual goals espoused by Federal, State, and County systems to integrate services, prevent relapse through the use of community support services, reduce fragmentation of care and establish better communication and collaboration at all levels, but particularly among local providers and agencies who work with this target population.

9) Outcomes Reporting:

a) Develop and maintain written procedures to identify Outcomes of program services and Outcome Measures utilized for the program such as:

- Reduced recidivism rate for criminal justice clients.
- Client's abstinence from all illicit drugs, alcohol and marijuana for a measured time period.
- Client's obtainment or continuation of secure and adequate housing upon exit from the program.
- Clients remain engaged in meaningful recovery efforts through their treatment program.
- Client's increased understanding of the health benefits of regular attendance at medical/dental appointments as identified by reported attendance at scheduled appointments.
- Client's increased understanding and reported/observed use of positive socialization skills.
- For youth, reductions in school related problems.

b) Submit quarterly written reports regarding specified outcomes and specific objectives of the program, methods employed to resolve problems in achieving stated outcomes and objectives and any program modifications that occurred as a result of outcomes evaluated. The quarterly reports shall be due to SUDRS Administration no later than 30 days following the last day of the reportable quarter.

c) Work in collaboration with DBH so that outcomes will be collected, reported and measured. Selected Contractors may wish to use Substance Abuse and Mental Health Services Administration (SAMHSA) developed National Outcome Measures (NOMs). The NOMs are designed to embody meaningful, real life outcomes for people who are striving to attain and sustain recovery.

b. Program Description - Adult Court Program

1) Adult Drug Court Programs (age 18 and over)

Adult Drug Court is a special court given responsibility to handle cases involving substance abusing offenders through comprehensive supervision, drug testing, treatment services and

immediate sanctions and incentives. Clients must be minimum 18 years of age to be considered for the program. They are drug tested frequently and must attend substance use disorder treatment and recovery activities and make regular court appearances as required by the Adult Drug Court. Drug Court programs bring the weight of all interveners and justice partners/stakeholders (Judges, prosecutors, defense counsel, substance abuse treatment specialist, probation officers, law enforcement and correctional officers, education and vocational experts, community leaders and others) together to force the offender to deal with his or her substance use disorder problem from every angle. After voluntarily consenting to the program, individuals referred must meet eligibility and suitability for participation. Assessments are conducted by the ADC (Adult Drug Court) team offering a wide range of treatment options. Clients are placed on formal probation with terms and conditions as well as judicial mandates. Ultimately, the selected treatment provider(s) will work closely with the ADC (Adult Drug Court) team to monitor abstinence, compliance and behavior while in the Drug Court program.

2) Program Specific Responsibilities

   a) Adult Drug Court clients shall be considered eligible to participate in Drug Court Program Services if they are at least eighteen (18) years old; and they meet eligibility requirements of the court.

      The priority populations shall be:

      i. Pregnant intravenous (IV) drug users;

      ii. Pregnant substance abusers;

      iii. Intravenous (IV) drug users; and

      iv. All other eligible individuals.

   b) The Adult Drug Court Treatment Program shall not exceed 18 months in length.

   c) The Adult Drug Court Treatment Program shall establish medical necessity through a comprehensive biopsychosocial multidimensional assessment. The initial medical necessity determination shall be provided through a review by a Medical Director or LPHA who will provide a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders (with

the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders). After establishing a diagnosis, the ASAM criteria will be applied to determine placement into the appropriate level of assessed services.

d) The Adult Drug Court Treatment Program shall provide or arrange round trip transportation to ensure clients attend scheduled court dates.

Note: Only drivers licensed for the type of vehicle operated shall be permitted to transport clients. Manufacturers rated seating capacity of vehicles shall not be exceeded. Motor vehicles used to transport clients shall be maintained in safe operating condition.

e) The Adult Drug Court Treatment Program shall utilize the implementation of the four-phase program as detailed below and described hereafter, in close cooperation with the DCT, and other stakeholders. While some of the activities described do not directly involve the Contractor, it is expected that the Contractor will cooperate with the Court and other stakeholders and will provide motivation for the adult client to participate in and complete those activities.

f) Each Adult Drug Court District is limited to a maximum capacity of clients at any given time in Drug Court Program Services in phases I through III

- Rancho = 60 Clients
- Fontana = 50 Clients
- San Bernardino = 60 Clients
- Redlands = 50 Clients
- Joshua Tree = 50 Clients
- Victorville = 50 Clients

For any contract awarded as a result of the RFP, no minimum or maximum number of referrals or enrollment's will be guaranteed by the County.

3) Program Scope of Services

Utilization of at minimum two evidence-based models will be used for all Drug Courts. Drug Court structure is based on at minimum two evidence-based models consisting of cognitive behavioral therapy / bio psychosocial curriculum.

a) Adult Drug Court Treatment Curriculum

Phase I: Evidence-based model primary treatment.

Phase II: Evidence-based model support groups and gender specific groups.

Phase III: Evidence-based model support groups and/or gender specific groups.

Phase IV: Evidence-based model Continuing/Aftercare Services.

b) Adult Group Attendance

Phase I: Minimum of nine (9) hours per week.

Phase II: up to nine (9) hours per week.

Phase III: up to (9) hours per week.

Phase IV: No minimum, as medically necessary based on the individual treatment plan.

c) Adult Drug Testing: random and observed

Phase I: Minimum of three (3) times per week.

Phase II: Minimum of two (2) times per week.

Phase III: Minimum of one (1) time per week.

Phase IV: Minimum of once a month

d) Adult Drug Court Program Phase Length

Adult Drug Court Program Services total no more than 18 months.

Phase I: Minimum of sixteen (16) weeks.

Phase II: Minimum of eight (8) weeks.

Phase III: Minimum of ten (10) weeks.

Phase IV: Up to 38 weeks

4) Adult Drug Court Program Phases

a) In Phase I, the client will be participating in the Drug Court Treatment Program that is an Intensive Outpatient Treatment Program as defined by ASAM Level 2.1 for a minimum of sixteen (16) consecutive weeks. Face-to-face group activities shall be conducted for a minimum of 90 minutes and an individual face-to-face contact shall be for a minimum of 45 minutes. During this phase, the client

shall attend individual counseling, group counseling, and be provided crisis intervention services when necessary. The client shall also attend three (3) weekly outside self-help groups of his/her choice. An Individual Treatment Plan will be completed within the first 30 days in this Phase. The client shall be randomly drug tested a minimum of three (3) times per week. All drug testing is in a controlled environment where the client is observed. A collected client fee of $15 per week is to be paid to the selected Contractor.

b) In Phase II, the client continues participating in the Drug Court Treatment Program that is an Intensive Outpatient Treatment Program as defined by ASAM Level 2.1 for a minimum of eight (8) weeks. Face-to-face group activities shall be conducted for a minimum of 90 minutes and an individual face-to-face contact shall be for a minimum of 45 minutes. During this phase, the program shall incorporate age appropriate evidenced-based curriculum addressing relapse prevention, reasoning, and recovery (may include gender specific groups). The client shall attend two (2) weekly outside self-help groups of his/her choice. The client shall be randomly drug tested a minimum of two (2) times per week. All drug testing is in a controlled environment where the client is observed. A collected client fee of $15 per week is to be paid to the selected Contractor.

c) In Phase III, the client will transition and be participating in the Drug Court Treatment Program that is an Outpatient Treatment Program as defined by ASAM Level 1. Phase III will provide support to the client who struggled in the early stages of recovery. Relapse prevention, reasoning and recovery portion shall continue in this outpatient level of care and will introduce the social skills development portion of the program. The client must be seeking employment (or be employed) or be involved in an education or vocational program or any other full time schedule approved by the DCT and appear in court at least once a month or as required by the DCT. The client shall attend three (3) weekly self-help groups of his/her choice. The client shall continue to be randomly drug tested a minimum of one (1) time per month. All drug testing is in a controlled environment where the client is

observed. A collected client fee of $15 per week is to be paid to the selected Contractor.

- Program fees must be current in order for the client to graduate from phase III.
- In order to graduate from phase III, the client must also participate in a pre-completion interview with the DCT. Prior to the interview, the client must answer in writing a series of questions that address his/her long and short term goals, support systems, engagement in the community, employment/education course/vocational training, and how he/she is going to maintain ongoing abstinence.
- Phase III is available to those who had a relapse and have not yet met the minimum six (6) month abstinence requirement from drug/alcohol use.
- Phase III is also available to those who have reached six (6) months abstinence yet have not obtained employment or a full time schedule of a productive person.

d) In Phase IV Recovery Services, there is no minimum weekly hour requirement, services are provided as medically necessary based on the individual treatment plan and provided by the Drug Court Treatment program. Recovery Services length of time is up to 38 weeks at the discretion of the DCT. Tracking the clients will be a multi-level responsibility between probation/law enforcement, and Contractor. Participation may include the following groups: Drug Education, Relapse Prevention/Aftercare, Parenting, Life Skills, Family Support, and Smoking Cessation. The client shall attend three (3) weekly self-help groups of his/her choice. The client shall continue to be randomly drug tested by Contractor once a month. All drug testing is in a controlled environment where the client is observed. A collected client fee of $15 per month is to be paid to the selected Contractor.

Adult Drug Court Graduation will be based on:

- Minimum of six (6) months abstinence from drugs and/or alcohol.

- A full-time schedule of employment, education, vocational training or another purpose which the DCT determines to be beneficial to client success.
- Full payment of treatment fees.
- Completion of the treatment goals as indicated on the client's individual treatment plan.

c. Program Description - Juvenile Court Program

1) Juvenile Drug Court Programs (age 12 through 17)

Juvenile drug court programs provide the intensive judicial intervention and intensive community supervision of juveniles involved in substance abuse that is not generally available through the traditional juvenile court process. With the growing prevalence of substance abuse among juveniles and the complexity of their treatment, which must involve both the youth and his or her living environment, the traditional juvenile justice process may be unable to deal effectively with the whole problem that leads juveniles to commit drug offenses. The juvenile drug court approach is designed to fill this gap by providing immediate and continuous court intervention in the lives of youth using drugs or involved in family situations in which substance use disorders is present. This intervention includes requiring the youth to begin treatment, submit to frequent drug testing, appear at regular and frequent court status hearings, and comply with other court conditions geared to accountability, rehabilitation, long-term sobriety, and cessation of criminal activity.

2) Program Specific Responsibilities

a) Juvenile Drug Court clients shall be considered eligible to participate in Drug Court Program Services if they are juvenile offenders between the ages of twelve (12) years and seventeen (17) years of age and meet the eligibility requirements of the court.

b) The Juvenile Drug Court Treatment Program shall be a minimum of eight (8) months in length.

The Juvenile Drug Court Treatment Program shall utilize the implementation of the four-phase program as detailed below and described hereafter, in close cooperation with the DCT, and other stakeholders. While some of the activities described do not directly involve the Contractor, it is

expected that the Contractor will cooperate with the Court and other stakeholders and will provide motivation for the juvenile client to participate in and complete those activities.

c) Each Juvenile Court Treatment Program shall establish medical necessity through a comprehensive biopsychosocial multidimensional assessment. The initial medical necessity determination shall be provided through a review by a Medical Director or LPHA who will provide a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders (with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders). After establishing a diagnosis, the ASAM criteria will be applied to determine placement into the appropriate level of assessed services.

d) Each Juvenile Court Treatment Program shall refer clients to the appropriate ASAM criteria level of care for services that are not provided through the Outpatient Treatment and/or IOT Drug Court provider.

e) Each Juvenile Court Treatment Program shall provide or arrange round trip transportation to ensure clients attend scheduled court dates.

Note: Only drivers licensed for the type of vehicle operated shall be permitted to transport clients. Manufacturers rated seating capacity of vehicles shall not be exceeded. Motor vehicles used to transport clients shall be maintained in safe operating condition.

f) Each Juvenile Court District is limited to a maximum capacity of clients at any given time in Drug Court Program Services:

- Rancho = 20 Clients
- San Bernardino = 20 Clients
- Victorville = 20 Clients

For any contract awarded as a result of the RFP, no minimum or maximum number of referrals or enrollment's will be guaranteed by the County.

3) Program Scope of Services

Utilization of at minimum two evidence-based models will be used for all Drug Courts. Drug Court structure is based on an

evidence-based model of cognitive behavioral therapy / bio psychosocial curriculum.

a) Juvenile Drug Court Treatment Curriculum

Phase I: Evidence-based model primary treatment.

Phase II: Evidence-based model support groups and gender specific groups.

Phase III: Evidence-based model support groups and/or gender specific groups.

Phase IV: Evidence-based model Continuing/Aftercare Services.

b) Juvenile Individual/Group Attendance

Phase I: Minimum of six (6) hours per week.

Phase II: Less than six (6) hours per week.

Phase III: Less than six (6) hours per week.

Phase IV: No minimum requirement, as medically necessary based on the individual treatment plan.

c) Juvenile Drug Testing

Phase I: The client shall be randomly drug tested frequently as determined by the DCT. All drug testing is in a controlled environment where the client is observed (must attain 30 days of consecutive abstinence to be eligible for Phase II) .

Phase II: The client shall be randomly drug tested frequently as determined by the DCT. All drug testing is in a controlled environment where the client is observed (must attain 45 days of consecutive abstinence to be eligible for Phase III).

Phase III: The client shall be randomly drug tested frequently as determined by the DCT. All drug testing is in a controlled environment where the client is observed (must attain 55 days of consecutive abstinence to be eligible for Phase IV).

Phase IV: The client shall be randomly drug tested frequently as determined by the DCT. All drug testing is in a controlled environment where the client is observed (must attain 60 days of consecutive abstinence to be eligible for graduation).

d) Juvenile Drug Court Program Phase Length

Phase I: Minimum of 60 days.

Phase II: Minimum of 60 days.

Phase III: Minimum of 60 days.

Phase IV: Minimum of 60 days.

e) Juvenile Drug Court Program Phases

i. In Phase I the client will be participating in the Drug Court Treatment Program that is an Intensive Outpatient Treatment Program as defined by ASAM Level 2.1 (for the adolescent population), for a minimum of 60 days. Face-to-face group activities shall be conducted for a minimum of 90 minutes and an individual face-to-face contact shall be for a minimum of 45 minutes. During this phase, the client shall attend individual counseling, group counseling, and be provided crisis intervention services when necessary. The client shall also attend three (3) weekly outside self-help groups of his/her choice. An Individual Treatment Plan will be completed within the first 30 days in this Phase. Frequent and observed drug testing will be completed as determined by the DCT (Juvenile must attain 30 days of abstinence to be eligible for Phase II).

ii. In Phase II, I the client will be participating in the Drug Court Treatment Program that is an Intensive Outpatient Treatment Program as defined by ASAM Level 2.1 (for the adolescent population), for a minimum of 60 days. Face-to-face group activities shall be conducted for a minimum of 90 minutes and an individual face-to-face contact shall be for a minimum of 45 minutes. During this phase, the program shall incorporate age appropriate evidenced-based curriculum addressing relapse prevention, reasoning, and recovery (may include gender specific groups). The client shall be encouraged to attend two (2) weekly outside self-help groups of his/her choice. Frequent and observed drug testing will be completed as determined by the DCT (Juvenile must attain 45 days of consecutive of abstinence to be eligible for Phase III).

iii. In Phase III, the client will transition and be participating in the Drug Court Treatment Program that

is an Outpatient Treatment Program as defined by ASAM Level 1 (for the adolescent population), for a minimum of 60 days. Face-to-face group activities shall be conducted for a minimum of 90 minutes and an individual face-to-face contact shall be for a minimum of 45 minutes. Relapse prevention, reasoning and recovery portion shall continue in this outpatient level of care and will introduce the social skills development portion of the program. Frequent and observed drug testing will be completed as determined by the DCT (Juvenile must attain 55 days of consecutive of abstinence to be eligible for Phase IV).

iv. In Phase IV, Recovery Services, there is no minimum weekly hour requirement, services are provided as medically necessary based on the individual treatment plan and provided by the Drug Court Treatment program, for a minimum of 60 days. Face-to-face group activities shall be conducted for a minimum of 90 minutes and an individual face-to-face contact shall be for a minimum of 45 minutes. Frequent and observed drug testing will be completed as determined by the DCT (Juvenile must attain 60 days of consecutive of abstinence to be eligible for graduation)

Juvenile Graduation will be based on:

- Minimum of 60 days of continuous abstinence from drugs and/or alcohol.
- Completion of the treatment goals as indicated on the client's individual treatment plan.

---END OF ADDENDUM---

303 E. Vanderbilt Way, 2nd Floor, San Bernardino CA, 92415-0026 | Phone: 800-968-2636 • Fax: 909-890-3813
www.SBCounty.gov

SAN BERNARDINO COUNTY

Department of Behavioral Health
Alcohol and Drug Services

NOTICE OF PERSONAL RIGHTS

In accordance with the Alcohol And/ Or Other Drug Program Certification Standards and Title 9, Chapter 4, Section 10569, of the California Code of Regulations, each person receiving services from an Alcohol and Drug Abuse Recovery Program shall have rights, which include, but are not limited to the following: The Right:

To be accorded dignity in personal relationships with staff, volunteers, board members, and other individuals/persons;

To be accorded safe, healthful and comfortable accommodations to meet his/her needs;

To be free from verbal, intellectual, emotional, physical abuse, and/or inappropriate sexual behavior;

To be informed by the program/licensee of the provisions of the law and procedures regarding a complaint and/or grievance and/or appeal discharge, including but not limited to, the address and telephone number of the Department of Health Care Services;

To be free to attend religious services or activities of his/her choice and to have visits from spiritual advisor provided that these services or activities do not conflict with facility program requirements. Participation in religious services will be voluntary only;

To be referred to another program should they object to the religious nature of any program in accordance with Title 42, Part 54;

To be provided with confidentiality in accordance with federal regulation (CFR, Title 42, Chapter I, Subchapter A, Part 2, Section 2.1-2.67);

To be accorded access to his/her file.

NOTICE OF CIVIL RIGHTS

In accordance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title 9, Section 10800; Americans with Disabilities Act of 1990. No person shall experience discrimination on the basis of:

Ethnic Group Identification, Religion, Age, Sex, Race, Color, Mental and/or Physical Disability, Ancestry, National Origin, Gender Identity, Sexual Orientation, or Ability to Pay.

In cases where the complaint is filed initially with the Office of Civil Rights, that Office may proceed to investigate.

Certain complaints may also be filed directly with

U.S. Dept. of Health & Human Services
90 7th Street, Suite 4-100, San Francisco, CA 94103
Voice Phone (800) 368-1019, FAX (415) 437-8329, TDD (800) 537-7697

From the date of violation of Civil Rights you have a maximum of 180 days to file a written complaint.

COMPLAINTS SHOULD BE DIRECTED TO:

Department of Behavioral Health, ACCESS Unit
303 E. Vanderbilt Way, 3rd Floor, San Bernardino, CA 92418-0026
(888) 743-1478 or (909) 386-8256, [TDD] 711 Fax (909) 890-0353

Department of Health Care Services, Substance Use Disorder Services
P.O. Box 997413, MS# 2601, Sacramento, CA 95899-7413
Fax form to (916) 445-5084

Complaints for Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities may also be made by telephoning the appropriate licensing branch listed below:
SUD Compliance Division, Public Number: (916) 322-2911, Toll Free Number: (877) 685-8333

Print Client Name	Client Signature	Date

303 E. Vanderbilt Way, 2nd Floor, San Bernardino CA, 92415-0026 | Teléfono: 800-968-2636 • Fax: 909-890-3813
www.SBCounty.gov

SAN BERNARDINO COUNTY

Departamento de Salud Mental
Servicios de Alcohol y Drogas

AVISO DE DERECHOS PERSONALES

De acuerdo con las Normas de Certificación del Programa de Alcohol y/u Otras Drogas y el Titulo 9, Capitulo 4, Sección 10569, del Código de Regulaciones de California, cada persona que recibe servicios de un programa de recuperación relacionado con el Abuso de Alcohol y Drogas tendrá los derechos, que incluyen, pero no se limitan a lo siguiente: El derecho a:

Ser tratado con dignidad por el personal, los voluntarios, los miembros del consejo, y otros individuos/personas;

Ser concedido(a) un alojamiento seguro, saludable y confortable para satisfacer sus necesidades;

Estar libre de abuso verbal, intelectual, emocional, físico y/o comportamiento sexual inapropiado;

Ser informado(a) por el programa/propietario de las disposiciones de la ley y los procedimientos con respecto a una queja y/o reclamo y/o apelación, incluyendo pero no limitado a, la dirección y número de teléfono del Departamento de Servicios de Salud;

Tener libertad de asistir a servicios religiosos o actividades de su preferencia y tener visitas de un consejero espiritual siempre y cuando estos servicios o actividades no interfieran con los requisitos del programa del lugar. La participación en servicios religiosos será solo voluntaria;

Ser referido(a) a otro programa en caso de oponerse a la naturaleza religiosa de cualquier programa de conformidad con el Título 42, Parte 54;

Tener confidencialidad de acuerdo con la reglamentación federal (CFR, Título 42, Capítulo I, Subcapítulo A, Parte 2, Sección 2,1 a 2,67);

Que se le conceda tener acceso a su expediente.

AVISO DE DERECHOS CIVILES

De conformidad con el Título VI de la Ley de Derechos Civiles de 1964, la Sección 504 de la Ley de Rehabilitación de 1973, Título 9, Sección 10800; Ley de Estadounidenses con Discapacidades de 1990. Ninguna persona será objeto de discriminación basándose en:

La identificación de grupo étnico, religión, edad, sexo, raza, color, discapacidad mental y/o física, ascendencia, origen nacional, identificación de género, orientación sexual o la capacidad de pago;

En los casos en que se presenta la queja inicialmente con la Oficina de Derechos Civiles, esa Oficina podrá proceder a investigar. Ciertas quejas también se pueden presentar directamente ante:

U.S. Department of Health & Human Services
90 7th Street, Suite 4-100, San Francisco, CA 94103
Teléfono de Voz (800) 368-1019, FAX (415) 437-8329, TDD (800) 537-7697

A partir de la fecha de la violación a los derechos civiles, usted tiene un máximo de 180 días para presentar la queja por escrito.

LAS QUEJAS DEBEN SER DIRIGIDAS A:

Department of Behavioral Health, ACCESS Unit
303 E. Vanderbilt Way, 3rd Floor, San Bernardino, CA 92418-0026
(888) 743-1478 ó (909) 386-8256, TDD 711 Fax (909) 890-0353

Department of Health Care Services, Substance Use Disorder Services
P.O. Box 997413, MS# 2601, Sacramento, CA 95899-7413
Mande la forma por fax al: (916) 445-5084.

Quejas de los lugares de Alcoholismo de Adultos Residencial o Recuperación de Uso de Drogas o de Tratamiento también pueden ser hechas llamando a la oficina apropiada y autorizada que esta listada abajo:
SUD Compliance Division, Número Público: (916) 322-2911, Número de Teléfono Gratuito (877) 685-8333 ^

Nombre del Cliente (con letra de molde)	Firma del Cliente	Fecha

ATTESTATION REGARDING INELIGIBLE/EXCLUDED PERSONS

Contractor High Desert Child, Adolescent and Family Services Center, Inc .shall:
To the extent consistent with the provisions of this Agreement, comply with regulations as set forth in Executive Order 12549; Social Security Act, 42 U.S. Code, Section 1128 and 1320 a-7; Title 42 Code of Federal Regulations (CFR), Parts 1001 and 1002, et al; and Welfare and Institutions Code, Section 14043.6 and 14123 regarding exclusion from participation in federal and state funded programs, which provide in pertinent part:

1. Contractor certifies to the following:
   a. it is not presently excluded from participation in federal and state funded health care programs,
   b. there is not an investigation currently being conducted, presently pending or recently concluded by a federal or state agency which is likely to result in exclusion from any federal or state funded health care program, and/or
   c. unlikely to be found by a federal and state agency to be ineligible to provide goods or services.
2. As the official responsible for the administration of Contractor, the signatory certifies the following:
   a. all of its officers, employees, agents, and/or sub-contractors are not presently excluded from participation in any federal or state funded health care programs,
   b. there is not an investigation currently being conducted, presently pending or recently concluded by a federal or state agency of any such officers, employees, agents and/or sub-contractors which is likely to result in an exclusion from any federal and state funded health care program, and/or
   c. its officers, employees, agents and/or sub-contractors are otherwise unlikely to be found by a federal or state agency to be ineligible to provide goods or services.
3. Contractor certifies it has reviewed, at minimum prior to hire or contract start date and monthly thereafter, the following lists in determining the organization nor its officers, employees, agents, and/or sub-contractors are not presently excluded from participation in any federal or state funded health care programs:
   a. OIG's List of Excluded Individuals/Entities (LEIE).
   b. United States General Services Administration's System for Award Management (SAM).
   c. California Department of Health Care Services Suspended and Ineligible Provider (S&I) List, if receives Medi-Cal reimbursement.
4. Contractor certifies that it shall notify DBH immediately (within 24 hours) by phone and in writing within ten (10) business days of being notified of:
   a. Any event, including an investigation, that would require Contractor or any of its officers, employees, agents and/or sub-contractors exclusion or suspension under federal or state funded health care programs, or
   b. Any suspension or exclusionary action taken by an agency of the federal or state government against Contractor, or one or more of its officers, employees, agents and/or sub-contractors, barring it or its officers, employees, agents and/or sub-contractors from providing goods or services for which federal or state funded healthcare program payment may be made.

_____
Printed name of authorized official

_____
Signature of authorized official

_____
Date

DATA SECURITY REQUIREMENTS

Pursuant to its contract with the State Department of Health Care Services, the Department of Behavioral Health (DBH) requires Contractor adhere to the following data security requirements:

A. Personnel Controls

1. Formal Policies and Procedures. Policies and procedures must be in place to reasonably protect against unauthorized uses and disclosures of patient identifying information and protect against reasonably anticipated threats or hazards to the security of patient identifying information. Formal policies and procedures must address 1) paper records and 2) electronic records, as specified in 42 CFR §2.16.

2. Employee Training. All workforce members who assist in the performance of functions or activities on behalf of DBH, or access or disclose DBH Protected Health Information (PHI) or Personal Information (PI) must complete information privacy and security training, at least annually, at Contractor's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member's name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following termination of this Agreement.

3. Employee Discipline. Appropriate sanctions must be applied against workforce members who fail to comply with privacy policies and procedures or any provisions of these requirements, including termination of employment where appropriate.

4. Confidentiality Statement. All persons that will be working with DBH PHI or PI must sign a confidentiality statement that includes, at a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The Statement must be signed by the workforce member prior to accessing DBH PHI or PI. The statement must be renewed annually. The Contractor shall retain each person's written confidentiality statement for DBH inspection for a period of six (6) years following termination of the Agreement.

5. Background Check. Before a member of the workforce may access DBH PHI or PI, a background screening of that worker must be conducted. The screening should be commensurate with the risk and magnitude of harm the employee could cause, with more thorough screening being done for those employees who are authorized to bypass significant technical and operational security controls. The Contractor shall retain each workforce member's background check documentation for a period of three (3) years.

B. Technical Security Controls

1. Workstation/Laptop Encryption. All workstations and laptops that store DBH PHI or PI either directly or temporarily must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by DBH's Office of Information Technology.

2. Server Security. Servers containing unencrypted DBH PHI or PI must have sufficient administrative, physical, and technical controls in place to protect that data, based upon a risk assessment/system security review.

3. Minimum Necessary. Only the minimum necessary amount of DBH PHI or PI required to perform necessary business functions may be copied, downloaded, or exported.

4. Removable Media Devices. All electronic files that contain DBH PHI or PI data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, Blackberry, backup tapes, etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES.

5. Antivirus / Malware Software. All workstations, laptops and other systems that process and/or store DBH PHI or PI must install and actively use comprehensive anti-virus software / Antimalware software solution with automatic updates scheduled at least daily.

6. Patch Management. All workstations, laptops and other systems that process and/or store DBH PHI or PI must have all critical security patches applied with system reboot if necessary. There must be a documented 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 time frame due to significant operational reasons must have compensatory controls implemented to minimize risk until the patches can be installed. Application and systems that cannot be patched must have compensatory controls implemented to minimize risk, where possible.

7. User IDs and Password Controls. All users must be issued a unique user name for accessing DBH PHI or PI. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password. Passwords are not to be shared. Passwords must be at least eight characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed at least every ninety (90) days, preferably every sixty (60) days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three of the following four groups from the standard keyboard:

    a. Upper case letters (A-Z)
    b. Lower case letters (a-z)
    c. Arabic numerals (0-9)
    d. Non-alphanumeric characters (special characters))

8. Data Destruction. When no longer needed, all DBH PHI or PI must be wiped using the Gutmann or U.S. Department of Defense (DoD) 5220.22-M (7 Pass) standard, or by degaussing and in accordance with 42 C.F.R. § 2.16 Security for Records. Media may also be physically destroyed in accordance with NIST Special Publication 800-88. Other methods require prior written permission of DBH's Office of Information Technology.

9. System Timeout. The system providing access to DBH PHI or PI must provide an automatic timeout, requiring re-authentication of the user session after no more than twenty (20) minutes of inactivity.

10. Warning Banners. All systems providing access to DBH PHI or PI must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.

11. System Logging. The system must maintain an automated audit trail which can identify the user or system process which initiates a request for DBH PHI or PI, or which alters DBH PHI or PI. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If DBH PHI or PI is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least three (3) years after occurrence.

12. Access Controls. The system providing access to DBH PHI or PI must use role based access controls for all user authentications, enforcing the principle of least privilege.

13. Transmission Encryption. All data transmissions of DBH PHI or PI outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128bit or higher, such as AES. Encryption can be end to end at the network level, or the data files containing DBH PHI can be encrypted. This requirement pertains to any type of DBH PHI or PI in motion such as website access, file transfer, and E-Mail.

14. Intrusion Detection. All systems involved in accessing, holding, transporting, and protecting DBH PHI or PI that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

C. Audit Controls

1. System Security Review. Contractor must ensure audit control mechanisms that record and examine system activity are in place. All systems processing and/or storing DBH PHI or PI must have at least an annual system risk assessment/security review which provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.

2. Log Review. All systems processing and/or storing DBH PHI or PI must have a routine procedure in place to review system logs for unauthorized access.

3. Change Control. All systems processing and/or storing DBH PHI or PI must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity and availability of data.

D. Business Continuity/Disaster Recovery Controls

1. Emergency Mode Operation Plan. Contractor must establish a documented plan to enable continuation of critical business processes and protection of the security of DBH PHI or PI held in an electronic format in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this Agreement for more than 24 hours.

2. Data Backup Plan. Contractor must have established documented procedures to backup DBH PHI to maintain retrievable exact copies of DBH PHI or PI. The plan must include a regular schedule for making backups, storing backups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore DBH PHI or PI should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of DBH data.

E. Paper Document Controls

1. Supervision of Data. DBH PHI or PI in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk or office. Unattended means that information is not being observed by an employee authorized to access the information. DBH PHI or PI in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

2. Escorting Visitors. Visitors to areas where DBH PHI or PI is contained shall be escorted and DBH PHI or PI shall be kept out of sight while visitors are in the area.

3. Confidential Destruction. DBH PHI or PI must be disposed of through confidential means, such as cross cut shredding and pulverizing and in accordance with 42 C.F.R. § 2.16 Security for Records.

4. Removal of Data. Removal of DBH PHI or PI may not be removed from the premises of Contractor unless authorized under 42 CFR Part 2.

5. Faxing. Faxes containing DBH PHI or PI shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending the fax.

6. Mailing. Mailings containing DBH PHI or PI shall be sealed and secured from damage or inappropriate viewing of such PHI or PI to the extent possible.

   Mailings which include 500 or more individually identifiable records of DBH PHI or PI in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of DBH to use another method is obtained.

EXHIBIT A - DHCS ODS WAIVER SUPPLEMENT

TABLE OF CONTENTS

I. Definition of Terminology

A. The words and terms of this Contract are intended to have their usual meaning unless a specific or more limited meaning is associated with their usage pursuant to CA Health and Safety Code, Title 6.

1. ***"Abuse"*** means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

2. ***"Adolescents"*** means beneficiaries between the ages of twelve and under the age of twenty-one.

3. ***"Administrative Costs"*** means the Contractor's actual indirect costs, as recorded in the Contractor's financial records and supported by source documentation, to administer the program or an activity to provide service to the DMC program. Administrative costs do not include the cost of treatment or other direct services to the beneficiary. Administrative costs may include, but are not limited to, the cost of training, programmatic and financial audit reviews, and activities related to billing. Administrative costs may include Contractor's overhead per the approved indirect cost rate proposal pursuant to OMB Omni-Circular and the State Controller's Office Handbook of Cost Plan Procedures.

4. ***"Adverse benefit determination"*** means, in the case of an MCO, PIHP, or PAHP, any of the following:

   a) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit.

   b) The reduction, suspension, or termination of a previously authorized service.

   c) The denial, in whole or in part, of payment for a service.

   d) The failure to provide services in a timely manner, as defined by the state

   e) The failure of an MCO, PIHP, or PAHP to act within the timeframes provided in § 438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.

   f) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise his or her right, under § 438.52(b)(2)(ii), to obtain services outside the network.

   g) The denial of an enrollee's request to dispute a financial liability, including

cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

5. ***"American Society of Addiction Medicine (ASAM***)" A professional society representing over 3,000 physicians and associated professionals dedicated to increasing access and improving the quality of addiction treatment; educating physicians, other medical professionals and the public; supporting research and prevention; and promoting the appropriate role of physicians in the care of patients with substance use disorders.

6. ***"ASAM Criteria"*** A set of guidelines for placement, continued stay, and transfer/discharge of patients with Substance Use Disorders and co-occurring conditions. The ASAM criterion provides separate placement criteria for adolescents and adults to create comprehensive and individualized treatment plans. Adolescent and adult treatment plans are developed through a multidimensional patient assessment over five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided, and the intensity of treatment services provided. ASAM's criterion uses six dimensions to create a holistic, bio-psychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care.

7. ***"Appeal"*** is the request for review of an adverse benefit determination.

8. ***"Authorization"*** is the approval process for DMC-ODS Services prior to the submission of a DMC claim.

9. ***"Available Capacity"*** means the total number of units of service (bed days, hours, slots, etc.) that a Contractor actually makes available in the current fiscal year.

10. ***"Beneficiary"*** means a person who: (a) has been determined eligible for Medi-Cal; (b) is not institutionalized; (c) has a substance-related disorder per the current "Diagnostic and Statistical Manual of Mental Disorders (DSM)" criteria; and (d) meets the admission criteria to receive DMC covered services.

11. ***"Beneficiary/Enrollee Encounter Data"*** means the information relating to the receipt of any item(s) or service(s) by an enrollee under a contract between a state and a MCO, PIHP, or PAHP that is subject to the requirements of §§438.242 and 438.818.

12. ***"Beneficiary Handbook"*** is the state developed model enrollee handbook.

13. ***"Calendar Week"*** means the seven day period from Sunday through Saturday.

14. ***"Case Management"*** means a service to assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

15. ***"Certified Provider"*** means a substance use disorder clinic location that has received certification to be reimbursed as a DMC clinic by the state to provide services as described in Title 22, California Code of Regulations, Section 51341.1.

16. ***"Collateral Services"*** means sessions with therapists or counselors and significant persons in the life of a beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.

17. ***"Complaint"*** means requesting to have a problem solved or have a decision changed because you are not satisfied. A complaint is sometimes called a grievance or an appeal.

18. ***"Co-Occurring Disorders***" means concurrent substance use and mental health disorders.

19. ***"Corrective Action Plan (CAP)"*** means the written plan of action document which the Contractor or its subcontracted service provider develops and submits to DBH to address or correct a deficiency or process that is non-compliant with laws, regulations or standards.

20. ***"County Realignment Funds"*** means Behavioral Health Subaccount funds received by the County as per California Code Section 30025.

21. ***"Crisis Intervention***" means a contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance, which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to stabilization of the beneficiary's emergency situation.

22. ***"Cultural and Linguistic Competency"*** Cultural competence is defined as a set of congruent practice skills, knowledge, behaviors, attitudes, and policies that come together in a system, agency, or among consumer providers and professionals that enables that system, agency, or those professionals and consumer providers to work effectively in cross-cultural situations.

23. ***"Days"*** means calendar days, unless otherwise specified.

24. ***"Dedicated Capacity"*** means the historically calculated service capacity, by modality, adjusted for the projected expansion or reduction in services, which the Contractor agrees to make available to provide DMC-ODS services to persons eligible for Contractor services.

25. ***"Delivery System"*** DMC-Organized Delivery System is a Medi-Cal benefit in counties that choose to opt into and implement the Pilot program. DMC-ODS shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in a county that opts into the Pilot program. Upon

approval of an implementation plan, the state shall contract with the county to provide DMC-ODS services. The county shall, in turn, contract with DMC certified providers or provide county-operated services to provide all services outlined in the DMC-ODS. Counties may also contract with a managed care plan to provide services. Participating counties with the approval from the state may develop regional delivery systems for one or more of the required modalities or request flexibility in delivery system design or comparability of services. Counties may act jointly in order to deliver these services.

26. ***"Discharge services"*** means the process to prepare the beneficiary for referral into another level of care, post treatment return or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

27. ***"DMC-ODS Services"*** means those DMC services authorized by Title XIX or Title XXI of the Social Security Act; Title 22 Section 51341.1; W&I Code, Section 14124.24; and California's Medicaid State Plan, including the DMC ODS 1115 Demonstration Waiver special terms and conditions.

28. ***"Drug Medi-Cal Program"*** means the state system wherein beneficiaries receive covered services from DMC-certified substance use disorder treatment providers.

29. ***"Drug Medi-Cal Termination of Certification"*** means the provider is no longer certified to participate in the Drug Medi-Cal program upon the state's issuance of a Drug Medi-Cal certification termination notice.

30. ***"Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT)"*** means the federally mandated Medicaid benefit that entitles full-scope Medi-Cal-covered beneficiaries less than 21 years of age to receive any Medicaid service necessary to correct or ameliorate a defect, mental illness, or other condition, such as a substance-related disorder, that is discovered during a health screening.

31. ***"Education and Job Skills"*** means linkages to life skills, employment services, job training, and education services.

32. ***"Emergency medical condition"*** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

    a) Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

    b) Serious impairment to bodily functions.

    c) Serious dysfunction of any bodily organ or part.

33. ***"Emergency services"*** means covered inpatient and outpatient services that are as follows:

    a) Furnished by a provider that is qualified to furnish these services under this Title.

    b) Needed to evaluate or stabilize an emergency medical condition.

34. ***"Evidence-Based"*** refers to programs that have been shown to have positive outcomes through high quality research. An evidenced-based program shall demonstrate the use of a minimum of two evidenced-based practices.

35. ***"Excluded Services"*** means services that are not covered under this Agreement.

36. ***"Face-to-Face"*** means a service occurring in person.

37. ***"Family Support"*** means linkages to childcare, parent education, child development support services, and family and marriage education. Family support is only available under Recovery services.

38. ***"Family Therapy"*** means including a beneficiary's family members and loved ones in the treatment process, and education about factors that are important to the beneficiary's recovery as well as their own recovery can be conveyed. Family members may provide social support to beneficiaries, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

39. ***"Fair Hearing"*** means the state hearing provided to beneficiaries upon denial of appeal pursuant to 22 CCR 50951 and 50953 and 9 CCR 1810.216.6. Fair hearings shall comply with 42 CFR 431.220(a)(5), 438.408(f), 438.414, and 438.10(g)(1).

40. ***"Federal Financial Participation (FFP)"*** means the share of federal Medicaid funds for reimbursement of DMC services.

41. ***"Final Settlement"*** means permanent settlement of the Contractor's actual allowable costs or expenditures as determined at the time of audit, which shall be completed within three years of the date the year-end cost settlement report was accepted for interim settlement. If the audit is not completed within three years, the interim settlement shall be considered as the final settlement.

42. ***"Fraud"*** means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or state law.

43. ***"Grievance"*** means an expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, and aspects of interpersonal

relationships such as rudeness of a provider or employee, or failure to respect the beneficiary's rights regardless of whether remedial action is requested. Grievance includes a beneficiary's right to dispute an extension of time proposed by the MCO, PIHP or PAHP to make an authorization decision.

44. ***"Grievance and Appeal System"*** means the processes the MCO, PIHP, or PAHP implements to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about them.***"***

45. ***"Hospitalization"*** means that a patient needs a supervised recovery period in a facility that provides hospital inpatient care.

46. ***"Individual Counseling"*** means contact between a beneficiary and a therapist or counselor. Services provided in-person, by telephone or by telehealth qualify as Medi-Cal reimbursable units of service, and are reimbursed without distinction.

47. ***"Intake"*** means the process of determining a beneficiary meets the medical necessity criteria and a beneficiary is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of the cause or nature of mental, emotional, psychological, behavioral, and substance use disorders; and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing (e.g., body specimen screening) necessary for substance use disorder treatment and evaluation.

48. ***"Intensive Outpatient Treatment"*** means (ASAM Level 2.1) structured programming services consisting primarily of counseling and education about addiction-related problems a minimum of nine (9) hours with a maximum of 19 hours per week for adults, and a minimum of six (6) hours with a maximum of 19 hours per week for adolescents. Services may be provided in any appropriate setting in the community. Services may be provided in-person, by telephone or by telehealth.

49. ***"Interim Settlement"*** means temporary settlement of actual allowable costs or expenditures reflected in the Contractor's year-end cost settlement report.

50. ***"Key Points of Contact"*** means common points of access to substance use treatment services from the county, including but not limited to the county's beneficiary problem resolution process, county owned or operated or contract hospitals, and any other central access locations established by the county.

51. ***"Long-Term Services and Supports (LTSS)"*** means services and supports provided to beneficiaries of all ages who have functional limitations and/or chronic illnesses that have the primary purpose of supporting the ability of the beneficiary to live or work in the setting of their choice, which may include the individual's home, a worksite, a provider-owned or controlled residential setting, a

nursing facility, or other institutional setting.

52. ***"Licensed Practitioners of the Healing Arts (LPHA)"*** includes: Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist (LCP), Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor (LPCC), and Licensed Marriage and Family Therapist (LMFT) and licensed-eligible practitioners working under the supervision of licensed clinicians.

53. ***"Managed Care Organization (MCO)"*** means an entity that has, or is seeking to qualify for, comprehensive risk contract under this part, and that is-

    a) A Federally qualified HMO that meets the advance directives requirements of subpart I of part 489 ; or

    b) Any public Any public or private entity that meets the advance directives requirements and is determined by the Secretary to also meet the following conditions:

        (1) Makes the services it provides to its Medicaid enrollees as accessible (in terms of timeliness, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity.

        (2) Meets the solvency standards of the §438.116.

54. ***"Managed Care Program"*** means a managed care delivery system operated by a state as authorized under sections 1915(a), 1915(b), 1932(a), or 1115(a) of the Act.

55. ***"Maximum Payable"*** means the encumbered amount reflected in the Standard Agreement.

56. ***"Medical Necessity" and "Medically Necessary Services"*** means those SUD treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of a disease, illness or injury consistent with and 42 CFR 438.210(a)(4) or, in the case of EPSDT, services that meet the criteria specified in Title 22, Sections 51303 and 51340.1.

57. ***"Medical Necessity Criteria"*** means adult beneficiaries must have one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders, and must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria. Youth under 21 may be assessed to be at risk for developing a substance use disorder, and if applicable, must meet the ASAM adolescent treatment criteria. Beneficiaries under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under age 21 are

eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health.

58. ***"Medical psychotherapy"*** means a type of counseling service that has the same meaning as defined in 9 CCR § 10345.

59. ***"Medication Services"*** means the prescription or administration of medication related to substance use disorder treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services.

60. ***"Modality"*** means those necessary overall general service activities to provide substance use disorder services as described in Division 10.5 of the HSC.

61. ***"Opioid (Narcotic) Treatment Program"*** means an outpatient clinic licensed by the state to provide narcotic replacement therapy directed at stabilization and rehabilitation of persons who are opiate-addicted and have a substance use diagnosis.

62. ***"Naltrexone Treatment Services"*** means an outpatient treatment service directed at serving detoxified opiate addicts by using the drug Naltrexone, which blocks the euphoric effects of opiates and helps prevent relapse to opiate addiction.

63. ***"Network"*** means the group of entities that have contracted with the PIHP to provide services under this Agreement.

64. ***"Network Provider"*** means any provider, group of providers, or entity that has a network provider agreement with a MCO, PIHP, PAHP, or a subcontract, and receives Medicaid funding directly or indirectly to order, refer or render covered services as a result of the state's contract with an MCO, PIHP or PAHP. A network provider is not a subcontractor by virtue of the network provider agreement.

65. ***"Non-participating provider"*** means a provider that is not engaged ***in*** the continuum of services under this Agreement.

66. ***"Non-Perinatal Residential Program"*** services are provided in DHCS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria. These residential services are provided to the non-perinatal population and do not require the enhanced services found in the perinatal residential programs.

67. ***"Nonrisk Contract"*** means a contract between the state and a PIHP or PAHP under which the PHIP or PAHP:

    a) Is not at financial risk for changes in utilization or for costs incurred under the contract that do not exceed the upper payment limits specified in § 447.362, and

b) May be reimbursed by the state at the end of the contract period on the basis of the incurred costs, subject to the specified limits.

68. ***"Notice of Adverse Benefit Determination"*** means a formal communication of any action and consistent with 42 CFR 438.404 and 438.10.

69. ***"Observation"*** means the process of monitoring the beneficiary's course of withdrawal. It is to be conducted as frequently as deemed appropriate for the beneficiary and the level of care the beneficiary is receiving. This may include but is not limited to observation of the beneficiary's health status.

70. ***"Outpatient Services"*** means (ASAM Level 1.0) outpatient service directed at stabilizing and rehabilitating persons up to nine hours of service per week for adults, and less than six hours per week for adolescents.

71. ***"Overpayment"*** means any payment made to a network provider by a MCO, PIHP, or PAHP to which the network provider is not entitled to under Title XIX of the Act or any payment to a MCO, PIHP, or PAHP by a state to which the MCO, PIHP, or PAHP is not entitled to under Title XIX of the Act.

72. ***"Patient Education"*** means providing research based education on addiction, treatment, recovery and associated health risks.

73. ***"Participating provider"*** means a provider that is engaged in the continuum of services under this Agreement.

74. ***"Payment Suspension"*** means the Drug Medi-Cal certified provider has been issued a notice pursuant to W&I Code, Section 14107.11 and is not authorized to receive payments after the payment suspension date for DMC services, regardless of when the service was provided.

75. ***"Performance"*** means providing the dedicated capacity, , including all applicable state and federal statutes, regulations, and standards, ***including*** Alcohol and/or Other Drug Certification Standards, in expending funds for the provision of SUD services hereunder.

76. "***Perinatal DMC Services"*** means covered services as well as mother/child habilitative and rehabilitative services; services access (i.e., provision or arrangement of transportation to and from medically necessary treatment); education to reduce harmful effects of alcohol and drugs on the mother and fetus or infant; and coordination of ancillary services (Title 22, Section 51341.1(c) 4).

77. ***"Physician"*** as it pertains to the supervision, collaboration, and oversight requirements in sections 1861(aa)(2)(B) and (aa)(3) of the Title XIX or Title XXI of the Social Security Act (hereinafter referred to as the Act), a doctor of medicine or osteopathy legally authorized to practice medicine or surgery in the State in which the function is performed.

78. ***"Physician Consultation"*** services are to support DMC physicians with complex

cases, which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

79. ***"Physician services"*** means services provided by an individual licensed under state law to practice medicine.

80. ***"Plan"*** means any written arrangement, by one or more entities, to provide health benefits or medical care or assume legal liability for injury or illness.

81. ***"Postpartum"*** as defined for DMC purposes, means the 60-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 60th day occurs.

82. ***"Postservice Postpayment (PSPP) Utilization Review"*** means the review for program compliance and medical necessity conducted by the state after service was rendered and paid. DHCS may recover prior payments of Federal and state funds if such a review determines that the services did not comply with the applicable statutes, regulations, or terms as specified in this Agreement.

83. ***"Potential Beneficiary/Enrollee"*** means a Medicaid beneficiary who is subject to mandatory enrollment or may voluntarily elect to enroll in a given MCO, PIHP, PAHP, PCCM or PCCM entity, but is not yet an enrollee of a specific MCO, PIHP, PAHP, PCCM, or PCCM entity.

84. ***"Preauthorization"*** means approval by the Plan that a covered service ***is*** medically necessary.

85. ***"Prepaid Ambulatory Health Plan (PAHP)"*** means an entity that:

    a) Provides services to beneficiaries under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State Plan payment rates.

    b) Does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its beneficiaries; and

    c) Does not have a comprehensive risk contract.

86. ***"Prepaid Inpatient Health Plan (PIHP)"*** means an entity that:

    a) Provides services to beneficiaries under contract with the state, and on the basis of capitation payments, or other payment arrangements that do not use State Plan payment rates.

    b) Provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its beneficiaries; and

    c) Does not have a comprehensive risk contract.

87. ***"Prescription drugs"*** means simple substances or mixtures of substances

prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are:

a) Prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law;

b) Dispensed by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and

c) Dispensed by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records.

88. ***"Primary Care"*** means all health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by the State Medicaid program, to the extent the furnishing of those services is legally authorized in the state in which the practitioner furnishes them.

89. ***"Primary Care Case Management Entity (PCCM entity)"*** means an organization that provides any of the following functions, in addition to primary care case management services, for the state:

a) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line.

b) Development of beneficiary care plans.

c) Execution of contracts with and/or oversight responsibilities for the activities of FFS providers in the FFS program.

d) Provision of payments to FFS providers on behalf of the state.

e) Provision of beneficiary outreach and education activities.

f) Operation of a customer service call center.

g) Review of provider claims, utilization and practice patterns to conduct provider profiling and/or practice improvement.

h) Implementation of quality improvement activities including administering beneficiary satisfaction surveys or collecting data necessary for performance measurement of providers.

i) Coordination with behavioral health systems/providers.

j) Coordination with long-term services and supports systems/providers.

90. ***"Primary Care Case Manager (PCCM)"*** means a physician, a physician group practice or, at State option, any of the following:

a) A physician assistant.

b) A nurse practitioner.

c) A certified nurse-midwife.

91. ***"Primary care physician (PCP)"*** means a Physician responsible for supervising, coordinating, and providing initial and Primary Care to patients and serves as the medical home for Members. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist.

92. ***"Primary care provider"*** means a person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non- Physician Medical Practitioner.

93. ***"Projected Units of Service"*** means the number of reimbursable DMC units of service, based on historical data and current capacity, the Contractor expects to provide on an annual basis.

94. ***"Provider"*** means any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is legally authorized to do so by the state in which it delivers the services.

95. ***"Provider-preventable condition"*** means a condition that meets the definition of a health care-acquired condition — a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary under section 1886(d)(4)(D)(iv) of the Act for purposes of the Medicare program identified in the State Plan as described in section 1886(d)(4)(D)(ii) and (IV) of the Act; other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients — or an "other provider- preventable condition," which is defined as a condition occurring in any health care setting that meets the following criteria:

a) Is identified in the State Plan.

b) Has been found by the state, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines.

c) Has a negative consequence for the beneficiary.

d) Is auditable.

e) Includes, at a minimum, wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

96. ***"Re-certification"*** means the process by which the DMC certified clinic is required to submit an application and specified documentation, as determined by

DHCS, to remain eligible to participate in and be reimbursed through the DMC program. Re-certification shall occur no less than every five years from the date of previous DMC certification or re-certification.

97. ***"Recovery monitoring"*** means recovery coaching, monitoring via telephone and internet. Recovery monitoring is only available in Recovery services.

98. ***"Recovery Services"*** are available after the beneficiary has completed a course of treatment. Recovery services emphasize the beneficiary'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 patients.

99. ***"Rehabilitation Services"*** includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under state law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.

100. ***"Relapse"*** means a single instance of a beneficiary's substance use or a beneficiary's return to a pattern of substance use.

101. ***"Relapse Trigger"*** means an event, circumstance, place or person that puts a beneficiary at risk of relapse.

102. ***"Recovery"*** – Recovery is a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential. Recovery is built on access to evidence-based clinical treatment and recovery support services for all populations. The process of recovery is highly personal and occurs via many pathways. It may include clinical treatment, medications, faith-based approaches, peer support, family support, self-care, and other approaches. Recovery is characterized by continual growth and improvement in one's health and wellness that may involve setbacks. Resilience becomes a key component of recovery because setbacks are a natural part of life.

103. ***"Residential Treatment Services"*** means a non-institutional, 24-hour non-medical, short-term residential program of any size that provides rehabilitation services to beneficiaries. Each beneficiary 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. Programs shall provide a range of activities and services. Residential treatment shall include 24-hour structure with available trained personnel, seven days a week, including a minimum of five (5) hours of clinical service a week to prepare beneficiary for outpatient treatment.

104. ***"Revenue"*** means Contractor's income from sources other than the state allocation.

105. ***Safeguarding medications,"*** means facilities will store all resident medication and facility staff members may assist with resident's self- administration of medication.

106. ***"Service Area"*** means the geographical area under Contractor's jurisdiction.

107. ***"Service Authorization Request"*** means a beneficiary's request for the provision of a service.

108. ***"Short-Term Resident"*** means any beneficiary receiving residential services pursuant to DMC-ODS, regardless of the length of stay, is a "short-term resident" of the residential facility in which they are receiving the services.

109. ***"Stakeholders"*** means persons or organizations involved with the individual participants, including their families, the Courts, Probation Officers, Parole Agents, Social Services staff, DBH, their employers and others.

110. ***"Subcontract"*** means an agreement between the Contractor and its subcontractors. A subcontractor shall not delegate its obligation to provide covered services or otherwise subcontract for the provision of direct beneficiary services.

111. ***"Subcontractor"*** means a vendor who has entered into a procurement agreement with the Contractor to provide any of the administrative functions related to fulfilling the Contractor's obligations under the terms of this Agreement.

112. ***"Substance Abuse Assistance"*** means peer-to-peer services and relapse prevention. Substance abuse assistance is only available in Recovery services.

113. ***"Substance Abuse Block Grant (SABG)"*** *are f*unds awarded to US States and the District of Columbia, Puerto Rico, the U.S. Virgin Islands, 6 Pacific jurisdictions, and 1 tribal entity through the Substance Abuse and Mental Health Services Administration (SAMHSA). Grantees use the funds to plan, implement, and evaluate activities that prevent and treat substance use disorders and promote public health.

114. ***"Substance Use Disorder (SUD)"*** includes substance abuse and substance dependence. Substance abuse is a maladaptive pattern of substance use manifested by recurrent and significant adverse consequences related to the repeated use of substances. Substance dependence is a cluster of cognitive, behavioral, and physiological symptoms indicating that an individual continues use of substances despite significant substance related problems. SUD Services is the provision of services to prevent or reduce the harm of alcohol and other drugs throughout San Bernardino County through community action, education, support, and collaboration.

115. ***"Substance Use Disorder and Recovery Services (SUDRS)"*** Refers to the County of San Bernardino Department of Behavioral Health - Substance Use Disorder and Recovery Services, formerly known as Alcohol and Drug Services

(ADS) Administration.

116. ***"Substance Use Disorder Diagnoses"*** are those set forth in the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, published by the American Psychiatric Association.

117. ***"Substance Use Disorder Medical Director"*** has the same meaning as in 22 CCR § 51000.24.4.

118. ***"Support Groups"*** means linkages to self-help and support, spiritual and faith-based support.

119. ***"Support Plan"*** means a list of individuals and/or organizations that can provide support and assistance to a beneficiary to maintain sobriety.

120. ***"Telehealth between Provider and Beneficiary"*** means office or outpatient visits via interactive audio and video telecommunication systems.

121. ***"Telehealth between Providers"*** means communication between two providers for purposes of consultation, performed via interactive audio and video telecommunications systems.

122. ***"Temporary Suspension"*** means the provider is temporarily suspended from participating in the DMC program as authorized by W&I Code, Section 14043.36(a). The provider cannot bill for DMC services from the effective date of the temporary suspension.

123. ***"Threshold Language"*** means a language that has been identified as the primary language, as indicated on the Medi-Cal Eligibility System (MEDS), of 3,000 beneficiaries or five percent of the beneficiary population, whichever is lower, in an identified geographic area.

124. ***"Transportation Services"*** means provision of or arrangement for transportation to and from medically necessary treatment.

125. "***Treatment Planning"*** means the act of a provider preparing an individualized written treatment plan, based upon information obtained in the intake and assessment process.

126. ***"Urgent care"*** means a condition perceived by a beneficiary as serious, but not life threatening. A condition that disrupts normal activities of daily living and requires assessment by a health care provider and if necessary, treatment within 24-72 hours.

127. ***"Utilization"*** means the total actual units of service used by beneficiaries.

128. ***"Withdrawal Management"*** means detoxification services provided in either an ambulatory or non-ambulatory setting consistent with the ASAM level of care criteria to DMC ODS beneficiaries.

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

A. The Contractor shall comply with the care and coordination requirements of this section.

B. As all beneficiaries receiving DMC-ODS services shall have special health care needs, the Contractor shall implement mechanisms for identifying, assessing, and producing a treatment plan for all beneficiaries that have been assessed to need a course of treatment, and as specified below.

C. The Contractor shall implement procedures to deliver care to and coordinate services for all of its beneficiaries. These procedures shall meet DBH requirements and shall do the following:

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

2. Coordinate the services the Contractor furnishes to the beneficiary:

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

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

   c) With the services the beneficiary receives in FFS Medicaid.

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

3. Make a best effort to conduct an initial screening of each beneficiary's needs, within 90 calendar days of the effective date of enrollment for all new beneficiaries, including subsequent attempts if the initial attempt to contact the beneficiary is unsuccessful.

4. Share with DBH and managed care organizations serving the beneficiary the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities (see f. below).

5. Contractor ensures when furnishing services to beneficiaries they maintain and share, as appropriate, a beneficiary health record in accordance with professional standards.

6. Ensure that in the process of coordinating care, each beneficiary's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E and 42 CFR Part 2, to the extent that they are applicable.

D. The Contractor shall implement mechanisms to comprehensively assess each Medicaid beneficiary seeking services for special health care needs to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care

monitoring. The assessment mechanisms shall use appropriate contractor providers.

E. The Contractor shall produce a treatment or service plan meeting the criteria below for beneficiaries with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan shall be:

1. Developed with beneficiary participation, and in consultation with any providers caring for the beneficiary;
2. Developed by a person trained in person-centered planning using a person-centered process and plan as defined in 42 CFR §441.301(c)(1);
3. Approved by DBH in a timely manner, if this approval is required by DBH and/or regulation;
4. In accordance with any applicable DBH quality assurance and utilization review standards; and
5. Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the beneficiary's circumstances or needs change significantly, or at the request of the beneficiary per 42 CFR §441.301(c)(3).

F. For beneficiaries with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the Contractor shall have a mechanism in place to assist beneficiaries in directly accessing a specialist as appropriate for the beneficiary's condition and identified needs.

III. Coverage and Authorization of Services (42 CFR §438.210)

A. The Contractor shall furnish medically necessary services covered by this Agreement in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under FFS Medicaid, as set forth in 42 CFR §440.230, and for beneficiaries under the age of 21, if applicable, as set forth in 42 CFR Section 440, subpart B.

B. The Contractor:

1. Shall ensure that the medically necessary services provided are sufficient in amount, duration, or scope to reasonably achieve the purpose for which the services are furnished; and
2. Shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of diagnosis, type of illness, or condition of the beneficiary.

IV. Practice Guidelines (42 CFR §438.236)

A. Contractor shall adhere to DBH's practice guidelines that meet the following requirements:

1. Are based on valid and reliable clinical evidence or a consensus of providers in

the particular field;

2. Consider the needs of DBH's beneficiaries;

3. Are adopted in consultation with contracting health care professionals; and

4. Are reviewed and updated periodically as appropriate.

B. Contractor shall disseminate the guidelines to all providers and, upon request, to beneficiaries and potential beneficiaries.

C. Contractor shall ensure that all decisions for utilization management, beneficiary education, coverage of services, and other areas to which the DBH guidelines apply are consistent with the guidelines.

V. Provider Specifications

A. Contractor and the contractor staff agree to the following requirements: Professional staff shall be licensed, registered, certified or recognized under California scope of practice statutes.

B. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioners of the Healing Arts (LPHA) include:

1. Physician
2. Nurse Practitioners
3. Physician Assistants
4. Registered Nurses
5. Registered Pharmacists
6. Licensed Clinical Psychologists
7. Licensed Clinical Social Worker
8. Licensed Professional Clinical Counselor
9. Licensed Marriage and Family Therapists
10. License Eligible Practitioners working under the supervision of Licensed Clinicians

C. Contractor agrees that non-professional staff shall receive appropriate onsite orientation and training prior to performing assigned duties. A professional and/or administrative staff may supervise non-professional staff.

D. Contractor agrees professional and non-professional staff are required to have appropriate experience and any necessary training at the time of hiring. Documentation of trainings, certifications and licensure shall be contained in personnel files.

E. Professional staff (LPHAs) shall receive a minimum of five (5) hours of continuing

education related to addiction medicine each year.

F. Registered and certified SUD counselors shall adhere to all requirements in Title 9, Chapter 8.

VI. Services for Adolescents and Youth

Assessment and services for adolescents will follow the ASAM adolescent treatment criteria.

VII. Organized Delivery System (ODS) Timely Coverage Non-Discrimination - Member Discrimination Prohibition

A. Contractor agrees that DMC-ODS services shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in San Bernardino County. Determination of who may receive the DMC-ODS benefits shall be performed in accordance with DMC-ODS Special Terms and Conditions (STC) 128(d), and as follows:

1. The Contractor shall verify the Medicaid eligibility determination of an individual. When the contractor conducts the initial eligibility verification, that verification shall be reviewed and approved by DBH prior to payment for services. If the individual is eligible to receive services from tribal health programs operating under the Indian Self-Determination Education Assistance Act (ISDEAA), then the determination shall be conducted as set forth in the Tribal Delivery System - Attachment BB to the STCs.

2. The initial medical necessity determination, for an individual to receive a DMC-ODS benefit, shall be performed through a face-to- face review or telehealth by a Medical Director or a LPHA. After establishing a diagnosis and documenting the basis for diagnosis, the American Society of Addiction Medicine (ASAM) Criteria shall be applied by the diagnosing individual to determine placement into the level of assessed services.

   a) Medical necessity for an adult (an individual age 21 and over) is determined using the following criteria:

      (1) The individual shall have received at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance- Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders; and

      (2) The individual shall meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.

   b) Individuals under age 21 are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under the age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Nothing in the DMC-ODS overrides any EPSDT

requirements. Medical necessity for an adolescent individual (an individual under the age of 21) is determined using the following criteria:

(1) The adolescent individual shall be assessed to be at risk for developing a SUD.

(2) The adolescent individual shall meet the ASAM adolescent treatment criteria.

3. For an individual to receive ongoing DMC-ODS services, the Medical Director or LPHA shall reevaluate that individual's medical necessity qualification at least every six months through the reauthorization process and document their determination that those services are still clinically appropriate for that individual. For an individual to receive ongoing Opioid Treatment Program/Narcotic Treatment Program (OTP/NTP) services, the Medical Director or LPHA shall reevaluate that individual's medical necessity qualification at least annually through the reauthorization process and determine that those services are still clinically appropriate for that individual.

VIII. Financing

A. Payment for Services

1. Pursuant to Title 42 CFR 433.138 and 22 CCR 51005(a), if a beneficiary has Other Heath Coverage (OHC), then the contractor agrees to bill that OHC prior to billing DMC to receive either payment from the OHC, or a notice of denial from the OHC indicating that:

a) The recipient's OHC coverage has been exhausted, or

b) The specific service is not a benefit of the OHC.

2. If the Contractor submits a claim to an OHC and receives partial payment of the claim, contractor may submit the claim to DMC and is eligible to receive payment up to the maximum DMC rate for the service, less the amount of the payment made by the OHC.

B. OTP/NTP (only in these contracts)

The contracted OTP/NTP Contractor agrees to provide DBH with requested financial data on an annual basis.

IX. Access to Services

A. Subject to State and County provider enrollment certification requirements, Contractor shall maintain continuous availability and accessibility of covered services and facilities, service sites, and personnel to provide the covered services through use of DMC certified providers. Contractor agrees to the following requirements:

1. If services are denied, inform the beneficiary in accordance with this contract and DBH policy/procedure.

2. Review the DSM and ASAM Criteria documentation to ensure that the beneficiary meets the requirements for the service.

3. Pursuant to 42 CFR 438.3(l), allow each beneficiary to choose his or her health professional to the extent possible and appropriate.

4. Ensure treatment programs are accessible to people with disabilities in accordance with Title 45, Code of Federal Regulations (hereinafter referred to as CFR), Part 84 and the Americans with Disabilities Act.

5. Refer prospective beneficiaries to DBH's 24/7 toll free number to call to access DMC-ODS services.

6. Provide and make available DMC-ODS services to all beneficiaries that reside in San Bernardino County and enrolled in the ODS Plan.

X. Residential Programs (Only in Residential Contracts)

Contractor agrees to ensure that residential services are provided in DHCS or Department of Social Services (DSS) licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.

XI. Laboratory Testing Requirements (Only in Contracts Doing Testing)

A. Contractor agrees that all laboratories shall meet to be certified to perform testing on human specimens under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Except as specified in paragraph (2) of this section, a laboratory will be cited as out of compliance with section 353 of the Public Health Service Act unless it:

1. Has a current, unrevoked or unsuspended certificate of waiver, registration certificate, certificate of compliance, certificate for PPM procedures, or certificate of accreditation issued by HHS applicable to the category of examinations or procedures performed by the laboratory.

2. Is CLIA-exempt.

B. These rules do not apply to components or functions of:

1. Any facility or component of a facility that only performs testing for forensic purposes.

2. Research laboratories that test human specimens but do not report patient specific results for the diagnosis, prevention or treatment of any disease or impairment of, or the assessment of the health of individual patients.

3. Laboratories certified by the Substance Abuse and Mental Health Services Administration (SAMHSA), in which drug testing is performed which meets SAMHSA guidelines and regulations. However, all other testing conducted by a SAMHSA-certified laboratory is subject to this rule.

XII. Description of Services

A. Outpatient Services (ASAM Level 1.0)

1. Outpatient services consist of up to nine hours per week of medically necessary services for adults and less than six hours per week of services for adolescents.

2. Contractor agrees to provide ASAM Level 1 services including: assessment, treatment planning; individual and group counseling; family therapy; patient education; medication services; collateral services; crisis intervention services; and discharge planning and coordination.

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

B. Intensive Outpatient Services (ASAM Level 2.1)

1. Intensive outpatient involves structured programming provided to beneficiaries as medically necessary for a minimum of nine hours and a maximum of 19 hours per week for adult perinatal and non-perinatal beneficiaries. Adolescents are provided a minimum of six and a maximum of 19 hours per week.

2. Contractor agrees to provide intensive outpatient services including: assessment, treatment planning, individual and/or group counseling, patient education, family therapy, medication services, collateral services, crisis intervention services, treatment planning, and discharge planning and coordination.

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

C. Residential Treatment Services

1. Residential services are provided in DHCS or DSS licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.

2. Residential services can be provided in facilities with no bed capacity limit.

3. The length of residential services range from 1 to 90 days with a 90-day maximum for adults and 30-day maximum for adolescents per 365-day period; unless medical necessity authorizes a one-time extension of up to 30 days per 365-day period.

   a) Only two non-continuous 90-day regimens may be authorized in a one-year period (365 days). The average length of stay for residential services is 30 days.

   b) Perinatal beneficiaries shall receive a length of stay for the duration of their pregnancy, plus 60 days postpartum.

   c) Adolescent beneficiaries shall receive a longer length of stay, if found to be medically necessary.

D. Case Management

1. Case management services are defined as a service that assist a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

2. Contractor agrees to provide case management services focusing on coordination of SUD care, integration around primary care especially for beneficiaries with a chronic substance use disorder, and interaction with the criminal justice system, if needed.

3. Case management services may be provided by a LPHA or a certified counselor.

4. Case management services may be provided face-to-face, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.

E. Physician Consultation Services

1. Physician Consultation Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are designed to assist DMC physicians by allowing them to seek expert advice when developing treatment plans for specific DMC-ODS beneficiaries. Physician consultation services may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

2. Contractor agrees that it may contract with one or more physicians or pharmacists in order to provide consultation services.

3. Contractor agrees to only allow DMC providers to bill for physician consultation services.

F. Recovery Services

1. Recovery Services shall include:

a) Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care.

b) Recovery Monitoring: Recovery coaching, monitoring via telephone and internet.

c) Substance Abuse Assistance: Peer-to-peer services and relapse prevention.

d) Education and Job Skills: Linkages to life skills, employment services, job training, and education services.

e) Family Support: Linkages to childcare, parent education, child development support services, family/marriage education.

f) Support Groups: Linkages to self-help and support, spiritual and faith-based

support.

g) Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

2. Contractor agrees to utilize recovery services when the beneficiary is triggered, when the beneficiary has relapsed, or simply as a preventative measure to prevent relapse. As part of the assessment and treatment needs of Dimension 6, Recovery Environment of the ASAM Criteria and during the transfer/transition planning process, Contractor shall provide beneficiaries with recovery services.

3. Additionally, Contractor shall:

a) Provide recovery services to beneficiaries as medically necessary.

b) Provide beneficiaries with access to recovery services after completing their course of treatment.

c) Provide recovery services either face-to-face, by telephone, or by telehealth, and in any appropriate setting in the community with the beneficiary.

G. Withdrawal Management

1. Contractor agrees to provide a minimum one of the five levels of withdrawal management (WM) services according to the ASAM Criteria, when determined by a Medical Director or LPHA as medically necessary, and in accordance with the beneficiary's individualized treatment plan.

2. Contractor agrees to ensure that all beneficiaries that are receiving both residential services and WM services are monitored during the detoxification process.

3. Contractor agrees to provide medically necessary habilitative and rehabilitative services in accordance with an individualized treatment plan prescribed by a licensed physician or licensed prescriber.

H. Opioid (Narcotic) Treatment Program Services (NTP)

1. Pursuant to W&I Code, Section 14124.22, a Narcotic Treatment Program provider who is also enrolled as a Medi-Cal provider may provide medically necessary treatment of concurrent health conditions to Medi-Cal beneficiaries who are not enrolled in managed care plans as long as those services are within the scope of the provider's practice. Narcotic treatment providers shall refer all Medi-Cal beneficiaries that are enrolled in managed care plans to their respective managed care plan to receive medically necessary medical treatment of their concurrent health conditions.

2. The diagnosis and treatment of concurrent health conditions of Medi- Cal beneficiaries that are not enrolled in managed care plans by a Narcotic Treatment Program provider may be provided within the Medi- Cal coverage limits. When the services are not part of the SUD treatment reimbursed pursuant

to W&I Code, Section 14021.51, the services rendered shall be reimbursed in accordance with the Medi-Cal program. Services reimbursable under this section shall include all of the following:

a) Medical treatment visits;

b) Diagnostic blood, urine, and X-rays;

c) Psychological and psychiatric tests and services;

d) Quantitative blood and urine toxicology assays; and

e) Medical supplies.

3. An NTP provider who is enrolled as a Medi-Cal fee-for-service provider shall not seek reimbursement from a beneficiary for SUD treatment services, if the NTP provider bills the services for treatment of concurrent health conditions to the Medi-Cal fee-for-service program.

4. As a licensed NTP, Contractor agrees to offer services to beneficiaries who meet medical necessity criteria requirements.

5. Services shall be provided in accordance with an individualized beneficiary plan determined by a licensed prescriber.

6. Contractor agrees to offer and prescribe medications to patients covered under the DMC- ODS formulary including methadone, buprenorphine, naloxone, and disulfiram.

7. Services provided as part of an NTP shall include: assessment, treatment planning, individual and group counseling, patient education; medication services; collateral services; crisis intervention services; treatment planning; medical psychotherapy; and discharge services.

8. Beneficiaries shall receive between 50 and 200 minutes of counseling per calendar month with a therapist or counselor, and, when medically necessary, additional counseling services may be provided.

XIII. Youth Treatment Guidelines

Contractor shall follow the guidelines in the document referenced as "Youth Treatment Guidelines," in developing and implementing adolescent treatment programs funded under this Exhibit, until such time new Youth Treatment Guidelines are established and adopted. No formal amendment of this contract is required when new guidelines are incorporated.

XIV. Medication Assisted Treatment

Contractor agrees to have procedures for linkage/integration for beneficiaries requiring medication assisted treatment. Contractor staff will regularly communicate with physicians of beneficiaries who are prescribed these medications unless the beneficiary refuses to consent to sign a 42 CFR part 2 compliant release of information for this purpose.

XV. Evidence Based Practices (EBPs)

A. Contractor agrees to implement at least two of the following EBPs based on the timeline established in DBH's implementation plan. The two EBPs are per provider per service modality. Contractor acknowledges that County will ensure EBPs are implemented. County will monitor the implementation and regular training of EBPs to staff during reviews. The required EBPs include:

1. Motivational Interviewing: A beneficiary-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on beneficiaries' past successes.

2. Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.

3. Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.

4. Trauma-Informed Treatment: Services shall take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.

5. Psycho-Education: Psycho-educational groups are designed to educate beneficiaries about substance abuse, and related behaviors and consequences. Psycho- educational groups provide information designed to have a direct application to beneficiaries' lives; to instill self- awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

XVI. DMC Claims and Reports

A. Contractor agrees to bill DBH for DMC- ODS services by submitting claims in accordance with Department of Health Care Service's DMC Provider Billing Manual.

B. Contractor agrees to provide DMC services and shall be responsible for verifying the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for DMC services to that beneficiary for that month. Medi-Cal eligibility verification should be performed prior to rendering service, in accordance with and as described in the DHCS DMC Provider Billing Manual. Options for verifying the eligibility of a Medi-Cal beneficiary are described in the Department of Health Care Services DMC Provider Billing Manual.

XVII. Training

A. DBH shall ensure the Contractor receives training on the DMC-ODS requirements, at least annually.

B. The Contractor agrees to be trained in the ASAM Criteria prior to providing services.

1. Contractor shall ensure that, at minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care". A third module entitled, "Introduction to The ASAM Criteria" is recommended for Contractor participating in the Waiver.

2. Contractor agrees that all its residential service providers meet the established ASAM criteria for each level of residential care they provide and receive an ASAM Designation prior to providing DMC-ODS services.

XVIII. Requirements for Service

A. Perinatal Services

1. Perinatal services shall address treatment and recovery issues specific to pregnant and postpartum women, such as relationships, sexual and physical abuse, and development of parenting skills.

2. Perinatal services shall include:

a) Mother/child habilitative and rehabilitative services (i.e., development of parenting skills, training in child development, which may include the provision of cooperative child care pursuant to Health and Safety Code Section 1596.792);

b) Service access (i.e., provision of or arrangement for transportation to and from medically necessary treatment);

c) Education to reduce harmful effects of alcohol and drugs on the mother and fetus or the mother and infant; and

d) Coordination of ancillary services (i.e., assistance in accessing and completing dental services, social services, community services, educational/vocational training and other services which are medically necessary to prevent risk to fetus or infant).

3. Medical documentation that substantiates the beneficiary's pregnancy and the last day of pregnancy shall be maintained in the beneficiary record.

B. Narcotic Treatment Programs

Narcotic treatment programs services and regulatory requirements shall be provided in accordance with Title 9, Chapter 4.

C. Naltrexone Treatment Services

1. For each beneficiary, all of the following shall apply:

a) Confirm and document that the beneficiary meets all of the following

conditions:

(1) Has a documented history of opiate addiction.

(2) Is at least 18 years of age.

(3) Has been opiate-free for a period of time to be determined by a physician based on the physician's clinical judgment. Administer a body specimen test to confirm the opiate free status of the beneficiary.

(4) Is not pregnant and is discharged from the treatment if she becomes pregnant.

(5) The physician shall certify the beneficiary's fitness for treatment based upon the beneficiary's physical examination, medical history, and laboratory results; and

(6) The physician shall advise the beneficiary of the overdose risk should the beneficiary return to opiate use while taking Naltrexone and the ineffectiveness of opiate pain relievers while on Naltrexone.

D. Substance Use Disorder Medical Director

1. The substance use disorder medical director's responsibilities shall, at a minimum, include all of the following:

a) Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.

b) Ensure that physicians do not delegate their duties to non- physician personnel.

c) Develop and implement medical policies and standards for contractor.

d) Ensure that physicians, registered nurse practitioners, and physician assistants follow contractor’s medical policies and standards.

e) Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.

f) Ensure that provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries, determine the medical necessity of treatment for beneficiaries.

g) Ensure that provider's physicians are adequately trained to perform other physician duties, as outlined in this section.

2. The substance use disorder medical director may delegate his/her responsibilities to a physician consistent with the contractor's medical policies and standards; however, the substance use disorder medical director shall remain responsible for ensuring all delegated duties are properly performed.

E. Provider Personnel

1. Contractor shall furnish such qualified professional personnel prescribed by Title 9 of the California Code of Regulations as are required for the types of services Contractor shall perform, which services are described in such Addenda as may be attached hereto and/or in all memos, letters, or instruction given by the Director and/or Program Manager II or designee in the provision of any and all Substance Use Disorder programs.
2. Contractor shall obtain records from the Department of Justice of all convictions of persons offered employment or volunteers as specified in Penal Code Section 11105.3
3. Contractor agrees that clients have the right to be free from sexual harassment and sexual contact by all staff members and other professional affiliates.
    a) Contractor shall inform DBH within twenty-four (24) hours or next business day of any allegations of sexual harassment, physical abuse, etc., committed by Contractor's employees against clients served under this Contract. Contractor shall report incident as outlined in Notification of Unusual Occurrences or Incident/Injury Reports paragraph in the Administrative Procedures Article.
4. Personnel files shall be maintained on all employees and volunteers/interns and shall contain the following:
    a) Application for employment and/or resume;
    b) Signed employment confirmation statement/duty statement;
    c) Job description;
    d) Performance evaluations;
    e) Health records/status as required by the provider, AOD Certification or Title 9;
    f) Other personnel actions (e.g., commendations, discipline, status change, employment incidents and/or injuries);
    g) Training documentation relative to substance use disorders and treatment;
    h) Current registration, certification, intern status, or licensure;
    i) Proof of continuing education required by licensing or certifying agency and program; and
    j) Contractor's Code of Conduct signed annually and for registered, certified, and licensed staff, a copy of the certifying/licensing body's code of conduct as well.
5. Job descriptions shall be developed, revised as needed, and approved by the Contractor's governing body. The job descriptions shall include:
    a) Position title and classification;

b) Duties and responsibilities;

c) Lines of supervision; and

d) Education, training, work experience, and other qualifications for the position.

6. Written code of conduct for employees and volunteers/interns shall be established which addresses at least the following:

a) Use of drugs and/or alcohol;

b) Prohibition of social/business relationship with beneficiary's or their family members for personal gain;

c) Prohibition of sexual contact with beneficiary's;

d) Conflict of interest;

e) Providing services beyond scope;

f) Discrimination against beneficiary's or staff;

g) Verbally, physically, or sexually harassing, threatening, or abusing beneficiary's, family members or other staff;

h) Protection beneficiary confidentiality;

i) The elements found in the code of conduct(s) for the certifying organization(s) the program's counselors are certified under; and

j) Cooperate with complaint investigations.

7. If utilizing the services of volunteers and or interns, procedures shall be implemented which address:

a) Recruitment;

b) Screening; Selection;

c) Training and orientation;

d) Duties and assignments;

e) Scope of practice;

f) Supervision;

g) Evaluation; and

h) Protection of beneficiary confidentiality.

8. Written roles and responsibilities and a code of conduct for the medical director shall be clearly documented, signed and dated by a contractor representative and the physician.

F. Beneficiary Admission

1. Each contractor shall include in its policies, procedures, and practice, written

admission and readmission criteria for determining beneficiary's eligibility and the medical necessity for treatment. That are compatible with Department of Behavioral Health service priorities. These criteria shall include, at minimum:

a) DSM diagnosis;

b) Use of alcohol/drugs of abuse;

c) Physical health status;

d) Documentation of social and psychological problems; and

e) Be available to the public.

2. If a potential beneficiary does not meet the admission criteria, the beneficiary shall be referred to an appropriate service provider.

3. If a beneficiary is admitted to treatment, the beneficiary shall sign a consent to treatment form.

4. The medical director or LPHA shall document the basis for the diagnosis in the beneficiary record.

5. All referrals made by contractor staff shall be documented in the beneficiary record.

6. Copies of the following documents shall be provided to the beneficiary upon admission:

a) Share of cost if applicable, notification of DMC funding accepted as payment in full, and consent to treatment.

7. Copies of the following shall be provided to the beneficiary or posted in a prominent place accessible to all beneficiaries:

a) A statement of nondiscrimination by race, religion, sex, ethnicity, age, disability, sexual preference, and ability to pay;

b) Complaint process and grievance procedures;

c) Appeal process for involuntary discharge; and

d) Program rules and expectations.

8. Where drug screening by urinalysis is deemed medically appropriate the program shall:

a) Establish procedures which protect against the falsification and/or contamination of any urine sample; and

b) Document urinalysis results in the beneficiary's file.

G. Assessment

1. Contractor shall assure a counselor or LPHA completes a personal, medical, and

substance use history for each beneficiary upon admission to treatment.

Assessment for all beneficiaries shall include at a minimum:

a) Drug/Alcohol use history

b) Medical history

c) Family history

d) Psychiatric/psychological history

e) Social/recreational history

f) Financial status/history

g) Educational history

h) Employment history

i) Criminal history, legal status

j) Previous SUD treatment history

k) The medical director or LPHA shall review each beneficiary's personal, medical and substance use history if completed by a counselor.

H. Beneficiary Record

1. In addition to the requirements of 22 CCR § 51476(a), contractor shall:

a) Establish, maintain, and update as necessary, an individual beneficiary record for each beneficiary admitted to treatment and receiving services.

b) Each beneficiary's individual beneficiary record shall include documentation of personal information.

c) Documentation of personal information shall include all of the following:

(1) Information specifying the beneficiary's identifier (i.e., name, number).

(2) Date of beneficiary's birth, the beneficiary's sex, race and/or ethnic background, beneficiary's address and telephone number, beneficiary's next of kin or emergency contact.

2. Documentation of treatment episode information shall include documentation of all activities, services, sessions, and assessments, including but not limited to all of the following:

a) Intake and admission data, including, if applicable, a physical examination

b) Treatment plans

c) Progress notes

d) Continuing services justifications

e) Laboratory test orders and results

f) Referrals

g) Counseling notes

h) Discharge plan

i) Discharge summary

j) DBH authorizations for Residential Services

k) Any other information relating to the treatment services rendered to the beneficiary

I. Medical Necessity and Diagnosis Requirements

1. The medical director or LPHA shall evaluate each beneficiary's assessment and intake information if completed by a counselor through a face-to-face review or telehealth with the counselor to establish a beneficiary meets medical necessity criteria.

2. The medical director or LPHA shall document separately from the treatment plan the basis for the diagnosis in the beneficiary's record within 30 calendar days of each beneficiary's admission to treatment date.

3. The Medical Director or LPHA shall type or legibly print their name, and sign and date the diagnosis documentation.

J. Physical Examination Requirements

1. If a beneficiary had a physical examination within the twelve month period prior to the beneficiary's admission to treatment date, the physician or registered nurse practitioner or physician's assistant (physician extenders) shall review documentation of the beneficiary's most recent physical examination within 30 calendar days of the beneficiary's admission to treatment date.

   a) If a contractor is unable to obtain documentation of a beneficiary's most recent physical examination, the contractor shall describe the efforts made to obtain this documentation in the beneficiary's individual patient record.

2. As an alternative to complying with paragraph (i) above or in addition to complying with paragraph (i) above, the physician or physician extender may perform a physical examination of the beneficiary within 30 calendar days of the beneficiary's admission to treatment date.

3. If the physician or a physician extender, has not reviewed the documentation of the beneficiary's physical examination as provided for in paragraph (i), or the provider does not perform a physical examination of the beneficiary as provided for in paragraph (ii), then the LPHA or counselor shall include in the beneficiary's initial and updated treatment plans the goal of obtaining a physical examination, until this goal has been met.

K. Treatment Plan

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

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

      The initial treatment plan and updated treatment plans shall include all of the following:

      (1) A statement of problems identified through the ASAM, other assessment tool(s) or intake documentation.

      (2) Goals to be reached which address each problem.

      (3) Action steps that will be taken by the provider and/or beneficiary to accomplish identified goals.

      (4) Target dates for the accomplishment of action steps and goals.

      (5) A description of the services, including the type of counseling, to be provided and the frequency thereof.

      (6) The assignment of a primary therapist or counselor.

      (7) The beneficiary's diagnosis as documented by the Medical Director or LPHA.

      (8) If a beneficiary has not had a physical examination within the 12-month period prior to the beneficiary's admission to treatment date, a goal that the beneficiary have a physical examination.

      (9) If documentation of a beneficiary's physical examination, which was performed during the prior twelve months, indicates a beneficiary has a significant medical illness, a goal that the beneficiary obtain appropriate treatment for the illness.

   b) Contractor shall ensure that the initial treatment plan meets all of the following requirements:

      (1) The LPHA or counselor shall complete, type or legibly print their name, and sign and date the initial treatment plan within 30 calendar days of the admission to treatment date.

      (2) The beneficiary shall review, approve, type or legibly print their name, sign and date the initial treatment plan, indicating whether the beneficiary participated in preparation of the plan, within 30 calendar days of the admission to treatment date.

      If the beneficiary refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the

beneficiary to participate in treatment.

(3) If a counselor completes the initial treatment plan, the medical director or LPHA shall review the initial treatment plan to determine whether services are a medically necessary and appropriate for the beneficiary.

If the medical director or LPHA determines the services in the initial treatment plan are medically necessary, the medical director or LPHA shall type or legibly print their name, and sign and date the treatment plan within 15 calendar days of signature by the counselor.

2. Contractor shall ensure that the treatment plan is reviewed and updated as described below:

a) The LPHA or counselor shall complete, type or legibly print their name, sign and date the updated treatment plan no later than 90 calendar days after signing the initial treatment plan, and no later than every 90 calendar days thereafter, or when there is a change in treatment modality or significant event, whichever comes first.

b) The beneficiary shall review, approve, type or legibly print their name and, sign and date the updated treatment plan, indicating whether the beneficiary participated in preparation of the plan, within 30 calendar days of signature by the LPHA or counselor.

If the beneficiary refuses to sign the updated treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment.

c) If a counselor completes the updated treatment plan, the medical director or LPHA shall review each updated treatment plan to determine whether continuing services are a medically necessary and appropriate for the beneficiary.

If the medical director or LPHA determines the services in the updated treatment plan are medically necessary, they shall type or legibly print their name and, sign and date the updated treatment plan, within 15 calendar days of signature by the counselor.

L. Sign-in Sheet

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

a) The typed or legibly printed name and signature of the LPHA(s) and/or counselor(s) conducting the counseling session. By signing the sign-in sheet, the LPHA(s) and/or counselor(s) attest that the sign-in sheet is accurate and complete.

b) The date of the counseling session.

c) The topic of the counseling session.

d) The start and end time of the counseling session.

e) A typed or legibly printed list of the participants' names and the signature of each participant that attended the counseling session. The participants shall sign the sign-in sheet at the start of or during the counseling session.

M. Progress Notes

1. Progress notes shall be legible and completed as follows:

a) For outpatient services, Naltrexone treatment services, and recovery services, each individual and group session, the LPHA or counselor who conducted the counseling session or provided the service shall record a progress note for each beneficiary who participated in the counseling session or treatment service.

(1) The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven calendar days of the counseling session.

(2) Progress notes are individual narrative summaries and shall include all of the following:

i. The topic of the session or purpose of the service.

ii. A description of the beneficiary's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals.

iii. Information on the beneficiary's attendance, including the date, start and end times of each individual and group counseling session or treatment service.

iv. Identify if services were provided in-person, by telephone, or by telehealth.

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

b) For intensive outpatient treatment and residential treatment services, the LPHA or counselor shall record at a minimum one progress note, per calendar week, for each beneficiary participating in structured activities including counseling sessions or other treatment services.

(1) The LPHA or counselor shall type or legibly print their name, and sign and date progress notes within the following calendar week.

(2) Progress notes are individual narrative summaries and shall include all of the following:

i. A description of the beneficiary's progress on the treatment plan,

problems, goals, action steps, objectives, and/or referrals.

ii. A record of the beneficiary's attendance at each counseling session including the date, start and end times and topic of the counseling session.

iii. Identify if services were provided in-person, by telephone, or by telehealth.

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

c) For each beneficiary provided case management services, the LPHA or counselor who provided the treatment service shall record a progress note.

(1) The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven calendar days of the case management service.

(2) Progress notes shall include all of the following:

i. Beneficiary’s name.

ii. The purpose of the service.

iii. A description of how the service relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referrals.

iv. Date, start and end times of each service.

v. Identify if services were provided in-person, by telephone, or by telehealth.

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

d) For physician consultation services, additional medication assisted treatment, and withdrawal management, the medical director or LPHA working within their scope of practice who provided the treatment service shall record a progress note and keep in the beneficiary’s file.

(1) The medical director or LPHA shall type or legibly print their name, and sign and date the progress note within seven calendar days of the service.

(2) Progress notes shall include all of the following:

i. Beneficiary’s name.

ii. The purpose of the service.

iii. Date, start and end times of each service.

iv. Identify if services were provided face-to-face, by telephone or by

telehealth.

N. Continuing Services

1. Continuing services shall be justified as shown below:

a) For case management, intensive outpatient treatment, Naltrexone treatment, and outpatient services:

(1) For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the LPHA or counselor shall review the beneficiary's progress and eligibility to continue to receive treatment services, and recommend whether the beneficiary should or should not continue to receive treatment services at the same level of care.

(2) For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the medical director or LPHA shall determine medical necessity for continued services for the beneficiary. The determination of medical necessity shall be documented by the medical director or LPHA in the beneficiary's individual patient record and shall include documentation that all of the following have been considered:

i. The beneficiary's personal, medical and substance use history.

ii. Documentation of the beneficiary's most recent physical examination.

iii. The beneficiary's progress notes and treatment plan goals.

iv. The LPHA’s or counselor's recommendation pursuant to Paragraph (i) above.

v. The beneficiary's prognosis.

The medical director or LPHA shall type or legibly print their name, and sign and date the continuing services information when completed.

(3) If the medical director or LPHA determines that continuing treatment services for the beneficiary is not medically necessary, the provider shall discharge the beneficiary from treatment and arrange for the beneficiary to an appropriate level of treatment services.

2. Residential services length of stay shall be in accordance with Article III.H of this Agreement.

O. Discharge

1. Discharge of a beneficiary from treatment may occur on a voluntary or

involuntary basis. For outpatient services, intensive outpatient services and residential services, in addition to the requirements of this subsection, an involuntary discharge is subject to the requirements set forth in Article II.G.2. Timely and Adequate Notice of Adverse Benefit.

2. An LPHA or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom the provider loses contact.

   a) The discharge plan shall include, but not be limited to, all of the following:

      (1) A description of each of the beneficiary's relapse triggers.

      (2) A plan to assist the beneficiary to avoid relapse when confronted with each trigger.

      (3) A support plan.

   b) The discharge plan shall be prepared within 30 calendar days prior to the scheduled date of the last face-to-face treatment with the beneficiary.

      (1) If a beneficiary is transferred to a higher or lower level of care based on ASAM criteria within the same DMC certified program, they are not required to be discharged unless there has been more than a 30 calendar day lapse in treatment services.

   c) During the LPHA's or counselor's last face-to-face treatment with the beneficiary, the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. A copy of the discharge plan shall be provided to the beneficiary and documented in the beneficiary record.

3. The LPHA or counselor shall complete a discharge summary, for any beneficiary with whom the provider lost contact, in accordance with all of the following requirements:

   a) The LPHA or counselor shall complete the discharge summary within 30 calendar days of the date of the last face-to-face treatment contact with the beneficiary.

   b) The discharge summary shall include all of the following:

      (1) The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment.

      (2) The reason for discharge.

      (3) A narrative summary of the treatment episode.

      (4) The beneficiary's prognosis.

P. Reimbursement of Documentation

1. If permitted by DBH, reimbursement of units of service for documentation

activities shall be as follows:

a) The Medical Director, LPHA or counselor shall record their completion of progress notes, treatment plans, continuing services justification and discharge documentation that includes at a minimum the following:

(1) Name of beneficiary

(2) Date original treatment service was provided

(3) Date documentation of progress note, treatment plan, continuing services justification or discharge documentation was completed, which includes start and end time.

b) The medical director, LPHA or counselor shall type or legibly print their name, and sign and date the record within seven calendar days of the service requiring documentation.

XIX. References

A. The following references are hereby incorporated by reference into the DMC-ODS Waiver contract though they may not be physically attached to the contract:

1. Reference 1: DMC-ODS Special Terms and Conditions. Refer to pages 104-136 and 378-408 for the DMC-ODS system. (Updated June 1, 2017)

   http://www.dhcs.ca.gov/provgovpart/Documents/Medi-Cal2020STCs12-22-17.pdf

2. Reference 2: Drug and Alcohol Treatment Access Report (DATAR)

   http://www.dhcs.ca.gov/provgovpart/Pages/DATAR.aspx

3. Reference 3: Alcohol and/or Other Drug Program Certification Standards (March 15, 2004)

   http://www.dhcs.ca.gov/provgovpart/Pages/Facility_Certification.aspx

4. Reference 4: Youth Treatment Guidelines

   http://www.dhcs.ca.gov/individuals/Documents/Youth_Treatment_Guideli nes.pdf

5. Reference 5: Sobky v. Smoley, Judgment, Signed February 1, 1995

   http://www.dhcs.ca.gov/provgovpart/Documents/FMAB/Contract_Information/Doc_2K-2Lc/2a_Document_2A-Sobky_v._Smoley.tiff

6. Reference 6: Drug Medi-Cal Billing Manual

   http://www.dhcs.ca.gov/formsandpubs/Documents/DMC_Billing_Manual_2017-Final.pdf

   a) Document 2L(a): Good Cause Certification (6065A)

      http://www.dhcs.ca.gov/formsandpubs/Documents/DHCS_6065A_FORM.pdf

   b) Document 2L(b): Good Cause Certification (6065B)

      http://www.dhcs.ca.gov/formsandpubs/Documents/DHCS_6065B_FORM.pdf

c) Document 2M(a): Drug Medi-Cal (DMC) Claim Submission Certification – County Contracted Provider

http://www.dhcs.ca.gov/formsandpubs/forms/Documents/DHCS_100186_Form.pdf

7. Reference 7: California Code of Regulations, Title 9 – Rehabilitation and Developmental Services, Division 4 – Department of Alcohol and Drug Programs, Chapter 4 – Narcotic Treatment Programs

   http://www.calregs.com

8. Reference 8: California Code of Regulations, Title 9 – Rehabilitation and Developmental Services, Division 4 – Department of Alcohol and Drug Programs, Chapter 8 – Certification of Alcohol and Other Drug Counselors

   http://www.calregs.com

9. Reference 9: CalOMS Treatment Data Collection Guide

   http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Tx_Data_Collection_Guide_JAN%202014.pdf

10. Reference 10: CalOMS Treatment Data Compliance Standards

    http://www.dhcs.ca.gov/provgovpart/Documents/CalOMS_Data_Cmpliance%20Standards%202014.pdf

11. Reference 11: Culturally and Linguistically Appropriate Services (CLAS) National Standards

    https://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15