

**AGREEMENT BETWEEN COUNTY OF LAKE AND SY PSYCHIATRY,
LLC.TO PERFORM SUBSTANCE USE DISORDER TREATMENT
MEDICAL DIRECTOR RESPONSIBILITIES ON BEHALF OF LAKE
COUNTY BEHAVIORAL HEALTH SERVICES FOR
FISCAL YEAR 2026-2027**

This Agreement is made and entered into by and between the County of Lake, hereinafter referred to as “County,” and SY Psychiatry LLC, 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 services, for Medi-Cal beneficiaries served by the County; and

WHEREAS, County requires qualified physician services to perform Substance Use Disorder Medical Director responsibilities and provide clinical consultation and medical oversight in support of the County’s Drug Medi-Cal Organized Delivery System (DMC-ODS); and

WHEREAS, County has determined that Contractor possesses the professional qualifications, licensure, experience, and expertise necessary to provide SUD Medical Director and clinical consultation services on behalf of Lake County Behavioral Health Services; and

WHEREAS, County has determined that this Agreement is exempt from the formal Request for Proposals process pursuant to the County’s applicable purchasing and/or consultant selection policies; and

WHEREAS, Contractor desires to provide such services to County upon the terms and conditions set forth herein.

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

- 1. SERVICES** Subject to the terms and conditions set forth in this Agreement, Sy Psychiatry shall provide to County the services described in the “**Scope of Services**” attached hereto and incorporated herein as **Exhibit A** at the time and place and in the manner specified therein. In the event of a conflict or inconsistency between the terms of this Agreement and Exhibit A, any applicable Exhibit B-series addendum, Exhibits C, D, E, or any other exhibit or contract-specific addendum incorporated into this Agreement, the Agreement shall prevail, unless a contract-specific addendum expressly states that it controls for the specific service type, rate, location, or provider-type requirement addressed therein.
- 2. TERM** This Agreement shall commence on July 1, 2026, and shall terminate on June 30, 2027, 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, County has selected Contractor to provide the services described hereunder in **Exhibit A, titled, “Scope of Services.”**

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Compensation to Contractor shall not exceed **Four Hundred and Twenty-Five Thousand Dollars (\$425,000.00)**.

The County shall compensate Contractor for services rendered, in accordance with the provisions set forth in **Exhibit C**, titled “**Fiscal Provisions**” attached hereto and incorporated herein, provided that Contractor is not in default under any provisions of this Agreement.

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. 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 Notwithstanding any other provision of this agreement, this Agreement may be terminated by mutual consent of the parties or by County upon thirty (30) calendar 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.

In addition to any other remedies available under this Agreement or applicable law, County may, at its sole discretion, take one or more of the following actions in response to Contractor’s noncompliance with this Agreement or applicable DHCS requirements:

- A. Require Contractor to submit and implement a corrective action plan (CAP);
- B. Require additional training, supervision, or technical assistance;
- C. Suspend referrals or authorization of services;
- D. Withhold, delay, or deny payment for services;
- E. Disallow costs and seek recoupment of previously paid funds not used for services specifically outlined in Exhibit A of this agreement; and/or
- F. Terminate this Agreement, upon fifteen (15) calendar days written notice to Contractor.
- G. Impose progressive or immediate sanctions based on the severity of non-compliance;
- H. Require repayment of funds associated with non-compliant or disallowed services;
- I. Require additional reporting, monitoring, or oversight activities;
- J. Upon termination of the contract for cause, to the extent possible, assets purchased with County-provided funds shall revert to the County.
- K. Escalate enforcement actions without prior progressive steps when necessary to ensure member safety or regulatory compliance.

The exercise of any of the above remedies shall not preclude County from exercising any other rights or remedies available under this Agreement or at law. Upon termination, Contractor shall be paid a prorated amount for the services provided up to the date of termination. Within thirty (30) calendar days of the effective termination, Contractor shall:

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- A. Submit all financial documents for the effective period of this agreement, including, but not limited to, invoices, canceled checks, bookkeeping records, financial ledgers and bank records;
- B. Return any payments received that are above and beyond amount based on the results of an audit by County of said financial documents.

Upon notice of expiration, termination, loss of certification, program closure, or material service reduction, Contractor shall cooperate with County in implementing a member transition plan. Contractor shall not notify beneficiaries of service termination or transfer until the communication has been coordinated with County, unless immediate notice is legally required.

At County's direction, Contractor shall provide:

- A. A current member roster;
- B. Current authorization and level-of-care information;
- C. Upcoming appointments and medication needs;
- D. Identification of beneficiaries with urgent clinical, safety, housing, transportation, or continuity risks;
- E. Discharge and transfer summaries;
- F. Information necessary to support reassignment and continuity of care;
- G. Secure transfer of records; and
- H. Reasonable transition assistance for the period established by County.

Contractor shall take all reasonable steps to avoid abandonment, interruption of medically necessary services, or interruption of medications for addiction treatment.

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.

Formal notices concerning termination, breach, indemnification, amendment, or other legal matters shall be submitted to the addresses stated below. Routine programmatic, clinical, authorization, quality-management, compliance, fiscal, reporting, and corrective-action communications shall be submitted to the Lake County Behavioral Health Services (LCBHS) program representative, quality management representative, fiscal representative, or other County representative identified in a County-issued contact and reporting matrix.

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County may update operational contacts, email addresses, secure submission methods, and system-access instructions by written notice to Contractor without requiring a formal amendment to this Agreement.

County	Contractor	
County of Lake	Legal Name:	Sy Psychiatry
Lake County Behavioral Health Services	Address:	2705 Rockwell Dr.
PO Box 1024		Davis, CA 95618
6302 Thirteenth Avenue		
Lucerne, Ca 95458-1024	ATTN:	Hardeep Singh, MD
ATTN: Elise Jones, MA, Director	Title:	

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

Exhibit A – Universal Scope of Services
Exhibit B-8-DMC-ODS Medical Director & Clinical Consultation 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, titled “Universal Scope of Services”**; each applicable **Exhibit B-series addendum** identified in Section 7; **Exhibit C, titled “Fiscal Provisions”**; **Exhibit D, titled “Compliance Provisions”**; **Exhibit E, titled “Business Associate Agreement”**; and any other exhibit or contract-specific addendum identified in Section 7 and attached hereto, in addition to all other applicable federal, state, and local laws, regulations, and policies.

8.1 Provider Monitoring and Oversight

Contractor agrees to participate in County monitoring activities, including but not limited to annual program, clinical, and fiscal reviews.

Contractor shall submit documents requested for routine County monitoring within ten business days after the request, unless County specifies a different reasonable deadline based on the nature, volume, urgency, or availability of the records.

Documents requested in connection with urgent health or safety concern, suspected fraud or abuse, active authorization review, member grievance or appeal, State Hearing, NOABD, DHCS request, or time-sensitive audit shall be submitted within the shorter timeframe specified by County.

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Contractor shall submit any required corrective action plan within the timeframe stated in County's written notice and shall provide evidence of implementation and effectiveness as requested by County.

Contractor shall provide all requested documentation within timelines established by County. Contractor shall cooperate with on-site and desk reviews conducted by County, DHCS, CMS, or their designees.

If deficiencies are identified, Contractor shall submit a Corrective Action Plan (CAP) within **thirty (30) calendar days** of notification, unless otherwise specified by County. Contractor shall fully implement all CAP requirements within **sixty (60) calendar days** and provide evidence of resolution(s).

Failure to meet documentation and medical necessity requirements shall result in disallowance of claims and recoupment of funds.

8.2 Subcontractors. Contractor shall ensure that all subcontractors comply with all applicable federal, state, and DHCS requirements. Contractor remains fully responsible for the performance of all subcontractors.

9. DHCS COMPLIANCE AND ORDER OF PRECEDENCE

Contractor shall comply with all applicable federal, state, and local laws, regulations, Medi-Cal requirements, and controlling guidance issued by the California Department of Health Care Services (DHCS), including Behavioral Health Information Notices, Mental Health and Substance Use Disorder Services Information Notices, manuals, standards, directives, and successor guidance, as applicable to the services and delegated functions performed under this Agreement.

In the event of a conflict, applicable federal and state law and controlling DHCS requirements shall govern. County policies and procedures shall govern to the extent they are consistent with such requirements. Contractor shall promptly notify County of any identified or suspected conflict and shall follow County's written direction regarding resolution.

Contractor acknowledges that County relies on Contractor's compliance with this Agreement to satisfy County's obligations under its agreement with DHCS. To the extent County delegates a function to Contractor, Contractor shall perform the delegated function in accordance with the written delegation, this Agreement, County policy, and all applicable DHCS requirements. County retains ultimate responsibility for compliance with its agreement with DHCS

10. INSURANCE

Contractor shall maintain all insurance coverage required by applicable federal and state law, Medi-Cal requirements, County policy, licensure requirements, certification standards, and

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current DHCS guidance applicable to the services provided under this Agreement. Contractor shall provide evidence of such coverage to County upon request and shall maintain such coverage continuously throughout the term of this Agreement.

11. 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 previously conducted or exchanged between the parties.

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

COUNTY OF LAKE

SY PSYCHIATRY LLC

Chair, Board of Supervisors



[Hardeep Singh \(Sep 4, 2026 09:08:53 PDT\)](#)
Hardeep Singh, MD

Date: _____

Date: **09/04/2026**

APPROVED AS TO FORM:

ATTEST:

LLOYD GUINTIVANO
County Counsel

SUSAN PARKER
Clerk to the Board of Supervisors

By:  
Digitally signed by Lloyd C. Guintivano
DN: cn=Lloyd C. Guintivano, c=US,
o=County of Lake, ou=Office of the County
Counsel,
email=Lloyd.Guintivano@lakecountycs.gov
Date: 2026.08.28 15:33:44 -0700

By: _____

Date: August 28, 2026

Date: _____

EXHIBIT A – UNIVERSAL SCOPE OF SERVICES

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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 MEMBER: “Beneficiary” or “member” 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.

2. CONTRACTOR’S RESPONSIBILITIES

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

- 2.1 Contractor shall provide administrative and/or direct program services, as applicable to the services authorized under this Agreement and any contract-specific addendum. Contractor shall provide only those DMC-ODS services, levels of care, service locations, and deliverables expressly authorized by County. For beneficiaries under the age of 21, Contractor shall provide medically necessary SUD services consistent with the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements set forth in 42 U.S.C. § 1396d(r) and applicable DHCS guidance.
- 2.2 Certification of Eligibility. Contractor shall, in cooperation with County, comply with all applicable federal and state laws, Medi-Cal requirements, and current DHCS guidance governing member eligibility, access criteria, screening, assessment, and authorization for Drug Medi-Cal Organized Delivery System (DMC-ODS) services, including 42 C.F.R. § 455.1(a)(2) and any superseding or successor guidance issued by DHCS or CMS.
- 2.3 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

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providers and shall review for continued compliance with standards at least every three (3) years.

- 2.4 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.
- 2.5 Contractor acknowledges that this Agreement is funded in whole or in part through agreements between County and the California Department of Health Care Services (DHCS), including but not limited to County Performance Contracts.
- 2.6 Contractor shall comply with all applicable DHCS, federal, state, Medi-Cal, and County requirements as further described in Section 9, DHCS Compliance and Order of Precedence.
- 2.7 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 per page.
- 2.8 Contractor is to make voter registration materials available in their offices/facilities and assist individuals in completing materials if requested.
- 2.9 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.
- 2.10 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.
- 2.11 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.

3. RECORDS RETENTION, ACCESS, AND DISPOSITION

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- 3.1 **General Records.** Contractor shall prepare, maintain, safeguard, and make available to County upon request all records and supporting documentation pertaining to this Agreement, including financial, statistical, administrative, property, personnel, subcontractor, member, service, claiming, billing, grievance, appeal, quality, compliance, and program records.

Unless a longer period is required by applicable federal or state law, licensing or certification requirements, DHCS, CMS, County policy, or another provision expressly identified in this Agreement, Contractor shall retain such records for at least ten (10) years following the final date of the Agreement period.

If an audit, investigation, litigation, claim, appeal, overpayment review, corrective action, or other proceeding involving the records is initiated or remains unresolved before the retention period expires, Contractor shall retain the affected records until the later of:

- A. Expiration of the ten-year retention period; or
- B. Final resolution of the matter, including completion of the audit or investigation and exhaustion of applicable administrative and legal remedies.

County, DHCS, CMS, the U.S. Department of Health and Human Services Office of Inspector General, the Comptroller General of the United States, and their authorized designees shall have the right to inspect, evaluate, copy, and audit such records for the period required by this section. This audit right shall exist through ten (10) years from the final date of the Agreement period or from the date of completion of any audit, whichever is later, consistent with 42 C.F.R. § 438.230(c)(3).

- 3.2 **Clinical Records.** Contractor shall maintain a complete legal clinical record for each member served under this Agreement in accordance with applicable federal and state law, licensing and certification requirements, DHCS requirements, County policy, and this Agreement.

Clinical records shall be retained for at least ten (10) years following the member's discharge or final date of service, whichever is later, unless a longer retention period is required under subsection 3.1 or applicable law. Clinical records of unemancipated minors shall be retained until at least one (1) year after the minor reaches eighteen (18) years of age and, in no event, for less than ten (10) years following the last date of treatment. Records maintained by a licensed psychologist for a member who was a minor shall be retained for at least seven (7) years after the member reaches eighteen (18) years of age, or longer when required by subsection 3.1 or applicable law.

Clinical records shall contain sufficient detail to support access criteria, medical necessity, diagnosis or applicable ICD code, ASAM level-of-care determinations, service

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delivery, service authorization, claims, billing, utilization review, care coordination, quality review, audit, and compliance monitoring.

- 3.3 **Cessation of Operations.** If Contractor ceases operations, dissolves, files for bankruptcy, terminates the applicable program, or is otherwise unable to maintain or provide access to records for the required retention period, Contractor shall, before ceasing operations, transfer the affected records to County. Contractor shall not destroy, abandon, conceal, alter, or make any record subject inaccessible to this section.
- 3.4 **Secure Disposition.** After the applicable retention period and any litigation, investigation, or audit hold have expired, Contractor shall securely destroy confidential records in accordance with applicable federal and state confidentiality, privacy, and records-disposition requirements.
- 3.5 **Survival.** Contractor's record-retention, production, confidentiality, transfer, inspection, and audit obligations shall survive the expiration, termination, cancellation, or completion of this Agreement for the entire applicable retention period.
- 3.6 **Records Requests.** County may process member access requests for responsive records maintained in the shared County-operated electronic health record system when such records are maintained by or for County, used by County or the County Behavioral Health Plan to make decisions about the member, included in the member's designated record set, or otherwise within County custody, control, or lawful possession.

Contractor remains responsible for responding to member access requests for records maintained solely by Contractor outside the shared County-operated electronic health record system, including records maintained in Contractor's separate electronic health record, paper chart, administrative file, or other recordkeeping system.

For Contractor-authored records maintained in the shared County-operated electronic health record system, County may coordinate with Contractor as needed to confirm authorship, completeness, accuracy, applicable restrictions, and any legal or clinical review considerations prior to release.

A member shall not be required to submit a duplicate request to Contractor for records already maintained in the shared County-operated electronic health record system, unless County determines that the requested records are maintained solely by Contractor outside the shared County-operated electronic health record system.

Each party shall comply with applicable confidentiality, privacy, and records-access requirements, including HIPAA, 42 CFR Part 2, the California Confidentiality of Medical Information Act, California Health and Safety Code section 123110, Welfare and Institutions Code section 5328, and all other applicable federal and state confidentiality

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and records-access laws. HIPAA generally provides individuals access to protected health information in a designated record set, while California Health and Safety Code section 123110 provides patient access rights to inspect or obtain copies of patient records. 42 CFR Part 2 imposes additional restrictions on use and disclosure of SUD treatment records, and Welfare and Institutions Code section 5328 governs confidentiality of mental health records.

- 3.7 **Data Sharing and Interoperability.** Contractor shall comply with all applicable federal and state requirements related to data sharing, interoperability, care coordination, event notification, and patient access to health information, including but not limited to applicable DHCS Behavioral Health Information Notices, 42 C.F.R. Part 2, HIPAA, and County policies.

Contractor shall provide timely, complete, and accurate data to County in the format and within the timelines specified by County, DHCS, or other applicable regulatory authorities. Required data may include, but is not limited to, admissions, discharges, transfers, status changes, referrals, care coordination information, ASAM assessments and level-of-care determinations, utilization data, service data, event notifications, and information necessary for state and federal reporting.

Contractor shall cooperate with County in implementing data exchange, interoperability, and real-time data-sharing requirements, including requirements related to BHIN 26-013, BHIN 26-008, and any subsequent or superseding DHCS guidance. Contractor shall correct incomplete, inaccurate, or untimely data within timeframes specified by County.

4. SERVICES AND ACCESS PROVISIONS

4.1 Access to Substance Use Disorder Services.

A. Access Criteria and Medical Necessity. In collaboration with County, Contractor shall ensure that individuals receiving substance use disorder (SUD) services under this Agreement meet applicable DMC-ODS access criteria and medical necessity requirements in accordance with applicable federal and state law, Medi-Cal requirements, County policy, and guidance issued by the California Department of Health Care Services (DHCS), including but not limited to BHIN 24-001 and any subsequent or superseding DHCS guidance. Contractor shall ensure that the member record contains documentation demonstrating, as a whole, that the member's presentation, condition, and service needs are consistent with the applicable access criteria and medical necessity standards in effect at the time services are rendered, including age-specific criteria where applicable.

B. Admission, Readmission, and Suitability Criteria. Contractor shall maintain written admission, readmission, and suitability criteria applicable to the services provided under this Agreement. Beneficiaries admitted to services shall meet applicable admission criteria, and Contractor shall document the basis for admission in the member record.

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C. Non-Discrimination and Special Populations. Contractor shall ensure that its policies, procedures, practices, and program rules do not discriminate against protected populations or create barriers to access. When the member's needs cannot be reasonably accommodated by Contractor, Contractor shall make reasonable efforts to refer or link the member to County, the County care coordinator, an appropriate provider, or the appropriate level of care.

D. Criminal Justice Status. Contractor shall ensure that parole, probation, justice involvement, or pending legal status is not, by itself, a barrier to access to medically necessary DMC-ODS services. Contractor shall ensure that the member record, as a whole, supports the member's presentation and service needs align with the applicable access criteria and medical necessity requirements.

E. Initial Assessment. The initial assessment may be performed in person, by telehealth, or by telephone by a Licensed Practitioner of the Healing Arts (LPHA) or a registered or certified SUD counselor, and may occur in the community, the home, or another appropriate setting consistent with applicable law, DHCS guidance, County policy, and scope of practice.

If the assessment is completed by a registered or certified SUD counselor and a diagnosis is required, an LPHA shall evaluate the assessment with the counselor and make the diagnosis. The consultation between the LPHA and the registered or certified SUD counselor may be conducted in person, by video, or by telephone and shall be documented in the member record.

F. Access Criteria During the Initial Assessment Period.

Contractor shall comply with DMC-ODS access criteria and assessment timelines during the initial assessment period.

1. For beneficiaries 21 years of age and older, a full assessment using the ASAM Criteria shall be completed within 30 days of the member's first visit with an LPHA or registered or certified counselor.
2. For beneficiaries under the age of 21, a full assessment using the ASAM Criteria shall be completed within 60 days of the member's first visit with an LPHA or registered or certified counselor.
3. For beneficiaries experiencing homelessness and where the provider documents that are 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 member's first visit with an LPHA or registered or certified counselor.

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4. If a member 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 period starts over.

G. Access Criteria After Initial Assessment.

Contractor shall comply with beneficiaries' access criteria after initial assessment requirements:

1. Beneficiaries 21 years of age and older, to qualify for DMC-ODS services after the initial assessment, must meet one of the following criteria:
 - i. 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
 - ii. 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.
2. Beneficiaries under the age of 21 qualify for DMC-ODS medically necessary services after the initial assessment, in the following circumstances:
 - i. 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.
 - ii. Services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and SUDs, consistent with federal guidance.
 - iii. 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.

Contractor shall comply with all current and future BHINs, including those that supersede prior guidance.

4.2 American Indian / Alaska Native (AI/AN) Beneficiaries.

Contractor shall allow AI/AN beneficiaries to access services from Indian Health Care Providers (IHCPs) consistent with federal and state law.

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- A. Contractor shall not require prior authorization for AI/AN beneficiaries to receive covered services from IHCPs.
- B. Contractor shall cooperate with County in ensuring eligible beneficiaries have access to covered Traditional Healer and Natural Helper services provided by or through participating Indian Health Care Providers in accordance with BHIN 25-007 and subsequent or superseding DHCS guidance. Contractor shall not impede referral, coordination, access, or continuity of care involving approved traditional health care practices.
 - 1. When Contractor is a participating Indian Health Care Provider or is otherwise authorized to furnish traditional health care practices, Contractor shall comply with all applicable approval, qualification, documentation, coordination, claiming, reporting, and monitoring requirements.

4.3 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 beneficiaries 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 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 member's condition changes.
- F. Requirements for ASAM LOC assessments apply to NTP beneficiaries and settings.

4.4 Medical Necessity.

- A. Pursuant to applicable federal and state law, including Welfare and Institutions Code section 14059.5, and DHCS guidance including but not limited to BHIN 24-001 and any subsequent or superseding guidance, all DMC-ODS services provided under this Agreement shall be medically necessary.

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- B. For beneficiaries aged 21 and older, a service is medically necessary 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 age 21, a service is medically necessary if the service is necessary to correct or ameliorate screened health conditions. Services need not be curative or completely restorative to ameliorate health condition, including substance misuse or an SUD. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and may be covered as EPSDT services when otherwise allowable.

4.5 Additional Coverage Requirements and Clarifications.

- A. The target population for DMC-ODS SUD services includes beneficiaries 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:
 - 1. Services are provided prior to the completion of an assessment or prior to determination of whether DMC-ODS access criteria are met, or prior to the determination of a diagnosis.
 - 2. Clinically appropriate and covered DMC-ODS services provided to beneficiaries over the age of 21 are reimbursable during the assessment process. Similarly, if the assessment determines that the member does not meet the DMC-ODS access criteria after initial assessment, those clinically appropriate and covered DMC-ODS services provided are reimbursable.
 - 3. 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.”
- C. Contractor shall comply with all applicable federal and state laws, regulations, Medi-Cal requirements, and guidance issued by the California Department of Health Care Services (DHCS), including, but not limited to, Behavioral Health Information Notices (BHINs), Mental Health and Substance Use Disorder Services Information Notices (MHSUDS INs), plan letters, billing manuals, and any subsequent updates, amendments, replacements, or superseding guidance issued during the term of this Agreement. Any

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reference in this Agreement to a specific statute, regulation, BHIN, MHSUDS IN, manual, or other DHCS guidance shall include any successor authority or replacement guidance addressing the same or substantially similar subject matter.

- D. Treatment plans, plans of care, or similar care-planning documents are required only when required by federal law, state law, DHCS guidance, licensing or certification standards, County policy, or the applicable provider-type addendum. This includes, but is not limited to, Narcotic Treatment Programs (NTPs), Peer Support Services when an approved plan of care is required, and other services or circumstances identified by DHCS or County.
- E. Medically necessary covered DMC-ODS services delivered by Contractor shall be covered and reimbursable Medi-Cal services, whether or not the member has a co-occurring mental health condition, provided all applicable access, documentation, claiming, and reimbursement requirements are met.

4.6 Diagnosis During Initial Assessment.

Contractor shall comply with all applicable federal and state laws, regulations, Medi-Cal requirements, DHCS guidance, State Plan requirements, Medicaid and Medi-Cal billing guidance, provider manuals, and County policies related to diagnosis and claiming during the initial assessment period.

When a diagnosis has not yet been established, Contractor may use clinically appropriate ICD-10 codes permitted by CMS, DHCS, and County policy during the assessment period, including but not limited to:

- A. ICD-10 codes Z55-Z65, Potential health hazards related to socioeconomic and psychosocial circumstances, as clinically appropriate during the assessment period prior to diagnosis;
- B. ICD-10 code Z03.89, Encounter for observation for other suspected diseases and conditions ruled out, when used by an LPHA during the assessment phase when a diagnosis has not yet been established; and
- C. Other CMS-approved ICD-10 codes, including “Other specified,” “Unspecified,” or “Factors influencing health status and contact with health services” codes, when clinically appropriate and permitted by applicable guidance.

4.7 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.

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- B. Contractor shall identify the person responsible for care coordination for each member and shall document applicable care-coordination activities in SmartCare or another County-approved system.
- C. Contractor shall notify the assigned County care coordinator or other County-designated staff of:
 - 1. Admission to residential or withdrawal-management services;
 - 2. Significant changes in condition or level-of-care needs;
 - 3. Hospitalization, emergency department transfer, or incarceration;
 - 4. Planned discharge or transition;
 - 5. Unplanned discharge, administrative discharge, or member departure against advice;
 - 6. Medication-continuity concerns;
 - 7. Housing, transportation, or other barriers that may jeopardize transition; and
 - 8. Failure to connect with the next provider following discharge.

Notice shall be provided within the timeframe and by the method specified in the LCBHS care-coordination and discharge procedures.

- D. Contractor shall ensure that all care, treatment, and services provided pursuant to this Agreement are coordinated among all providers who are serving the member. Coordination and continuity of care procedures shall meet the following requirements:
 - 1. Ensure that each member 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 member. The member shall be provided with information on how to contact their designated person or entity.
 - 2. All services provided to beneficiaries shall be coordinated:
 - i. Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.
 - ii. With the services the member receives from any other managed care organization.
 - iii. With the services the member receives in FFS Medi-Cal.
 - iv. With the services the member receives from community and social support providers.
 - 3. Share with other providers serving the member, as allowed by regulations, the results of any identification and assessment of that member's needs to prevent duplication of those activities.

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- 4. Ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a member health record in accordance with professional standards.
 - 5. Ensure that in the process of coordinating care, each member'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.
 - E. Contractor shall engage in care coordination activities beginning at intake and throughout the treatment and discharge planning processes.
 - F. To facilitate care coordination, Contractor will request a HIPAA, 42 C.F.R. Part 2, and California law compliant member authorization to share member information with and among other providers involved in the member's care, when required by applicable law.
- 4.8 Site Licenses, Certifications, Permits, and Designations.** Contractor shall obtain, maintain, and comply with all licenses, permits, registrations, certifications, fire clearances, site certifications, ASAM Level of Care certifications, DHCS Level of Care designations, and any other approvals required for the specific DMC-ODS services, levels of care, facility type, provider type, and service locations authorized under this Agreement.
- A. As specified in BHIN 24-001 and in accordance with Health and Safety Code section 11834.015, DHCS has adopted the American Society of Addiction Medicine (ASAM) Criteria as the minimum standard of care for licensed substance use disorder treatment facilities. Contractor shall comply with all applicable ASAM Criteria, DHCS requirements, and County requirements applicable to the services, levels of care, facility type, provider type, and service locations authorized under this Agreement.
 - B. Contractor shall obtain, maintain, and comply with all licenses, permits, registrations, certifications, fire clearances, site certifications, Medi-Cal certifications, ASAM Level of Care certifications, DHCS Level of Care designations, and any other approvals required for the specific DMC-ODS services, levels of care, facility type, provider type, and service locations authorized under this Agreement.
 - C. Contractor shall obtain and maintain at least one DHCS Level of Care Designation and/or at least one residential ASAM Level of Care Certification, as applicable and consistent with the services provided. If a licensed SUD facility obtains an applicable ASAM Level of Care Certification, the facility is not required to obtain a DHCS Level of Care Designation for that same applicable service; however, nothing precludes a facility from obtaining both a DHCS Level of Care Designation and ASAM Level of Care Certification.
 - D. Contractor shall obtain and comply with DMC site certification and ASAM designation, ASAM Level of Care Certification, or DHCS Level of Care Designation for each

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contracted service, level of care, facility type, and service location, as applicable. Contractor shall also obtain any additional licensure, registration, permit, accreditation, or approval required by federal, state, County, municipal, regulatory, or contractual requirements.

- E. Contractor shall not provide, bill, or claim DMC-ODS services at any site, facility, level of care, or service location unless all required approvals are current, valid, and applicable to the specific service being provided.
- F. Contractor shall have and maintain a valid fire clearance for each service delivery site where direct services are provided to beneficiaries, when required by applicable law, regulation, DHCS requirement, local authority, or County requirement.
- G. Requirements specific to a provider type, facility type, service location, or level of care shall be identified in the applicable Scope of Work, Exhibit, Attachment, Enclosure, Provider Addendum, or another County-approved contract-specific addendum.
- H. Contractor shall immediately notify County of any change, expiration, suspension, revocation, corrective action, provisional status, relocation, capacity change, ownership change, or other issue affecting any license, certification, permit, designation, fire clearance, site approval, or other authorization required to provide services under this Agreement.
- I. Contractor shall not add, relocate, modify, or expand services, service locations, levels of care, or facility capacity without prior County review and written approval, and without obtaining any required DHCS, state, federal, local, or County approvals. Services provided outside the approved scope, location, level of care, provider type, or authorization are not eligible for reimbursement unless expressly approved in writing by County and allowed under applicable law and guidance.

4.9 Tobacco Use Disorder Requirements.

If Contractor operates a licensed and/or certified SUD recovery or treatment facility, or otherwise provides services subject to tobacco use disorder assessment, treatment, referral, or education requirements, Contractor shall comply with all applicable federal and state laws, licensing and certification requirements, County policy, and DHCS guidance, including but not limited to Assembly Bill 541, Health and Safety Code section 11756.5, BHIN 22-024, and any subsequent or superseding law or DHCS guidance.

Contractor shall assess beneficiaries for tobacco use at intake, provide information regarding how continued use of tobacco products may affect recovery from SUD, recommend treatment for tobacco use disorder when indicated, and offer treatment within the limits of Contractor's license or certification or provide referral for tobacco use disorder treatment.

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4.10 Naloxone and Overdose Prevention Requirements.

If Contractor operates a DHCS-licensed residential SUD recovery or treatment facility, provides opioid treatment services, stores or administers medications, or otherwise provides services subject to overdose prevention, naloxone, or opioid antagonist requirements, Contractor shall comply with all applicable federal and state laws, licensing and certification requirements, County policy, and DHCS guidance related to overdose prevention, naloxone availability, FDA-approved opioid antagonist medications, medication storage, staff training, emergency response, and opioid overdose prevention and treatment, including but not limited to Assembly Bill 381, Health and Safety Code section 11834.26, BHIN 22-025, and any subsequent or superseding law or DHCS guidance. For DHCS-licensed residential SUD recovery or treatment facilities, Contractor shall maintain opioid antagonist medication and staff training documentation as required by Health and Safety Code section 11834.26 and BHIN 22-025.

4.11 Medi-Cal peer support services.

A. Authorization. Contractor may provide and claim Medi-Cal Peer Support Services only when:

1. The services are included within Contractor's County-approved scope of services;
2. The services are provided by an individual holding a current certification under a DHCS-approved Medi-Cal Peer Support Specialist Certification Program;
3. The services are based on an approved plan of care containing individualized recovery goals;
4. The services are medically necessary, properly documented, and provided in accordance with County policy and applicable DHCS requirements; and
5. Claims and encounter data are submitted using the procedure codes, modifiers, units, provider taxonomy, and other billing requirements established by County and DHCS.

B. Covered Activities. Medi-Cal Peer Support Services may include allowable individual or group activities that support:

1. Recovery and resiliency;
2. Engagement in behavioral health treatment;
3. Development of individualized recovery goals;
4. Self-advocacy and self-sufficiency;
5. Development of natural supports;
6. Wellness and relapse-prevention planning;
7. Navigation of behavioral health and community resources;
8. Transition between services and levels of care; and
9. Education and support for members and their families, caregivers, or other significant support persons.

C. Prior Authorization. Medi-Cal Peer Support Services shall not be subject to prior authorization.

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- D. Coordination and Nonduplication. Contractor shall coordinate Medi-Cal Peer Support Services with the member's other services and shall ensure that services and claims are not duplicative.
- E. Peer Qualifications. Contractor shall verify and maintain documentation that each Medi-Cal Peer Support Specialist:
1. Holds a current state-approved certification;
 2. Complies with applicable continuing-education requirements;
 3. Complies with the Medi-Cal Code of Ethics for Peer Support Specialists;
 4. Provides services within the authorized peer scope of practice; and
 5. Completes all County- and Contractor-required orientation and training.
- F. Peer Supervision. Contractor shall ensure that each Medi-Cal Peer Support Specialist is supervised by a qualified Medi-Cal Peer Support Specialist Supervisor who meets applicable DHCS requirements and completes the required DHCS-approved supervisor training.
- G. Clinical Direction. Medi-Cal Peer Support Services shall be provided under the direction of a Behavioral Health Professional qualified under DHCS requirements applicable to DMC-ODS services. The Behavioral Health Professional shall act as the clinical team leader, provide direct or functional oversight of service delivery, and assume ultimate clinical responsibility for the Medi-Cal Peer Support Services provided.
- The Behavioral Health Professional is not required to be physically present at the service location unless physical presence is required by law, scope-of-practice requirements, County policy, or the member's clinical condition.
- H. Professional Services. Medi-Cal Peer Support Services shall not replace an assessment, diagnosis, treatment decision, crisis evaluation, medical service, psychotherapy service, or other function that must be performed by a licensed, registered, certified, or otherwise qualified professional.

4.12 Medications for Addiction Treatment

Contractor shall accept and serve beneficiaries who receive Medications for Addiction Treatment ("MAT") and shall not deny admission, restrict participation, require dosage reduction, tapering, or discontinuation, or discharge a beneficiary solely because the beneficiary receives MAT. Contractor shall either offer MAT directly, when authorized and within Contractor's licensed and approved scope, or maintain an effective referral process that actively facilitates access to clinically appropriate MAT.

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An effective referral process shall include an established relationship with an appropriate MAT provider and assistance necessary to access services, including care coordination and transportation assistance when needed. Providing only contact information, a website, or a provider list does not constitute an effective referral.

Methadone maintenance treatment shall be provided only through an appropriately licensed and certified Narcotic Treatment Program.

5. DESCRIPTION OF SERVICES

5.1 Authorized Services.

Contractor shall provide only those DMC-ODS covered services, levels of care, service locations, and deliverables specifically authorized by County. Services may include outpatient treatment, intensive outpatient treatment, residential treatment, withdrawal management, narcotic treatment program/opioid treatment program services, medication-assisted treatment, recovery services, peer support services, care coordination, or other covered DMC-ODS services, as applicable to Contractor's licensure, certification, site approval, County authorization, and DHCS requirements.

5.2 Approved Service Locations.

Services shall be provided only at County-approved service location(s). Contractor shall not provide or bill for services at any location not approved by County, DHCS, or any applicable licensing or certification authority, unless expressly authorized by County in writing.

5.3 Hours of Operation.

Contractor shall maintain hours of operation for Medi-Cal beneficiaries that are no less than the hours of operation during which Contractor offers comparable services to non-Medi-Cal beneficiaries, as applicable. If Contractor only serves Medi-Cal beneficiaries, Contractor shall maintain hours of operation sufficient to meet applicable DMC-ODS access, timely access, and network adequacy requirements.

Contractor shall notify the LCBHS Director and County AOD Administrator as soon as practicable of any unplanned closure, service interruption, staffing shortage, intake limitation, waitlist, or other event that may materially affect member access. Planned closures or material reductions in services require prior written notice to and approval by County.

6. AUTHORIZATIONS AND DOCUMENTATION PROVISIONS.

6.1 Service Authorization

A. General Requirements. Contractor shall comply with all applicable County and DHCS service authorization, utilization management, medical necessity, and level-of-care requirements, including BHIN 24-001, the County's agreement with DHCS, County policies and procedures, and any subsequent or superseding requirements.

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- B. Payment Requirements. Contractor shall not be paid for any service, level of care, placement, supplemental service, or other cost unless the service:
1. Is authorized by County when authorization is required;
 2. Is properly documented;
 3. Meets applicable access, medical necessity, and level-of-care requirements;
 4. Is allowable and reimbursable under DMC-ODS or another authorized funding source; and
 5. Is included within this Agreement or a County-approved contract-specific addendum.
- C. Non-Residential and Non-Inpatient Services.
1. Prior authorization shall not be required or imposed for non-residential or non-inpatient DMC-ODS assessment or treatment services.
 2. Contractor shall not require a centralized, County-administered comprehensive ASAM assessment before a member may begin receiving non-residential or non-inpatient DMC-ODS services.
 3. Withdrawal management services shall not be subject to prior authorization.
 4. Nothing in this subsection eliminates applicable access, medical necessity, documentation, utilization-review, or level-of-care requirements.
- D. Residential Services.
1. Residential DMC-ODS services, excluding withdrawal management services, are subject to prior authorization and independent review by County.
 2. Contractor shall submit complete and timely requests for initial and continued authorization in accordance with County policies and procedures. Requests shall include the clinical documentation reasonably necessary to establish the members' need for the requested service and level of care, including applicable ASAM, medical necessity, and continued-stay information.
 3. County shall evaluate the request using applicable access, medical necessity, and ASAM Criteria and shall ensure placement in the least intensive level of care clinically appropriate to treat the member's condition.
 4. County shall notify Contractor of its authorization determination within 24 hours after Contractor submits the authorization request.
 5. Contractor shall not delay a member's access to medically necessary services while awaiting completion of documentation that is not required before services may begin under applicable DHCS requirements.
- E. Inpatient SUD Services.
- Hospital-based inpatient SUD services in an acute care hospital at ASAM Levels 3.7 and 4.0 are administered and authorized by the members' Medi-Cal Managed Care Plan or other responsible payer. Contractor shall coordinate with County and the responsible payer and shall provide the information reasonably necessary to facilitate authorization, admission, continued stay, discharge planning, and transition to an appropriate DMC-

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ODS service. County shall manage the member's transition to the DMC-ODS continuum when notified that the member no longer requires inpatient care.

F. Continued Authorization and Changes in Condition.

1. Contractor shall timely submit continued-stay authorization requests and supporting clinical documentation within the deadlines established by County.
2. Contractor shall promptly notify County of any material change in the member's condition, treatment needs, placement, or circumstances that may require:
 - a. Modification of authorized services;
 - b. Continued authorization;
 - c. Transition to another level of care;
 - d. Expedited clinical review; or
 - e. Additional care coordination or discharge planning.
3. Contractor shall regularly evaluate each member's progress and continued need for the authorized level of care. Length of stay shall be based on individualized clinical need and medical necessity and shall not be limited solely by a predetermined number of days.

G. Authorization Decisions and Notices.

1. County retains responsibility for making authorization determinations unless a specific function is expressly delegated in writing.
2. Any decision to deny an authorization request or to authorize a service in an amount, duration, or scope less than requested shall be made by a health care professional with appropriate clinical expertise in addressing the member's medical and behavioral health needs.
3. County shall provide Contractor and the member with notices required by applicable federal or state law when services are denied, reduced, suspended, delayed, terminated, or authorized in an amount, duration, or scope less than requested.
4. Contractor shall not issue a Notice of Adverse Benefit Determination unless County has expressly delegated or authorized that function in writing.
5. Any additional authorization, submission, documentation, continued-stay, utilization-review, or payer-coordination requirements specific to a service, level of care, facility type, or provider type shall be identified in Exhibit C or another County-approved contract-specific addendum.

If County expressly delegates an authorization-decision function to Contractor, Contractor shall make and provide notice of a standard decision no later than seven (7) calendar days of receipt of request and expedited decision as expeditiously as the members condition requires but no later than seventy-two (72) hours after receipt. These timeframes shall not be exceeded.

H. Lake County Authorization Submission Process. Contractor shall submit initial authorization, continued-stay, and other utilization-review requests to the LCBHS unit

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designated by County using SmartCare, secure email, secure file transfer, or another County-approved submission method.

County shall provide Contractor with written authorization procedures identifying:

1. The County unit and contact responsible for receiving requests;
2. The required request form or electronic workflow;
3. Required clinical and ASAM documentation;
4. Submission deadlines for initial and continued authorization;
5. Procedures for urgent or expedited requests;
6. Procedures for incomplete requests and requests for additional information;
7. After-hours submission procedures; and
8. Procedures for communicating approval, modification, denial, and expiration of authorization.

Contractor shall maintain evidence of timely submission and shall promptly respond to County requests for additional information. Contractor shall not represent that County has authorized a service unless Contractor has received written or electronically documented authorization from County.

No function shall be considered delegated to Contractor solely because Contractor performs an administrative, clinical, documentation, or reporting activity related to that function. Any delegation must be expressly identified in this agreement or in separate written direction issued by County.

6.2 Documentation Requirements

- A. **General Documentation Standard.** Contractor shall comply with all applicable documentation requirements for DMC-ODS services, including federal and state laws, Medi-Cal requirements, DHCS guidance, County policy, County-approved documentation standards, and the County's agreement with DHCS. This includes, but is not limited to, BHIN 23-068, BHIN 24-001, and any subsequent or superseding DHCS guidance.
- B. **Accuracy and Required Service Information.** All documentation shall be accurate, complete, legible, timely, and sufficient to support the service provided, service code, medical necessity, access criteria, ASAM level-of-care determination when applicable, billing, claiming, utilization review, audit, and compliance monitoring.

Documentation shall include, as applicable:

1. Date of service;
2. Type of service provided;

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3. Duration of the service, including travel and documentation time when allowable and claimed;
4. Service modality, including in person, telephone, telehealth, field-based, or another approved modality;
5. Provider name, title, credential/license/registration/certification type, and signature or electronic authentication when required;
6. Relationship of the service to the member's identified needs, condition, diagnosis, symptoms, risk factors, or problem list;
7. Next steps, follow-up, referrals, care coordination, or updates to the problem list when applicable; and
8. Any additional elements required by DHCS, County policy, the billing code, service type, funding source, or provider-type addendum.

C. County-Approved Systems and Compliance Remedies. Contractor shall document services using County-approved forms, templates, systems, and documentation standards, unless otherwise authorized by County. Failure to comply with applicable documentation requirements may result in corrective action, denial or disallowance of claims, recoupment, withholding of payment, sanctions, termination, or other remedies authorized under this Agreement or applicable law.

6.3 Assessment

- A. **ASAM Criteria.** Contractor shall use the American Society of Addiction Medicine (ASAM) Criteria to determine the appropriate substance use disorder level of care for DMC-ODS beneficiaries, in accordance with applicable DHCS guidance, County policy, and the applicable provider-type addendum.
- B. **Assessment Documentation.** The assessment shall include sufficient information to support access criteria, medical necessity, diagnosis or applicable assessment-period ICD code, ASAM level-of-care determination, service recommendations, care coordination, referrals, and discharge planning.
- C. **Provider Signature and Authentication.** When required, the assessment shall include the typed or legibly printed name, title, credential/license/registration/certification type, signature or electronic authentication of the provider completing the assessment, and the date of signature or authentication.
- D. **Counselor-Completed Assessments and Diagnosis.** If the assessment is completed by a registered or certified SUD counselor and a diagnosis is required, an LPHA shall evaluate the assessment with the counselor and make the diagnosis. The consultation between the LPHA and the registered or certified SUD counselor may be conducted in person, by video, or by telephone and shall be documented in the member record.

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- E. **Supporting Documentation.** The member record, including the assessment, problem list, progress notes, and other required documentation, shall support the medically necessary services provided and the medical necessity of each claimed service.
- F. **Assessment Updates.** Assessments shall be updated as clinically appropriate and as required by applicable federal and state laws, regulations, Medi-Cal requirements, DHCS guidance, County policy, and the applicable provider-type addendum.

6.4 Diagnosis and ICD-10 Coding

- A. **Diagnostic Determinations.** Contractor shall use the criteria set forth in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) as the clinical tool to make substance use disorder diagnostic determinations, when a diagnosis is required.
- B. **ICD-10 Coding and Claims.** Once a DSM diagnosis is established, Contractor shall identify the corresponding ICD-10 diagnosis code and use the ICD-10 code for claiming and billing purposes, consistent with CMS, DHCS, Medi-Cal billing guidance, County policy, and County billing procedures.
- C. **Services During Assessment Period.** When a diagnosis has not yet been established, Contractor may use clinically appropriate CMS-approved ICD-10 codes permitted by DHCS and County policy during the assessment period. The member record shall support the ICD-10 code used.
- D. **Youth/EPSDT Early Intervention.** For members under age twenty-one, a confirmed substance use disorder diagnosis or comprehensive ASAM assessment is not required before receiving a Medi-Cal-coverable prevention or Early Intervention Service that is clinically appropriate and medically necessary under EPSDT requirements. Contractor may use an abbreviated ASAM screening or another County-approved screening tool. If the member meets diagnostic criteria for a substance use disorder, Contractor shall complete or arrange for a comprehensive ASAM assessment and actively link the member to the clinically appropriate level of care.
- E. **Updates to ICD-10-CM Codes.** The ICD-10 code set is maintained by CMS and may be updated during the term of this Agreement. Changes to ICD-10 diagnosis codes or billing guidance do not require amendment of this Agreement, and County may implement such changes as required or permitted by DHCS, CMS, or Medi-Cal billing guidance.

6.5 Problem List

- A. **Required Problem List.** Contractor shall create and maintain an active and ongoing Problem List for each member receiving DMC-ODS services, in accordance with applicable DHCS documentation requirements, County policy, and the applicable provider-type addendum.

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B. Content of Problem List. The Problem List shall include symptoms, conditions, diagnoses, risk factors, substance use-related needs, co-occurring needs, social drivers, or other clinically relevant issues identified through assessment, screening, crisis encounters, service encounters, member report, significant support person report, or other clinically relevant information.

C. Required Elements.

The Problem List shall include, as applicable:

1. Diagnoses identified by a provider acting within their scope of practice;
2. Problems, symptoms, conditions, risk factors, or treatment needs identified by a provider acting within their scope of practice;
3. Problems or illnesses identified by the member or significant support person;
4. The name, title, and applicable credential, license, registration, or certification type of the provider who identified, added, modified, or removed the problem; and
5. The date the problem was identified, added, modified, or removed.

D. Updates. Contractor shall update the Problem List when there is a relevant change to the member's condition, presentation, diagnosis, risk factors, treatment needs, or service needs. A problem identified during a service encounter may be addressed by the provider during that encounter and subsequently added to the Problem List, when clinically appropriate and within the provider's scope of practice.

E. Coding Standards. Contractor shall maintain the Problem List consistent with applicable DHCS documentation standards and County EHR requirements, including use of required coding standards such as SNOMED CT and ICD-10-CM when required by DHCS, County policy, or the County-approved EHR.

F. Authentication. The provider's electronic entry, signature, or authentication shall be maintained in accordance with County EHR standards, Contractor policy, and applicable documentation requirements.

6.6 Progress Notes

A. Required Progress Notes. Contractor shall complete progress notes for all DMC-ODS services provided under this Agreement in accordance with applicable federal and state laws, Medi-Cal requirements, DHCS documentation requirements, County policy, County-approved documentation standards, and any applicable provider-type addendum.

B. Documentation Standard. Each progress note shall include sufficient detail to support the service provided, service code, billing claim, medical necessity, and relationship of the service to the member's identified needs, condition, diagnosis, symptoms, risk factors, or problem list.

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C. Required Elements.

Progress notes shall include all elements required by applicable DHCS guidance, County policy, and the service type billed, including, as applicable:

1. Type of service provided;
2. Narrative describing the service, including how the service addressed the member's behavioral health need;
3. Date of service;
4. Duration of service, including travel and documentation time when allowable and claimed;
5. Service modality, including in person, telephone, telehealth, field-based, or another approved modality;
6. Location of the member at the time of service, when required;
7. Provider name, title, credential/license/registration/certification type, and signature or electronic authentication when required;
8. ICD-10-CM code and CPT/HCPCS code when required for claiming; and Next steps, follow-up, referrals, care coordination, collaboration, or updates to the problem list, as applicable.

D. Timeliness. Contractor shall complete progress notes within the timeframe required by DHCS guidance, County policy, or the applicable provider-type addendum. Unless County specifies a different timeframe, progress notes shall be completed within three (3) business days of the service. Crisis service notes shall be completed within 24 hours when required by County policy or applicable service requirements.

E. Daily Unit and Group Services. Contractor shall complete documentation for services billed on a daily unit basis in accordance with applicable DHCS, County, and service-specific requirements.

For group services, Contractor shall maintain documentation identifying group participants. If more than one provider renders a group service, one group progress note may be completed when permitted by County policy and DHCS requirements, provided the note documents each provider's involvement and time, including documentation time when allowable and claimed.

6.7 Treatment Plans, Plans of Care, and Other Care-Planning Documents

A. Applicability. Contractor shall complete a Treatment Plan, Plan of Care, or other formal care-planning document only when required by applicable federal law, state law, Medical requirements, DHCS guidance, licensing or certification standards, Alcohol and/or Other Drug Program Certification requirements, County policy, SUBG requirements, or the applicable provider-type addendum.

B. Required Elements. When a Treatment Plan, Plan of Care, or other formal care-planning document is required, Contractor shall include only the elements required by the

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applicable authority. Contractor shall involve the member in ongoing, interactive care planning to the greatest extent appropriate and shall document the member's participation, preferences, and agreement or disagreement with planned services. Care-planning information shall be updated when clinically appropriate, including when the member's needs, condition, goals, services, or level of care materially change, and may be documented in the assessment, problem list, progress notes, a separate care-plan document, or a combination of locations within the member record. Contractor shall complete a formal care plan, including all required elements and signatures, when required by applicable law, DHCS or County policy, or the applicable service, program, facility, funding source, or member population. Subject to applicable confidentiality requirements, Contractor shall be able to produce and communicate relevant care-planning information to the member, County, and other authorized providers as necessary to facilitate coordinated, high-quality care.

Required elements may include:

1. The member's identified needs and treatment or recovery goals;
2. Services, interventions, and supports necessary to address those needs;
3. Medications for Addiction Treatment and other medication needs;
4. Physical and behavioral health coordination;
5. Family, caregiver, peer, and natural-support involvement when appropriate and authorized;
6. Referrals and active linkages to other services;
7. Barriers to participation and strategies to improve engagement;
8. Transition, discharge, and continuing-care needs; and
9. The member's progress and need for changes in services or level of care.

- C. **Review and Updates.** Contractor shall review and update required Treatment Plans, Plans of Care, or other formal care-planning documents within the timeframes required by the applicable authority and whenever clinically indicated by a significant change in the member's condition, treatment needs, level of care, or service plan.
- D. **Peer Support Services.** When Contractor provides Medi-Cal Peer Support Services, Contractor shall comply with applicable DHCS and County requirements for an approved Plan of Care. Peer Support Services shall be documented in the member record and approved by a treating provider who can render reimbursable Medi-Cal services, when required.
- E. **NTP/OTP Services.** When Contractor provides Narcotic Treatment Program or Opioid Treatment Program services, Contractor shall comply with applicable federal opioid treatment program requirements, state NTP requirements, DHCS requirements, County policy, and provider-type addendum requirements related to treatment planning, plans of care, continuing care, and documentation.

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6.8 Telehealth

- A. **Applicability.** If Contractor provides DMC-ODS services by telehealth, telephone/audio-only, video, or other remote modality, Contractor shall comply with all applicable federal and state laws, Medi-Cal requirements, DHCS telehealth guidance, including BHIN 23-018, BHIN 23-068, and any subsequent or superseding DHCS telehealth or documentation guidance, County policy, privacy and security requirements, confidentiality requirements, documentation requirements, and scope-of-practice requirements.
- B. **Clinical Appropriateness and Member Choice.** Telehealth, telephone/audio-only, or remote services shall be clinically appropriate, within the provider's scope of practice, and consistent with member consent and choice. Beneficiaries shall retain the right to request and receive in-person services when available and clinically appropriate.
- C. **Consent and Documentation.** Contractor shall obtain and document all required member consent for telehealth or telephone/audio-only services before initiating services, in accordance with DHCS guidance and County policy. Documentation shall identify the service modality used and shall include all required documentation elements for the service provided.
- D. **Privacy and Security.** Contractor shall ensure confidentiality, privacy, and security during telehealth, telephone/audio-only, or remote service delivery, including appropriate safeguards for the service location, equipment, platform, communication method, and member information.
- E. **Monitoring and Audit.** County may audit Contractor's telehealth, telephone/audio-only, or remote service practices at any time. Contractor shall provide records, policies, procedures, consent documentation, service documentation, and other materials necessary for County to monitor compliance.

6.9 Discharge Planning and Documentation. Contractor shall maintain written discharge, transfer, and referral procedures, or adopt County-approved procedures, consistent with applicable DMC-ODS requirements, DHCS guidance, AOD certification requirements, licensing requirements, County policy, and the applicable provider-type addendum.

- A. Discharge planning shall be provided as part of care coordination when clinically indicated and based on the member's needs. Discharge planning may include linkage to the next appropriate level of care, recovery services, MAT/NTP/OTP services, medical care, mental health care, housing supports, social services, or other appropriate resources.
- B. A discharge plan, continuing recovery plan, or discharge summary is required when required by AOD certification, residential licensing, withdrawal management

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requirements, NTP/OTP requirements, SUBG requirements, County policy, DHCS guidance, or the applicable provider-type addendum.

- C. For AOD-certified and/or licensed programs, Contractor shall complete a discharge summary within seven calendar days of discharge. The discharge summary shall include, at minimum:
 - 1. summary of services provided;
 - 2. date of termination;
 - 3. reason for termination; and
 - 4. referrals, if any.
- D. When required by applicable licensing, certification, County policy, or provider-type addendum, discharge documentation may also include:
 - 1. whether discharge was voluntary, administrative, involuntary, or due to transfer;
 - 2. whether the member successfully completed the program;
 - 3. current substance use status, when clinically relevant and known;
 - 4. recovery supports or services completed;
 - 5. continuing care, recovery, relapse prevention, or transition recommendations;
 - 6. referrals and linkages made;
 - 7. member participation or comments, when obtained; and
 - 8. provider signature or electronic authentication when required.
- E. Residential treatment providers shall comply with applicable residential licensing, AOD certification, ASAM Level of Care Certification, DHCS Level of Care Designation, DMC-ODS, County, and provider-type discharge requirements.
- F. Withdrawal management providers shall document discharge or transition information required by applicable licensing, certification, ASAM, DHCS Level of Care Designation, County, and provider-type requirements, including documentation supporting safe transition to the next clinically appropriate service or level of care when indicated.
- G. NTP/OTP providers shall comply with applicable federal opioid treatment program regulations, state NTP requirements, DHCS DMC-ODS requirements, County policy, and provider-type requirements related to discharge, transfer, administrative withdrawal, continuing care, and documentation, including continuity of medication and care when applicable.
- H. When discharge documentation is required, Contractor shall maintain the documentation in the member record.

7. MINIMUM QUALITY TREATMENT STANDARDS.

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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 Use Prevention, Treatment, and Recovery Services Block Grant (SUBG).

- A. Contractor shall maintain personnel files for all employees, volunteers, and interns. Personnel files shall include, as applicable:
 - 1. application for employment and/or resume;
 - 2. signed employment confirmation statement or duty statement;
 - 3. job description;
 - 4. performance evaluations;
 - 5. health records or health status documentation required by the program, Title 9, or applicable law;
 - 6. personnel actions, including commendations, discipline, status changes, employment incidents, or workplace injuries;
 - 7. training documentation related to substance use disorder treatment and program requirements;
 - 8. current registration, certification, intern status, or licensure;
 - 9. proof of continuing education required by the licensing or certifying agency and program;
 - 10. program code of conduct; and
 - 11. for registered, certified, or licensed staff, a copy of the applicable certifying or licensing body's code of conduct.
- B. Contractor shall develop, maintain, review, and revise job descriptions as needed. Job descriptions shall be approved by the program's governing body or authorized program representative and shall include:
 - 1. position title and classification;
 - 2. duties and responsibilities;
 - 3. lines of supervision; and
 - 4. education, training, work experience, and other qualifications required for the position.
- C. Contractor shall establish and maintain a written code of conduct for employees, volunteers, and interns. The code of conduct shall address, at minimum:
 - 1. use of drugs and/or alcohol;
 - 2. prohibition of social or business relationships with beneficiaries or their family members for personal gain;
 - 3. prohibition of sexual contact with beneficiaries;
 - 4. conflict of interest;
 - 5. providing services beyond scope of practice;
 - 6. discrimination against beneficiaries or staff;
 - 7. verbal, physical, or sexual harassment, threats, or abuse of beneficiaries, family members, or staff;
 - 8. protection of member confidentiality;

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9. the applicable elements of the code of conduct for the certifying organization under which the program's counselors are certified or registered; and
10. cooperation with complaint investigations.

D. If Contractor uses volunteers or interns, Contractor shall implement written procedures addressing:

1. recruitment;
2. screening;
3. selection;
4. training and orientation;
5. duties and assignments;
scope of practice;
6. supervision; and evaluation.

E. If Contractor uses a medical director, Contractor shall maintain written roles, responsibilities, and a code of conduct for the medical director. The document shall be signed and dated by an authorized program representative and the medical director.

7.1 Program Management

- A. Contractor shall maintain written admission and readmission criteria consistent with applicable DMC-ODS requirements, DHCS guidance, ASAM Criteria, AOD certification or licensing standards, SUBG requirements when applicable, County policy, and the applicable provider-type addendum.
- B. Admission or readmission shall be based on the member's eligibility, applicable DMC-ODS access criteria, medical necessity, ASAM level-of-care determination when required, and suitability for the service or level of care provided by Contractor.
- C. Contractor shall not deny admission or readmission based solely on the member's current or recent use of alcohol or other drugs, return to use, relapse, or the member appearing to be under the influence. When the member's presentation creates an immediate health or safety concern, Contractor shall follow applicable emergency, intoxication, withdrawal management, overdose response, referral, transfer, or higher-level-of-care procedures and shall document the clinical rationale and actions taken.
- D. Licensed residential treatment providers shall comply with Health and Safety Code section 11834.26(c)(2) and applicable DHCS guidance, including BHIN 26-006, which prohibit denial of admission based solely on a person having consumed, used, or otherwise been under the influence of alcohol or other drugs.
- E. Contractor shall not deny admission or readmission based solely on justice involvement, co-occurring mental health needs, use of medications for addiction treatment, disability,

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race, color, national origin, sex, gender identity, sexual orientation, age, religion, or any other protected status.

- F. If Contractor determines that the member does not meet admission or readmission criteria for Contractor's program or level of care, or cannot be safely served in Contractor's setting, Contractor shall refer or link the member to County, another appropriate DMC-ODS provider, another level of care, emergency services, withdrawal management, residential treatment, NTP/OTP, or another appropriate service provider, as applicable.
- G. If a member is admitted to treatment, Contractor shall obtain and maintain consent for treatment in accordance with applicable law, DHCS guidance, AOD certification or licensing standards, County policy, and the applicable provider-type addendum.
- H. Contractor shall document admission, readmission, denial of admission, referrals, linkages, clinical rationale, and related care coordination activity in the member record.
- I. Upon admission, Contractor shall provide the member with required admission documents in accordance with applicable DHCS AOD Certification standards, DMC-ODS requirements, licensing requirements, County policy, and the applicable provider-type addendum. Required admission documents shall include, as applicable:
 - 1. member/client rights;
 - 2. consent to treatment;
 - 3. program rules, expectations, and requirements;
 - 4. fee policy, when fees or financial responsibility may apply; and grievance, appeal, and complaint procedures.
- J. Contractor shall make required member/client information available upon admission and/or post the information in a prominent location accessible to beneficiaries, as required by applicable DHCS AOD Certification standards, licensing requirements, DMC-ODS requirements, County policy, and the applicable provider-type addendum. Required information shall include, as applicable:
 - 1. statement of nondiscrimination;
 - 2. member/client rights;
 - 3. grievance and complaint procedures;
 - 4. appeal and NOABD information, when applicable to DMC-ODS services;
 - 5. program rules, expectations, and requirements; and
 - 6. fee policy, when applicable.
- K. The nondiscrimination statement shall include protection from discrimination based on 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, ability to pay, or any other protected status.

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- L. If Contractor provides, stores, monitors, assists with, or otherwise manages medications, Contractor shall comply with all applicable federal, state, DHCS, County, pharmacy, medication storage, monitoring, disposal, and documentation requirements; maintain written medication policies and procedures; ensure appropriate staff training; and dispose of expired, unused, abandoned, or biohazardous pharmaceutical waste, including used syringes or related supplies, in accordance with applicable law, regulation, Contractor policy, and County requirements.
- M. Contractor shall maintain an alcohol and/or drug-free treatment and recovery environment, as applicable to the program type and level of care; permit and appropriately manage medications for the treatment of substance use disorders, mental health conditions, or physical health conditions; and maintain written policies and procedures for responding to relapse, recurrence of use, intoxication, withdrawal symptoms, medication misuse, or other substance-related incidents in a clinically appropriate and safety-focused manner.
- N. When drug screening or urinalysis is used, Contractor shall maintain written procedures to protect against falsification, substitution, contamination, or improper handling of specimens.
- O. Drug screening and urinalysis results shall be documented in the member record when used for treatment, monitoring, care coordination, level-of-care review, court/probation coordination when authorized, or other allowable program purposes.
- P. Drug screening shall not be used in a discriminatory manner or as the sole basis to deny admission or readmission, terminate services, or deny medically necessary DMC-ODS services. Licensed residential treatment providers shall also comply with BHIN 26-006 and Health and Safety Code section 11834.26(c)(2), which prohibit denying admission based solely on a person having consumed, used, or otherwise been under the influence of alcohol or other drugs.
- Q. Current DHCS AOD certification requirements are referred to as Certification for Alcohol and Other Drug Programs, revised February 2025, or any subsequent or superseding DHCS certification standards.

7.2 Assessment, Problem List, Treatment Plans, Progress Notes, and Discharge Documentation

- A. Contractor shall comply with the assessment, ASAM level-of-care determination, problem list, treatment plan or plan of care, progress note, and discharge documentation requirements set forth in Section 6.3 through Section 6.9 of this Agreement. For services partially or fully funded by SUBG, Contractor shall also comply with any additional

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SUBG-specific documentation, treatment, admission, discharge, referral, and reporting requirements applicable to the service, population, or funding source.

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:

Contractor will collaborate with the County in the collection and reporting 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:

1. Follow up After Emergency Department Visit for Alcohol and Other Drug Abuse (FUA)
2. Use of Pharmacotherapy for Opioid Use Disorder (POD)
3. Pharmacotherapy of Opioid Use Disorder
4. 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.

9.2 Failure to submit required reports or data within established timelines may result in sanctions, including withholding payment.

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.

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- 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 member 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 MEDICAL OR SUBG

- 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 shall preserve the integrity, availability, privacy and confidentiality of protected health information.
- 11.2 **Counselor Registration and Certification.** Any individual providing counseling services in a DHCS licensed or certified alcohol and other drug program shall be registered or certified as required by California Code of Regulations, Title 9, Division 4, Chapter 8, Health and Safety Code section 11833, DHCS counselor certification requirements, County policy, and any applicable provider-type addendum.

For purposes of this section, counseling services include, but are not limited to, intake, assessment of need for services, treatment planning, recovery planning, individual counseling, and group counseling provided to participants, patients, residents, clients, or beneficiaries in a DHCS licensed or certified program.

Non-licensed and non-certified individuals providing counseling services shall be registered with a DHCS-recognized counselor certifying organization. Registered counselors shall obtain certification within five (5) years from the date of initial registration. A registered counselor who does not obtain certification within the required five-year period shall not provide counseling services until legally authorized to do so.

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Certified counselors shall maintain current certification, including continuing education and renewal requirements, through a DHCS-recognized counselor certifying organization. Licensed professionals may provide services within their scope of practice when permitted by applicable law, licensure, DHCS requirements, County policy, and the applicable provider-type addendum.

Contractor shall verify and maintain documentation of each counselor's registration, certification, licensure, renewal status, expiration date, scope of practice, and any required supervision as described in BHIN 25-029. Contractor shall ensure counselors do not provide services outside their lawful scope or after expiration, suspension, revocation, or lapse of registration, certification, or licensure.

DHCS-recognized certifying organizations currently include CAADE, CADTP, and CCAPP.

- 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 SUBG 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 member based on 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 member or prospective program member objects to the religious character of a program participant, within a reasonable period of time after the date of such objection, such program member shall have rights to notice, referral, and alternative services as outlined in paragraphs (b) through (d) of Title 42 CFR 54.8.
- D. Religious organizations that receive applicable program funds for substance abuse services are subject to the same regulations as other non-governmental organizations to account, in accordance with general accepted auditing and accounting principles, for the use of such funds.

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- 11.4 **Corrective Action Plans (CAPs).** County will ensure all DMC Post-service Post-Payment-(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 Use prevention, Treatment, and Recovery Services Block Grant (SUBG) 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 made 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 people 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 member’s 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).
 - D. **Marijuana Restriction:** Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders (e.g. requiring HHS to “ensure that Federal funding is expended...in full accordance with U.S. statutory...requirements.”); 21 USC § 812(c) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under Federal law.

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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 **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 (g).

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 subgrantee 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).

11.8 **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.

11.9 **Syringe Services Programs.** Contractor shall not use SUBG or other federal funds to purchase sterile needles or syringes. Subject to prior written authorization by County and DHCS, Contractor may use SUBG funds for other allowable costs of an approved syringe services program, including personnel, allowable supplies, testing kits, educational materials, outreach, disposal services, risk-reduction counseling, naloxone, and referral or linkage to treatment, recovery, medical, and behavioral health services.

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

- A. Routinely make available TB services to each individual receiving treatment for alcohol and other drug use and/or abuse.
- B. Reduce barrier to patient's accepting TB treatment; and,

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

- 11.11 **Tuberculosis screening for Contractor and Subcontractors.** 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:

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

The good physical health of 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 is not required for volunteers whose functions do not necessitate frequent or prolonged contact with residents.

- 11.12 **HIV, Tuberculosis, and Infectious Disease Education and Referral.** Contracted DMC-ODS providers receiving SUBG funding, including SUBG funds used for allowable room and board costs, shall maintain procedures for HIV, tuberculosis, infectious disease education, referral, voluntary linkage, and documentation.

Under 45 CFR § 96.121, HIV Early Intervention Services include appropriate pre-test counseling, HIV testing, appropriate post-test counseling, and therapeutic measures related to preventing and treating immune system deterioration and conditions arising from HIV/AIDS.

Providers are not required to directly provide HIV testing or medical treatment unless specifically authorized and contractually required. However, providers should inform beneficiaries of available HIV/AIDS, tuberculosis, STI, harm reduction, primary care, prenatal care, and emergency medical services, and shall refer or link beneficiaries to appropriate qualified providers when indicated.

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Education and referral information should address HIV/AIDS, tuberculosis, risks related to injection drug use and needle-sharing, risks of transmission to sexual partners and infants, prevention measures, and available treatment resources.

Participation in HIV testing, counseling, HIV Early Intervention Services, tuberculosis services, or other infectious disease-related services shall be voluntary and shall not be required as a condition of admission, continued participation, room and board support, residential placement, or receipt of DMC-ODS SUD services.

Providers shall document applicable education, referrals offered, member acceptance or refusal, linkage efforts, follow-up activity, and barriers to access in the member record, consistent with HIPAA, 42 CFR Part 2, state confidentiality laws, and contract requirements.

- 11.13 **Charting and Confidentiality of HIV Information.** Contracted DMC-ODS providers shall maintain confidentiality protections for HIV-related information, including HIV testing, test results, referrals, counseling, and related documentation, in accordance with applicable federal and state confidentiality laws, including HIPAA, 42 CFR Part 2, and California HIV confidentiality requirements.

When a provider directly arranges for or administers HIV testing, informed consent must be obtained and documented in accordance with applicable law and the provider's governing licensure, certification, and organizational policies. In California, HIV test consent may be oral or written, but the provider administering or arranging the test must document that informed consent was obtained.

Minors aged 12 and older may consent to HIV/STI testing, treatment, and prevention services as allowed under California law. Providers shall protect minor consent confidentiality consistent with applicable state law.

HIV test results and HIV-related records shall not be disclosed without a valid written authorization for each separate disclosure, unless an exception is specifically permitted by law. A general release of information is not sufficient when separate authorization is required for disclosure of HIV test results.

Documentation of HIV/AIDS status, HIV testing, HIV-related referrals, or HIV-related services shall be limited to the minimum necessary information needed for treatment, care coordination, referral, billing, compliance, or legal documentation purposes. Providers shall exercise heightened caution when charting, storing, transmitting, or releasing HIV-related information.

A member's decision to accept or decline HIV testing, counseling, or referral services shall be documented when applicable and shall not be used as a basis to deny, delay,

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suspend, or terminate SUD treatment, residential participation, room and board support, or other DMC-ODS-related services.

- 11.14 **ASAM Criteria.** Contractor shall comply with ASAM Criteria requirements as set forth in Sections 4.3, 6.3, and any applicable provider-type addendum.
- 11.15 **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.
- 11.16 **Intravenous Drug Use (IVDU) Treatment.** Contracted DMC-ODS providers receiving SUBG funding, including SUBG-funded room and board support, shall comply with applicable requirements under 42 U.S.C. § 300x-23 and 45 CFR § 96.126 for individuals who request or are identified as needing treatment for injection drug use. This includes applicable requirements related to priority admission, capacity reporting, timely admission, interim services, outreach, referral, monitoring, and documentation.
- 11.17 **Additional Practice Guidelines.** Contractor shall comply with all applicable federal, state, DHCS, and County-adopted practice guidelines, clinical standards, administrative requirements, Behavioral Health Information Notices, and other guidance applicable to the services provided under this Agreement.

- A. If Contractor provides services to pregnant or parenting individuals, Contractor shall follow the current DHCS Substance Use Disorder Perinatal Practice Guidelines, or any successor guidance issued or adopted by DHCS, in developing and implementing perinatal treatment and recovery services funded under this Agreement. Guidelines can be found at: [Perinatal Practice Guidelines 2025](#)
- B. If Contractor provides services to youth or adolescents, Contractor shall follow the current DHCS Adolescent Substance Use Disorder Best Practices Guide, or any successor youth/adolescent treatment guidance issued or adopted by DHCS, in developing and implementing youth treatment and recovery services funded under this Agreement. Guidelines can be found at: [Adolescent Best Practices Guide OCTOBER 2020](#)

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- C. If Contractor receives or provides services funded in whole or in part by Substance Use Prevention, Treatment, and Recovery Services Block Grant funds, Contractor shall comply with applicable block grant requirements, including, as applicable, the Minimum Quality Drug Treatment Standards, culturally and linguistically appropriate service requirements, perinatal requirements, youth/adolescent treatment requirements, and other DHCS or federal requirements tied to those funds.
- D. Contractor shall comply with all County-adopted practice guidelines, policies, procedures, documentation standards, care coordination expectations, access requirements, and quality assurance requirements applicable to the services provided under this Agreement.
- E. Contractor is responsible for maintaining awareness of and complying with updated DHCS, federal, state, and County guidance applicable to the services provided. No formal amendment to this Agreement is required for updated or successor guidelines, standards, or requirements to apply, unless otherwise required by law or expressly required by the County.

12. MEMBER PROTECTIONS

12.1 Grievances, Appeals and Notices of Adverse Benefit Determination

- A. County shall provide Contractor with the current LCBHS grievance, appeal, and NOABD routing procedure, including the quality management contact, secure submission method, required forms, and escalation contacts.
- B. Contractor shall forward any grievance, complaint, appeal, request for continuation of benefits, State Hearing communication, or circumstance potentially requiring a NOABD to LCBHS Quality Management on the same business day it is received or identified. If received after normal business hours, Contractor shall forward the information no later than the beginning of the next business day.
- C. Contractor shall not investigate, resolve, characterize, or close a grievance or appeal on behalf of County unless the specific function has been expressly delegated in writing.
- D. Contractor shall comply with all applicable federal, state, DHCS, and County requirements governing grievances, appeals, and Notices of Adverse Benefit Determination, including 42 CFR Part 438, Subpart F, applicable DHCS Behavioral Health Information Notices, County policy, and the County's agreement with DHCS.
- E. All grievances, complaints, appeals, and issues that may constitute an expression of dissatisfaction received by Contractor shall be immediately forwarded to County designated staff, through a secure method, including encrypted email, secure file transfer,

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or fax. Contractor shall forward such information promptly to allow County sufficient time to acknowledge receipt, investigate, resolve, and issue required notices or responses within applicable timeframes.

- F. Contractor shall not discourage, obstruct, delay, or interfere with a member's right to file a grievance, appeal, State Hearing request, or request for assistance. A member is not required to use the term "grievance" for a complaint or expression of dissatisfaction to be treated as a grievance.
- G. **County Responsibility and Limited Delegation of NOABD Functions.** County retains ultimate responsibility for compliance with all applicable federal and state requirements governing grievances, appeals, adverse benefit determinations, and Notices of Adverse Benefit Determination (NOABDs). Nothing in this Agreement or in any delegation to Contractor shall transfer, limit, or relieve County of that responsibility. Contractor issuance of NOABDs is not a standard or automatically delegated responsibility under this Agreement. Contractor shall not make an adverse benefit determination or prepare, sign, issue, or deliver a NOABD unless:
1. County has expressly delegated the specific NOABD-related function to Contractor in writing; or
 2. County has provided case-specific written direction or authorization for Contractor to issue the NOABD.

Any written delegation shall identify the delegated function, the types of decisions covered, applicable services or programs, effective period, authorized Contractor personnel, and County oversight and reporting requirements. Delegation shall be limited to functions within Contractor's actual contractual scope and decision-making authority.

County shall retain responsibility for NOABDs arising from County access determinations, service authorization determinations, utilization-management decisions, level-of-care determinations, and decisions made by County to deny, reduce, suspend, or terminate services. Contractor shall not issue a NOABD concerning such a County decision unless specifically directed or authorized by County.

- H. **Requirements Applicable to Delegated NOABD Functions.** When County expressly delegates or specifically authorizes a NOABD-related function, Contractor shall:
1. Comply with 42 C.F.R. Part 438, Subpart F; applicable DHCS requirements; County policies and procedures; and all required notice-content, language, accessibility, delivery, and timing standards;
 2. Use only County-approved NOABD templates, procedures, and delivery methods;

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3. Ensure that personnel performing the delegated function complete County-approved training before exercising delegated authority;
 4. Provide County with same-day notice and a copy of every NOABD issued;
 5. Maintain a complete and accurate NOABD log and all supporting documentation in a form accessible to County;
 6. Cooperate with County regarding any resulting grievance, appeal, continuation-of-benefits request, State Hearing, audit, monitoring review, or corrective action; and
 7. Make all NOABD records available to County, DHCS, CMS, and other authorized oversight entities upon request.
- I. When Contractor has been expressly delegated authority by County to make an adverse benefit determination, or when Contractor has been directed or authorized by County to issue a NOABD, Contractor shall issue the NOABD only in accordance with County policy, County-approved templates, applicable DHCS guidance, and 42 C.F.R. Part 438, Subpart F. Contractor shall provide County with same-day notice and a copy of any NOABD issued, maintain a NOABD log, and make all related records available to County upon request. Contractor shall not issue a NOABD concerning a County authorization or utilization management decision unless directed or authorized by County. 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).
- J. Contractor must provide beneficiaries with any reasonable assistance in completing forms and taking other procedural steps related to grievance or appeal such as auxiliary aids and interpreter services.
- K. 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 **Advance Directives.** Contractor must comply with all County policies and procedures regarding Advance Directives in compliance with the requirements of 42 C.F.R. § 422.128, 42 C.F.R. § 438.3(j), and 42 C.F.R. § 489.100, as applicable.
- 12.3 **Transition of Care.** Contractor shall comply with County’s transition of care policies and all applicable federal and state laws, regulations, Medi-Cal requirements, parity requirements, and guidance issued by the California Department of Health Care Services (DHCS) relating to transition of care, continuity of care, and coordination of behavioral health services, including, but not limited to, Title 42 Code of Federal Regulations section 438.62, Behavioral Health Information Notices (“BHINs”), Mental Health and Substance Use Disorder Services Information Notices (“MHSUDS INs”), and any subsequent

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updates, amendments, replacements, or superseding guidance issued during the term of this Agreement.

References in this Agreement to specific statutes, regulations, BHINs, MHSUDS INs, manuals, County policies, or other guidance documents shall include any successor authority or replacement guidance governing the same or substantially similar subject matter, without requiring a formal amendment to this Agreement. Beneficiaries 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 member 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, not exceeding 12 months. Specific criteria must be met.

12.4 Advertising Requirements

- A. Contractor shall comply with all applicable federal and state laws, regulations, licensing and certification requirements, consumer protection requirements, County policies, and DHCS guidance relating to advertising, marketing, service representations, and protection of individuals receiving substance use disorder services.
- B. Contractor shall comply with applicable requirements, including but not limited to Senate Bill 434, Health and Safety Code section 11831.9, applicable Behavioral Health Information Notices, applicable Mental Health and Substance Use Disorder Services Information Notices, and any subsequent or superseding DHCS guidance issued during the term of this Agreement.
- C. Contractor shall not engage in false, deceptive, misleading, or fraudulent advertising or representations regarding nature, availability, effectiveness, location, or provision of services.
- D. Licensed and/or certified SUD recovery or treatment facilities and certified alcohol or other drug programs shall not make false or misleading statements or provide false or misleading information about the entity's products, goods, services, or geographical locations in marketing, advertising materials, media, internet websites, or third-party internet websites.
- E. Licensed and/or certified SUD recovery or treatment facilities and certified alcohol or other drug programs shall not include on an internet website a picture, description, staff information, or 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.

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- F. Licensed and/or certified SUD recovery or treatment facilities and certified alcohol or other drug programs shall not include false information on an internet website or an electronic link that provides false information or surreptitiously directs the reader to another internet website.
- G. Contractor shall comply with any subsequent DHCS regulations, guidance, or requirements related to advertising, marketing, service representations, patient brokering, client solicitation, or consumer protection for SUD recovery or treatment facilities and certified alcohol or other drug programs.

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 evidence-based criteria as the minimum standard of care for AOD facilities.
- B. For this Agreement and subsequent 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 include but are 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.** Credentialing, Recredentialing, Screening, and Enrollment. Contractor shall ensure that all providers, licensed staff, registered or certified alcohol and other drug counselors, interns, trainees, subcontractors, and other personnel furnishing services under this Agreement meet all applicable licensing, certification, registration, scope of practice, Drug Medi-Cal certification, Medi-Cal enrollment, screening, credentialing, recredentialing, exclusion-check, and provider-selection requirements before furnishing covered services and throughout the term of this Agreement. Contractor shall maintain written credentialing and recredentialing policies and procedures consistent with 42 C.F.R. § 438.214, 42 C.F.R. Part 455, applicable DHCS guidance, County policy, and professional licensing or certification requirements.

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Contractor shall not permit excluded, suspended, debarred, unlicensed, uncertified, unregistered, or otherwise ineligible individuals or entities to provide, supervise, bill for, or receive payment for services under this Agreement. Contractor shall maintain documentation of credentialing, recredentialing, license verification, certification or registration verification, exclusion screening, and corrective action, and shall make such documentation available to County upon request.

- 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, waived, and/or certified.
- C. Contractor must not employ or subcontract with providers debarred, suspended or otherwise excluded (individually, and collectively referred to as "Excluded") from participation in Federal Health Care Programs, including Medi-Cal/Medicaid or procurement activities, as set forth in 42 C.F.R. § 438.610. See relevant section below regarding specific requirements for exclusion monitoring.
- D. Contractor shall ensure that all 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:
 - 1. Any limitations or disabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
 - 2. A history of loss of license or felony convictions;
 - 3. A history of loss or limitation of privileges or disciplinary activity;
 - 4. A lack of present illegal drug use; and
 - 5. The application's accuracy and completeness
- E. Contractor must file and keep track of attestation statements for all 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 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

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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 beneficiaries (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 beneficiaries 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 required by 42 C.F.R. § 438.608(a)(1). The compliance program shall include:
 - 1. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under this Agreement and all applicable federal and state requirements;
 - 2. A Compliance Officer 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;
 - 3. 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 this Agreement;

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4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees regarding the federal and state standards and requirements under this Agreement;
 5. Effective lines of communication between the Compliance Officer and the organization's employees;
 6. Enforcement of standards through well-publicized disciplinary guidelines;
 7. 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 identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement; and
 8. Prompt reporting and repayment of any identified overpayments.
- B. Contractor shall have administrative and management arrangements or procedures designed to detect and prevent fraud, waste, and abuse of federal or state health care funding. Contractor shall report suspected fraud, waste, or abuse to County within five (5) business days of identification and shall report fraud and abuse information to County, including but not limited to:
- i. Any potential fraud, waste, or abuse, as required by 42 C.F.R. § 438.608(a) and 42 C.F.R. § 438.608(a)(7);
 - ii. All overpayments identified or recovered, specifying any overpayment due to potential fraud, as required by 42 C.F.R. § 438.608(a)(2);
 - iii. Information about a change in a member's circumstances that may affect the member's eligibility, including changes in the member's residence or the death of the member, as required by 42 C.F.R. § 438.608(a)(3); and
 - iv. Information about a change in Contractor's circumstances that may affect the Contractor's eligibility to participate in the managed care program, including termination of this Agreement, as required by 42 C.F.R. § 438.608(a)(6).
- C. Contractor shall implement written policies that provide detailed information about the False Claims Act and other federal and state laws described in section 1902(a)(68) of the Social Security Act, including information about the 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 determines that there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23 and 42 C.F.R. § 438.608(a)(8).

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- F. Contractor shall report to County all identified overpayments within five (5) business days of discovery and provide the reason for the overpayment, including overpayments due to potential fraud. Contractor shall return any overpayments to County within sixty calendar days after the date on which the overpayment was identified, as required by 42 C.F.R. § 438.608(a)(2) and 42 C.F.R. § 438.608(c)(3). 42 C.F.R. § 438.608 still contains the compliance program, fraud/waste/abuse, overpayment, and payment suspension requirements referenced here.

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 shall 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:
1. Disclosure of 5% or More Ownership Interest:
 - i. 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.
 - ii. 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.
 - iii. 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.
 - iv. 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)
 2. Disclosures Related to Business Transactions:

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- i. 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.
 - ii. 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).)
- 3. Disclosures Related to Persons Convicted of Crimes:
 - i. 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.)
 - ii. 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.
 - iii. 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.
 - iv. 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.

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- 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:
1. www.oig.hhs.gov/exclusions - LEIE Federal Exclusions
 2. www.sam.gov/portal/SAM - GSA Exclusions Extract
 3. www.Medi-Cal.ca.gov - Suspended & Ineligible Provider List
 4. <https://nppes.cms.hhs.gov/#/> - National Plan and Provider Enumeration System (NPPES)
 5. 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. [Social Security Death Master File -> Home](#)
- 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

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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 beneficiaries' 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, member and system outcomes, utilization management, utilization review, provider appeals, provider credentialing and re-credentialing, and member grievances. Contractor shall measure, monitor, and annually report to the County its performance.
- C. Contractor shall implement mechanisms to assess member/family satisfaction based on County's guidance. The Contractor shall assess member/family satisfaction by:
 - 1. Surveying member/family satisfaction with the Contractor's services at least annually.
 - 2. Evaluating member grievances, appeals and State Hearings at least annually.
 - 3. Evaluating requests to change persons providing services at least annually.
 - 4. Informing the County and beneficiaries of the results of member/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.

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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.** Contractor shall cooperate with County in meeting all DMC-ODS and integrated behavioral health network adequacy, provider network, access, availability, capacity, and certification requirements, including but not limited to 42 C.F.R. §§ 438.68, 438.206, and 438.207, applicable DHCS BHIN 26-023 and any subsequent or superseding DHCS guidance.

Contractor shall submit complete, accurate, and timely information needed for County's annual certification, significant-change reporting, monthly 274 provider-network submissions, timely-access reporting, corrective action plans, compliance reassessments, alternative access standard requests, and other network-monitoring activities applicable to Contractor's service scope.

Contractor shall provide County, in the format and timeframe required by County, complete and accurate information regarding provider capacity, service locations, levels of care, modalities, telehealth availability, languages, cultural and linguistic capabilities, accessibility, hours of operation, appointment availability, whether providers are accepting new beneficiaries, provider-to-member capacity, and any limitations on service availability.

Contractor shall notify County within five business days, or sooner if required by County, of any change that may affect network adequacy, including provider additions, terminations, suspensions, leave, changes in service location, changes in capacity, changes in hours, or changes in available levels of care. Contractor shall assist County with annual, periodic, and ad hoc network adequacy submissions, corrective action plans, and DHCS requests for documentation.

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

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- 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 beneficiaries, and changes in geographic service area.
- D. Contractor shall submit provider-network, provider-directory, capacity, and timely-access information to LCBHS Quality Management in the County-designated format.

Contractor shall notify County within five business days, or sooner when required by County, of:

- 1. Provider additions or terminations;
- 2. Changes in licensure, certification, registration, enrollment, NPI, or taxonomy;
- 3. Changes in service location, telephone number, website, or hours;
- 4. Changes in age groups, populations, modalities, or levels of care served;
- 5. Temporary or permanent intake closure;
- 6. Development of a waitlist;
- 7. Material staffing or capacity changes;
- 8. Changes in telehealth availability;
- 9. Changes in language or accessibility capabilities; and
- 10. Changes in whether the provider is accepting new beneficiaries.

Contractor shall submit monthly 274 and other provider-network data elements when requested by County and shall cooperate with LCBHS regarding annual network certification, significant-change submissions, alternative access standards, corrective action plans, and DHCS compliance reassessments.

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, considering the urgency of the need for services. County shall monitor Contractor to determine compliance with timely access requirements and shall take corrective action in the event of noncompliance.
- B. Timely access and tracking standards include:
 - i. Contractors must 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. If the Contractor's provider only serves Medi-Cal beneficiaries, the provider must provide hours of

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operation comparable to the hours the Contractor makes available for Medi-Cal services that are not covered by the Agreement or another County.

- ii. Contractor shall track, monitor, and report timely access data for all applicable DMC-ODS services provided under this Agreement. Required data may include, but is not limited to, appointment requests, request dates, offered appointment dates, accepted appointment dates, appointment type, urgent and non-urgent requests, initial appointments, follow-up appointments, missed appointments, rescheduled appointments, member preferences, provider availability, wait times, and any exceptions to applicable timely access standards.
- iii. Contractor shall track and report timely access data applicable to its contracted DMC-ODS service scope, including, when applicable, outpatient treatment, intensive outpatient treatment, residential treatment, withdrawal management, opioid treatment program services, medication-assisted treatment, care coordination, recovery services, and any other DMC-ODS service category required by County, DHCS, or applicable law.
- iv. Contractor shall submit timely access data to County in the format, method, and frequency required by County. Contractor shall ensure that services under this Agreement collect and submits timely access data sufficient for County to monitor compliance with applicable federal, state, DHCS, and County timely access requirements.
- v. Contractor shall notify County as soon as practicable if Contractor is unable to meet applicable timely access standards, experiences a capacity issue, closes or limits intake, develops a waitlist, has staffing limitations, or otherwise identifies a barrier that may delay access to covered DMC-ODS services.
- vi. Contractor shall meet the following DMC-ODS timely access standards, as applicable to Contractor's contracted service scope:
 - 1. **Narcotic Treatment Program/Opioid Treatment Program Services**
Contractor shall ensure that beneficiaries seeking NTP/OTP services are provided an appointment within three business days of the service request.
 - 2. **Outpatient and Intensive Outpatient Services**
Contractor shall ensure that beneficiaries seeking outpatient or intensive outpatient non-NTP services are provided an appointment within 10 business days of the service request.
 - 3. **Non-Urgent Appointments with Non-Physician SUD Providers**
Contractor shall ensure that beneficiaries seeking non-urgent appointments

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with a non-physician SUD provider are provided an appointment within 10 business days of the request.

4. Non-Urgent Follow-Up Appointments

Contractor shall ensure that beneficiaries receiving ongoing SUD treatment are provided non-urgent follow-up appointments with a non-physician SUD provider within 10 business days of the prior appointment, unless an allowable exception applies.

5. Contractor shall submit appointments and timely access data, including wait times for requested services, to County monthly, or more frequently if required by County, in the format and method specified by County. Data shall be submitted to County's Quality Management department or other County-designated staff.

14.4 DMC-ODS and SUBG Data Reporting Requirements

A. General Requirements. Contractor shall comply with all applicable data-collection, data-quality, submission, certification, and reporting standards established by County, DHCS, CMS, and SAMHSA, based on the services provided and funding received under this Agreement.

B. Accuracy and Completeness. Contractor shall ensure that all data maintained or submitted to County, DHCS, or any designated data-collection system is complete, accurate, timely, truthful, and supported by source documentation. Contractor shall promptly correct and resubmit rejected, incomplete, or inaccurate data within the timeframe established by County.

C. California Outcomes Measurement System for Treatment (CalOMS-Tx).

1. Contractor shall collect and submit all required CalOMS-Tx records, including admission, discharge, annual-update, correction, resubmission, and provider-no-activity records.
2. Contractor shall submit CalOMS-Tx data directly to DHCS or through another process designated by County.
3. CalOMS-Tx data shall be submitted within 45 calendar days following the end of the applicable reporting month or by an earlier deadline established by County.
4. Contractor shall comply with the current DHCS CalOMS-Tx Data Collection Guide, applicable data-compliance standards, submission requirements, and County policies and procedures.

D. Drug and Alcohol Treatment Access Report (DATAR).

1. Contractor shall submit a complete and accurate monthly DATAR for each applicable service location, including a non-activity report when required.

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- 2.DATAR data shall be submitted directly to DHCS or through another process designated by County no later than the 10th calendar day of the month following the reporting month or by an earlier deadline established by County.
- 3.A Contractor operating a perinatal treatment program shall immediately notify County when the program reaches or exceeds 90 percent of its designated perinatal treatment capacity.

E. SUBG Program and Fiscal Reporting. When Contractor receives, administers, or expends Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG) funds under this Agreement:

1. Contractor shall comply with all applicable SUBG programmatic, fiscal, performance, outcome, audit, and reporting requirements established by County, DHCS, applicable federal award conditions, and the current DHCS SUBG Policy Manual.
2. Contractor shall submit complete, accurate, timely, and source-supported programmatic, demographic, service, performance, outcome, fiscal, and expenditure information at the frequency and within the timeframe established by County.
3. Contractor shall separately account for SUBG expenditures and activities by program, funding source, allocation, and applicable set-aside, including Discretionary, Primary Prevention, Perinatal, Adolescent and Youth Treatment, and any other designated allocation.
4. Contractor shall provide invoices, general-ledger detail, payroll records, time studies, cost-allocation documentation, indirect-cost documentation, subcontractor expenditures, and other source documentation necessary for County to complete SUBG invoices, ledger reports, cost reports, applications, program narratives, reconciliations, and required federal or state reports.
5. Contractor shall maintain and submit information demonstrating:
 - i. Eligibility of individuals, services, activities, and expenditures supported with SUBG funds;
 - ii. Compliance with applicable priority-population and service requirements;
 - iii. Program capacity, admissions, waiting lists, interim services, outreach, referrals, and service timeliness;
 - iv. Insurance status including Medi-Cal eligibility,
 - v. That SUBG expenditures do not improperly duplicate or supplant another available funding source.

F. System or Submission Failures. Contractor shall notify County before the applicable reporting deadline of any actual or anticipated system failure, service interruption, staffing issue, vendor failure, data-quality problem, or other circumstance that may

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affect the accuracy or timeliness of the required submission. The notice shall identify the affected report, anticipated impact, planned corrective action, and expected resolution date.

- G. Encounter, Claims, and Service Data.** Contractor shall collect, maintain, and submit complete, accurate, timely, and source-supported claims, encounter, provider, service, and utilization data in the form, format, system, frequency, and timeframe specified by County.

Contractor shall ensure that submitted encounter data identifies the member, rendering provider, service, service date, service location, procedure code, diagnosis, units, and all other data elements required by County, DHCS, CMS, or applicable law. All data shall be supported by documentation in the member record.

Contractor shall screen submitted data for completeness, accuracy, logic, consistency, and timeliness and shall promptly correct and resubmit rejected, incomplete, inconsistent, or inaccurate data within the timeframe established by County.

- H. Provider-Preventable Condition Reporting.** Contractor shall identify and immediately report to County any provider-preventable condition involving services furnished under this Agreement. Contractor shall provide all clinical, fiscal, claims, incident, corrective-action, and other information and documentation necessary for County to investigate the condition and satisfy applicable DHCS and CMS reporting requirements. Contractor shall comply with the payment restrictions and repayment requirements contained in Exhibit C.

- I. Additional State Reporting.** Contractor shall submit all reports, data, notices, logs, certifications, attestations, and supporting documentation required by County for County to comply with its agreement with DHCS, applicable Medi-Cal requirements, federal or state law, and DHCS guidance.

Required information may include grievance, appeal, and NOABD logs; provider-network and 274 data; timely-access information; ownership and control disclosures; overpayment identification and recoveries; excluded or prohibited affiliations; quality and performance measures; corrective action plans; audited financial information; provider complaints and appeals; incident and unusual-occurrence information; and customer-service performance information.

Contractor shall submit such information in the form, format, system, frequency, and timeframe specified by County.

- J.** County may update reporting contacts, templates, systems, submission methods, and internal deadlines by written notice to Contractor when necessary to comply with

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DHCS or operational requirements, provided the change does not materially alter Contractor's compensated scope of services.

- K. Upon County request, Contractor shall certify that submitted data, claims, encounters, reports, and supporting documentation are accurate, complete, and truthful. Certification shall be made by Contractor's chief executive officer, chief financial officer, or another authorized individual who reports directly to such officer, as applicable to the Contractor's organizational structure.

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:

1. Are based on valid and reliable clinical evidence or a consensus of providers in the field.
2. Consider the needs of the Contractor's beneficiaries
3. Are adopted in consultation with network providers
4. Are reviewed and updated periodically as appropriate

- B. Contractor shall disseminate the guidelines to all affected providers and, upon request, to beneficiaries and potential beneficiaries.

14.7 Evidence-Based Practices (EBPs)

- A. Contractors shall 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:

1. Motivational Interviewing
2. Cognitive-Behavioral Services
3. Relapse Prevention
4. Trauma-Informed Treatment
5. Psychoeducation

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).

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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 beneficiaries, staff and/or members of the community, including, but not limited to, physical injury and death.

B. **Immediate Reporting.** Contractor shall immediately notify the LCBHS Behavioral Health Services Director or designee, and County AOD Administrator of any occurrence presenting an immediate or substantial threat to member or public health or safety. Immediate verbal notice shall be followed by written notice no later than the next business day.

Events requiring immediate notice include:

1. Member death or serious injury;
2. Suspected abuse, neglect, exploitation, or sexual misconduct;
3. Overdose requiring emergency medical intervention;
4. Medication error resulting in or creating a substantial risk of serious harm;
5. Suicide attempt or serious self-harm occurring during service delivery;
6. Violence, weapon involvement, or serious threat;
7. Law-enforcement, fire-department, or emergency-medical response at the program;
8. Elopement or missing member when a material safety risk exists;
9. Facility evacuation, closure, or disruption materially affecting services;
10. Suspected confidentiality or data-security breach; and
11. Any event likely to result in licensing action, significant media attention, litigation, or material County exposure.

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. **Other Reportable Occurrences.** Other unusual occurrences shall be reported in writing within three working days after Contractor becomes aware of the event, unless a shorter timeframe is required by law, licensing or certification requirements, County policy, or written County direction.

E. Mandatory reporting to Adult Protective Services, Child Welfare Services, law enforcement, licensing agencies, or other authorities remains the contractor's independent responsibility.

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**EXHIBIT B-8
DMC-ODS SUBSTANCE USE DISORDER MEDICAL DIRECTOR AND CLINICAL
CONSULTATION SERVICES ADDENDUM**

This Addendum is incorporated into the Agreement between the County of Lake ("County") and SY Psychiatry, LLC. ("Contractor").

1. AUTHORIZED SERVICE

County authorizes Contractor to provide substance use disorder ("SUD") Medical Director and clinical consultation services on behalf of Lake County Behavioral Health Services ("LCBHS") and its Drug Medi-Cal Organized Delivery System ("DMC-ODS").

Contractor shall provide these services in accordance with:

- A. Exhibit A, Universal Scope of Services;
- B. Exhibit C, Fiscal Provisions;
- C. Exhibit D, Compliance Provisions;
- D. Exhibit E, Business Associate Agreement; and
- E. All other applicable provisions of the Agreement.

2. SCOPE AND APPLICABILITY

Contractor is retained to provide professional medical oversight, physician consultation, clinical review, and related SUD Medical Director functions for County. Contractor is not authorized under this Addendum to operate a separate ASAM treatment program, residential treatment facility, withdrawal management program, Narcotic Treatment Program/Opioid Treatment Program, or Traditional Health Care Practices program.

Exhibits B-1 through B-7 are not incorporated into this Agreement unless subsequently added by written amendment. Requirements in Exhibit A that are specific to the operation of a treatment facility, certified service site, residential program, bed capacity, direct program admission or discharge operations, medication storage, or another provider/facility function shall apply to Contractor only when Contractor is expressly assigned or authorized by County to perform the applicable function and the requirement is otherwise applicable to Contractor.

3. CONTRACTOR AND MEDICAL DIRECTOR INFORMATION

- A. Contractor Legal Name: SY Psychiatry, LLC.
- B. Designated SUD Medical Director: Hardeep Singh, MD.
- C. Authorized Service Delivery: In person, by telephone, by secure video conference or telehealth, through secure electronic health record consultation, or through another County-approved method, as clinically appropriate and permitted by applicable law and County policy.
- D. Before services begin, Contractor and the designated SUD Medical Director shall review, sign, and date the written roles and responsibilities and applicable code of conduct required

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by this Agreement. Contractor shall provide the executed documents to County and shall execute updated documents whenever the designated Medical Director or material responsibilities change.

Contractor shall ensure that the designated SUD Medical Director:

1. Is a physician currently licensed in California and in good standing;
2. Acts only within the physician's lawful scope of practice;
3. Maintains all professional licenses, registrations, credentials, professional liability insurance, and other qualifications applicable to the services performed under this Addendum;
4. Is enrolled with DHCS, screened under the applicable federal categorical-risk requirements, and has executed any required Medicaid provider agreement before serving as SUD Medical Director;
5. Is not suspended, excluded, debarred, or otherwise prohibited from participating in Medi-Cal, Medicare, or another federally funded healthcare program; and
6. Promptly notifies County of any investigation, restriction, lapse, suspension, disciplinary action, exclusion, or other event that may affect the physician's qualifications or ability to perform the authorized services.

4. SUD MEDICAL DIRECTOR RESPONSIBILITIES

Contractor, through the designated SUD Medical Director, shall perform the following functions, as applicable to County programs and cases assigned or referred by County:

- A. Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care;
- B. Ensure that physicians do not improperly delegate physician duties to nonphysician personnel;
- C. Develop and implement written medical policies and standards for the County DMC-ODS;
- D. Ensure that physicians, registered nurse practitioners, and physician assistants follow applicable County medical policies and standards;
- E. Ensure that medical decisions made by physicians are not influenced by fiscal considerations;
- F. Ensure that physicians and LPHAs performing diagnoses of substance use disorders or determining whether services are medically necessary are adequately trained and qualified to perform those functions;

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- G. Ensure that physicians are adequately trained and qualified to perform other physician or LPHA duties assigned under the County DMC-ODS;
- H. Provide physician oversight and consultation regarding medications, Medications for Addiction Treatment (“MAT”), medication interactions, co-occurring medical or psychiatric conditions, and other medical issues affecting SUD treatment;
- I. Participate in County quality-assurance, quality-improvement, utilization-management, credentialing, compliance, and clinical-policy activities requiring physician expertise; and
- J. Perform other physician and SUD Medical Director duties assigned by County that are within the designated physician’s professional scope, within the compensated scope of the Agreement, and consistent with applicable law and DMC-ODS requirements.

The Medical Director shall perform these responsibilities for County-operated DMC-ODS programs and for network-provider matters specifically assigned by County. Nothing in this Addendum makes Contractor the medical director of an independently operated network provider or transfers that provider’s legal, licensing, or professional responsibilities to Contractor unless expressly stated in writing.

5. MEMBER CLINICAL REVIEW

When requested by County or required for an assigned medical-director function, Contractor shall review and evaluate member information relevant to the clinical question presented, which may include:

- A. Personal, medical, psychiatric, medication, and substance use history;
- B. Assessment findings and diagnosis;
- C. Medical necessity and access criteria;
- D. ASAM level-of-care information and recommendations;
- E. Treatment documentation, problem lists, progress notes, and clinical plans;
- F. Physical examination or medical evaluation requirements applicable to the service or level of care;
- G. Continued-service or continued-medical-necessity information; and
- H. Other clinical documentation reasonably necessary for the assigned review.

Contractor shall document medical-necessity determinations, physician recommendations, and other required clinical conclusions within the applicable County-approved record or documentation system.

6. CLINICAL CONSULTATION SERVICES

Contractor shall provide clinical consultation services to County SUD treatment program staff and, when authorized by County, to County-contracted DMC-ODS providers. Consultation may include medical team conferences, interprofessional consultation, chart or record review, case consultation, and other physician consultation appropriate to the clinical question presented.

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Clinical consultation may address, as applicable:

- A. Complex SUD presentations and diagnostic questions;
- B. Medical necessity and level-of-care considerations;
- C. MAT and other medication-related questions;
- D. Co-occurring medical and psychiatric conditions;
- E. Potential contraindications, medication interactions, safety risks, or need for additional medical evaluation;
- F. Treatment recommendations and continuity of care;
- G. Documentation or clinical-quality concerns requiring physician expertise; and
- H. Other SUD-related clinical issues within Contractor's professional scope.

Nothing in this Addendum independently authorizes Contractor, solely in its capacity as a consulting clinician, to submit a Medi-Cal claim. Claiming, coding, and reimbursement for consultation or other covered DMC-ODS services shall comply with Exhibit C, current DHCS requirements, and County billing instructions.

7. DRUG TESTING AND LABORATORY OVERSIGHT

A. **Authorized Role.** The designated SUD Medical Director is authorized to perform the following functions:

- ☒ Serve as the ordering provider for clinically indicated urine drug testing.
- ☐ Serve as the laboratory director identified on the facility's CLIA certificate and applicable California clinical laboratory registration.
- ☒ Review and interpret urine drug-testing results.
- ☐ Other laboratory responsibility expressly authorized by County: _____.

Contractor shall not perform a laboratory function that is not selected above or otherwise authorized in writing by County.

8. ASSESSMENT AND LEVEL-OF-CARE CONSULTATION

When Contractor conducts, reviews, or consults on an SUD assessment or level-of-care determination, Contractor shall apply the ASAM Criteria and other applicable County and DHCS requirements to support placement in the clinically appropriate level of care.

A. Contractor shall ensure that assessments or clinical reviews performed by Contractor are signed, dated, and attributable to the rendering or reviewing practitioner as required by County and applicable law.

B. When Contractor reviews an assessment completed by another practitioner, Contractor shall provide physician or LPHA review, diagnosis, consultation, or confirmation only to the extent required by applicable law, County policy, the practitioner's scope of practice, or the specific clinical assignment.

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C. Contractor shall update or recommend reassessment when clinically appropriate due to a material change in the member's condition, treatment needs, or level-of-care considerations.

D. The problem list, progress notes, assessment documentation, and other clinical records reviewed or authored by Contractor shall support the clinical conclusions and medically necessary services addressed by Contractor.

9. DOCUMENTATION REQUIREMENTS

Contractor shall comply with all documentation requirements applicable to the services performed under this Addendum, including federal, state, DHCS, and County requirements.

A. All Contractor documentation shall be accurate, complete, legible, timely, and shall identify the date of service or activity.

B. Contractor shall document the duration of services when time is relevant to billing, invoicing, claiming, or County reporting requirements.

C. Documentation shall identify the method of service or consultation when required, including in-person, telephone, telehealth or secure video, or electronic health record consultation.

D. Contractor shall use County-approved templates, forms, and electronic health record workflows when required by County.

E. Contractor shall complete documentation within applicable regulatory, contractual, County, and professional timeframes.

F. Contractor shall cooperate with County in correcting incomplete or deficient documentation and in responding to clinical, fiscal, quality, compliance, audit, grievance, or appeal reviews involving Contractor's services.

10. UTILIZATION MANAGEMENT AND SERVICE AUTHORIZATION

A. When assigned by County, Contractor shall provide physician consultation and clinical review for DMC-ODS utilization-management and service-authorization activities requiring physician expertise.

B. Contractor shall base each recommendation on the member's individual clinical circumstances, applicable DMC-ODS access criteria, the ASAM Criteria, medical necessity when applicable, and County and DHCS requirements. Clinical recommendations shall not be influenced by fiscal considerations.

C. Contractor may review initial or continued residential-service authorization requests, level-of-care questions, complex clinical cases, and other matters specifically assigned by County.

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- D. Contractor shall complete and document assigned reviews within applicable County and DHCS timeframes. The documentation shall identify the information reviewed, clinical rationale, recommendation, date of review, and reviewing physician.
- E. Contractor shall not impose prior authorization on a service for which prior authorization is prohibited.
- F. Unless County expressly delegates final decision-making authority in writing, Contractor's recommendation is advisory, and County retains final authority for authorization, coverage, and member-notice decisions.
- G. Contractor shall not issue a Notice of Adverse Benefit Determination unless County expressly delegates that function in writing.
- H. Contractor shall be available for reasonable clinical consultation or clarification regarding a review in which Contractor participated, within the compensated scope of the Agreement.

11. DELEGATION AND RESPONSIBILITY

- A. The designated SUD Medical Director may delegate a medical-director responsibility only to another physician and only when the delegation is consistent with applicable law, professional standards, County policy, and the County's written medical policies and standards.
- B. The designated SUD Medical Director remains responsible for ensuring that every delegated medical-director duty is properly performed.
- C. Contractor shall provide County, before the delegated physician performs services, documentation demonstrating that the physician possesses all required licenses, enrollment, screening, credentials, training, experience, and professional qualifications.
- D. Contractor shall not subcontract or permanently reassign the designated SUD Medical Director's responsibilities without prior written County approval.
- E. Nothing in this section authorizes delegation of a physician-only function to a nonphysician practitioner.

12. CONTINUING MEDICAL EDUCATION

The designated SUD Medical Director shall complete a minimum of five (5) hours of continuing medical education in addiction medicine each year, or such successor requirement as may be established by applicable law or DHCS, and shall provide County proof of completion annually and upon request.

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13. COUNTY COORDINATION AND AVAILABILITY

Contractor shall maintain reasonable availability to County for medical-director consultation, clinical review, urgent case consultation, policy development, quality-improvement activities, and other authorized services within the scope of this Addendum.

- A. Contractor shall coordinate with County clinical, quality-assurance, utilization-management, fiscal, compliance, and program staff as reasonably necessary to perform the duties assigned under this Addendum.
- B. Contractor shall immediately report an imminent threat to member health or safety, a serious medication risk, suspected patient abuse or neglect, or another urgent quality-of-care concern through the County-designated escalation process. Other material clinical or compliance concerns shall be reported no later than one business day after identification.
- C. Contractor shall participate in meetings, case conferences, trainings, audits, utilization reviews, quality-improvement activities, corrective-action activities, and technical-assistance activities when reasonably requested by County and within the authorized and compensated scope of the Agreement.
- D. Contractor shall document and cooperate with County regarding the review, investigation, resolution, and follow-up of concerns identified under this section, subject to applicable confidentiality and professional requirements.

14. LIMITATION OF AUTHORIZED SERVICES AND FACILITY OPERATION

Except for the limited direct clinical services expressly authorized in Section 7, this Addendum authorizes SUD Medical Director and clinical-consultation services only. Contractor shall not independently operate, furnish, or claim an ASAM level of care, residential service, withdrawal-management service, NTP/OTP service, or Traditional Health Care Practice unless separately authorized through a written amendment.

15. COMPENSATION

Compensation, invoicing requirements, hourly rates, and other fiscal terms applicable to services under this Addendum are set forth in Exhibit C, Fiscal Provisions. Nothing in this Addendum establishes a separate rate or payment entitlement.

16. TERM AND MODIFICATION

This Addendum shall remain effective for the term of the Agreement unless amended or terminated in writing. A material expansion of Contractor's authorized service scope, addition of a separately reimbursable DMC-ODS service, or material change to Contractor's compensated responsibilities shall be documented through a written amendment or other legally sufficient agreement.

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Upon expiration or termination, Contractor shall cooperate in an orderly transition to County or a successor Medical Director, including transfer of pending reviews, policies, recommendations, and other County records. Contractor shall not retain or withhold County records except as required by law.

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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. **FISCAL DEFINITIONS**
 - 2.1 “Delayed Reimbursement” means a delay in payment to County from federal or state funding sources, including but not limited to Medi-Cal, that is unrelated to the allowability or validity of Contractor’s claim. Delayed reimbursement does not constitute a denial or disallowance of services and does not obligate County to advance payment prior to receipt of funds.
 - 2.2 “Denied Claim” means a claim for services that is rejected for payment by County, DHCS, CMS, or another payer due to failure to meet billing, coding, authorization, eligibility, timeliness, documentation, or other applicable requirements. Denied Claims are not payable unless and until corrected, resubmitted within applicable timelines, and accepted for payment.
 - 2.3 “Disallowed Claim” means a claim for which payment has been determined to be unallowable, in whole or in part, because of audit, review, investigation, or other compliance determination by County, DHCS, CMS, or other authorized entity. Disallowed Claims are not eligible for reimbursement and are subject to recoupment.
 - 2.4 “Overpayment” means any funds paid to Contractor to which Contractor is not entitled, including but not limited to payments associated with Denied Claims, Disallowed Claims, duplicate payments, billing errors, unsupported services, or services that do not meet applicable medical necessity, documentation, authorization, eligibility, or program requirements. Contractor shall report and return any identified Overpayment in accordance with timelines established by County and applicable law.
 - 2.5 “Recoupment” means the recovery by County of Overpayments or amounts associated with Denied Claims or Disallowed Claims, whether by direct repayment from Contractor or by offset against current or future amounts due to Contractor under this Agreement or any other agreement between the parties.
 - 2.6 “Offset” means County’s recovery of an Overpayment, Denied Claim, Disallowed Claim, questioned cost, or other amount owed by Contractor by deducting such amount from current or future payments due to Contractor.
3. **CLAIMING**
 - 3.1 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

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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.

- 3.2 Claims shall be complete and accurate and must include all required information regarding the services claimed.
- 3.3 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.
- 4. INVOICES.**
- 4.1 Contractor's invoices shall be submitted in arrears no later than the 15th working day of the following month for which services are being billed, or such other time that is mutually agreed upon in writing and shall be itemized and formatted to the satisfaction of the County.
- 4.2 Monthly payments for claimed services shall be calculated in accordance with the applicable compensation structure and rates set forth in Section 9, Payment Terms, of this Exhibit and any applicable provider-type or level-of-care Addendum, based on services properly claimed, documented, and accepted by County
- 4.3 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.
- 4.4 Contractor's invoices shall be submitted electronically to:
<https://filetransfer.co.lake.ca.us/filedrop/BHFiscalInvoicing>
- 4.5 County shall make payment to Contractor within thirty (30) calendar days after County receives applicable state, federal, or other reimbursement for the services billed, provided the invoice is undisputed, allowable, properly documented, and accepted by County. County shall have no obligation to advance payment to Contractor prior to receiving applicable reimbursement from DHCS, CMS, the State, Federal government, or other funding source.

Payment shall be limited to services that are authorized when required, medically necessary, properly documented, eligible for reimbursement, and not otherwise denied, disallowed, unsupported, or subject to recoupment. Payment on partial deliverables or partially reimbursed claims may be made when amounts due so warrant or when requested by Contractor and approved by County. Any disputed, denied, disallowed, unsupported, or non-reimbursed amounts may be withheld, denied, offset, or recouped as provided in this Agreement.

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- 4.6 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 ninety (90) calendar days after the date Contractor provides the services, or more than sixty (60) calendar days after this Agreement terminates, whichever is earlier.
- 4.7 Monthly payment may vary based on actual services billed.
- 4.8 County beneficiaries who are able to pay for services from other public or private resources are not billable under this Agreement.
- 4.9 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.

5. ADDITIONAL FINANCIAL REQUIREMENTS

- 5.1 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.
- 5.2 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.
- 5.3 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.
- 5.4 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)).
- 5.5 Contractor shall not charge employee meals, promotional or marketing items, gifts, entertainment, or similar expenses to this Agreement unless expressly authorized by County in writing. Travel expenses, if applicable to this agreement must be necessary, reasonable, properly documented, and shall not exceed the rates or limitations established by applicable County travel and reimbursement policies. Any amount exceeding those limits shall be the

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sole responsibility of Contractor.

6. CONTRACTOR PROHIBITED FROM REDIRECTION OF CONTRACTED FUNDS

6.1 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.

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

7. 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.

8. AUDIT REQUIREMENTS AND AUDIT EXCEPTIONS

8.1 Maintenance of Records

Contractor shall maintain proper clinical and fiscal records relating to beneficiaries served under the terms of this Agreement, as required by the Director, DHCS, and all applicable state and federal statutes and regulations. Member records shall include but not be limited to admission records, diagnostic studies and evaluations, member 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. All

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records described in this section shall be retained in accordance with Exhibit A, Section 3, Records Retention, Access, and Disposition.

8.2 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 Comptroller 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. Access, inspection, evaluation, and audit rights under this section shall be governed by Exhibit A, Section 3.

8.3 Federal, State and County Audits

In accordance with all applicable federal and state laws, regulations, Medi-Cal requirements, and guidance issued by the Centers for Medicare & Medicaid Services ("CMS") and the California Department of Health Care Services ("DHCS"), including, but not limited to, Title 42 Code of Federal Regulations sections 438.66, 438.230, 438.604, 438.606, 438.608, 438.610, 438.808, 438.900 et seq., Behavioral Health Information Notices ("BHINs"), Mental Health and Substance Use Disorder Services Information Notices ("MHSUDS INs"), and any subsequent updates, amendments, replacements, or superseding guidance issued during the term of this Agreement, County may conduct monitoring, oversight, audit, investigative, compliance, programmatic, clinical, fiscal, utilization review, and quality assurance activities related to Contractor's programs, services, operations, records, and performance under this Agreement.

The purpose of such activities includes, but is not limited to, verifying that services are medically necessary; appropriately authorized and documented; provided to eligible beneficiaries; compliant with applicable access criteria, quality standards, and program requirements; properly billed and reimbursed; and otherwise, consistent with applicable federal and state laws, regulations, County policies, Medi-Cal requirements, and the terms of this Agreement.

Contractor shall fully cooperate with County, DHCS, CMS, the Office of Inspector General ("OIG"), the California Department of Health Care Services Audits and Investigations Division, the California State Auditor, the United States Department of Health and Human Services, and any other authorized governmental agency or designee conducting audits, monitoring, reviews, inspections, investigations, or oversight activities related to services provided under this Agreement. References in this Agreement to specific statutes, regulations, BHINs, MHSUDS INs, manuals, County policies, or other guidance documents shall include any successor authority or replacement guidance governing the same or substantially similar subject matter, without requiring a formal amendment to this Agreement.

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8.4 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.

8.5 Confidentiality in Audit Process

- A. Contractor and County mutually agree to maintain the confidentiality of Contractor's member 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 its officers, employees and agents of the confidentiality provisions of all applicable statutes.
- B. Contractors' 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.

8.6 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:
 - 1. Identification of Fraud, Waste or Abuse as defined in federal regulation.
 - I. Fraud and abuse are defined in Code of Federal Regulations, Title 42, § 455.2 and Welfare & Institutions Code, § 14107.11, subdivision (d).
 - II. Definitions for "fraud," "waste," and "abuse" can also be found in the Medicare Managed Care Manual available at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c21.pdf.
 - 2. 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

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timeframes required by applicable law or specified by County or the applicable state or federal oversight agency.

- D. Contractor shall permit inspection, evaluation, and audit of its records, documents, systems, premises, equipment, and facilities as required by this Agreement. Contractor's record-retention obligations and the duration of applicable inspection and audit rights shall be governed by Exhibit A, Section 3.
- E. County may disallow any expense, claim, or payment determined through an audit, review, or investigation to be inconsistent with this Agreement or applicable law. Contractor shall repay the disallowed amount, and County may recover it through repayment, offset, recoupment, or any other remedy available under this Agreement or law.

8.7 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, member 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.

8.8 Record Retention and Audit Period. The retention of records and duration of audit, inspection, and evaluation rights under this Exhibit shall be governed by Exhibit A, Section 3, Records Retention, Access, and Disposition.

8.9 Provider-Preventable Conditions. Contractor shall not submit a claim, seek payment, receive payment, or retain payment for any provider-preventable condition for which payment is prohibited under applicable federal or state law, the State Plan, DHCS requirements, or CMS requirements. Any payment made for such a condition constitutes an overpayment subject to repayment, offset, disallowance, or recoupment by County. Contractor shall maintain documentation sufficient to identify and support the reporting and payment treatment of provider-preventable conditions and shall cooperate with County in any related review, audit, investigation, corrective action, or recovery

9.PAYMENT TERMS

9.1 County shall reimburse Contractor for covered services provided under this Agreement in accordance with the compensation structure, rate schedule, budget, CPT/HCPCS rate, per diem rate, provider-type rate, hourly rate, deliverable-based payment schedule, or other approved payment terms set forth, subject to the terms and conditions of this Agreement and applicable DHCS requirements.

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9.2 Reimbursement is contingent upon all the following, as applicable:

- A. Services are medically necessary;
- B. Services meet DMC-ODS access criteria and coverage requirements;
- C. Services are authorized by County when authorization is required;
- D. Services are properly documented in accordance with DHCS and County requirements;
- E. Services are eligible for reimbursement under Medi-Cal or another applicable funding source;
- F. Claims and invoices are complete, accurate, timely, and supported by required documentation; and
- G. Services are not denied, disallowed, unsupported, duplicative, non-reimbursable, or subject to recoupment.

9.3 SUD Medical Director and Professional Service Rate.

County shall compensate Contractor at the rate of Two Hundred Dollars (\$200.00) per hour for authorized Substance Use Disorder Medical Director, clinical consultation, utilization management, service authorization, quality assurance/quality improvement, and other professional services performed pursuant to Exhibit B-8, whether or not the activity is separately claimable to Medi-Cal. Medi-Cal-claimable services shall be documented and entered into SmartCare as required by Section 9.4. No separate percentage or Federal Financial Participation (FFP) pass-through payment shall apply unless expressly authorized by written amendment to this Agreement.

9.4 Billable DMC-ODS Services.

When Contractor personally renders a covered DMC-ODS service that is eligible for Medi-Cal claiming, Contractor shall timely and accurately enter the service into the County's electronic health record and billing system, SmartCare, using the applicable CPT or HCPCS code, service duration or unit, diagnosis, rendering provider information, and other information required by County and DHCS.

Payment for services shall be calculated based upon the Contractor's hourly rate established in Section 9.3, unless a different rate is expressly established in this Agreement.

9.5 Non-Claimable Medical Director and Consultation Activities.

Authorized SUD Medical Director, administrative, clinical consultation, policy development, meeting, quality-review, chart-review, training, or other activities that are not separately claimable to Medi-Cal may be invoiced to County based upon actual time worked at the hourly rate established in Section 9.3.

Contractor's invoice shall identify the date, duration, and general nature of the activity performed in sufficient detail for County to validate the service.

9.6 No Duplicate Payment.

Contractor shall not receive duplicate payment for the same time, activity, or service. A service

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or activity entered into SmartCare as a billable DMC-ODS service shall not also be separately invoiced as non-billable Medical Director or consultation time for the same service period, except when the separately invoiced activity is distinct, separately performed, and supported by documentation sufficient to establish that no duplicate payment occurred.

9.7 Claims and Documentation.

All billable services shall be coded, documented, and claimed in accordance with the current DHCS DMC-ODS Billing Manual, applicable DHCS service tables, County billing instructions, and the requirements of this Agreement. Contractor shall correct denied or deficient claims and documentation within the timeframes established by County and applicable DHCS requirements.

9.8 Payment Limitation.

Payment under this Agreement is limited to services and activities expressly authorized under Exhibit B-8 and shall not exceed the maximum compensation stated in the Agreement. Nothing in this section authorizes payment for a service that is denied, disallowed, unsupported, duplicative, outside Contractor's professional scope, or otherwise ineligible for payment under this Agreement.

10. SmartCare Access Provision:

Contractor shall ensure that each authorized SmartCare user:

1. Completes County-required privacy, security, documentation, and system training before access is activated;
2. Uses only individually assigned credentials and does not share passwords or accounts;
3. Accesses only information necessary to perform authorized duties;
4. Complies with County documentation, correction, signature, and data-entry requirements;
5. Immediately reports suspected unauthorized access or disclosure;
6. Cooperates with County access reviews and audits; and
7. Discontinues access immediately upon separation, reassignment, suspension, or loss of business need.

Contractor shall notify the County no later than one business day after a user separates from employment, changes duties, or no longer requires access. Contractor is responsible for charges associated with accounts that remain active because Contractor failed to provide timely notice.

SmartCare access does not authorize Contractor to access records unrelated to beneficiaries or duties assigned under this Agreement.

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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 statutes, regulations and sub regulatory 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 member 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

Contractor shall comply with all applicable federal and state civil rights, nondiscrimination, accessibility, disability accommodation, language access, and equal opportunity laws, regulations, Medi-Cal requirements, County policies, and guidance issued by the Centers for Medicare & Medicaid Services (“CMS”) and the California Department of Health Care Services (“DHCS”), including, but not limited to, Title 42 Code of Federal Regulations section 438.3, Behavioral Health Information Notices (“BHINs”), Mental Health and Substance Use Disorder Services Information Notices (“MHSUDS INs”), and any subsequent updates, amendments, replacements, or superseding guidance issued during the term of this Agreement. Contractor shall not discriminate in the provision of services, referrals, access to care, treatment, admission, discharge, participation, or any other activity under this Agreement on the basis of race, color, religion, creed, ancestry, national origin, ethnic group identification, citizenship, immigration status, age, sex, gender, gender identity, gender expression, sexual orientation, marital status, medical condition, genetic information, disability, health status, need for health care services, veteran status, or any other characteristic protected by applicable law. Contractor shall take affirmative action to ensure that services to intended Medi-Cal beneficiaries are provided without use of any

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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 504 of the Rehabilitation Act and the Americans with Disabilities Act, Contractor must provide physical access, reasonable accommodations, and accessible equipment for Medi-Cal beneficiaries with physical or mental disabilities.

2.3 Applicable Fees

- A. Contractor shall not charge any beneficiaries or third-party payers any fee for service unless directed to do so by the Director at the time the member is referred to 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 member 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 member or persons acting on behalf of the member 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 beneficiaries, for covered services, any amount greater than would be owed if the County provided the services directly as per and otherwise not bill member 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 beneficiaries, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

2.5 Member Informing Materials

- A. Basic Information Requirements
 - 1. Contractor shall provide information in a manner and format that is easily understood and readily accessible to beneficiaries. (42 C.F.R. § 438.10(c)(1)). Contractor shall provide all written materials for beneficiaries in easily understood language, format, and alternative formats that take into consideration

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the special needs of beneficiaries in compliance with 42 C.F.R. § 438.10(d)(6). Contractor shall inform beneficiaries that information is available in alternate formats and how to access those formats in compliance with 42 C.F.R. § 438.10.

2. Contractor shall provide the required information in this section to each member receiving SUD services under this Agreement and upon request.
3. 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.
4. Contractor shall use DHCS/County developed model member handbook and member notices. (42 C.F.R. §§ 438.10(c)(4)(ii), 438.62(b)(3)).
5. Member information required in this section may only be provided electronically by the Contractor if all the following conditions are met:
 - i. The format is readily accessible;
 - ii. The information is placed in a location on the Contractor's website that is prominent and readily accessible;
 - iii. The information is provided in an electronic form which can be electronically retained and printed;
 - iv. The information is consistent with the content and language requirements of this Agreement;
 - v. The member 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

1. Contractor shall provide all written materials for potential beneficiaries and beneficiaries in a font size no smaller than 12 point. (42 C.F.R. § 438.10(d)(6)(ii).)
2. Contractor shall ensure its written materials that are critical to obtaining services are available in alternative formats, upon request of the member or potential member at no cost.
3. Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, member 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).)
4. Contractor shall notify beneficiaries, prospective beneficiaries, 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))
5. Contractor shall make auxiliary aids and services available upon request and free of charge to each member. (42 C.F.R. § 438.10(d)(3)-(4).)

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6. 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).
7. Taglines for written materials critical to obtaining services must be printed in a conspicuously visible font size.

C. Member Informing Materials

1. Each member must receive and have access to the member informing materials upon request by the member and when first receiving SUD services. Member informing materials include but are not limited to:
 - i. County Integrated Behavioral Health Member Handbook, in accordance with BHIN 25-042 and any subsequent or superseding DHCS guidance;
 - ii. DMC-ODS Formulary
 - iii. Advance Health Care Directive Form (required for adult beneficiaries only)
 - iv. Notice of Language Assistance Services available upon request at no cost to the member
 - v. Language Taglines
 - vi. Grievance/Appeal Process and Form
 - vii. Notice of Privacy Practices
 - viii. EPSDT poster (if serving beneficiaries under the age of 21)
1. Contractor shall provide each member with a member handbook at the time the member first accesses services. The member handbook shall be provided to beneficiaries within 14 business days after receiving notice of enrollment.
2. Contractor shall provide beneficiaries with notice of material or significant changes to information provided to beneficiaries in accordance with all applicable federal and state laws, regulations, Medi-Cal requirements, County policies, and guidance issued by the Centers for Medicare & Medicaid Services (“CMS”) and the California Department of Health Care Services (“DHCS”), including, but not limited to, Behavioral Health Information Notices (“BHINs”), Mental Health and Substance Use Disorder Services Information Notices (“MHSUDS INs”), member notice requirements, and any subsequent updates, amendments, replacements, or superseding guidance issued during the term of this Agreement. Such notices shall be provided within all applicable required timeframes and in a manner consistent with accessibility, language access, and member communication requirements. Required informing materials must be electronically available on the Contractor’s website and must be physically available at the Contractor agency facility lobby for beneficiaries’ access.

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3. 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 beneficiaries within five business days. Large print materials shall be in a minimum 18-point font size.
4. Informing materials will be considered provided to the member if Contractor does one or more of the following:
 - i. Mail a printed copy of the information to the member's mailing address before the member first receives a SUD service;
 - ii. Mail a printed copy of the information upon the member's request to the member's mailing address;
 - iii. Provides the information by email after obtaining the member's agreement to receive the information by email;
 - iv. Posts the information on the Contractor's website and advises the member in paper or electronic form that the information is available on the internet and includes applicable internet addresses, provided that beneficiaries with disabilities who cannot access this information online are provided auxiliary aids and services upon request and at no cost; or,
 - v. Provides the information by any other method that can reasonably be expected to result in the member receiving that information. If the Contractor provides informing materials in person, when the member first receives SUD services, the date and method of delivery shall be documented in the member's file.

D. Provider Directory

1. Contractor shall comply with County's provider directory policy and all applicable DHCS provider directory requirements, including but not limited to BHIN 25-026, BHIN 26-008, 42 C.F.R. § 438.10(h), and any subsequent or superseding DHCS guidance.
2. Contractor shall provide County with complete, accurate, and timely provider directory information in the format required by County. Required information may include, but is not limited to, provider name, license, certification, registration, NPI, taxonomy, service location, phone number, website, specialty, service type, cultural and linguistic capabilities, language capacity, accessibility, telehealth availability, whether the provider is accepting new beneficiaries, and any limitations on availability.
3. Contractor shall notify County of any change affecting provider directory information within five (5) business days of the change, or sooner if required by County policy. Contractor shall cooperate with County to ensure provider directory

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information is accurate, current, and updated within timeframes required by DHCS.

4. Contractor shall report on provider directory changes for all providers, sites, service locations, and provider types required by County, DHCS, or applicable law.

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 member 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 beneficiaries served through this Agreement shall contain a warning banner regarding the PHI or PII contained within the EHR. Contractor that utilizes an

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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 member 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 member 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. MEMBER RIGHTS

Contractor shall take all appropriate steps to fully protect beneficiaries' 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- AUDITS, RECORDS AND RETENTION

- A. County, or any subdivision or appointee thereof, and the State of California, or any subdivision or appointee thereof, including the Auditor General, shall have the right to review and audit all records, books, papers, documents, corporate minutes, financial records, staff information, member records, and other pertinent items as requested. County and the State shall have the right to monitor the performance of Contractor in the delivery of services provided under this Agreement. Contractor shall provide full cooperation in any auditing or monitoring conducted pursuant to this Agreement.
- B. Contractor shall make all 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 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, the U.S. Department of Health and Human Services Office of Inspector General, the United States Comptroller General or their designees, and other authorized federal and state agencies.

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- C. The duration of all audit, inspection, evaluation, and record-access rights under this Exhibit shall be governed by Exhibit A, Section 3, including the extended period applicable to unresolved audits, investigations, litigation, claims, appeals, overpayment reviews, corrective actions, or other proceedings.
- D. County, DHCS, CMS, or the U.S. Department of Health and Human Services Office of Inspector General may inspect, evaluate, and audit Contractor at any time if there is a reasonable possibility of fraud or similar risk. Such inspection shall occur at Contractor's place of business, premises, or physical facilities, pursuant to 42 C.F.R. § 438.230(c)(3)(i)-(iv).
- E. Contractor shall cooperate with County in the implementation, monitoring, and evaluation of this Agreement and shall comply with all reporting requirements established by County. If County identifies an issue or receives notification of a complaint or potential, actual, or suspected violation of requirements, County may audit, monitor, and/or request information from Contractor to ensure compliance with applicable laws, regulations, and requirements.
- F. Contractor shall maintain complete, current, accurate, and auditable physical and electronic records sufficient to demonstrate compliance with this Agreement and applicable federal and state requirements. Such records include, as applicable, clinical, service, financial, statistical, administrative, personnel, subcontractor, grievance, appeal, prescription, claiming, billing, quality, and compliance records and supporting source documentation.
- G. Fiscal records shall be maintained in accordance with generally accepted accounting principles, applicable provisions of 2 C.F.R. Part 200, and other applicable federal, state, DHCS, and County requirements.
- H. All records described in this section shall be retained, made available, transferred, and securely disposed of in accordance with Exhibit A, Section 3, Records Retention, Access, and Disposition.
- I. Failure to maintain or produce complete and acceptable records may constitute grounds for withholding or disallowing payment, corrective action, recoupment, probationary status, or termination, subject to the terms of this Agreement and applicable law.
- J. Contractor shall maintain member and community service records in compliance with all applicable local, state, and federal requirements, laws, and regulations, and shall provide County staff access to clinical records as required under this Agreement.

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- K. Contractor shall comply with the Medical Records/Protected Health Information section regarding relinquishing or maintaining medical records.
- L. All records shall be retained in accordance with Exhibit A, Section 3, Records Retention, Access, and Disposition.
- M. Contractor shall submit audited financial reports annually to County. The audit shall be conducted in accordance with generally accepted government auditing standards, generally accepted auditing standards, and applicable federal and state audit requirements.
- N. Upon expiration or termination of this Agreement, termination of an applicable program, or cessation of Contractor's operations, Contractor shall maintain, transfer, and make records available in accordance with Exhibit A, Section 3. County may establish a reasonable written deadline for delivery or transfer of records based on the circumstances and the volume, format, security, and confidentiality of the affected records.
- O. Contractor shall provide all reasonable facilities and assistance for the safety and convenience of County representatives in the performance of their duties. All inspections and evaluations shall be performed in a manner that does not unduly delay Contractor's work.
- P. County has the discretion to revoke full or partial provisions of this Agreement, delegated activities or obligations, or apply other remedies permitted by state or federal law when County or DHCS determines Contractor has not performed satisfactorily as required under this Agreement.

6. SITE INSPECTIONS

- A. Without limiting any other provision related to inspections or audits set forth in this Agreement, Contractor shall permit authorized County, state, and/or federal agencies, through any authorized representative, the right to inspect or otherwise evaluate the work performed or being performed under this Agreement, including subcontract support activities and the premises where work is being performed.
- B. Contractor shall provide all reasonable assistance for the safety and convenience of the authorized representative in the performance of their duties.
- C. 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.

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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 presently not debarred, suspended, proposed for debarment, 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

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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 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 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.

- A. Contractor shall procure and maintain Workers' Compensation Insurance for all its employees.
- B. Contractor shall procure and maintain Comprehensive Public Liability Insurance, including 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. Coverage shall include, but not be limited to, endorsements for the following:
 - 1. personal injury;
 - 2. premises-operations;
 - 3. products and completed operations;
 - 4. blanket contractual; and
 - 5. independent Contractor's liability.
- C. Contractor shall procure and maintain Comprehensive Automobile Liability Insurance, including 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.

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- D. Contractor shall procure and maintain Professional Liability Insurance for 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).
- E. Contractor shall not commence work under this Agreement until it has obtained all insurance required herein and submitted certificates of insurance to County naming the County of Lake as additional insured. Contractor shall provide County certificates of insurance within thirty (30) calendar days of execution of this Agreement. Contractor shall provide County with a new certificate of insurance at least thirty (30) calendar days prior to the expiration date of any required insurance coverage.
- F. In the case of any subcontract, Contractor shall require each subcontractor to provide all the same coverage as detailed herein. Subcontractors shall provide certificates of insurance naming the County of Lake as additional insured. Subcontractors shall not commence work until the required insurance has been obtained.
- G. For any claims related to work performed under this Agreement, Contractor's insurance coverage shall be primary insurance as to 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 Contractor's insurance and shall not contribute with it.
- H. The Commercial General Liability and Automobile Liability Insurance must each contain, or be endorsed to contain, the following provision:
 - 1. 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 10, CG 2037. Contractor shall not commence work under this Agreement until Contractor has delivered to County the Additional Insured Endorsements required herein.
 - 2. 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.
 - 3. Insurance coverage in the minimum amounts set forth herein shall not be construed to relieve Contractor of liability in excess of such coverage, nor shall it preclude County from taking other action available under any other provision of this Agreement or applicable law.
 - 4. Failure of County to enforce any provision of this section in a timely manner shall not act as a waiver of enforcement of any provision at a later date.

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5. Any failure of Contractor to maintain the insurance required by this section, or to comply with any requirement of this section, shall constitute a material breach of this 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 obligation to provide services or perform delegated functions under this Agreement. Approval is at the discretion of the Director but shall not be unreasonably withheld.

Contractor shall ensure that each subcontract is in writing and includes all applicable terms and conditions of this Agreement, including but not limited to licensing, certification, credentialing, screening and enrollment, privacy, data security, confidentiality, documentation, billing, audit, inspection, reporting, program integrity, corrective action, and compliance requirements. Each subcontract shall include the applicable provisions of 42 C.F.R. § 438.230 and shall clearly identify any delegated activities and reporting responsibilities.

Contractor shall monitor each subcontractor's performance on an ongoing basis and shall ensure that subcontractors comply with all applicable federal, state, DHCS, County, and contract

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requirements. Contractor shall require subcontractors to make records, books, contracts, computer systems, facilities, and other information available to County, DHCS, CMS, HHS Inspector General, the Comptroller General, and their designees for audit, evaluation, and inspection.

If County, DHCS, CMS, or another authorized entity determines that a subcontractor's performance is deficient or noncompliant, Contractor shall require corrective action, impose remedies, revoke delegated activities, or terminate the subcontract as directed by County or as necessary to protect member safety, program integrity, and regulatory compliance.

Contractor shall remain fully responsible for the performance, acts, omissions, compliance, billing, documentation, confidentiality, data security, and service delivery of all subcontractors, whether approved by 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 Cal OSHA 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

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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.

26. OVERSIGHT

Lake County Behavioral Health Services shall conduct oversight and may impose sanctions or other contractual remedies for Contractor's failure to comply with this Agreement or applicable federal and state law, including Welfare and Institutions Code § 14712(c)(3) and Title 9, California Code of Regulations §§ 1810.380 and 1810.385. Contractor's record-retention obligations and the duration of County's audit rights shall be governed by Exhibit A, Section 3.

27. 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.

28. 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.

29. 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.

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- 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) 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.

30. NON-APPROPRIATION

In the event County is unable to obtain funding at the end of each fiscal year for drug medical 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.

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EXHIBIT E – BUSINESS ASSOCIATE AGREEMENT

THIS HIPAA BUSINESS ASSOCIATE AGREEMENT (the "Agreement") is entered into effective July 1, 2026 (the "Effective Date"), by and between **Sy Psychiatry** ("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, shall have 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 its 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

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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 ON 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
Services 1-877-610-2355
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 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 the Designated 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.

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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 by 45 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.

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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 have in 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.

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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 purposes 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 revised legislation, 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.

26.27.3 _DMC-ODS_SY Psychiatry_ FY 2026-27

Final Audit Report

2026-09-04

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