AGREEMENT BETWEEN COUNTY OF LAKE AND ARCHWAY RECOVERY SERVICES, INC. FOR ASAM LEVELS 3.1, 3.2, 3.3, 3.5, AND WITHDRAWAL MANAGEMENT LEVELS 1 AND 2. FOR FISCAL YEAR 2025-26

This Agreement is made and entered into by and between the County of Lake, hereinafter referred to as "County," and Archway Recovery Services, Inc., hereinafter referred to as "Contractor," collectively referred to as the "parties."

RECITALS

WHEREAS, County is under contract with the State of California to provide or arrange for the provision of certain mandated services, including substance use disorder (SUD) services, for Medi-Cal beneficiaries served by the County; and

WHEREAS, County has determined that it will arrange for a contractor to provide ASAM Levels 3.1, 3.2, 3.3, 3.5and Withdrawal Management Levels 1 and 2;

NOW, THEREFORE, based on the forgoing recitals, the parties hereto agree as follows:

1. SERVICES. Subject to the terms and conditions set forth in this Agreement CONTRACTOR shall provide to County the services described in the "**Scope of Services**" attached hereto and incorporated herein as **Exhibit B** at the time and place and in the manner specified therein. In the event of a conflict in or inconsistency between the terms of this Agreement and **Exhibits A/B/C/D/E**, the Agreement shall prevail.

2. TERM. This Agreement shall commence on July 1, 2025, and shall terminate on June 30, 2026, unless earlier terminated as hereinafter provided (the "initial term"). In the event County desires to temporarily continue services after the expiration of this Agreement, such continuation shall be deemed on a month-to-month basis (each such period being a "successive term"), subject to the same terms, covenants, and conditions contained herein.

3. COMPENSATION. PAYMENT FOR SERVICES BY COUNTY, Contractor has been selected by County to provide the services described hereunder in **Exhibit A**, titled, "**Scope of Services.**" **Compensation to Contractor shall not exceed Five Hundred Thousand Dollars ($500,000.00)**.

This Agreement shall be subject to any restrictions, limitations, and/or conditions imposed by County or state or federal funding sources that may in any way affect the fiscal provisions of, or funding for this Agreement. This Agreement is also contingent upon sufficient funds being made available by County, state, or federal funding sources for the term of the Agreement. In the event of delayed reimbursement from the State or Federal government, County may delay payment to Contractor until funds are received. If the federal or state governments reduce financial participation in the Medi-Cal program, County agrees to meet with Contractor to discuss renegotiating the services required by this Agreement.

4. TERMINATION. This Agreement may be terminated by mutual consent of the parties or by County upon 30 days written notice to Contractor.

In the event of non-appropriation of funds for the services provided under this Agreement, County may terminate this Agreement, without termination charge or other liability.

Upon termination, Contractor shall be paid a prorated amount for the services provided up to the date of termination.

5. MODIFICATION. This Agreement may only be modified by a written amendment hereto, executed by both parties; however, matters concerning scope of services which do not affect the compensation may be modified by mutual written consent of Contractor and County executed by the Lake County Behavioral Health Services Director.

6. NOTICES. All notices that are required to be given by one party to the other under this Agreement shall be in writing and shall be deemed to have been given if delivered personally or enclosed in a properly addressed envelope and deposited with the United States Post Office for delivery by registered or certified mail addressed to the parties at the following addresses, unless such addresses are changed by notice, in writing, to the other party.

County of Lake
Lake County Behavioral Health Services
PO Box 1024
6302 Thirteenth Avenue
Lucerne, CA 95458-1024
Attn: Elise Jones,
Director

Archway Recovery Services
609 Jefferson Street, Ste. H
Fairfield, CA 95433

Attn: Wanda L. Cook
Chief Operations Officer

7. EXHIBITS. The Agreement Exhibits, as listed below, are incorporated herein by reference:

Exhibit A - Definitions
Exhibit B - Scope of Services
Exhibit C - Fiscal Provisions
Exhibit D – Compliance Provisions
Exhibit E – Business Associate Agreement

8. TERMS AND CONDITIONS. Contractor warrants and agrees that it shall comply with all terms and conditions of this Agreement including **Exhibit A**, **Exhibit B**, **Exhibit C**, **Exhibit D** and Exhibit E attached hereto and incorporated herein, in addition to all other applicable federal, state, and local laws, regulations and policies.

9. INTEGRATION. This Agreement, including attachments, constitutes the entire agreement between the parties regarding its subject matter and supersedes all prior Agreements, related proposals, oral and written, and all negotiations, conversations, or discussions heretofore and between the parties

County and Contractor have executed this Agreement on the day and year first written above.

COUNTY OF LAKE

_____
Chair
Board of Supervisors
Date: _____

APPROVED AS TO FORM:
LLOYD GUINTIVANO
County Counsel

By: _____

Date: 7/7/25
Signed for by Jackson Bennett
// Deputy County Counsel

Archway Recovery Services

_____
Kevin Phillips, Director

Date: 7/14/2025

ATTEST:
SUSAN PARKER
Clerk to the Board of Supervisors

By: _____

Date: _____

EXHIBIT A – DEFINITONS

AGREEMENT BETWEEN COUNTY OF LAKE AND ARCHWAY RECOVERY SERVICES, INC. FOR ASAM LEVELS 3.1, 3.2, 3.3, 3.5, AND WITHDRAWAL MANAGEMENT LEVELS 1 AND 2. FOR FISCAL YEAR 2025-26

1. DEFINITIONS

1.1 BEHAVIORAL HEALTH INFORMATION NOTICE (BHIN): "Behavioral Health Information Notice" or "BHIN" means guidance from DHCS to inform counties and contractors of changes in policy or procedures at the federal or state levels. These were previously referred to as a Mental Health and Substance Use Disorder Services Information Notice (MHSUDS IN). BHINs and MHSUDS INs are available on the DHCS website.

1.2 BENEFICIARY OR CLIENT: "Beneficiary" or "client" means the individual(s) receiving services.

1.3 DHCS: California Department of Health Care Services.

1.4 DIRECTOR: the Director of the County Behavioral Health Department, unless otherwise specified.

AGREEMENT BETWEEN COUNTY OF LAKE AND ARCHWAY RECOVERY SERVICES, INC. FOR ASAM LEVELS 3.1, 3.2, 3.3, 3.5, AND WITHDRAWAL MANAGEMENT LEVELS 1 AND 2. FOR FISCAL YEAR 2025-26

EXHIBIT B – SCOPE OF SERVICES

1. **CONTRACTOR'S RESPONSIBILITIES.** Contractor agrees to comply with all applicable Medi-Cal laws, regulations, including 1915(b) Waiver and any Special Terms and Conditions.

1.1 As an organizational provider agency, Contractor shall provide administrative and direct program services to County's Medi-Cal clients as defined in Title 9, Division 1, Chapter 11 of the California Code of Regulations. For clients under the age of 21, the Contractor shall provide all medically necessary SUD services required pursuant to Section 1396d(r) of Title 42 of the United States Code (Welfare & Institutions Code 14184.402 (e)).

1.2 Certification of Eligibility. Contractor will, in cooperation with County, comply with 42 C.F.R. § 455.1(a)(2) and BHIN 24-001, to obtain a certification of a client's eligibility for SUD services under Medi-Cal.

1.2 Contractor shall possess and maintain all necessary licenses, permits, certificates and credentials required by the laws of the United States, the State of California, County of Lake and all other appropriate governmental agencies, including any certification and credentials required by County. Failure to maintain the licenses, permits, certificates, and credentials shall be deemed a breach of this Agreement and constitutes grounds for the termination of this Agreement by County. Contractor and County shall comply with California Code of Regulations (CCR), Title 9, Section 1810.435, in the selection of providers and shall review for continued compliance with standards at least every three (3) years.

1.3 Contractor will observe and comply with all applicable Federal, State and local laws, ordinances and codes which relate to the services to be provided pursuant to this Agreement, including but not limited to the Deficit Reduction Act (DRA) of 2005, the Federal and State False Claims Acts, and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and the Health Information Technology for Economic and Clinical Health Act, found in Title XIII of the American Recovery and Reinvestment Act of 2009, Public Law 111-005 (HITECH Act); and the HIPAA Omnibus Final Rule.

1.4 All expenses of copying records and other documents shall be borne by the party seeking to review those records and/or documents and charged at the rate of $0.25 cents per page.

1.5 Contractor is to make voter registration materials available in their offices/facilities and assist individuals in completing materials if requested.

1.6 Contractor shall comply with the Dymally-Alatorre Bilingual Services Act of 1973, Gov. Code §§ 7290 – 7298 and provision of the County's Cultural Competency Plan by maintaining 100% compliance with National Culturally Linguistically Appropriate Services (CLAS) standards. Contractor shall provide proof, no less than annually or upon County's request, evidence of compliance including but not limited to attendance and training agendas, or other such documentation which reasonably evidences compliance.

1.7 Contractor shall ensure that the logo for Lake County Behavioral Health Services (LCBHS) is included on flyers, handouts, and any advertising materials for any projects or events that LCBHS contributes to via funding from this Agreement.

1.8 Contractor will notify the County about any change that may affect Contractor's eligibility and ability to provide services including, but not limited to, changes in licensing, certification, ownership, and address.

2. <u>RECORDS RETENTION</u>.

2.1 Contractor shall prepare, maintain and/or make available to County upon request, all records and documentation pertaining to this Agreement, including financial, statistical, property, recipient and service records and supporting documentation for a period of ten (10) years from the date of final payment of this Agreement. If at the end of the retention period, there is ongoing litigation or an outstanding audit involving the records, Contractor shall retain the records until resolution of litigation or audit. After the retention period has expired, Contractor assures that confidential records shall be shredded and disposed of appropriately.

2.2 To the extent permitted by law, clinical records of each client served at the Facility and for whom the County makes payment to Contractor hereinunder, shall be the property of County and shall be kept at least ten (10) years following discharge. Clinical records of un-emancipated minors shall be kept at least one (1) year after such minor has reached the age of eighteen (18) years or ten (10) years past the last date of treatment, whichever is longer. Records of minors who have been treated by a licensed psychologist must be retained until minor has reached age 25. All information and records obtained in the course of providing services under this Agreement shall be confidential and Contractor shall comply with State and Federal requirements regarding confidentiality of patient information (including but not limited to section 5328 of the Welfare and Institutions Code (W&I), and Title 45, and CFR, section 205.50 for Medi-Cal-eligible patients). All applicable regulations and statutes relating to patients' rights shall be adhered to. This provision shall survive the termination, expiration, or cancellation of this Agreement. Clinical records shall contain sufficient detail to make possible an evaluation by County's Behavioral Health Director or designee, or DHCS and shall be kept in accordance with the rules and regulations of the Community Mental Health Services Act of 1967 (MHSA), as amended.

3. SERVICES AND ACCESS PROVISIONS

3.1 **Certification of Eligibility**. Contractor will, in cooperation with County, comply with 42 C.F.R. § 455.1(a)(2) and BHIN 24-001, to obtain a certification of a client's eligibility for SUD services under Medi-Cal.

3.2 **Access to Substance Use Disorder Services**.

a. In collaboration with the County, Contractor will work to ensure that individuals to whom the Contractor provides SUD services meet access criteria and medical necessity requirements, as per DHCS guidance specified in BHIN 24-001. Specifically, the Contractor will ensure that the clinical record for each client includes information as a whole indicating that client's presentation and needs are aligned with the criteria applicable to their age at the time of service provision as specified below.

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

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

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

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

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

g. Contractor shall comply with beneficiaries' access criteria and services provided during the initial assessment process requirements:

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

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

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

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

h. Contractor shall comply with beneficiaries' access criteria <u>after initial assessment</u> requirements:

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

1) Have at least one diagnosis from the most current edition of the Diagnostic and Statistical Manual (DSM) of Mental Disorders for Substance-Related and Addictive Disorders, except for Tobacco-Related Disorders and Non-Substance-Related Disorders, OR

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

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

1) All services that are Medi-Cal-coverable, appropriate, and medically necessary, needed to correct and ameliorate health conditions shall be provided, as per federal Early & Periodic Screening, Diagnostic and Treatment (EPSDT) statutes and regulations.

2) Services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and SUDs, consistent with federal guidance.

3) Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

3.3 **ASAM Level of Care Determination**

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

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

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

d. A full ASAM Criteria assessment, or brief screening ASAM Criteria tool for preliminary LOC recommendations, shall not be required to begin receiving DMC-ODS services.
e. A full ASAM Criteria assessment does not need to be repeated unless the client's condition changes.

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

3.4 **Medical Necessity**

a. Pursuant to BHIN 24-001 and consistent with Welfare & Institutions Code § 14059.5, DMC-ODS services must be medically necessary.

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

c. For beneficiaries under the age of 21, a service is "medically necessary" or a "medical necessity" if the service is necessary to correct or ameliorate screened health conditions. Consistent with federal guidance, services need not be curative or completely restorative

to ameliorate a health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

3.5 **Additional Coverage Requirements and Clarifications**

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

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

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

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

d. All Medi-Cal claims shall include a current CMS approved International Classification of Diseases (ICD) diagnosis code. In cases where services are provided due to a suspected SUD that has not yet been diagnosed, options are available in the CMS approved ICD-10 code list, for example, codes for “Other specified” and “Unspecified” disorders, or “Factors influencing health status and contact with health services.”

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

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

g. Treatment plans are required by federal law for:
    i. Narcotic Treatment Programs (NTPs)
    ii. Peer Support Services
    iii. The beneficiary has a co-occurring mental health condition.

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

3.6 **Diagnosis During Initial Assessment**

a. Contractor may use the following options during the assessment phase of client's treatment when a diagnosis has yet to be established as specified in BHIN 22-013:
   i. ICD-10 codes Z55-Z65 Potential health hazards related to socioeconomic and psychological circumstances: may be used by all providers as appropriate during the assessment period prior to diagnosis and do not require certification as, or supervision, of, an LPHA.
   ii. ICD-10 code Z03.89 Encounter for observation for other suspected diseases and conditions ruled out: may be used by an LPHA during the assessment phase of a client's treatment when a diagnosis has yet to be established.
   iii. CMS approved diagnosis code on the ICD 10 tabular, available in the CMS 2022 ICD-10-CM page at: https://www.cms.gov/medicare/icd-10/2022-icd-10-cm, which may include Z codes. LPHAs may use any clinically appropriate ICD-10 code, for example, codes for "Other specified" and "Unspecified" disorders, or "Factors influencing health status and contact with health services."

3.7 **Coordination and Continuity of Care**

a. Contractor shall comply with the care and coordination requirements established by the County and per 42 C.F.R. § 438.208.

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

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

   ii. All services provided to clients shall be coordinated:

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

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

3) With the services the client receives in FFS Medi-Cal.

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

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

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

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

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

d. To facilitate care coordination, Contractor will request a HIPPA and California law compliant client authorization to share client information with and among all other providers involved in the client's care, in satisfaction of state, and federal privacy laws and regulations.

3.8 **Site Licenses, Certifications, Permits Requirements**

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

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

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

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

3.9 **Medications**

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

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

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

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

3.10 **Alcohol and/or Drug-Free Environment**

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

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

3.11 **Assessment of Tobacco Use Disorder**

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

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

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

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

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

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

3.12 **Naloxone Requirements**

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

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

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

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

4. <u>DESCRIPTION OF SERVICES</u>. Archway Recovery Services Inc. provides Withdrawal Management and ASAM Level 3.1/3.5 services and is licensed and certified by the California State Department of Health Care Services.

4.1 These services shall be provided pursuant to the laws and regulations of the State of California governing such programs. These services shall be provided at Contractor's facility, hereinafter called "**Facility**", and located at the following addresses **1095 E.**

4.2 Contractor shall have hours of operation during which services are provided to Medi-Cal beneficiaries that are no less than the hours of operation during which the Contractor offers services to non-Medi-Cal beneficiaries.

4.3 Contractor shall provide the following medically necessary covered SUD services, as defined in the Drug Medi-Cal Billing Manual available in the DHCS County Claims Customer Services Library page at https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx, or subsequent updates to this billing manual, to clients who meet access criteria for receiving SUD services. Contractor shall observe and comply with all lockout and non-reimbursable service rules, as outlined in the Drug Medi-Cal Billing Manual. Current Procedural Terminology (CPT) Codes for use by Contractor:

ASAM / Service Level	CPT Code Name	CPT Code
ASAM Level 3.1, 3.3, 3.5 (Non-Perinatal and Perinatal)	Interactive Complexity	90785
	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	99368
	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician. Patient and/or Family not Present. 30 Minutes or More	99367
	Medication Training and Support, per 15 Minutes	H0034
	Multiple-Family Group Psychotherapy, 15 Minutes	90849
	Office or Other Outpatient Visit of a New patient, 30- 44 Minutes	99203
	Office or Other Outpatient Visit of a New Patient, 45- 59 Minutes	99204
	Office or Other Outpatient Visit of a New Patient, 60- 74 Minutes	99205

	Office or Other Outpatient Visit of an Established Patient, 10-19 Minutes	99212
	Office or Other Outpatient Visit of an Established Patient, 20-29 Minutes	99213
	Office or Other Outpatient Visit of an Established Patient, 30-39 Minutes	99214
	Office or Other Outpatient Visit of an Established Patient, 40-54 Minutes	99215
	Office or Other Outpatient Visit of New Patient, 15-29 Minutes	99202
	Oral Medication Administration, Direct Observation, 15 Minutes	H0033
	Prolonged Office or Other Outpatient Evaluation and Management Service(s) beyond the Maximum Time; Each Additional 15 Minutes	G2212
	Psychiatric Diagnostic Evaluation with Medical Services, 15 Minutes	90792
	Psychiatric Diagnostic Evaluation, 15 Minutes	90791
	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests, and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	90885
	Psychological Testing Evaluation, Each Additional Hour	96131
	Psychological Testing Evaluation, First Hour	96130
	Psychosocial Rehabilitation, per 15 Minutes	H2017
	Sign Language or Oral Interpretive Services, 15 Minutes	T1013
	Targeted Case Management, Each 15 Minutes	T1017
	Family Psychotherapy (Without the Patient Present), 26-50 minutes	90846
	Family Psychotherapy (Conjoint psychotherapy with Patient Present), 26-50 minutes	90847
	Nacrosynthesis for Psychiatric Diagnostic and Therapeutic Purposes, 15 Minutes	90865
	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.	90882
	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	90887
	Preparation of report of patient’s psychiatric status, history, treatment, or progress (other than for legal or consultative	90889

	purpose) for other individuals, agencies, or insurance carries.	
	Administration of patient-focused health risk assessment instrument. (Note: Applicable to ASAM Level 3.1 Only)	96160
	Health behavior intervention, family (without the patient present), face-to-face. 16-30 minutes	96170
	Health behavior intervention, family (without the patient present), face-to-face. Each additional 15 minutes.	96171
	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Problem(s) requiring Admission are of Low Severity, 16- 29 Minutes	99304
	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Problem(s) Requiring Admission are of Moderate Severity, 30-39 Minutes	99305
	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Problem(s) Requiring Admission are of High Severity, 40- 60 Minutes	99306
	Subsequent Nursing Facility Care per Day for the Evaluation and Management of a Patient. Usually, the Patient is Stable, Recovering or Improving, 1-12 Minutes	99307
	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Patient is Responding Inadequately to Therapy or Has Developed a Minor Complication, 13- 19 Minutes	99308
	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Patient has Developed a Significant Complication or a Significant New Problem, 20-29 Minutes	99309
	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. The Patient May Be Unstable or May Have Developed a Significant New Problem Requiring Immediate Physician Attention, 30-40 Minutes	99310
	Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT, DAST), and brief intervention (SBI) services. 15-30 minutes.	99408
	Alcohol and/or substance (other than tobacco) abuse structural screening (e.g., AUDIT, DAST), and brief intervention (SBI) services. Greater than 30 minutes.	99409
	Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days.	99495

	Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 7 calendar days.	99496
	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0396
	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0397
	Alcohol and/or substance (other than tobacco) abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G2011
	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	H0001
	Alcohol and/or drug screening. Laboratory analysis	H0003
	Behavioral health counseling and therapy, 15 minutes.	H0004
	Alcohol and/or drug services; group counseling by a clinician, 15 minutes.	H0005
	Alcohol and/or drug services; crisis intervention (outpatient),	H0007
	Behavioral Health; Long Term Residential	H0019
	Alcohol and/or other drug testing. (Note: Use this code to submit claims for point of care tests)	H0048
	Alcohol and/or drug screening	H0049
	Prenatal Care, at risk assessment.	H1000
	Crisis Intervention Services, per 15 minutes (Use code to submit claims for Mobile Crisis Services)	H2011
	Skills training and development, per 15 minutes. (Use this code to submit claims for Patient Education Services).	H2014
	Comprehensive community support services, per 15 minutes	H2015
	Community-Based Wrap-Around Services, per 15 Minutes	H2021
	Psychoeducational Service, per 15 minutes	H2027
	Alcohol and/or other drug treatment program, Per Hour Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.	H2035
	Alcohol and/or substance abuse services, family/couple counseling	T1006
	Alcohol and/or substance abuse services, treatment plan development and/or modification.	T1007

Peer Support Services	Behavioral Health Prevention Education service, delivery of service with target population to affect knowledge, attitude, and/or behavior.	H0025
	Self-help/peer services, per 15 minutes	H0038
Withdrawal Management (WM) Level 1	Interactive Complexity	90785
	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	99368
	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician. Patient and/or Family not Present. 30 Minutes or More	99367
	Medication Training and Support, per 15 Minutes	H0034
	Office or Other Outpatient Visit of a New patient, 30- 44 Minutes	99203
	Office or Other Outpatient Visit of a New Patient, 45- 59 Minutes	99204
	Office or Other Outpatient Visit of a New Patient, 60- 74 Minutes	99205
	Office or Other Outpatient Visit of an Established Patient, 10-19 Minutes	99212
	Office or Other Outpatient Visit of an Established Patient, 20-29 Minutes	99213
	Office or Other Outpatient Visit of an Established Patient, 30-39 Minutes	99214
	Office or Other Outpatient Visit of an Established Patient, 40-54 Minutes	99215
	Office or Other Outpatient Visit of New Patient, 15-29 Minutes	99202
	Oral Medication Administration, Direct Observation, 15 Minutes	H0033
	Prolonged Office or Other Outpatient Evaluation and Management Service(s) beyond the Maximum Time; Each Additional 15 Minutes	G2212
	Psychiatric Diagnostic Evaluation with Medical Services, 15 Minutes	90792
	Psychiatric Diagnostic Evaluation, 15 Minutes	90791
	Psychiatric Evaluation of Hospital Records, Other Psychiatric Reports, Psychometric and/or Projective Tests,	90885

	and Other Accumulated Data for Medical Diagnostic Purposes, 15 Minutes	
	Psychological Testing Evaluation, Each Additional Hour	96131
	Psychological Testing Evaluation, First Hour	96130
	Psychosocial Rehabilitation, per 15 Minutes	H2017
	Sign Language or Oral Interpretive Services, 15 Minutes	T1013
	Targeted Case Management, Each 15 Minutes	T1017
	Telephone Evaluation and Management Service, 11-20 Minutes	99442
	Telephone Evaluation and Management Service, 21-30 Minutes	99443
	Telephone Evaluation and Management Service, 5-10 Minutes	99441
	Nacrosynthesis for Psychiatric Diagnostic and Therapeutic Purposes, 15 Minutes	90865
	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions.	90882
	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	90887
	Preparation of report of patient’s psychiatric status, history, treatment, or progress (other than for legal or consultative purpose) for other individuals, agencies, or insurance carries.	90889
	Administration of patient-focused health risk assessment instrument.	96160
	Health behavior intervention, family (without the patient present), face-to-face. 16-30 minutes	96170
	Health behavior intervention, family (without the patient present), face-to-face. Each additional 15 minutes.	96171
	Telephone Assessment and Management Service, 5-10 Minutes	98966
	Telephone Assessment and Management Service, 11-20 Minutes	98967
	Telephone Assessment and Management Service, 21-30 Minutes	98968
	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Problem(s) requiring Admission are of Low Severity, 16- 29 Minutes	99304

	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Problem(s) Requiring Admission are of Moderate Severity, 30-39 Minutes	99305
	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Problem(s) Requiring Admission are of High Severity, 40- 60 Minutes	99306
	Subsequent Nursing Facility Care per Day for the Evaluation and Management of a Patient. Usually, the Patient is Stable, Recovering or Improving, 1-12 Minutes	99307
	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Patient is Responding Inadequately to Therapy or Has Developed a Minor Complication, 13- 19 Minutes	99308
	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. Usually, the Patient has Developed a Significant Complication or a Significant New Problem, 20-29 Minutes	99309
	Initial Nursing Facility Care per Day, for the Evaluation and Management of a Patient. The Patient May Be Unstable or May Have Developed a Significant New Problem Requiring Immediate Physician Attention, 30-40 Minutes	99310
	Domiciliary or Rest Home Visit of a New Patient, 15- 25 Minutes	99324
	Domiciliary or Rest Home Visit of a New Patient, 26-35 Minutes	99325
	Domiciliary or Rest Home Visit of a New Patient, 36-50 Minutes	99326
	Domiciliary or Rest Home Visit of a New Patient, 51-65 Minutes	99327
	Domiciliary or Rest Home Visit of a New Patient, 66-80 Minutes	99328
	Domiciliary or Rest Home Visit of an Established Patient, 10-20 Minutes	99334
	Domiciliary or Rest Home Visit of an Established Patient, 21-35 Minutes	99335
	Domiciliary or Rest Home Visit of an Established Patient, 36-50 Minutes	99336
	Domiciliary or Rest Home Visit of an Established Patient, 51-70 Minutes	99337
	Individual physician supervisory of a patient (patient not present) in home, 15 – 29 minutes	99339
	Individual physician supervisory of a patient (patient not present) in home. Each additional 30 minutes	99340

	Home Visit of a New Patient, 15-25 Minutes	99341
	Home Visit of a New Patient, 26-35 Minutes	99342
	Home Visit of a New Patient, 36-50 Minutes	99343
	Home Visit of a New Patient, 51-65 Minutes	99344
	Home Visit of a New Patient, 66-80 Minutes	99345
	Home Visit of an Established Patient, 10-20 Minutes	99347
	Home Visit of an Established Patient, 21-35 Minutes	99348
	Home Visit of an Established Patient, 36-50 Minutes	99349
	Home Visit of an Established Patient, 51-70 Minutes	99350
	Inter-Professional Telephone/Internet/ Electronic Health Record Assessment Provided by a Consultative Physician, 5-15 Minutes	99451
	Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 14 calendar days.	99495
	Transitional Care Management Services: Communication (direct contact, telephone, electronic) within 7 calendar days.	99496
	Alcohol and/or substance (other than tobacco) abuse structured assessment. 15-30 Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0396
	Alcohol and/or substance (other than tobacco) abuse structured assessment. 30+ Minutes. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G0397
	Alcohol and/or substance (other than tobacco) abuse structured assessment 5 -14 Min. (Note: Use codes G2011, G0396, and G0397 to determine the ASAM Criteria).	G2011
	Alcohol and/or drug assessment. (Note: Use this code for screening to determine the appropriate delivery system for beneficiaries seeking services)	H0001
	Alcohol and/or drug screening. Laboratory analysis	H0003
	Alcohol and/or drug services; ambulatory detoxification	H0014
	Alcohol and/or other drug testing. (Note: Use this code to submit claims for point of care tests)	H0048
	Alcohol and/or drug screening	H0049
	Prenatal Care, at risk assessment.	H1000
	Skills training and development, per 15 minutes. (Use this code to submit claims for Patient Education Services).	H2014
	Comprehensive community support services, per 15 minutes	H2015

	Community-Based Wrap-Around Services, per 15 Minutes	H2021
	Psychoeducational Service, per 15 minutes	H2027
	Alcohol and/or other drug treatment program, Per Hour Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.	H2035
	Alcohol and/or substance abuse services, treatment plan development and/or modification.	T1007
Withdrawal Management (WM) Level 2	Interactive Complexity	90785
	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Non- Physician. Patient and/or Family Not Present. 30 Minutes or More	99368
	Medical Team Conference with Interdisciplinary Team of Health Care Professionals, Participation by Physician. Patient and/or Family not Present. 30 Minutes or More	99367
	Medication Training and Support, per 15 Minutes	H0034
	Office or Other Outpatient Visit of a New patient, 30- 44 Minutes	99203
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	Psychological Testing Evaluation, Each Additional Hour	96131
	Psychological Testing Evaluation, First Hour	96130
	Psychosocial Rehabilitation, per 15 Minutes	H2017
	Sign Language or Oral Interpretive Services, 15 Minutes	T1013
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	Interpretation or Explanation of Results of Psychiatric or Other Medical Procedures to Family or Other Responsible Persons, 15 Minutes	90887
	Preparation of report of patient’s psychiatric status, history, treatment, or progress (other than for legal or consultative purpose) for other individuals, agencies, or insurance carries.	90889
	Administration of patient-focused health risk assessment instrument.	96160
	Health behavior intervention, family (without the patient present), face-to-face. 16-30 minutes	96170
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	Alcohol and/or drug services; ambulatory detoxification	H0014
	Alcohol and/or other drug testing. (Note: Use this code to submit claims for point of care tests)	H0048
	Alcohol and/or drug screening	H0049
	Prenatal Care, at risk assessment.	H1000
	Skills training and development, per 15 minutes. (Use this code to submit claims for Patient Education Services).	H2014
	Comprehensive community support services, per 15 minutes	H2015

	Community-Based Wrap-Around Services, per 15 Minutes	H2021
	Psychoeducational Service, per 15 minutes	H2027
	Alcohol and/or other drug treatment program, Per Hour Except with modifiers 59, XE, XP, or XU. Modifiers have to be on the target or excluded service.	H2035
	Alcohol and/or substance abuse services, treatment plan development and/or modification.	T1007

5. AUTHORIZATIONS AND DOCUMENTATION PROVISIONS.

5.1 SERVICE AUTHORIZATION

a. Contractor will collaborate with County to complete authorization requests in line with County and DHCS policy.
b. Contractor shall respond to County in a timely manner when consultation is necessary for County to make appropriate authorization determinations.
c. County shall provide Contractor with written notice of authorization determinations within the timeframes set forth in BHIN 24-001, or any subsequent DHCS notices.
d. For SUD Non-Residential and Non-Inpatient Levels of Care service authorization:
    i. Contractor shall follow County's policies and procedures around non-residential/non-inpatient levels of care according to BHIN 24-001.
    ii. Contractor is not required to obtain service authorization for non-residential/non-inpatient levels of care. Prior authorization is prohibited for non-residential DMC-ODS services.
e. For SUD Residential and Inpatient Levels of Care service authorization:
    i. Contractor shall have in place, and follow, County written authorization policies and procedures for processing requests for initial and continuing authorization, or prior authorization, for residential treatment services, including inpatient services, but excluding withdrawal management services.
    ii. County will review the DSM and ASAM Criteria to ensure that the beneficiary meets the requirements for service.
    iii. Prior authorization for residential and inpatient services (excluding withdrawal management services) shall be made within 24 hours of the prior authorization request being submitted by the provider.
        a. County will ensure that prior authorization processes are completed in a manner that assures the provision of a covered SUD service to a client in a timely manner appropriate for the client's condition.
    iv. Contractor shall alert County when an expediated service authorization decision is necessary due to a client's specific needs and circumstances that could seriously jeopardize the client's life or health, or ability to attain, maintain, or regain maximum function. Expediated service authorizations shall not exceed 72 hours after receipt of the request for service, with a possible extension of up to 14 calendar days if the client or provider requests an extension.
    v. Contractor shall alert County when a standard authorization decision is necessary. Standard service authorizations shall not exceed 14 calendar days following receipt of the request for service, with a possible extension of up to 14 additional calendar days if the client or provider requests an extension.
f. Contractor, if applicable, shall ensure that length of stay (LOS) in residential program complies with the following:
    i. LOS shall be determined by individualized clinical need (statewide LOS goal is 30 days). LOS for clients shall be determined by an LPHA and authorized by the County as medically necessary.

ii. Clients receiving residential treatment must be transitioned to another LOC when clinically appropriate based on treatment progress.
iii. Perinatal clients may receive a longer LOS than those described above, if determined to be medically necessary.
iv. Nothing in this section overrides any EPSDT requirements. EPSDT clients may receive a longer length of stay based on medical necessity.

5.2 DOCUMENTATION REQUIREMENTS

a. Contractor agrees to comply with documentation requirements for non-hospital services as specified in Article 5.2-5.9 inclusive in compliance with federal, state and County requirements.
b. All Contractor documentation shall be accurate, complete, legible, and shall list each date of service. Contractor shall document the face-to-face duration of the service, including travel and documentation time for each service. Services must be identified as provided in-person, by telephone, or by telehealth.
c. All services shall be documented utilizing County-approved templates and contain all required elements. Contractor agrees to satisfy the chart documentation requirements set forth in BHIN 22-019 and the contract between County and DHCS. Failure to comply with documentation standards specified in this Article require corrective action plans.

5.3 ASSESSMENT

a. Contractor shall use the American Society of Addiction Medicine (ASAM) Criteria assessment for DMC-ODS clients to determine the appropriate level of SUD care.
b. The assessment shall include a typed or legibly printed name, signature of the service provider and date of signature. Assessment shall include the provider's LOC determination and recommendation for services. If the assessment of the client is completed by a registered or certified counselor, then the LPHA shall evaluate that assessment with the counselor and the LPHA shall make the initial diagnosis. The consultation between the LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.
c. The problem list and progress note requirements shall support the medically necessary services or medical necessity of each service provided.
d. Assessments shall be updated as clinically appropriate when the beneficiary's condition changes. Additional information on assessment requirements can be found in Article 3 Section 2 Access to Substance Use Disorder Services or BHIN 24-001.

5.4 ICD-10

a. Contractor shall use the criteria set forth in the current edition of the DSM as the clinical tool to make diagnostic determinations.
b. Once a DSM diagnosis is determined, the Contractor shall determine the corresponding diagnosis in the current edition of ICD. Contractor shall use the ICD diagnosis code(s) to submit a claim for SUD services to receive reimbursement from County.

c. Under the EPSDT mandate, for youth under the age of 21, a diagnosis from the ICD-10 for Substance-Related and Addictive Disorders is not required for early intervention services.
d. The ICD Tabular List of Diseases and Injuries is maintained by CMS and may be updated during the term of this Agreement. Changes to the lists of ICD diagnoses do not require an amendment to this Agreement, and County may implement these changes as provided by DHCS.

5.5. PROBLEM LIST

a. Contractor will create and maintain a Problem List for each client served under this Agreement. The problem list is a list of symptoms, conditions, diagnoses, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.
b. Contractor must document a problem list that adheres to industry standards utilizing at minimum SNOMED International, Systematized Nomenclature of Medicine Clinical Terms (SNOMED CT®) U.S. Edition, March 2021 Release, and ICD-10-CM 2023.
c. A problem identified during a service encounter may be addressed by the service provider (within their scope of practice) during that service encounter and subsequently added to the problem list.
d. The problem list shall be updated on an ongoing basis to reflect the current presentation of the client.
e. The problem list shall include, but is not limited to the following:
    i. Diagnoses identified by a provider acting within their scope of practice, if any. Diagnosis-specific specifiers from the current DSM shall be included with the diagnosis, when applicable.
    ii. Problems identified by a provider acting within their scope of practice, if any.
    iii. Problems or illnesses identified by the client and/or significant support person, if any.
    iv. The name and title of the provider that identified, added, or removed the problem, and the date the problem was identified, added, or removed.
    v. Contractor shall add to or remove problems from the problem list when there is a relevant change to a beneficiary's condition.
f. County does not require the problem list to be updated within a specific timeframe or have a requirement about how frequently the problem list should be updated after a problem has initially been added. However, Contractor shall update the problem list within a reasonable time such that the problem list reflects the current issues facing the client, in accordance with generally accepted standards of practice and in specific circumstances specified in BHIN 22-019.

5.6 PROGRESS NOTES

a. Contractor shall create progress notes for the provision of all DMC-ODS services provided under this Agreement.

b. Each progress note shall provide sufficient detail to support the service code selected for the service type as indicated by the service code description.
c. Progress notes shall include all elements specified in BHIN 22-019, whether the note be for an individual or group service, and shall include:
    i. The type of service rendered
    ii. A narrative describing the service, including how the service addressed the client's behavioral health need (e.g., symptom, condition, diagnosis, and/or risk factors)
    iii. The date that the service was provided to the beneficiary
    iv. Duration of the service, including travel and documentation time
    v. Location of the client at the time of receiving the service
    vi. A typed or legibly printed name, signature of the service provider and date of signature
    vii. ICD-10 code
    viii. Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) code
    ix. Next steps, including, but not limited to, planned action steps by the provider or by the client, collaboration with the client, collaboration with other provider(s) and any update to the problem list as appropriate.
d. Contractor shall complete progress notes within three business days of providing a service, with the exception of notes for crisis services, which shall be completed within 24 hours.
e. Contractor shall complete a daily progress note for services that are billed on a daily basis, such as residential and inpatient services, if applicable.
f. When a group service is rendered by the Contractor, the following conditions shall be met:
g. A list of participants is required to be documented and maintained by the Contractor.
h. If more than one provider renders a group service, one progress note may be completed for a group session and signed by one provider. Contractor shall ensure that in this case, the progress note clearly documents the specific involvement and the specific amount of time of involvement of each provider during the group activity, including documentation time.

5.7 PLAN OF CARE

a. As specified in BHIN 22-019, when a plan of care is required, Contractor shall follow the DHCS requirements outlined in the Alcohol and/or Other Drug Program Certification Standards document, available in the DHCS Facility Certification page at: https://www.dhcs.ca.gov/provgovpart/Pages/Licensing-and-Certification-Facility-Certification.aspx
b. Contractor shall develop plans of care for all clients when required. Plans of care shall include the following:
    i. Statement of problems experienced by the client to be addressed.
    ii. Statement of objectives to be reached that address each problem.

iii. Statement of actions that will be taken by the program and/or client to accomplish the identified objectives.
iv. Target date(s) for accomplishment of actions and objectives.

c. Contractor shall develop the plan of care with participation from the client in accordance with the timeframes specified below:
   i. For outpatient programs, the plan of care shall be developed within 30 calendar days from the date of the client's admission. The client's progress shall be reviewed and documented within 30 calendar days after signing the plan of care and not later than every 30 calendar days thereafter.
   ii. For residential programs, the plan of care shall be developed within 10 calendar days from the date of the client's admission.
   iii. An LPHA, registered or certified counselor shall ensure and document, together with the client, that the plan of care is reviewed and updated, when a change in problem identification or focus of treatment occurs, or no later than 90 calendar days after signing the plan of care and no later than every 90 calendar days thereafter, whichever comes first.
d. Contractor is not required to complete a plan of care for clients under this Agreement, except in the below circumstances:
   i. Peer Support Services require a specific care plan based on an approved Plan of Care. The plan of care shall be documented within the progress notes in the client's clinical record and approved by any treating provider who can render reimbursable Medi-Cal services.
   ii. Narcotic Treatment Programs (NTP) are required to create a plan of care for clients as per federal law. This requirement is not impacted by the documentation requirements in BHIN 22-019. NTPs shall continue to comply with federal and state regulations regarding plans of care and documentation requirements.

5.8 TELEHEALTH

a. Contractor may use telehealth, when it deems clinically appropriate, as a mode of delivering behavioral health services in accordance with all applicable County, state, and federal requirements, including those related to privacy/security, efficiency, and standards of care. Such services will conform to the definitions and meet the requirements included in the Medi-Cal Provider Manual: Telehealth, available in the DHCS Telehealth Resources page at: https://www.dhcs.ca.gov/provgovpart/Pages/TelehealthResources.aspx.
b. All telehealth equipment and service locations must ensure that client confidentiality is maintained.
c. Licensed providers and staff may provide services via telephone and telehealth as long as the service is within their scope of practice.
d. Medical records for clients served by Contractor under this Agreement must include documentation of written or verbal consent for telehealth or telephone services if such services are provided by Contractor. Such consent must be obtained at least once prior to

initiating applicable health care services and consent must include all elements as specified in BHIN 22-019.

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

5.9 DISCHARGE PLANNING

a. Contractor shall have written policies and procedures or shall adopt the County's policies and procedures regarding discharge. These procedures shall contain the following:
   i. Written criteria for discharge defining:
   ii. Successful completion of program;
   iii. Administrative discharge;
   iv. Involuntary discharge;
   v. Transfers and referrals.
   vi. A discharge summary that includes:
   vii. Reason for discharge, including whether the discharge was voluntary or involuntary and whether the client successfully completed the program;
   viii. Description of treatment episodes;
   ix. Description of recovery services completed;
   x. Current alcohol and/or other drug usage;
   xi. Vocational and educational achievements;
   xii. Client's continuing recovery or discharge plan signed by an LPHA, or registered or certified counselor and client;
   xiii. Transfers and referrals; and
   xiv. Client's comments.

6. <u>MINIMUM QUALITY TREATMENT STANDARDS</u>. Compliance with the following Minimum Quality Treatment Standards is required for all SUD treatment programs (contractors and sub-contractors) either partially or fully funded by Substance Abuse and Prevention Treatment Block Grant (SABG).

6.1 **PERSONNEL POLICIES**

1. 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 program 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 orders and treatment.

h. Current registration, certification intern status, or licensure.
i. Proof of continuing education required by licensing or certifying agency and program and Program Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying/licensing body's code of conduct as well.

2. Job descriptions shall be developed, revised as needed, and approved by the Program's governing body. The job descriptions shall include:
   a. Position title and classification.
   b. Duties and responsibilities.
   c. Lines of supervision.
   d. Education, training, work experience, and other qualifications for the position.

3. Written code of conduct for employees and volunteers/interns shall be established which address at least the following:
   a. Use of drugs and/or alcohol.
   b. Prohibition of social/business relationship with clients or their family members for personal gain.
   c. Prohibition of sexual contact with clients.
   d. Conflict of interest.
   e. Providing services beyond scope.
   f. Discrimination against clients or staff.
   g. Verbally, physically, or sexually harassing, threatening, or abusing clients, family members or other staff.
   h. Protection of client confidentiality.
   i. The elements found in the code of conduct for the certifying organization(s) the program's counselors are certified under; and
   j. Cooperation with complaint investigations.

4. If a program utilizes the services of volunteers and/or interns, procedures shall be implemented which address:
   a. Recruitment.
   b. Screening.
   c. Selection.
   d. Training and orientation.
   e. Duties and assignments.
   f. Scope of practice.
   g. Supervision.
   h. Evaluation; and
   i. Protection of client confidentiality.

5. Written roles and responsibilities and a code of conduct for the medical director (if applicable) shall be clearly documented, signed and dated by an authorized program representative and the medical director.

6.2 PROGRAM MANAGEMENT

1. Admission or Readmission
    a. Each program shall include in its policies and procedures written admission and readmission criteria for determining client's eligibility and suitability for treatment. These criteria shall include, at minimum:
        i. Use of alcohol/drugs of abuse.
        ii. Physical health status; and
        iii. Documentation of social and psychological problems.
    b. If a potential client does not meet the admission criteria, the client shall be referred to an appropriate service provider.
    c. If a client is admitted to treatment, a consent to treatment form shall be signed by the client.
    d. All referrals made by the program shall be documented in the client record.
    e. Copies of the following documents shall be provided to the client upon admission: Client rights, client fee policies, and consent to treatment.
    f. Copies of the following shall be provided to the client or posted in a prominent place accessible to all clients:
        i. A Statement of nondiscrimination by sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation or ability to pay.
        ii. Grievance procedures.
        iii. Appeal process for involuntary discharge; and
        iv. Program rules, expectations, and regulations.
    g. Where drug screening by urinalysis is deemed appropriate the program shall:
        i. Establish procedures which protect again the falsification and/or contamination of any urine sample; and
        ii. Document urinalysis results in the client's file.
2. Treatment
    a. Assessment for all clients shall include:
        i. Drug/Alcohol use history.
        ii. Medical history.
        iii. Family history.
        iv. Psychiatric history.

v. Social/recreational history.
vi. Financial status/history.
vii. Educational history.
viii. Employment history.
ix. Criminal history, legal status, and
x. Previous SUD treatment history.

b. Treatment plans shall be developed with the client within 30 days of admission and include:
   i. A problem statement for all problems identified through the assessment whether addressed or deferred.
   ii. Goals to address each problem statement (except when deferred).
   iii. Action steps to meet the goals that include who is responsible for the action and the target date for completion; and
   iv. Signature of primary counselor and client.
c. All treatment plans shall be reviewed periodically and updated to accurately reflect the client's progress or lack of progress in treatment.
d. Progress notes shall document the client's progress toward completion of activities and achievement of goals on the treatment plan.
e. Discharge documentation shall be developed with the client, if possible and include:
   i. Description of the treatment episode.
   ii. Prognosis.
   iii. Client's plan for continued recovery including support systems and plans for relapse prevention.
   iv. Reason and type of discharge.
   v. Signature of primary counselor and client; and
   vi. A copy of the discharge documentation shall be given to the client.

7. DISCHARGE CRITERIA AND PROCESS

7.1 Contractor will engage in discharge planning beginning at intake for each client served under this Agreement. Discharge planning will include regular reassessment of client functioning, attainment of goals, determination of treatment needs and establishment of discharge goals.

7.2 When possible, discharge will include treatment at a lower LOC or intensity appropriate to client's needs and provision of additional referrals to community resources for client to utilize after discharge.

8. CONTRACT DELIVERABLES, OBJECTIVES AND OUTCOMES

8.1 Contractor shall comply with all requests regarding local, state, and federal performance outcomes measurement requirements and participate in the outcomes measurement processes as requested.

8.2 Contractor shall work collaboratively with County to develop process benchmarks and monitor progress in the following areas:

8.3 Contractor will collaborate with the County in the collection and reporting of performance outcomes data, including data relevant to Healthcare Effectiveness Data and Information Set (HEDIS®) measures, as required by DHCS. Measures relevant to this Agreement include:

a. Follow up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA)
b. Use of Pharmacotherapy for Opioid Use Disorder (POD)
c. Pharmacotherapy of Opioid Use Disorder
d. Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

9. REPORTING AND EVALUATION REQUIREMENTS

9.1 Contractor shall complete all reporting and evaluation activities as required by the County and described herein.

10. ORIENTATION, TRAINING AND TECHNICAL ASSISTANCE

10.1 County will endeavor to provide Contractor with training and support in the skills and competencies to (a) conduct, participate in, and sustain the performance levels called for in the Agreement and (b) conduct the quality management activities called for by the Agreement. County will provide the Contractor with all applicable standards for the delivery and accurate documentation of services.

10.2 County will make ongoing technical assistance available in the form of direct consultation to Contractor upon Contractor's request to the extent that County has capacity and capability to provide this assistance. In doing so, the County is not relieving Contractor of its duty to provide training and supervision to its staff or to ensure that its activities comply with applicable regulations and other requirements included in the terms and conditions of this Agreement.

10.3 Any requests for technical assistance by Contractor regarding any part of this Agreement shall be directed to the County's designated contract monitor.

a. Contractor shall require all new employees in positions designated as "covered individuals" to complete compliance training within the first 30 days of their first day of work. Contractor shall require all covered individuals to attend, at minimum, one compliance training annually.
b. These trainings shall be conducted by County or, at County's discretion, by Contractor staff, or both, and may address any standards contained in this Agreement.

c. Covered individuals who are subject to this training are any Contractor staff who have or will have responsibility for, or who supervises any staff who have responsibility for, ordering, prescribing, providing, or documenting client care or medical items or services.

10.4 Contractor shall require that physicians receive a minimum of five hours of continuing medical education related to addiction medicine each year.

10.5 Contractor shall require that professional staff (LPHAs) receive a minimum of five hours of continuing education related to addiction medicine each year.

11. ADDITIONAL REQUIREMENTS PER DRUG MEDI-CAL OR SABG

11.1 **PHI Compliance**. Contractor will adhere to Titles 9 and 22 and all other applicable Federal and State statutes and regulations, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 42 CFR Part 2 and will make his best efforts to preserve data integrity and confidentiality of protected health information.

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

11.3 **Charitable Choice.** As separation of church and state is fundamental, it is imperative that County as a governmental organization not be viewed as promoting any one religion, belief or sect in general or specifically.

The following guidelines shall be followed by Lake County Behavioral Health Services (LCBHS) – SUDs and its subcontractors in accordance with Title 42, CFR part 54:

a. No SABG funds, nor any other federal or state funds, may be expended for inherently religious activities such as worship, religious instruction, or proselytization nor shall any state funds be used to provide direct, immediate, or substantial support to any religious activity.

b. A religious organization that is a program participant shall not, in providing program services or engaging in outreach activities under applicable programs, discriminate against a program beneficiary on the basis of religion, a religious belief, a refusal to hold a religious belief, or a refusal to actively participate in a religious practice.

c. If an otherwise eligible program beneficiary or prospective program beneficiary objects to the religious character of a program participant, within a reasonable period of time after the date of such objection, such program beneficiary shall have rights to notice, referral, and alternative services as outlined in paragraphs (b) through (d) of Title 42 CFR Part 54.8.

d. Religious organizations that receive applicable program funds for substance abuse services are subject to the same regulations as other nongovernmental organizations to account, in accordance with general accepted auditing and accounting principles, for the use of such funds.

11.4 **Corrective Action Plans (CAPs). County will ensure all DMC Postservice Postpayment (PSPP) cited deficiencies are remediated and monitored for ongoing compliance:**

a. When a deficiency is revealed, services will be denied and a Corrective Action Plan will be submitted to the DMC PSP Unit within 60 days of report.

b. County will then continue to monitor Contractor and provide training and/or technical assistance to ensure deficiency is remedied and found to be in compliance.

11.5 **Substance Abuse Block Grant (SABG) funds.** The Block Grant money that may be spent for Section 96.124 (c) and (e), and 96.127 and 96.128 is governed by 96.137 which ensure that funding from the Block Grant will be the "payment of last resort." Services funded under the Block Grant are required to have had every reasonable effort, including the establishment of systems for eligibility determination, billing, and collection, to:

a. Collect reimbursement of the costs of providing such services to persons who are entitled to insurance benefits under the Social Security Act, any State compensation program, any other public assistance program for medical expenses, any grant program, any private health insurance, or any other benefit program; and
b. Secure from patients or clients payments for services in accordance with their ability to pay.
c. None of the funds made available through this Contract may be used for any activity that promotes the legalization of any drug or other substance included in Schedule I of Section 202 of the Controlled Substances Act (21 USC 812).

11.6 **Monitoring Tool.** Contractor is subject to an annual site review by County. Contractor will be notified of the date of the Review via a Notification of Site Review letter. The County's Substance Use Disorder Services Monitoring Tool will accompany the Notification of Site Review letter. Contractor may also be subject to site reviews during the year as deemed necessary by County.

11.7 **California Outcomes Measurement System (CalOMS)**:

a. Contractor shall comply with data collection and reporting requirements established by DHCS CalOMS – Tx Data Collection Guide. And all former Department of Alcohol and Drug Programs Bulletins and DHCS Information Notes relevant to CalOMS –TX Data Collection.

b. Contractor shall comply with the CalOMS-Tx Data Compliance Standards established by DHCS identified for reporting data content, data quality completeness, reporting frequency, reporting deadlines, and reporting method.
c. Contractor shall implement and maintain a system for collecting and electronically submitted CalOMS – Tx data.
d. Contractor shall comply with the treatment and prevention data quality standards established by the State.
e. Electronic submission of CalOMS – Tx data is due 45 days from the end of the last day of the report month.
f. If the Contractor submits data after the established deadlines, due to a delay or problem, Contractor is still responsible for collecting and reporting data from time of the delay or problem.
g. Contractor shall submit CalOMS –TX admission, discharge, annual update, resubmissions of records containing errors or in need of correction, and "provider no activity" report records in an electronic format approved by DHCS.
h. Contractor shall participate in CalOMS-Tx informational meetings, training, and conference calls.
i. Contractor will need to report CalOMS-Tx Data on all other clients not associated financially to County directly to the State.

11.8 **Trafficking Victim Prevention Act (TVPA).** To ensure that any grant, contract, or cooperative agreement provided or entered into Lake County Behavioral Health Services Department includes a condition that authorizes termination, or takes any of the other remedial action authorized under 22 U. S. C. 7104 – Prevention of Trafficking, without penalty, if the grantee (or sub grantee), Contractor, etc., engages in, or uses labor recruiters, brokers, or other agents who engage in the violations described in 22 U. S. C. 7104.

Upon receipt of an Inspectors General's report substantiating an allegation that the recipient of a contract, grant, or cooperative agreement; a sub grantee or subcontractor of the recipient; or any agent of the recipient of a sub grantee or subcontractor, engaged in any of the activities described in U. S. C. 22, Section 7104(g), or notification of an indictment, information, or criminal complaint for an offense under subsection (1)(3), the head of agency shall consider taking one or more of the remedial actions described in U. S. C. 22, Section 7104b(c)(1-4).

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

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

11.11 **Tuberculosis Treatment.** Contractor shall ensure the following related to Tuberculosis (TB):

Routinely make available TB services to each individual receiving treatment for alcohol and other drug use and/or abuse.

Reduce barrier to patient's accepting TB treatment; and,

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

11.12 **Tuberculosis screening for Contractor and Subcontractors**:

Except as specified in (3) below, good physical health shall be verified by a health screening, including a test for tuberculosis, performed under licensed medical supervision not more than sixty (60) days prior to or seven (7) days after employment with tuberculosis testing renewable every year.

Personnel with a known record of tuberculosis or record of positive testing shall not be required to be retested if a physician verified the individual has been under regular care and monitoring for tuberculosis. Such verification will be renewed annually.

A health screening report signed by the person performing such screening shall be made for each person specified above, and shall indicate the following:

a. The person's physical qualification to perform assigned duties, and
b. The presence of any health condition that would create a hazard to the person, resident or other staff members.

The good physical health each volunteer who works in the facility shall be verified by a statement signed by each volunteer affirming that he/she is in good health, and a test for tuberculosis performed not more than sixty (60) days prior to or seven (7) days after initial presence in the facility and annually thereafter. At the discretion of the licensee, tuberculosis testing need not be required for volunteers whose functions do not necessitate frequent or prolonged contact with residents.

11.13 **Human Immunodeficiency Virus (HIV) Early Intervention.** At intake LCBHS requires that each client complete a self-administered health questionnaire. The questionnaire is then forwarded to the SUD Medical Director for review, authorization and recommendation for treatment, further medical attention, and or preventative care.

In addition, each person that enrolls in LCBHS is informed of the risks of HIV/AIDS, provided with ta referral to the Community Care HIV/AIDS Program (C-CHAP) for counseling, support and additional therapeutic measure for preventing and treating condition arising from the disease, and given an opportunity to have a HIV blood test administered by C-CHAP at no charge. In the event, that C-CHAP is not available, LCBHS will pay to have the test performed by client's primary physician. Regardless of the test or whether the individual even partakes in testing, the individual will continue to receive outpatient services with LCBHS.

Per 45 CFR 96.121, Early Intervention Services Relating to HIV means:

a. Appropriate pretest counseling for HIV and AIDS;
b. Testing individuals with respect to such disease, including tests to confirm the presence of the disease, tests to diagnose the extent of the deficiency in the immune system, and tests to provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease;
c. Appropriate post-test counseling; and
d. Providing the therapeutic measures described in Paragraph (2) of this definition.

11.14 **Charting and Confidentiality of HIV Information.** Special protections regarding confidentiality of HIV testing and documentation apply. Special documentation is required to validate advised consent to testing and the release of test results.

At such times as a physician affiliated with Lake County Behavioral Health Services requests HIV testing of any patient or consumer, including doing so at the patient/consumer's request, the physician must document informed consent and written consent using Form CAHHS 31-1 "Consent for the HIV Antibody Blood Test" issued by the California Associate of Hospitals and Health Systems. This consent applies to competent adults (with "adult" in this case having been determined to be age 12 and above). Patients on LPS (or probate) conservatorship must have the consent signed by their conservator.

Test results must not be disclosed without written authorization for each separate disclosure.

The charting of the illness HIV/AIDS is subject to the same confidentiality as general medical or psychiatric information. Due to the continuing high sensitivity of this subject area, utmost caution should be maintained.

11.15 **ASAM Criteria.** The primary goal underlying the ASAM Criteria is for the patient to be placed in the most appropriate level of care. For both clinical and financial reasons, the preferable level of care is that which is the least intensive while still meeting treatment objectives and providing safety and security for the patient. The ASAM criteria is a single, common standard for assessing patient needs, optimizing placement, determining medical necessity, and documenting the appropriateness of reimbursement. County expects Contractor to work towards the implementation and utilization of the ASAM criteria.

11.16 **POLITICAL ACTIVITIES.** Contractor shall not campaign or conduct any political activity while performing scheduled activities during normal work hours.

Contractor and Contractor's officers, employees, and agents who seek elective office of Lake County may either request an unpaid leave of absence or use accrued vacation/compensatory time off during campaign activities. If successful in the election, contractor will deem that the staff member, upon assuming office, has resigned from their position with Contractor.

No Contractor and Contractor's officers, employees, and agents whose principal employment is in connection with any activity financed in whole or in part by Federal loans or grants shall undertake or participate in political activities barred by the Federal Political Activities (HATCH) Act as amended, 5 U.S.C. 1502 and Byrd Anti-Lobbying Amendment 31 USC 1352.

11.17 **INTRAVENOUS DRUG USE (IVDU) TREATMENT**. County shall ensure that individuals in need of IVDU treatment shall be encouraged to undergo AOD treatment (42 USC 300x-23 (45 CFR 96.126(e)).

11.18 **ADDITIONAL PRACTICE GUIDELINES:**

a. If applicable, the Contractor will follow the guidelines in Document 1G, "Perinatal Practice Guidelines," in developing and implementing perinatal treatment and recovery programs funded under this Exhibit, until new Perinatal Practice Guidelines are established and adopted. No formal amendment of this Contract is required for new guidelines to be incorporated into this Contract.

b. If applicable, the Contractor will follow the guidelines in Document 1V, "Youth Treatment Guidelines," in developing and implementing youth treatment programs funded under this Exhibit, until new Youth Treatment Guidelines are established and adopted. No formal amendment of this Contract is required for new guidelines to be incorporated into this Contract.

c. County must utilize DHCS guidelines in developing and implementing youth treatment programs funded under this Enclosure. The Adolescent Best Practices Guidelines can be found at:

https://www.dhcs.ca.gov/Documents/CSD_CMHCS/Adol%20Best20Practices20Guide/AdolBestPracGuideOCTOBER2020.pdf

12. CLIENT PROTECTIONS

12.1 GRIEVANCES, APPEALS AND NOTICES OF ADVERSE BENEFIT DETERMINATION

A. All grievances (as defined by 42 C.F.R. § 438.400) and complaints received by Contractor must be immediately forwarded to the County's Quality Management Department or other designated persons via a secure method (e.g., encrypted email or by fax) to allow ample time for the Quality Management staff to acknowledge receipt of the grievance and complaints and issue appropriate responses.
B. Contractor shall not discourage the filing of grievances and clients do not need to use the term "grievance" for a complaint to be captured as an expression of dissatisfaction and, therefore, a grievance.
C. Aligned with MHSUDS 18-010E and 42 C.F.R. § 438.404, the appropriate and delegated Notice of Adverse Benefit Determination (NOABD) must be issued by Contractors within the specified timeframes using the template provided by the County.
D. NOABDs must be issued to clients anytime the Contractor has made or intends to make an adverse benefit determination that includes the reduction, suspension, or termination of a previously authorized service and/or the failure to provide services in a timely manner. The notice must have a clear and concise explanation of the reason(s) for the decision as established by DHCS and the County. The Contractor must inform the County immediately after issuing a NOABD.
E. Procedures and timeframes for responding to grievances, issuing, and responding to adverse benefit determinations, appeals, and state hearings must be followed as per 42 C.F.R., Part 438, Subpart F (42 C.F.R. §§ 438.400 – 438.424).
F. Contractor must provide clients with any reasonable assistance in completing forms and taking other procedural steps related to a grievance or appeal such as auxiliary aids and interpreter services.
G. Contractor must maintain records of grievances and appeals and must review the information as part of its ongoing monitoring procedures. The record must be accurately maintained in a manner accessible to the County and available upon request to DHCS.

12.2 ADVANCED DIRECTIVES

Contractor must comply with all County policies and procedures regarding Advanced Directives in compliance with the requirements of 42 C.F.R. §§ 422.128 and 438.6.

12.3 TRANSITION OF CARE

A. Contractor shall follow County's transition of care policy in accordance with applicable state and federal regulations, MHSUDS IN 18-051: DMC-ODS Transition of Care Policy, and any BHINs issued by DHCS for parity in SUD and mental health

benefits subsequent to the effective date of this Agreement (42 C.F.R. § 438.62(b)(1)-(2).)

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

12.4 ADVERTISING REQUIREMENTS

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

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

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

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

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

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

13. PROGRAM INTEGRITY

13.1 GENERAL

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

13.2 ASAM STANDARDS OF CARE

A. In accordance with Health and Safety Code section 11834.015, DHCS has adopted the ASAM treatment criteria, or other equivalent evidenced based criteria as the minimum standard of care for AOD facilities.

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

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

I. ASAM Module I- Multidimensional Assessment
II. ASAM Module II- From Assessment to Service Planning and Level of Care
III. ASAM Module III-Introduction to the ASAM Criteria

13.3 CREDENTIALING AND RE-CREDENTIALING OF PROVIDERS

A. Contractors must follow the uniform process for credentialing and recredentialing of network providers established by County, including disciplinary actions such reducing, suspending, or terminating provider's privileges. Failure to comply with specified requirements can result in suspension or termination of a provider.
B. Upon request, the Contractor must demonstrate to the County that each of its providers are qualified in accordance with current legal, professional, and technical standards, and that they are appropriately licensed, registered, waivered, and/or certified.
C. Contractor must not employ or subcontract with providers debarred, suspended or otherwise excluded (individually, and collectively referred to as "Excluded") from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. § 438.610. See relevant section below regarding specific requirements for exclusion monitoring.
D. Contractors shall ensure that all of their network providers, delivering covered services, sign and date an attestation statement on a form provided by County, in which each provider attests to the following:
   I. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
   II. A history of loss of license or felony convictions;
   III. A history of loss or limitation of privileges or disciplinary activity;
   IV. A lack of present illegal drug use; and
   V. The application's accuracy and completeness
E. Contractor must file and keep track of attestation statements for all of their providers and must make those available to the County upon request at any time.
F. Contractor is required to sign an annual attestation statement at the time of Agreement renewal in which they will attest that they will follow County's Credentialing Policy and MHSUDS IN 18-019 and ensure that all of their rendering providers are credentialed as per established guidelines.
G. Contractor is required to verify and document at a minimum every three years that each network provider that delivers covered services continues to possess valid credentials, including verification of each of the credentialing requirements as per the County's uniform process for credentialing and recredentialing. If any of the requirements are not up-to-date, updated information should be obtained from network providers to complete the re-credentialing process.

13.4 SCREENING AND ENROLLMENT REQUIREMENTS

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

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

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

13.5 PROVIDER APPLICATION AND VALIDATION FOR ENROLLMENT (PAVE)

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

13.6 COMPLIANCE PROGRAM, INCLUDING FRAUD PREVENTION AND OVERPAYMENTS

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

I. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Agreement, and all applicable federal and state requirements.

II. A Compliance Office (CO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Agreement and who reports directly to the CEO and the Board of Directors.

III. A Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Agreement.

IV. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the Agreement.

V. Effective lines of communication between the Compliance Officer and the organization's employees.

VI. Enforcement of standards through well-publicized disciplinary guidelines.

VII. The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, corrections of such problems promptly and thoroughly to reduce the potential for recurrence, and ongoing compliance with the requirements under the Agreement.

VIII. The requirement for prompt reporting and repayment of any overpayments identified.

B. Contractor must have administrative and management arrangements or procedures designed to detect and prevent fraud, waste and abuse of federal or state health care funding. Contractor must report fraud and abuse information to the County including but not limited to:

I. Any potential fraud, waste, or abuse as per 42 C.F.R. § 438.608(a), (a)(7),

II. All overpayments identified or recovered, specifying the overpayment due to potential fraud as per 42C.F.R. § 438.608(a), (a)(2).

III. Information about change in a client's circumstances that may affect the client's eligibility including changes in the client's residence or the death of the client as per 42 C.F.R. § 438.608(a)(3).

IV. Information about a change in the Contractor's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of this Agreement with the Contractor as per 42 C.F.R. § 438.608 (a)(6).

C. Contractor shall implement written policies that provide detailed information about the False Claims Act ("Act") and other federal and state Laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

D. Contractor shall make prompt referral of any potential fraud, waste or abuse to County or potential fraud directly to the State Medicaid Fraud Control Unit.

E. County may suspend payments to Contractor if DHCS or County determine that there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23. (42 C.F.R. § 438.608 (a)(8)).

F. Contractor shall report to the County all identified overpayments and reason for the overpayment, including overpayments due to potential fraud. Contractor shall return any overpayments to the County within 60 calendar days after the date on which the overpayment was identified. (42 C.F.R. § 438.608 (a)(2), (c)(3)).

13.7 INTEGRITY DISCLOSURES

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

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

C. Contractor must disclose the following information as requested in the Provider Disclosure Statement:
   I. Disclosure of 5% or More Ownership Interest:
      a. In the case of corporate entities with an ownership or control interest in the disclosing entity, the primary business address as well as every business location and P.O. Box address must be disclosed. In the case of an individual, the date of birth and Social Security Number must be disclosed.
      b. In the case of a corporation with ownership or control interest in the disclosing entity or in any subcontractor in which the disclosing entity has a five percent (5%) or more interest, the corporation tax identification number must be disclosed.
      c. For individuals or corporations with ownership or control interest in any subcontractor in which the disclosing entity has a five percent (5%) or more interest, the disclosure of familial relationship is required.
      d. For individuals with five percent (5%) or more direct or indirect ownership interest of a disclosing entity, the individual shall provide evidence of completion of a criminal background check, including fingerprinting, if required by law, prior to execution of Agreement. (42 C.F.R. § 455.434)
   II. Disclosures Related to Business Transactions:
      a. The ownership of any subcontractor with whom Contractor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request.
      b. Any significant business transactions between Contractor and any wholly owned supplier, or between Contractor and any subcontractor, during the 5-year period ending on the date of the request. (42 C.F.R. § 455.105(b).)
   III. Disclosures Related to Persons Convicted of Crimes:
      a. The identity of any person who has an ownership or control interest in the Contractor or is an agent or managing employee of the Contractor who has been convicted of a criminal offense related to that person's involvement in any program under the Medicare, Medicaid, or the Title XXI services program since the inception of those programs. (42 C.F.R. § 455.106.)
      b. County shall terminate the enrollment of Contractor if any person with five percent (5%) or greater direct or indirect ownership interest in the disclosing entity has been convicted of a criminal offense related to the person's involvement with Medicare, Medicaid, or Title XXI program in the last 10 years.

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

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

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

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

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

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

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

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

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

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

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

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

14. QUALITY IMPROVEMENT PROGRAM

14.1 QUALITY IMPROVEMENT ACTIVITIES AND PARTICIPATION

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

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

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

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

II. Evaluating client grievances, appeals and State Hearings at least annually.

II. Evaluating requests to change persons providing services at least annually.

III. Informing the County and clients of the results of client/family satisfaction activities.

D. Contractor, if applicable, shall implement mechanisms to monitor the safety and effectiveness of medication practices. This mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs, at least annually.

E. Contractor shall implement mechanisms to monitor appropriate and timely intervention of occurrences that raise quality of care concerns. The Contractor shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by the Contractor at least annually and shared with the County.

F. Contractor shall collaborate with County to create a QI Work Plan with documented annual evaluations and documented revisions as needed. The QI Work Plan shall evaluate the impact and effectiveness of its quality assessment and performance improvement program.

G. Contractor shall attend and participate in the County's Quality Improvement Committee (QIC) to recommend policy decisions, review and evaluate results of QI activities, including PIPs, institute needed QI actions, and ensure follow-up of QI processes. Contractor shall ensure that there is active participation by the Contractor's practitioners and providers in the QIC.

H. Contractor shall assist County, as needed, with the development and implementation of Corrective Action Plans.

I. Contractor shall participate, as required, in annual, independent external quality reviews (EQR) of the quality, timeliness, and access to the services covered under this Contract, which are conducted pursuant to Subpart E of Part 438 of the Code of Federal Regulations. (42 C.F.R. §§ 438.350(a) and 438.320)

14.2 NETWORK ADEQUACY

A. Contractor shall ensure that all services covered under this Agreement are available and accessible to clients in a timely manner and in accordance with the network adequacy standards required by regulation. (42 C.F.R. § 438.206 (a),(c)).

B. Contractor shall submit, when requested by County and in a manner and format determined by the County, network adequacy certification information to County, utilizing a provided template or other designated format.

C. Contractor shall submit updated network adequacy information to the County any time there has been a significant change that would affect the adequacy and capacity of services. Significant changes include, but are not limited to, changes in services or providers available to clients, and changes in geographic service area.

14.3 TIMELY ACCESS

A. Contractor shall comply with the requirements set forth in CCR, Title 9, § 1810.405, including meeting County and State Contract standards for timely access to care and services, taking into account the urgency of the need for services. County shall monitor Contractor to determine compliance with timely access requirements and shall take corrective action in the event of noncompliance.

B. Timely access standards include:

I. Contractors must have hours of operation during which services are provided to Medi-Cal clients that are no less than the hours of operation during which the Contractor offers services to non-Medi-Cal clients. If the Contractor's provider only serves Medi-Cal clients, the provider must provide hours of operation comparable to the hours the Contractor makes available for Medi-Cal services that are not covered by the Agreement or another County.

II. Appointments data, including wait times for requested services, must be recorded and tracked by Contractor, and submitted to the County on a monthly basis in a format specified by the County. Appointments' data should be submitted to the County's Quality Management department or other designated persons.

III. Contractor shall ensure that all clients seeking NTP services are provided with an appointment within three business days of a service request.

IV. Contractor shall ensure that all clients seeking outpatient and intensive outpatient (non-NTP) services are provided with an appointment within 10 business days of a non-NTP service request.

V. Contractor shall ensure that all clients seeking non-urgent appointments with a non-physician SUD provider are provided within 10 business days of the request for the appointment. Similarly, Contractor shall ensure that all clients seeking non-urgent follow-up appointments with a non-physician SUD provider are provided within 10 business days of the prior appointment for those undergoing a course of treatment for an ongoing SUD condition. These timely standards must be followed, except in the following circumstances:

a. The referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, has determined and noted that in the relevant record that a longer waiting time will not have a detrimental impact on the client's health.

b. Preventive care services and periodic follow-up care, including office visits for SUD conditions, may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of their practice.

VI. Contractor shall ensure that, if necessary for a client or a provider to reschedule an appointment, the appointment is promptly rescheduled in a manner that is appropriate for the client's health care needs and ensures continuity of care consistent with good professional practice.

VII. Contractor shall ensure that during normal business hours, the waiting time for a client to speak by telephone with staff knowledgeable and competent regarding the client's questions and concerns does not exceed 10 minutes.

14.4 DATA REPORTING REQUIREMENTS

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

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

I. California Outcomes Measurement System Treatment (CalOMS Tx)

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

II. Drug and Alcohol Treatment Access Report (DATAR)

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

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

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

14.5 TREATMENT PERCEPTION SURVEY (TPS)

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

14.6 PRACTICE GUIDELINES

A. Contractor shall adopt practice guidelines (or adopt County's practice guidelines) that meet the following requirements as per 42 C.F.R. § 438.236:
   I. Are based on valid and reliable clinical evidence or a consensus of providers in the field.
   II. Consider the needs of the Contractor's clients
   III. Are adopted in consultation with network providers
   IV. Are reviewed and updated periodically as appropriate
B. Contractor shall disseminate the guidelines to all affected providers and, upon request, to clients and potential clients.

14.7 EVIDENCE-BASED PRACTICES (EBPs)

A. Contractors will comply with County and DHCS standards related to Evidenced Based Practices (EBPs).
B. Contractor will implement at least two of the following EBP to fidelity per provider, per service modality:
   I. Motivational Interviewing
   II. Cognitive-Behavioral Services
   III. Relapse Prevention
   IV. Trauma-Informed Treatment
   V. Psycho-Education

14.8 PHYSICIAN INCENTIVE PLAN

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

14.9 REPORTING UNUSUAL OCCURRENCES

A. Contractor shall report unusual occurrences to the Director. An unusual occurrence is any event which jeopardizes the health and/or safety of clients, staff and/or members of the community, including, but not limited to, physical injury and death.
B. Unusual occurrences are to be reported to the County within timelines specified in County policy after becoming aware of the unusual event. Reports are to include the following elements:
   I. Complete written description of event including outcome;
   II. Written report of Contractor's investigation and conclusions;
   III. List of persons directly involved and/or with direct knowledge of the event.
C. County and DHCS retain the right to independently investigate unusual occurrences and the Contractor will cooperate in the conduct of such independent investigations.
D. An unusual occurrence shall be reported to the County in writing (or electronic mail) as soon as possible but no later than three (3) working days of the Contractor's knowledge of the event.

AGREEMENT BETWEEN COUNTY OF LAKE AND ARCHWAY RECOVERY SERVICES, INC. FOR ASAM LEVELS 3.1, 3.2, 3.3, 3.5, AND WITHDRAWAL MANAGEMENT LEVELS 1 AND 2. FOR FISCAL YEAR 2025-26

EXHIBIT C – FISCAL PROVISIONS

1. CONTRACTOR'S FINANCIAL RECORDS. Contractor shall keep financial records for funds received hereunder, separate from any other funds administered by Contractor, and maintained in accordance with Generally Accepted Accounting Principles and Procedures and the Office of Management and Budget's Cost Principles.

2. CLAIMING

2.1 Contractor shall enter claims data into the County's billing and transactional database system within the timeframes established by County. Contractor shall use Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, as provided in the DHCS Billing Manual available at https://www.dhcs.ca.gov/services/MH/Pages/MedCCC-Library.aspx, as from time to time amended.

2.2 Claims shall be complete and accurate and must include all required information regarding the claimed services.

2.3 Contractor shall maximize the Federal Financial Participation (FFP) reimbursement by claiming all possible Medi-Cal services and correcting denied services for resubmission in a timely manner as needed.

3. INVOICES.

3.1 Contractor's invoices shall be submitted in arrears no more than 180 days after the date of service, or such other time that is mutually agreed upon in writing, and shall be itemized and formatted to the satisfaction of the County.

3.2 Monthly payments for claimed services shall be based on the units of time assigned to each CPT or HCPCS code entered in the County's billing and transactional database multiplied by the service rates in item 8 below.

3.3 County's payments to Contractor for performance of claimed services are provisional and subject to adjustment until the completion of all settlement activities. County's adjustments to provisional payments for claimed services shall be based on the terms, conditions, and limitations of this Agreement or the reasons for recoupment set forth in Article 5, Section 6.

3.4 Contractor's invoices shall be submitted electronically to the link: https://filetransfer.co.lake.ca.us/filedrop/BHFiscalInvoicing

3.5 County shall make payment within 30 business days of reimbursement from the Department of Health Care Services for an undisputed invoice for the compensation stipulated herein for supplies delivered and accepted or services rendered and accepted, less potential deductions, if any, as herein provided. Payment on partial deliverables may be made whenever

amounts due so warrant or when requested by the Contractor and approved by the Assistant Purchasing Agent.

3.6 County shall not be obligated to pay Contractor for services provided which are the subject of any bill if Contractor submits such bill to County more than one hundred and eighty days (180) after the date Contractor provides the services, or more than one hundred and eighty days (180) days after this Agreement terminates, whichever is earlier.

3.7 Monthly payment may vary based on actual services billed.

3.8 County clients who are able to pay for services from other public or private resources are not billable under this Agreement.

3.9 Contractor and County shall each appoint one responsible representative for the purpose of resolving any billing questions or disputes which may arise during the term of this Agreement. Should such issues arise, County shall still be obligated to pay Contractor on a timely basis for those amounts and/or services which are not in dispute or with respect to which there are no questions. Questioned amounts, once adjusted (if necessary) as agreed by the two representatives, shall be paid to Contractor immediately after the Agreement is reached by the two representatives.

4. ADDITIONAL FINANCIAL REQUIREMENTS

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

4.2 Contractor must comply with the False Claims Act employee training and policy requirements set forth in 42 U.S.C. 1396a(a)(68) and as the Secretary of the US DHHS may specify.

4.3 Contractor agrees that no part of any federal funds provided under this Agreement shall be used to pay the salary of an individual per fiscal year at a rate in excess of Level 1 of the Executive Schedule at https://www.opm.gov/ (U.S. Office of Personnel Management), as from time to time amended.

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

5. CONTRACTOR PROHIBITED FROM REDIRECTION OF CONTRACTED FUNDS

5.1 Contractor may not redirect or transfer funds from one funded program to another funded program under which Contractor provides services pursuant to this Agreement except through a duly executed amendment to this Agreement.

5.2 Contractor may not charge services delivered to an eligible client under one funded program to another funded program unless the client is also eligible for services under the second funded program.

6. FINANCIAL AUDIT REPORT REQUIREMENTS FOR PASS-THROUGH ENTITIES

A. If County determines that Contractor is a "subrecipient" (also known as a "pass-through entity") as defined in 2 C.F.R. § 200 et seq., Contractor represents that it will comply with the applicable cost principles and administrative requirements including claims for payment or reimbursement by County as set forth in 2 C.F.R. § 200 et seq., as may be amended from time to time. Contractor shall observe and comply with all applicable financial audit report requirements and standards.

B. Financial audit reports must contain a separate schedule that identifies all funds included in the audit that are received from or passed through the County. County programs must be identified by Agreement number, Agreement amount, Agreement period, and the amount expended during the fiscal year by funding source.

C. Contractor will provide a financial audit report including all attachments to the report and the management letter and corresponding response within six months of the end of the audit year to the Director. The Director is responsible for providing the audit report to the County Auditor.

D. Contractor must submit any required corrective action plan to the County simultaneously with the audit report or as soon thereafter as it is available. The County shall monitor implementation of the corrective action plan as it pertains to services provided pursuant to this Agreement.

7. AUDIT REQUIREMENTS AND AUDIT EXCEPTIONS.

7.1 MAINTENANCE OF RECORDS

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

7.2 ACCESS TO RECORDS

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

7.3 FEDERAL, STATE AND COUNTY AUDITS

In accordance with 42 C.F.R. § 438.66 and as applicable with 42 C.F.R. §§ 438.604, 438.606, 438.608, 438.610, 438.230, 438.808, 438.900 et seq., County will conduct

monitoring and oversight activities to review the Contractor's SUD programs and operations. The purpose of these oversight activities is to verify that medically necessary services are provided to clients, who meet medical necessity and criteria for access to DMC-ODS as established in BHIN 24-001, in compliance with the applicable state and federal laws and regulations, and/or the terms of the Agreement between Contractor and County, and future BHINs which may spell out other specific requirements.

7.4 INTERNAL AUDITING

A. Contractors of sufficient size as determined by County shall institute and conduct a Quality Assurance Process for all services provided hereunder. Said process shall include at a minimum a system for verifying that all services provided and claimed for reimbursement shall meet DMC-ODS definitions and be documented accurately.
B. Contractor shall provide County with notification and a summary of any internal audit exceptions and the specific corrective actions taken to sufficiently reduce the errors that are discovered through Contractor's internal audit process. Contractor shall provide this notification and summary to County in a timely manner.

7.5 CONFIDENTIALITY IN AUDIT PROCESS

A. Contractor and County mutually agree to maintain the confidentiality of Contractor's client records and information, in compliance with all applicable state and federal statutes and regulations, including but not limited to HIPAA, 42 CFR Part 2, and California Welfare and Institutions Code, § 5328, to the extent that these requirements are applicable. Contractor shall inform all of its officers, employees and agents of the confidentiality provisions of all applicable statutes.
B. Contractor's fiscal records shall contain sufficient data to enable auditors to perform a complete audit and shall be maintained in conformance with standard procedures and accounting principles.
C. Contractor's records shall be maintained as required by the Director and DHCS on forms furnished by DHCS or the County. All statistical data or information requested by the Director shall be provided by the Contractor in a complete and timely manner.

7.6 REASONS FOR RECOUPMENT

A. County will conduct periodic audits of Contractor files to ensure appropriate clinical documentation, high quality service provision and compliance with applicable federal, state and county regulations.
B. Such audits may result in requirements for Contractor to reimburse County for services previously paid in the following circumstances:
    I. Identification of Fraud, Waste or Abuse as defined in federal regulation.
        a. Fraud and abuse are defined in Code of Federal Regulations, Title 42, § 455.2 and Welfare & Institutions Code, § 14107.11, subdivision (d).
        b. Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf.
    II. Overpayment of Contractor by County due to errors in claiming or documentation.

C. Contractor shall reimburse County for all overpayments identified by Contractor, County and/or state or federal oversight agencies as an audit exception within the timeframes required by law or Country or state or federal agency.

7.7 COOPERATION WITH AUDITS

A. Contractor shall cooperate with County in any review and/or audit initiated by County, DHCS, or any other applicable regulatory body. This cooperation may include such activities as onsite program, fiscal, or chart reviews and/or audits.
B. In addition, Contractor shall comply with all requests for any documentation or files including, but not limited to, client and personnel files.
C. Contractor shall notify the County of any scheduled or unscheduled external evaluation or site visits when it becomes aware of such visit. County shall reserve the right to attend any or all parts of external review processes.
D. Contractor shall allow inspection, evaluation and audit of its records, documents and facilities for 10 years from the term end date of this Agreement or in the event Contractor has been notified that an audit or investigation of this Agreement has been commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later pursuant to 42 C.F.R. §§ 438.3(h) and 438.230(c)(3)(i-iii).

7.8 The right to audit will exist through ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later per 42 CFR 438.230(c)(3)(iii).

8. PAYMENT TERMS.

8.1 County shall reimburse Contractor at a daily bundled daily rate for ASAM 3.1, 3.3, 3.5 services at $288.46/bed day; and

8.2 Withdrawal Management Level 1, 2, and 3.2 services at $304.23/bed day; and

8.3 Fee-for-Service Targeted Case Management at $4.37/minute.

8.4 **SmartCare Access Provision:**
County shall provide Contractor with up to three (3) user licenses for access to the County's Electronic Health Record system (SmartCare) at no cost. If Contractor requires access for additional staff beyond the three provided licenses, the County will charge a rate of sixty-two dollars and twelve cents ($62.12) per user, per month. Contractor shall be responsible for payment of these additional access costs, which will be invoiced by the County.

AGREEMENT BETWEEN COUNTY OF LAKE AND ARCHWAY RECOVERY SERVICES, INC. FOR ASAM LEVELS 3.1, 3.2, 3.3, 3.5, AND WITHDRAWAL MANAGEMENT LEVELS 1 AND 2. FOR FISCAL YEAR 2025-26

EXHIBIT D – COMPLIANCE PROVISIONS

1. CONFORMITY WITH STATE AND FEDERAL LAWS AND REGULATIONS

1.1 Contractor shall provide services in conformance with all applicable state and federal statues, regulations and subregulatory guidance, as from time to time amended, including but not limited to:

(a) California Code of Regulations, Title 9;
(b) California Code of Regulations, Title 22;
(c) California Welfare and Institutions Code, Division 5;
(d) United States Code of Federal Regulations, Title 42, including but not limited to Parts 2, 438 and 455;
(e) United States Code of Federal Regulations, Title 45;
(f) United States Code, Title 42 (The Public Health and Welfare), as applicable;
(g) Balanced Budget Act of 1997;
(h) Health Insurance Portability and Accountability Act (HIPAA); and
(i) Applicable Medi-Cal laws and regulations, including applicable sub-regulatory guidance, such as BHINs, MHSUDS INs, and provisions of County's state or federal contracts governing client services.

1.2 In the event any law, regulation, or guidance referred to in subsection (A), above, is amended during the term of this Agreement, the Parties agree to comply with the amended authority as of the effective date of such amendment without amending this Agreement.

2. ADDITIONAL FINAL RULE PROVISIONS

2.1 NON-DISCRIMINATION

A. Contractor shall not discriminate against Medi-Cal eligible individuals in its County who require an assessment or meet medical necessity criteria for DMC-ODS in the provision of SUD services because of race, color, religion, ancestry, marital status, national origin, ethnic group identification, sex, sexual orientation, gender, gender identity, age, medical condition, genetic information, health status or need for health care services, or mental or physical disability as consistent with the requirements of applicable federal law, such as 42 C.F.R. § 438.3(d)(3) and (4), BHIN 22-060 Enclosure 4 and state law.
B. Contractor shall take affirmative action to ensure that services to intended Medi-Cal clients are provided without use of any policy or practice that has the effect of discriminating on the basis of race, color, religion, ancestry, marital status, national origin, ethnic group identification, sex, sexual orientation, gender, gender identity, age, medical condition, genetic information, health status or need for health care services, or mental or physical disability.

2.2 PHYSICAL ACCESSIBILITY

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

2.3 APPLICABLE FEES

A. Contractor shall not charge any clients or third-party payers any fee for service unless directed to do so by the Director at the time the client is referred for services. When directed to charge for services, Contractor shall use the uniform billing and collection guidelines prescribed by DHCS.
B. Contractor will perform eligibility and financial determinations for each beneficiary prior to rendering services in accordance with the Drug Medi-Cal Billing Manual, unless directed otherwise by the Director.
C. Contractor shall not submit a claim to, or demand or otherwise collect reimbursement from, the client or persons acting on behalf of the client for any SUD or related administrative services provided under this Agreement, except to collect other health insurance coverage, share of cost, and co-payments (California Code of Regulations, tit. 9, § 1810.365(c)).
D. The Contractor must not bill clients, for covered services, any amount greater than would be owed if the County provided the services directly as per and otherwise not bill client as set forth in 42 C.F.R. § 438.106.

2.4 CULTURAL COMPETENCE

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

2.5 CLIENT INFORMING MATERIALS

A. Basic Information Requirements
   I. Contractor shall provide information in a manner and format that is easily understood and readily accessible to clients. (42 C.F.R. § 438.10(c)(1)). Contractor shall provide all written materials for clients in easily understood language, format, and alternative formats that take into consideration the special needs of clients in compliance with 42 C.F.R. § 438.10(d)(6). Contractor shall inform clients that information is available in alternate formats and how to access those formats in compliance with 42 C.F.R. § 438.10.
   II. Contractor shall provide the required information in this section to each client receiving SUD services under this Agreement and upon request.
   III. Contractor shall utilize the County’s website that provides the content required in this section and 42 C.F.R. § 438.10 and complies with all the requirements regarding the same set forth in 42 C.F.R. § 438.10.

IV. Contractor shall use DHCS/County developed model beneficiary handbook and client notices. (42 C.F.R. §§ 438.10(c)(4)(ii), 438.62(b)(3)).

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

B. Language and Format

I. Contractor shall provide all written materials for potential clients and clients in a font size no smaller than 12 point. (42 C.F.R. § 438.10(d)(6)(ii).)

II. Contractor shall ensure its written materials that are critical to obtaining services are available in alternative formats, upon request of the client or potential client at no cost.

III. Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, beneficiary handbook, appeal and grievance notices, denial and termination notices, and the Contractor's SUD health education materials, available in the prevalent non-English languages in the County. (42 C.F.R. § 438.10(c)(3).)
   a. Contractor shall notify clients, prospective clients, and members of the public that written translation is available in prevalent languages free of cost and how to access those materials. (42 C.F.R. § 438.10(d)(5)(i), (iii); Welfare & Institutions Code § 14727(a)(1); California Code of Regulations. tit. 9 § 1810.410, subd. (e), para. (4))

IV. Contractor shall make auxiliary aids and services available upon request and free of charge to each client. (42 C.F.R. § 438.10(d)(3)- (4).)

V. Contractor shall make oral interpretation and auxiliary aids, such as Teletypewriter Telephone/Text Telephone (TTY/TDY) and American Sign Language (ASL), available and free of charge for any language in compliance with 42 C.F.R. § 438.10(d)(2), (4)-(5).

VI. Taglines for written materials critical to obtaining services must be printed in a conspicuously visible font size.

C. Beneficiary Informing Materials

I. Each client must receive and have access to the beneficiary informing materials upon request by the client and when first receiving SUD services. Beneficiary informing materials include but are not limited to:
   a. County DMC-ODS Beneficiary Handbook (BHIN 22-060)

b. Provider Directory
c. DMC-ODS Formulary
d. Advance Health Care Directive Form (required for adult clients only)
e. Notice of Language Assistance Services available upon request at no cost to the client
f. Language Taglines
g. Grievance/Appeal Process and Form
h. Notice of Privacy Practices
i. EPSDT poster (if serving clients under the age of 21)

II. Contractor shall provide each client with a beneficiary handbook at the time the client first accesses services. The beneficiary handbook shall be provided to beneficiaries within 14 business days after receiving notice of enrollment.

III. Contractor shall give each client notice of any significant change to the information contained in the beneficiary handbook at least 30 days before the intended effective date of change as per BHIN 22-060.

IV. Required informing materials must be electronically available on the Contractor's website and must be physically available at the Contractor agency facility lobby for clients' access.

V. Informing materials must be made available upon request, at no cost, in alternate formats (i.e., Braille or Audio) and Auxiliary Aids (i.e., California Relay Service (CRS) 711 and American Sign Language) and must be provided to clients within five business days. Large print materials shall be in a minimum 18-point font size.

VI. Informing materials will be considered provided to the client if Contractor does one or more of the following:
a. Mails a printed copy of the information to the client's mailing address before the client first receives a SUD service;
b. Mails a printed copy of the information upon the client's request to the client's mailing address;
c. Provides the information by email after obtaining the client's agreement to receive the information by email;
d. Posts the information on the Contractor's website and advises the client in paper or electronic form that the information is available on the internet and includes applicable internet addresses, provided that clients with disabilities who cannot access this information online are provided auxiliary aids and services upon request and at no cost; or,
e. Provides the information by any other method that can reasonably be expected to result in the client receiving that information. If the Contractor provides informing materials in person, when the client first receives SUD services, the date and method of delivery shall be documented in the client's file.

D. Provider Directory

I. Contractor must follow the County's provider directory policy, in compliance with MHSUDS BHIN 18-020.

II. Contractor must make available to clients, in paper form upon request and electronic form, specified information about its provider network as per 42 C.F.R. § 438.10(h). The most current provider directory is electronically available on the County website and is updated by the County no later than 30 calendar days after information is received to update provider information. A paper provider directory must be updated as set forth in 42 C.F.R. § 438.10(h)(3)(i).

III. Any changes to information published in the provider directory must be reported to the County within two weeks of the change.

IV. Contractor will only need to report changes/updates to the provider directory for each licensed SUD service provider.

E. Medication Formulary

I. Contractor shall make available in electronic or paper form, the following information about the County's formulary as outlined in 42 C.F.R. § 438.10(i):
   a. Which medications are covered (for both generic and name brand).
   b. What tier each medication resides on.

II. Contractor shall inform clients about County's formulary drug lists availability in a machine-readable file and format on the County's website.

3. DATA, PRIVACY, AND SECURITY REQUIREMENTS

3.1 CONFIDENTIALITY AND SECURE COMMUNICATIONS

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

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

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

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

3.2 ELECTRONIC PRIVACY AND SECURITY

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

B. Contractor shall institute compliant password management policies and procedures, which shall include but are not limited to procedures for creating, changing, and

safeguarding passwords. Contractor shall establish guidelines for creating passwords and ensuring that passwords expire and are changed at least once every 90 days.

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

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

3.3 BUSINESS ASSOCIATE AGREEMENT (BAA)

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

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

4. CLIENT RIGHTS

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

5. RIGHT TO MONITOR

5.1 County or any subdivision or appointee thereof, and the State of California or any subdivision or appointee thereof, including the Auditor General, shall have absolute right to review and audit all records, books, papers, documents, corporate minutes, financial records, staff information, client records, other pertinent items as requested, and shall have absolute right to monitor the performance of Contractor in the delivery of services provided under this Agreement. Full cooperation shall be given by the Contractor in any auditing or monitoring conducted, according to this Agreement.

5.2 Contractor shall make all of its premises, physical facilities, equipment, books, records, documents, contracts, computers, or other electronic systems pertaining to Medi-Cal enrollees, Medi-Cal-related activities, services, and activities furnished under the terms of this Agreement, or determinations of amounts payable available at any time for inspection, examination, or copying by County, the State of California or any subdivision or appointee thereof, CMS, U.S. Department of Health and Human Services (HHS) Office of Inspector General, the United States Comptroller General or their designees, and other authorized federal and state agencies. This audit right will exist for at least 10 years from the final date

of the Agreement period or in the event the Contractor has been notified that an audit or investigation of this Agreement has commenced, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later (42 CFR § 438.230(c)(3)(i)-(ii)).

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

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

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

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

5.7 Contractor shall maintain all records and management books pertaining to service delivery and demonstrate accountability for contract performance and maintain all fiscal, statistical, and management books and records pertaining to the program. Records should include, but are not limited to, monthly summary sheets, sign-in sheets, and other primary source documents. Fiscal records shall be kept in accordance with Generally Accepted Accounting Principles and must account for all funds, tangible assets, revenue and expenditures. Fiscal records must also comply with the Code of Federal Regulations (CFR), Title II, Subtitle A, Chapter II, Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards.

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

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

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

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

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

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

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

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

6. SITE INSPECTIONS

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

7. INFORMATION INTEGRITY AND SECURITY. Contractor shall immediately notify County of any known or suspected breach of personal, sensitive, and confidential information related to Contractor's work under this Agreement.

8. **NON-DISCRIMINATION.** Contractor shall not unlawfully discriminate against any qualified worker or recipient of services because of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, sexual orientation and ability to pay.

9. **DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS.**

9.1 The Contractor certifies to the best of its knowledge and belief, that it and its subcontractors:

a. Are not presently debarred, suspended, proposed for disbarment, declared ineligible, or voluntarily excluded from covered transactions by any federal department or agency;

b. Have not, within a three-year period preceding this Agreement, been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public transaction; violation of federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

c. Are not presently indicted for or otherwise criminally or civilly charged by a governmental entity with commission of any of the offenses enumerated in the preceding paragraph; and

d. Have not, within a three-year period preceding this Agreement, had one or more public transactions terminated for cause or default.

9.2 Contractor shall report immediately to County, in writing, any incidents of alleged fraud and/or abuse by either Contractor or Contractor's subcontractor. Contractor shall maintain any records, documents, or other evidence of fraud and abuse until otherwise notified by County.

10. **INDEMNIFICATION AND HOLD HARMLESS.** Contractor shall indemnify and defend County and its officers, employees, and agents against and hold them harmless from any and all claims, losses, damages, and liability for damages, including attorney's fees and other costs of defense incurred by County, whether for damage to or loss of property, or injury to or death of person, including properties of County and injury to or death of County officials, employees or agents, arising out of, or connected with Contractor's operations hereunder or the performance of the work described herein, unless such damages, loss, injury or death is caused solely by the negligence of County.

11. **STANDARD OF CARE.** Contractor represents that it is specially trained, licensed, experienced, and competent to perform all the services, responsibilities and duties specified herein and that such services, responsibilities, and duties shall be performed, whether by Contractor or designated subcontractors, in a manner according to generally accepted practices.

12. **INTEREST OF CONTRACTOR.** Contractor assures that neither it nor its employees have any interest, and that it shall not acquire any interest in the future, direct or indirect, which would conflict in any manner or degree with the performance of services hereunder.

13. **DUE PERFORMANCE – DEFAULT.** Each party agrees to fully perform all aspects of this agreement. If a default to this agreement occurs, then the party in default shall be given written notice of said default by the other party. If the party in default does not fully correct (cure) the default within 30 days of the date of that notice (i.e. the time to cure) then such party shall be in default. The time period for corrective action of the party in default may be extended in writing executed by both parties, which must include the reason(s) for the extension and the date the extension expires.

Notice given under this provision shall specify the alleged default and the applicable Agreement provision and shall demand that the party in default perform the provisions of this Agreement within the applicable time period. No such notice shall be deemed a termination of this Agreement, unless the party giving notice so elects in that notice, or so elects in a subsequent written notice after the time to cure has expired.

14. **INSURANCE.**

14.1 Contractor shall procure and maintain Workers' Compensation Insurance for all of its employees.

14.2 Contractor shall procure and maintain Comprehensive Public Liability Insurance, both bodily injury and property damage, in an amount of not less than one million dollars ($1,000,000) combined single limit coverage per occurrence, including but not limited to endorsements for the following coverage: personal injury, premises-operations, products and completed operations, blanket contractual, and independent Contractor's liability.

14.3 Contractor shall procure and maintain Comprehensive Automobile Liability Insurance, both bodily injury and property damage, on owned, hired, leased and non-owned vehicles used in connection with Contractor's business in an amount of not less than one million dollars ($1,000,000) combined single limit coverage per occurrence.

14.4 Contractor shall procure and maintain Professional Liability Insurance for the protection against claims arising out of the performance of services under this Agreement caused by errors,

omissions or other acts for which Contractor is liable. Said insurance shall be written with limits of not less than one million dollars ($1,000,000).

14.5 Contractor shall not commence work under this Agreement until it has obtained all the insurance required hereinabove and submitted to County certificates of insurance naming the County of Lake as additional insured. Contractor shall provide County certificates of insurance within 30 days of date of execution of the Agreement. Contractor agrees to provide to County, at least 30 days prior to expiration date, a new certificate of insurance.

14.6 In case of any subcontract, Contractor shall require each subcontractor to provide all of the same coverage as detailed hereinabove. Subcontractors shall provide certificates of insurance naming the County of Lake as additional insured and shall submit new certificate to commence work until the required insurances have been obtained.

14.7 For any claims related to the work performed under this Agreement, the Contractor's insurance coverage shall be primary insurance as to the County, its officers, officials, employees, agents and volunteers. Any insurance or self-insurance maintained by County, its officers, officials, employees, agents or volunteers shall be in excess of the Contractor's insurance and shall not contribute with it.

14.8 The Commercial General Liability and Automobile Liability Insurance must each contain, or be endorsed to contain, the following provision:

a. The County, its officers, officials, employees, agents, and volunteers are to be covered as additional insureds and shall be added in the form of an endorsement to Contractor's insurance on Form CG 20 10 11 85. Contractor shall not commence work under this Agreement until Contractor has had delivered to County the Additional Insured Endorsements required herein.

14.9 Insurance coverage required of Contractor under this Agreement shall be placed with insurers with a current A.M. Best rating of no less than A: VII.

Insurance coverage in the minimum amounts set forth herein shall not be construed to relieve the Contractor for liability in excess of such coverage, nor shall it preclude County from taking other action as is available to it under any other provision of this Agreement or applicable law. Failure of County to enforce in a timely manner any of the provisions of this section shall not act as a waiver to enforcement of any of these provisions at a later date.

14.10 Any failure of Contractor to maintain the insurance required by this section, or to comply with any of the requirements of this section, shall constitute a material breach of the entire Agreement.

15. ATTORNEY'S FEES AND COSTS. If any action at law or in equity is necessary to enforce or interpret the terms of this Agreement, the prevailing party shall be entitled to reasonable attorney's fees, costs, and necessary disbursements in addition to any other relief to which such part may be entitled.

16. ASSIGNMENT. Contractor shall not assign any interest in this Agreement and shall not transfer any interest in the same without the prior written consent of County except that claims for money due or to become due Contractor from County under this Agreement may be assigned by Contractor to a bank, trust company, or other financial institution without such approval. Written notice of any such transfer shall be furnished promptly to County. Any attempt at assignment of rights under this Agreement except for those specifically consented to by both parties or as stated above shall be void.

17. INDEPENDENT CONTRACTOR. It is specifically understood and agreed that, in the making and performance of this Agreement, Contractor is an independent Contractor and is not an employee, agent or servant of County. Contractor is not entitled to any employee benefits. County agrees that Contractor shall have the right to control the manner and means of accomplishing the result agreed for herein.

Contractor is solely responsible for the payment of all federal, state and local taxes, charges, fees, or contributions required with respect to Contractor and Contractor's officers, employees, and agents who are engaged in the performance of this Agreement (including without limitation, unemployment insurance, social security and payroll tax withholding.)

18. SUBCONTRACTS

Contractor shall obtain prior written approval from the Director before subcontracting any of its obligations to provide services under this Agreement. Approval is at the discretion of the Director but shall not be unreasonably withheld. Contractor shall ensure that all subcontracts are subject to the applicable terms and conditions of this Agreement, including, without limitation, the licensing, certification, privacy, data security and confidentiality requirements set forth herein, and include the applicable provisions of 42 C.F.R. § 438.230.

Contractor shall remain legally responsible for the performance of all terms and conditions of this Agreement, including, without limitation, all SUD services provided by third parties under subcontracts, whether approved by the County or not.

19. OWNERSHIP OF DOCUMENTS. All non-proprietary reports, drawings, renderings, or other documents or materials prepared by Contractor hereunder are the property of County. In the event of the termination of this Agreement for any reason whatsoever, Contractor shall promptly turn over all said reports, drawings, renderings, information, and/or other documents or materials to County without exception or reservation.

20. SEVERABILITY. If any provision of this Agreement is held to be unenforceable, the remainder of this Agreement shall be severable and not affected thereby.

21. ADHERENCE TO APPLICABLE DISABILITY LAW. Contractor shall be responsible for knowing and adhering to the requirements of Section 504 of the Rehabilitation Act of 1973, the Americans with Disabilities Act, (42 U.S.C. Sections 12101, et seq.). California Government Code Sections 12920 et seq., and all related state and local laws.

22. SAFETY RESPONSIBILITIES. Contractor will adhere to all applicable CalOSHA requirements in performing work pursuant to this Agreement. Contractor agrees that in the performance of work under this Agreement, Contractor will provide for the safety needs of its employees and will be responsible for maintaining the standards necessary to minimize health and safety hazards.

23. JURISDICTION AND VENUE. This Agreement shall be construed in accordance with the laws of the State of California and the parties hereto agree that venue of any action or proceeding regarding this Agreement or performance thereof shall be in Lake County, California. Contractor waives any right of removal it might have under California Code of Civil Procedure Section 394.

24. RESIDENCY. All independent Contractors providing services to County for compensation must file a State of California Form 590, certifying California residency or, in the case of a corporation, certifying that they have a permanent place of business in California.

25. NO THIRD-PARTY BENEFICIARIES. Nothing contained in this Agreement shall be construed to create, and the parties do not intend to create, any rights in or for the benefit of third parties.

27. OVERSIGHT. Lake County Behavioral Health Services shall conduct oversight and impose sanctions on the Contractor for violations of the terms of this Agreement, and applicable federal and state law and regulations, in accordance with Welfare & Institutions Code 14712(c)(3) and CCR, Title 9, Section 1810.380 and 1810.385. Remedies in instances where the State Department of Health Care Services or the County Mental Health Plan determine the subcontractor has not performed satisfactorily and right to audit will exist through 10 years from the final data of the contract period or from the date of completion of any audit, whichever is later.

28. Limitation on Use of Funds for Promotion of Legalization of Controlled Substances: Restriction on the Promotion of Drug Legalization (P.L. 115-31, Division H, Title V, Section 509) Award funds may not be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under section 202 of the Controlled Substances Act.

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

30. FEDERAL AND STATE LAW REQUIREMENTS

a. Title VI of the Civil Rights Act of 1964, Section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in federally-funded programs.
b. Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.
c. Age Discrimination Act of 1975 (45 CFR Part 90), as amended 42 USC Sections 6101 – 6107), which prohibits discrimination on the basis of age.
d. Age Discrimination in Employment Act (29 CFR Part 1625).
e. Title I of the Americans with Disabilities Act (29 CFR Part 1630) prohibiting discrimination against the disabled in employment.
f. Title II of the Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities.
g. Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.
h. Section 504 of the Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.
i. Executive Order 11246 (42 USC 2000e, et seq. and 41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than $10,000 funded by federal financial assistance.
j. Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.
k. The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.
l. Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2, Subparts A – E).
m. Fair Employment and Housing Act (Government Code Section 12900 et seq.) and the applicable regulations (California administrative code, Title 2, Section 7285.0 et seq.).
n. Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135.
o. Title 9, Division 4, Chapter 8, CCR, commencing with section 13000.
p. No federal funds shall be used by the County or its subcontractors for sectarian worship, instruction, or proselytization. No federal funds shall be used by the County or its subcontractors to provide direct, immediate, or substantial support to any religious activity.

31. **NON-APPROPRIATION.** In the event County is unable to obtain funding at the end of each fiscal year for specialty mental health services required during the next fiscal year, County shall have the right to terminate this Agreement, without incurring any damages or penalties, and shall not be obligated to continue performance under this Agreement. To the extent any remedy in this Agreement may conflict with Article XVI of the California Constitution or any other debt limitation provision of California law applicable to County, Contractor hereby expressly and irrevocably waives its right to such remedy.

AGREEMENT BETWEEN COUNTY OF LAKE AND ARCHWAY RECOVERY SERVICES, INC. FOR ASAM LEVELS 3.1, 3.2, 3.3, 3.5, AND WITHDRAWAL MANAGEMENT LEVELS 1 AND 2. FOR FISCAL YEAR 2025-26

EXHIBIT E - BUSINESS ASSOCIATE AGREEMENT

THIS HIPAA BUSINESS ASSOCIATE AGREEMENT (the "Agreement") is entered into effective July 1, 2025 (the "Effective Date"), by and between **Archway Recovery Services Inc.,**("Business Associate") and **Lake County Behavioral Health Services** (the "Covered Entity").

Business Associate and Covered Entity have a business relationship (the "Relationship" or the"Agreement") in which Business Associate may perform functions or activities on behalf of Covered Entity involving the use and/or disclosure of protected health information received from, or created or received by, Business Associate on behalf of Covered Entity. ("PHI"). Therefore, if Business Associate is functioning as a business associate to Covered Entity, Business Associate agrees to the following terms and conditions set forth in this HIPAA Business Associate Agreement.

1. **Definitions.** For purposes of this Agreement, the terms used herein, unless otherwise defined, shallhave the same meanings as used in the Health Insurance Portability and Accountability Act of 1996,and any amendments or implementing regulations ("HIPAA"), or the Health Information Technology for Economic and Clinical Health Act (Title XIII of the American Recovery and Reinvestment Act of 2009), and any amendments or implementing regulations ("HITECH"). Additionally, for this agreement, Protected Health Information (PHI) includes electronic Protected Health Information (ePHI); Personally Identifiable Information (PII); and Personal Information (PI).

2. **Compliance with Applicable Law.** The parties acknowledge and agree that, beginning with the relevant effective dates, Business Associate shall comply with its obligations under this Agreement and with all obligations of a business associate under HIPAA, HITECH and other related laws, as they exist at the time this Agreement is executed and as they are amended, for so long as this Agreement is in place.

3. **Permissible Use and Disclosure of Protected Health Information.** Business Associate may use and disclose PHI to carry out is duties to Covered Entity pursuant to the terms of the Relationship. Business Associate may also use and disclose PHI (i) for its own proper management and administration, and (ii) to carry out its legal responsibilities. If Business Associate discloses Protected Health Information to a third party for either above reason, prior to making any such disclosure, Business Associate must obtain: (i) reasonable assurances from the receiving party that such PHI will be held confidential and be disclosed only as required by law or for the purposes for

which it was disclosed to such receiving party; and (ii) an agreement from such receiving party to immediately notify Business Associate of any known breaches of the confidentiality of the PHI.

4. **Limitations on Uses and Disclosures of PHI.** Business Associate shall not, and shall ensure that its directors, officers, employees, and agents do not, use or disclose PHI in any manner that is not permitted or required by the Relationship, this Agreement, or required by law. All uses and disclosures of, and requests by Business Associate, for PHI are subject to the minimum necessary rule of the Privacy Standards and shall be limited to the information contained in a limited data set, to the extent practical, unless additional information is needed to accomplish the intended purpose, or as otherwise permitted in accordance with Section 13405(b) of HITECH and any implementing regulations.

5. **Required Safeguards To Protect PHI.** Business Associate agrees that it will implement appropriate safeguards in accordance with the Privacy Standards to prevent the use or disclosure of PHI other than pursuant to the terms and conditions of this Agreement.

6. **Reporting of Improper Use and Disclosures of PHI.** Business Associate shall report within 24 business hours to Covered Entity a use or disclosure of PHI not provided for in this Agreement by Business Associate, its officers, directors, employees, or agents, or by a third party to whom Business Associate disclosed PHI. Business Associate shall also report within 24 business hours to Covered Entity a breach of unsecured PHI, in accordance with 45 C.F.R. §§ 164.400-414, and any security incident of which it becomes aware. Report should be made to:

Compliance Officer
Lake County Behavioral Health
Services1-877-610-2355

7. **Mitigation of Harmful Effects.** Business Associate agrees to mitigate, to the extent practicable, any harmful effect of a use or disclosure of PHI by Business Associate in violation of the requirements of this Agreement, including, but not limited to, compliance with any state law or contractual data breach requirements. Business Associate shall cooperate with Covered Entity's breach notification and mitigation activities and shall be responsible for all costs incurred by Covered Entity for those activities.

8. **Agreements by Third Parties.** Business Associate shall enter into an agreement with any agent or subcontractor of Business Associate that will have access to PHI. Pursuant to

such agreement, the agent or subcontractor shall agree to be bound by the same restrictions, terms, and conditions that apply to Business Associate under this Agreement with respect to such PHI.

9. **Access to Information.** Within five (5) days of a request by Covered Entity for access to PHI about an individual contained in a Designated Record Set, Business Associate shall make available to Covered Entity such PHI for so long as such information is maintained by Business Associate in theDesignated Record Set, as required by 45 C.F.R. § 164.524. In the event any individual delivers directly to Business Associate a request for access to PHI, Business Associate shall within two (2) days forward such request to Covered Entity.

10. **Availability of PHI for Amendment.** Within five (5) days of receipt of a request from Covered Entity for the amendment of an individual's PHI or a record regarding an individual contained in a Designated Record Set (for so long as the PHI is maintained in the Designated Record Set), Business Associate shall provide such information to Covered Entity for amendment and incorporate any such amendments in the PHI as required by45 C.F.R. § 164.526. In the event any individual delivers directly to Business Associate a request for amendment to PHI, Business Associate shall within two (2) days forward such request to Covered Entity.

11. **Documentation of Disclosures.** Business Associate agrees to document disclosures of PHI and information related to such disclosures as would be required for Covered Entity to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

12. **Accounting of Disclosures.** Within five (5) days of notice by Covered Entity to Business Associate that it has received a request for an accounting of disclosures of PHI regarding an individual during the six (6) years prior to the date on which the accounting was requested, Business Associate shall make available to Covered Entity information to permit Covered Entity to respond to the request for an accounting of disclosures of PHI, as required by 45 C.F.R. § 164.528. In the case of an electronic health record maintained or hosted by Business Associate on behalf of Covered Entity, the accounting period shall be three (3) years and the accounting shall include disclosures for treatment, payment and healthcare operations, in accordance with the applicable effective date of Section 13402(a) of HITECH. In the event the request for an accounting is delivered directly to Business Associate, Business Associate shall within two (2) days forward such request to Covered Entity.

13. **Electronic PHI.** To the extent that Business Associate creates, receives, maintains or transmits electronic PHI on behalf of Covered Entity, Business Associate shall:

(a) Comply with 45 C.F.R. §§164.308, 312, and 316 in the same manner as such sections apply to Covered Entity, pursuant to Section 13401(a) of HITECH, and otherwise implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI;

(b) Ensure that any agent to whom Business Associate provides electronic PHI agrees to implement reasonable and appropriate safeguards to protect it; and

(c) Report to Covered Entity any security incident of which Business Associate becomes aware.

14. **Judicial and Administrative Proceedings.** In the event Business Associate receives a subpoena, court or administrative order or other discovery request or mandate for release of PHI, Covered Entity shall have the right to control Business Associate's response to such request. Business Associate shall notify Covered Entity of the request as soon as reasonably practicable, but in any event within two (2) days of receipt of such request.

15. **Availability of Books and Records.** Business Associate shall make its internal practices, books, and records relating to the use and disclosure and privacy protection of PHI received from Covered Entity, or created, maintained or received by Business Associate on behalf of the Covered Entity, available to the Covered Entity, the State of California, and the Secretary of the Department of Health and Human Services, in the time and manner designated by the Covered Entity, State or Secretary, for purposes of determining Covered Entity's compliance with the Privacy Standards. Business Associate shall notify the Covered Entity upon receipt of such a request for access by the State or Secretary and shall provide the Covered Entity with a copy of the request as well as a copy of all materials disclosed.

16. **Breach of Contract by Business Associate.** In addition to any other rights Covered Entity may havein the Relationship, this Agreement or by operation of law or in equity, Covered Entity may i) immediately terminate the Relationship if Covered Entity determines that Business Associate has violated a material term of this Agreement, or ii) at Covered Entity's option, permit Business Associate to cure or end any such violation

within the time specified by Covered Entity. Covered Entity's option to have cured a breach of this Agreement shall not be construed as a waiver of any other rights Covered Entity has in the Relationship, this Agreement or by operation of law or in equity.

17. **Effect of Termination of Relationship.** Upon the termination of the Relationship or this Agreement for any reason, Business Associate shall return to Covered Entity or, at Covered Entity's direction, destroy all PHI received from Covered Entity that Business Associate maintains in any form, recorded on any medium, or stored in any storage system, unless said information has been de-identified and is no longer PHI. This provision shall apply to PHI that is in the possession of Business Associates or agents of Business Associate. Business Associate shall retain no copies of the PHI. Business Associate shall remain bound by the provisions of this Agreement, even after termination of the Relationship or the Agreement, until such time as all PHI has been returned, de-identified or otherwise destroyed as provided in this Section.

18. **Injunctive Relief.** Business Associate stipulates that its unauthorized use or disclosure of PHI while performing services pursuant to this Agreement would cause irreparable harm to Covered Entity, and in such event, Covered Entity shall be entitled to institute proceedings in any court of competent jurisdiction to obtain damages and injunctive relief.

19. **Indemnification.** Business Associate shall indemnify and hold harmless Covered Entity and its officers, trustees, employees, and agents from any and all claims, penalties, fines, costs, liabilities or damages, including but not limited to reasonable attorney fees, incurred by Covered Entity arising from a violation by Business Associate of its obligations under this Agreement.

20. **Exclusion from Limitation of Liability.** To the extent that Business Associate has limited its liability under the terms of the Relationship, whether with a maximum recovery for direct damages or a disclaimer against any consequential, indirect or punitive damages, or other such limitations, all limitations shall exclude any damages to Covered Entity arising from Business Associate's breach of its obligations relating to the use and disclosure of PHI.

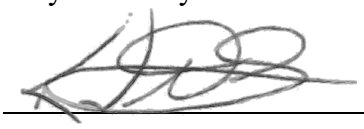
21. **Owner of PHI.** Under no circumstances shall Business Associate be deemed in any respect to be the owner of any PHI used or disclosed by or to Business Associate by Covered Entity.

22. **Third Party Rights.** The terms of this Agreement do not grant any rights to any parties other than Business Associate and Covered Entity.

23. **Independent Contractor Status.** For the purposed of this Agreement, Business Associate is an independent contractor of Covered Entity, and shall not be considered an agent of Covered Entity.

24. **Changes in the Law.** The parties shall amend this Agreement to conform to any new or revisedlegislation, rules and regulations to which Covered Entity is subject now or in the future including, without limitation, HIPAA, HITECH, the Privacy Standards, Security Standards or Transactions Standards.

IN WITNESS WHEREOF, each Party hereby executes this Agreement as of the Effective Date.

Archway Recovery Services	County of Lake
By: 	By: _____
Name: Kevin Phillips	
Title: Director	Chair, Board of Supervisors

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