TULARE COUNTY AGREEMENT NO. _____

COUNTY OF TULARE
HEALTH & HUMAN SERVICES AGENCY
SERVICES AGREEMENT

THIS AGREEMENT ("Agreement") is entered into as of _____ between the **COUNTY OF TULARE**, a political subdivision of the State of California ("COUNTY"), and **TURNING POINT OF CENTRAL CALIFORNIA, INC,** a California Corporation, ("CONTRACTOR"). COUNTY and CONTRACTOR are each a "Party" and together are the "Parties" to this Agreement, which is made with reference to the following:

A. COUNTY wishes to retain services of CONTRACTOR for providing alcohol and drug treatment services to non-perinatal adults; and

B. CONTRACTOR has the experience and qualifications to provide the services COUNTY requires pertaining to the COUNTY'S Mental Health Program; and

C. CONTRACTOR is willing to enter into this Agreement with COUNTY upon the terms and conditions set forth herein.

THE PARTIES AGREE AS FOLLOWS:

1. **TERM:** This Agreement becomes effective upon Board signatures, and expires at 11:59 PM on June 30, 2020, unless earlier terminated as provided below, or unless the Parties extend the term by a written amendment to this Agreement. This contract shall replace and supersede PA4557 and PA4558.

2. **SERVICES:** See attached **Exhibits A-1, A-2**

3. **PAYMENT FOR SERVICES:** See attached **Exhibits B-1, B-2.**

4. **INSURANCE:** Before approval of this Agreement by COUNTY, CONTRACTOR must file with the Clerk of the Board of Supervisors evidence of the required insurance as set forth in the attached **Exhibit C.**

5. **GENERAL AGREEMENT TERMS AND CONDITIONS:** COUNTY'S "General Agreement Terms and Conditions" are hereby incorporated by reference and made a part of this Agreement as if fully set forth herein. COUNTY'S "General Agreement Terms and Conditions" can be viewed at http://tularecountycounsel.org/default/index.cfm/public-information/

6. **ADDITIONAL EXHIBITS:** CONTRACTOR shall comply with the terms and conditions of the Exhibits listed below and identified with a checked box, which are by this reference made a part of this Agreement. Complete Exhibits D, E, F, G, G-1, and H can be viewed at http://tularecountycounsel.org/default/index.cfm/public-information/

COUNTY OF TULARE
HEALTH & HUMAN SERVICES AGENCY
SERVICES AGREEMENT

☒	**Exhibit D**	Health Insurance Portability and Accountability Act (HIPAA) Business Associate Agreement
☒	**Exhibit E**	Cultural Competence and Diversity
☒	**Exhibit F**	Information Confidentiality and Security Requirements
☒	**Exhibit G**	Contract Provider Disclosures (Must be completed by Contractor and submitted to County prior to approval of agreement.)
☒	**Exhibit G1**	National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
☒	**Exhibit H**	Additional terms and conditions for federally-funded contracts
☒	**Exhibit I**	Substance Use Disorder Service Programs

7. NOTICES: (a) Except as may be otherwise required by law, any notice to be given must be written and must be either personally delivered, sent by facsimile transmission or sent by first class mail, postage pre-paid and addressed as follows:

COUNTY:

CONTRACT UNIT
TULARE COUNTY HEALTH & HUMAN SERVICES AGENCY
5957 S. Mooney Boulevard
Visalia, CA 93277
Phone No.: 559-624-8000
Fax No.: 559-737-4059

With a Copy to:

COUNTY ADMINISTRATIVE OFFICER
2800 W. Burrel Ave.
Visalia, CA 93291
Phone No.: 559-636-5005
Fax No.: 559- 733-6318

CONTRACTOR:

Turning Point of Central California, Inc.
220 N. Locust Street
Visalia, CA. 93291
Phone No.: 559- 267-1385
Fax No.: 559-636-2105

(b) Notice personally delivered is effective when delivered. Notice sent by facsimile transmission is deemed to be received upon successful transmission. Notice sent by first class mail will be deemed received on the fifth calendar day after the date of mailing. Either Party may change the above address by giving written notice under this section.

8. AUTHORITY: CONTRACTOR represents and warrants to COUNTY that the individual(s) signing this Agreement on its behalf are duly authorized and have legal capacity to sign this Agreement and bind CONTRACTOR to its terms. CONTRACTOR acknowledges that COUNTY has relied upon this representation and warranty in entering into this Agreement.

COUNTY OF TULARE
HEALTH & HUMAN SERVICES AGENCY
SERVICES AGREEMENT

9. COUNTERPARTS: The Parties may sign this Agreement in counterparts, each of which is an original and all of which taken together form one single document.

THE PARTIES, having read and considered the above provisions, indicate their agreement by their authorized signatures below.

TURNING POINT OF CENTRAL CALIFORNIA, INC.

Date: 1/10/20

By _____

Print Name Raymond R. Banks

Title Chief Executive Officer

Date: 1/10/20

By _____

Print Name Bruce Tyler

Title Chief Financial Officer

[Pursuant to Corporations Code section 313, County policy requires that contracts with a Corporation be signed by both (1) the chairman of the Board of Directors, the president or any vice-president (or another officer having general, operational responsibilities), and (2) the secretary, any assistant secretary, the chief financial officer, or any assistant treasurer (or another officer having recordkeeping or financial responsibilities), unless the contract is accompanied by a certified copy of a resolution of the corporation's Board of Directors authorizing the execution of the contract. Similarly, pursuant to California Corporations Code section 17703.01, County policy requires that contracts with a Limited Liability Company be signed by at least two managers, unless the contract is accompanied by a certified copy of the articles of organization stating that the LLC is managed by only one manager.]

COUNTY OF TULARE

Date: _____

By _____
Chairman, Board of Supervisors

ATTEST: JASON T. BRITT
County Administrative Officer/Clerk of the Board
of Supervisors of the County of Tulare

By _____
Deputy Clerk

Approved as to Form
County Counsel

By _____
Deputy

Matter # 20192056 1.14.2020

EXHIBIT A1 – Drug Medi-Cal – Organized Delivery System

FISCAL YEAR 2019-2020

The Drug Medi-Cal Organized Delivery System (DMC-ODS) is a pilot program to test a new paradigm for the organized delivery of health care services for Medicaid eligible individuals with a Substance Use Disorder (SUD). DMC-ODS has the potential to address the aforementioned limitations on California's DMC-funded services. It will provide access to treatment modalities and services previously not covered by DMC benefits, making available a full continuum of evidence-based SUD treatment and thus increasing the likelihood that beneficiaries will be able to achieve and sustain long-term recovery.

In addition, DMC-ODS will facilitate increased coordination and integration of SUD services with physical health and mental health care, potentially leading to improved clinical and fiscal outcomes. Furthermore, by enhancing counties' ability to selectively contract with providers and expanding the provider types included in the SUD workforce, DMC-ODS can address limitations that have hampered the delivery of effective SUD services to Medi-Cal beneficiaries. Consequently, it is anticipated that the implementation of DMC-ODS will lead to improvements in four key areas: (1) access to care, (2) quality of care, (3) cost, and (4) the integration and coordination of SUD care, both within the SUD system and with medical and mental health services.

ASAM Criteria is a collection of objective guidelines that give clinicians a way to standardize treatment planning and where patients are placed in treatment, as well as how to provide continuing, integrated care and ongoing service planning. The criteria were developed by the American Society of Addiction Medicine (ASAM), and presented in a book written by a group of renowned doctors and professionals, working in a variety of mental health and addiction treatment fields. The ASAM Criteria has become the most widely used set of criteria in the United States for the treatment of substance-use issues, and it has been continually revised and updated over the years with the newest science in the field of addiction. The ASAM Criteria has been in use since 1991, and its foundations extend back even further into history. The ASAM Criteria specifies that a professional can use a reference tool such as the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-V) to determine if beneficiaries meet medical necessity criteria. Services available through DMC-ODS, through the use of the ASAM criteria include:

A. .5 Early Intervention
B. 1 – Outpatient Services
C. 2.1 – Intensive Outpatient Services
D. 2.5 – Partial Hospitalization
E. 3.1 – Clinically Managed Low-intensity Residential Services
F. 3.3 – Clinically Managed Population-specific High-intensity Residential Services
G. 3.5 – Clinically Managed High-intensity Residential Services
H. 3.7 – Medically Monitored Intensive Inpatient Services
I. 4.0 – Medically Managed Intensive Inpatient Services
J. 1-WM – Ambulatory Withdrawal Management without Extended On-site Monitoring
K. 2-WM – Ambulatory Withdrawal Management with Extended On-site Monitoring
L. 3.2-WM – Clinically Managed Residential Withdrawal Management
M. 3.7-WM – Medically Monitored Inpatient Withdrawal Management
N. 4-WM – Medically Managed Intensive Inpatient Withdrawal Management
O. Recovery Services
P. Case Management
Q. Physician Consultation
R. Additional Medication Assisted Treatment (MAT)
S. Partial Hospitalization

It is highly encouraged that CONTRACTOR reaches out to community-based organizations and other county resources to maximize CONTRACTOR's services. It is the responsibility of CONTRACTOR to highlight resources available by CONTRACTOR for the community. Beneficiaries have the ability to seek SUD services with CONTRACTOR without prior COUNTY approval, except for residential services, which require a Treatment Authorization Request (TAR) by COUNTY.

EXHIBIT A2 – SCOPE OF SERVICES

TURNING POINT OF CENTRAL CALIFORNIA

FISCAL YEAR 2019-2020

Section 1 - Services Provided

A. **Outpatient Drug Free (ODF) Services (American Society of Addiction Medicine (ASAM) Level 1):** Counseling services are provided to beneficiaries (up to 9 hours a week for adults, and less than 6 hours a week for adolescents) when determined by a Medical Director or Licensed Practitioner of the Healing Arts (LPHA) to be medically necessary and in accordance with an individualized client plan. Group size is limited to no less that two (2) and no more than twelve (12) beneficiaries.

1. CONTRACTOR providers may provide Drug Medi-Cal – Organized Delivery System (DMC-ODS) ODF services in-person or by telephone by a licensed professional or a registered or certified counselor in any appropriate setting in the community, in accordance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA) and 42 Code of Federal Regulations (CFR) Part 2.

B. **Intensive Outpatient Treatment (IOT) Services (ASAM Level 2.1):** Structured programming services provided to beneficiaries a minimum of nine (9) hours with a maximum of nineteen (19) hours a week for adults, and a minimum of six (6) hours with a maximum of nineteen (19) hours a week for adolescents. Group size is limited to no less that two (2) and no more than twelve (12) beneficiaries.

1. CONTRACTOR shall provide IOT services in-person or by telephone by a LPHA or a certified counselor in any appropriate setting in the community in accordance with HIPAA and 42 CFR Part 2.
2. Adults
    a) CONTRACTOR may provide more than 19 hours per week to adults when determined by a Medical Director or LPHA to be medical necessary, and in accordance with the individualized treatment plan.
    b) CONTRACTOR may extend a beneficiary's length of treatment when determined by a Medical Director or LPHA to be medically necessary, and in accordance with the individualized treatment plan.
3. Adolescents
    a) CONTRACTOR shall provide more than 19 hours per week to adolescents when determined by a Medical Director or LPHA to be medical necessary, and in accordance with the individualized treatment plan.
    b) CONTRACTOR may extend a beneficiary's length of treatment when determined by a Medical Director or LPHA to be medically necessary, and in accordance with the individualized treatment plan.

C. The components of ODF and IOT services include the following services:

1. **Intake:** The process of determining that a beneficiary meets the medical necessity criteria and a beneficiary is admitted into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders, the diagnosis of substance use disorders, and the assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.
2. **Individual and/or Group Counseling:** Contacts between a beneficiary and a therapist or counselor.
3. **Patient Education:** Provide research based education on addiction, treatment, recovery, and associated health risks.

4. **Family Therapy:** The effects of addiction are far-reaching and patient's family members and loved ones are also affected by the disorder. By including family members in the treatment process, education about factors that are important to the patient's recovery, as well as their own recovery, can be conveyed. Family members can provide social support to the patient, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

5. **Medication Services:** The prescription or administration of medication related to substance use treatment services, or the assessment of the side effects or results of that medication conducted by staff lawfully authorized to provide such services and/or order laboratory testing within their scope of practice or licensure.

6. **Collateral Services:** Sessions with therapists or counselors and significant persons in the life of the beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.

7. **Crisis Intervention Service:** Contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the beneficiary's emergency situation.

8. **Treatment Planning:** The provider shall prepare an individualized written treatment plan, based upon information obtained in the intake and assessment process. The treatment plan shall be completed within the regulatory timeframe then updated every subsequent 90 days unless there is a change in treatment modality or significant event that would then require a new treatment plan.

9. **Discharge Services:** The process to prepare the beneficiary for referral into another Level of Care (LOC), return to post treatment or reentry into the community, and/or the linkage of the individual to essential community treatment, housing, and human services.

10. **Case Management:** Service to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Case management can be face-to-face or over the telephone and shall be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 CFR Part 2, and California law.

    a) CONTRACTOR shall provide case management services to beneficiaries receiving ODF services and IOT services to coordinate care with ancillary service providers and facilitate transitions between LOC.

    b) The components of case management include:

        (i) Comprehensive assessment and periodic reassessment of individual needs to determine the need for the continuation of case management;

        (ii) Transition to a higher or lower level of Substance Use Disorder (SUD) care;

        (iii) Development and periodic revision of a client plan that includes service activities;

        (iv) Communication, coordination, referral, and related activities;

        (v) Monitoring service delivery to ensure beneficiary access to service and the service delivery system;

        (vi) Monitoring the beneficiary's progress; and

        (vii) Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services.

11. **Recovery Services**

CONTRACTOR shall comply with the following Contractor specific recovery services requirements:

a) CONTRACTOR shall offer DMC-ODS beneficiaries SUD recovery services, when a Medical Director or LPHA has determined that recovery services are medically necessary and after the DMC-ODS beneficiary has been discharged from SUD treatment services.

(i) Recovery services shall be made available to DMC-ODS beneficiaries in accordance with their individualized treatment plan.

(ii) CONTRACTOR shall not provide a DMC-ODS beneficiary with recovery services while the DMC-ODS beneficiary is receiving SUD treatment services.

b) The components of recovery services shall include:

(i) ODF individual or group counseling (relapse prevention).

(ii) Recovery monitoring/coaching (via telephone or the internet).

(iii) Peer-to-peer assistance.

(iv) Care coordination to services to education services, life skills, employment services, and job training.

c) Care coordination to child care, child development and support services, and marriage/family counseling.

d) Care coordination to housing assistance, transportation, case management, and individual service coordination.

12. **Physician Consultation:** Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are not with DMC-ODS beneficiaries; rather, they are designed to assist DMC physicians with seeking expert advice on designing treatment plans for specific DMC-ODS beneficiaries, and to support DMC providers with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or LOC considerations.

D. **Residential (ASAM Level 3.1):** Clinically Managed Low Intensity – Provides 24-hour structure with available trained personnel; at least 5 hours of clinical service per week and preparation for outpatient treatment.

1. The length of residential services ranges from one to 90 days with a 90-day maximum for adults, unless medical necessity authorizes a one-time extension of up to 30 days on an annual basis.

2. Adolescents, under the age of 21, shall receive continuous residential services for a maximum of 30 days. Adolescent beneficiaries may receive a 30-day extension if that extension is determined to be medically necessary. Adolescent beneficiaries are limited to one extension per year.

a) Nothing in the DMC-ODS overrides any EPSDT requirements. Adolescent beneficiaries may receive a longer length of stay based on medical necessity.

3. For adult beneficiaries, only two non-continuous 90 day regimens shall be authorized in a one-year period.

4. Pursuant to STC 138 (c), perinatal clients shall receive lengths of stay up to the length of the pregnancy and postpartum period (60 days after the pregnancy ends).

5. The components of Residential Treatment Services shall include:

a) **Intake:** The process of determining that a beneficiary meets the medical necessity criteria and admitting the beneficiary into a substance use disorder treatment program. Intake includes the evaluation or analysis of substance use disorders; the diagnosis of substance use disorders; and the

assessment of treatment needs to provide medically necessary services. Intake may include a physical examination and laboratory testing necessary for substance use disorder treatment.

b) **Individual and Group Counseling:** Contacts between a beneficiary and a therapist or counselor. Services are provided in-person or by telephone qualify as Medi-Cal reimbursable units of service, and are reimbursed without distinction

c) **Patient Education:** Provide research-based education on addiction, treatment, recovery, and associated health risks

d) **Family Therapy:** The effects of addiction are far-reaching and patient's family members and loved ones also are affected by the disorder. By including family members in the treatment process, education about factors that are important to the patient's recovery, as well as their own recovery, can be conveyed. Family members can provide social support to the patient, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well.

e) **Safeguarding Medications:** Facilities will store all resident medication and facility staff members may assist with resident's self-administration of medication.

f) **Collateral Services:** Sessions with therapists or counselors and significant persons in the life of the beneficiary, focused on the treatment needs of the beneficiary in terms of supporting the achievement of the beneficiary's treatment goals. Significant persons are individuals that have a personal, not official or professional, relationship with the beneficiary.

g) **Crisis Intervention Services:** Contact between a therapist or counselor and a beneficiary in crisis. Services shall focus on alleviating crisis problems. "Crisis" means an actual relapse or an unforeseen event or circumstance which presents to the beneficiary an imminent threat of relapse. Crisis intervention services shall be limited to the stabilization of the beneficiary's emergency situation.

h) **Treatment Planning:** The provider shall prepare an individualized written treatment plan, based upon information obtained in the intake and assessment process. The treatment plan will be completed within regulatory timeframes, reviewed every 30 days, and then updated every 90 days unless there is a change in treatment modality or significant event that would then require a new treatment plan.

i) **Transportation Services:** Provision of or arrangement for transportation to and from medically necessary treatment.

j) **Discharge Services:** The process to prepare the beneficiary for referral into another level of care, return to post treatment or reentry into the community, and/or the linkage of the individual to essential community treatment, housing and human services.

k) **Physician Consultation:** Services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are not with DMC-ODS beneficiaries; rather, they are designed to assist DMC physicians with seeking expert advice on designing treatment plans for specific DMC-ODS beneficiaries, and to support DMC providers with complex cases which may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

Section 2 - Assessments

A. Face-to-Face: Assessments shall be face-to-face and performed by qualified staffing. If the face-to-face assessment is provided by a certified counselor, the "face-to-face" interaction must take place, at minimum, between the certified counselor who has completed the assessment for the beneficiary and the Medical Director, licensed physician, or LPHA. This interaction also must be documented appropriately in the medical record to establish the determination of medical necessity for the beneficiary.

B. Re-Assessments:

1. CONTRACTOR shall reassess all ODF and IOT beneficiaries, at a minimum of every 90 calendar days, unless medical necessity warrants more frequent reassessments as documented in the individualized treatment plan.
2. CONTRACTOR shall reassess beneficiaries initially authorized for residential treatment, at a minimum of every 30 calendar days, unless medical necessity warrants more frequent reassessments as documented in the individualized treatment plan.

B. ASAM Training: Staff performing assessments shall complete, via Relias, the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and LOC".

Section 3 - Program Requirements

C. Counselors

1. In accordance with Title IX, at least thirty percent (30%) of staff providing counseling services in all AOD programs shall be licensed or certified and the remaining seventy percent (70%) may be registered.
2. Best practices for providing SUD services are when staffing is a balance of Registrants and AOD Counselors and LPHAs for continuity of care. It is highly recommended to provide the best possible services to beneficiaries, CONTRACTOR utilize the following ratio:
    a) At least seventy percent (70%) of staff providing counseling services be licensed or certified and the remaining thirty percent (30%) may be registered.
3. Upon the date of hire, all non-licensed or non-certified individuals in an AOD program shall be registered to obtain certification as an AOD Counselor by an approved certifying organization prior to providing counseling services, in accordance with Title IX regulation.
    a) Registrants shall complete certification as an AOD counselor within two (2) years of the date of registration.
4. Registrants shall be accompanied by a licensed or certified AOD counselor when conducting individual counseling sessions, group counseling sessions, face-to-face interviews, or counseling for families, couples, and other individuals significant in the life of the participants, patients, or residents.

D. Volunteers and Interns

1. In the event volunteers and/or interns are used by CONTRACTOR, CONTRACTOR shall meet the following requirements:
2. Volunteers/interns shall NOT be currently receiving treatment by the provider.
3. Volunteers/interns shall NOT have access to beneficiaries' information, to include:
    a) Access to EHR systems;
    b) Personnel files; and
    c) Beneficiaries PII
4. If CONTRACTOR utilizes the services of volunteers/interns, it shall develop and implement written policies and procedures, which shall be available for, and reviewed with all volunteers/interns. The policies and procedures shall address all of the following:
    a) Recruitment;
    b) Screening;
    c) Selection;

d) Training and orientation;

e) Duties and assignments;

f) Supervision

g) Protection of beneficiaries' confidentiality; and

h) Code of Conduct

5. The program shall maintain personnel files on all volunteers and interns. Each personnel file shall contain:

a) Health records including a health screening report or health questionnaire and tuberculosis test result records as required;

b) Code of Conduct statement;

c) Protection of confidentiality statement; and

d) Job description including lines of supervision

e) At no time shall a volunteer be alone with beneficiaries during treatment.

Section 4 - Performance Standards

CONTRACTOR shall be evaluated by the University of California, Los Angeles, Integrated Substance Abuse Programs (UCLA ISAP), to measure and monitor outcomes of DMC-ODS. The evaluation will focus on four areas: (1) access to care, (2) quality of care, (3) cost, and (4) the integration and coordination of SUD care, both within the SUD system and with medical and mental health services. As part of DMC-ODS, CONTRACTOR shall make available, the Treatment Perception Survey (TPS), which can be found at http://www.uclaisap.org/ca-policy/html/client-treatment-perceptions-survey.html. The data may also be used by CONTRACTOR to evaluate and improve the quality of care and beneficiary experience.

After the first year of DMC-ODS, COUNTY will review CONTRACTOR's performance and identify potential patterns and areas that may indicate quality of care issues (e.g., timeliness of placement, effective ASAM assessment, patient-centered focus). After year one of DMC-ODS, COUNTY may implement baselines for CONTRACTOR performance.

A. Access to Care

1. Contractor shall accept individuals eligible for enrollment in the order in which they apply without restriction in accordance with this Agreement. CONTRACTOR shall take affirmative action to ensure that beneficiaries are provided covered services and will not discriminate against individuals eligible to enroll under the laws of the United States and the State of California. CONTRACTOR shall not unlawfully discriminate against any person pursuant to:

a) Title VI of the Civil Rights Act of 1964.

b) Title IX of the Education Amendments of 1972 (regarding education and programs and activities).

c) The Age Discrimination Act of 1975.

d) The Rehabilitation Act of 1973.

e) The Americans with Disabilities Act.

2. DMC-ODS services shall be available as a Medi-Cal benefit for individuals who meet the medical necessity criteria and reside in this opt-in County. Determination of who may receive the DMC-ODS benefits shall be performed in accordance with DMC-ODS Special Terms and Conditions (STC) 132(d), Article II.E.4 of the State-County Contract, and as follows:

a) CONTRACTOR shall verify the Medicaid eligibility determination of an individual. When

CONTRACTOR conducts the initial eligibility verification, that verification shall be reviewed and approved by CONTRACTOR prior to payment for services. If the individual is eligible to receive services from tribal health programs operating under the Indian Self-Determination Education Assistance Act (ISDEAA), then the determination shall be conducted as set forth in the Tribal Delivery System - Attachment BB to the STCs.

b) All beneficiaries shall meet the following medical necessity criteria:

   (i) The individual shall have received a diagnosis from the Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-V) for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders or be assessed to be at risk for developing substance use disorder (for youth under 21).

   (ii) The individual shall meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.

   (iii) For beneficiaries in treatment prior to implementation of the DMC-ODS, the provider must conduct an ASAM assessment by the due date of the next updated treatment plan or continuing services justification, whichever occurs first.

      a. If the assessment determines a different level of care, the provider shall refer the beneficiary to the appropriate level of care.

c) Adolescents are eligible to receive Medicaid services pursuant to the Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. Under the EPSDT mandate, beneficiaries under the age 21 are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. Nothing in the DMC-ODS overrides any EPSDT requirements.

d) The initial medical necessity determination, for an individual to receive a DMC-ODS benefit, shall be performed by a Medical Director or an LPHA. The Medical Director or LPHA shall evaluate each beneficiary's assessment and intake information if completed by a counselor through a face-to-face review or telehealth with the counselor to establish a beneficiary meets medical necessity criteria. After establishing a diagnosis and documenting the basis for diagnosis, the ASAM Criteria shall be applied to determine placement into the level of assessed services.

e) For an individual to receive ongoing DMC-ODS services, the Medical Director or LPHA shall reevaluate that individual's medical necessity qualification at least every six (6) months through the reauthorization process and document their determination that those services are still clinically appropriate for that individual. For an individual to receive ongoing Opioid Treatment Program/Narcotic Treatment Program (OTP/NTP) services, the Medical Director or LPHA shall reevaluate that individual's medical necessity qualification at least annually through the reauthorization process and determine that those services are still clinically appropriate for that individual.

3. Timely access data—including date of initial contact, date of first offered appointment and date of scheduled assessment—shall be entered into AVATAR within seven (7) days of the intake.

   Performance Standard:

   a) First face-to-face appointment shall occur within five (5) and no later than 10 business days of initial contact.

      (i) CONTRACTOR shall allow beneficiaries to appear in person and receive same-day screening, ASAM assessments, and referral, if available.

   b) First face-to-face appointment Medication Assisted Treatment appointment for beneficiaries with alcohol or opioid disorders shall occur within five (5) and no later than 10 business days.

c) Tulare County strives to ensure the highest quality of care, which included time and location of services. CONTRACTOR shall provide all beneficiaries the TPS, to guarantee the best possible care is provided.

d) Timely access data shall be entered in AVATAR within seven (7) days of first contact for all beneficiaries.

B. Progress Notes

1. For ODF services, Naltrexone treatment services, and recovery services, each individual and group session, the LPHA or counselor who conducted the counseling session or provided the service shall record a progress note for each beneficiary who participated in the counseling session or treatment service.

   a) The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven calendar days of the counseling session. The signature shall be adjacent to the typed or legibly printed name.

   b) Progress notes are individual narrative summaries and shall include all of the following:

      (i) The topic of the session or purpose of the service.

      (ii) A description of the beneficiary's progress on the treatment plan problems, goals, action steps, objectives, and/or referrals.

      (iii) Information on the beneficiary's attendance, including the date, start and end times of each individual and group counseling session or treatment service.

      (iv) Identify if services were provided in-person, by telephone, or by telehealth.

      (v) If services were provided in the community, identify the location and how CONTRACTOR ensured confidentiality.

2. For IOT services and residential treatment services, the LPHA or counselor shall record, at a minimum, one progress note, per calendar week, for each beneficiary participating in structured activities including counseling sessions or other treatment services.

   a) The LPHA or counselor shall type or legibly print their name, and sign and date progress notes within the following calendar week. The signature shall be adjacent to the typed or legibly printed name.

   b) Progress notes are individual narrative summaries and shall include all of the following:

      (i) A description of the beneficiary's progress on the treatment plan, problems, goals, action steps, objectives, and/or referrals.

      (ii) A record of the beneficiary's attendance at each counseling session including the date, start and end times and topic of the counseling session.

      (iii) Identify if services were provided in-person, by telephone, or by telehealth.

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

3. For each beneficiary provided case management services, the LPHA or counselor who provided the treatment service shall record a progress note.

   a) The LPHA or counselor shall type or legibly print their name, and sign and date the progress note within seven calendar days of the case management service. The signature shall be adjacent to the typed or legibly printed name.

   b) Progress notes shall include all of the following:

(i) Beneficiary's name.

(ii) The purpose of the service.

(iii) A description of how the service relates to the beneficiary's treatment plan problems, goals, action steps, objectives, and/or referrals.

(iv) Date, start and end times of each service.

(v) Identify if services were provided in-person, by telephone, or by telehealth.

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

4. For physician consultation services, additional medication assisted treatment, and withdrawal management, the Medical Director or LPHA working within their scope of practice who provided the treatment service shall record a progress note and keep in the beneficiary's file.

a) The Medical Director or LPHA shall type or legibly print their name, and sign and date the progress note within seven calendar days of the service. The signature shall be adjacent to the typed or legibly printed name.

b) Progress notes shall include all of the following:

(i) Beneficiary's name.

(ii) The purpose of the service.

(iii) Date, start and end times of each service.

(iv) Identify if services were provided face-to-face, by telephone or by telehealth.

C. Continuing Services.

1. Continuing services shall be justified as shown below:

a) For ODF services, IOT services, and case management:

(i) For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the LPHA or counselor shall review the beneficiary's progress and eligibility to continue to receive treatment services, and recommend whether the beneficiary should or should not continue to receive treatment services at the same level of care.

(ii) For each beneficiary, no sooner than five months and no later than six months after the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the Medical Director or LPHA shall determine medical necessity for continued services for the beneficiary. The determination of medical necessity shall be documented by the Medical Director or LPHA in the beneficiary's individual patient record and shall include documentation that all of the following have been considered:

a. The beneficiary's personal, medical and substance use history.

b. Documentation of the beneficiary's most recent physical examination.

c. The beneficiary's progress notes and treatment plan goals.

d. The LPHA's or counselor's recommendation pursuant to Paragraph (i) above.

e. The beneficiary's prognosis.

f. The Medical Director or LPHA shall type or legibly print their name, and sign and date the continuing services information when completed. The signature shall be adjacent to the typed or legibly printed name.

(iii) If the Medical Director or LPHA determines that continuing treatment services for the beneficiary is not medically necessary, the provider shall discharge the beneficiary from the current LOC and transfer to the appropriate services.

D. Transitions Between LOCs

1. CONTRACTOR shall ensure the transition of the beneficiaries to appropriate LOC. This may include step-up or step-down in SUD treatment services. Case Managers shall provide warm hand-offs and transportation to the new LOC when medically necessary and documented in the individualized treatment plan.
2. CONTRACTOR shall ensure transitions to other LOCs will occur within 10 business days from the time of assessment or reassessment with no interruption of current treatment services.

E. Coordination and Continuity of Care (42 CFR §438.208).

1. CONTRACTOR shall comply with the care and coordination requirements of this section.
2. As all beneficiaries receiving DMC-ODS services shall have special health care needs, CONTRACTOR shall implement mechanisms for identifying, assessing, and producing a treatment plan for all beneficiaries that have been assessed to need a course of treatment, and as specified below.
3. CONTRACTOR shall implement procedures to deliver care to and coordinate services for all of its beneficiaries. These procedures shall meet Department requirements and shall do the following:
   a) Ensure that each beneficiary has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the beneficiary. The beneficiary shall be provided information on how to contact their designated person or entity.
   b) Coordinate the services the Contractor furnishes to the beneficiary:
      (i) Between settings of care, including appropriate discharge planning for short-term and long-term hospital and institutional stays.
      (ii) With the services the beneficiary receives from any other managed care organization.
      (iii) With the services the beneficiary receives in FFS Medicaid.
      (iv) With the services the beneficiary receives from community and social support providers.
   c) Make a best effort to conduct an initial screening of each beneficiary's needs, within 90 calendar days of the effective date of enrollment for all new beneficiaries, including subsequent attempts if the initial attempt to contact the beneficiary is unsuccessful.
   d) Share with the Department or other managed care organizations serving the beneficiary, the results of any identification and assessment of that beneficiary's needs to prevent duplication of those activities.
   e) Ensure that each provider furnishing services to beneficiaries maintains and shares, as appropriate, a beneficiary health record in accordance with professional standards.
   f) Ensure that in the process of coordinating care, each beneficiary's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E and 42 CFR Part 2, to the extent that they are applicable.
   g) CONTRACTOR shall implement mechanisms to comprehensively assess each Medicaid beneficiary identified by the Department as having special health care needs to identify any ongoing special conditions of the beneficiary that require a course of treatment or regular care monitoring. The assessment mechanisms shall use appropriate providers.

h) CONTRACTOR shall produce a treatment or service plan meeting the criteria below for beneficiaries with special health care needs that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan shall be:

(i) Developed with beneficiary participation, and in consultation with any providers caring for the beneficiary.

(ii) Developed by a person trained in person-centered planning using a person-centered process and plan, as defined in 42 CFR §441.301(c)(1).

(iii) Approved by CONTRACTOR in a timely manner, if this approval is required by CONTRACTOR.

(iv) In accordance with any applicable Department quality assurance and utilization review standards.

(v) Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the beneficiary's circumstances or needs change significantly, or at the request of the beneficiary per 42 CFR §441.301(c)(3).

(vi) For beneficiaries with special health care needs determined through an assessment to need a course of treatment or regular care monitoring, the Contractor shall have a mechanism in place to allow beneficiaries to directly access a specialist as appropriate for the beneficiary's condition and identified needs.

F. Care Coordination and Linkage with Ancillary Service

1. CONTRACTOR shall adhere to COUNTY's care coordination plan that provides for seamless transitions of care for beneficiaries with the DMC-ODS system of care. CONTRACTOR is responsible for ensuring that beneficiaries successfully transition between levels of SUD care (i.e. withdrawal management, residential, ODF) without disruptions to services.
2. In addition to specifying how beneficiaries will transition across levels of acute and short-term SUD care without gaps in treatment, CONTRACTOR shall ensure that beneficiaries have access to recovery supports and services immediately after discharge or upon completion of an acute care stay, with the goal of sustained engagement and long-term retention in SUD and behavioral health treatment.
3. CONTRACTOR shall ensure 42 CFR Part 2 compliant releases are in place in order to coordinate care. CONTRACTOR shall screen for and link clients with mental and physical health, as indicated.
4. It is required that CONTRACTOR document all interactions with beneficiaries. It is highly recommended CONTRACTOR document if a beneficiary refuses continuity of care services.
5. CONTRACTOR shall not be penalized for beneficiaries that refuse services.
6. Performance Standard:

a) COUNTY strives to ensure Quality of Care, which includes ensuring the coordination of care, as well as linkages with ancillary services. Continuity of care is of the whole person model and performance measures will be measured at the following:

b) There is documentation of physical health and mental health screening in all beneficiary records

c) Beneficiaries have 42 CFR compliant releases in place to coordinate care with physical health providers

d) Beneficiary records have documentation of coordination with physical health

e) Beneficiaries engaged in treatment for at least 30 days have an assigned Primary Care Provider

f) Beneficiaries who screen positive for mental health disorders have 42 CFR compliant releases in

place to coordinate care with mental health providers

g) Beneficiary records for individuals who screen positive for mental health disorders have documentation of coordination with mental health (e.g. referral for mental health assessment or consultation with existing providers).

G. Narcotic Treatment Programs (NTPs)

1. CONTRACTOR shall have procedures for linkage/integration for beneficiaries requiring NTP services for substance use disorders. CONTRACTOR staff shall regularly communicate with physicians of beneficiaries who are prescribed these medications unless the beneficiary refuses to consent a 42 CFR, Part 2 compliant release of information for this purpose.
2. It is required that CONTRACTOR document all contact with beneficiaries. It is highly recommended CONTRACTOR document if a beneficiary refuses continuity of care services.
   a) CONTRACTOR shall not be penalized for beneficiaries that refuse services
3. Performance Standard:
   a) CONTRACTOR shall strive to ensure beneficiary records for individuals receiving Medication Assisted Treatment for substance use disorders have 42 CFR compliant releases in place to coordinate care
   b) CONTRACTOR shall strive to ensure that beneficiaries with a primary opioid or alcohol use disorder be linked to an MAT assessment and/or MAT services

H. Delivery of Individualized and Quality Care

1. Beneficiary Satisfaction: DMC-ODS Providers (serving adults 18+) shall participate in the annual statewide Treatment Perceptions Survey (administration period to be determined by DHCS). Upon review of Provider-specific results, Contractor shall select a minimum of one quality improvement initiative to implement annually.
2. Evidence-Based Practices (EBPs): CONTRACTOR shall implement, and assess fidelity to, at the least Motivational Interviewing, and two of the following EBPs per service modality: Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment and Psycho-Education.
3. ASAM LOC: All beneficiaries participate in an assessment using ASAM dimensions. The assessed and actual LOC (and justification if the levels differ) shall be recorded in AVATAR with seven (7) days of the assessment.
4. Performance Standards:
   a) Beneficiaries' TPS shall identify overall satisfaction with the program and their individualized treatment plan
   b) CONTRACTOR shall implement with fidelity at least three approved EBPs
      (i) CONTRACTOR shall implement Motivational Interviewing as an EBP

I. CONTRACTOR shall ensure beneficiaries participated in an assessment using ASAM dimensions and are provided with a recommendation regarding ASAM LOC

J. Discharge

1. Discharge of a beneficiary from treatment may occur on a voluntary or involuntary basis. For ODF services and IOT service, in addition to the requirements of this subsection, an involuntary discharge is subject to the requirements set forth in Article II.G.2. of this Agreement.
2. An LPHA or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom CONTRACTOR loses contact.

a) The discharge plan shall include, but not be limited to, all of the following:

(i) A description of each of the beneficiary's relapse triggers.

(ii) A plan to assist the beneficiary to avoid relapse when confronted with each trigger.

(iii) A support plan.

3. The discharge plan shall be prepared within 30 calendar days prior to the scheduled date of the last face-to-face treatment with the beneficiary.

a) If a beneficiary is transferred to a higher or lower level of care based on ASAM criteria within the same DMC certified program, they are not required to be discharged unless there has been more than a 30-calendar day lapse in treatment services.

4. During the LPHA's or counselor's last face-to-face treatment with the beneficiary, the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. The signatures shall be adjacent to the typed or legibly printed name. A copy of the discharge plan shall be provided to the beneficiary and documented in the beneficiary record.

5. The LPHA or counselor shall complete a discharge summary, for any beneficiary with whom the provider lost contact, in accordance with all of the following requirements:

a) The LPHA or counselor shall complete the discharge summary within 30 calendar days of the date of the last face-to-face treatment contact with the beneficiary.

b) The discharge summary shall include all of the following:

(i) The duration of the beneficiary's treatment as determined by the dates of admission to and discharge from treatment.

(ii) The reason for discharge.

(iii) A narrative summary of the treatment episode.

(iv) The beneficiary's prognosis.

K. Culturally Competent Services

A. Contractors are responsible to provide culturally competent services. Contractors must ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations. Translation and oral interpreter services must be available for beneficiaries, as needed and at no cost to the beneficiary.

1. Performance Standard:

a) COUNTY strives to ensure Quality of Care services are provided, which includes providing culturally competent services to beneficiaries. Performance measures will be measured at the following:

(i) CONTRACTOR shall adopt Federal Culturally & Linguistic Appropriate Services (CLAS) standards and develop cultural competence plan with regular updates.

(ii) Translation services shall be available for beneficiaries and services will be culturally competent and accessible.

(iii) Provide written information in all threshold languages based on county population.

Section 5 - Outcomes

A. In order to assess whether beneficiaries: 1) Reduce substance abuse or achieve a substance-free life; 2) Maximize multiple aspects of life functioning; 3) Prevent or reduce the frequency and severity of relapse; and 4) Improve overall quality of life, the following indicators that shall be evaluated and measured include, but

are not limited to:

1. Engagement in the first 30 days of treatment (at least two treatment sessions within 30 days after initiating treatment)
2. Reduction in substance use
3. Reduction in criminal activity or violations of probation/parole and days in custody
4. Increase in employment or employment (and/or educational) skills
5. Increases in family reunification
6. Increase engagement in social supports
7. Maintenance of stable living environments and reduction in homelessness
8. Improvement in mental and physical health status
9. Beneficiary satisfaction

Section 6 - Training and Certification

A. Applicable staff are required to participate in the following training:

1. Title 22, DMC (At least annually)
2. Information Privacy and Security (At least annually)
3. ASAM E-modules 1 and 2 (via Relias) (Prior to Conducting Assessments)
4. Cultural Competency (At least annually)
5. Oath of Confidentiality (Review and sign at hire and annually thereafter)

B. Program Licensure, Certification and Standards

1. Contractor shall possess valid DHCS Alcohol and Drug Certification and DHCS DMC certification for the contracted LOC.

C. Beneficiary Protections and Beneficiary Informing Materials

1. Beneficiary Informing Materials

   a) Contractor shall make available at initial contact, and shall notify beneficiaries of their right to request and obtain at least once a year and thereafter upon request, the following materials: DMC-ODS Beneficiary Booklet and Provider Directory.

   b) Contractor shall also post notices explaining grievance, appeal and expedited appeal processes in all program sites, as well as make available forms and self-addressed envelopes to file grievances, appeals and expedited appeals without having to make a verbal or written request to anyone. COUNTY shall produce required beneficiary informing materials in English and Spanish. Contractor shall request materials from COUNTY, as needed. Refer to 42 CFR 438.10(g)(2)(xi) for additional information about the grievance and appeal system.

Section 7 – Authorization Process – ASAM Level 3.1

A. Initial Authorization

Requests for initial authorization are to be submitted to HHSA Access on the Treatment Authorization Request (TAR) - Initial Authorization form at least 24 hours before the scheduled admission date. A copy of the ASAM Continuum or County-provided ASAM assessment tool shall be attached to the TAR. Initial authorizations can be granted for up to 30 days for youth and up to 45 days for adults. An approved authorization allows for a client to be admitted to treatment within seven (7) calendar days of the approval

date. Admissions later than seven (7) calendar days from the authorization date will be considered on a case-by-case basis and will require written approval by the County.

B. Continuing Authorization

Requests for continuing authorizations are to be submitted to HHSA Access on the TAR – Continuing Authorization form seven (7) calendar days before to the expiration date of the current authorization. A copy of the re-assessment (ASAM Continuum or County-provided ASAM assessment tool) shall be attached to the TAR. For youth, a one-time extension for up to 30 days on an annual basis can be granted. For adults, continuing authorizations can be granted for up to an additional 45 days, for a total length of stay not to exceed 90 days. A one-time extension for up to 30 days on an annual basis can be granted, for a total length of stay not to exceed 120 days. Only two, non-continuous, 90 day regimens will be authorized in a one-year period. Perinatal, EPSDT and criminal justice clients may receive a longer length of stay based on medical necessity.

C. Additional Information - TARs

B. For a TAR to be considered eligible for authorization, the individual must be a Tulare County Medi-Cal beneficiary or Tulare County low-income (<138% FPL) uninsured resident and meet medical necessity and the ASAM criteria for the proposed level of care. Payment and submission of claims to Medi-Cal are subject to a beneficiary's eligibility and services being rendered and documented in accordance with Title 22, ASAM diagnostic and dimensional criteria and the DMC-ODS STCs.

Section 8 - Notice of Adverse Benefit Determination (NOABD)

A. Contractor shall have written procedures to ensure compliance with the following:

1. Contractor shall request consent from beneficiaries for the County of Tulare to issue a NOABD to the address on record should covered services be reduced, denied, modified, delayed or terminated. If a beneficiary should refuse to consent, it is CONTRACTOR's responsibility for issuing any applicable NOABD directly to the beneficiary.

    a) Contractor shall immediately notify COUNTY in writing of any actions that may require a NOABD be issued, including, but not limited to: 1) not meeting timely access standards; 2) not meeting medical necessity for any substance use disorder treatment services; and 3) terminating or reducing authorized covered services.

Section 9 - Locations

Turning Point Youth Services
220 N. Locust St.
Visalia, Ca 93291

Visalia Reentry Center
1845 S. Court St.
Visalia, CA 93277

Section 10 – Additional Contract Information

A. If significant changes are expected, you must submit a request in writing to the contract manager. You must receive written approval prior to any changes being implemented and/or reimbursed. Significant changes include, but are not limited to:

1. Scope of Work

    a) Proposing to re-distribute units of service between existing service codes by more than 20%

    b) Proposing to add or remove a service modality

c) Proposing to transfer substantive programmatic work to a subcontractor

d) Proposing to provide any services by telephone or field-based

2. Budget

a) Proposing to re-distribute more than 20% between budget categories

b) Proposing to increase or decrease FTE

c) Proposing to increase the contract maximum

B. Contractor shall also report any other key changes per the timelines and processes outlined in applicable Policies and Procedures, including, but not limited to: 1) Staff Updates; 2) Facility alterations/renovations; 3) Unusual occurrences or incidents; 4) Reduction in DMC services; and 5) Not accepting beneficiaries (facility at capacity).

EXHIBIT B1 - TERMS AND CONDITIONS OF PAYMENT

FISCAL YEAR 2019-2020

Part I – General Fiscal Provisions

Section 1 - Claims Submission and Re-Submission

A. Invoices and applicable supporting documentation are due by the 10th of the month for services delivered the preceding month.

B. Following claims submissions to the County by the 10th of the month for services delivered the preceding month and a subsequent utilization review of Drug/Medi-Cal (DMC) files, the County will submit eligible DMC claims received by the Contractor to DHCS.

C. Any DMC denials shall be resubmitted, as appropriate, by the Contractor to the County, not later than six months after the date of the replaced claim was finalized. Extensions will not be granted.

D. As claims for Physician Consultation services can only be billed by the eligible DMC provider receiving Physician Consultation services, Contractor is responsible for submitting claims for any Physician Consultation services provided by the County to the Contractor. The County will retain all reimbursements for Physician Consultation services provided by the County to the Contractor. The County can provide receipts to Contractor for the purposes of documentation.

E. Claims for final payment must be submitted within thirty (30) days of the expiration date of this Agreement. Payment of claims due may be withheld pending receipt of documents required by this contract.

Section 2 – Reimbursement

Service Provided	FY 19/20	
DMC	$	1,062,343
SABG	$	574,114
TOTAL	**$**	**1,636,458**

A. Contractor will be paid on a monthly basis, following the submission of an invoice (submitted through AVATAR, as applicable, and on a template provided and/or agreed to by the County) for services delivered to the County's satisfaction. Contractor will be reimbursed the negotiated unit of service rate for all approved claims. Final settlement will be the total of approved claims times the negotiated Fee for Service rate, up to the contract maximum, except for DMC amounts. DMC is an entitlement and cannot be capped.

B. Contractor will be reimbursed on a Net 30 basis, meaning generally, payments will be processed within 30 days from the invoice date.

C. Unless otherwise noted in the contract, services provided and reimbursed under this contract are only for Tulare County DMC beneficiaries and low-income (< 138% FPL) uninsured Tulare residents.

D. CONTRACTOR shall use funds provided by COUNTY exclusively for the purposes of performing the services described in **EXHIBITS A – A2**.

Section 3 - Monitoring and Reporting

A. All clients whose treatment is paid for by COUNTY using funding from the State Department of Health Care Services Substance Use Drug Programs must have received a Health & Human Services Agency (HHSA) authorization through Placement Orientation Services (POS). No payments will be made for client services provided prior to the authorization date. CONTRACTOR shall enter all relevant information into AVATAR at client admission, but it must be done not later than 5 days after admission date. CalOMS (California Outcomes Measurement System) client data must be entered within 48 business hours of admittance to and discharge from the treatment program. CONTRACTOR must correct CalOMS data within 2 working days after notification from POS of any and all errors. On-line DATAR (Drug and Alcohol Treatment Access Report) entries shall be made no later than the 10th day of each month. If CONTRACTOR fails to file any claim or other requested report, enter client information into AVATAR in a timely fashion, and/or comply with any other part of this Agreement, COUNTY may withhold future payments until appropriate reports have been filed. CONTRACTOR is subject to annual fiscal monitoring by the County or County's qualified designee.

B. CONTRACTOR shall certify that all UOS entered/submitted by CONTRACTOR into AVATAR for any payor sources covered by this Agreement are true and accurate to the best of CONTRACTOR's knowledge.

C. Based upon information obtained from clients, CONTRACTOR shall be responsible for verification of DMC eligibility, which payment source shall be used before any other.

D. Contractor shall NOT charge a DMC client a fee for services other than a share of cost, pursuant to Article 12 (commencing with Section 50651), Chapter 2, Division 3, Title 22, CCR.

E. At mid-year, or as requested by the County, Contractor shall submit supporting documentation (e.g. copy of General Ledger, report of expenses from financial system) for actual costs to the Tulare County Division of Behavioral Health and Recovery Services for management information and planning purposes.

F. Annual Cost Reports and all supporting documentation must be submitted within sixty (60) days of the expiration date of this Agreement. The Cost Report shall be based on actual costs.

Part II – SABG Specific Funding Provisions

Section 1 – SABG Funding

A. The non-DMC reimbursement shall NOT exceed the contract amount (Exhibit B1); this amount is federally-funded under the Substance Use, Treatment, and Prevention Block Grant (SABG). There shall be no opportunity to exchange money between sources or programs within this Agreement, unless both parties agree to such an exchange in writing and is agreed

by both parties. CONTRACTOR will be reimbursed on a cost per Unit of Service (UOS) basis.

B. Prior to expending SABG funding, every reasonable effort should be made to, including the establishment of systems for eligibility determination, billing, and collection:

1. Collect reimbursement of the costs of providing such services to persons who are entitled to insurance benefits under the Social Security Act, including programs under Title XVIII and Title XIX, 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

2. Secure from beneficiary payments for services in accordance with their ability to pay.

C. Pursuant to 45 CFR Section 75.371 and HSC Section 11817.8, COUNTY may withhold SABG payments if CONTRACTOR fails to:

1. Submit any forms and/or reports to COUNTY by each due date.

2. Complete Corrective Action Plan (CAP) items within the timeframe agreed upon by COUNT and CONTRACTOR.

D. CONTRACTOR shall comply with the financial management standards contained in 45 CFR Sections 75.302(b)(1) through (6), and 45 CFR Section 96.30.

1. Non-profit subcontractors receiving SABG funds shall comply with the financial management standards contained in 45 CFR Section 75.302(b)(1) through (4) and (b)(7), and 45 CFR Section 96.30.

E. CONTRACT shall not use SABG funds provided by COUNTY on the following activities:

1. Provide inpatient services.

2. Make cash payments to intended recipients of health services.

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

4. Satisfy any requirement for the expenditure of SABG funds as a condition for the receipt of federal funds.

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

6. Pay the salary of an individual through a grant or other extramural mechanism at a rate in excess of level I of the Executive Salary Schedule for the award year: see http://grants.nih.gov/grants/policy/salcap_summary.htm.

7. Purchase treatment services in penal or correctional institutions of the State of California.

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

9. Carry out any program prohibited by 42 USC 300x–21 and 42 USC 300ee–5 such that

none of the funds provided under this Act or an amendment made by this Act shall be used to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless the Surgeon General of the United States Public Health Service determines that a demonstration needle exchange program would be effective in reducing drug abuse and the risk that the public will become infected with the etiologic agent for acquired immune deficiency syndrome.

10. Provide services reimbursable by DMC:

    a) Contractor shall not utilize SABG funds to pay for a service that is reimbursable by DMC.

    b) The Contractor may utilize SABG funds to pay for a service included in the DMC-ODS, but which is not reimbursable by DMC.

    c) If CONTRACTOR utilizes SABG funds to pay for a service that is included in DMC-ODS, CONTRACTOR shall maintain documentation sufficient to demonstrate that DMC reimbursement was not available.

        (i) If CONTRACTOR is unable to provide adequate documentation, those funds shall be recuperated by COUNTY.

Section 2 - Fiscal Audit Requirements

A. COUNTY shall monitor the activities of CONTRACTOR to ensure that the SABG funds are used for authorized purposes, in compliance with federal statutes, regulations, and the terms and conditions of the grant, and that performance goals are achieved.

B. COUNTY may use a variety of monitoring mechanisms, including limited scope audits, on-site visits, progress reports, financial reports, and review of documentation support requests for reimbursement, to meet the COUNTY's monitoring objectives.

C. On-site visits focus on compliance and controls over compliance areas. COUNTY shall make site visits to the CONTRACTOR location(s), and can use a variety of monitoring mechanisms to document compliance requirements. COUNTY shall follow-up on any findings and the corrective actions.

D. If any fiscal adjustments remain after the COUNTY and COUNTRACTOR have exhausted the internal appeals process, any SABG funds outstanding shall be returned to DHCS. This section shall not apply to those grievances or compliances arising from the financial findings of an audit or examination made by or on behalf of DHCS.

E. If CONTRACTOR fails to comply with Federal statues, regulations, or the terms and conditions of the grant, COUNTY may impose additional conditions, including:

    1. Requiring additional or more detailed financial reports.

    2. Requiring technical or management assistance.

    3. Establishing additional prior approvals.

F. If DHCS determines that the Contractor's noncompliance cannot be remedied by imposing

additional conditions, DHCS may take one or more of the following actions:

1. Temporarily withhold cash payment pending correction of the deficiency by CONTRACTOR.
2. Disallow all or part of the cost of the activity or action not in compliance.
3. Wholly or partly suspend the award activities or terminate CONTRACTOR's Agreement.
4. Take other remedies that may be legally available.

Section 3 - Maintenance of Records

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

1. CONTRACTOR shall include in any contract with an audit firm a clause to permit access by County, State, and/or Federal representatives to the working papers of the external independent auditor, and require that copies of the working papers shall be made at its request.
2. CONTRACTOR shall keep adequate and sufficient financial records and statistical data to support COUNTY's year-end documents filed with DHCS. All records must be capable of verification by qualified auditors.
3. Accounting records and supporting documents shall be retained for a three-year period from the date the year-end cost settlement report was approved by DHCS for interim settlement. When an audit by the Federal Government, DHCS, or the California State Auditor has been started before the expiration of the three-year period, the records shall be retained until completion of the audit and final resolution of all issues that arise in the audit. Final settlement shall be made at the end of the audit and appeal process. If an audit has not been completed within three years, the interim settlement shall be considered as the final settlement.
4. Financial records shall be kept so that they clearly reflect the source of funding for each type of service for which reimbursement is claimed. These documents include, but are not limited to, all ledgers, books, vouchers, time sheets, payrolls, appointment schedules, client data cards, and schedules for allocating costs. All records must be capable of verification by qualified auditors.
5. Should CONTRACTOR discontinue its contractual agreement with the COUNTY, or cease to conduct business in its entirety, CONTRACTOR shall provide COUNTY with CONTRACTOR's fiscal and program records for the required retention period. The

State Administrative Manual (SAM) contains statutory requirements governing the retention, storage, and disposal of records pertaining to state funds. CONTRACTOR shall follow SAM requirements located at http://sam.dgs.ca.gov/TOC/1600.aspx.

6. CONTRACTOR shall retain all records in accordance with the time periods outlined in 45 CFR Section 75.361.

Part III – DMC Specific Fiscal Requirements

Section 1 – DMC Funding

A. For services satisfactorily rendered, and upon receipt and approval of documentation as identified in Exhibit A, COUNTY agrees to compensate the CONTRACTOR for actual expenditures incurred in accordance with the rates and/or allowable costs specified herein.

B. CONTRACTOR may not use allocated DMC to pay for any non-DMC services.

C. If CONTRACTOR receives a combination of DMC-ODS funding and other federal or county realignment funding for the same service element and location, COUNTY shall reimburse CONTRACTOR based on the CONTRACTOR's actual costs in accordance with Medicaid reimbursement requirements as specified in Title XIX or of the Social Security Act, DMC-ODS Special Terms and Conditions (STCs), and STCs' Attachments. Payments at interim rates shall be settled to lower of actual cost or customary charge at year-end.

D. CONTRACTOR shall comply with 45 CFR 162.410(a)(1) for any subpart that would be a covered health care provider if it were a separate legal entity. For purposes of this paragraph, a covered health care provider shall have the same definition as set forth in 45 CFR 160.103. DHCS shall make payments for covered services only if Contractor is in compliance with federal regulations.

Section 2 – DMC-ODS Rates

Service	Type of Unit of Service (UOS)	FY18/19 Non-Perinatal (Regular) Rate Per UOS	FY18/19 Perinatal Rate Per UOS
NTP – Methadone Dosing	Daily	$ 13.54	$ 14.58
NTP – Individual Counseling (*)	10-min increment	$ 15.88	$ 16.39
NTP – Group Counseling (*)	10-min increment	$ 3.43	$ 4.28
NTP – Buprenorphine [1]	Daily	$ 16.91	$ 20.15
NTP – Buprenorphine-Naloxone Combo Product	Daily	$ 20.10	$ 23.34
NTP – Disulfiram [2]	Daily	$ 7.36	$ 7.59
NTP – Naloxone [3] (2-pack Nasal Spray)	Dispensed as needed	$ 144.60	$ 144.60

(*) The NTP Contractors may be reimbursed for up to 200 minutes (20 ten-minute increments) of individual and/or group counseling per calendar month. If a medical necessity determination is made that requires

additional NTP counseling beyond 200 minutes per calendar month, NTP Contractors may bill and be reimbursed for additional counseling (in 10 minute increments). Medical justification for the additional counseling must be clearly documented in the patient record. Reimbursement for covered NTP services shall be limited to the lower of the NTP's usual and customary charge to the general public for the same or similar services or the USDR rate.

1 - Buprenorphine: Average daily dose of 16 milligrams, sublingual tablets.

2 - Disulfiram: Average daily dose between 250 and 500 milligrams.

3 - Naloxone: One dose equal to 4 milligrams per 0.1 milliliter.

Services Provided by Modality (funded by DMC-ODS)	**Billing/Unit of Service (OuS)**	**Interim Rates**
Encounter Rates		
Outpatient	15 min increments	$ 33.59
Intensive Outpatient	15 min increments	$ 32.18
Case Management	15 min increments	$ 31.16
Recovery Services	15 min increments	$ 20.83
Physician Consultation	15 min increments	$ 74.71
Daily Rates		
Level 3.2-WM	Per Day	$ 135.77
Level 3.1 – Residential	Per Day	$ 106.04
Level 3.5 – Residential	Per Day	$ 123.24

Section 3 – Maintenance of Records

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

1. Accounting records and supporting documents shall be retained for ten years. When an audit by the Federal Government, DHCS, or the California State Auditor has been started, the records shall be retained until completion of the audit and final resolution of all issues that arise in the audit. Final settlement shall be made at the end of the audit and appeal process.

2. Should CONTRACTOR discontinue its contractual agreement with the COUNTY, or cease to conduct business in its entirety, CONTRACTOR shall provide COUNTY with CONTRACTOR's fiscal and program records for the required retention period. The State Administrative Manual (SAM) contains statutory requirements governing the retention, storage, and disposal of records pertaining to state funds. CONTRACTOR shall follow SAM requirements located at http://sam.dgs.ca.gov/TOC/1600.aspx.

3. The Contractor shall retain all records required by W&I Code section 14124.1, 42 CFR 433.32, Exhibit A, Attachment I, the DMC-ODS STCs and STCs' Attachments for reimbursement of services and financial audit purposes.

In accordance with Title 45 Code of Federal Regulations, Part 96, Section 96.137, SAPT Block Grant funding is the **"payment of last resort"** for services for Pregnant and Parenting Women, Tuberculosis, and HIV.

EXHIBIT B-2

Electronic Health Records Software Charges
Fiscal Year 2019-2020

Turning Point of Central California

CONTRACTOR understands that COUNTY utilizes Netsmart's Avatar for its Electronic Health Records management. CONTRACTOR agrees to reimburse COUNTY for all user license fees for accessing Netsmart's Avatar, as set forth below:

One time per user license fee	$800.00
Yearly hosting fee per user	$480.00
OrderConnect Medication Management Prescriber yearly per user fee	$855.00
Non-Prescriber yearly per user fee	$159.00
EPCS Token per user	$75.00
EPCS Subscription	$96.00
Yearly Maintenance fee per user	$212.60

Yearly maintenance fee per user: Amount determined based on formula listed below:

Formula: [Total Maintenance Amount ÷ Total Number of Users]

Should CONTRACTOR choose not to utilize Netsmart's Avatar for its Electronic Health Records management, CONTRACTOR will be responsible for obtaining its own system for Electronic Health Records management. CONTRACTOR shall be responsible for administrative costs incurred by the County as a result of Contractor's disassociation with County's Electronic Health Record System. Administrative costs will be calculated based on the costs to add an additional staff position in the Mental Health Department as a result of the service provided under this Agreement and/or if user licenses are purchased so the contractor will have the minimal functionality to the EHR system for consumer setup and billing purposes. The administrative billing would be performed on a monthly basis by invoice to the contractor.

PROFESSIONAL SERVICES CONTRACTS
INSURANCE REQUIREMENTS

CONTRACTOR shall provide and maintain insurance for the duration of this Agreement against claims for injuries to persons and damage to property which may arise from, or in connection with, performance under the Agreement by the CONTRACTOR, his agents, representatives, employees and subcontractors, if applicable.

A. Minimum Scope & Limits of Insurance

1. Coverage at least as broad as Commercial General Liability, insurance Services Office Commercial General Liability coverage occurrence form GC 00 01, with limits no less than $1,000,000 per occurrence including products and completed operations, property damage, bodily injury and personal & advertising injury. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location (ISO CG 25 03 or 25 04) or the general aggregate limit shall be twice the required occurrence limit.

2. Insurance Services Office Form Number CA 00 01 covering Automobile Liability of $1,000,000 per occurrence including any auto or, if the CONTRACTOR has no owned autos, hired and non-owned auto coverage. If an annual aggregate applies it must be no less than $2,000,000.

3. Workers' Compensation insurance as required by the State of California, with Statutory Limits, and Employer's Liability Insurance with limit of no less than $1,000,000 per accident for bodily injury or disease.

4. Professional Liability (Errors and Omissions) insurance appropriate to the CONTRACTOR's profession, with limit no less than $1,000,000 per occurrence or claim, $2,000,000 aggregate.

B. Specific Provisions of the Certificate

1. If the required insurance is written on a claims made form, the retroactive date must be before the date of the contract or the beginning of the contract work and must be maintained and evidence of insurance must be provided for at least three (3) years after completion of the contract work.

2. CONTRACTOR must submit endorsements to the General Liability reflecting the following provisions:

   a. *The COUNTY, its officers, agents, officials, employees and volunteers are to be covered as additional insureds as respects; liability arising out of work or operations performed by or on behalf of the CONTRACTOR including material, parts, or equipment furnished in connection with such work or operations.*

   b. *For any claims related to this project, the CONTRACTOR's insurance coverage shall be primary insurance as respects the COUNTY, its officers, agents, officials, employees and volunteers. Any insurance or self-insurance maintained by the COUNTY, its officers, agents, officials, employees or volunteers shall be excess of the CONTRACTOR's insurance and shall not contribute with it.*

   c. *CONTRACTOR hereby grants to COUNTY a waiver of any right to subrogation which any insurer of CONTRACTOR may acquire against the county by virtue of the payment of any loss under such insurance. CONTRACTOR agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the COUNTY has received a waiver of subrogation endorsement from the insurer.*

d. Each insurance policy required by this agreement shall be endorsed to state that coverage shall not be canceled, except after written notice has been provided to the COUNTY.

3. The Workers' Compensation policy shall be endorsed with a waiver of subrogation in favor of the COUNTY for all work performed by the CONTRACTOR, its employees, agents and subcontractors. CONTRACTOR waives all rights against the COUNTY and its officers, agents, officials, employees and volunteers for recovery of damages to the extent these damages are covered by the workers compensation and employers liability.

C. Deductibles and Self-Insured Retentions

Deductibles and Self-insured retentions must be declared and any deductible or self-insured retention that exceeds $100,000 will be reviewed by the COUNTY Risk Manager for approval.

D. Acceptability of Insurance

Insurance must be placed with insurers with a current rating given by A.M. Best and Company of no less than A-:VII and a Standard & Poor's Rating (if rated) of at least BBB and from a company approved by the Department of Insurance to conduct business in California. Any waiver of these standards is subject to approval by the County Risk Manager.

E. Verification of Coverage

Prior to approval of this Agreement by the COUNTY, the CONTRACTOR shall file with the submitting department, certificates of insurance with original endorsements effecting coverage in a form acceptable to the COUNTY. Endorsements must be signed by persons authorized to bind coverage on behalf of the insurer. The COUNTY reserves the right to require certified copies of all required insurance policies at any time.

WAIVERS:

I represent and attest that I am a person authorized to make representations on behalf of the CONTRACTOR, and represent the following:

(mark X if applicable)

☐ Automobile Exemption: I certify that _____ does not own nor use vehicles in the performance of the agreement for which this insurance requirement is attached.

☐ Workers' Compensation Exemption: I certify that _____ is not required to carry workers' compensation coverage or has filed an exemption with the State of California as required by law.

I acknowledge and represent that we have met the insurance requirements listed above.

Print Name Raymond R. Banks, Chief Executive Officer Date: 3/22/19

Contractor Name Turning Point of Central California, Inc.

Signature Raymond R. Banks

EXHIBIT I

Substance Use Disorder Service Programs

1. Services

Services and work provided by Contractor at the County's request under this Agreement will be performed in a timely manner, and in accordance with applicable federal and state statutes and regulations, including, but not limited to, sections 96.126, 96.127, 96.128, 96.131 and 96.132, and all references therefrom, of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reauthorization Act, Public Law 106-310, the State of California Alcohol and/or Other Drug Program Certification Standards (2017 version), Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8; Drug Medi-Cal Certification Standards for Substance Abuse Clinics; Title 22, CCR, Sections 51341.1, 51490.1, and 51516.1; Title 9, CCR, Division 4, Chapter 4, Subchapter 1, Sections 10000, et seq.; Title 22, CCR, Division 3, Chapter 3, sections 51000 et. seq. and any and all guidelines promulgated by the State Department of Health Care Services' (DHCS) Alcohol and Drug Programs and the Tulare County Department of Health and Human Services to serve special populations and groups, as applicable; County laws, ordinances, regulations and resolutions; and in a manner in accordance with the standards and obligations of Contractor's profession. Contractor shall devote such time to the performance of services pursuant to this Agreement as may be reasonably necessary for the satisfactory performance of Contractor's obligations. The County shall maintain copies of above-mentioned statutes, regulations, and guidelines for Contractor's use. Copies of Substance Use Disorder Service Programs Policies and Procedures are sent to Contractors, as applicable, and can be resubmitted on request. Contractor shall adhere to the applicable provisions of the Multi- Year State-County Contract referenced below in their entirety.

1.1 Counselor Certification: Any registered or certified counselor providing intake, assessment of need for services, treatment or recovery planning, individual or group counseling to participants, patients, or residents in a DHCS licensed or certified program is required to be certified as defined in Title 9, CCR, Division 4, Chapter 8. [State-County Contract, Exhibit A, Attachment I, Part I]

1.2 Re-Certification Events: Contractor shall notify DHCS and the County Alcohol and Drug Administrator within the timeframes noted in the State Contract, in addition to applicable federal, state and local regulations and policies of any triggering recertification events, such as change in ownership, change in scope of services, remodeling of facility, or change in location. [State-County Contract, Exhibit A, Attachment I]

1.3 Cultural and Linguistic Proficiency: To ensure access to quality care by diverse populations, each service provider receiving funds from the State-County Contract shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Services (CLAS) national standards (2016 version). [State-County Contract, Exhibit A, Attachment I, Part I; 42 CFR 438.206(c)(2)]

1.4 Perinatal Services Network Guidelines: Perinatal programs shall comply with the Perinatal Services Network Guidelines FY 2016-17 until such time new Perinatal Services Network Guidelines are established and adopted. [State-County Contract, Exhibit A, Attachment I, Part IV]

1.5 Charitable Choice Requirements: Contractors shall not use funds provided through this contract for inherently religious activities, such as worship, religious instruction, or proselytization. Contractors that are religious organizations shall establish a referral process to a reasonably accessible program for clients who may object to the religious nature of the Contractor's program and contractors shall be required to notify clients of their rights prohibiting discrimination and to be referred to another program if they object to the religious nature of the program at intake. Referrals that were made due to the religious nature of the Contractor's program shall be submitted annually to the County Alcohol and Drug Administrator by June 30 for referrals made during the fiscal year. [State-County Contract, Exhibit A, Attachment I, Part III]

1.6 Trafficking Victims Protection Act of 2000: Contractor shall comply with Section 106(g) of the Trafficking Victims Protection Act of 2000 as amended (22 U.S.C. 7104). The County is authorized to terminate the

contract, without penalty, if the Contractor: (a) Engages in severe forms of trafficking in persons during the period of time that the award is in effect; (b) Procures a commercial sex act during the period of time that the award is in effect; or (c) Uses forced labor in the performance of the award or subawards under the award. [State-County Contract, Exhibit A, Attachment I, Part I]

1.7 Access to Drug/Medi-Cal Services: When a request for covered services is made by a beneficiary, services shall be initiated within 10 business days of the Contractor's receipt of the request. Contractor shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop regarding waiting times and appointments. Contractor shall also 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 provider offers services to non-Medi-Cal beneficiaries [State-County Contract, Exhibit A, Attachment I, Part V; State-County Intergovernmental Agreement, Exhibit A, Attachment I]

1.8 Contractors that are Drug/Medi-Cal certified shall also comply with the applicable 42 CFR 438 Managed Care requirements, including, but not limited to the following [State-County Intergovernmental Agreement, Exhibit A, Attachment I]:

1.8.1 Culturally Competent Services: Contractors are responsible to provide culturally competent services. Contractors must ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations. Translation and oral interpreter services must be available for beneficiaries, as needed and at no cost to the beneficiary.

1.8.2 Medication Assisted Treatment: Contractors will have procedures for linkage/integration for beneficiaries requiring medication assisted treatment. Contractor staff will regularly communicate with physicians of beneficiaries who are prescribed these medications unless the beneficiary refuses to consent to a 42 CFR, Part 2 compliant release of information for this purpose.

1.8.3 Evidence-Based Practices (EBPs): Contractors will implement at the least two of the following EBPs per service modality: Motivational Interviewing, Cognitive-Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment and Psycho-Education.

1.8.4 Beneficiary Informational Materials: Contractor shall make available at initial contact, and shall notify beneficiaries of their right to request and obtain the following information at least once a year and thereafter upon request: DMC-ODS Beneficiary Booklet and Provider Directory. Contractor shall also post notices explaining grievance, appeal and expedited appeal processes in all program sites, as well as make available forms and self-addressed envelopes to file grievances, appeals and expedited appeals without having to make a verbal or written request to anyone. The County will produce required beneficiary informational materials in English and Spanish. Contractor shall request materials from the County, as needed.

1.8.5 Notice of Adverse Benefit Determination (NOABD): Contractor shall immediately notify County of any action that may require a NOABD be issued to a beneficiary, including, but not limited to: failing to provide the beneficiary with an initial face-to-face assessment appointment within 10 business days of the request; or determining that a beneficiary does not meet medical necessity for any substance use disorder treatment services.

1.8.6 Verifying Medi-Cal Eligibility: Contractor shall verify the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for Drug/Medi-Cal services to that beneficiary for that month. Medi-Cal eligibility verification should be performed prior to rendering service, in accordance with and as described in the DHCS's DMC Provider Billing Manual. [State-County Intergovernmental Agreement, Exhibit A, Attachment I]

1.8.7 American Society of Addiction Medicine (ASAM) Criteria: Contractor shall be trained in the ASAM Criteria prior to providing services. At a minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care". [State-County Intergovernmental Agreement, Exhibit A, Attachment I]

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

1.10 Restriction on Distribution of Sterile Needles: No Substance Abuse Prevention and Treatment (SAPT) Block Grant funds made available through this Contract shall be used to carry out any program that includes the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug unless the State chooses to implement a demonstration syringe services program for injecting drug users. [State County Contract, Exhibit A, Attachment I, Part I]

1.11 Limitation on Use of Funds for Promotion of Legalization of Controlled Substances: 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). [State-County Contract, Exhibit A, Attachment I]

2. Program Evaluation

2.1 Contractor shall maintain books, records, files, documents and evidence directly pertinent to work under this Agreement in sufficient detail to make possible an evaluation of services provided and compliance with DHCS regulations, as applicable, and in accordance with accepted professional practice and accounting procedures for a minimum of five (5) years after the termination of the Agreement. Contractor agrees to extend to DHCS and to the County and their designees the right to review and investigate records, programs, and procedures, as well as overall operation of Contractor's program with reasonable notice.

2.2 Formal evaluation of the program shall be made annually through a Provider Self-Audit and on-site visit. This evaluation shall result in a written report to the Contractor within fifteen (15) working days of the site visit. Any report that results from a site visit shall be submitted to the Contractor within fifteen (15) working days. Contractor shall submit a written response within the timeframe outlined in the site visit report, and such response shall be part of the official written report provided for in this section.

2.3 Contractor shall meet the requirements of and participate in the management information system of County, and maintain fiscal, administrative, and programmatic records and such other data as may be required by the County Alcohol and Drug Administrator for program and research requirements.

2.4 Contractor shall notify the County Alcohol and Drug Administrator within two business days of receipt of any DHCS report identifying non-compliance services or processes requiring a Corrective Action Plan (CAP). Contractor shall submit the CAP to DHCS with the designated timeframe specified by DHCS and shall concurrently send a copy to the County Alcohol and Drug Administrator.

3. Records

3.1 Contractor and the County mutually agree to maintain the confidentiality of Contractor's participant records, including billings, pursuant to Sections 11812(c) and 11879, Health & Safety Code and Federal Regulations for Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2, dated June 9.1987), the Federal Health Insurance Portability and Accountability Act (HIPAA) and all other applicable State and Federal laws and any amendments. Contractor shall inform all its officers, employees, and agents of the confidentiality provisions of said regulations, and provide all necessary policies and procedures and training to ensure compliance. Contractor shall

ensure staff participate in information privacy and security training at least annually, and prior to accessing PHI or PI, sign a confidentiality statement that includes, at a minimum, General use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The statement must be renewed annually and shall be retained for a period of six (6) years following termination of this contract. [State-County Contract, Exhibit F, Attachment I]

3.2 Where contracts exceed $10,000 of state funding – the Contractor shall be subject to examination and audit of the Department of Auditor General for a period of three (3) years after final payment under contract (Government Code § 8546.7).

3.3 Contractor shall allow DHCS, US HHS, the Comptroller General of the US and other authorized federal and state agencies, or their duly authorized representatives to inspect books, records and facilities, as permitted by law.

3.4 The Contractor, if applicable, shall maintain medical records required by Title 22 of the California Code of Regulations, and other records showing a Medi-Cal beneficiary's eligibility for services, the service(s) rendered, the Medi-Cal beneficiary to whom the service was rendered, the date of the services, the medical necessity of the service and the quality of care provided. Records shall be maintained in accordance with Title 22 California Code of Regulations.

3.5 Contractor is responsible for the repayment of all exceptions and disallowances taken by local, State and Federal agencies, related to activities conducted by Contractor under the Agreement. Where unallowable costs have been claimed and reimbursed, they will be refunded to County. When a financial audit is conducted by the Federal Government, the State, or the California State Auditor directly with Contractor, and if the Contractor disagrees with audit disallowances related to its programs, claims or services, County shall, at the Contractor's request, request an appeal to the State via the County. [State-County Intergovernmental Agreement, Exhibit B]

3.6 Financial records shall be kept so that they clearly reflect the source of funding for each type of service for which reimbursement is claimed. These documents include, but are not limited to, all ledgers, books, vouchers, time sheets, payrolls, appointment schedules, client data cards, and schedules for allocating costs. Fiscal records shall contain sufficient data to enable auditors to perform a complete audit and shall be maintained in conformance with the procedures and accounting principles set forth in the State Department of Health Care Services' Cost Reporting/Data Collection Systems.

4. Unusual Occurrence and Incident Reporting

4.1 Contractor shall report unusual occurrences to the County of Tulare Substance Use Services' Program Manager or designee. An unusual occurrence is any event which jeopardizes the health and/or safety of clients, staff and/or members of the community, including but not limited to physical injury and death.

4.2 Unusual occurrences are to be reported to the County within five (5) calendar days of the event or as soon as possible after becoming aware of the unusual event. Reports are to include the following elements:

4.2.1 Complete written description of event including outcome;

4.2.2 Written report of Contractor's investigation and conclusions;

4.2.3 List of persons directly involved and/or with direct knowledge of the event.

4.3 The County and DHCS retain the right to independently investigate unusual occurrences and Contractor will cooperate in the conduct of such independent investigations.

4.4 Residential substance use treatment facilities licensed by DHCS shall also comply with reporting unusual incidents as outlined in Title 9 CCR, Chapter 5, Subchapter 3, Article 1. Contractor shall notify the County Alcohol and Drug Administrator concurrently, which is a telephonic report within one (1) working day of the event, followed by a copy of the written report submitted to DHCS within seven (7) days of the event.

5. Applicable Fee(s)

5.1 Contractor shall charge participant fees. No one shall be denied services based solely on ability or inability to pay.

5.2 Contractor shall perform eligibility and financial determinations in accordance with a fee schedule approved by the Chief of Alcohol and Drug Programs for this purpose. Individual income, expenses, and number of dependents shall be considered in formulating the fee schedule and in its utilization.

5.3 Contractor agrees to have on file with the County a schedule of Contractor's published charges, if applicable.

5.4 Contractor shall conduct community-centered fundraising activities, as appropriate.

6. Non-Discrimination

6.1 Contractor shall develop and implement policies and procedures that ensure: non-discrimination in the provision of services based on a diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Complex (ARC), or upon testing positive for Human Immunodeficiency Virus (HIV); the prohibition of the use of HIV antibody testing as a screening criterion for program participation; training of all staff and all participants regarding high-risk behaviors, safer sex practices, and perinatal transmission of HIV infection ; and development of procedures for addressing the special needs and problems of those individuals who test positive for antibodies to HIV. No individual shall be required to disclose his or her HIV status.

6.2 The contractor and/or any permitted sub-contractor shall not discriminate in the provision of services because of race, color, religion, national origin, sex, sexual orientation, age or mental or physical handicap as provided by State and Federal law. For the purpose of this contract, distinctions on the grounds of race, color, religion, national origin, age or mental or physical handicap include but are not limited to the following: denying a Medi-Cal beneficiary any service or benefit which is different, or is provided in a different way manner or at a different time from that provided to other beneficiaries under this contract; subjecting a beneficiary to segregation or separate treatment in any matter related to receipt of any service; restricting a beneficiary in any way in the enjoyment, advantage or privilege enjoyed by others receiving ant service or benefit; treating a beneficiary differently from others in determining whether the beneficiary satisfied any admission, eligibility, other requirement or condition which individuals must meet in order to be provided any benefit; the assignment of times or places for the provision of services on a basis of the race, color, religion, national origin, sexual orientation, age or mental or physical handicap of the beneficiaries to be served.

6.3 The Contractor shall take affirmative action to ensure that services to intended Medi-Cal beneficiaries are provided without regard to race, color, religion, national origin, sex, sexual orientation, age or mental or physical handicap.

7. Required Program Submissions

7.1 Contractor agrees to maintain, and provide to County upon request, job descriptions, including minimum qualifications for employment and duties performed, for all personnel whose salaries, wages, and benefits are reimbursable in whole or in part under this Agreement.

7.2 Contractor agrees to maintain, and to provide to County upon request, an organizational chart that reflects the Contractor's current operating structure.

7.3 Contractor shall maintain, and provide to County upon request, the complaint procedure to be utilized in the event that there is a complaint regarding services provided under this Agreement. Contractor shall ensure that recipients of service under this Agreement have access to and are informed of Contractor's complaint procedure.

7.4 Upon Contractor's completion of services under this Agreement to County's satisfaction, payment to Contractor shall be made monthly in accordance with the procedures set forth in Exhibit B. All billings and reports shall clearly reflect and in reasonable detail give information regarding the services for which the claim is being made. It is understood and agreed that County may withhold payment until receipt of billings and reports in the prescribed detail and format. Billings and reports shall be made and forwarded to County of Tulare Health & Human Services Agency promptly at the end of each calendar month; no later than the 10th day of the month following the month in which the services, for which billing is made, were rendered. Payments received after that date may result in a delay in payment until the next monthly billing cycle. The payment for the month of September may be withheld pending receipt of the preceding year's Cost Report on continuing services contracts.

7.5 Contractor shall provide County with an annual Cost Report no later than sixty (60) days after the termination of this agreement. In addition to the annual Cost Report, Contractor shall furnish County, within one hundred and eighty (180) days of close of contractor fiscal year, a certified copy of an Audit Report from an independent CPA firm. This Audit Report shall cover Contractor's fiscal year which most nearly coincides with County's fiscal year. Contractors receiving federal funds shall comply with Office of Management and Budget (OMB) Circular Number A-133, Uniform administrative Requirements for Grants and Other Agreements with Institutions of Higher Education, Hospitals, and other Nonprofit Organizations. Cost Report settlements shall be made when a proper Cost Report has been submitted to the County. The findings of the annual Cost Report shall be subject to an audit by County and State. The State of California may make such audits as it deems necessary for the purpose of determining reimbursement due to the County.

7.6 Contractor will have an MOU in place with all approved subcontractors that defines the services to be provided by the subcontractors and is consistent with and fully reflects the services and conditions described in this contract. Such MOUs will be made available to County within a reasonable time upon request.

7.7 Contractor will report all data and outcomes, such as CalOMS and DATAR, as required by state or county and as required by the State-County Contract.

8. Contractor's Compliance with Provisions of State Contract

8.1 The County receives funding from DHCS pursuant to an annual contracting arrangement (hereinafter "State Contract"). The State Contract contains certain requirements pertaining to the privacy and security of personally identifiable information (hereinafter "PII") and/or protected health information (hereinafter "PHI") and requires that County contractually obligate any of its sub-contractors to also comply with these requirements. Contractor hereby agrees to be bound by, and comply with, any and all terms and conditions of the State Contract pertaining to the privacy and/or security of PII and/or PHI, a hard copy of which County will provide to the Contractor upon request, and an electronic copy of which can be found on the DHCS website at http://www.dhcs.ca.gov/Pages/DMC-ODS-Executed-Contracts.aspx.

8.2 Additionally, in the event the State Contract requires the County to notify the State of a breach of privacy and/or security of PII and/or PHI, Contractor shall, immediately upon discovery of a breach of privacy and/or security of PII and/or PHI by Contractor, notify County of such breach by telephone and email or facsimile to the following contact: Privacy Officer – privacyofficer@tularehhsa.org. Contractor further agrees that it shall notify County of any such breaches prior to the time the County is required to notify the State pursuant to the State Contract.

8.3 In the event the State Contract requires the County to pay any costs associated with a breach of privacy and/or security of PII and/or PHI, including but not limited to the costs of notification, Contractor shall pay on County's behalf any and all such costs arising out of a breach of privacy and/or security of PII and/or PHI by Contractor.

9. Electronic Signature

If Contractor uses electronic medical records, the Contractor agrees to use a system that is consistent with DHCS requirements.

If Contractor uses electronic medical records, the Contractor agrees to submit staff updates, including changes in roles or new or separated staff, to the AVATAR Administrator within the timeframes outlined in the HHSA Policy 30-02 EHR Privacy and Security. The notification shall include submission of the AVATAR Electronic Signature Agreement and AVATAR User Request/Change Form, as applicable. If a user suspects that their electronic signature may be comprised, Contractor shall notify the AVATAR Administrator within the timeframes outlined in the HHSA Policy.

10. Compliance with Anti-Kickback Statute

Contractor shall comply with the provisions of the "Anti-Kickback Statute" (42 U.S.C. § 1320a-7b) as they pertain to Federal healthcare programs.

11. Davis-Bacon Act

Contractor must comply with the provisions of the Davis-Bacon Act, as amended (40 U.S.C. § 3141 et seq.). When required by Federal Medicaid Program legislation, all construction contracts awarded by the Contractor and its subcontractors of more than $2,000 must include a provision for compliance with the Davis-Bacon Act (40 U.S.C. § 3141 et seq.) as supplemented by Department of Labor regulations (Title 29, CFR Part 5, "Labor Standards Provisions Applicable to Contracts Governing Federally Financed and Assisted Construction").

12. Conditions for Federal Financial Participation

12.1 Contractor shall meet all conditions for Federal Financial Participation, consistent with 42 CFR 438.802, 42 CFR 438.804, 42 CFR 438.806, 42 CFR 438.808, 42 CFR 438.810, 42 CFR 438.812.

12.2 Pursuant to 42 CFR 438.808, Federal Financial Participation (FFP) is not available to the Contractor if the Contractor:

12.2.1 Is an entity that could be excluded under section 1128(b)(8) as being controlled by a sanctioned individual;

12.2.2 Is an entity that has a substantial contractual relationship as defined in section 431.55(h)(3), either directly or indirectly, with an individual convicted of certain crimes described in section 1128(8)(B); or

12.2.3 Is an entity that employs or contracts, directly or indirectly, for the furnishing of health care utilization review, medical social work, or administrative services, with one of the following: i. Any individual or entity excluded from participation in federal health care programs under section 1128 or section 1126A; or ii. An entity that would provide those services through an excluded individual or entity.

13. Certification of Non-Exclusion or Suspension from Participation in Federal Health Care Program

13.1 Federal and State Excluded, Suspension and Debarment List: The County and the Contractor shall comply with the provisions of Title 42 § 438.610 and Executive Orders 12549 and 12689,"Debarment and Suspension," which excludes parties listed on the General Services Administration (GSA) list of parties excluded from federal procurement or non-procurement programs from having a relationship with the County or Contractor.

13.2 Prior to the effective date of this Contract, 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 so certify will render all provisions of this Contract null and void and may result in the immediate termination of the Contract.

13.3 Contractor shall certify, prior to the execution of the contract, that the Contractor does not employ staff or sub-contractors who are excluded from participation in federally funded health care programs. Contractor shall conduct initial and monthly Exclusion & Suspension searches of the following databases and provide evidence of these completed searches when requested by County, CA Department of Health Care Services or the US Department of Health & Human Services.

13.3.1 www.oig.hhs.gov/exclusions - LEIE Federal Exclusions

13.3.2 www.sam.gov/portal/SAM - GSA Exclusions Extract

13.3.3 www.Medi-Cal.ca.gov – Suspended & Ineligible Provider List

13.4 Contractor shall certify, prior to the execution of the contract that the Contractor does not employ staff or sub-contractors that are on the Social Security Administration's Death Master File. Contractor shall check the following database prior to employing staff or sub-contractors, and provide evidence of these completed searches when requested by County, CA Department of Health Care Services or the US Department of Health & Human Services.

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

13.5 Contractor is required to notify County immediately if they become aware of any information that may indicate their (including employees and subcontractors) potential placement on an exclusions list.

14. License Verification

Contractor shall ensure that all staff and subcontractors providing services will have all necessary and valid professional certification(s) or license(s) to practice the contracted services. This includes implementing procedures of professional license checks, credentialing and re-credentialing, monitoring limitations and expiration of licenses, and ensuring that all providers have a current National Provider Identifier (NPI) through the National Plan and Provider Enumeration System (NPPES). Contractor shall provide evidence of these completed verifications when requested by County, DHCS or the US Department of Health & Human Services.