KERN COUNTY / Behavioral Health & Recovery Services

Alison Burrowes, MA, LCSW
DIRECTOR

November 17, 2026

Board of Supervisors
Kern County Administrative Center
1115 Truxtun Avenue
Bakersfield, CA 93301

PROPOSED RETROACTIVE AGREEMENT WITH COMMUNITY SERVICES ORGANIZATION BEHAVIORAL HEALTH PROGRAMS, INC. TO PROVIDE OUTPATIENT SUBSTANCE USE TREATMENT SERVICES
(Fiscal Impact: $1,600,000; State/Federal; Budgeted; Discretionary)

Behavioral Health and Recovery Services (BHRS) requests the approval of a retroactive agreement with Community Services Organization Behavioral Health Programs, Inc., from November 1, 2026, through June 30, 2027, to provide substance use outpatient treatment services for residents in the Bakersfield area, in an amount not to exceed $1,600,000.

Under this proposed retroactive agreement, Community Services Organization Behavioral Health Programs, Inc., will provide outpatient substance use disorder treatment services for adults, including defendants with criminal justice and child protective services involvement. Services include but are not limited to individual and group counseling, treatment planning, discharge planning, and health education.

In accordance with Chapter 5, Section 511 of the Kern County Policy and Procedures manual, regarding the procurement of professional services, the department published and distributed a Request for Proposal (RFP) for Outpatient Substance Use Treatment Services in Fiscal Year 2025-2026. Community Services Organization, Behavioral Health Programs, Inc., was selected as the service provider. This is the first year of a five-year RFP cycle. The next RFP for Outpatient Substance Use Treatment Services is due in Fiscal Year 2030-2031.

This agreement has been approved as to form by the Office of County Counsel. This agreement is retroactive due to delays in the contract negotiations process.

Therefore, IT IS RECOMMENDED that the Board approve the retroactive agreement with Community Services Organization Behavioral Health Programs, Inc. to provide substance use outpatient treatment services for adult clients residing in the Bakersfield area, from November 1, 2026 through June 30, 2027, in an amount not to exceed $1,600,000 and authorize the Chairman to sign.

Respectfully submitted,

Heath Howe for Alison Burrowes

Alison Burrowes, MA, LCSW
Director

cc: County Administrative Office
County Counsel
Auditor-Controller-County Clerk

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Kern County Agreement No. _____

AGREEMENT FOR PROFESSIONAL SERVICES

(COUNTY OF KERN – COMMUNITY SERVICES ORGANIZATION BEHAVIORAL HEALTH PROGRAMS, INC.)

OUTPATIENT SUBSTANCE USE TREATMENT SERVICES
RECOVERY INCENTIVES PROGRAM
PENAL CODE 1000 DRUG DIVERSION PROGRAM

FY 2026 – 2027

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AGREEMENT FOR PROFESSIONAL SERVICES

COUNTY OF KERN – COMMUNITY SERVICES ORGANIZATION BEHAVIORAL HEALTH PROGRAMS, INC.

OUTPATIENT SUBSTANCE USE TREATMENT SERVICES
RECOVERY INCENTIVES PROGRAM
PENAL CODE 1000 DRUG DIVERSION PROGRAM

THIS AGREEMENT is made and entered into on _____, by and between the County of Kern ("County"), a political subdivision of the State of California, as represented by the Behavioral Health and Recovery Services Department ("County", "KernBHRS" or "Department"), and Community Services Organization Behavioral Health Programs, Inc. ("Contractor"), a California non-profit organization, with its principal place of business located at 1124 Baker Street, Bakersfield, CA 93305.

WITNESSETH:

WHEREAS:

A. Government Code sections 31000 and 53060 permit the County Board of Supervisors to contract for the furnishing of special services with individuals specially trained and experienced and competent to perform those services.

B. The Department requires a full continuum of specialty behavioral health outpatient substance use treatment services in a treatment environment that maximizes the integration of the services for Kern County adult clients of diverse ethnic, racial, and social backgrounds residing in the Bakersfield.

C. The department will provide motivational incentives to treat individuals living with stimulant use disorder and support their path to recovery through the Recovery Incentives Program. Eligible Medi-Cal beneficiaries will participate in a structured 24-week outpatient program, followed by six or more months of additional recovery support services.

D. The department will provide Penal Code 1000 program services at no cost to the clients; develop a curriculum for the PC 1000 Drug Diversion Program, and train Contractor in its use and application.

E. County desires to engage Contractor to provide said services and Contractor, by reason of Contractor's qualifications, experience, and facilities for doing the type of work herein contemplated, has offered to provide the required services in accordance with the terms set forth herein.

NOW, THEREFORE, IT IS AGREED between the parties hereto as follows:

1. TERM

This agreement shall commence on November 1, 2026, and shall remain in effect through June 30, 2027, unless sooner terminated as hereinafter provided.

2. MODIFICATIONS OF AGREEMENT

Material changes to this agreement may be modified in writing only, signed by the parties in interest at the time of the modification.

3. STANDARDS OF SERVICE

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A. Contractor shall provide the services and adhere to the standards of service described in **Exhibit A, A-1, and A-2 "Description and Standards of Services,"** which is attached hereto and made a part hereof. Failure to comply with the standards of service shall be deemed a material breach of this agreement and may result in termination of the agreement.

B. Contractor shall comply with all applicable regulations set forth by the California Department of Health Care Services (DHCS) and any other applicable governing bodies. By this reference, those regulations are made a part of this agreement. Additionally, County requires Contractor to provide proof of adherence to specific administrative and ethical principles in order to be eligible to contract with County. These principles are included in **Exhibit B**, "**Additional Administrative and Ethical Requirements**," which is attached hereto and made a part hereof. Failure to comply with all applicable regulations and principles shall be deemed a material breach of this agreement and may result in termination of the agreement.

C. Contractor shall not be required to provide, reimburse for, or provide coverage of, a counseling or referral service if Contractor objects to the service on moral or religious grounds. (Section 1932(b)(3)(B)(i) of the Social Security Act, 42 Code of Federal Regulations ("CFR") § 438.10(g)(2)(ii)(A) and 438.102(a)(2).) If there are any referrals to services or counseling that Contractor will not provide, Contractor shall inform KernBHRS prior to the execution of this agreement or at least thirty (30) days prior to the effective date during the performance of this agreement. Contractor shall provide the same information to potential beneficiaries before and during enrollment and to beneficiaries at least thirty (30) days prior to the effective date of the policy for any particular service.

4. COMPENSATION TO CONTRACTOR

A. KernBHRS shall reimburse Contractor for client services provided and documented into the KernBHRS' electronic health record within the timeframes established by County, up to the maximum amount set forth in **Exhibit C and C- 1, "Funding Schedule,"** which is attached hereto and made a part hereof. Contractor shall use Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, as provided in the DHCS Billing Manual.

1. Payment terms are a net thirty (30) days from the date County receives an acceptable Claim for Payment from Contractor.

B. No funds paid to Contractor through this agreement shall be utilized to compensate employees of the Contractor for overtime or compensatory time off, except to the extent that Contractor is required to pay for overtime or compensatory time off, pursuant to the Fair Labor Standards Act of 1938, 29 United States Code (USC) Section 201, et seq., or applicable state law.

C. This agreement is subject to County's annual appropriation process. In the event that funds representing Contractor's compensation and reimbursement for expenses of the services provided pursuant to this agreement are not appropriated within the approved County budget in any fiscal year, this agreement shall be deemed terminated and shall be of no further force or effect as of the date County's budget is approved. County will provide Contractor with thirty (30) days' prior notice of any such action.

D. No payment shall be made to Contractor if Contractor has any federal, state, or county liens outstanding. Should County discover a record of an outstanding lien, County shall immediately notify Contractor about the lien record, immediately investigate the circumstances, and determine a course of action within thirty (30) days of discovery. The Department may consider a repayment arrangement between Contractor and the lien-maker as reasonably satisfying this agreement stipulation. Contractor shall provide to County, within fifteen (15) days of request, a copy of the repayment arrangement document(s), the name of the contact person with the lien-maker agency that can verify the repayment arrangement, and a written statement explaining what resources Contractor is using to accomplish the repayment.

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E. County will periodically evaluate Contractor's program costs for the purpose of assessing the reasonableness of County's payments for services provided. Contractor will be provided reasonable notice if additional contractual and/or service delivery issues are to be reviewed. Contractor is expected to prepare necessary reports and other material to adequately explain Contractor's use of funds as specified in **Exhibit C and C- 1** of this agreement. County may prescribe specific report formats and data content as deemed necessary at the sole discretion of County.

F. Monitoring and other reviews may be conducted by DHCS or other governing bodies in accordance with regulations in effect during this agreement. County will recoup payments for all claims disallowed from Contractor. Upon receiving notification of disallowed claims, County will send a demand notice to Contractor. Contractor shall reimburse County within thirty (30) days of the date of the demand notice. If disallowed claims are not paid to County within thirty (30) days of the date of the demand notice, County may exercise the option to withhold payments from Contractor until such time as payment is received in full. For all cases, County amounts withheld from Contractor shall be considered as payments to Contractor.

G. Contractor shall take all necessary measures to obtain and maintain state certifications and/or licensure of the site(s) at which Contractor provides services under this agreement. Certification must be in accordance with Drug Medi-Cal (DMC) regulations and the Americans with Disabilities Act (ADA). Official fire clearance must take place prior to service provision and annually thereafter. Contractors performing laboratory testing on human specimens shall have the appropriate certification by the Clinical Laboratory Improvement Amendments of 1988 (CLIA) or maintain a CLIA-Exemption.

H. Contractor shall provide documentation of all applicable certifications and/or licensure to the SOC Administrator or designee upon agreement and annually thereafter. If a site is not Drug Medi-Cal certified, or if the Drug Medi-Cal renewal is delinquent, County will not bill for Medi-Cal services, or forward payments to Contractor, until site certification is obtained or renewed. Contractor shall comply with the following regulations and guidelines:

1. Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8
2. Title 22, CCR, Sections 51341.1, 51490.1, and 51516.1
3. Minimum Quality Treatment Standards
4. Title 9, CCR, Division 4, Chapter 4, Subchapter 1, Sections 10000, et. Seq.
5. Title 22, CCR, Division 3, Subdivision 1, Article 1, Sections 51000.3 et. Seq.
6. In the event of conflicts, the provisions of Title 22 shall control if they are more stringent.
7. Terms of Drug Medi-Cal Organized Delivery System Intergovernmental Agreement.

I. Contractor shall be responsible for notifying the KernBHRS SUD SOC Administrator or designee of intent to reduce covered services or relocate. Contractor must inform DHCS Licensing Division of intent to relocate with adequate time to allow for AOD certification/licensing to remain current and active. Any reduction in covered services or relocation shall not be implemented until approval is issued by DHCS. A DMC certification application must be submitted to DHCS Provider Enrollment Division sixty (60) days prior to the desired effective date of the reduction of covered services or relocation.

J. **Complaints:** Contractor will provide information on all complaints, and grievances to KernBHRS within forty-eight (48) hours of discovery as stated in **Exhibit A, A-1, and A-2**. KernBHRS shall be responsible for

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investigating complaints and providing the results of all investigations to DHCS within two (2) business days of completion. Additionally, as per Title 9, California Code of Regulations, Section 13065, Alcohol or Drug Abuse Recovery or Treatment Facilities licensed or certified by DHCS are required to report counselor misconduct to DHCS and the counselor's certifying organization within twenty-four (24) hours of the violation. Complaints may be made using the DHCS provided Complaint Form which is available and may be submitted online: http://www.dhcs.ca.gov/individuals/Pages/Sud Complaints.aspx.

K. Drug Medi-Cal Post-Service-Post–Payment (PSPP) utilization review site visits are required under the Interagency agreement between the County and the Department of Health Care Services (DHCS). Following a PSPP site visit, the state will notify County of any disallowed claims. County will collect payments made for all disallowed claims from Contractor as mandated by Title 22 of the California Code of Regulations (CCR), Section 51341.1(j) and (m). Upon receiving notification of disallowed claims from the state, County will send a demand notice to Contractor. Contractor shall reimburse County within thirty (30) days of the date of the demand notice. If disallowed claims are not paid to County within thirty (30) days of the date of the demand notice, County may exercise the option to withhold payments from Contractor until such time as payment is received in full. In all cases, County amounts withheld from Contractor shall be considered as payments to Contractor.

L. Contractor shall determine the availability of any third-party insurance or payer source (including Medi-Cal) available to client at admission and monthly thereafter and notify County if any is available. Medi-Cal verification must specify county that issued Medi-Cal benefits. Any changes must be provided to KernBHRS billing staff monthly. KernBHRS follows the guidance in BH Information Notice 21-032 regarding County of Responsibility. Medi-Cal verification must specify Kern as the county that issued Medi-Cal benefits. If an individual has Medi-Cal that originated in a different county, Contractor shall assist the individual to update benefit information to Kern County. Contractor shall inform SUD Administration when such changes would pose a hardship for the individual and/or family members receiving other healthcare services in a different county.

M. County and Contractor shall abide by the Department's SUD Program Monitoring policy 5.6.23 and Medical Review Policy 11.1.6. Additionally, County shall have the right to suspend claims for payment to Contractor for late submission of corrective action plans required in response to Department's review of Contractor's client treatment charts or other programmatic and administrative reviews conducted by the County. Payments will be reinstated when Contractor has submitted an acceptable corrective action plan demonstrating how Contractor will resolve identified deficiencies.

N. Medi-Cal Rate-Based Reimbursement

1. Contractor shall enter client services data into the County's electronic health record within the timeframes established by County. Contractor shall use Current Procedural Terminology (CPT) or Healthcare Common Procedure Coding System (HCPCS) codes, as provided in the DHCS Billing Manual.

2. KernBHRS will provide Contractor with Monthly Claim statements for Contractor approval in arrears, in accordance with **Exhibit K "Claim for Medi-Cal Rate Based Reimbursement Agreements.**

3. Information regarding exclusions reports is required at the time of claim submission.

5. PROGRAM DIRECTION, FISCAL AUDIT, INSPECTION, AND RETENTION OF RECORDS

A. County's Alcohol and Drug Program Administrator, as defined in Health and Safety Code Sections 11800 and 11962, shall be the Director of KernBHRS. Contractors' services pursuant to this agreement shall be provided and performed under the Director's general guidance or his/her designated representative. It shall be Contractor's responsibility to determine the specific means and methodology for accomplishing the services required under this agreement.

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B. Contractor agrees to maintain and make available to County all of its premises, physical facilities, documents, contracts, computers, other electronic systems, accurate books, and records relative to all activities of the organization, including client information, information related to Medi-Cal enrollees, Medi-Cal related activities and information included in personnel records, limited to that needed for the verification of credentialing, experience, background and payroll testing. Review of the organization's personnel files shall be subject to applicable confidentiality laws. Contractor shall maintain such data and records in an accessible location and condition for a minimum of ten (10) years after the close of the fiscal year in which services are rendered or until all audit issues are resolved, whichever is later, in accordance with 42 CFR 438.3(h), 42 CFR 438.3(u), and Welfare and Institutions Code, Section 14124.1. The State of California and/or any federal agency having an interest in the subject of this agreement shall have the same rights conferred upon County herein.

C. KernBHRS, DHCS, Centers for Medicare/Medicaid Services ("CMS"), or the Health and Human Services ("HHS") Inspector General may inspect, evaluate, and audit Contractor at any time if there is a reasonable possibility of fraud or similar risk. The inspection shall occur at Contractor's place of business, premises, or physical facilities. Contractor shall make all of its books and records available, in a form maintained in accordance with general standards, applicable to such books or recordkeeping, for a term of at least ten (10) years from the close of the fiscal year in which the subcontract was in effect. Contractor will need to contact County to ensure the time period for retaining these records has been exceeded before record destruction occurs. Contractor shall inform KernBHRS of all scheduled and unscheduled audits that occur at Contractor's place of business related to the services in this agreement and provide copies of all results and reports to KernBHRS. Additionally, Contractor shall provide all results and/or audit reports to KernBHRS.

D. Contractor shall permit County to audit, examine, and make excerpts and transcripts from such records; and to conduct audits, reviews, and monitoring of Medi-Cal and financial records; and all other data related to matters covered by this agreement. At County's discretion, County may request that Contractor deliver by mail or electronic transmission to County, a copy of Contractor's accounting records prior to an on-site audit by County. Failure by Contractor to allow review shall be a material breach of this agreement by Contractor. County, at its sole option, may terminate this agreement and obtain damages from Contractor resulting from said breach, or County may exercise the option to withhold payments from Contractor until such time as all required documents are made available. Further, as one component of Medi-Cal records review and financial monitoring, Contractor may be required, at the sole option of County, to complete a Corrective Action Plan. County may exercise the option to withhold payments from the Contractor until such time as County accepts the Corrective Action Plan.

6. EARLY AND PERIODIC, SCREENING, DIAGNOSIS AND TREATMENT

A. Contractor shall provide Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) Medi-Cal Services and/or Short-Doyle/Medi-Cal Services in accordance with California Code of Regulations Title 9, Chapter 11.

B. Except as otherwise provided in this agreement, if Contractor provides EPSDT Medi-Cal services and/or Short-Doyle/Medi-Cal services, then Contractor shall be reimbursed by County for the federal and state-approved Medi-Cal Service Function Code units furnished to eligible Medi-Cal beneficiaries; and/or for the state approved Short-Doyle/Medi-Cal Service Function Code units furnished to eligible Medi-Cal beneficiaries to the extent of actual EPSDT Medi-Cal; and/or for the Short-Doyle/Medi-Cal payments made by the federal and state governments to County for such services and activities.

C. Such reimbursement by County to Contractor shall be paid solely in County's capacity as the fiscal intermediary for such EPSDT Medi-Cal services and/or Short-Doyle/Medi-Cal services.

D. Notwithstanding any other provision of this agreement, if Contractor provides EPSDT Medi-Cal services and/or Short-Doyle/Medi-Cal services, such services shall comply with, and be compensated in accordance with, all applicable federal and state reimbursement requirements.

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E. If EPSDT Medi-Cal services and/or Short-Doyle/Medi-Cal services are provided under this agreement, County will serve as the fiscal intermediary for claiming and reimbursement for such EPSDT Medi-Cal services and/or Short-Doyle/Medi-Cal services, and to act on Contractor's behalf with the state in regard to claiming reimbursement for EPSDT Medi-Cal services and/or Short-Doyle/Medi-Cal services.

F. Contractor shall be solely liable and responsible for all data and information provided by Contractor to County in support of all claims for EPSDT Medi-Cal services and/or Short-Doyle/Medi-Cal services that County submits, as the fiscal intermediary to the state, and for any subsequent state approvals or denials of such claims that may be based on data and information submitted by Contractor. Contractor shall process all EPSDT Medi-Cal and/or Short-Doyle/Medi-Cal Explanation of Benefits (EOB) or other data within the time frame prescribed by the state and federal governments. County shall have no liability for Contractor's failure to comply with state and federal time frames.

G. Notwithstanding any other provision of this agreement, Contractor shall be totally liable and responsible for: (a) the accuracy of all data and information on all claims for EPSDT Medi-Cal services and/or CCR Title IX Short-Doyle/Medi-Cal services which Contractor inputs into ITS, (b) the accuracy of all data and information which Contractor provides to County, and (c) ensuring that all EPSDT Medi-Cal services and/or Short-Doyle/Medi-Cal services are performed appropriately within Medi-Cal guidelines, including, but not limited to, administration, utilization review, documentation, and staffing.

H. As the state-designated Short-Doyle/Medi-Cal fiscal intermediary, County shall submit a claim to the Department of Health Care Services for EPSDT Medi-Cal and/or Short-Doyle/Medi-Cal reimbursement only for those services entered by Contractor into ITS. Contractor shall comply with all written instructions from County and/or the State regarding EPSDT Medi-Cal and/or Short-Doyle/Medi-Cal claiming and documentation.

I. County may modify the claiming system for EPSDT Medi-Cal services and/or Short-Doyle/Medi-Cal services at any time in order to comply with changes in, or interpretations of, state or federal laws, rules, regulations, manuals, guidelines, and directives. When reasonably possible, County shall notify Contractor in writing of any such modification and the reason for the modification thirty (30) days prior to the implementation of the modification.

7. FINANCIAL SOLVENCY

A. Contractor shall collect reimbursement for the costs of providing such services to persons who are entitled to insurance benefits under the Social Security Act, including programs under title XVII and title XIX, any state compensation program, any other public assistance program for medical expenses, any grant program, and private health insurance, or any other benefit program.

B. Contractor shall maintain adequate provisions against the risk of insolvency.

8. RECOVERY FROM OTHER SOURCES OR PROVIDERS

A. Contractor shall recover the value of covered services rendered to beneficiaries whenever the beneficiaries are covered for the same services, either fully or partially, under any other state or federal medical care program or under other contractual or legal entitlement including, but not limited to, a private group or indemnification program, but excluding instances of the tort liability of a third party or casualty liability insurance.

B. The monies recovered are retained by the Contractor. However, Contractor's claims for Federal Financial Participation (FFP) for services provided to beneficiaries under this agreement shall be reduced by the amount recovered.

C. Contractor shall maintain accurate records of monies recovered from other sources.

D. Nothing in this section supersedes Contractor's obligation to follow federal requirements for claiming FFP for services provided to beneficiaries with other coverage under this agreement.

9. TAX INFORMATION REPORTING

A. Contractor shall submit its signed IRS form W-9, "Request for Taxpayer Identification Number and Certification," or Social Security Number, whichever is applicable, to facilitate appropriate fiscal management and reporting, and to ensure compensation is paid to the proper party. A new W-9 will need to be completed every five (5) years.

B. Upon County's request, Contractor shall provide County with certain documents relating to Contractor's employee income tax withholding. These documents shall include, but not be limited to:

1. A copy of Contractor's federal and state quarterly income tax withholding returns, i.e., federal form 941 and state Form DE-9 or their equivalents.

2. A copy of a receipt for or other proof of payment of, each employee's federal and state income tax withholding, whether such payments are made on a monthly or quarterly basis.

10. COMPLIANCE WITH LAW

A. Contractor shall observe and comply with all applicable county, state, and federal laws, ordinances, rules, and regulations now in effect or hereafter enacted, each of which are hereby made a part hereof and incorporated herein by reference, including, but not limited to, CCR Title 9, Chapter 11, Section 1810.436(a)(1-5) and 42 CFR § 438.230(c)(2), and 42 CFR § 438.3(d)(3)(4) which provide that:

1. Medi-Cal beneficiaries shall receive the same level of care as provided to all other clients; and

2. Contractor shall not, on the basis of health status or need for health care services, discriminate against individuals, including but not limited to, Medi-Cal eligible individuals who require an assessment or meet medical necessity criteria for specialty mental health services (SMHS) or substance use disorder services (SUD) and

3. Contractor shall not discriminate against individuals, including but not limited to Medi-Cal eligible individuals who require an assessment or meet medical necessity criteria for SMHS or SUD services on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation gender identity, or disability; and

4. Medi-Cal beneficiaries shall not be discriminated against in any manner; and

5. Rates charged for Medi-Cal beneficiaries shall be the same or less than rates charged to beneficiaries of other programs or private pay individuals; and

6. The rate paid is considered to be payment in full, subject to third party liability and beneficiary share-of-cost for the specialty mental health or substance use disorder services provided; and

7. Contractor shall make all records, program compliance, and beneficiary complaints available for authorized review and fiscal audit whenever requested to do so by county, state, or federal authorities; and

8. Contractor shall adhere to Title XIX of the Social Security Act and conform to all other applicable federal and state statutes and regulations.

B. Contractor shall adhere to the following:

1. Additional Contract Restrictions: This agreement is subject to any additional restrictions, limitations, or conditions enacted by the Congress, or any statute enacted by the Congress, which may affect the provisions, terms, or funding of this agreement in any manner.

2. Contractor shall follow all federal and state civil rights laws. Contractor shall not unlawfully discriminate, exclude people, or treat them differently, on any ground protected under federal or state law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

3. Contractor will not use any policy or practice that has the effect of discriminating on the basis of sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation.

4. Voluntary Termination of Drug Medi-Cal Organized Delivery System ("DMC-ODS") Services: County may terminate its DMC-ODS contract with DHCS at any time for any reason, by giving sixty (60) days written notice to DHCS. Contractor shall be paid for DMC-ODS services provided to beneficiaries up to the date of termination. Upon termination, Contractor shall immediately begin providing DMC services to beneficiaries in accordance with the State Plan.

5. Nullification of this agreement: Contractor understands that failure to comply with the provisions of W&I Code Section 14124.24, the Special Terms and Conditions, and this agreement, shall be deemed a breach that results in the termination of this agreement for cause. In the event of a breach, DMC-ODS services shall terminate. Contractor shall immediately begin providing DMC services to beneficiaries in accordance with the State Plan.

6. Hatch Act: Contractor shall comply with the provisions of the Hatch Act (Title 5 USC, Sections 1501-1508), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.

7. No Unlawful Use or Unlawful Use Messages Regarding Drugs: Contractor shall agree 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 the 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). Contractor shall agree that it shall enforce, and shall require its subcontractors to enforce, these requirements.

8. Noncompliance with Reporting Requirements: Contractor shall agree that the Department and/or DHCS has the right to withhold payments until Contractor has submitted any required data and reports to the Department and/or DHCS as identified in this agreement.

9. Limitation on use of Funds for Promotion of Legalization of Controlled Substances: Contractor shall understand that none of the funds made available through this agreement 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).

10. Health Insurance Portability and Accountability Act (HIPAA) of 1996:

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(i) If any of the work performed under this agreement is subject to HIPAA, Contractor shall perform the work in compliance with all applicable provisions of HIPAA. The Department and the Contractor shall ensure mutual agreement as to those transactions between them, to which this provision applies.

(ii) Trading Partner Requirements: Contractor agrees that for the personal health information (Information), it shall not change any definition, data condition, or use of a data element or segment as proscribed in the federal HHS Transaction Standard Regulation (45 CFR Part 162.915 (a)).

(iii) Contractor shall agree that for the Information, it shall not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation (45 CFR Part 162.915 (b)).

(iv) No Unauthorized Uses. Contractor shall agree that for the Information, it shall not use any code or data elements that either are marked "not used" In the HHS Transaction's Implementation specification or are not in the HHS Transaction Standard's implementation specifications (45 CFR Part 162.915 (d)).

(v) Concurrence for Test Modifications to HHS Transaction Standards: Contractor agrees and understands that there exists the possibility that the Department or DHCS may request an extension from the uses of a standard in the HHS Transaction Standards. If this occurs, Contractor shall agree that it shall participate in such test modifications.

(vi) Adequate Testing: Contractor shall adequately test all business rules appropriate to their types and specialties. If Department is acting as clearinghouse for Contractor, Department has the obligation to adequately test all business rules appropriate to Contractor.

(vii) Deficiencies: Department will cure transactions errors or deficiencies identified by Contractor if Department is acting as a clearinghouse for Contractor. If Contractor is a clearinghouse, the Contractor agrees to properly communicate deficiencies and other pertinent information regarding electronic transactions to subcontractors for which they provide clearinghouse services.

(viii) Code Retention: Contractor and Department agree to keep open code sets being processed or used in this agreement for at least the current billing period or any appeal period, whichever is longer.

(ix) Data Transmission Log: Both Department and Contractor shall establish and maintain a Data Transmission Log, which shall record all data transmissions taking place between both Parties during the term of this agreement. Each Party shall take necessary and reasonable steps to ensure that such Data Transmission Logs constitute a current, accurate, complete, and unaltered record of any and all Data Transmissions between the Parties and shall be retained by each Party for no less than twenty-four (24) months following the date of the Data Transmission. The Data Transmission Log may be maintained on computer media or other suitable means provided that, if necessary, to do so, the information contained in the Data Transmission Log may be retrieved in a timely manner and presented in readable form.

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

12. Cultural and Linguistic Proficiency: To ensure equal access to quality care by diverse populations, Contractor shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards.

13. Trafficking Victims Protection Act of 2000: Contractor and its subcontractors that provide services covered by this agreement shall comply with Section 106 (g) of the Trafficking Victims Protections Act of 2000 ("TVPA") (22 U.S.C.7104(g)) as amended by section 1702.

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Contractor, Contractor's employees, and subcontractors shall not:

(i) Engage in any form of trafficking of persons during the period of time that the agreement is in effect;

(ii) Procure a commercial sex act during the period of time the agreement is in effect; or

(iii) Use forced labor in the performance of the contract or subcontract.

This agreement may be unilaterally terminated if Contractor or any subcontractor is determined to have violated a prohibition of the TVPA or has an employee who is determined by County to have violated a prohibition of the TVPA through conduct that is associated with the performance under the contract using the standards and due process for imputing the conduct of an individual to an organization that are provided in 2 CFR part 180, "OMB Guidelines to Agencies on Government-wide Debarment and Suspension (Non-procurement)."

Contractor must inform the SOC Administrator or designee immediately of any information received from any source alleging a violation of a prohibition of the TVPA.

Additionally, Contractor and Contractor's employees are required to complete Human Trafficking training (Understanding Human Trafficking – 1.0 hrs. (REL-ALL-0-UHT) or a comparable KernBHRS assigned Relias course) annually on the Relias training system. KernBHRS Administrator or designee will monitor training completion through the Relias training system, if Contractor utilizes this program. If Contractor does not utilize Relias, Contractor will need to develop an internal tracking mechanism to monitor training completion. This tracking system should be available for County to review at any time to ensure that these required trainings are being completed.

14. Adolescent Substance Use Disorder Best Practices Guide: Contractor shall follow the guidelines incorporated by this reference, "Youth Treatment Guidelines," in developing and implementing adolescent treatment programs funded under this agreement, until such time new Youth Treatment Guidelines are established and adopted. No formal amendment of this agreement is required for new guidelines to be incorporated into this agreement.

15. Nondiscrimination in Employment and Services: By signing this agreement, Contractor certifies that under the laws of the United States and the State of California, incorporated into this agreement by reference and made a part hereof as if set forth in full, Contractor shall not unlawfully discriminate against any person.

C. Federal Law Requirements:

1. Title VI of the Civil Rights Act of 1964, Section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in federally funded programs.

2. Title IX of the education amendments of 1972(regarding education and programs and activities), if applicable.

3. Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.

4. Age Discrimination Act of 1975 (45 CFR Part 90), as amended (42 USC Sections 6101 – 6107), which prohibits discrimination on the basis of age.

5. Age Discrimination in Employment Act (29 CFR Part 1625).

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6. Title I of the Americans with Disabilities Act (29 CFR Part 1630) prohibiting discrimination against the disabled in employment.

7. Title II of the Americans with Disabilities Act (28 CFR Part 35) prohibiting discrimination against the disabled by public entities.

8. Americans with Disabilities Act (28 CFR Part 36) regarding access.

9. Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.

10. Executive Order 11246 (42 USC 2000(e) et seq. and (41 CFR Part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than $10,000 funded by federal financial assistance.

11. Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.

12. The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.

13. The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination based on alcohol abuse or alcoholism.

14. Confidentiality of Alcohol Drug Abuse Patient Records (42 CFR Part 2, Subparts A-E).

D. State Law Requirements:

1. Fair Employment and Housing Act (Government Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (2 CCR 7285.0 et seq.).

2. Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135.

3. Title 9, Division 4, Chapter 6, Article 1 of the CCR, commencing with Section 10800.

4. No state or federal funds shall be used by Contractor or its subcontractors for sectarian worship, instruction, or proselytization. No state funds shall be used by the Contractor or its subcontractors to provide direct, immediate, or substantial support to any religious activity.

5. Noncompliance with the requirements of nondiscrimination in services shall constitute grounds for DHCS to withhold payments under this Contract or terminate all, or any type, of funding provided hereunder.

6. Title 9 CCR Rehabilitative and Developmental Services, Division 4 Department of Alcohol and Drug Programs, Chapter 8 Certification of Alcohol and Other Drug Counselors Section 13000.

7. State Administrative Manual (SAM) Chapter 7200, General Outline of Procedures.

8. Government Code Title 2. Government of the State of California, Division 4. Fiscal Affairs, Part 2. State Funds, Chapter 2. Special funds, Article 1.7 Federal Block Grant Funds, Section 16367.8.

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9. Title 21, CFR, Food and Drugs, Chapter II Part 1301 – Registration of Manufacturers, Distributors and Dispensers of Controlled Substances.

10. Title 42, CFR – Public Health Chapter 1 Public Health Service, Department of Health and Human Services, Subchapter A Part 8 – Certification of Opioid Treatment Programs Subpart A – Accreditation Section 8.1-8.6.

a. Health and Safety Code Division 10.5, Article 1. Statement of Problems Related to the Inappropriate Use of Alcoholic Beverages and Other Drug Use and the Reasons for and Limitations on State Government's Role, commencing with Section 11760.Investigations and Confidentiality of Administrative Actions:

i. Contractor shall acknowledge that if under investigation by DHCS or any other state, local, or federal law enforcement agency for fraud or abuse, DHCS may temporarily suspend Contractor from the DMC-ODS program, pursuant to WIC 14043.36(a). Information about Contractor's administrative sanction status shall be held confidential until such time as the action is either completed or resolved. DHCS may also issue a Payment Suspension to a provider pursuant to WIC 14107.11 and Code of Federal Regulations, Title 42, Section 455.23. Department will withhold payments from Contractor during the time a Payment Suspension is in effect.

ii. Subcontract Provisions: Contractor shall include all of the foregoing provisions in all of its subcontracts.

b. Coordination and Continuity of Care (42 CFR Section 438.208): Contractor shall comply with all KernBHRS policies and procedures pertaining to Coordination and Continuity of Care.

i. Provider-Preventable Conditions: Contractor shall comply with all requirements pertaining to Provider-Preventable Conditions:

ii. Contractor shall ensure compliance with the requirements mandating provider identification of provider-preventable conditions as a condition of payment.

iii. Contractor shall report Provider Preventable Conditions as specified by DHCS in MHSUDS Information Notice 17-046.

11. Title 9, Division 4, Chapter 8 of the Government Code, commencing with Section 11135.

11. FINANCIAL AND STATISTICAL RECORDS

A. Contractor shall maintain and preserve all fiscal records, documents, and correspondence related to this agreement for a minimum period of ten (10) years after the close of the fiscal year in which services are rendered, or ten (10) years after final payment is made (Medi-Cal or MHSA), or until all audit issues are resolved, whichever is latest.

B. Contractor shall maintain all financial, statistical, or accounting records associated with the provision of each type of service described in **Exhibit A** of this agreement, necessary to support the costs claimed pursuant to this agreement or any other federal or state reimbursement claim report forms. Moreover, Contractor shall maintain all statistical data necessary to support the allocation of such cost among programs or types of programs and/or among payers; shall maintain auditable records, in accordance with generally accepted accounting principles, reflecting the methods and calculations used to make such allocations; and shall maintain such other statistical data as shall be necessary to satisfy the requirements of state and federal law.

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C. Contractor shall make any and all records, whether fiscal or other, generated pursuant to this agreement available for County's inspection. At County's discretion, County may request that Contractor deliver by mail or electronic transmission to County, a copy of Contractor's accounting records prior to an on-site audit by County. The State of California and/or federal agency having an interest in the subject of this agreement shall have the same rights conferred upon County herein.

12. MEDICAL RECORDS MANAGEMENT

A. Contractor shall retain all medical treatment records for a period of at least ten (10) years after the client is discharged. If the client is a minor, the medical treatment records shall be retained for at least one (1) year after the minor attains the age of twenty-one (21), and no less than ten (10) years following discharge. Retention and destruction of medical records are subject to the provisions of Health & Safety Code Section 1457; Title 22 CCR 75343, 70751, and 72543. Such medical records shall be shredded before disposal or may be disposed of in any other commercially practicable fashion, which assures the confidentiality of the clients.

B. Contractor shall obtain written approval for the destruction of the medical records from its Board of Directors. In the absence of a Board of Directors, the President or sole proprietor shall provide written approval for the medical record destruction.

C. A log shall be maintained which shall include, for each record destroyed, at least the following information on the client: name; chart number; date of birth; social security number; gender; treatment dates; and the date of destruction. The log of records destroyed shall also include the written authorization of the destruction and shall be maintained in such a format and location as to be readily available for purposes of monitoring contractual performance, as well as to provide information in response to legally authorized inquiries.

D. Contractor shall be authorized and charged with the responsibility of determining when records may be destroyed pursuant to this agreement and in compliance with applicable law.

E. Contractor shall make any and all records, whether medical or other, generated pursuant to this agreement available for inspection by County. At County's discretion, County may request that Contractor deliver by mail or electronic transmission to County, a copy of Contractor's accounting records prior to an on-site audit by County. The state of California and/or federal agency having an interest in the subject of this agreement shall have the same rights conferred upon County herein.

13. ADDITIONAL PROVISIONS

A. Books and Records - Contractor shall maintain such books and records as are necessary to disclose how Contractor discharged its obligations under this agreement. These books and records shall identify the quantity of covered services provided under this agreement, the quality of those services, the manner and amount of payment made for those services, the beneficiaries who received covered services, the manner in which Contractor administered the provision of specialty mental health services or substance use disorder services, and the cost thereof.

Such books and records shall include, but are not limited to, all physical records originated or prepared pursuant to performance under this agreement including working papers, reports submitted to the Department, financial records, all medical and treatment records, medical charts and prescription files, and other documentation pertaining to services rendered to beneficiaries.

These books and records shall be maintained for a minimum of ten (10) years after the final payment is made and all pending matters closed, or, in the event Contractor has been notified that the Department, DHCS, HHS, or the Comptroller General of the United States, or their duly authorized representatives, have commenced an

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audit or investigation of the agreement, until such time as the matter under audit or investigation has been resolved, including the exhaustion of all legal remedies, whichever is later.

Contractor shall include in any subcontract for a sum in excess of Ten Thousand Dollars ($10,000), which utilizes state funds a provision that states: "The contracting parties shall be subject to the examination and audit of the Department or Auditor General for a period of ten (10) years after final payment under contract (Government Code § 8546.7)." Contractor shall also be subject to the examination and audit of the Department and the State Auditor General for a period of ten (10) years after final payment under contract (Government Code § 8546.7).

B. Transfer of Care - Prior to the termination or expiration of this agreement, and upon request by the Department, Contractor shall assist the state in the orderly transfer of mental health or substance use disorder care for beneficiaries in Kern County. In doing this, Contractor shall make available to the Department copies of medical records, patient files, and any other pertinent information, including information maintained by any subcontractor that is necessary for efficient case management of beneficiaries, as determined by the Department. Costs of reproduction shall be borne by the Department. In no circumstances shall a beneficiary be billed for this service.

C. Department Memos, DHCS Letters and Behavioral Health Information Notices, and Requirements From State Contract Agreements - Contractor shall comply with all policy memos issued by the Department. Contractor shall also comply with DHCS Letters and Information Notices issued to all Mental Health Plans as defined in California Code title 9, § 1810.226, County Alcohol and Drug Administrators, Substance Use Disorder ("SUD") state plans and DMC-ODS plan, as such DHCS Letters and Information Notices remain in effect unless amended, repealed, or readopted by the Department. DHCS Letters and Information Notices shall provide specific details of procedures established for performance of contract terms when procedures not covered in this agreement are determined to be necessary for performance under this agreement but are not intended to change the basis and general terms of the agreement.

1. Contractor shall permit county to audit and monitor compliance with such regulations. Contractor may be required, at the sole option of the county, to complete a Corrective Action Plan. County may exercise the option to withhold payments from the Contractor until such time as County accepts the Corrective Action Plan".

14. BEHAVIORAL HEALTH MEMBER HANDBOOK

Contractor must offer the BHRS Behavioral Health Member Handbook to enrollees (and upon request) who are first accessing specialty mental health services or substance use disorder services. The Behavioral Health Member Handbook may be made available in hard copy, electronically through the BHRS public website, or through the provider website.

15. BENEFICIARY RIGHT TO GRIEVANCE, APPEAL, AND FAIR HEARINGS

Contractor is to provide all Medi-Cal beneficiaries who access specialty mental health or substance use disorder services with information on their rights and a process to file a grievance, appeal, or expedited appeal, and a State Fair Hearing as outlined in KernBHRS Policy 10.1.3.

16. GRIEVANCES AND APPEALS

A. Contractor shall notify beneficiaries or beneficiaries' representatives of KernBHRS's grievance and appeal system which includes the grievance process and the appeal or expedited appeal processes.

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B. Any grievances shall be reported as directed by the Patients' Rights Office following DHCS guidelines. Per DHCS, "Plan shall establish, implement, and maintain a grievance and appeal system to ensure the receipt, review, and resolution of grievance and appeals. The Grievance and Appeal system shall operate in accordance with all applicable federal regulations and plan contract requirements".

C. KernBHRS currently employs the Grievance and Appeal Web Application or (Grievance Management web application) to report and respond to any grievance and appeal. As such, contract facilities should enter any verbalized information pertaining to any grievance and appeal into the above-named application. Any grievance or appeal forms submitted by a beneficiary or beneficiaries' representative must be sealed and mailed to the Patients' Rights Office within one (1) business day. Any Grievances or Appeals reported verbally by a beneficiary or beneficiaries' representative must be reported to the Patients' Rights Office by submitting the grievance or appeal through the same portal within one (1) business day of receiving this information from the beneficiary. Contractor shall not subject a beneficiary to discrimination or any other penalty for filing a grievance, appeal, or expedited appeal.

D. Grievance and Appeal informational posters and forms shall be displayed in a central location. Inpatient facilities shall also display informational posters and forms next to the lock box.

E. If a grievance related to Transgender, Gender Diverse, and Intersex (TGI), and/or sexual orientation is found in the member's favor, the staff whom the grievance is the subject of will have to receive TGI training within 45 days, and before having contact with members again.

17. NOTICE OF ADVERSE BENEFIT DETERMINATION

A. Contractor shall comply with KernBHRS policy and procedure number 10.1.9. Contractor shall provide a beneficiary with a Notice of Adverse Benefit Determination (NOABD) under the following circumstances:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. (42 CFR § 438.400(b)(1).)

2.The reduction, suspension, or termination of a previously authorized service. (42 CFR § 438.400(b)(2).)

3.The denial, in whole or in part, of payment for a service. (42 CFR § 438.400(b)(3).)

4.The failure to provide services in a timely manner, as defined by the Department. (42 CFR § 438.400(b)(4).)

5. The failure of the Contractor to act within the timeframes provided in 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals. (42 CFR § 438.400(b)(5).)

6. The denial of a beneficiary's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other beneficiary financial liabilities. (42 CFR § 438.400(b)(7).)

B. Contractor shall give beneficiaries timely and adequate notice of an adverse benefit determination in writing and shall meet the language and format requirements of 42 CFR Part 438.10 (42 CFR § 438.404(a); 42 CFR § 438.10) and DHCS Information Notice 18-010E. The NOABD shall contain the items specified in 42 CFR Part 438.404 (b) and California Code of Regulations, Title 9, Section 1850.212.

C. When the denial or modification involves a request from a provider for continued Contractor payment authorization of a specialty mental health or DMC-ODS service or when Contractor reduces or terminates a previously approved Contractor payment authorization, notice shall be provided in accordance with California Code of Regulations, Title 22, Section 51014.1. (Cal. Code Regs., tit. 9, § 1850.210(a)(1).)

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D. An NOABD is not required when a denial is a non-binding verbal description to a provider of the specialty mental health services that may be approved by Contractor (Cal. Code Regs., tit. 9, § 1850.210(a)(2).)

E. Except as provided in Subparagraph F below, an NOABD is not required when the denial or modification is a denial or modification of a request for Contractor payment authorization for a specialty mental health or DMC-ODS service that has already been provided to the beneficiary. (Cal. Code Regs., tit. 9, § 1850.210(a)(4).)

F. An NOABD is required when Contractor denies or modifies a payment authorization request for a SMH or DMC-ODS service that has already been provided to the beneficiary when the denial or modification is a result of post-service, prepayment determination by the Contractor that the service was not medically necessary or otherwise was not a service covered by Contractor (Cal. Code Regs., tit. 9, § 1850.210(b).)

G. County shall deny Contractor's payment authorization request and provide the beneficiary with an NOABD when Contractor does not have sufficient information to approve or modify, or deny on the merits, a Contractor payment authorization request from a provider within the timeframes required by Cal. Code Regs., tit. 9, §§ 1820.220 or 1830.215. (Cal. Code Regs., tit. 9, § 1850.210(c).)

H. Contractor shall provide the beneficiary with an NOABD if Contractor fails to notify the affected parties of a resolution of a grievance within ninety (90) calendar days of an appeal decision within thirty (30) days, or of an expedited appeal decision within seventy-two (72) hours. If the timeframe for a grievance, appeal, or expedited appeal decision is extended pursuant to sections 1850.206, 1850.207, or 1850.208 of Title 9 of the California Code of Regulations and the Contractor failed to notify the affected parties of its decision within the extension period, the Contractor shall provide the beneficiary with an NOABD. (42 CFR § 438.408.)

I. Contractor shall provide a beneficiary with an NOABD when Contractor determines that the medical necessity criteria in sections 1830.205(b)(1),(b)(2),(b)(3)(C), or 1830.210(a) of Title 9 of the California Code of Regulations have not been met and that the beneficiary is not entitled to any specialty mental health services from Contractor. The NOABD shall, at the election of the Contractor, be hand-delivered to the beneficiary on the date of the Adverse Benefit Determination or mailed to the beneficiary in accordance with Cal. Code Regs., tit. 9, § 1850.210(f)(1), and shall specify the information contained in Cal. Code Regs., tit. 9, § 1850.212(b). (Cal. Code Regs., tit. 9, § 1850.210(g).)

J. For the purpose of this paragraph, each reference to a Medi-Cal managed care plan in Cal. Code Regs., tit. 22, § 51014.1, shall mean the Contractor. (Cal. Code Regs., tit. 9, § 1850.210(h).)

K. For the purposes of this paragraph, "medical service," as used in Cal. Code Regs., tit. 22, § 51014.1, shall mean SMH services that are subject to prior authorization by a Contractor pursuant to Cal. Code Regs., tit. 9, §§ 1820.100 and 1830.100. (Cal. Code Regs., tit. 9, § 1850.210(i).)

L. Contractor shall complete all NOABDs via the NOABD Application. The Department will engage in quarterly reviews to ensure compliance with this regulation. Cal. Code Regs., tit. 9, § 1850.210(j).)

M. Contractor shall allow the State to engage in reviews of Contractor's records pertaining to an NOABD so the Department may ensure that Contractor is notifying beneficiaries in a timely manner.

18. FAIR HEARINGS

State "Fair Hearing" means the State hearing provided to beneficiaries pursuant to Sections 50951 and 50953 of Title 22 of the California Code of Regulations and Section 1810.216.6 of Title 9 of the California Code of Regulations 1810.216.6:

A. If a beneficiary requests a State Fair Hearing, the Department shall grant the request. (42 CFR § 431.220(a)(5).) The right to a State Fair Hearing, how to obtain a hearing, and representation rules at a hearing must be explained to the beneficiary and provider by Contractor in its notice of decision or NOABD. (42 CFR § 431.206(b); 42 CFR § 431.228(b).) Beneficiaries and providers shall also be informed of the following:

1. A beneficiary may request a State Fair Hearing only after receiving notice that the Contractor is upholding the adverse benefit determination. (42 CFR § 438.408(f)(1).)

2. If Contractor fails to adhere to notice and timing requirements under § 438.408, the beneficiary is deemed to have exhausted the Contractor's appeals process, and the beneficiary may initiate a state fair hearing. (42 CFR 438.408(f)(1)(i); 42 CFR 438.402(c)(1)(i)(A).)

3. The contractor may request a State Fair Hearing only if the Department permits Contractor to act as the beneficiary's authorized representative. (42 CFR § 438.402(c)(1)(ii).)

19. ADVANCE DIRECTIVES

For purposes of this agreement, advance directive means a written instruction, such as a living will or durable power of attorney for health care, recognized under California law, relating to the provision of health care when the individual is incapacitated. (42 CFR § 489.100.)

A. Contractor shall maintain written policies and procedures on advance directives that include a description of applicable California law. (42 CFR §§ and 438.3(j)(1)-(3), 422.128). Any written materials prepared by Contractor for beneficiaries shall be updated to reflect changes in state laws governing advance directives as soon as possible, but no later than ninety (90) days after the effective date of the change. (42 CFR § 438.3(j)(4).)

B. Contractor shall provide adult beneficiaries with the written information on advance directives. (42 CFR § 438.3(j)(3).)

C. Contractor shall not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive. (42 CFR §§ 422.128(b)(1)(ii)(F), 438.3(j).)

D. Contractor shall educate staff concerning its policies and procedures on advance directives. (42 CFR §§ 422.128(b)(1)(ii)(H), 438.3(j).)

20. NOTICES

A. All notices required or provided for in this agreement shall be provided to the parties at the following addresses, by personal delivery or deposit in the U.S. Mail, postage prepaid, registered or certified mail, addressed as specified below. Notices delivered personally shall be deemed received upon receipt; mailed or expressed notices shall be deemed received five (5) business days after deposit. A party may change the address to which notice is to be given by giving notice as provided below.

1. To County:
   Behavioral Health and Recovery Services
   Attn: Director
   PO Box 1000
   Bakersfield, CA 93302-1000
   cc: Contracts Management

2. To Contractor:
   Juan Garcia, Director

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Community Services Organization Behavioral Health Programs, Inc.
1124 Baker Street
Bakersfield, CA 93305

B. County requires Contractor to notify County thirty (30) days prior to any change in name, legal business status, corporate address, service site address, or Contractor's signatory power that occurs during the term of this agreement. At its option, County may choose to acknowledge a notice of these specific changes without a written amendment to the agreement.

C. Nothing in this Agreement shall be construed to prevent or render ineffective delivery of notices required or permitted under this agreement by personal service.

21. MANDATORY MEETINGS

Contractor is required to participate in a monthly provider meeting and other meetings that the KernBHRS Administrator may call. Meetings may be held at Contractor's site, at a County location, or through video conferencing as the KernBHRS Administrator determines. Meeting attendees must be familiar with and well-versed in the requirements of this agreement. Failure to comply with this requirement may lead to termination of the agreement.

22. CULTURAL COMPETENCE

Contractor shall comply with Cultural Competence requirements set forth by County, in accordance with Welfare and Institutions Code Section 5600.2 and CCR Title 9 Section 1810.410 Contractor shall participate in the Department's efforts to promote the delivery of services in a culturally and linguistically competent manner to all enrollees, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity. Failure to comply with the following requirements may result in sanctions such as withholding of payments, corrective action notices, or any other actions deemed necessary to ensure contract and performance compliance (i.e., DHCS 10-02 and 10-17 and the Federal CLAS standards).

A. No later than sixty (60) days after the beginning date of the agreement, Contractor must use the provided cultural competence plan template and submit its agency's annual cultural competence plan to the Department's Ethnic Services Manager via the Cultural Competence email address CulturalCompetence@KernBHRS.org.

B. Contractor must submit its agency's Bilingual Quarterly Report prior to the fifteenth (15th) of the month following the close of the calendar quarter to their System of Care Administrator.

C. Contractor understands that its staff must receive at least six (6) hours of cultural competence training each year. Training that is not provided through the Department must have the pre-approval of the Department's Ethnic Services Manager by submitting course material via the Cultural Competence email address CulturalCompetence@KernBHRS.org. If Contractor has Board of Behavioral Sciences or similar authorization to provide continuing education units for training it provides, it does not need pre-approval.

D. KernBHRS will monitor Contractor's attendance of required Cultural Competence trainings through the Relias training system if Contractor utilizes this program. If Contractor does not utilize Relias, Contractor will need to develop an internal tracking mechanism to monitor their staff's attendance. This tracking system should be available for County to review at any time to ensure that these required trainings are being completed.

E. Contractor will provide additional cultural competence training specifically regarding Transgender, Gender Diverse, and Intersex in compliance with BHIN 25-019 (W&I Code 14197.09).

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23. TRANSLATION AND INTERPRETATION SERVICES

A. Contractor shall make translation and interpretation services available for beneficiaries, as needed. Pursuant to WIC Section 14029.91(a)(1)(C), Contractor shall not require a beneficiary with limited English proficiency to provide his or her own interpreter or rely on a staff member who does not meet the qualifications described in WIC 14029.91(a)(1)(B).

B. Contractor shall not rely on an adult or minor child accompanying the limited-English-proficient beneficiary to interpret or facilitate communication except under the circumstances described in WIC Section 14029.91 (a)(1)(D).

C. Contractor shall not require a beneficiary with limited English proficiency to accept language assistance services, pursuant to 45 CFR Section 92.201.

D. Contractor shall notify its beneficiaries that oral interpretation is available for any language and written translation is available in prevalent languages to individuals whose primary language is not English. This may include, but is not limited to, qualified interpreters and information written in other languages.

E. Contractor shall notify its beneficiaries that auxiliary aids and services are available upon request and at no cost for beneficiaries with disabilities to help them communicate better. These aids and services may include qualified sign language interpreters and written information in other formats.

F. Pursuant to WIC 14029.91(a)(1)(B), oral interpretation services shall be provided by an interpreter that, at a minimum, meets all of the following qualifications:

1. Demonstrated proficiency in speaking and understanding both spoken English and the target language spoken by the limited-English-proficient beneficiary. Contractors should submit to submit to CulturalCompetence@KernBHRS.org how proficiency is determined, which language(s) are supported via staff, and how these staff are supported in their knowledge of necessary specialized vocabulary.

2. Knowledge in both English and the target language of health care terminology and concepts relevant to health care delivery systems. The ability to interpret effectively, accurately, and impartially, both receptively and expressly, to and from the language spoken by the limited-English-proficient beneficiary and English, using any necessary specialized vocabulary, terminology, and phraseology.

3. Adheres to generally accepted interpreter ethics principles, including client confidentiality.

24. NON-DISCRIMINATION AND FAITHFUL PERFORMANCE

A. The parties mutually agree to abide by all federal, state, and local laws including, but not limited to, all laws respecting employment discrimination. Each party further agrees to fully and faithfully perform all covenants and portions of this agreement, and to take no action that may be inimical to the other party's faithful performance hereof.

B. Contractor shall provide services that incorporate the racial and ethnic values and beliefs of the client and shall deliver such services in a manner which meets the needs of the client and their families' lifestyles whenever possible.

C. Contractor shall have in place written policies regarding nondiscrimination on the basis of race, color, creed, etc., and shall include nondiscrimination and compliance provisions in all subcontracts. Contractor and its subcontractors shall ensure that the evaluation and treatment of their employees and applicants for employment are free from discrimination and harassment.

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25. EMERGENCY AND DISASTER PREPARATION AND RESPONSE

A. Contractor shall develop and maintain an emergency response plan specific to each service delivery site. Plans shall be updated annually and submitted to the KernBHRS Director or his or her designee within sixty (60) days of the execution of this agreement. Contractor shall provide, at each service delivery site, annual training to its employees regarding the provisions of Contractor's plan. Failure to develop an emergency response plan, and train staff on the provisions of the plan, may result in sanctions such as withholding of payments, corrective action notices, or any other actions deemed necessary to prompt and ensure contract and performance compliance.

B. Upon request, Contractor shall expeditiously provide any additional information necessary to aid the County in planning to serve clients prior to an imminent man-made or natural disaster.

C. In the event of a declared local, state, or federal disaster, and while providing requested disaster behavioral health services, Contractor shall complete all necessary documentation required to support County's reimbursement claims.

26. PUBLIC ANNOUNCEMENTS AND LITERATURE

A. In public announcements and literature distributed by Contractor for the purpose of apprising clients and the general public of the nature of its treatment services, Contractor shall clearly indicate that the County of Kern funds the services that Contractor provides under this agreement.

B. Contractor shall provide all written materials for potential beneficiaries and beneficiaries in a font size no smaller than twelve (12) point. (42 CFR 438.10(d)(6)(ii).)

C. Contractor shall ensure its written materials are available in alternative formats, including large print, upon request of the potential beneficiary or beneficiary at no cost. Large print means printed in a font size no smaller than twenty (20) point. (42 CFR § 438.10(d)(3)).

D. Contractor shall make its written materials that are critical to obtaining services, including, at a minimum, provider directories, beneficiary handbooks, appeal and grievance notices, denial and termination notices, and Contractor's mental health and/or substance use education materials, available in the prevalent non-English languages in the county. (42 CFR § 438.10(d)(3).)

E. Contractor shall include language taglines in the top sixteen (16) non-English languages in the state, as well as large print, explaining the availability of written translation or oral interpretation to understand the information provided. (42 CFR § 438.10(d)(2).)

F. Contractor shall include language taglines in the top sixteen (16) non-English languages in the state, as well as large print, explaining the availability of the toll-free and Teletypewriter Telephone/Text Telephone (TTY/TDY) telephone number of Contractor's member/customer service unit. (42 CFR § 438.10(d)(3).)

G. Contractor shall notify beneficiaries that written translation is available in prevalent non-English languages free of cost and shall notify beneficiaries how to access those materials. (42 C.F.R. § 438.10(d)(5)(i), (iii); Cal. Code Regs., Title. 9, § 1810.410(e)(4).)

H. Contractor shall make auxiliary aids and services available upon request and free of charge to each beneficiary. (Contractor shall also notify beneficiaries of how to access these services. (42 CFR § 438.10(d)(5)(ii)-(iii).) 42 CFR § 438.10(d)(3)-(4).) Contractor shall also notify beneficiaries of how to access these services. (42 CFR § 438.10(d)(5)(ii)-(iii).)

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I. Contractor shall make oral interpretation and auxiliary aids, such as TTY/TDY and American Sign Language (ASL), available and free of charge for any language. (42 CFR § 438.10(d)(2), (4)-(5).) Contractor shall notify beneficiaries that the service is available and of how to access those services. (42 CFR § 438.10(d)(5)(i), (iii).)

27. NETWORK ADEQUACY CERTIFICATION

A. Contractor shall ensure that all services covered under this agreement are available and accessible to beneficiaries in a manner that complies comply with KernBHRS policy and procedure 5.1.12, Timeliness of Access to Services, 42 CFR 438.68, and Welfare and Institutions Code (WIC) Section 14197 Services will be available to Medi-Cal beneficiaries that are no less than the hours of operation during which the contractor offers services to non-Medi-Cal beneficiaries. If Contractor serves only Medi-Cal beneficiaries, Contractor shall ensure hours of operation are consistent with the needs of the beneficiaries in the geographic area. Contractor shall provide evidence that they are able to stay in compliance with these standards within the prescribed time frame.

B. Contractor shall submit to the KernBHRS Quality Improvement Division ("QID") Administrator or designee all requested information necessary to certify the adequacy of the network. Contractor shall enter the needed information into the Network Adequacy Certification Tool (NACT) within the specified time frames. Information may include, but is not limited to, the names of individual rendering providers, caseload size, bilingual certification, and specialized training of rendering providers. The information should be accurate and complete and will be published in the Provider Directory. This information shall be provided to the Quality Improvement Division (QID) Administrator or their designee when any changes occur and shall be reviewed and certified on a monthly basis. The monthly review will ensure the accuracy of previously submitted information even if no changes have occurred during the month. In addition, the information will be submitted to the Department of Healthcare Services as evidence of network capacity and availability.

28. NATIONAL PROVIDER IDENTIFICATION

A. Contractor shall comply with the National Provider Identification (NPI) system and will provide the Department with the NPI numbers for all staff providing direct health care or clinical services.

B. Contractor shall comply with all guidelines and requirements set forth in **Exhibit G**, "**Program Integrity Requirements,"** attached hereto.

29. ACCREDITATION

A. Contractor shall inform KernBHRS if it has been accredited by a private independent accrediting entity. Contractor shall authorize the accrediting agency to provide KernBHRS with a copy of its most recent accreditation review, including: the accreditation status, survey type, and level, review results including recommended actions or improvements, corrective action plans, summaries of findings, and the accreditation expiration date. Contractor shall submit the information to the System of Care Administrator and the QID Administrator at the time of accreditation, and every new accreditation period thereafter.

30. CREDENTIALING

A. County and/or its delegated third-party vendor, shall establish and conduct a provider Credentialing Program for credentialing and re-credentialing of contractor and sub-contractors. Contractor has two (2) options to satisfy the Credentialing and Re-Credentialing requirements listed in **Exhibit I, "Credentialing and Re-Credentialing Requirements,"** of this agreement. The options are as follows:

Option 1:

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Contractor shall complete the Credentialing and Re-Credentialing process for all employees that are licensed, waivered, or registered mental health providers and licensed, registered, or certified Alcohol or Other Drug Counselors at the time of hire and during the increments outlined in **Exhibit I**. County will audit these efforts annually to ensure compliance with this requirement. Non-adherence to the Credentialing and Re-Credentialing requirements will result in County issuing a plan of correction to Contractor to address this issue immediately. Serial plans of corrections in this area will result in Contractor no longer having the ability to Credential or Re-Credential their own staff and this task will be then managed by County. Contractors will need to complete an attestation indicating that all new hires have been credentialed before services completed by that employee can be entered into the EHR.

Option 2:

KernBHRS will complete the Credentialing and Re-Credentialing for Contractor. In order for County to complete this task, Contractor shall provide the necessary information for all employees that are licensed, waivered, or registered mental health providers and licensed, registered, or certified Alcohol or Other Drug Counselors at the time of hire and during the increments outlined in **Exhibit I**.

Regardless of the option chosen by Contractor, any employees who are licensed, waivered, or registered mental health providers and licensed, registered, or certified Alcohol or Other Drug Counselors who are not credentialed will not be allowed to provide Medi-Cal reimbursable services nor participate in the plan's provider network.

31. EXCLUSION REPORTING

A. Contractor shall not knowingly have a relationship with any individual or entity who is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in any of such programs by any federal agency or by any department, agency, or political subdivision of the state.

B. Contractor shall comply with all guidelines and requirements set forth in **Exhibit G "Program Integrity Requirements,"** pertaining to exclusion reporting.

32. SERVICE VERIFICATION

A. Contractor shall comply with the requirements pertaining to services verification contained in **Exhibit G, "Program Integrity Requirements,**" attached herein.

33. REPORTING UNUSUAL OCCURRENCES

A. Contractor shall comply with KernBHRS policy 11.1.1, Unusual Occurrence Reporting (UOR). Contractor shall utilize the Unusual Occurrence Reporting application referenced in KernBHRS policy 11.1.1. No other variations of reporting will be accepted. Inpatient psychiatric facilities should continue to report unusual occurrences as outlined by the KernBHRS Crisis Administrator or their designee.

An unusual occurrence is any event or situation that has occurred at a service site or in the field that may have caused, or has the potential to cause, physical or psychological harm to clients who are receiving services from KernBHRS or contracted providers. This definition also applies to visitors (i.e., individuals who are not directly receiving behavioral health services). An unusual occurrence that takes place in any type of work capacity must be reported.

In addition, an Unusual Occurrence report is required when:

1. A client may have injured a staff member, another client, or visitor;

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2. A client makes a serious threat to harm another person;
3. There is a suspected violation of professional licensure and/or ethics.
4. There is an unauthorized/inappropriate release of PHI, PI, and/or PII; and/or
5. There is the possibility of threat or legal action and/or negative media attention for the department.

B. Principles: Unusual occurrences shall include but not be limited to:

1. Death other than by suicide;
2. Death by suspected or known suicide;
3. Suicide attempt requiring Emergency Medical Treatment (EMT);
4. Suicide threat with intent or plan;
5. Tarasoff Report, i.e., client makes a threat to harm another person;
6. Aggressive/Threatening or destructive behaviors;
7. Intentional injury (not suicide attempt) requiring EMT;
8. Seclusion, restraint, or emergency manual/chemical containment;
9. Client or visitor in possession of a weapon at the treatment site;
10. Client unintentionally injured another client or visitor at a KernBHRS site or work-related site;
11. Client injured in a vehicular accident during treatment activities;
12. Slip, trips, falls, non-serious accidents not requiring immediate medical attention;
13. Natural disaster, environmental hazard or biohazard exposure while at treatment site;
14. Medication prescription and/or administration errors;
15. Medical health incident requiring immediate/urgent medical attention;
16. Client exposed to communicable disease while at treatment site;
17. Client exposed to infections (BBP, OPIM) while at treatment site;
18. Allegations of neglect, verbal, physical, sexual assault of client/visitor as reported;
19. Client/visitor is a victim of physical, sexual or verbal assault as observed / witnessed by staff;
20. Client/visitor is a perpetrator of physical, sexual, or verbal assault as observed / witnessed by staff;
21. Unauthorized/inappropriate access, use, disclosure or storage of PHI, PI, and/or PII;

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22. PHI, PI, and/or PII compromised due to inadequate security measures or theft;

23. Allegations of unethical relationships, behaviors, or other unprofessional conduct or licensure violation by staff;

24. Observation and/or information regarding questionable or inappropriate staff behavior related to client or visitor's care;

25. Possibility or threat of legal action and/or negative media attention;

26. Client at PEC longer than 23:59 hours;

27. AWOL from facility, elopement, or wandering;

28. Unauthorized use and/or possession of legal or illegal substances; and

29. Allegations of client/visitor's property loss as reported.

C. County retains the right to independently investigate unusual occurrences with the cooperation of Contractor.

34. CONFLICT OF INTEREST

A. Contractor shall comply with the conflict of interest safeguards described in 42 CFR Part 438.58 and the prohibitions described in Section 1902(a)(4)(C) of the Act. (42 CFR § 438.3(f)(2).)

B. Contractor's officers and employees shall not have a financial interest in this agreement, or a subcontract of this agreement made by them in their official capacity, or by anybody or board of which they are members unless the interest is remote. (Gov. Code §§ 1090, 1091; 42 CFR § 438.3(f)(2).)

C. Contractor shall not utilize in the performance of this agreement any state or county officer or employee in the state or county civil service or other appointed state or county official unless the employment, activity, or enterprise is required as a condition of the officer or employee's regular state or county employment. (Pub. Con. Code § 10410; 42 CFR § 438.3(f)(2).) Contractor shall submit documentation to KernBHRS of employees (current and former state and county employees) who may present a conflict of interest.

D. The parties to this agreement have read and are aware of the provisions of Section 1090, et seq., and Section 87100, et seq., of the Government Code relating to conflict of interest of public officers and employees. Contractor agrees that it is unaware of any financial or economic interest of any public officer or employee of County relating to this agreement. It is further understood and agreed that if such a financial interest does exist at the inception of this agreement, County may immediately terminate this agreement by giving written notice thereof. Contractor shall comply with the requirements of Government Code Section 87100, et seq., during the term of this agreement.

35. DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

A. Contractor shall comply with the requirements pertaining to the Disclosure of Ownership and Control Interest Statement contained in **Exhibit G, "Program Integrity Requirements,"** and submit to County the "**Disclosure of Ownership and Control Interest Statement,"** included herein as **Exhibit H.**

36. TECHNOLOGY REQUIREMENTS

A. Contractor shall make reports as required by Director, Director's designee, or state regarding Contractor's activities and operations as they relate to Contractor's performance under this agreement as specified in their Exhibit A.

1. Based on programmatic requirements, as specified in **Exhibit A**, Contractor shall enter information into the **KernBHRS electronic health record**.

2. Contractor shall provide any billing services, which are not part of the entry of clinical documentation using direct data entry as specified in Exhibit A.

3. Contractor's staff shall be trained by the Department in the operation, procedures, policies, and all related uses of the **KernBHRS electronic health record**. In exceptional circumstances, the KernBHRS Administrator may authorize or direct Contractor to provide some or all elements of KernBHRS electronic health record training internally. The Technology Services Manager, or designee, must approve any requests for a contractor to provide any **KernBHRS electronic health record** training. Staff who have not been trained will not be provided with a username and will not have access to the **KernBHRS electronic health record** system.

4. Prior to the training, Contractor's staff are to show proof of current **Information Privacy and Information Security training completion**. Staff who do not provide proof of current Information Privacy and Information Security training will be trained on use of the **KernBHRS electronic health record** but will not be provided with their username until Information Privacy and Information Security training is completed and verification submitted. The Director, or Director's designee, shall endeavor to provide as much advance notice as possible of required data or other information to be reported, but in no event shall such notice be less than fifteen (15) working days.

5. Contractor's staff who are required to be credentialed will not receive their user identification login for the **KernBHRS electronic health record** until KernBHRS receives the appropriate attestation from Contractor that all credentialing elements have been completed for each staff person. This attestation should be sent to Credentialing@kernbhrs.org. KernBHRS Credentialing team will submit this form for all of Contractor's staff for whom KernBHRS completes the credentialing process.

6. Withholding of Payments for Non-submission of ITS and Other Information:

County may withhold a maximum of ten percent (10%) of any monthly claim for payment, if any data, periodic evaluation data, as described herein, or other information is not submitted by Contractor to KernBHRS within the time limits of submission as prescribed in this agreement or as specified by the Director, or Director's designee, from time to time; or if any ITS data, periodic evaluation data, or other information is incomplete, incorrect, or is not completed in accordance with the requirements of this agreement or as specified by the Director, or Director's designee. The Director or Director's designee shall endeavor to provide as much advance notice of required data as possible, but in no event shall such notice be less than fifteen (15) working days.

37. HIPAA/HITECH COMPLIANCE

A. During the term of this agreement, Contractor may receive from County, or may receive or create on behalf of County, certain confidential health or Medi-Cal information ("Protected Health Information" or "PHI"). This PHI is subject to protection under state and federal law, including the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the "HIPAA Regulations") and other applicable laws. Contractor represents that

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it has in place policies and procedures that will adequately safeguard any PHI it receives or creates, and Contractor specifically agrees, on behalf of itself, its subcontractors, and agents, to safeguard and protect the confidentiality of PHI consistent with applicable law, including currently effective provisions of HIPAA, the HITECH Act, and the HIPAA Regulations.

B. For purposes of this section, PHI means any information, whether oral or recorded in any form or medium: (a) that relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual, and (b) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

C. The parties acknowledge that state and federal laws relating to electronic data security and privacy are rapidly evolving and that amendment of this agreement may be required to provide for procedures to ensure compliance with such developments. The parties hereto specifically agree to take such action as is necessary to implement the requirements of HIPAA, the HITECH Act, and HIPAA Regulations and other applicable laws relating to the security or confidentiality of PHI. The parties understand and agree that Contractor must provide to County, after request by County, written evidence that Contractor is in compliance with the HITECH Act and applicable HIPAA Regulations.

D. Notwithstanding any other provision of this agreement, County may terminate this agreement upon twenty (20) days' notice in the event: (a) Contractor does not promptly provide written evidence of compliance with the HITECH Act and applicable HIPAA Regulations, or (b) County becomes aware that Contractor or any of its subcontractors or agents discloses PHI in a manner that is not authorized by County or by applicable law.

E. Contractor is a Business Associate under the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the "HIPAA Regulations") and other applicable laws.

F. Contractor agrees to execute a **"Business Associate Addendum"** with County to supplement this agreement, which is attached as **Exhibit D**, and incorporated herein by reference.

G. Contractor represents that it has in place policies and procedures that will adequately safeguard any PHI it receives or creates, and Contractor specifically agrees, on behalf of itself, its subcontractors, and agents, to safeguard and protect the confidentiality of PHI consistent with applicable law, including currently effective provisions of HIPAA, the HITECH Act, and the HIPAA Regulations. Policies must address the confidentiality, integrity, and availability of all PHI and electronic Protected Health Information (ePHI) that is created, received, maintained or transmitted; identify and protect against reasonably anticipated threats to the security or integrity of PHI and ePHI; protect against reasonably anticipated, impermissible uses and disclosures; and ensure compliance by workforce members.

H. No later than thirty (30) days after the beginning date of the initial agreement, Contractor must submit to the KernBHRS Privacy and Corporate Compliance Office, the names and contact information of its current Privacy Officer, Security Officer, and Compliance Officer, and within thirty (30) days of any change of officer(s) during the year in any subsequent agreements, in accordance with federal and state regulations.

I. Where applicable, Contractor agrees to implement appropriate safeguards and maintain individually identifiable patient health information ("Protected Health Information or "PHI," including electronic PHI) as required by HIPAA.

J. Contractor agrees to submit to County a current copy of their HIPAA Security Rule Annual Risk Assessment upon request.

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K. Contractor shall use and disclose only the minimum necessary PHI.

L. Contractor may use and disclose PHI only as permitted under HIPAA for legal, management, and administrative purposes in connection with treatment, payment, and healthcare operations or as required by law.

M. Contractor shall require third parties to whom it may disclose PHI to agree in writing to similar restrictions and to comply with HIPAA.

N. Contractor shall track disclosures of PHI as required under HIPAA, to include the nature of the information disclosed, the date of the disclosure, to whom the information was disclosed, address of the recipient, if known, and the purpose of the disclosure and provide County with an accounting of such disclosures promptly upon request.

O. Contractor shall notify County of disclosures of PHI in violation of HIPAA and this agreement and take steps to mitigate, to the extent practicable, deleterious effects of improper use of PHI within twenty - four (24) hours.

P. Contractor shall promptly make PHI available to County and clients upon request.

Q. Contractor shall permit clients to request amendment to or correction of PHI, amend and/or correct PHI as appropriate when so requested, notify County of requests for correction and amendments to PHI by clients, and incorporate into PHI amendments and/or corrections made to PHI by County as directed by County.

R. Contractor acknowledges that PHI received from County shall remain County's property and that within ten (10) business days of County's request or upon termination of this agreement, said PHI shall be returned to County or be destroyed, if County so directs.

S. If such return or destruction is infeasible, Contractor shall use such PHI only for purposes that make such return or destruction infeasible, and the provisions of this agreement shall survive termination of the agreement with respect to such PHI. Contractor has established internal policies and procedures regarding HIPAA compliance, privacy, and security and agrees to make such policies and procedures available to County upon request.

T. Contractor agrees to comply with the terms set forth in **Exhibit E "Privacy and Information Security Provisions,"** This Exhibit contains language from the Department of Health Care Services Performance contract, which discusses controls for public, confidential, sensitive, and personal information.

U. Contractor shall agree to comply with the terms set forth in **Exhibit G, "Program Integrity Requirements,"** This Exhibit contains language from the Department of Health Care Services Performance contract, which addresses the Compliance conditions for receiving payment under a Medi-Cal managed care program.

38. CONFIDENTIALITY

A. Contractor, in accordance with Title 45, CFR Regulations, Part 96, Section 96.132(e), shall have in effect a system to protect from inappropriate disclosure of patient records maintained by Contractor, in connection with an activity funded under the program involved or by any entity, and such system shall be in compliance with all applicable state and federal laws and regulations, including 42 CFR Part 2, Substance Use Disorder and Treatment records. This system shall include provisions for employee education on the confidentiality requirements and the fact that disciplinary action may occur upon inappropriate disclosures.

B. Contractor shall not, without the written consent of the Department, communicate confidential information, designated in writing or identified in this agreement as such, to any third party and shall protect such information

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from inadvertent disclosure to any third party in the same manner that it protects its own confidential information, unless such disclosure is required in response to a validly issued subpoena or other process of law. The provisions of this paragraph shall survive the termination of this agreement.

39. INDEMNIFICATION

A. Contractor agrees to indemnify, defend, and hold harmless County and County's agents, board members, elected and appointed officials and officers, employees, volunteers, and authorized representatives from any and all losses, liabilities, charges, damages, claims, liens, causes of action, awards, judgments, cost, and expense (including, but not limited to, reasonable attorneys' fees of County Counsel and counsel retained by county, expert fees, costs of staff time, and investigation costs) of whatever kind or nature, that arise out of or are in any way connected with any act or omission of Contractor or Contractor's officers, agents, employees, independent contractors, subcontractors of any tier, or authorized representatives. Without limiting the generality of the foregoing, the same shall include bodily and personal injury or death to any person or persons; damage to any property, regardless of where located, including the property of County; and any workers' compensation claim, or suit arising from or connected with any services performed pursuant to this agreement on behalf of Contractor by any person or entity.

40. IMMIGRATION REFORM AND CONTROL ACT

A. Contractor, and all subcontractors hired by Contractor to perform services under this agreement, are aware of and understand the Immigration Reform and Control Act ("IRCA") of 1986, Public Law 99-603. Contractor is and shall remain in compliance with IRCA and shall ensure that any subcontractors hired by Contractor to perform services under this agreement are in compliance with IRCA. In addition, Contractor agrees to indemnify, defend, and hold harmless County, its agents, officers, and employees, from any liability, damages, or causes of action arising out of or relating to any claims that Contractor's employees, or the employees of any subcontractor hired by Contractor, are not authorized to work in the United States for Contractor or its subcontractor and/or any other claims based upon alleged IRCA violations committed by Contractor or Contractor's subcontractor(s).

41. INSURANCE

Contractor, in order to protect County and its board members, officials, agents, officers, and employees against all claims and liability for death, injury, loss, and damage as a result of Contractor's actions in connection with the performance of Contractor's obligations, as required in this agreement, shall secure and maintain insurance as described below. Contractor shall not perform any work under this agreement until Contractor has obtained all insurance required under this section, and the required certificates of insurance and all required endorsements have been filed with the Department's Contracts Division. Receipt of evidence of insurance that does not comply with all applicable insurance requirements shall not constitute a waiver of the insurance requirements set forth herein.

The required documents must be signed by the authorized representative of the insurance company shown on the certificate. Upon request, Contractor shall supply proof that such person is an authorized representative thereof and is authorized to bind the named underwriter(s) and their company to the coverage, limits and termination provisions shown thereon.

Contractor shall promptly deliver to the Department's Contracts Division certificates of insurance, and all required endorsements, with respect to each renewal policy, as necessary to demonstrate the maintenance of the required insurance coverage for the term specified herein. Such certificates and endorsements shall be delivered to Department's Contracts Division prior to the expiration date of any policy and bear a notation evidencing payment of the premium thereof if so requested. Contractor shall immediately pay any deductibles and self-insured retentions under all required insurance policies upon the submission of any claim by Contractor or County as an additional insured.

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A. Workers' Compensation and Employers Liability Insurance Requirements:

In the event Contractor has employees or volunteers who may perform any services pursuant to this agreement, Contractor shall submit written proof that Contractor is insured against liability for workers' compensation in accordance with the provisions of section 3700 of the California Labor Code.

Contractor shall require any subcontractors to provide workers' compensation for all of the subcontractors' employees, unless the subcontractors' employees are covered by the insurance afforded by Contractor. If any class of employees engaged in work or services performed under this agreement is not covered by California Labor Code section 3700, Contractor shall provide and/or require each subcontractor to provide adequate insurance for the coverage of employees not otherwise covered.

Contractor shall also maintain employer's liability insurance with limits of **ONE MILLION DOLLARS ($1,000,000)** for bodily injury or disease.

B. Liability Insurance Requirements:

Contractor shall maintain in full force and effect, at all times during the term of this agreement, the following insurance:

1. Commercial General Liability Insurance including, but not limited to, Contractual Liability Insurance (specifically concerning the indemnity provisions of this agreement with the county), Products-Completed Operations Hazard, Personal Injury (including bodily injury and death), and Property Damage for liability arising out of Contractor's performance of work under this agreement. The Commercial General Liability insurance shall contain no exclusions or limitation for independent contractors working on the behalf of the named insured. Contractor shall maintain the Products-Completed Operations Hazard coverage for the longest period allowed by law following termination of this agreement. The amount of said insurance coverage required by this agreement shall be the policy limits, which shall be at least **ONE MILLION DOLLARS ($1,000,000) each occurrence and TWO MILLION DOLLARS ($2,000,000)** aggregate.

2. Automobile Liability Insurance against claims of Personal Injury (including bodily injury and death) and Property Damage covering any vehicle and/or all owned, leased, hired and non-owned vehicles used in the performance of services pursuant to this agreement with coverage equal to the policy limits, which shall be at least **ONE MILLION DOLLARS ($1,000,000)** each occurrence.

3. Professional Liability (Errors and Omissions) Insurance, for liability arising out of, or in connection with, the performance of all required services under this agreement, with coverage equal to the policy limits, which shall not be less than **ONE MILLION DOLLARS ($1,000,000) per occurrence and THREE MILLION DOLLARS ($3,000,000)** aggregate.

4. Cyber Liability Insurance/Technology Professional Liability Insurance, for liability arising out of, or in connection with, the performance of all required services under this Agreement, involving access to personal and or confidential information, software or technology services where a data breach or exposure to personal and or confidential information could impact the County, coverage shall be equal to the policy limits, which shall be at least **ONE MILLION DOLLARS ($1,000,000) per occurrence and TWO MILLION DOLLARS ($2,000,000)** aggregate. Coverage shall respond to the duties and obligations as is undertaken by Contractor in this agreement and shall include, but not limited to, claims involving security breach, system failure, data recovery, business interruption, cyber extortion, social engineering, infringement of intellectual property, including but not limited to infringement of copyright, trademark, trade dress, invasion of privacy violations, information theft, damage to or destruction of electronic information, release of private information, and

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alteration of electronic information. The policy shall provide coverage for breach response costs, regulatory fines and penalties as well as credit monitoring expenses.

5. If the Commercial General Liability policy or Professional Liability policy is not endorsed to include affirmative coverage for sexual abuse or molestation, Contractor shall obtain and maintain a policy covering sexual abuse or molestation. The amount of said insurance coverage required by this Agreement shall be the policy limits, which shall be at least ONE MILLION DOLLARS ($1,000,000) per occurrence or claim and TWO MILLION DOLLARS ($2,000,000) aggregate.

The Commercial General Liability insurance required in this sub-paragraph B shall include an endorsement naming County and County's board members, officials, officers, agents and employees as additional insureds for liability arising out of this agreement and any operations related thereto. Said endorsement shall be provided using one of the following three options: (i) on Insurance Services Office (ISO) form Commercial General (CG) 20 10 11 85; or (ii) on ISO form CG 20 37 10 01 plus either ISO form CG 20 10 10 01 or CG 20 33 10 01; or (iii) on such other forms which provide coverage at least equal to or better than form CG 20 10 11 85.

C. The Contractor may use Umbrella or Excess Policies to provide the liability limits as required in this agreement. This form of insurance will be acceptable provided that all of the Primary and Umbrella or Excess Policies shall provide all of the insurance coverages herein required, including, but not limited to, primary and non-contributory, additional insured, Self-Insured Retentions (SIRs), indemnity, and defense requirements. The Umbrella or Excess policies shall be provided on a true "following form" or broader coverage basis, with coverage at least as broad as provided on the underlying Liability insurance. No insurance or self-insurance maintained by the County, whether primary or excess, and which also apply to a loss covered hereunder, shall be called upon to contribute to a loss.

D. Any self-insured retentions in excess of **ONE HUNDRED THOUSAND DOLLARS ($100,000)** must be declared on the Certificate of Insurance or other documentation provided to county and must be approved by the County Risk Manager.

E. If any of the insurance coverages required under this agreement is written on a claims-made basis, Contractor, at Contractor's option, shall either (i) maintain said coverage for at least three (3) years following the termination of this agreement with coverage extending back to the effective date of this agreement; (ii) purchase an extended reporting period of not less than three (3) years following the termination of this agreement; or (iii) acquire a full prior acts provision on any renewal or replacement policy.

F. Cancellation of Insurance – The above-stated insurance coverages required to be maintained by Contractor shall be maintained until the completion of all of Contractor's obligations under this agreement except as otherwise indicated herein. Each insurance policy supplied by the Contractor must be endorsed to provide that the coverage shall not be suspended, voided, canceled or reduced in coverage or in limits except after ten (10) days written notice in the case of non-payment of premiums, or thirty (30) days written notice in all other cases. Such notice shall be by certified mail, return receipt requested. This notice requirement does not waive the insurance requirements stated herein. Contractor shall immediately obtain replacement coverage for any insurance policy that is terminated, canceled, non-renewed, or whose policy limits have been exhausted or upon insolvency of the insurer that issued the policy.

G. All insurance shall be issued by a company or companies admitted to do business in the State of California and listed in the current "Best's Key Rating Guide" publication with a minimum rating of A-; VII. Any exception to these requirements must be approved by the County's Risk Manager.

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H. If Contractor is, or becomes during the term of this agreement, self-insured or a member of a self-insurance pool, Contractor shall provide coverage equivalent to the insurance coverages and endorsements required above. County will not accept such coverage unless County determines, in its sole discretion and by written acceptance, that the coverage proposed to be provided by Contractor is equivalent to the above-required coverages.

I. All insurance afforded by Contractor pursuant to this agreement shall be primary to and not contributing to all insurance or self-insurance maintained by County. An endorsement shall be provided on all policies, except professional liability/errors and omissions, which shall waive any right of recovery (waiver of subrogation) against the county.

J. Insurance coverages in the minimum amounts set forth herein shall not be construed to relieve Contractor for any liability, whether within, outside, or in excess of such coverage, and regardless of solvency or insolvency of the insurer that issues the coverage; nor shall it preclude County from taking such other actions as are available to it under any other provision of this agreement or otherwise in law.

K. Failure by Contractor to maintain all such insurance in effect at all times required by this agreement shall be a material breach of this agreement by Contractor. County, at its sole option, may terminate this agreement and obtain damages from Contractor resulting from said breach. Alternatively, County may purchase such required insurance coverage, and without further notice to Contractor, County shall deduct from sums due to Contractor any premiums and associated costs advanced or paid by County for such insurance. If the balance of monies obligated to Contractor pursuant to this agreement is insufficient to reimburse County for the premiums and any associated costs, Contractor agrees to reimburse County for the premiums and pay for all costs associated with the purchase of said insurance. Any failure by County to take this alternative action shall not relieve Contractor of its obligation to obtain and maintain the insurance coverages required by this agreement.

42. SUBROGATION

In the event a beneficiary is injured by the act or omission of a third party, or has a potential or existing claim for a workers' compensation award, or a claim/recovery through uninsured motorist coverage, the right to pursue subrogation and the receipt of payments shall be as follows:

A. Contractor may submit to the Department claims for Medi-Cal covered services rendered, but Contractor shall not make claims to or attempt to recoup the value of these services from the above-referenced entities.

B. Contractor shall notify the Department within ten (10) days of discovery of all cases that could reasonably result in recovery by the beneficiary of funds from a third-party, third-party insurance carrier, workers' compensation award, and/or uninsured motorist coverage.

43. REPRESENTATIONS

Contractor makes the following representations, which are agreed to be material to and form a part of the inducement of this agreement:

A. Contractor has the expertise, training, and experience necessary to provide the services described in this agreement; and

B. Contractor does not have any actual or potential interest adverse to County nor does Contractor represent a person or firm with an interest adverse to County with reference to the subject of this agreement; and

C. Contractor is willing and able to diligently provide all required services in a timely and professional manner in accordance with the terms and conditions stated in this agreement; and

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D. Contractor shall provide a beneficiary's choice of the person providing services to the extent feasible in accordance with California Code of Regulations, Title 9, Section 1830.225 and 42 CFR Part 438.3(l).

44. POLITICAL-RELIGIOUS ACTIVITY

A. No person performing any service or providing any goods designated under this Contract shall participate in any political or religious activity on County time or in any manner involving the use of county property or expenditure of public funds nor conveying the implication of County endorsement or support for a candidate for local, state, or federal office.

B. Notwithstanding the foregoing, nothing in this Contract shall be construed to unlawfully limit an individual's Constitutional rights. Accordingly, the limitations contained in this section are for the sole purpose of preventing proselytizing and politicking while engaged in the performance of services under this Contract.

45. NON-ASSIGNMENT AND SUBCONTRACTING

A. Contractor shall not assign, sublet, or transfer this agreement, or any part hereof, nor assign any monies due or that become due to Contractor under this agreement, without the prior written or electronic and express approval of County.

B. Functions undertaken by Contractor may be carried out under subcontracts only upon obtaining the prior written approval of County. All such subcontracts shall be in writing and shall abide by such federal, state, and local laws and regulations that pertain to this agreement. No subcontract shall terminate or lessen the legal responsibility of Contractor to County to ensure that all activities under this agreement will be carried out.

C. This section is applicable to only those subcontracts entered into by Contractor, the purpose of which is to provide services required under this agreement, and not to any other contracted services obtained by Contractor.

D. Individuals subcontracted to work within contracted programs, who are working under programmatic supervision of Contractor, may be subject to the pre-approval requirement, as determined by County.

E. Subcontracting requirements contained in the agreement between the California Department of Health Care Services (DHCS) and County of Kern specify the following:

1. No subcontract terminates the legal responsibility of County to the state to ensure all activities under this contract are carried out.

2. All inpatient subcontracts shall require that subcontractors maintain necessary licensing and certification.

3. No person performing any service or providing any goods designated under this Contract shall participate in any political or religious activity on County time or in any manner involving the use of county property or expenditure of public funds nor conveying the implication of County endorsement or support for a candidate for local, state, or federal office. Notwithstanding the foregoing, nothing in this Contract shall be construed to unlawfully limit an individual's Constitutional rights. Accordingly, the limitations contained in this section are for the sole purpose of preventing proselytizing and politicking while engaged in the performance of services under this Contract

4. Each subcontract shall contain:

    a. Full disclosure of the method and amount of compensation or other consideration to be received by the subcontractor from County.

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b. Specification of the services to be provided.

c. Specification that the subcontract shall be governed by County and construed in accordance with all laws and regulations and all contractual obligations of County to the state DHCS.

d. Specification of the term of the subcontract including the beginning and ending dates, as well as methods for amendment, termination and, if applicable, extension of the subcontract. The subcontract must be subject to full or partial termination if Contractor's performance is inadequate.

e. Contractor's agreement to make all of its books and records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's Contractor pertaining to the goods and services furnished or determination of amounts payable under the terms of the subcontract available for inspection, examination, evaluation, or copying by the Department, DHCS, United States Department of Health and Human Services (HHS), the Comptroller General of the United States, and other authorized federal and state agencies, or their duly authorized representatives.

f. The subcontract shall also state that inspection shall occur at all reasonable times, at Contractor's place of business, or at such other mutually agreeable location in California, in a form maintained in accordance with the general standards applicable to such book or record keeping, for a term of at least ten (10) years from the close of the state fiscal year in which the subcontract was in effect or from the date of completion or any audit, whichever is later. If the Department, DHCS, HHS, or the Comptroller General of the United States determines that there is a reasonable possibility of fraud or similar risk, they may inspect, evaluate, and audit the subcontractor at any time.

g. Contractor's agreement that assignment or delegation of the subcontract shall be void unless prior written approval is obtained from County.

h. Contractor's agreement to hold harmless both the state and beneficiaries in the event the County cannot or does not pay for services performed by the subcontractor pursuant to the subcontract.

i. Contractor's agreement to comply with County's policies and procedures on advance directives and County's obligations for Physician Incentive Plans, if applicable based on the services provided under the subcontract.

j. A requirement that County monitors Contractor and Contractor's obligation to provide a corrective action plan if deficiencies are identified.

46. NO THIRD-PARTY BENEFICIARIES

A. It is expressly understood and agreed that the enforcement of these terms and conditions and all rights of action relating to such enforcement, shall be strictly reserved to County and Contractor. Nothing contained in this agreement shall give or allow any claim or right of action whatsoever by any other third person. It is the express intention of County and Contractor that any such person or entity, other than County or Contractor, receiving services or benefits under this agreement shall be deemed an incidental beneficiary only.

47. AUTHORITY TO BIND COUNTY

A. It is understood that Contractor, in Contractor's performance of any and all duties under this agreement, except as otherwise provided in this agreement, has no authority to bind County to any agreements or undertakings.

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48. DISPUTE AND ISSUE RESOLUTION

A. Should a dispute occur concerning Contractor's performance or Contractor's interpretation of specific terms of this agreement, including, but not limited to, the validity of overpayment demands and proposed budget modifications, Contractor shall notify the KernBHRS Administrator of this issue within sixty (60) days of its occurrence. Such notification shall include specific identification of the issue(s) under dispute, Contractor's factual basis for the issue, Contractor's proposed solutions, and the documentary support for the solutions.

B. The KernBHRS Administrator shall have fifteen (15) workdays from receipt of the notification to render a decision on the dispute. The KernBHRS Administrator may convene a conference between County and Contractor as part of the decision-making process. The KernBHRS Administrator and Contractor may agree to extend the time period for a decision by the execution of a written memorandum, signed by the parties, specifying the new time period. The decision made by the KernBHRS Administrator shall be in writing and shall contain sufficient factual data and documentary evidence to reasonably explain the decision.

C. If Contractor disputes the decision made by the KernBHRS Administrator, Contractor may request that the Director of KernBHRS, or the Director's designee, review the decision. Such request shall be in writing and received by the Director, or the Director's designee, within five (5) workdays of the date of the KernBHRS Administrator's decision. Such request shall include identification of the items under dispute, Contractor's proposed solutions in summary form, the date of the KernBHRS Administrator's decision and any additional information Contractor deems necessary in support of its position. The Director, or the Director's designee, shall have fifteen (15) workdays from the date of receipt of Contractor's request to render a final administrative decision. The Director, or the Director's designee, may convene a conference between County and Contractor as a part of the decision-making process. The decision of the Director, or the Director's designee, shall be the final administrative decision. Nothing in this agreement prevents Contractor from seeking judicial review of such a final administrative decision.

D. Pending conclusion of any dispute, the interpretation placed upon the agreement by County will govern operation hereunder, and Contractor shall proceed diligently with the performance of the agreement, except that Contractor may terminate this agreement in the manner set forth herein.

E. Contractor Appeal Process

Contractor may appeal a denied or modified request for County payment authorization or a dispute with County concerning the processing or payment of a provider's claim to county.

1. The written appeal shall be submitted to County within ninety (90) calendar days of the date of receipt of the non-approval of payment or within ninety (90) calendar days of County's failure to act on the request in accordance with time frames required by the California Code of Regulations, Title 9, "Provider Appeal Process."

2. County has sixty (60) calendar days from its receipt of the appeal to inform Contractor in writing of the decision, including a statement of the reasons for the decision that addresses each issue raised by Contractor, and any action required by Contractor to implement the decision.

3. If the appeal is not granted in full, Contractor shall be notified of any right to submit an appeal to the state as required by the California Code of Regulations, Title 9.

4. If applicable, Contractor shall submit a revised request for County payment authorization within thirty (30) calendar days from receipt of County's decision.

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5. If applicable, County shall have fourteen (14) calendar days from the date of receipt of Contractor's revised request for County payment authorization to submit the documentation to the Medi-Cal fiscal intermediary that is required to process County's payment authorization.

6. If County does not respond within sixty (60) calendar days to the appeal, the appeal shall be considered denied in full by the Mental Health Plan (MHP) and DMC ODS**.**

49. CHOICE OF LAW AND VENUE

A. The parties hereto agree that the provisions of this agreement will be construed pursuant to the laws of the state of California. This agreement has been entered into and is to be performed in the County of Kern. Accordingly, the parties agree that the venue of any action relating to this agreement shall be in the County of Kern.

50. NON-WAIVER

A. No covenant or condition of this agreement can be waived except by the written consent of County. Forbearance or indulgence by County in any regard whatsoever shall not constitute a waiver of the covenant or condition to be performed by Contractor. County shall be entitled to invoke any remedy available to County under this agreement or by law or in equity despite said forbearance or indulgence.

51. ENFORCEMENT OF REMEDIES

A. No right or remedy herein conferred upon or reserved to County is exclusive of any other right or remedy herein or by law or equity provided or permitted, but each shall be cumulative of every other right or remedy given hereunder, now or hereafter existing by law or in equity or by statute or otherwise and may be enforced concurrently or from time to time.

52. CAPTIONS AND INTERPRETATION

A. Paragraph headings in this agreement are used solely for convenience and shall be wholly disregarded in the construction of this agreement.

B. No provision of this agreement shall be interpreted for or against a party because that party or its legal representative drafted such provision, and this agreement shall be construed as if jointly prepared by the parties.

53. TIME OF ESSENCE

A. Time is hereby expressly declared to be of the essence of this agreement and of each and every provision hereof, and each such provision is hereby made and declared to be a material, necessary, and essential part of this agreement.

54. COUNTERPARTS

A. This agreement may be executed simultaneously in any number of counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instruments.

55. NON-COLLUSION COVENANT

A. Contractor represents and agrees that it has in no way entered into any contingent fee arrangement with any firm or person concerning the obtaining of this agreement with County. Contractor has not received from County

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any incentive or special payments, or considerations not related to the provision of services under this agreement.

56. ENTIRE AGREEMENT

A. This document, including all attachments hereto, contains the entire agreement between the parties relating to the services, rights, obligations, and covenants contained herein and assumed by the parties respectively. No inducements, representations, or promises have been made, other than those recited in this agreement. No oral promise, modification, change, or inducement shall be effective or given any force or effect.

57. NEGATION OF PARTNERSHIP

A. In the performance of all services under this agreement, Contractor shall be, and acknowledges that Contractor is, in fact and law, an independent contractor and not an agent or employee of County. Contractor has and retains the right to exercise full supervision and control of the manner and methods of providing services to County under this agreement. Contractor retains full supervision and control over the employment, direction, compensation, and discharge of all persons assisting Contractor in the provision of services under this agreement. With respect to Contractor's employees, if any, Contractor shall be solely responsible for payment of wages, benefits, and other compensation, compliance with all occupational safety, welfare, and civil rights laws, tax withholding and payment of employee taxes, whether federal, state, or local, and compliance with any and all other laws regulating employment.

58. SEVERABILITY

A. Should any part, term, portion, or provision of this agreement be decided finally to be in conflict with any law of the United States or the State of California, or otherwise be unenforceable or ineffectual, the validity of the remaining parts, terms, portions, or provisions shall be deemed severable and shall not be affected thereby, provided such remaining portions or provisions can be construed in substance to constitute the agreement that the parties intended to enter into in the first instance.

59. TERMINATION

A. Either party may terminate this agreement in whole, with or without cause, upon thirty (30) days' prior written notice to the other party. In the event of termination of this agreement for any reason, County shall have no further obligation to pay for any services rendered or expenses incurred by Contractor after the effective date of the termination, and Contractor shall be entitled to receive compensation for services satisfactorily rendered, calculated on a prorated basis up to the effective date of termination. Should DHCS or any other oversight agency or KernBHRS determine that the delivery of service is unsatisfactory, KernBHRS may terminate the agreement in part or in whole.

60. IMMEDIATE TERMINATION

A. Notwithstanding the foregoing, County shall have the right to terminate this agreement effective immediately after giving written notice to Contractor in the event County determines that Contractor does not have the proper credentials, experience, or skill to perform the required services under this agreement; or in the event that continuation by Contractor in the providing of services may result **(i)** in civil, criminal, or monetary penalties against County, **(ii)** in the breach of any federal or state or regulatory rule or regulation or condition of accreditation or certification, or **(iii)** in the loss or threatened loss of County's ability to participate in any federal or state health care program, including Medicare or Medi-Cal.

61. REQUIRED DOCUMENTS

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A. Agreements That Are Renewed Annually: Contractor shall submit all required documents to the Contract Monitoring Unit before KernBHRS sends the contract to the Board of Supervisors or County Purchasing Manager to be executed. Required documents include but are not limited to: Pre-Award Risk Assessment, and Disclosure of Ownership Form.

1. If applicable, Telehealth Attestations are collected each year, upon initial contact.

B. Multi-Year Agreements: Contractor shall submit all required documents to the Contract Monitoring Team on or before or before March 1 annually. Failure to submit the required documents in a timely manner shall be deemed a material breach of this agreement and may result in termination of the agreement.

62. ROLES AND RESPONSIBILITIES WITH MANAGED CARE PLANS

Contractor shall provide the services and adhere to the standards of service described in **Exhibit J, "Roles and responsibilities in Partnership with Kern's Managed Care Plans**, which is attached hereto and made a part hereof. This exhibit outlines Department of Health Care Services requirements for County and County's Subcontractors in partnership with all of Kern County's Managed Care Plans (MCP). Failure to comply with the standards of service shall be deemed a material breach of this agreement and may result in the termination of the agreement.

63. SIGNATURE AUTHORITY

A. Each party has full power and authority to enter into and perform this agreement, and the person signing this agreement on behalf of each party has been properly authorized and empowered to enter into this agreement.

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IN WITNESS TO WHICH, each party to this agreement has signed this agreement upon the date indicated, and agrees for itself, its employees, officers, partners, and successors, to be fully bound by all terms and conditions of this agreement.

APPROVED AS TO CONTENT:
Behavioral Health and Recovery Services

By: Alison Burrowes
Alison Burrowes, MA, LCSW, Director

COUNTY OF KERN
Board of Supervisors

By: _____
,Chairman

APPROVED AS TO FORM:
Office of the County Counsel

By: Kyle W. Holmes
Kyle Holmes, Deputy

COMMUNITY SERVICES ORGANIZATION BEHAVIORAL HEALTH PROGRAMS, INC.

By: Juan Garcia
Juan Garcia, Director

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COMMUNITY SERVICES ORGANIZATION BEHAVIORAL HEALTH PROGRAMS, INC.

OUTPATIENT SUBSTANCE USE TREATMENT SERVICES
RECOVERY INCENTIVES PROGRAM
PENAL CODE 1000 DRUG DIVERSION PROGRAM

EXHIBIT A – OUTPATIENT SUBSTANCE USE TREATMENT SERVICES
DESCRIPTION OF STANDARDS AND SERVICES

NOTE: THIS EXHIBIT WILL BE REVIEWED ANNUALLY

I. LEVELS OF SERVICE

The levels of service shall be delivered in accordance with the American Society of Addiction Medicine (ASAM) criteria, regardless of funding source. The ASAM Levels of Care described in this Exhibit are:

LOC	Description
1.0	Outpatient Services for adults
2.1	Intensive Outpatient Services for adults

Contractor agrees to provide, at a maximum, the following services at the onset of this Agreement:

A. Bakersfield

a. 150 slots of Level 1.0 Outpatient services for adults
b. 75 slots of Level 2.1 Intensive Outpatient services for adults
c. Contingency Management Services for adults with moderate to severe Stimulant Use Disorder
d. PC 1000 Drug Diversion Services

The turnover rate for levels 1.0 and 2.1 is about two (2) times per year based on an average treatment length of six (6) months, according to current utilization rates.

II. GUIDING PRINCIPLES

Kern Behavioral Health and Recovery Services (KernBHRS) has embarked on a mission to develop a system-wide performance improvement process with the goal of implementing a system of care characterized by providing supportive, accessible, recovery-oriented individual and family-centered, culturally competent services that are capable of supporting those with co-occurring mental health conditions and substance use disorders. Substance use disorder providers have been specifically welcomed into this process due to recognition of the fact that, among clients receiving substance use disorder treatment, the presence of co-occurring mental health conditions, whether previously diagnosed or not, is sufficiently common to be considered an expectation.

The following standards are intended to be consistent with the aforementioned mission, and to provide a structure for services offered within the KernBHRS Substance Use Disorder System of Care (SUD SOC) that are not regulated under existing requirements. Providers receiving funding from Drug Medi-Cal (DMC), the Substance Use Prevention and Treatment Block Grant (SUPT) Discretionary, Perinatal Drug Medi-Cal, and/or SUPT Perinatal Set Aside, must also comply with the regulations and standards of those funding sources and programs. The above-mentioned funding sources and programs support an integrated approach to addressing co-occurring mental health conditions during substance use disorder treatment.

A. Contractor accepts that it is a member of a network of providers of KernBHRS's SUD SOC, a continuum of care based on American Society of Addiction Medicine (ASAM) criteria which includes prevention, early intervention, outpatient treatment, residential treatment, care coordination, recovery services, medications for

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addiction treatment, contingency management, peer services, opioid treatment services and withdrawal management. Contractor readily accepts and shares the responsibility of providing quality services to all clients.

B. Contractor shall demonstrate support of KernBHRS's SUD SOC by sharing information and resources and by actively seeking to recruit staff and volunteers who are multilingual and who represent the ethnic and cultural diversity of the community in which it serves.

C. Contractor recognizes that within its current caseload are clients who have co-occurring mental health conditions. It is important that these clients are welcomed into care without experiencing stigma, and that the number of these clients is accurately identified so that needs can be effectively recognized and met.

D. Contractor shall strive to participate in local area collaboration efforts and organized collaborative organizations and networks to raise awareness and educate its partners regarding the scope and breadth of substance use disorder problems in the community it serves.

E. Contractor's programs and activities shall operate in a drug and alcohol-free environment. Any information produced through these funds, and which pertain 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. 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 per HSC Section 11999-11999.3.

F. Contractor shall collaborate with other programs, including behavioral health programs and physical healthcare providers, when using multiple social systems and levels within a community.

G. The family unit and social support are considered integral parts of the treatment program for a person experiencing substance use or co-occurring disorders. Treatment interventions must always consider issues of family dynamics and key social relationships, including the possible presence of co-occurring mental health conditions within the family.

H. Contractor shall make efforts to provide outreach to the diverse cultural and ethnic groups within the community served, while ensuring that the dignity of clients and communities is preserved.

I. Contractor shall ensure that all pertinent written, oral, and symbolic client and family materials, including but not limited to signage, pamphlets, educational brochures, referrals to resources or speakers, audiovisuals, and self-help kits, are interpreted and translated in the primary language, and from the appropriate cultural perspective, of the communities served.

J. Contractor shall continually evaluate the needs of the communities being served and shall always endeavor to meet those needs. Further, Contractor shall incorporate the values of the community into its activities, services, and programs.

K. Cultural and Linguistic Proficiency: To ensure equal access to quality care by diverse populations, Contractor shall adopt the federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards.

L. If receiving Substance Use Prevention and Treatment (SUPT) Block Grant funds, Contractor shall comply with the pre-award risk assessment requirements contained in 2 CFR Part 200 Uniform Administrative Requirements, Cost Principles for Federal Awards, commonly referred to as the Uniform Guidance.

M. Contractor shall be subject to an annual fiscal review conducted by KernBHRS, per state agreement guidelines.

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N. Contractor shall be subject to all current and prior Department of Alcohol and Drug Program Bulletins and DHCS Behavioral Health Information Notices relevant to the services provided through this contract.

O. Medi-Cal funded Contractors shall adhere to the Minimum Quality Drug Treatment Standards for DMC.

P. If SUPT-funded, Contractor shall adhere to the Minimum Quality Drug Treatment Standards for SUPT.

Q. Contractor shall adopt the DMC-ODS Clinical Practice Guidelines developed by KernBHRS, which follow the Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Improvement Protocols (TIPS) and Technical Assistance Publications (TAPs) series.

III. FUNDING SOURCES

A. Drug Medi-Cal (DMC)**:** A program to fund medically necessary alcohol and drug treatment services for clients meeting eligibility requirements, including limited income and resources.

B. 2011 Realignment: Realignment funding is provided through sales tax and vehicle license fee revenues. Each county is allotted these funds through a statewide formula for substance use disorder treatment services. These funds are available as a match to the Federal Financial Participation and may also be used to cover room and board costs.

C. Perinatal Drug Medi-Cal: Services for pregnant or postpartum (defined as the three hundred and sixty five (365) day period after the last day of pregnancy) women, including substance use disorders treatment services and certain case management services including childcare during treatment sessions, and transportation. Funding is applicable for clinical residential services only.

D. SUPT Perinatal Set Aside: Enhanced services for women who are either pregnant and abusing substances, or women who are parenting and abusing substances, with a child or children ages birth through seventeen (17) years. This funding is available to those women who are attempting to regain legal custody of their child or children. Services are subject to the most current version of the Perinatal Practice Guidelines published by DHCS. Funding only available for room and board costs for qualifying residential stay.

E. Proposition 47 Grant Funds: Funding awarded by the Board of State and Community Corrections to support behavioral health treatment. This funding can be utilized as a match to the Federal Financial Participation cost of DMC-ODS treatment for clients referred by the courts for Proposition 36.

IV. ACCESS TO TREATMENT

A. KernBHRS's SUD SOC allows for clients to access services directly using any outpatient KernBHRS approved treatment provider site or through the KernBHRS SUD Access Line, which is the screening and referral team for KernBHRS SUD SOC. The SUD Access Line will screen and refer clients with substance use problems. Following a screening through the SUD Access Line, clients are offered a referral to a KernBHRS contracted treatment provider based on one (1) or more of the following: level of care needed, required funding need, client preference, and/or location proximity to the client. When clients access services directly at a contracted treatment provider, the treatment provider shall provide pre-assessment services (if needed), complete an assessment and all required intake documentation, and admit the client to a level of care based on medical necessity.

B. Contractor requirements to receive referrals: Contractor shall document assessment appointment availability using the Calendar within the Department Electronic Health Record (EHR) and make the appointments available for use by the SUD Access Line for the purpose of referring individuals.

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C. Contractor shall receive referrals through one of the following methods:

1. For individuals screened face-to-face or through the SUD Access Line, Contractor shall receive an SUD Access Line Referral through their program calendar in the EHR. Contractor shall have the assigned staff complete an ROI in the EHR with the client, no later than at the time of first service/assessment, to allow for ongoing communication between the KernBHRS SUD Division and Contractor.

2. If an individual presents at Contractor's program prior to screening through KernBHRS, Contractor shall offer pre-assessment services, schedule the individual for an assessment, or alternatively, link the client through the SUD Access Line. Contractor shall have a clinician complete an ROI for **Kern Behavioral Health and Recovery Services SUD Division** with the individual requesting services. Contractor shall scan into the KernBHRS EHR any ROI that is completed or signed outside of the KernBHRS EHR.

D. County of Responsibility: Contractor is responsible for verifying Medi-Cal eligibility at least monthly. Contractor shall provide DMC-ODS services to Kern County Medi-Cal beneficiaries. KernBHRS is not responsible for reimbursing services for clients with a different County of Responsibility indicated on their Medi-Cal. If client resides in Kern, but Medi-Cal is listed as any other county, then Contractor shall assist the client to initiate the inter-county transfer of Medi-Cal coverage. Upon documented initiation of the inter-county transfer, contractor shall inform the Billing team. KernBHRS shall ensure beneficiaries receive all covered DMC-ODS services. According to BHIN 21-032, if the beneficiary moves to a new county and initiates an intercounty transfer, the new county is immediately responsible for DMC-ODS treatment services.

E. Informing Materials:

1. Contractor shall make the DMC-ODS Clinical Practice Guidelines available in print or electronically to clients upon request.

2. Contractor shall make written materials in English and Spanish available to clients with special needs, for example, visual disability or limited reading proficiency.

3. Contractor shall inform clients that information is available in alternative formats and how to access those formats. Contractor shall track requests for alternative formats and additional Beneficiary Handbooks in the KernBHRS provided template.

4. Contractor shall follow requirements included in KernBHRS policy 11.1.13 Beneficiary Informing Materials.

5. Contractor shall adopt and make available to all clients and prospective clients, a client bill of rights that meets the requirements of Behavioral Health Information Notice No: 23-045: California Ethical Treatment for Persons with Substance Use Disorder (SUD) Act: Implementation of Senate Bill 349 (SB 349).

F. Service Priority:

1. Service Priority will be set in the following order:

a. Urgent referrals (including: Pregnant injecting drug users, Pregnant substance users; individuals using a life-threatening combination of substances (i.e. alcohol and benzodiazepines or heroin, cocaine and alcohol.), individuals at risk of severe withdrawal or severe reactions to withdrawal, individuals with recent hospitalization due to SUD (including individuals in the process of discharge from an acute care hospital or withdrawal management), and individuals requesting services from a Recovery Station, the Psychiatric Evaluation Center (PEC), or the Crisis Walk in Clinic (CWIC).

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b. Injecting drug users; and

c. All others.

G. Timeliness of Access into Treatment:

1. Contractor shall ensure to meet all applicable timeliness standards outlined in KernBHRS Policy 5.1.12, Timeliness of Access to Services.

2. Contractor shall have a system in place to address timeliness requirements. When Contractor's available assessment and first-time service appointments do not meet the standards for timeliness into treatment, SUD Access Line shall notify Contractor. Contractor shall coordinate to add appointments to bring appointment availability into compliance.

3. Contractor shall track all clients' initial request for services and follow-up services as outlined in KernBHRS Policy 5.1.12, Timeliness of Access to Services, using the current Timeliness Record KernBHRS has available in the EHR.

H. Contractor may begin providing outpatient pre-assessment services to clients prior to their assessment or first-time service appointment as allowable by DHCS Behavioral Health Information Notices 23-068; and BHIN 24-001 and shall document these services accordingly. When access to treatment exceeds the timeliness standards described in KernBHRS Policy 5.1.12, Contractor shall refer clients to the SUD Access Line for a referral to an alternate provider.

I. Contractor agrees to report information regarding program capacity and waiting lists by submitting a Drug Abuse Treatment Access Report (DATAR) to County as outlined in KernBHRS policy 5.6.24, *Substance Use Disorder Drug Abuse Treatment Access Reporting (DATAR)*.

J. There shall be no barrier to access based solely on the presence of a current or past co-occurring psychiatric or medical diagnosis, or solely due to the client receiving prescribed medication.

K. Admission and readmission criteria shall be in a written policy as stated in Paragraph XI.B of this document. Any exclusionary criteria shall be submitted to the KernBHRS SUD SOC Administrator for approval. Contractor shall submit exclusionary criteria for review prior to the agreement start date.

V. SERVICES

A. Description of Services: Contractor shall strive to provide all services in a welcoming, recovery-oriented, family inclusive, culturally competent, and co-occurring capable manner. Level of care placement will be based on the ASAM criteria in the continuum of care that ranges from early intervention to medically managed inpatient treatment.

1. Early Intervention Services (ASAM Level of Care 0.5)

a. Description: Early intervention services are covered DMC-ODS services for beneficiaries under the age of twenty-one (21). Any beneficiary under the age of twenty-one (21) who is screened and determined to be at risk of developing an SUD may receive any service component covered under the 1.0 outpatient level of care as early intervention services. An SUD diagnosis is not required for early intervention services. All DMC-ODS claims shall include a CMS approved ICD-10 diagnosis code. In cases where services are provided due to a suspected SUD that has not yet been diagnosed, options are available in the CMS approved ICD-10-CM code list. For example, these include codes for "Other specified" and "Unspecified" disorders," or "Factors influencing health status and contact with health services" as

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described in BHIN 22-013. Early intervention services may be delivered in a wide variety of settings, and can be provided in person, by telehealth, or by telephone. Nothing in this section limits or modifies the scope of the EPSDT mandate.

b. Services: Early intervention Services include all the services listed under Outpatient Treatment Services. Please note that a full assessment utilizing the ASAM criteria is not required for a beneficiary under the age of twenty-one (21) to receive early intervention services; an abbreviated ASAM screening tool may be used. If the beneficiary under twenty-one (21) meets diagnostic criteria for SUD, a full ASAM assessment shall be performed and the beneficiary shall receive a referral to the appropriate level of care indicated by the assessment.

c. Duration: Early intervention services have a variable length of stay and are provided under the outpatient treatment modality and must be available as needed based on individual clinical need, even if the beneficiary under age twenty-one (21) is not participating in the full array of outpatient treatment services.

d. Treatment Goals: The goal of early intervention services is to reduce the harms associated with substance misuse or risky behavior, to improve health and social function, and to prevent substance misuse and risky behaviors to advance into a disorder requiring additional substances use disorder treatment services.

2. Outpatient Treatment Services (ASAM Level of Care 1.0)

a. Description: Outpatient Treatment Services (also known as Outpatient Drug Free or ODF) are provided to beneficiaries when medically necessary and consist of less than nine (9) hours of services per week for adults and less than six (6) hours per week for adolescents. These services may be provided in person, by telehealth, or by telephone.

b. Services: Outpatient services shall include the following:

i. Assessment, Care Coordination, counseling (individual and group), family therapy, medication services, MAT for Opioid Use Disorder (OUD), MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs, patient education, recovery services, and SUD crisis intervention services.

ii. Contractor shall either directly offer Medication for Addiction Treatment (MAT) or offer a warm handoff referral directly to a MAT provider or refer clients to the SUD Access Line for a MAT referral to a Narcotic Treatment Program (NTP) or an outpatient MAT provider for all clients diagnosed with a disorder treatable with FDA-approved medications and biological products at any time during treatment services.

a) Contractor shall have in place a MAT policy that is in compliance with HSC Section 11834.28(c)(1)) and 11834.28(c) outlined in Behavioral Health Information Notice No: 23-054 Medications for Addiction Treatment (MAT) Services Requirements for Licensed and/or Certified Substance Use Disorder (SUD) Recovery or Treatment Facilities.

c. Duration: Outpatient services have a variable length of stay, and progress will be measured based on an individualized problem list. Determination of duration of treatment will incorporate consideration of the severity of the client's illness, treatment engagement, and his or her response to treatment based on key indicators.

d. Treatment Goals: At the end of treatment, the client should demonstrate an understanding of factors that have contributed to their drug and/or alcohol use; an ability to deal with daily stressors without the

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use of drugs and/or alcohol; engagement and participation in fulfilling activities that support recovery; and a commitment to abstinence.

3. Intensive Outpatient Treatment Services (ASAM Level of Care 2.1)

a. Description: Intensive outpatient services are provided to beneficiaries when medically necessary in a structured programming environment. These services may be offered for 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 clients under the age of 21 with a focus on recovery or motivational enhancement. Services may exceed the maximum based on individual medical necessity.

b. Services: Intensive Outpatient Services include the following:

i. Assessment, Care Coordination, counseling (individual and group), family therapy, medication services, MAT for Opioid Use Disorder (OUD), MAT for Alcohol Use Disorder (AUD) and other non-opioid SUDs, patient education, recovery services, and SUD crisis intervention services.

ii. Contractor shall either directly offer Medication Assisted Treatment (MAT) or offer a warm handoff referral directly to a MAT provider, or refer clients to the SUD Access Line for a MAT referral to a Narcotic Treatment Program (NTP) or an outpatient MAT provider for all clients diagnosed with a disorder treatable with FDA-approved medications and biological products at any time during treatment services.

a) Contractor shall have in place a MAT policy that is in compliance with HSC Section 11834.28(c)(1)) and 11834.28(c) outlined in Behavioral Health Information Notice No: 23-054 Medications for Addiction Treatment (MAT) Services Requirements for Licensed and/or Certified Substance Use Disorder (SUD) Recovery or Treatment Facilities.

c. Duration: Intensive Outpatient Services have a variable length of stay, and progress will be measured based on the progress made on the problem list. Determination of duration of treatment will incorporate consideration of the severity of the client's illness, treatment engagement, and his or her response to treatment based on key indicators.

d. Treatment Goals: At the end of treatment, the client should demonstrate an understanding of factors that have contributed to his or her drug and/or alcohol use; an ability to deal with daily stressors without the use of drugs and/or alcohol; engagement and participation in fulfilling activities that support recovery; and a commitment to abstinence.

4. Contingency Management

a. Description: Contingency Management (CM) is an evidence-based, cost-effective behavioral treatment for SUD that provides motivational incentives to treat individuals and reinforces positive behavior change for an individual to reduce the use of stimulants. DHCS began piloting Medi-Cal coverage of CM through the Recovery Incentives Program.

b. Services: The Recovery Incentives Program is intended to complement SUD treatment services and other evidence-based practices already offered by DMC-ODS providers. The services provided in the Recovery Incentives Program are for clients with a moderate to severe stimulant use disorder and involve providing urine drug tests at pre-determined intervals. If these drug tests are stimulant free, the individual is eligible for monetary incentives that increase in value over time.

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i. Participation in the Recovery Incentives Program is optional for DMC-ODS providers, participating providers must receive KernBHRS SUD Administrator Approval and follow the program specifications outlined in Exhibit A-1 of this agreement.

B. Coordination and Continuity of Care

1. Contractor shall comply with the coordination and continuity of care requirements as set in 42 CFR §438.208. This shall include at a minimum:

a. All clients receiving DMC-ODS services from Contractor shall have, or, if under twenty-one (21) years of age, be at risk of developing a substance use disorder.

b. Contractor shall identify mechanisms to assess all clients, produce, and maintain a problem list for those clients that have a substance use disorder. The problem list shall:

i. Be developed with client participation, and in consultation with any providers or significant support person caring for the client.

ii. Be 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). Relias course “Person-Centered Planning in Behavioral Health” (REL-BHC-0-PCPBH) is recommended for direct service provider staff.

iii. Be in accordance with quality assurance and utilization review standards.

iv. Be reviewed and revised at any point in treatment by all service providers acting within their scope of practice, as client’s circumstances or needs change, at the request of the client, or at generally accepted standards of practice per DHCS BHIN 23-068.

v. List symptoms, conditions, diagnosis, social drivers, and/or risk factors identified through assessment, evaluations, crisis encounters, or other types of service encounters as per DHCS BHIN 23-068.

c. Contractor shall have procedures in place to deliver care and to coordinate services for all clients.

d. Clients shall have a designated primary server and be provided with contact information for primary server.

e. Contractor shall assure uninterrupted transitions in level of care, other healthcare services, and community and social support services.

f. Contractor shall meet the standards of timeliness into treatment.

g. Contractor shall maintain and share, as appropriate, the client health record in accordance with professional standards.

h. Contractor shall ensure that in the process of coordinating care, each client’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.

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2. Treatment Modifications:

a. Contractor shall request a treatment modification from the SUD Access Line following the established process in the "Guide to Level of Care Modification". A treatment modification is completed when an LPHA determines that a client is:

i. Ready to transition to a lower level of care; or

ii. In need of a higher level of care; or

iii. The needed level of care is not available in the program where the client is being served. Or

iv. The client is requesting to move from one provider site to another at the current level of care, and that new provider site is located at a different physical location.

b. Services shall continue at the assigned program and level of care until the treatment modification form is approved, and an appointment can be secured at the requested level of care. The SUD Access Line will communicate with the requesting provider so that the client can be informed of the new provider location and appointment date and time, provided there is a valid Release of Information (ROI) to do so

c. The requesting provider will assist the client to transition to the newly approved level of care.

d. The requesting provider shall not make direct referrals to other SUD treatment providers.

C. Zero Suicide: Contractor is required to participate in KernBHRS' system-wide suicide prevention initiative. This participation includes but is not limited to mandatory screening of clients at all contacts (unless less frequent screenings are indicated) assessing, and treating individuals identified as at risk according to the Zero Suicide Protocol as outlined in Policy 5.1.32, Zero Suicide Protocol for Suicide Safe Care.

D. Transportation

1. Senate Bill 43 (SB43) made substantive changes to the Lanterman-Petris-Short (LPS) Act and amended the definitions of "gravely disabled" contained in subdivisions (h)(1)(A) and (h)(2) of Welfare and Institutions Code, Section 5008.

2. "Gravely disabled" now means a condition in which a person:

a. As a result of a mental health disorder, impairment by chronic alcoholism, severe substance use disorder, or a co-occurring mental health disorder and a severe use disorder;

b. Is unable to provide for their basic personal need for food, clothing, shelter, personal safety, or necessary medical care.

3. As clients may be detained on a 5150 hold and receive intensive treatment, they may be referred for ongoing SUD treatment after discharge from hospitalization.

4. After receipt of a referral from an inpatient psychiatric unit, acute care hospital or detoxification unit requesting ongoing SUD treatment, contractor shall provide transportation assistance to clients either by providing transportation directly, or connecting the individual to utilize their Medi-Cal Managed Care transportation benefits.

VI. CLINICAL COMPONENTS

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A. Assessment

1. Contractor is required to use the KernBHRS assessment tool in the current EHR or an approved American Society of Addiction Medicine (ASAM) Criteria based assessment.

2. The assessment shall include a typed or legibly printed name, signature of the service provider, provider's title (credentials) and date of signature.

3. The assessment shall include the provider's determination and recommendations for ASAM Level of Care and medical necessity of services, and additional provider referrals as clinically appropriate. The problem list and progress notes shall support the medical necessity of each service provided.

4. The assessment is an individual session conducted by a Licensed Practitioner of the Healing Arts ("LPHA"), or license-eligible LPHA using a Department-approved tool, based on ASAM Criteria dimensions and risk ratings, and other additional KernBHRS-approved assessment instruments. The assessment is used to determine medical necessity, eligibility, and level of care for SUD treatment services. Initial assessment may be conducted in person (face to face), by telehealth (synchronous audio and video), or by telephone (synchronous audio only) following BHIN 23-018.

a. Contractor shall obtain prior approval, in writing, from SOC Administrator to request an alternative staffing classification to conduct ASAM assessments, if an LPHA is not available.

b. Registered and/or Certified counselors may conduct assessments, and shall present their findings to an LPHA, who will then determine the appropriate diagnosis for the client.

c. Counselor or therapist shall document this discussion as a Targeted Case Management service in the electronic health record to demonstrate that consultation and discussion occurred between the counselor who conducted the assessment and the LPHA determining one or more applicable substance use disorder diagnoses.

5. The assessment may be completed with the client, or the client and a supportive family member, or with another individual that the client requests, if indicated and with the appropriate client authorization to release information.

6. The assessment interview is conducted for developing a biopsychosocial profile of the client and shall include the six (6) ASAM Criteria dimensions of withdrawal potential, medical conditions, emotional cognitive or psychiatric, motivation for recovery, continued relapse/problem potential, and recovery environment.

7. The assessment must be completed in a manner that considers the client's age, gender, ethnicity, sexual orientation, stage of change, and all cultural or special needs.

8. The assessment is the foundation for the development of the problem list and the initiation of clinical services.

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9. Contractor shall ensure that individuals are referred to any additional indicated levels of care identified through the assessment. Contractor shall follow the treatment modification process to request a referral(s) to additional level(s) of care based on assessment results.

10. Clinically appropriate and medically necessary services are covered and Medi-Cal reimbursable when provided prior to the determination of a diagnosis, during the assessment, or prior to determination of whether DMC-ODS access criteria is met, even if the assessment ultimately indicates the client does not meet the access criteria for the delivery system in which they initially sought care.

B. Level of Care Placement

1. For beneficiaries twenty-one (21) and over, a full assessment using the ASAM Criteria shall be completed as expeditiously as possible.

2. For beneficiaries under twenty-one (21), a full assessment using the ASAM Criteria shall be completed as expeditiously as possible.

3. A full ASAM Criteria Assessment is not required to deliver prevention and early intervention services for beneficiaries under twenty-one (21); a brief screening ASAM Criteria tool is sufficient for these services.

4. If a client withdraws from treatment prior to completing the ASAM Criteria assessment, or initial provisional referral tool for preliminary level of care recommendations, client shall not be required to begin receiving DMC-ODS services.

5. Assessments should be updated as clinically appropriate, such as when the client's condition changes.

C. Medical Necessity of Services

1. DMC-ODS services must be medically necessary. Pursuant to W&I Section 14059.5(a), for individuals twenty-one (21) years of age or older, a service is "medically necessary" or a "medical necessity" when it is reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain.

2. For individuals under twenty-one (21) years of age, a service is "medically necessary" or a "medical necessity" if the service is necessary to correct or ameliorate screened health conditions. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or an SUD are considered to ameliorate the condition and are thus covered as EPSDT services. (Section 1396d(r)(5) of Title 42 of the United States Code; W&I Section 14059.5(b)(1)).

D. Problem List

1. The provider(s) responsible for the client's care shall create and maintain a problem list.

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2. A problem list is a list of symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters.

3. The problem list shall include, but it is not limited to, the following:

a. Diagnosis/es identified by a provider acting within their scope of practice if any. Diagnosis-specific specifiers from the current Diagnostic and Statistical Manual of Mental Disorders (DSM) shall be included with the diagnosis, when applicable.

b. Current International Classification of Diseases (ICD) Clinical Modification (CM) codes.

c. Problems identified by a provider acting within their scope of practice, if any.

d. Problems identified by the client and/or significant support person, if any.

e. Name and title (or credentials) of the provider that identified, added, or resolved the problem, and the date the problem was identified, added or resolved.

4. A problem identified during a crisis encounter (Crisis intervention) may be addressed by the provider (within their scope of practice) during that service encounter, and subsequently added to the problem list.

5. Providers shall update the problem list on an ongoing basis to reflect the client's current presentation. Providers, within their scope of practice, shall add to, amend, or resolve problems from the problem list when there is a relevant change to a client's condition.

6. Problem lists shall be updated within a reasonable time and in accordance with generally accepted standards of practice.

E. Physical Exams

1. Clients are required to have a physical examination. If they have had one within the twelve (12)-month period prior to admission, the physician shall review the results within thirty (30) calendar days of admission (for outpatient; ten (10) days for residential). The physician shall type or legibly print their name, sign, and date documentation to support that they have reviewed the physical examination results, and the signature shall be adjacent to the typed or legibly printed name. (This may be done on the physical examination results themselves, in a progress note, or on a form of the program's creation).

2. If the client has not had a physical examination within the twelve (12)-month period prior to admission, the physician may perform a physical examination within thirty (30) calendar days of admission for outpatient programs. Alternatively, the program may assist the client in obtaining a physical exam through primary care.

3. The physical examination results are to be uploaded in the client electronic health record.

F. Progress Notes

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1. Providers shall create progress notes for the provision of all treatment services. Each progress note shall provide enough detail to support the procedure code selected for the service type as indicated by the service code description.

a. Should more than one provider render a service either to a single client or to a group, at least one progress note per client must be completed. The note must be signed by at least one provider. The progress note shall clearly document the specific interventions/involvement and duration of direct patient care for each provider of the service.

2. Progress notes shall include:

a. The type of service rendered.

b. A narrative describing the service, including how the service addressed the client's behavior health need (i.e. symptom, condition, diagnosis, and/or risk factors).

c. The date that the service was provided to the client.

d. Duration of direct patient care for the service, including travel and documentation time.

e. Location/Place of the service.

f. A typed or legibly printed name, signature of the service provider and date of signature.

g. Next steps including, collaboration with the client, collaboration with the other provider(s) and any update to the problem list as appropriate.

h. For service notes that include a Care Plan, notes shall document a fully completed care plan with client's goals for treatment, measurable objectives, list of services to assist client in achieving their goals and a transition plan.

3. Providers shall complete progress notes within three (3) business days of providing a service, except for crisis services notes, which shall be completed within one (1) calendar day. The day of the service shall be considered day zero (0).

4. For Group Services:

a. When a group service is rendered, a list of participants is required to be documented and maintained by the provider.

b. Every participant shall have a progress note in their clinical record that documents the service encounter and their attendance in the group, and includes the information listed in section F (2) (a-h) above.

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c. The progress note for the group service encounter shall also include a brief description of the client's response/participation to the service.

G. Discharge Planning

1. Contractor shall ensure that a discharge plan is prepared with each client leaving the program, beginning at least thirty (30) days prior to the expected discharge date for LOC 1.0 and LOC 2.1. The discharge plan shall provide information related to the client's progress made in treatment, plans to support abstinence, and shall include provision for continuing medical care, behavioral health care and recovery services, when appropriate.

2. Contractor shall coordinate with the case manager and the SUD Access Line to ensure the pending transition in treatment is smooth and timely prior to discharge.

3. The discharge plan or my Recovery Plan shall be completed with the participation of the client.

4. A copy of the discharge plan/Recovery Plan shall be maintained in the client record.

5. A KernBHRS SUD Discharge Summary shall be completed within the body of the service note for all discharges regardless of treatment outcome which shall include the following:

a. The duration of the client's treatment as determined by the dates of admission to dates of discharge from treatment.

b. The reason for discharge.

c. A narrative summary of the treatment episode.

d. Vocational/educational goals.

e. The client's Prognosis; and

f. Client's comments.

H. Individual Counseling

1. Individual counseling is a clinical intervention provided by SUD clinical staff in order to effect psychological, emotional, or behavioral change consistent with the client's assessment and problem list that focuses on symptom reduction, and provide restoration, improvement, and maintenance of functioning.

2. Individual counseling can include contacts with a collateral party if the purpose of the collateral's participation is to focus on the treatment needs of the client by supporting the achievement of the client's treatment goals.

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3. All individual counseling sessions must be documented in the client record following a KernBHRS-approved format and include at minimum: date and duration of the service; identification of the problem list and problem addressed; interventions provided, client's response/participation in service, next steps, completed care plan, and the clinician's signature and title.

4. To monitor progress throughout the treatment episode, individual counseling sessions shall be provided in accordance with the client's individualized problem list, ASAM evaluation, using clinical judgement, and at the discretion of the clinician. The minimum requirements are listed below:

a. Clients will receive a minimum of one (1) monthly individual counseling session to address conditions along the six (6) ASAM dimensions. Individual sessions may and shall happen more often as clinically indicated.

I. Crisis Intervention

1. Crisis Intervention visits are contacts between a therapist or counselor and a client in crisis, which focus on alleviating immediate crisis problems specifically related to an actual relapse or an unforeseen event or circumstance, which presents an imminent threat of relapse or significant risk of harm to self or others. Crisis intervention services shall be limited to stabilization of the client's emergency.

J. Group Counseling

1. Group Counseling is defined as a contact in which one (1) or more counselors treat two (2) or more clients at the same time, focusing on the needs of the clients. For outpatient programs, clinical groups shall consist of at least two (2) clients but not more than twelve (12) clients, with a minimum of one (1) Drug Medi-Cal funded client. The session may be conducted by phone, telehealth, or in the office.

2. All group counseling sessions shall be documented in the client record. Documentation shall follow a KernBHRS-approved format and include, at minimum: the date and duration of the service; a description of the intervention provided to the entire group of participants and how this addresses the client's problem list, client's response to the service, next steps, completed care plan, and the clinician's signature and title.

3. Group counseling services shall be provided at a minimum of one (1) time weekly. More frequent group services may be provided based on clinical need and/or judgement. A list of participants is required to be documented and maintained by the provided to document client attendance and shall conform to all applicable BH Informational Notices.

K. Patient Education

This service consists of providing research-based education on addiction, treatment, recovery, and associated health risks. Psycho-educational groups are designed to educate clients about substance use, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to clients' lives, to instill self- awareness, suggest options for growth and change, identify community resources that can assist clients in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf. A list of participants is required to be documented

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and maintained by the provided to document client attendance and conform to all applicable DMC-ODS, Title 22 requirements, and BH Informational Notices regarding documentation and group size limits. Services may include topics including parenting, domestic violence, anger management, prenatal and post-natal drug effects, and research-based health information. Human immunodeficiency virus (HIV) education and intervention topics should include the following:

1. Health Education

a. Contractor shall provide clients with education about the prevention of HIV/AIDS, tuberculosis, and Hepatitis C.

b. The Department may assist the provider in acquiring screening and testing services for HIV/AIDS, tuberculosis, and Hepatitis C, but ultimate responsibility for referrals to screening and testing remains with the provider.

c. Contractor shall document the provision of the health education in the client record.

2. HIV Early Intervention Services

a. Contractor shall directly provide, or arrange for the provision of, HIV early intervention services to clients in substance use disorder treatment programs. Early intervention with respect to HIV disease is defined by Title 42, United States Code, Section 300x-24(b) (7) (B) as: Pre-test counseling, testing clients with respect to such disease, and appropriate post-test counseling.

b. All programs shall ensure that a confidential area is provided for pre/post-test counseling and collection of specimens for testing purposes.

c. HIV counselors may attend group alcohol and other drug (AOD) treatment sessions for the purposes of providing HIV education and offering testing services in a confidential manner.

d. Early intervention services for HIV disease must be undertaken voluntarily by, and with the informed consent of, each client. In addition, accepting such services cannot be a requirement of receiving substance use disorder treatment or any other such services.

e. Documentation related to clients receiving HIV testing and counseling shall be documented in accordance with KernBHRS Policy 10.1.6.

f. Contractor shall ensure that health education materials are current, available, and accessible, in English and Spanish versions.

L. Treatment services shall be provided in person, by telephone, or by telehealth and in any appropriate place in the community. Face-to-face services may be conducted in-person or through telehealth.

1. If a visit is provided through telehealth (synchronous audio or video) or telephone, the health care provider is required to obtain consent for the telehealth or telephone service, at least once prior to initiating applicable

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health care services via telehealth to a client; an explanation that the beneficiaries have the right to access covered services that may be delivered via telehealth is voluntary and that consent for the use of telehealth can be withdrawn at any time by the client without affecting their ability to access covered services in the future; an explanation of the availability of Medi-Cal coverage for transportation services to in-person visits when other available resources have been reasonably exhausted; and the potential limitations or risk related to receiving services through telehealth as compared to an in-person visit, to the extent any limitations or risks are identified by the provider. The provider must document in the patient Electronic Health Record the provision of this information and the client's verbal or written acknowledgement that the information was received.

M. Contractor shall review and reference KernBHRS Policy 5.1.14, Service Code Descriptions, for detailed service code descriptions and scope of practice information.

VII. COMMUNICATION WITH REFERRING AGENCIES

A. A current and valid consent to release information must be documented in the EHR before there is any communication with a referring agency if the client requests such communication.

B. Progress Reports: Contractor shall complete a monthly client progress report for the appropriate referring agency. Such reports may include information on client attendance, the program's clinical drug testing results, level of participation and compliance in treatment, fee compliance, progress evaluation and recommendations.

C. Contractor shall immediately inform referring agency of any unusual circumstances or developments that occur within the treatment setting, that may have an effect on the client's status with the referring agency, such as a need to take a leave of absence from the treatment program, changes of address, employment status, failure to comply with treatment, including fee compliance and positive drug tests completed for clinical purposes.

D. Contractor shall work collaboratively with the referring agency to address client needs, including but not limited to, vocational, employment, physical health care, etc. throughout treatment.

E. Final Discharge Progress Report: Contractor shall forward the final progress report to the referring agency prior to assignment closing in the electronic health record. Final progress report shall include the date of discharge, the reasons for the discharge, and other pertinent information.

VIII. OTHER TREATMENT RELATED SERVICES

A. Drug Testing

1. Clinical Drug Testing: All substance use disorder programs shall include drug testing as a part of their usual clinical procedures in addition to any court-ordered drug testing requirements. Contractor shall obtain and maintain current a Clinical Laboratory Improvement Amendments (CLIA) Certificate of Waiver to conduct drug testing onsite and maintain a current copy of CLIA certificate with Kern BHRS SUD SOC Administrator or designee. Drug testing shall be conducted at a minimum of one (1) time every thirty (30) days; additional drug testing may occur at random or for cause.

a. Clinical drug testing is administered as a therapeutic tool in treatment to address denial of substance use disorder and address substance use behavior with clients. Programs may refer to the consensus

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document by the American Society of Addiction Medicine, Appropriate Use of Drug Testing in Clinical Addiction Medicine for additional guidance.

b. Tests may be conducted through urine, or oral fluid (saliva), hair or blood. At a minimum, a five-panel screen must be administered.

c. Programs must advise clients upon admission that they are subject to testing according to the program policy and to enhance treatment services.

d. All positive test results must be discussed with the client, and such discussion shall be documented in the client record. Clinical interventions shall be provided to help clients achieve negative tests.

e. Program ordered drug testing shall be at no cost to the client.

2. Contractor shall adhere to the Urine Surveillance standards specified in the State of California Standards for Drug Treatment Programs, 1981. Programs must have in place a policy specifying drug testing procedures. The policy must address the following:

a. Handling of client relapses

b. Description of the conditions under which testing will occur, i.e. random draw, after an unexcused absence, prior to discharge.

c. Procedures established to protect against the falsification and/or contamination of any urine sample.

d. Stipulation that the urinalysis result will be documented in the client's file.

B. Clinician Consultation Services:

1. Clinician consultation is not a direct service provided to beneficiaries. This service is designed to support DMC-ODS licensed clinicians with complex cases and may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations. DMC clinicians may consult with designated KernBHRS consultants to support the provision of care. Consultants may include addiction medicine physicians, licensed clinicians, addiction psychiatrists, or clinical pharmacists.

2. The DMC-ODS licensed clinician and consultant may each bill for the clinical consultation service by documenting the consultation service note in the EHR using the designated service code.

3. Consultations may occur between DMC-ODS licensed clinicians and the consultant in person, by telehealth, by telephone, or by asynchronous telecommunication systems.

C. Care coordination

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1. Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support clients with linkages to services and supports designed to restore the client to their best possible functional level.

2. Care Coordination shall be provided to clients in conjunction with all levels of treatment; it may also be claimed as a standalone service. Contractor shall inform clients about care coordination service availability. Contractor shall make referrals to SUD Access Line for care coordination service on behalf of the client when needs are identified. Contractor shall collaborate with KernBHRS SUD care coordination teams to coordinate care.

a. Contractor shall provide care coordination services for all clients receiving SUD treatment services, including for clients that are linked to a KernBHRS SUD care coordination team. Contractor care coordination services shall be documented and billed in adherence to the DMC-ODS care coordination standards. Contractor shall continue to collaborate with KernBHRS SUD care coordination team as deemed necessary to serve the client's needs.

3. Care coordination services offered by Contractor shall be provided by an LPHA, a registered SUD counselor, or a certified SUD counselor.

4. Care coordination services may be provided in person, by telehealth, or by telephone with the client in any appropriate setting in the community.

5. Care coordination services include:

a. Coordinating with medical and mental health care providers to monitor and support comorbid health conditions;

b. Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers;

c. Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural resources, and mutual aid support groups.

D. Recovery Services

1. Recovery Services are designed to support recovery and prevent relapse with the objective of restoring clients to their best possible functional level. Recovery Services emphasize the client's central role in managing their health, use effective self-management support strategies, and organize internal and community resources to provide ongoing self-management support.

2. Recovery Services can be delivered concurrently with other levels of care or as a standalone service. Contractor shall inform clients about recovery services availability for clients in any level of care.

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3. Contractor will ensure client is eligible for recovery services; client does not need to have a diagnosis in remission to access recovery services. Recovery Services can be provided by SUD registered or certified counselors, LPHAs, and license eligible LPHAs.

4. Recovery Services include:

a. ASAM Assessment

b. Group and Individual counseling

c. Care Coordination

d. Family Therapy

e. Recovery Monitoring, including recovery coaching and monitoring designed for the maximum reduction of the client's SUD.

f. Relapse Prevention, which includes interventions designed to teach members with SUD to anticipate and cope with the potential for relapse for the maximum reduction of the client's SUD.

E. Performance Improvement Projects: Contractor shall adhere to performance improvement projects (PIPs) as designated by KernBHRS. This may include participating in routine or ad hoc PIP discussions with KernBHRS and/or DHCS, the requirement to provide clinical interventions, and discussion and reporting on progress.

F. Key Performance Indicators: Contractor shall perform at standard or exceed the applicable identified KernBHRS Key Performance Indicators. These indicators will include mandated measures as determined by DHCS and/or additional standards set by KernBHRS in order to improve quality of care. These indicators may include, and not be limited to, timeliness, successful discharges, CalOMS discharge status, level of care determinations, etc.

G. Self-Help Meetings

Contractor shall require clients to submit proof of attendance at provider-approved self-help meetings, which shall be documented in the case record.

1. Self-help meetings are defined as gatherings that focus on peer support for the purpose of overcoming substance use and other behavioral health disorders.

2. Self-help meetings may include twelve (12)-step meetings, or other meetings approved by the program if they satisfy the definition above.

3. Self-help meetings may also include meetings that have a specific focus on dual recovery.

4. Participation in self-help meetings is required at a minimum of two (2) meetings per month throughout the course of treatment, regardless of level of care.

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H. Sites of Service

1. Contractor shall advise the County Alcohol and Drug Program Administrator or designee in writing of any potential or planned changes to service locations and/or reductions in services provided within sixty (60) calendar days prior to the planned change.

2. Contractor shall obtain and maintain current DHCS certifications and/or licensure of the service site(s).

3. Contractor shall provide all current site certifications/licenses and fire clearance documentation to the KernBHRS SUD SOC Administrator and/or designee upon renewal.

I. Hours of Service

1. Contractor shall provide services at times that meet the needs of the clients. This should include evenings and weekends to increase treatment accessibility.

2. Hours of operation and emergency telephone numbers shall be posted in English and Spanish, and other languages that may be appropriate for the communities served, at the main entrance, and other entrances that clients may commonly access. This posting shall include at least the agency's own crisis and after-hours phone number on the door. Similar information shall be available on a telephone answering device for after-hours and weekend coverage.

J. Medi-Cal Peer Support Services

1. Medi-Cal Peer Support Services means culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self-sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities such as group and individual coaching to set recovery goals and identify steps to reach the goals. Services aim to prevent relapse, empower beneficiaries through strength-based coaching, support linkages to community resources, and to educate beneficiaries and their families about their conditions and the process of recovery.

2. Medi-Cal Peer Support Services may be provided with the beneficiary or significant support person(s) and may be provided in a clinical or non-clinical setting. Medi-Cal Peer Support Services can include contact with family members or other people supporting the beneficiary (defined as collaterals) if the purpose of the collateral's participation is to focus on the treatment needs of the beneficiary by supporting the achievement of the beneficiary's treatment goals. Medi-Cal Peer Support Services can be delivered and claimed as a standalone service, or may be provided in conjunction with other services or levels of care described in this agreement. Medi-Cal Peer Support Services consist of Educational Skill Building Groups, Engagement and Therapeutic Activity services.

3. Medi-Cal Peer Specialists must be certified in accordance with DHCS requirements outlined in Behavioral Health Information Notices 25-010 and 24-001; and any additional DHCS Behavioral Health Information Notices that make changes to these requirements.

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IX. SUCCESSFUL DISCHARGE FROM PROGRAM

A. At discharge from treatment, the progress on the problem list and other key indicators (for example, reduction or elimination of substance use, improvement in relationships and sober support) shall be considered to determine the type of discharge from treatment.

B. A successful discharge from treatment shall be marked by a discharge reason of “achieved goals” or “left before completion with satisfactory progress”. Clinical information will be evaluated for the whole treatment episode to determine whether a discharge is successful or not.

X. DOCUMENTATION AND THE ELECTRONIC HEALTH RECORD

The KernBHRS electronic health record supports the various reporting requirements of the Department. It includes demographic information, referral and discharge codes to match various reporting requirements, and outcomes systems created by state government.

The KernBHRS electronic health record is HIPAA compliant and preserves the security and privacy of each individual served by the Department. Audit reports are monitored by the HIPAA Compliance Officer of the Department.

The KernBHRS electronic health record supports Medi-Cal Rate-Based reimbursement. The billing rules ensure that any service expected to be reimbursed is compliant with regulations including the qualifications and license/certification status of the provider.

A. Contractor shall maintain necessary computer hardware and software to ensure that service data is entered into the Department EHR.

B. Contractor agrees to cooperate with outcomes management and reporting systems requirements for DHCS and KernBHRS.

C. Contractor shall meet the following minimum requirements to coordinate program documentation and access to the Department EHR:

1. All staff shall have a complete Staff Master Worksheet (SMW) submitted to KernBHRS SUD Division, or designee, to participate in (staff credentials entered in the EHR without access to the EHR for billing purposes), and/or receive access to, the Department EHR.

2. This document contains staff category, name, credential, start date, and a request for access to organizations’ reporting programs. Maintain all staff SMWs updated with KernBHRS SUD Division, or designee for Department EHR providers to continue participation and/or access.

3. Contractor shall ensure all staff complete privacy and security training prior to participating in and/or accessing the Department EHR, and annually thereafter.

4. Contractor shall ensure that all staff with access to the Department EHR complete Department EHR SUD training as provided by KernBHRS and as required by the staff role and access to the Department EHR.

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Additional training may be required by KernBHRS if staff is associated with multiple documentation deficiencies during KernBHRS audits, reviews, or other utilization review activities.

D. Additional requirements specific to clerical staff:

1. Clerical staff is responsible for the following:

a. Editing the client demographic information for accuracy.

b. Ensuring the accuracy of client financial information.

c. Ensuring correct pay sources of third-party coverage and closing files upon discharge.

d. Updating Client Program Assignments to the correct clinical staff responsible for the client chart.

E. Additional requirements specific to treatment staff:

1. Treatment staff are responsible for completing the following:

a. CA ASAM

b. Adult/Adolescent California Outcome Measurement System (CalOMS) standard admission standard discharge, and annual update forms

c. Diagnosis Document based upon Assessment/Reassessment

d. Problem List

e. Individual progress notes

f. Group progress notes

g. Progress Reports (if applicable)

h. Client Health Questionnaire

i. Admission Agreement

j. Program Rules

k. Consent for Treatment Form

l. Consent for Text Communication Form

m. Consent for Telehealth Form

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n. Releases of Information and/or a treatment, payment, or healthcare operations release (ASCMI) for KernBHRS SUD Division, client's Medi-Cal managed care plan, and others as appropriate to coordinate care.

o. My Recovery Plan (Discharge Planning)

2. LPHAs and license-eligible staff shall conduct and document assessments and determine medical necessity.

F. Additional requirements specific to clinical supervisors:

1. Supervisors are responsible for completing training on electronic health record reporting as it becomes available through KernBHRS. Reports to be reviewed include, but are not limited to:

a. Caseload Reports – to manage caseloads efficiently.

b. Pending Progress Notes Report- to monitor documented services that are not signed and ensure documentation timeliness standards are met.

c. Services with Errors Reports – to monitor documented services that have errors and ensure these are corrected promptly for services to move to complete status.

d. Diagnosis Errors Reports – to ensure that all enrolled clients have an active and accurate diagnosis

e. Program status reports – to ensure that clients in "Requested" status are transitioned to "Enrolled" or "Discharged" to ensure billing or discharged appropriately.

f. Additional reports as they become available.

G. Electronic health record training requirement may be waived, and/or training may be provided by the contractor internally at the discretion and approval of the KernBHRS SUD SOC Administrator and the Information Technology Services Manager.

H. Timeliness of Documentation

Contractor is responsible for compliance with medical record standards as defined by KernBHRS. All clinical service documentation shall be entered and completed in the electronic health record in a timely manner from the date of service and in accordance to BH Information Notice No.: 23-068 and subsequent updates, as follows:

1. Routine Services: To be documented in the Department EHR within three (3) business days of service.

2. Crisis Services: To be documented in the Department EHR within one (1) calendar day. The day of the service shall be considered day zero (0).

XI. REQUIRED POLICIES AND PROCEDURES

Policies developed for the provision of services in this agreement must include documentation of approval from the Contractor's Board of Directors or other governing body of the program.

A. Minimum Quality Drug Treatment Standards for DMC and/or SUPT: Each Contractor either partially or fully funded through DMC and/or SUPT shall adhere to each DMC and/or SUPT Minimum Quality Drug Treatment Standards, according to funding. Policies and procedures must be present as required by the Quality

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Drug Treatment Standards for DMC and/or SUPT. The required policies and/or procedures include Personnel Policies and Program Management.

B. Admission and Readmission Criteria

1. Contractor shall maintain a written policy that describes the criteria for admission, admission priorities, readmission, and exclusionary criteria. As noted above, the policy must clearly state that no client is automatically excluded due to the presence of past or present co-occurring mental illness or due to receiving appropriately prescribed psychotropic medication, or medications for addiction treatment (MAT).

2. The written policy shall describe the program's screening process and a review of eligibility factors that includes consideration of the client's strengths, needs, abilities, and preferences.

C. Client Fees

1. Contractor shall maintain a written description of its Client Fees Policies.

2. The description must include a complete list of customary fees, and state that the fee schedule will be posted on-site in an area easily accessible to clients.

3. A Uniform Method to Determine Ability to Pay (UMDAP) Form must be fully completed on all clients entering treatment, and when any significant changes in financial status take place. Client fees shall be determined based upon information from the UMDAP.

4. All clients, except those funded by Drug Medi-Cal, are to be assessed fees toward the cost of their treatment based on Contractor's determination of the client's ability to pay in accordance with Section 11991.5 of the Health and Safety Code.

D. Grievance Procedure

1. Contractor shall follow KernBHRS policy #10.1.03 (Grievance and Appeal system) and provide required information on grievances to the Patients' Rights Office of KernBHRS.

2. Discrimination Grievances: "Discrimination Grievance" means a complaint concerning the unlawful discrimination on the basis of any characteristic protected under federal or state law, including sex, race, color, religion, ancestry, national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, gender, gender identity, or sexual orientation. If a grievance related to Transgender, Gender Diverse, and Intersex (TGI), and/or sexual orientation is found in the member's favor, the staff whom the grievance is the subject of will have to receive TGI training within 45 days, and before having contact with members again. Contractor shall inform beneficiaries of processes for filing discrimination grievances as follows:

a. To file with KernBHRS contact:

Discrimination Grievance Coordinator
KernBHRS Patients' Rights and Family Advocacy
PO Box 1000 Bakersfield, CA 93302
Telephone number: 844-360-8250 (TTY 711)
Fax: 661-836-8143
BHRSPatientsRights@KernBHRS.org

b. To file with DHCS Office of Civil Rights contact:

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Office of Civil Rights
Department of Health Care Services
P.O. Box 997413, MS 0009
Sacramento, CA 95899-7413
(916) 440-7370
CivilRights@dhcs.ca.gov

c. Discrimination based on race, color, national origin, sex, age, or disability can be filed directly with either KernBHRS, DHCS Office of Civil Rights, as described above, or by contacting the United States Department of Health and Human Services Office of Civil Rights electronically at https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf or by phone or mail at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at: https://www.hhs.gov/ocr/complaints/index.html

E. Morbidity and Mortality

Contractor shall have a written procedure or policy for reviewing cases involving the following events as outlined in KernBHRS Policy #5.1.9: reviewing all deaths including death other than suicide, death by suspected or known suicide, suicide attempt, suicide threat with intent or plan.

1. Contractor shall assign a Morbidity and Mortality Reviewing Committee to review Morbidity and Mortality cases and make recommendations to continuously improve quality of care.

2. Contractor shall make initial report of event through an Unusual Occurrence Report, as specified by Policy #11.1.1, within three (3) business days of the occurrence.

3. Contractor shall review the event within thirty (30) calendar days of the incident or learning of the incident.

The contractor will submit a confidential summary (Attachment C-Adverse Event Summary Form for Contractors, from KernBHRS Policy #5.1.9) to the SUD Administrator once the Contractor's Review is complete.

F. Treatment Perceptions Survey

Annually, or as designated by DHCS, client perception data is collected for clients served by the programs. The information collected will be used to measure adult and youth clients' perceptions of access to services and the quality of care. KernBHRS will coordinate the survey process in accordance with the DHCS established survey period dates and available methods of administration. Contractor shall inform clients when the survey period will occur.

G. Point in Time Survey:

KernBHRS will conduct Point in Time surveys throughout the year with clients selected at random at different points in time during their treatment episode. Surveys will be conducted by KernBHRS staff by phone, telehealth, or in-person. Contractor shall inform clients about these ongoing surveys according to KernBHRS procedure and encourage participation in the data collection.

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H. Program Complaints:

1. Contractor shall comply with the reporting requirements outlined in KernBHRS Policy #5.6.27. All program complaints received by Contractor regarding a DMC certified facility shall be forwarded to the KernBHRS SUD SOC Administrator or designee and to DHCS as outlined in the policy.

a. Complaints for Residential Adult Alcoholism or Drug Abuse Recovery or Treatment Facilities, and counselor complaints may be made by completing a Complaint form, which is available and may be submitted online: http://www.dhcs.ca.gov/individuals/Pages/Sud-Complaints.aspx

XII. STAFFING STANDARDS

A. Counselor Certification Requirements

Contractor shall stay current regarding the State of California's regulations concerning counselor certification and LPHA requirements and comply with all aspects of those regulations in the timeframes allowed by law. Programs are responsible for being familiar with updates to regulations and law regarding these requirements. Those regulations supersede the terms of this agreement.

B. Program Staffing and Supervision

Contractor shall employ clinical staff consisting of LPHAs, license-eligible LPHAs, registered Alcohol and Other Drug (AOD) counselors, certified AOD counselors, and/or Medi-Cal peer support specialists.

A minimum of thirty percent (30%) of direct service staff will be either certified by a DHCS approved counselor certification agency or be a licensed/license-eligible LPHA.

1. AOD counseling staff: Contractor shall ensure that all AOD counseling staff members have the necessary credentials and expertise to perform assigned tasks, in accordance with the following requirements:

a. One hundred percent (100%) of all non-certified alcohol and drug counselors shall be registered with a DHCS approved counselor certification agency prior to initial date of hire.

b. Registered counselors will have completed at a minimum:

i. Seventy-five percent (75%) of the formal Alcohol and Other Drug (AOD) classroom hours of instruction; or

ii. A bachelor's degree from an accredited college or university in behavioral science or related field and one hundred sixty (160) supervised hours in a counseling setting.

c. Registered staff shall have direct supervision by certified staff while counseling clients.

d. Certified and registered AOD counselors will be able to provide individual counseling, group counseling, care coordination and recovery services.

2. LPHAs include the following:

a. Physician, Nurse Practitioner (NPs), Physician Assistants (PAs), Registered Nurses (RNs), Registered Pharmacists (RPs), Licensed Clinical Psychologists (LCPs), Licensed Clinical Social Workers (LCSWs), Licensed Professional Clinical Counselors (LPCCs), Licensed Marriage and Family Therapists (LMFTs),

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License-Eligible Practitioners working under the supervision of licensed clinicians. Contractor shall ensure that all LPHA staff members have the necessary credentials and expertise to perform assigned tasks, in accordance with the following requirements:

i. Licensed, waivered, and/or registered with the appropriate agency

ii. License-Eligible practitioners shall provide services under the direction of a licensed professional in accordance to applicable regulations.

3. Medi-Cal Peer Support Specialists

a. A Medi-Cal Peer Support Specialist shall be an individual in recovery or have lived experience with behavioral health conditions, and hold a current State approved Medi-Cal Peer Support Specialist Certification. The individual must meet all other applicable California state requirements, including ongoing education requirements.

b. A Medi-Cal Peer Support Specialist shall provide services under the direction of a Behavioral Health Professional (BHP). As defined by BHIN 21-075 a BHP is licensed, waivered, or registered in accordance with applicable State of California licensure requirements and listed in the California Medicaid State Plan as a qualified provider of DMC-ODS or Specialty Behavioral health Services.

c. Supervision may be provided by a Medi-Cal Peer Support Specialist Supervisor who must meet the standards set forth in BHIN 21-041.

C. Personnel Files

1. Personnel files shall be maintained for each staff member and volunteers/interns and shall adhere to the Minimum Quality Drug Treatment Standards for DMC and/or SUPT, as applicable to Contractor's funding. The file should contain, at a minimum, all of the following:

a. Application for employment and/or resume;

b. Signed employment confirmation statement/duty statement;

c. Job description;

d. Performance evaluations;

e. Health records/status as required by program or Title 9;

f. Training documentation relative to substance use disorders and treatment;

g. Current registration, certification, intern status, or licensure;

h. Proof of continuing education required by licensing or certifying agency and program;

i. Program Code of Conduct and for registered, certified, and licensed staff, a copy of the certifying/licensing body's code of conduct as well; and

j. Other personnel actions.

D. Staff Competencies

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1. Contractor understands that most individuals in substance use disorder treatment may have a current or past co-occurring mental health conditions. Contractor shall require staff to obtain training on co-occurring psychiatric disorders to continuously improve the quality of services that are provided within each program. Training topics may include review of specific disorders, evidence-based practices, and treatment approaches that include medications.

2. Contractor must ensure that treatment for co-occurring psychiatric conditions is addressed during SUD treatment, and that staff encourage clients to follow through with services with other treatment providers including therapy, psychiatric evaluations, psychiatric medication management, lab work, etc.

3. Contractor staff working with target population(s) (i.e.- perinatal women, youth, etc.) shall have experience and/or training to show competency for working with the specified target population. Experience and/or training shall be documented in the personnel file.

XIII. MEETING REQUIREMENTS

A. Contractor agrees to have staff and administrative representation at regular provider meetings including, but not limited to, the County's Chief Executive Officer meeting, the Quarterly Quality Improvement Division SUD meeting, and SUD Treatment Provider meetings.

XIV. TRAINING REQUIREMENTS

A. Relias is a training platform available to Contractor through KernBHRS. This platform serves as a training resource, with on demand classes and continuing education level courses, and is also used to monitoring training compliance. Contractor shall enroll staff in Relias to participate in these training resources.

B. Contractor shall have staff representation at County-offered training sessions that are applicable to the services performed in this agreement and/or Contractor may participate in an in-house training approved by the Board of Behavioral Sciences.

C. ASAM Criteria Training: All direct service staff shall be trained in ASAM Criteria Training prior to delivering SUD treatment services. Direct service staff are required to complete the following: Two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care" from The Change Companies®, or the most current training available in order to meet DHCS requirements.

D. Evidence Based Practices (EBP's): Contractor shall, for all contracted modalities of treatment, incorporate Evidence Based Practices. DHCS and County approved EBP's include the following: Motivational Interviewing, Cognitive-Behavioral Therapy, Relapse Prevention, Trauma-Informed Treatment, and Psychoeducation. Credit for courses other than the EBPs named above shall not be given unless course is approved by KernBHRS.

1. Contractor shall select two (2) evidence-based practices (EBPs) for each contracted modality of treatment; and

2. Ensure that direct service staff are trained in two (2) EBPs for each modality of treatment for which staff will provide direct services. Staff training requirements are as follows:

a. An introductory, foundational, and in-depth course for each selected EBP is required to prepare staff to put skills into practice. These one-time courses need to within the range of two to four continuing education (2 to 4 CE) units each and completed any time prior and no later than the first twelve (12) months of enrollment into the KernBHRS Relias training system and beginning provision of DMC-ODS

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services *(please note that courses meeting this requirement are not available in the Relias training system)*; and

b. Two (2) Relias training EBP courses per modality of treatment provided are required annually thereafter. The staff hire date demarcates annual increments. A list of approved courses is listed within the *KernBHRS SUD Division Contractor Training Requirements Guide*.

E. Addiction Medicine Continuing Education: All LPHA (including both doctors and therapists) staff shall complete a minimum of five (5) hours of continuing education related to addiction medicine within three (3) months of enrollment into the KernBHRS Relias training system and beginning provision of DMC-ODS services and annually thereafter. Courses will be assigned annually by KernBHRS.

F. Drug Medi-Cal Organized Delivery System (DMC-ODS)/Title 22 Training: Direct service staff and supervisor level staff shall complete the DMC-ODS/Title 22 Requirements Training within six (6) months of enrollment into the KernBHRS Relias training system and beginning provision of DMC-ODS services and annually thereafter. Staff are required to complete a training facilitated approved by KernBHRS or a compatible training pre-approved by KernBHRS.

G. Co-Occurring Training: Direct service staff is required to complete one (1) Co-Occurring Disorder training on Relias within the first twelve (12) months of enrollment into the KernBHRS Relias training system and beginning provision of DMC-ODS services. A list of approved courses is listed within the *KernBHRS SUD Division Contractor Training Requirements Guide*.

H. Medications for Addiction Treatment (MAT) Training: Direct service staff and supervisor level staff shall complete MAT training within six (6) months of enrollment into the KernBHRS Relias training system and beginning provision of DMC-ODS services and annually thereafter. Staff are required to complete MAT training in accordance with their agency's policies and procedures but not less frequently than annually.

I. Contractor shall maintain training documentation for all training requirements contained in this agreement and as specified in the *KernBHRS SUD Division Contractor Training Requirements Guide* for staff as follows (unless otherwise noted in this agreement):

1. File in the staff's personnel file, within seven (7) days, verification of all completed training required by this agreement. Verification documentation of training shall include name of course, source of training, CEs/CEHs earned, and completion date.

2. Trainings completed in Relias, or through a KernBHRS facilitated event may be verified with a Relias course transcript document.

3. Trainings completed through sources other than Relias or KernBHRS may be verified with a certificate of completion placed in the staff's personnel file and emailed to the SUD Provider Liaison Team at: SUDLiaison@KernBHRS.org

J. At a minimum 85 percent (85%) of all Contractor staff shall maintain a target completion rate of 85 percent (85%) of required training.

K. Contractor is subject to corrective action for non-compliance with training standards until Contractor is back in compliance.

1. Contractor shall write a Corrective Action Plan (CAP) for each non-compliance. That CAP shall be written as specified by KernBHRS.

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XV. ADDITIONAL REQUIREMENTS FOR CONTRACTORS SERVING CLIENTS IN KERNBHRS FUNDED SOBER-LIVING ENVIRONMENTS OR RECOVERY RESIDENCES

A. KernBHRS shall inform Contractor when a client is in housing subsidized by KernBHRS.

B. Contractor shall address, in the problem list, the transition to independent living or ongoing housing assistance for clients in housing subsidized by KernBHRS.

C. Contractor agrees to follow KernBHRS guidance regarding coordination with Managed Care Plans to support client's housing funding.

XVI. ADDITIONAL REQUIREMENTS FOR PENAL CODE 1000 DRUG DIVERSION PROGRAM SERVICE PROVIDERS

A. Contractor agrees to provide services for the Penal Code (PC) 1000 Program, known as Deferred Entry of Judgment, drug diversion program. PC 1000 permits first-time drug offenders with no prior criminal record to participate in a four (4) month, weekly class in lieu of incarceration. Once the client successfully completes the class, is not convicted, or arrested for a period of eighteen (18) months, and pays any required fees, the case against the client can be dismissed by the court. The charge against the client must not involve the sale of drugs. Contractor shall adhere to Exhibit A-2, "Standards for the Certification and Operation of Penal Code 1000 Drug Diversion Programs" for the minimum requirements and procedures for the successful operation and completion of the PC 1000 program. This program is client funded.

1. Services provided to PC 1000 clients shall not be documented in the KernBHRS Electronic Health Record (EHR), SmartCare. Services must be documented as required in the provider's own EHR or via paper charts and secured to properly protect the client's PHI.

XVI. OTHER REPORTING REQUIREMENTS

A. Drug Abuse Treatment Access Report (DATAR): Contractor shall report information regarding program capacity waiting lists to KernBHRS Administrator or designee per KernBHRS Policy 5.6.24.

B. Provider Quarterly Report: Contractor is required to send a Provider Quarterly Report to the SUD Administrator or designee. The report must be submitted electronically using the provided KernBHRS template. Information must be accurate and valid. Report must include updates to the following: Agency name; legal business status; corporate address; service site address; contractor's signature power; or other updates requested.

C. Provider Directory: Contractor shall adhere to Behavioral Health Information Notice 25-026 by following the KernBHRS Provider Directory reporting process. Contractor will maintain Provider Directory entries for each program site updated and accurate at a minimum of monthly within the NACT/Provider Directory web application tool. Contractor will mark themselves complete in the NACT/Provider Directory web application tool by the 5th of each month.

D. Suspense Corrections: Contractor shall monitor the EHR for items in suspense on an ongoing basis and ensure they are corrected in a timely manner.

E. CalOMS Corrections Report: Contractor will receive a monthly CalOMS Corrections Report from KernBHRS. Contractor shall adhere to the KernBHRS specified timelines to complete the corrections.

F. Contractor shall notify the KernBHRS SOC Administrator and QID designee of any external agency audit, review, or other utilization review immediately and no later than two (2) business days of notification. Results from external agency audits, reviews, or other utilization reviews must also be forwarded to KernBHRS SOC

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Administrator and QID designee within two (2) business days of review. Correction Plans for DHCS Post Service Post Payment (PSPP) reviews and Drug Medi-Cal Reviews must be submitted to KernBHRS for review and submission to DHCS.

XVII. OUTCOME MEASURES

A. Treatment Successful Discharge: A minimum of thirty-five percent (35%) of adults enrolled in treatment will discharge with positive outcomes. Outcome will be measured quarterly by the Department EHR report data for clients discharged with a CalOMS discharge code 1, 2, 3, and 4 during the contract term.

B. Retention in Treatment: A minimum of thirty percent (30%) of adults admitted into treatment will remain in treatment at least ninety (90) days. Outcome will be measured by length of stay data captured by the Department EHR report data on a quarterly basis for contract term.

XVIII. ADDITIONAL REQUIREMENTS FOR CONTRACTORS PROVIDING DMC-ODS SERVICES

A. Additional Contract Restrictions: This Contract is subject to any additional restrictions, limitations, or conditions enacted by the Congress, or any statute enacted by the Congress, which may affect the provisions, terms, or funding of this Contract in any manner.

B. HATCH Act: Contractor agrees to comply with the provisions of the Hatch Act (USC, Title 5, Part III, Subpart, F., Chapter 73, Subchapter III), which limit the political activities of employees whose principal employment activities are funded in whole or in part with federal funds.

C. 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, Division 10.7, Chapter 1429, Sections 11999-11999.3). By signing this Agreement, Contractor agrees that it will enforce, and will require its subcontractors to enforce, these requirements.

D. Limitation on Use of Funds for Promotion of Legalization of Controlled Substances: None of the funds made available through this Agreement 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).

E. Debarment and Suspension: Contractor shall not subcontract with or employ any party listed on the government wide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines at 2 CFR 180 that implement Executive Orders 12549 (3 CFR part 1986 Comp. p. 189) and 12689 (3 CFR part 1989., p. 235), "Debarment and Suspension." SAM exclusions contain the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549. The Contractor shall advise all subcontractors of their obligation to comply with applicable federal debarment and suspension regulations, in addition to the requirements set forth in 42 CFR Part 1001. If Contractor subcontracts or employs an excluded party, DHCS has the right to withhold payments, disallow costs, or issue a CAP, as appropriate, pursuant to HSC Code 11817.8(h).

F. Restriction on Distribution of Sterile Needles: No SABG 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 DHCS chooses to implement a demonstration syringe services program for injecting drug users.

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G. Health Insurance and Portability and Accountability Act (HIPAA) Act of 1996: All work performed under this Contract is subject to HIPAA, County shall perform the work in compliance with all applicable provisions of HIPAA. As identified in Exhibit E, DHCS and County shall cooperate to assure mutual agreement as to those transactions between them, to which this provision applies. Refer to Exhibit E for additional information.

1. Trading Partner Requirements:

a. No changes. Contractor hereby agrees that for the personal health information (Information), it will not change any definition, data condition or use of a data element or segment as proscribed in the Federal Health and Human Services (HHS) Transaction Standard Regulation (45 CFR 162.915 (a)).

b. No Additions. Contractor hereby agrees that for the Information, it will not add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation (45 CFR 162.915(b)).

c. No Unauthorized Uses. Contractor hereby agrees that for Information, it will not use any code or data elements that either are marked “not used” in the HHS Transaction’s Implementation specification or are not in the HHS Transaction Standard’s implementation specifications (45 CFR 162.915(d)).

d. No changes to Meaning or Intent. Contractor hereby agrees that the Information, it will not change the meaning or intent of any of the HHS Transaction Standard’s implementation specification (45 CFR 162.915(d)).

2. Concurrence for Test Modifications to HHS Transaction Standard: Contractor agrees and understands that there exists the possibility that DHCS or others may request an extension from the uses of a standard in the HHS Transaction Standards. If this occurs, County agrees that it will participate in such test modifications.

3. Adequate Testing: Contractor is responsible to adequately test all business rules appropriate to their types and specialties. If the County is acting as a clearinghouse for enrolled providers, County has obligations to adequately test all business rules appropriate to each and every provider type and specialty for which they provide clearinghouse services.

4. Deficiencies: Contractor agrees to correct transactions, errors, or deficiencies identified by DHCS, and transactions errors or deficiencies identified by an enrolled provider if the County is acting as a clearinghouse for that provider. When County is a clearinghouse, County agrees to properly communicate deficiencies and other pertinent information regarding electronic transactions to enrolled providers for which they provide clearinghouse services.

5. Code Set Retention: Both parties understand and agree to keep open code sets being processed or used in this Contract for at least the current billing period or any appeal period, whichever is longer.

6. Data Transmission Log: Both parties shall establish and maintain a Data Transmission Log which shall record any and all Data Transmissions taking place between the Parties during the term of this Contract. Each party will take necessary and reasonable steps to ensure that such Data Transmission Logs constitute a current, accurate, complete, and unaltered record of any and all Data Transmissions between the parties and shall be retained by each Party for no less than twenty-four (24) months following the date of the Data Transmission. The Data Transmission Log may be maintained on computer media or other suitable means provided that, if it is necessary to do so, the information contained in the Data Transmission Log may be retrieved in a timely manner and presented in readable form.

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H. Nondiscrimination and Institutional Safeguards for Religious Providers: Contractor shall establish such processes and procedures as necessary to comply with the provisions of USC, Title 42, Section 300x-65 and CFR, Title 42, Part 54.

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

J. Cultural and Linguistic Proficiency: To ensure equal access to quality care by diverse populations, each service provider receiving funds from this Contract shall adopt the Federal Office of Minority Health Culturally and Linguistically Appropriate Service (CLAS) national standards as outlined online at: https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=2&lvlid=53https://thinkculturalh ealth.hhs.gov/clas/standards

K. Intravenous Drug Use (IVDU) Treatment: Contractor shall ensure that individuals in need of IVDU treatment shall be encouraged to undergo AOD treatment (42 USC 300x-23 (45 CFR 96.126(e)).

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

1. Routinely make available TB services to individuals receiving treatment.

2. Reduce barriers to patients' accepting TB treatment.

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

M. Trafficking Victims Protection Act of 2000: Contractor and its subcontractors that provide services covered by this Contract shall comply with the Trafficking Victims Protection Act of 2000 (USC, Title 22, Chapter 78, Section 7104) as amended by section 1702 of Pub. L. 112-239.

N. Tribal Communities and Organizations: Contractor shall regularly review population information available through Census, compare to information obtained in the California Outcome Measurement System for Treatment (CalOMS-Tx) to determine whether the population is being reached, and survey Tribal representatives for insight in potential barriers to the substance use service needs of the American Indian/Alaskan Native (AI/AN) population within the County geographic area. Contractor shall also engage in regular and meaningful consultation and collaboration with elected officials of the tribe, Rancheria, or their designee for the purpose of identifying issues/barriers to service delivery and improvement of the quality, effectiveness, and accessibility of services available to AI/AN communities within the County.

O. Marijuana Restriction: Grant funds may not be used, directly or indirectly, to purchase, prescribe, or provide marijuana or treatment using marijuana. Treatment in this context includes the treatment of opioid use disorder. Grant funds also cannot be provided to any individual who or organization that provides or permits marijuana use for the purposes of treating substance use or mental disorders. See, e.g., 45 CFR. § 75.300(a) (requiring HHS to "ensure that Federal funding is expended . . . in full accordance with U.S. statutory . . . requirements."); 21 USC § 812(c) (10) and 841 (prohibiting the possession, manufacture, sale, purchase or distribution of marijuana). This prohibition does not apply to those providing such treatment in the context of clinical research permitted by the DEA and under an FDA-approved investigational new drug application where the article being evaluated is marijuana or a constituent thereof that is otherwise a banned controlled substance under Federal law.

P. Participation of County Behavioral Health Director's Association of California: The County AOD Program Administrator shall participate and represent the County in meetings of the County Behavioral Health Director's Association of California for the purposes of representing the counties in their relationship with DHCS

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with respect to policies, standards, and administration for AOD abuse services. The County AOD Program Administrator shall attend any special meetings called by the Director of DHCS. Participation and representation shall also be provided by the California Behavioral Health Director's Association of California.

Q. Adolescent Best Practices Guidelines: Contractor must utilize DHCS guidelines in developing and implementing youth treatment programs funded under this Enclosure The Adolescent Best Practices Guidelines can be found at: 0Guide/AdolBestPracGuideOCTOBER2020.pdf

R. Byrd Anti-Lobbying Amendment (31 USC 1352): Contractor certifies that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 USC 1352. Contractor shall also disclose to DHCS any lobbying with non-Federal funds that takes place in connection with obtaining any Federal award.

S. Nondiscrimination in Employment and Services: Contractor certifies that under the laws of the United States and the State of California, Contractor will not unlawfully discriminate against any person.

T. Federal Law Requirements:

1. Title VI of the Civil Rights Act of 1964, Section 2000d, as amended, prohibiting discrimination based on race, color, or national origin in federally-funded programs.

2. Title VIII of the Civil Rights Act of 1968 (42 USC 3601 et seq.) prohibiting discrimination on the basis of race, color, religion, sex, handicap, familial status or national origin in the sale or rental of housing.

3. Age Discrimination Act of 1975 (45 CFR Part 90), as amended 42 USC Sections 6101 – 6107), which prohibits discrimination on the basis of age.

4. Age Discrimination in Employment Act (29 CFR Part 1625).

5. Title I of the Americans with Disabilities Act (29 CFR Part 1630) prohibiting discrimination against the disabled in employment.

6. Title II of the Americans with Disabilities Act (29 CFR Part 35) prohibiting discrimination against the disabled by public entities.

7. Title III of the Americans with Disabilities Act (28 CFR Part 36) regarding access.

8. Section 504 of the Rehabilitation Act of 1973, as amended (29 USC Section 794), prohibiting discrimination on the basis of individuals with disabilities.

9. Executive Order 11246 (42 USC 2000(e) et seq. and 41 CFR part 60) regarding nondiscrimination in employment under federal contracts and construction contracts greater than $10,000 funded by federal financial assistance.

10. Executive Order 13166 (67 FR 41455) to improve access to federal services for those with limited English proficiency.

11. The Drug Abuse Office and Treatment Act of 1972, as amended, relating to nondiscrimination on the basis of drug abuse.

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12. Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2, Subparts A – E).

U. State Law Requirements:

1. Fair Employment and Housing Act (Government Code Section 12900 et seq.) and the applicable regulations promulgated thereunder (2 CCR 7285.0 et seq.).

2. Title 2, Division 3, Article 9.5 of the Government Code, commencing with Section 11135.

3. Title 9, Division 4, Chapter 8 of the CCR, commencing with Section 13000.

4. No federal funds shall be used by the Contractor or its subcontractors for sectarian worship, instruction, or proselytization. No federal funds shall be used by the Contractor or its subcontractors to provide direct, immediate, or substantial support to any religious activity.

V. Additional Contract Restrictions:

1. Noncompliance with the requirements of nondiscrimination in services shall constitute grounds for DHCS to withhold payments under this Contract or terminate all, or any type, of funding provided hereunder.

2. This Contract is subject to any additional restrictions, limitations, or conditions enacted by the federal or state governments that affect the provisions, terms, or funding of this Contract in any manner.

W. Information Access for Individuals with Limited English Proficiency:

1. Contractor shall comply with all applicable provisions of the Dymally-Alatorre Bilingual Services Act (Government Code sections 7290-7299.8) regarding access to materials that explain services available to the public as well as providing language interpretation services.

2. Contractor shall comply with the applicable provisions of Section 1557 of the Affordable Care Act (45 CFR Part 92), including, but not limited to, 45 CFR 92.201, when providing access to: (a) materials explaining services available to the public, (b) language assistance, (c) language interpreter and translation services, or (d) video remote language interpreting services.

X. Subcontract Provisions: Contractor shall include all of the foregoing Section XIX provisions in all of its subcontracts. These requirements must be included verbatim in contracts with subrecipients and not through documents incorporated by reference.

XIX. ADDITIONAL REQUIREMENTS FOR CONTRACTORS USING BOARD OF STATE AND COMMUNITY CORRECTIONS (BSCC) FUNDS

A. Non-Discrimination Clause: During the performance of this agreement, contractor and its subcontractors shall not deny the contract's benefits to any person on the basis of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military and veteran status, nor shall they discriminate unlawfully against any employee or applicant for employment because of race, religious creed, color, national origin, ancestry, physical disability, mental disability, medical condition, genetic information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or military and veteran status. Contractor shall ensure that the evaluation and treatment of employees and applicants for employment are free of such discrimination. Contractor and subcontractors shall comply with the provisions of the fair employment and housing act (gov. code §12900 et seq.), the regulations promulgated thereunder (cal. code regs., tit. 2, §11000 et seq.), the provisions of article 9.5, chapter 1, part 1, division 3, title 2 of the government

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code (gov. code §§11135-11139.5), and the regulations or standards adopted by the awarding state agency to implement such article. Contractor shall permit access by representatives of the department of fair employment and housing and the awarding state agency upon reasonable notice at any time during the normal business hours, but in no case less than 24 hours' notice, to such of its books, records, accounts, and all other sources of information and its facilities as said department or agency shall require to ascertain compliance with this clause. Contractor and its subcontractors shall give written notice of their obligations under this clause to labor organizations with which they have a collective bargaining or other agreement. (see cal. code regs., tit. 2, §11105.) Contractor shall include the nondiscrimination and compliance provisions of this clause in all subcontracts to perform work under the agreement.

B. Books and Records:

1. Contractor shall maintain adequate fiscal and project books, records, documents, and other evidence pertinent to their work on the project in accordance with generally accepted accounting principles. Adequate supporting documentation shall be maintained in such detail so as to permit tracing transactions from the invoices to the accounting records, to the supporting documentation. These records shall be maintained for a minimum of three (3) years after the acceptance of the final grant project audit under the Grant Agreement and shall be subject to examination and/or audit by the BSCC or designees, state government auditors or designees, or by federal government auditors or designees.

2. Contractor shall make such books, records, supporting documentations, and other evidence available to the BSCC or designee, the State Controller's Office, the Department of General Services, the Department of Finance, California State Auditor, and their designated representatives during the course of the project and for a minimum of three (3) years after acceptance of the final grant project audit. The Contractor shall provide suitable facilities for access, monitoring, inspection, and copying of books and records related to the grant-funded project.

C. Debarment, Fraud, Theft or Embezzlement: It is the policy of the BSCC to protect grant funds from unreasonable risks of fraudulent, criminal, or other improper use. As such, the Board will not enter into contracts or provide reimbursement to grantees that have been:

1. Debarred by any federal, state, or local government entities during the period of debarment; or

2. Convicted of fraud, theft, or embezzlement of federal, state, or local government grant funds for a period of three years following conviction. Furthermore, the BSCC requires grant recipients to provide an assurance that there has been no applicable debarment, disqualification, suspension, or removal from a federal, state or local grant program on the part of the grantee at the time of application and that the grantee will immediately notify the BSCC should such debarment or conviction occur during the term of the Grant contract.

BSCC also requires that all grant recipients include, as a condition of award to a subgrantee or subcontractor, a requirement that the subgrantee or subcontractor will provide the same assurances to the grant recipient. If a grant recipient wishes to consider a subgrantee or subcontractor that has been debarred or convicted, the grant recipient must submit a written request for exception to the BSCC along with supporting documentation.

All subcontractors of KernBHRS receiving these funds must have on file with KernBHRS a completed and signed Certification of Compliance with BSCC Policies on Debarment, Fraud, Theft and Embezzlement.

D. Union Activities:

1. No State funds received under the Grant Agreement will be used to assist, promote or deter union organizing.

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2. Contractor will not, for any business conducted while receiving grant funds, use any State property to hold meetings with employees or supervisors, if the purpose of such meetings is to assist, promote or deter union organizing, unless the State property is equally available to the general public for holding meetings.

3. If Contractor incurs costs or makes expenditures to assist, promote or deter union organizing, Contractor will maintain records sufficient to show that no reimbursement from State funds has been sought for these costs, and that Grantee shall provide those records to the Attorney General upon request.

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COMMUNITY SERVICES ORGANIZATION BEHAVIORAL HEALTH PROGRAMS, INC.

OUTPATIENT SUBSTANCE USE TREATMENT SERVICES
RECOVERY INCENTIVES PROGRAM
PENAL CODE 1000 DRUG DIVERSION PROGRAM

EXHIBIT A-1 – RECOVERY INCENTIVES PROGRAM DESCRIPTION AND STANDARDS OF SERVICES

NOTE: THIS EXHIBIT WILL BE REVIEWED ANNUALLY

I. Unit of Service

A Unit of Service is defined as 15-minute increments of contingency management (CM) services.
Service Locations:

- 1124 Baker Street, Bakersfield, CA 93305

II. Background

A. Contingency Management services are a benefit provided for Drug Medi-Cal members through the Recovery Incentives Program, a pilot Drug Medi-Cal coverage.

B. CM is an evidence-based, cost-effective treatment for substance use disorders; This program will focus on stimulant use disorder (StimUD). CM reinforces individual positive behavior change consistent with meeting treatment goals.

C. The Recovery Incentives Program is intended to complement substance use disorder (SUD) treatment services and other evidence-based practices for StimUD already offered by the Contractor. Eligible Medi-Cal members will participate in a structured 24-week outpatient CM service, followed by six or more months of additional treatment and recovery support services without incentives.

D. The initial 12 weeks of CM consists of a series of incentives for meeting treatment goals, specifically abstinence from stimulants objectively verified by urine drug tests (UDTs) negative for stimulant drugs (e.g., cocaine, amphetamine, and methamphetamine). The incentives consist of cash-equivalents (e.g., gift cards), consistent with evidence-based clinical research for treating SUD. CM should be offered alongside other therapeutic interventions, such as cognitive behavioral therapy and motivational interviewing that meet the definition of rehabilitative services as defined by 1905(a) of the Social Security Act and CFR 440.1CM.

III. Populations To Be Served

A. Kern County Medi-Cal adult and adolescent members that meet access criteria for a comprehensive, individualized course of SUD treatment for moderate or severe StimUD as defined by the clinical criteria in the Diagnostic and Statistical Manual (DSM, current edition).

B. Members shall be receiving services in a non-residential level of care.

IV. Program Standards

A. Eligibility Standards

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1. CM services delivered are only covered when medically necessary and appropriate as determined by an initial substance use disorder assessment showing (1) moderate or severe StimUD as defined by the clinical criteria in the Diagnostic and Statistical Manual (DSM, current edition); (2) clinical determination that outpatient treatment is appropriate per the American Society of Addiction Medicine (ASAM) criteria; and (3) that the CM benefit is medically necessary and appropriate based on the fidelity of treatment to the evidence-based practice. The presence of additional substance use disorders and/or diagnoses does not disqualify an individual from receiving CM services.

2. Members may access CM when transitioning to or from residential care or carceral settings, including services initiated on the day of admission and discharge or release respectively. Providing CM services on the date of admission and the date of discharge from a Drug Medi-Cal Organized Delivery System (DMC-ODS) residential level of care is an acceptable circumstance justifying multiple service billing for both a residential treatment service and a CM service at a non-residential level of care.

3. CM should never be used in place of medications for addiction treatment (MAT). CM may be offered in addition to MAT for people with co-occurring stimulant and alcohol or opioid use disorders.

4. Eligible Medi-Cal members shall be referred to, and admitted into, treatment through the Contractor's routine member admission process, which includes coordination with the SUD Access Line at 1-866-266-4898. Consistent with other DMC-ODS programs, there is no minimum age limit for an individual to receive CM services if they meet all eligibility criteria. In addition, pregnant and parenting people with StimUD are eligible to receive CM services. Medi-Cal members who are receiving care in residential treatment (e.g., ASAM levels 3.1–4.0) or institutional settings are ineligible for CM services until the day of discharge, when they are transitioned into outpatient care.

5. Medi-Cal members are eligible for the Recovery Incentives Program based on having any of the related *moderate or severe* cocaine or stimulant use disorder diagnoses, including diagnoses in remission. In all instances, there must be a determination of medical necessity (which includes establishment of impairment and a covered diagnosis) to qualify for admission to the Recovery Incentives Program, and the interventions offered must be determined to be consistent with the standard of care.

6. Members under the age of 21: Covered CM services shall include all medically necessary SUD services for individuals under 21 years of age as required pursuant to Section 1396d(r) of Title 42 of the United States Code. Federal Early and Periodic Screening, Diagnostic and Treatment (EPSDT) statutes and regulations require States to furnish all Medicaid-coverable, appropriate, and medically necessary services needed to correct and ameliorate health conditions, regardless of whether those services are covered in California's Medicaid State Plan. Consistent with federal guidance, services need not be curative or completely restorative to ameliorate a mental health condition, including substance misuse and SUDs. Services that sustain, support, improve, or make more tolerable substance misuse or a SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

B. Assessment

1. The initial clinical assessment shall confirm: (1) The individual has a diagnosis of StimUD of moderate or severe from the DSM for Substance-Related and Addictive Disorders (2) outpatient treatment is appropriate per the ASAM criteria; and (3) that CM is medically necessary.

C. Documentation

1. The Contractor shall document StimUD on the problem list (or treatment plan for Narcotic Treatment Providers, NTPs) within a member's medical record. Consistent with best clinical documentation practices, Contractor shall describe all interventions utilized with the member as part of their progress notes for each

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service to include CM in addition to any other outpatient services, such as motivational interviewing, cognitive behavioral therapy, or community reinforcement therapy.

2. CM should not be offered to a member as a standalone treatment, but rather as one component of an individualized treatment plan. However, if a member chooses to participate only in selected services (e.g., they only participate in CM and not in other aspects of treatment), they shall not be penalized, chastised, criticized or discharged from the program for declining to participate in any treatment or recovery service or for failure to participate in all recommended treatment services. Members needing or utilizing CM must be served and cannot be denied CM or be required to participate in other aspects of a SUD treatment program as a condition of entering or remaining in a Recovery Incentives Program.

3. Contractor is responsible for providing or referring members to additional services for other non-StimUD SUDs indicated in their problem list. For example, if a member has both a StimUD and a concurrent opioid use or alcohol use disorder, the Contractor shall, in addition to providing CM, provide the member with MAT or refer the member to another provider for MAT, following the same protocol required by Contractor's Outpatient Services/NTP Services agreement's Exhibit A. Each CM visit shall be documented consistent with existing DHCS policy described in BHIN 23-068 and Contractor's Outpatient/NTP services agreement.

E. Recovery Incentives Program Opt-In Process

1. DMC-ODS counties may elect to opt in to the Recovery Incentives Program and provide CM services at any time through the duration of the CalAIM 1115 demonstration period (ending December 31, 2026). DMC-ODS counties are required to complete and submit to DHCS an Implementation Plan. The Recovery Incentives Program Implementation Plan template shall be completed and submitted to DHCS for approval. For more information on the implementation process and to access the Implementation Plan template, please visit the Recovery Incentives Program webpage."

F. Member Education/Orientation

1. Before beginning CM treatment, a Medi-Cal member must complete a thorough orientation and consent to the conditions of the program. The orientation will address the following:

a. The days/times that a member must visit the facility in order to be eligible for incentives (during weeks 1–12, two weekly visits; during weeks 13–24, one weekly visit).

b. The manner in which incentives will be delivered as well as an understanding of how and where incentives can be redeemed, including the prohibition of using incentives to purchase alcohol, cannabis, tobacco, lottery tickets, or for any form of gambling.

c. The availability of incentives and ongoing program participation when a member lapses or relapses and seeks readmission and the process for a member to seek readmission.

d. Contractor's UDT procedures and an explanation and review of medications/substances that may result in false-positive UDTs.

i. An explanation that the incentives are contingent on the absence of evidence of stimulant (e.g., cocaine, amphetamine, methamphetamine) use on UDT only.

ii. An explanation that opioid testing will be done for the purpose of safety, due to association with overdose deaths, but will not impact the delivery of an incentive.

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iii. An explanation that all positive tests will be treated the same even if they result from use of one of the medications/substances known to provide false positive UDT results.

e. The amount of the initial incentive and how the value increases with consecutive stimulant-free UDTs and how the value will be re-set to a lower value in case of a positive test or unexcused absence, and that increases will be reinstated after repeated negative UDTs. The maximum incentive a member can receive per year in the Recovery Incentives Program is $599.

f. Signed patient agreement (containing key components required by DHCS) for each program participant, to sets forth the conditions of participation in the Recovery Incentives Program.

G. Treatment Framework

1. Incentives

a. Members will receive incentives for meeting the target behavior of stimulant-non-use as demonstrated by point-of-care UDTs. Participating members will be able to receive a maximum of $599 in total incentives per year for successful completion of the treatment protocol. Contractor shall have no discretion to determine the size or distribution of incentives. The size of the incentive will be based on the protocols in Section E.3 of this agreement.

2. Harm Reduction

a. Harm reduction is an essential component of any treatment program. According to provisional data released by the Centers for Disease Control and Prevention in May of 2022, drug overdose deaths continued to rise in the United States in 2021, surpassing 100,000 deaths. A high number of these deaths are due to the synthetic opioid fentanyl, which has been found mixed in or as a replacement for many other drugs of abuse, including benzodiazepines, opiates and other opioids, and stimulants. Given the presence of fentanyl in some stimulants, death as the result of accidental ingestion of fentanyl is a real risk for members in the Recovery Incentives Program. Contractor will:

i. Establish and implement a protocol to prescribe naloxone to all members with an opioid, sedative and/or stimulant use disorder as outlined below. Contractor shall submit protocol to KernBHRS SOC administrator, or designee, prior to beginning services.

ii. Establish and implement a naloxone distribution protocol for members who do not obtain prescription naloxone. Contractor shall submit protocol to KernBHRS SOC administrator, or designee, prior to beginning services.

iii. Provide education to each CM member regarding:

a) The risks associated with fentanyl and its presence in the illicit drug supply.

b) Harm reduction safety strategies, such as the use of fentanyl test strips and which harm reduction agencies distribute test strips for home use, based on information from the California Department of Public Health (see link).

c) Specific education regarding the use of naloxone to reverse an opioid overdose.

iv. Contractor shall either replace the naloxone whenever a member needs an additional dose, due to the naloxone expiring or due to use in the community or remind a member to obtain a new dose through a pharmacy or local organization. Contractor can dispense naloxone onsite to DMC-ODS

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members by leveraging the Medi-Cal pharmacy benefit. As a best practice overdose prevention measure, Contractor can prescribe naloxone to all DMC-ODS members who are participating in the Recovery Incentives Program and arrange for staff to routinely fill these naloxone prescriptions at a pharmacy on behalf of DMC-ODS members. The community pharmacy would bill these naloxone prescriptions to the Medi-Cal pharmacy benefit. Pharmacists may also directly dispense naloxone and bill to Medi-Cal. The staff could bring the dispensed naloxone back to the Contractor site for furnishing directly to patients. This method would enable the CM provider to better facilitate onsite access to naloxone reimbursed through the Medi-Cal pharmacy benefit.

3. Treatment Schedule

a. Overview

i. The Recovery Incentives Program will consist of two phases: (1) CM treatment and (2) CM continuing care. Phase 1 of CM treatment will consist of a 24-week outpatient program, during which incentives will be available for meeting the target behavior of stimulant-non-use. Weeks 1–12 of CM treatment will serve as the escalation/reset/recovery period, and weeks 13–24 will serve as the stabilizing period. Phase 2 begins when a member completes the initial 24-weeks of CM treatment. The participating member will receive CM continuing care of six months or more, with treatment services to support ongoing recovery (e.g., counseling and peer support services). During the period of CM continuing care, participating members may receive treatment and recovery-oriented support from DMC-ODS providers, as well as covered DMC-ODS services, including but not limited to Recovery Services.

b. CM Treatment Weeks 1-12: Escalation/Reset/Recovery Period

i. During the initial 12 weeks of the CM treatment, participating members will visit the treatment setting in person for two treatment visits per week. Visits will be separated by at least 48 hours, and ideally 72 hours (e.g., Monday and Thursday, or Tuesday and Friday) to minimize the chance that drug metabolites from the same drug use episode will be detected in more than one UDT. Participating members can earn incentives during each visit the UDT indicates they have a negative sample for stimulants.

ii. The initial incentive value is $10 for the first sample negative for stimulants in a series. For each week the participating member demonstrates non-use of stimulants (i.e., two consecutive UDTs negative for stimulants), the value of the incentive is increased by $1.50. The maximum aggregate incentive a participating member who consistently participates and has negative UDTs can receive during this initial 12-week period is $438.

iii. A “reset” will occur when the participating member submits a stimulant-positive sample or has an unexcused absence. The next time they submit a stimulant-negative sample, their incentive amount will return to the initial value of $10.

iv. A “recovery” of the pre-reset value will occur after two consecutive stimulant-negative urine samples. At that time, the participating member will recover their previously earned incentive level without having to restart the process, no matter when in the course of the program the stimulant use occurs. Members will not be penalized for stimulant-positive samples, even if there are several in a row, and even if the sample contains other drugs. If the member fails to achieve two consecutive stimulant- negative samples within the first 12-week period, the treatment provider and member should decide whether CM is a clinically appropriate intervention for that member, and, if necessary, modify the course of treatment and update the member’s problem list and progress notes.

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c. CM Treatment Weeks 13-24: Stabilizing Period

i. During weeks 13–24, participating members will visit the treatment setting for testing once a week. During weeks 13–18, participating members will be eligible to receive $15 per stimulant-negative UDT. During weeks 19–23, they will be eligible to earn $10 per stimulant-negative UDT, and if their sample is stimulant-negative on week 24, they will earn $21. The maximum aggregate incentive a participating member will be able to receive during weeks 13–24 is $161. The total possible earnings during weeks 1–24 for all stimulant-negative tests is $599.

d. Hypothetical Example: Incentive Delivery Schedule for Consistent Abstinence from Stimulants

i. Table 1 illustrates an incentive delivery schedule for a participating member in a scenario where the member has a consistent attendance record and submits samples that are stimulant-negative during each visit over the 24-week period.

Table 1: Sample Incentive Delivery Schedule

Week	**Incentive for Stimulant- Free Test**
Week 1	$10.00 + $10.00 = $20
Week 2	$11.50 + $11.50 = $23
Week 3	$13.00 + $13.00 = $26
Week 4	$14.50 + $14.50 = $29
Week 5	$16.00 + $16.00 = $32
Week 6	$17.50 + $17.50 = $35
Week 7	$19.00 + $19.00 = $38
Week 8	$20.50 + $20.50 = $41
Week 9	$22.00 + $22.00 = $44
Week 10	$23.50 + $23.50 = $47
Week 11	$25.00 + $25.00 = $50
Week 12	$26.50 + $26.50 = $53
Weeks 13-18	$15.00 per week/test
Weeks 19-23	$10.00 per week/test
Week 24	$21.00 per week/test
Total	**$599**

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e. Resets During Weeks 13-24 or Post-Discharge

i. Recovery from any substance use disorder is a process of change, not an endpoint. As such, despite the fact that weeks 13-24 are designed to be a stabilizing period, and that a member may be ready for discharge post 24 weeks, providers need to be aware of and expect lapse or relapse from members who are further along in the process and address such occurrences without judgement.

f. Extended Absence and Readmission Throughout CM Protocol

i. A member will be considered a readmission if they leave CM services for more than 30 days. At readmission, the member must have a new ASAM multidimensional assessment that indicates they can appropriately be treated in an outpatient treatment setting (i.e., ASAM levels 1.0–2.7) and confirm that the member meets the medical necessity criteria for CM. If the member has remained engaged in other services during their absence from CM, an update to the most recent ASAM assessment (or a re-assessment) is sufficient. Based on the assessment, a provider may offer other treatments as alternatives to CM if there is strong clinical evidence that CM is unlikely to produce the intended results. However, if the determination from the new assessment is that CM is an appropriate course of treatment for that member, the member may receive CM services and the incentive structure would restart at Week 1. If the member resumes CM services, they may earn incentives starting at the Week 1 scheduled incentive amount up to a maximum of $599 per year inclusive of all incentives earned that year, including previous Recovery Incentives Program participation. If a member leaves CM services (for any reason) and returns to the program within 30 days, they shall return to the schedule of incentives as if there was no break in service, as long as the member does not exceed the $599 annual limit inclusive of all incentives earned that year, including previous Recovery Incentives Program participation. Reaching the limit for incentives earned through the Recovery Incentives program does not mean that a member would be automatically discharged; all other clinically appropriate treatment services and/or recovery supports should continue to be offered per the member's treatment plan.

ii. In rare circumstances, following completion of the CM treatment phase of the program, a member may benefit from re-entering the CM treatment phase protocol instead of proceeding to CM continuing care services. Repeating the ASAM assessment and diagnostic assessment is not required for the member to re-enter the CM treatment phase of the program. In these instances, the clinical documentation, completed (or reviewed) by a LPHA, must demonstrate that CM services are medically necessary and appropriate based on the standard of care. The documentation must clarify that outpatient treatment continues to be appropriate for the member and include the provider's reasoning for resuming CM services. In this scenario, the member still may not exceed the $599 annual limit for earned incentives, and once that limit is reached the member would no longer be eligible for the Recovery Incentives Program and 2 should be transitioned to continuing care services.

4. Contractor and Staffing Criteria

a. Eligible Contractor Eligibility and Treatment Settings

i. Contractor offering outpatient, intensive outpatient, NTPs and/or partial hospitalization services that are licensed and certified to provide Medi-Cal and DMC- ODS services are eligible to participate in the Recovery Incentives Program. Contractor shall:

a) Serve DMC-ODS members residing in Kern.

b) Require that staff providing or overseeing CM services participate in CM-specific training

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developed and offered by a qualified contractor designated by DHCS.

c) Undergo a readiness review by the state's contracted trainer and technical advisor to ensure that program is capable to offer CM services in accordance with DHCS standards.

d) Participate in ongoing training and technical assistance, including fidelity reviews, as requested or identified by DMC-ODS counties or DHCS through ongoing monitoring to meet DHCS standards.

e) Follow all other requirements for DMC-ODS participation as described in BHIN 24-001.

b. CM Coordinator Requirements

i. At least one CM coordinator will administer CM services at each participating Contractor site. Practitioners eligible to deliver the CM benefit include:

a) Licensed Practitioner of the Healing Arts (LPHAs).

b) SUD counselors that are either certified or registered by an organization that is recognized by DHCS and accredited with the National Commission for Certifying Agencies.

c) Certified Peer Support Specialists.

d) Other trained staff under supervision of an LPHA (This designation only applies to CM services and does not extend to other DMC-ODS services).

ii. The optimal caseload for one full-time CM Coordinator is no more than 30 members at any given time and approximately 60 to 100 members over the course of a year.

c. CM Coordinator Responsibilities

i. The CM coordinator(s) will be the main point of contact for all members participating in the Recovery Incentives Program. The CM coordinator(s) will be responsible for adhering to CLIA protocol, collecting UDT samples, inputting test results, and supporting the delivery of incentives.

d. CM Coordinator, Backup Coordinator, and Supervisor Training Requirements

i. The following training is required for the primary staff of the Recovery Incentives Program, the CM Coordinator, Backup Coordinator, and the Supervisor:

a) Recovery Incentives Program Overview (two-hours self-paced).

b) Recovery Incentives Program Implementation Training (two three-hour live virtual sessions).

c) Site Readiness Assessment.

d) Monthly coaching calls.

e. CM Visit Workflow

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i. The CM coordinator will facilitate visits with participating members. The anticipated workflow for the first CM visit and subsequent visits is below.

f. Intake Visit

i. During a member's first visit, the CM coordinator will complete several steps to initiate the service, specifically:

a) Conduct eligibility check – Contractor's CM coordinator or other designated personnel will confirm the member's current Medi-Cal eligibility as well as their eligibility for the program before initiating the CM service. The eligibility check should be done via the Automated Eligibility Verification System (AEVS) for Medi-Cal.

b) Program participation consent – The CM coordinator will ask the member to complete a consent authorizing services and the secure sharing of data with DHCS and the program evaluation team, including all DHCS-required consent elements.

c) Explain the CM process and reinforce the expectations set forth in Section IV.D above.

d) Enroll the member into the Incentive Manager program – The CM coordinator will complete a member profile to enroll them into the computerized system that will keep track of incentive gift cards, hereinafter referred to as the Incentive Manager.

g. CM Visits

i. Engage the member and initiate the visit – The CM coordinator will greet the member, review their progress in the program (e.g., weeks completed out of 24), log into the Incentive Manager and locate the member's record/profile.

ii. Conduct eligibility check – The CM coordinator or other staff within the Contractor will check member Medi-Cal eligibility monthly or per Contractor policy.

iii. Administer UDT – The CM coordinator will administer the UDT, including processing the results of the UDT in real time.

iv. Log results in Incentive Manager – The CM coordinator will log the results of the UDT for stimulants (i.e., positive or negative).

v. Discuss results – The CM coordinator will discuss the UDT results with the member and offer other services if/as appropriate, which could include brief encouragement, motivational interviewing, and education based on the CM Coordinator's scope and training. The CM coordinator will encourage the member to meet with their counselor or LPHA. If opioid results are positive, the CM Coordinator shall document these results in the clinical chart, reinforce the risk of overdose, ensure the member has naloxone, and offer other treatment services as appropriate, including MAT if the member has a co-occurring alcohol or opioid use disorder.

vi. Disburse incentives consistent with "Incentive Delivery" section below:

a) If the UDT result entered is negative for stimulants, the Incentive Manager will disburse the incentive generated by the Incentive Manager consistent with the "Incentive Delivery" section

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below.

b) If the UDT result entered is positive for stimulants, the Incentive Manager will not disburse an incentive.

vii. Plan for next appointment – The CM coordinator will remind the member of their next scheduled appointment (date and time). The CM coordinator should offer to answer any questions before adjourning the visit.

viii. Documentation – The CM coordinator shall document the visit in the chart.

ix. Billing – The CM coordinator shall complete documentation within the EHR according to process developed by KernBHRS. The service will be documented according to the time spend providing the service, and will include the appropriate code below:

a) R82.998: positive urine test for stimulants

b) Z71.51: negative urine test for stimulants

x. Urine Drug Testing

a) During each visit, the CM coordinator will collect a urine sample from the participating member. The CM coordinator shall test the sample for stimulants, including cocaine, amphetamine and methamphetamine, as well as for opiates and oxycodone. The purpose of testing for opiates and oxycodone is to assess relative risk of exposure to fentanyl; this is based on the concept that people who use multiple categories of substances have a greater potential to accidentally ingest fentanyl than people who use a single substance due to the likelihood of additional drug sources. The tests for opiates and oxycodone, even if positive, shall not impact the member's ability to receive an incentive; however, coaching should be done and the clinical need for induction of evidence-based treatment for opioid use disorder assessed if a member tests positive for opioids. In addition, the CM coordinator shall discuss the risks associated with fentanyl; harm reduction safety strategies, including the use of fentanyl test strips, and ensure the member has access to naloxone and knows how it is used.

b) To receive Medi-Cal reimbursement for CM, Contractor shall hold a Clinical Laboratory Improvement Amendments (CLIA) "waived test" certification and be registered with the California Department of Public Health (CDPH) (or be accredited by an approved accreditation body).

c) Each UDT must be performed in accordance with the manufacturer's instructions for the test, and Contractor must ensure that waived testing personnel meet facility- defined minimum requirements and have records of training and competency assessment.

d) Contractor shall use appropriate precautions to avoid tampering with UDT specimens, including the following: requiring members to leave personal possessions (e.g., backpack, purse, items in pockets) in a secure location outside of the restroom; requiring members to thoroughly wash hands or use hand sanitizer prior to entering the restroom, including between fingers and under nails; turning off access to hot water in the restroom (or turning off the water faucet altogether, and requiring hand-washing outside of the restroom); and adding bluing agent to the toilet. Each test must be accompanied by reliability measures, including temperature, creatinine, and pH level.

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e) Four UDTs that meet program specifications, as listed in Table 2. All products listed met the following minimum requirements:

1) Cut-offs for Amphetamine (500 ng/ml), Cocaine (150 ng/ml), Methamphetamine (500 ng/ml), Opiate (300 ng/ml), and Oxycodone (100 ng/ml)

2) Specimen validity measures (temperature, pH, and creatinine)

f) CLIA waived by the Food and Drug Administration (FDA), and therefore meet at least one of three criteria:

1) Cleared by the FDA for home use; OR

2) Employ methodologies that are so simple and accurate as to render the likelihood of erroneous results negligible; OR

3) Pose no reasonable risk of harm to the patient if the test is performed incorrectly.

g) Cost per test is reasonable.

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Table 2: Recovery Incentives Program Approved UDTs

Company Name	Product Name	Required Tests	Additional Tests Included in Standard Cup	General Cost Estimate for Standard Cup (as of 6/15/22)	Company Website	Contact Information
CLIAWaived, Inc.	12 Panel IDTC Cups II with Adulterants	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BZO, MDMA, MTD, PCP, TCA, THC	$4.99 per cup; around $124.75 per box of 25.	https://cliawaived.com/cliawaived-inc-idtc-12-panel-cup-with-adulterants.html	Telephone: 858-481-5031 Email: info@cliawaived.com
CLIAWaived, Inc.	14 Panel IDTC II	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BUP, BZO, EDDP, MDMA, MTD, PCP, TCA, THC	$4.50 per cup; around $112.50 per box of 25.	https://cliawaived.com/cliawaived-inc-14-panel-idtc-ii.html	Telephone: 858-481-5031 Email: info@cliawaived.com
Lochness Medical	Multi-Drug One Step Cup II	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BZO, BUP, MDMA, EDDP, KET, THC, MTD, MDPM, PCP, PPX, TRA, TCA	$5.40 per cup.	https://www.lochnessmedical.com/Product/Cups/16970	General Inquiries: 1-888-506-2658 info@lochnessmedical.com Orders: orders@lochnessmedical.com Support: support@lochnessmedical.com
Premier Biotech	Bio-Cup 12-Drug Panel Drug Test	Amphetamine, Cocaine, Methamphetamine, Opiate, Oxycodone	BAR, BUP, BZO, MDMA, MTD, PCP, THC	$2.50-$3.00 per cup; around $68.75 per box of 25.	https://premierbiotech.com/innovation/rapid-testing/urine-testing/premier-bio-cup/	Product Questions: 888-686-9909 Laboratory Questions: 855-718-6917

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h) CLIA approved FDA list may be obtained at: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/analyteswaived.cfm

i) Contractor may request for an existing UDT product to be evaluated and approved for use in the Recovery Incentives Program by notifying KernBHRS SOC designee of intent to make this request and submitting the request to DHCS to the following email CountySupport@dhcs.ca.gov including the following information to:

1) Package Insert

2) Cut-offs for Amphetamine, Cocaine, Methamphetamine, Opiate, and Oxycodone

3) Cross-Reactivity List for Amphetamine, Cocaine, Methamphetamine, Opiate, and Oxycodone (if applicable)

4) Info on specimen validity (if the cup includes this or not): Temperature strip, pH, Creatinine

5) Certification: CLIA-Waived and/or FDA approved

j) DHCS will review requests submitted by Contractor for an alternative UDT and either approve or deny the request for an alternative UDT. Contractor cannot receive reimbursement for CM unless this test has been approved by DHCS.

xi. Incentive Delivery

a) Overview: Upon learning the results of the UDT, the CM coordinator must inform the member, and enter the results into a secure Incentive Manager program that includes strict safeguards against fraud and abuse. CM staff shall not play any role in calculating or determining the appropriate size of the incentive payment but shall follow the algorithm in the Incentive Manager program exactly. The Incentive Manager program shall compute the appropriate incentive amount earned according to the protocol detailed above. The incentive amount shall be delivered immediately to participating members in the format of an e-mail, hard copy, refillable gift card, or other mechanism as approved by DHCS.

b) Incentive Calculations: The Incentive Manager shall automatically calculate the appropriate incentive amount based on the UDT results with adjustments for the escalating value, re-set and recovery features as described in Section E.3 above. Upon each visit, the CM coordinator shall enter the results of the UDT into the Incentive Manager program, and the program will report the appropriate incentive amount, per the protocol. A positive test for stimulants shall result in the participating member receiving no incentive, along with encouraging coaching from the CM coordinator. A negative test for stimulants shall result in an incentive amount as indicated by the Incentive Manager program, considering escalations and resets.

c) After the incentive amount is determined, the Incentive Manager program shall disburse the incentive and shall track all incentives awarded to all participating members, including the CM staff who conducted the visit, the format of the incentive provided to the member, the date the incentive was distributed and the amount of the incentive.

d) Participating members shall receive incentives in a format approved by DHCS to which the Incentive Manager will make deposits upon entry of stimulant-negative UDT results. Restrictions shall be placed on the incentives so they cannot be used to purchase cannabis, tobacco, alcohol or lottery tickets.

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xii. Billing and Reimbursement

a) Contractor shall bill for each CM visit, similarly to billing for any other DMC-ODS service. Costs are bundled for each single member visit to a CM coordinator and are billed in 15-minute increments, which include:

1) CM coordinator time: pre-, during, and post-visit with the member

2) Supervision

3) Indirect overhead

4) Costs of purchasing urine drug test cups and testing strips.

b) SmartCare Procedures and diagnosis codes are as follows:

1) Procedure Code: Alcohol and/or Drug Services, brief intervention. For negative test results, use diagnosis code Z71.51: This service describes work associated with the Recovery Incentives Contingency Management pilot program in DMC-ODS outpatient programs in Kern County. The service can be performed by an LPHA, Registered or Certified SUD Counselors, Certified Peer Support Specialists, Other trained staff under supervision of an LPHA. This service includes contingency management services to adults and youth with stimulant use disorders, which involve collecting drug urine tests and determining the presence or absence of drugs like cocaine, methamphetamine and other amphetamines. If the result of the drug test is negative for stimulants, the participant will be given a monetary incentive according to program policy. This service also includes preparation for the appointment, conducting the test, providing result and incentive, and providing appropriate SUD interventions based on the staff's scope of practice.

2) Procedure Code: Alcohol and/or Drug Services, brief intervention. For positive test results, use diagnosis code R82.998: This service describes work associated with the Recovery Incentives Contingency Management pilot program in DMC-ODS outpatient programs in Kern County. The service can be performed by an LPHA, Registered or Certified SUD Counselors, Certified Peer Support Specialists, Other trained staff under supervision of an LPHA. This service includes contingency management services to adults and youth with stimulant use disorders, which involve collecting drug urine tests and determining the presence or absence of drugs like cocaine, methamphetamine and other amphetamines. If the result of the drug test is positive for stimulants, the participant will not be given a monetary incentive according to program policy. This service also includes preparation for the appointment, conducting the test, providing results and incentive and providing appropriate SUD interventions based on the staff's scope of practice.

xiii. Coordination Between Providers

a) Resolving Multiple Registrations: When it is determined that a member is actively receiving CM at one or more providers simultaneously, then Contractor will confer with the other provider(s) to determine which provider will assume treatment responsibility for the individual. In the medical record, an inquiring program shall document the names of each program contacted, the date contacted, the time of the contact (if made by telephone), the name of program staff contacted, and the results of the contact.

b) The provider that agrees to accept sole responsibility will provide CM services to the member. All other providers shall immediately cease providing CM services, discharge the member, and

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document in the medical record the reason for the discharge. Within 72 hours of the discharge the former providers must give the program assuming treatment responsibility written documentation of the discharge and send written notification to the DMC-ODS county(ies) with whom the providers are contracted of the circumstances involving the discharge. Within 72 hours of agreeing to accept sole responsibility for treatment, the provider that assumes sole responsibility must send written notification to KernBHRS SOC Administrator or designee. KernBHRS will document and maintain records of duplicative CM service provision and make available such information to DHCS upon request.

c) Inter-County Transfers: During the process of an inter-county transfer, in situations where the member resides in Kern county but the County of Responsibility, as recorded in the DHCS Medi-Cal Eligibility Determination System (MEDS), is another county, Contractor will conduct the screening/assessment and admit the member for medically necessary services while the inter-county transfer process is underway to update the County of Responsibility field in MEDS. Contractor cannot delay admission or the provision of medically necessary DMC-ODS services, including CM services, to members who reside in Kern based on the County of Responsibility being another county.

d) As described in BHIN 21-032, the claim adjudication system for DMC-ODS and DMC services allows the county submitting the claim to be either the member's County of Residence or the member's County of Responsibility as recorded in MEDS. The County of Residence may submit claims and receive payment for DMC-ODS and DMC services so long as the inter-county transfer has been initiated by the member and all other applicable requirements set forth in BHIN 21-032 are met. If Inter-County transfer has not been initiated, Contractor shall assist member in connecting with the Department of Human Services to begin the Inter-County transfer process before providing CM services.

e) Courtesy Services for Temporary Travel: In situations where a member receiving CM services from Contractor and temporarily travels to another DMC-ODS county that also participates in the Recovery Incentives Program, and the member is unable to attend scheduled CM service appointments during their travel, the DMC-ODS County of Responsibility, KernBHRS, must reimburse CM services that an out-of-county DMC-ODS provider participating in the Recovery Incentives Program delivers to the member.

f) The Contractor must provide a courtesy CM service order form to the out-of-county DMC-ODS CM service provider signed by the medical director or program physician and provide a copy to the KernBHRS SOC Administrator or designee. The order form must specify the member's last contact with the local CM coordinator, the number of weeks of participation in the protocol, interval of UDTs, and any other special instructions consistent with the guidelines for CM services issued within this BHIN.

h. Oversight, Monitoring, Fidelity Reviews, and Reporting

i. Oversight: KernBHRS is responsible for administering CM in accordance with DHCS policies and rules. DHCS expects KernBHRS to oversee the CM benefit as part of their DMC-ODS oversight capabilities. KernBHRS will oversee Contractor to ensure the quality and appropriateness of service delivery.

ii. Monitoring:

a) Contractor or designee responsible for overseeing the use of organizational funds (e.g., chief financial officer or their designee), shall conduct a monthly audit of the incentive delivery functions including the software calculations and incentive distribution records of the organization. Contractor must develop and implement a policy consistent with this requirement.

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Audit results must be made available to KernBHRS or DHCS upon request. KernBHRS will receive data from the Incentive Manager on a monthly basis that will include reports regarding Contractor's:

1) Utilization of CM services.

2) UDTs outcomes (i.e., positive and negative UDT results).

3) Completion rates of CM.

4) Total rewards.

b) KernBHRS shall review these data elements on a monthly basis to monitor utilization of CM services. KernBHRS will meet with Recovery Incentives Program on a quarterly basis to review data. KernBHRS will identify if Contractor would benefit from technical assistance to address issues regarding utilization or quality and refer Contractor for needed technical assistance to the state's contracted trainer and technical advisor based on KernBHRS' oversight efforts.
KernBHRS shall report to DHCS oversight activities in quarterly progress reports. Such reporting shall include the following:

1) Enrollment information to include the number of DMC-ODS members served in the Recovery Incentives Program.

2) Summary of operational or policy development issues, complaints, grievances, and appeals related to the Recovery Incentives Program.

3) Enrollment information in the Recovery Incentives Program for Contractor.

c) KernBHRS shall be responsible for monitoring Contractor to ensure compliance with state and federal law and contractual obligations. KernBHRS monitoring processes shall comply with:

1) State and federal law;

2) Medicaid guidance including the CalAIM 1915b and 1115 Waivers and the Medicaid State Plan;

3) CM protocol and other requirements as specified in this BHIN, and other relevant regulatory guidance documents including the DMC-ODS IA; and

4) Contractor agreement.

d) Monitoring activities shall include onsite visits, video meetings, and/or desk reviews. DHCS will provide an audit tool for KernBHRS to monitor Contractor. DHCS will train KernBHRS in the use of the audit tools.

iii. Fidelity Reviews

a) Contractor is required to participate in fidelity reviews to determine adherence to the CM protocol. Fidelity reviews will be facilitated by the state's contracted trainer and technical advisor as part of ongoing training and technical assistance. Contractor will participate in two fidelity reviews within the first 6 months of implementation of CM and then once every 6 months thereafter.

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b) Fidelity reviews will include a cross-check of incentives delivered to members with data in the incentive distribution database. The fidelity review shall also ensure that the Contractor's total amounts paid for incentives provided match UDT results.

c) In coordination with the state's trainer and technical advisor, KernBHRS will participate in fidelity reviews to ensure the provision of CM consistent with the clinical protocols described in this guidance and ensure that client record reviews are conducted for Contractor to evaluate assessment and treatment activities and confirm alignment between assessment information, ASAM criteria, level of care determinations and CM services provided. Contractor will receive support from KernBHRS and the State's training and technical advisor to address any deficiencies. A corrective action plan may be implemented for issues identified during reviews and any follow up action identified in these plans will be monitored by the county. The participation will support a potential future transition of fidelity reviews from the state's contracted trainer and technical advisor to KernBHRS.

iv. Reporting requirements

a) Evaluation: Contractor is subject to participate in surveys and interviews, as requested by KernBHRS and DHCS.

b) Quarterly Reporting: Contractors shall be responsible for complying with any reporting needs related to CM services.

c) Final Report: Contractor may be subject to submit a brief final report regarding the CM to KernBHRS no later than 60 days after the end of the CM pilot agreement.

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COMMUNITY SERVICES ORGANIZATION BEHAVIORAL HEALTH PROGRAMS, INC.

OUTPATIENT SUBSTANCE USE TREATMENT SERVICES
RECOVERY INCENTIVES PROGRAM
PENAL CODE 1000 DRUG DIVERSION PROGRAM

EXHIBIT A-2 – PENAL CODE 1000 DRUG DIVERSION PROGRAM DESCRIPTION AND STANDARDS OF SERVICES FOR CERTFICATION AND OPERATION

I. INTRODUCTION

A. Purpose

These Penal Code 1000 ("PC 1000") standards of service ("Standards") for the Drug Diversion Program provide KernBHRS, the Courts, the Kern County Probation Department, PC 1000 Contractor, and clients with the minimum requirements and procedures for the successful operation and completion of the PC 1000 program.

B. PC 1000 Drug Diversion Program Goals

The goals of the PC 1000 program include, but are not limited to, the following:

1. Increase clients' understanding of the addiction process and the negative impacts associated with the abuse of drugs and alcohol;

2. Create positive changes in clients' attitudes and behaviors that will lead to a reduction in drug and alcohol abuse;

3. Improve clients' social and personal coping skills;

4. Create an environment for change in which responsible decision-making and viable lifestyle alternatives are acceptable; and

5. Assist and encourage clients to explore healthy lifestyles that promote responsible use of alcohol and the non-use of illicit drugs.

C. Program Eligibility

When a defendant is deemed eligible for drug diversion through the court process, the court may suspend criminal proceedings and refer the defendant to Contractor. Defendants are eligible if all the following requirements are met:

1. There are no convictions for a prior offense involving controlled substances;

2. The current charge does not involve a crime of violence or threatened violence;

3. There is no evidence of a violation relating to narcotics or other restricted dangerous drugs other than a violation of the section listed in PC 1000(a).

4. There is no record of probation or parole being revoked;

5. There is no record of participation in a diversion program within the last five (5) years; and

6. There is no felony conviction within the last five (5) years.

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II. GENERAL ADMINISTRATION

A. Application of Standards

These Standards apply to Contractor and clients receiving PC 1000 Diversion Program services from Contractor.

B. Authorities Cited

1. Chapter 2.5, Title 6, Section 1000 of the California Penal Code.

2. Division 10, Chapter 6, Article 5, Paragraph 11357(b) of the California Health and Safety Code.

3. 42 CFR Sections 2.1-2.67(1).

C. KernBHRS Responsibilities

The County Alcohol and Drug Program Administrator shall:

1. Develop Contractor PC 1000 Diversion Program certification standards and procedures to ensure programmatic and fiscal integrity of PC 1000 programs;

2. Approve, renew, deny, or revoke Contractor certification;

3. At the court's request, review non-certified programs to determine their credibility and effectiveness to provide PC 1000 program services at no cost to the clients;

4. Recommend programs for approval to the County Board of Supervisors;

5. Develop a curriculum for the PC 1000 Drug Diversion Program, and train Contractor in its use and application;

6. Collaborate with Contractor, the courts, the Probation Department, and other interested parties to maintain quality assurance (program effectiveness and efficiency) in the PC 1000 Program and to develop on-going measures of program effectiveness;

7. Review and approve PC 1000 Program client fee schedules;

8. Monitor program performance and compliance with Standards through program financial information and client data;

9. Ensure that Contractor remains self-sufficient and funded entirely through client fees for the PC 1000 Diversion Program;

10. Establish a mechanism for Contractor to reimburse County costs incurred pursuant to these Standards;

11. Ensure program quality for all clients (i.e., women, disabled, non-English speaking, and other special populations);

12. Amend the Standards as needed based on quality reviews, service data, Contractor's needs, and court needs; and

13. Provide copies of the Standards to Contractor, the courts, district attorney, public defender, Probation

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Department, and all other interested parties.

D. Contractor Responsibilities

Contractor shall:

1. Operate and maintain Contractor PC 1000 Diversion Program services in compliance with these Standards.

2. Ensure fiscal integrity and maintain program costs within the client fee system.

3. Hire, train, and retain qualified staff to process enrollments, collect fees,conduct court liaison activities, provide required client services, and perform daily operational activities.

4. Provide the County Alcohol and Drug Program Administrator or designee access to all Contractor program and financial records to conduct program monitoring and evaluation. Access shall not conflict with any local, state, or federal confidentiality regulations.

5. Accept all referrals from the courts and Probation Department, except in cases in which the safety of the program staff or other clients may be in jeopardy.

6. Provide timely and factual reports to the Probation Department on client's status, according to the designated requirements.

7. Maintain a KernBHRS-approved annual program expenditure and revenue budget.

8. Develop and implement on-going quality control procedures to ensure that program resources are maximized and that client and support servicescomply with these Standards.

9. Provide a payment schedule for those who need financial assistance.

10. Maintain data collection according to KernBHRS requirements.

11. Post the name and telephone number of the County Alcohol and Drug Program Administrator.

E. Probation Department Responsibilities

The Probation Department shall:

1. After the court has granted the request for diversion, refer the client to Contractor.

2. Reschedule drug screening tests as necessary.

3. Report to the courts the client's performance and progress in Contractor's diversion program, and the final disposition of the client at the completion of the program.

III. CONTRACTOR CERTIFICATION OF PC 1000 PROGRAM

A. Certification Requirements

1. KernBHRS shall develop and implement a program certification process based on these Standards.

2. Contractor's PC 1000 program(s) shall be certified for a period of three (3) years, unless Contractor fails to meet these standards, and certification is revoked.

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B. Contractor Eligibility

1. Contractor shall have concurrent certification to provide outpatient drug free counseling from the California Department of Health Care Services (DHCS) to be eligible to receive certification as a PC 1000 Drug Diversion Program Contractor.

2. Contractor shall be selected and approved by the KernBHRS Substance Use Disorder System of Care to be certified as a PC 1000 program provider.

C. Initial Certification

1. **Competitive Selection Process.** KernBHRS issues a Request For Proposal (RFP) to competitively select providers for PC 1000 services. KernBHRS may limit the number of contracted providers. More than one (1) service site per Contractor may be allowed. The competitive process is usually conducted every five (5) years, or as approved by the County Board of Supervisors.

2. **Application Processes.** KernBHRS will follow standard County processes.

D. Administration Fee.

Contractor shall pay KernBHRS an administrative fee of five percent (5%) of its gross revenues for KernBHRS costs of Contractor certification, administration, and ongoing monitoring activities.

E. Contractor Monitoring and Evaluation

Contractor agrees to assist KernBHRS in contract compliance reviews, in any special data collection or research, and in the evaluation of program effectiveness.

1. **Measurable outcome objectives.** Contractor shall maintain and meet measurable outcome objectives to be determined by KernBHRS.

2. **Pre- and Post- Knowledge Tests.** All clients must complete a pre-test and a post-test prior to beginning Contractor's PC 1000 Drug Diversion program, prior to beginning and completing each program module, and at the conclusion of the program. KernBHRS shall develop and provide the pre- and post-test instruments. These pre- and post-tests will measure changes in the clients' knowledge and attitudes regarding drug and alcohol abuse. Contractor shall administer all the tests, document clients' scores, and make available a written report of results to KernBHRS on a regularly scheduled basis.

3. **Annual KernBHRS review of Contractor.** County will schedule and conduct annual monitoring visits to each Contractor. More monitoring visits may be completed if KernBHRS deems necessary. A written report of findings and recommendations will be prepared and forwarded to Contractor for response and corrective action, if needed.

4. **Revocation of Certification.** KernBHRS reserves the right to revoke or refuse to renew Contractor's PC 1000 Diversion Program certification any time Contractor fails to respond to KernBHRS requests to take corrective action, or the action(s) taken by Contractor are inadequate to resolve program deficiencies. County will provide to Contractor's program director a written notice within ten (10) days of the effective date of the intended action. The program director may, within five (5) days of the date of the notice, request a review of the findings from the KernBHRS director.

IV. PROGRAM STANDARDS

A. Staff Qualifications

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1. Contractor's PC 1000 program director shall possess the following minimum experience and education:

a. Two (2) years of experience providing substance use disorder treatment or recovery services;

b. One (1) year of experience supervising personnel; and

c. One (1) year of experience preparing or directing the preparation of budgets or cost reports.

2. Program staff providing education services must be classified as Certified Substance Abuse Counselors or as Entry-Level Substance Abuse Counselors.

a. A Certified Substance Abuse Counselor is a person who holds current drug and/or alcohol counselor certification from one (1) of the certifying bodies recognized by DHCS.

b. An Entry-Level staff is a Registered Substance Abuse Counselor who has completed at a minimum seventy-five (75) percent of the formal Alcohol and Other Drug (AOD) classroom hours of instruction or a bachelor's from an accredited college or university in behavioral science or related field and one hundred sixty (160) supervised hours in a counseling setting.

3. Staff shall reflect, as closely as possible, the demographics of the client population (e.g., age, race, gender, etc.).

4. Contractor shall maintain personnel records for all staff, containing, at a minimum:

a. Name, address, telephone number, position, duties, and date of hire;

b. Résumés, applications, and transcripts that document work experience and education used to meet the requirements of these standards.

c. Dates and topics of training attended since the date of hire; and

d. Any other related documents as required.

B. Staff Requirements

1. Contractor staff shall attend a KernBHRS-sponsored training provided to become familiar with the PC 1000 program curriculum.

2. Contractor staff shall perform their duties in an ethical manner at all times.

C. Program Services

1. Program Requirements: Contractor agrees to deliver services as follows:

a. One (1) hour of orientation and enrollment, including a brief substance abuse history, other intake paperwork and a pre-test;

b. Eighteen (18) hours of program services, in twelve (12) ninety (90) minute, non-sequential sessions, including:

i. 1.5 hours of education on the effects of alcohol;

ii. 3 hours of education on the attitudes created by drug and alcohol use;

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iii. 4.5 hours of Skill Number 1, Goal Setting Skills Development Introduction, Practice and Mastery;

iv. 4.5 hours of Skill Number 2, Communication Skills Development Introduction, Practice and Mastery; and

v. 4.5 hours of Skill Number 3, Coping Skills Development Introduction, Practice and Mastery.

c. Twelve (12) hours of Advanced Peer Support, in twelve (12) sixty (60) minute sessions, held no more than once each week for twelve (12) weeks.

d. Monitor the client's compliance with the random drug testing program (including completion of three (3) drug screening tests per client), and reports the screening results to the Probation Department.

e. Monitor client attendance at a minimum of twenty-four (24) hours of self-help meetings (self-help meetings must be focused on alcohol and/or drug related issues, such as AA, NA, or CA).

f. Ensure that any classroom or group discussion other than didactic or lectures does not exceed fifteen (15) persons.

g. Offer a payment schedule for those who need financial assistance.

h. Provide service delivery that is sensitive to the cultural, linguistic and special needs of clients.

2. Client Enrollment

a. Contractor may enroll only those individuals specifically referred to its program. Transfers among programs will, however, be considered acceptable.

b. Clients shall be enrolled by the date specified by the court and the Probation Department.

c. Program orientation must include and explain:

i. Required program services;

ii. Requirements for successful program completion;

iii. Program rules and regulations;

iv. Reasons for dismissal;

v. Grievance process;

vi. Abstinence policy;

vii. Confidentiality policy; and

viii. Fees.

d. Contractor must enroll a client by completing:

i. A brief substance abuse history; and

ii. A client contract, which shall list the services to be provided, all program fees, payment schedule,

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attendancerequirements, other program rules, reasons for dismissal,and grievance procedures.

a) The contract shall be dated and signed by staffand the client.

b) Program staff shall give one copy of the completed contract to the client and retain one copy in the case record.

3. Educational Sessions

a. Contractor shall provide no fewer than eighteen (18) hours of drug and alcohol education services during a three (3) month period.

b. Educational sessions shall be scheduled to reasonably accommodate day/evening client needs.

c. Educational topics listed in Paragraph IV. C. 1. b above may be offered in any order that Contractor deems appropriate. However, skills development education must be provided in the following sequence: Introduction, Practice, and Mastery.

d. Educational sessions should employ adult learning theory strategies and methods to promote maximum learning.

e. Contractor shall document attendance and participation at educational sessions in each client's case record.

4. Drug Testing

a. Each client will be subject to three (3) random drug tests during the program.

b. Each client will be charged a fee of Eighteen Dollars ($18.00) for each test, in addition to the program fees.

c. A suspicious test result may be considered a positive test for drug presence and may be grounds for discharge from the program.

d. A client may be discharged after two (2) suspicious tests.

e. Contractor shall use the National Toxicology Laboratories, Inc. for testing.

5. Referral to Ancillary Services

a. Contractor may refer clients, based on individual needs, to ancillary services, such as family counseling, residential treatment and recovery services, self-help programs, and/or anyadditional outpatient services. The referral and the reasons for such referral shall be documented in the case file.

b. Contractor shall notify the Probation Department of the referral for ancillary services for follow-up with the client.

6. Client Exit Interview

The Client Exit Interview shall include, but not be limited to, the following:

a. A post-test, using a KernBHRS-approved instrument, which measures changes in client attitudes toward the use of drugs and alcohol;

b. A final report to the Probation Department, noting final disposition of the client at the completion of his or

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her diversion program; and

c. Completion of the client satisfaction survey.

D. Client Records

1. Organization and Contents

a. Contractor will prepare a case folder containing all relevant program material and documentation for each client. The client record shall include, at a minimum:

i. The referral form from the Probation Department;

ii. A copy of the signed contract between the client and the program;

iii. Copies of the Episode Opening and Registration screens;

iv. A copy of the signed Statement of Confidentiality;

v. A copy of the signed program rules and regulations;

vi. All completed pre- and post-tests, including the attitudinal tests and those for each educational module;

vii. The completed brief screening instrument;

viii. Signed Consents to Release Information and/or an ASCMI form;

ix. Documentation of self-help meeting attendance;

x. Copies of progress reports to the Probation Department;

xi. Drug screening test results;

xii. Attendance logs;

xiii. Correspondance;

xiv. Payment records;

xv. Client written notes for each class or session;

xvi. Requests for leaves of absence;

xvii. Discharge Summary;

xviii. Copy of the Certificate of Program Completion;

xix. File checklist; and

xx. Other miscellaneous information.

2. Record Retention

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Contractor will maintain client records, including completed copies of all required forms and records for a minimum period of seven (7) years aftercompletion of the program.

3. Confidentiality

Contractor will assure confidentiality of client records and information in accordance with Sections 2.1-2.67 (1); Title 42, CFR.

E. Program Reporting

1. Reporting to the Probation Department

a. Contractor shall report to the Probation Department, within ten (10) working days, the following information:

i. Failure to report to the program for enrollment, dismissal from the program, or failure to complete the program; and the reason(s), including documented violations; and

ii. Successful completion of the program requirements.

b. Contractor shall submit to the Probation Department on a monthly basis, a progress report on each client, including the followinginformation:

i. Attendance, including excused and unexcused absences;

ii. Results of drug screening tests, including the date of the test and, if positive, the drugs identified as present in the screening; and

iii. Other information necessary.

c. Client failures to appear for drug screening shall be reported to the Probation Department immediately upon Contractor receipt of the information. The Probation Department shall determine the necessity of rescheduling the drug screening test.

2. Standard Reports to the KernBHRS Substance Use Disorder System of Care

a. Contractor shall:

i. Submit program admissions, discharges, and completions on a monthly basis;

ii. Submit the results of pre- and post-tests, including attitudinal and module tests, on a monthly basis;

iii. Notify KernBHRS within twenty-four (24) hours of any unusual occurrences, according to Policy 11.1.1;

iv. Submit annual financial reports in the format requested by the KernBHRS Substance Use Disorder System of Care;

v. Submit monthly financial data to document and accompany the amount of the KernBHRS administrative fee;

vi. Submit client data; and

vii. Submit any other reports as required.

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V. CLIENT STANDARDS

A. Alcohol and Other Drug Use Policy

Clients shall agree to totally abstain from the use of alcohol and other drugs during program attendance.

B. Client Attendance

1. Contractor shall require each client to attend all scheduled activities unless the client has been granted an approved leave of absence.

2. No more than five (5) excused absences are allowed. Excused absences may be granted for:

   a. Medical reasons;

   b. Out of town employment;

   c. Family deaths, and

   d. Vacation (allowed only if all prior program obligations have been met).

3. No more than three (3) unexcused absences are allowed.

4. Contractor shall document all excused absences, and their reasons, and unexcused absences in the client's record.

5. Contractor shall require each client to make up all absences before the successful completion of the program. The client must complete each educational meeting topic.

C. Leaves of Absence

1. Leaves of absence may be approved if requested in advance and in writing. The Contractor's program director may approve a leave of absence, for the following reasons:

   a. Military personnel whose orders or responsibilities require an extended absence;

   b. Clients whose work requires travel for an extended period of time;

   c. Clients who are absent due to their own extended illness or medical treatment, or that of a family member;

   d. Clients who become incarcerated;

   e. Clients with an extreme personal hardship or family emergency. The program shall document in the client's case record the nature of the personal hardship or family emergency; and

   f. Clients who have requested a leave of absence for a vacation, if the client is in good standing and is current with all his or her program requirements.

2. Prior to the completion of the program, each client will be required to make up all scheduled program activities missed, and to pay all outstanding fees assessed by the program.

3. Any absences that take place without an approved leave of absence will be considered unexcused.

D. Client Program Fees

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1. Contractor shall charge a fee of $550 for PC 1000 Diversion Program services unless KernBHRS revises the fee.

a. Contractor may establish an enrollment fee of $70. The balance ($480) is to be collected in installments of $40 per session or $20 per session. If a system for reimbursement is unavailable through the PC 1000 Program Provider, then installments must be collected at $20 per session.

b. The client is responsible to pay for his or her own drug screen conducted by the National Toxicology Laboratories, Inc. No more than three (3) tests will be required during the course of the program, unless the Probation Department orders additional testing.

c. The program may charge a re-instatement fee of Twenty-Five Dollars ($25).

2. The client's payment schedule shall be documented in the client contract signed at enrollment. The program shall amend the contract to reflect any subsequent increase or decrease in the assessed program fee or the payment schedule.

3. Contractor shall refund to the client any program fee paid in advance for a service the program did not provide.

4. Contractor shall allow the client to pay fees on a schedule other than the one cited above, provided that all fees are paid before the client is deemed to have successfully completed the program.

5. Fee exemptions must be granted in cases of program clients' inability to pay.

E. Financial Assessment to Determine Participant's Ability to Pay Program Fees

1. A participant may request a financial assessment be conducted by the program, by completing a "Participant's Request for a FinancialAssessment" form.

2. Contractor shall not deny services to a participant if, based on the results of a financial assessment, the program determines that the participant is unable to pay the full program fee as shown on the standardized payment schedule.

3. Prior to conducting a financial assessment, Contractor shall notify the participant that he/she:

a. Is required to provide documentation of his/her income at the time of the financial assessment interview, and

b. Will be assessed the full program fee, as shown on the standardized payment schedule, if he/she fails to provide documentation of income at the time of the financial assessment interview.

4. Contractor shall consider as income any of the following, when earned or received by the participant or any person legally required to support the participant:

a. Gross wages, salaries, bonuses, commissions, and tips;

b. Compensation for work-related expenses in excess of the actual expense;

c. Net profits from self-employment,

d. Net income from real or personal property;

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e. Spousal support;

f. Regular payments from Social Security, retirement, unemployment compensation, strike benefits from union funds, workers' compensation, veterans' payments, public assistance including Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI), emergency assistance money, non- federally funded general assistance or general relief money payments], educational grants, or training stipends; and

g. Gross personal income as reported on the federal income tax return.

5. Contractor shall require any participant who has requested a financial assessment to provide the following documentation of income at the time of assessment, and monthly thereafter:

a. If the participant provides an award letter from the county welfare department, confirming eligibility for general assistance, the program shall require no further documentation of income for that month.

b. If the participant does not provide a general assistance award letter, Contractor shall require him/her to provide the following documentation at the time of assessment, and monthly thereafter:

i. An award letter from the county welfare department, or other governmental agency, documenting eligibility for other public assistance and indicating the income level on which eligibility was based; or

ii. Pay vouchers or pay stubs documenting salary for the prior two months; or

iii. Income tax returns for the prior calendar year. The licensee may require the participant to provide a transcript or letter from the Internal Revenue Service or the State Franchise Tax Board verifying the income reported on the prior year's tax return.

6. Contractor shall not require documentation of income other than that specified.

F. Reinstatements

1. Clients who leave the program may be reinstated if the return is within ninety (90) days of the date of discharge. At that point, the client may begin services from the point at which he or she left the program.

2. If the return to the program is longer than ninety (90) days, the client must start the program from the beginning, unless the court stipulates otherwise.

3. Contractor may charge a reinstatement fee of Twenty-Five Dollars ($25). The client will be responsible for the remainder of the fees assessed in the original referral to PC 1000 Drug Diversion Program services.

4. If repeat reinstatements are necessary, the client may be charged additional reinstatement fees of Twenty-Five Dollars ($25) for each reinstatement.

G. Inter-program Transfer

1. A client transferring to another PC 1000 program within Kern County must request authorization in writing from the initial program. Theprogram must notify the Probation Department in advance of said transfer.

2. KernBHRS shall report to the receiving program within twenty-one (21) days of cessationof services by the sending program.

3. The following requirements apply to inter-program transfers:

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a. The program client must sign an authorization for the sending program to release information to the receiving program;

b. Notice of Transfer shall be provided on County-approved forms to the court of conviction and to the receiving program;

c. The receiving program shall notify the sending program and the court of the client's enrollment or non-enrollment; and

d. In cases of transfers to out of county programs, the receiving program shall be responsible for client fees, as determined by these Standards.

H. Criteria for Successful Program Completion

The minimum requirements and criteria for successful program completion include:

1. Completion of all required program services;

2. Completion of all pre-and post-knowledge tests; and

3. Payment of all fees.

I. Criteria for Unsuccessful Program Completion

1. Two positive or suspicious drug screens;

2. More than three (3) unexcused absences;

3. Violence or threats of violence against program staff or other program clients;

4. Refusal to comply with any program requirement; or

5. Perpetrating a crime on the premises.

J. Client Grievance Process

1. Contractor shall use protocol and forms developed by County for handling client grievances.

2. The client attempts to resolve the matter with his/her primary program staff member.

3. Within five (5) business days of the alleged grievance, if the matter cannot be resolved, the client may bring the matter to the program supervisor.

4. Contractor has five (5) business days to respond, in writing, to the client. A copy shall be sent to KernBHRS.

5. If there is no resolution, the client may appeal to the County Alcohol and Drug Program Administrator, in writing. The Administrator or designee has five (5) business days in which to respond. The Administrator's decision will be considered final.

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COMMUNITY SERVICES ORGANIZATION BEHAVIORAL HEALTH PROGRAMS, INC.

OUTPATIENT SUBSTANCE USE TREATMENT SERVICES
RECOVERY INCENTIVES PROGRAM
PENAL CODE 1000 DRUG DIVERSION PROGRAM

EXHIBIT B – ADDITIONAL ADMINISTRATIVE AND ETHICAL REQUIREMENTS

Contractor shall provide to County:

1. **Mission:** Contractor's mission statement and related policies indicating Contractor's dedication to the same or similar mission as Kern Behavioral Health and Recovery Services. The statement or policies shall include a requirement that employees will be trained in and expected to uphold a code of ethical conduct.

2. **Oversight:** Proof that the organization has a Board of Directors that conforms to the requirements set forth in the organization's Articles of Incorporation. The Board of Directors shall be responsible for the actions of the organization and able to demonstrate due diligence in the following areas.

3. **Insurance:** Certificates of adequate and appropriate insurance as required in the paragraph of this agreement entitled **"INSURANCE."** A written description of the Board of Directors accountability process assuring Contractor maintains proper and adequate insurance.

4. **Statutory Responsibilities:** Documentation delineating Contractor's plan to monitor the following statutory responsibilities:

   A. Ensuring that all labor laws relating to individuals and employers are obeyed.

   B. Adherence to labor standards, human rights, and occupational health and safety regulations.

   C. Commitment to an anti-drug work environment.

   D. Enforcement of non-smoking regulations.

   E. Ensuring that all computer software copyright laws are enforced.

   F. Complying with laws related to fundraising practices and the maintenance of non-profit status, including, but not limited to, those required by Internal Revenue Service and the Franchise Tax Board.

5. **Fiscal:** Written documentation in the form of plans, policies and/or statements outlining and demonstrating their strategies to accomplish the following fiscal responsibilities:

   A. Developing a financial budget and monitoring financial performance.

   B. Avoiding a deficit and meeting the requirement of the paragraph entitled **"Financial Solvency"** of this agreement.

   C. Ensuring the collection and remittance of required employee payroll deductions.

   D. Ensuring that expenditures reflect the appropriate use of funds and are appropriately authorized.

   E. Ensuring that no board member holds a financial interest in or receives financial benefit from the organization.

   F. Maintaining accurate and appropriate financial records.

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6. **Standards of Care:** A current copy of their standards of care and related policies, which outline measures taken to ensure that standards are followed, and staff is trained in the concepts therein. Standards shall clearly state the following:

   A. The range of programs.

   B. Services provided.

   C. How quality and outcomes are measured and tracked.

7. **Contracts:** A statement or plan proving their awareness of organizational obligations regarding contracts, including the requirements and consequences for failure to meet funding source obligations, and a plan for monitoring the organization's compliance with contractual obligations.

8. **Conflict of Interest:** Policies showing the requirement for all employees, including members of the Board of Directors, and corporate officers, to adhere to each of the standards related to conflict of interest as is applicable to governing boards, officers, and employees of public entities.

9. **By-Laws:** By-laws and policies that incorporate and set the courses of action for the following practices:

   A. Financial management.

   B. Human resources.

   C. Personnel safety.

   D. Client care.

10. **Monitoring:** A monitoring plan indicating that the Board of Directors is responsible for completing the following:

    A. Reviews of financial statements (monthly or quarterly).

    B. Initiation of an audit of financial transactions (annually).

    C. Review of all reports on activities (e.g. monthly executive director's report).

    D. Monitoring the implementation of key policies (e.g. part of the annual evaluation for the executive director).

11. **Accreditation:** In lieu of the above, Contractor shall provide to County documentation of accreditation from a County-recognized accreditation body, including but not limited, to CARF, Council on Accreditation, or the Joint Commission on Accreditation of Healthcare Organizations. Such accreditation warrants, and County concurs, that Contractor meets the requirements set forth in this Exhibit, provided that Contractor continuously maintains valid accreditation during the term of this agreement. Contractor shall notify County within twenty-four (24) hours of any change in the status of its accreditation. Contractor agrees that County may ask for, and Contractor shall provide, information with regard to the items listed above.

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COMMUNITY SERVICES ORGANIZATION BEHAVIORAL HEALTH PROGRAMS, INC.

OUTPATIENT SUBSTANCE USE TREATMENT SERVICES
RECOVERY INCENTIVES PROGRAM
PENAL CODE 1000 DRUG DIVERSION PROGRAM

EXHIBIT C – FUNDING SCHEDULE

NOVEMBER 1, 2026 – JUNE 30, 2027

COST CENTER 1670 CC	STATE / FEDERAL	TOTAL FUNDING
FISCAL YEAR 26-27	ALLOWED	$1,600,000
MAXIMUM REIMBURSEMENT		**$1,600,000**

Service Delivery Site: 1124 Baker Street. Bakersfield, CA 93305

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COMMUNITY SERVICES ORGANIZATION BEHAVIORAL HEALTH PROGRAMS, INC.

OUTPATIENT SUBSTANCE USE TREATMENT SERVICES
RECOVERY INCENTIVES PROGRAM
PENAL CODE 1000 DRUG DIVERSION PROGRAM

EXHIBIT C – 1 FISCAL YEAR 26-27 OUTPATIENT RATE TABLE

NOVEMBER 1, 2026 – JUNE 30, 2027

SmartCare Procedure code	Service Description	Time	HCPC	Time	CPT	Rate
SUD Screening	Assessment	15 min	H0001	1 unit	G2011	$54.08
Contingency Management	Recovery Incentives Program only	15 min	H0050			$43.03
SUD Crisis Intervention	SUD Crisis Intervention	15 min	H0007			$45.00
Group Counseling	Group Counseling	15 min	H0005			$10.92
Discharge Planning	Discharge Planning	15 min	T1007			$49.70
Individual Counseling	Individual Counseling	15 min	H0004			$50.77
Behavioral Health Prevention Education Service	Peer Service – Group	15 min	H0025			$10.92
Self Help/Peer Services	Peer Services – Individual	15 min	H0038			$43.03
TCM/ICC	Care Coordination	15 min	T1017			$50.66
Comprehensive Community Support Service	Recovery Services only	15 min	H2015			$49.02
Psychosocial Rehabilitation Individual	Recovery Services only	15 min	H2017			$49.35
Psychosocial Rehabilitation Group	Recovery Services only	15 min	H2017 HQ			$10.92
Family Therapy-Client Present Or Family Therapy—Client not present	Family Therapy	50 min		1 unit	93046/90847	$165.20
Family Therapy-Client Present Or Family Therapy—Client not present > 58 min	Family Therapy	15 min	T2021			$49.62
Supplemental	Sign language/oral interpretive services	15 min	T1013			$21.35

Service Delivery Site(s): 1124 Baker Street, Bakersfield, CA 93305

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EXHIBIT D - BUSINESS ASSOCIATE ADDENDUM

THIS BUSINESS ASSOCIATE ADDENDUM ("Addendum") supplements and is made a part of the agreement ("agreement") by and between the County of Kern ("Covered Entity" or "CE") and Community Services Organization Behavioral Health Programs, Inc. ("Business Associate" or "BA"). This Addendum is effective as of date first written above (the "Addendum Effective Date").

RECITALS:

A. CE wishes to disclose certain information to BA pursuant to the terms of the agreement, some of which may constitute Protected Health Information ("PHI"), Personal Information ("PI"), or Personally Identifiable Information ("PII") (defined below). For the purpose of this Exhibit, PHI, PI, and PII all refer to confidential information that must be protected.

B. CE and BA intend to protect the privacy and provide for the security of PHI disclosed to BA pursuant to the agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the "HIPAA Regulations") and other applicable laws.

C. As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) require CE to enter into a contract containing specific requirements with BA prior to the disclosure of PHI, as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(e), and 164.504(e) of the Code of Federal Regulations ("CFR") and contained in this Addendum.

D. In consideration of the mutual promises below and the exchange of information pursuant to this Addendum, the parties agree as follows:

1. DEFINITIONS

A. Catch-All Definition

The following terms used in this agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

B. Specific Definitions

(1) **Business Associate**. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean Community Services Organization Behavioral Health Programs, Inc.

(2) **Covered Entity.** "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean the County of Kern.

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(3) **Electronic Health Record** shall have the meaning given to such term in the HITECH Act, including, but not limited to, 42 USC Section 17921.

(4) **HIPAA Rules.** "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

(5) **Personal Information (PI)** shall mean information that identifies or describes an individual, including, but not limited to, name, social security number, physical description, address, telephone number, education, financial matters, and medical or employment history. It includes statements made by, or attributed to, the individual.

(6) **Personally Identifiable Information (PII)** means any information about an individual which can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, and biometric records. This information can be in paper or electronic files and includes, but is not limited to, education records, financial transactions, employment history, criminal records, and medical files.

(7) **Privacy Rule** shall mean the HIPAA Regulation that is codified at 45 CFR Parts 160 and 164, Subparts A and E.

(8) **Protected Health Information (PHI)** means individually identifiable health information that is transmitted or maintained in any form or medium, created or received by a health care provider or health plan, that relates to past, present, and future physical or mental health condition of an individual; provisions of healthcare to an individual; or past, present, and future payment for the provision of healthcare to an individual. Health information that is considered subject to the regulations contained in the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes: name, date of birth, telephone number, names of relatives, names of employers, photographic images, facsimile number, medical record number, finger or voice prints, certificate/license number, social security number, internet (IP) address, web URL, e-mail address, and any device or serial number. "Protected Health Information" includes electronic protected health information.

2. PERMITTED USES AND DISCLOSURES

A. BA may only use or disclose PHI, PI, or PII as necessary to perform the services set forth in the attached agreement.

B. BA may use or disclose PHI, PI, or PII as required by law.

C. BA agrees to make uses and disclosures and requests for PHI, PI, or PII consistent with CE's minimum necessary policies and procedures.

D. BA may not use or disclose PHI in a manner that would violate Subpart E of 45 CFR Part 164 if done by CE except for the specific uses and disclosures set forth below.

E. BA may use PHI, PI, or PII for the proper management and administration of BA or to carry out the legal responsibilities of BA.

F. BA may disclose PHI, PI, or PII for the proper management and administration of BA or to carry out the legal responsibilities of BA, provided the disclosures are required by law, or BA obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies BA of any instances of which it is aware in which the confidentiality of the information has been breached.

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G. BA may provide data aggregation services relating to the health care operations of CE.

3. OBLIGATIONS AND ACTIVITIES OF BA

BA agrees to:

A. Use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI to prevent use or disclosure of PHI other than as provided for by the agreement;

B. In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of BA agree to the same restrictions, conditions, and requirements that apply to BA with respect to such information;

C. Make available PHI in a designated record set to CE as necessary to satisfy CE's obligations under 45 CFR 164.524;

D. Make any amendment(s) to PHI in a designated record set as directed or agreed to by CE pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy CE's obligations under 45 CFR 164.526;

E. Maintain and make available the information required to provide an accounting of disclosures to CE as necessary to satisfy CE's obligations under 45 CFR 164.528;

F. Provide beneficiaries with the Notice of Privacy Practices, in accordance with 45 CFR 164.520 and KernBHRS Policy 10.1.21;

G. To the extent BA is to carry out one or more of CE's obligations under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to CE in the performance of such obligation(s);

H. Make its internal practices, books, and records available to the Secretary for purposes of determining compliance with the HIPAA Rules.

I. Report to CE any use or disclosure of PHI, PI, or PII not provided for by the agreement of which it becomes aware, including breaches of unsecured PHI as required at 45 CFR 164.410, and any security incident of which it becomes aware, without unreasonable delay, and in no case later than one (1) business day of discovery [42 USC Section 17921; 45 CFR Section 164.504(e)(2)(ii)(C); 45 CFR Section 164.308(b)].

4. BA's Agents. BA shall ensure that any agents, including subcontractors, to whom it provides PHI, agree in writing to the same restrictions and conditions that apply to BA with respect to such PHI and implement the safeguards required by Paragraph A above with respect to Electronic PHI [45 CFR Section 164.504(e)(2)(ii)(D); 45 CFR Section 164.308(b)]. BA shall implement and maintain sanctions against agents and subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation (see 45 CFR Sections 164.530(f) and 164.530(e)(1)).

5. Amendment of PHI. If applicable, within ten (10) days of receipt of a request from CE for an amendment of PHI or a record about an individual contained in a Designated Record Set, BA or its agents or subcontractors shall make such PHI available to CE for amendment and incorporate any such amendment to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR Section 164.526. If any individual requests an amendment of PHI directly from BA or its agents or subcontractors, BA must notify CE in writing within five (5) days of the request. Any approval or denial

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of amendment of PHI maintained by BA or its agents or subcontractors shall be the responsibility of CE [45 CFR Section 164.504(e)(2)(ii)(F)].

6. **Accounting Rights.** Within ten (10) days of notice by CE of a request for an accounting of disclosures of PHI, BA and its agents or subcontractors shall make available to CE the information required to provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR Section 164.528, and the HITECH Act, including but not limited to 42 USC Section 17935(c), as determined by CE. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents or subcontractors for at least six (6) years prior to the request, for all disclosures made without written consent. However, accounting of disclosures from an Electronic Health Record for treatment, payment, or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent that BA maintains an electronic health record and is subject to this requirement. At a minimum, the information collected and maintained shall include: (i) the date of disclosure; (ii) the name of the entity or person who received PHI and, if known, the address of the entity or person; (iii) a brief description of PHI disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. In the event that the request for an accounting is delivered directly to BA or its agents or subcontractors, BA shall within five (5) days of a request forward it to CE in writing. It shall be CE's responsibility to prepare and deliver any such accounting requested. BA shall not disclose any PHI except as set forth in this Addendum [45 CFR Sections 164.504(e)(2)(ii)(G) and 165.528]. The provisions of this subparagraph shall survive the termination of this agreement.

7. **Governmental Access to Records.** BA shall make its internal practices, books, and records relating to the use and disclosure of PHI available to CE and to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") for purposes of determining BA's compliance with the Privacy Rule [45 CFR Section 164.504(e)(2)(ii)(H)]. BA shall provide to CE a copy of any PHI that BA provides to the Secretary concurrently with providing such PHI to the Secretary.

8. **Data Ownership.** BA acknowledges that BA has no ownership rights with respect to the PHI.

9. BA shall report to covered entity any use or disclosure of PHI not provided for by the agreement of which it becomes aware, including breaches of unsecured PHI as required at 45 CFR 164.410, 45 CFR Section 164.504(e)(2)(ii)(C) and 45 CFR Section 164.308(b).

10. **Notification of Breach.** During the term of the agreement, BA shall notify CE within twenty-four (24) hours of any suspected or actual breach of security, intrusion, or unauthorized use or disclosure of PHI, PI, or PII of which BA becomes aware and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations. BA shall take (i) prompt corrective action to cure any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations (including conducting a "risk of compromise" assessment and/or appropriate patient notification under applicable state and/or federal law). For specific instruction on breach notification, see **Exhibit E, "Privacy and Information Security Provisions."**

11. **Breach Pattern or Practice by CE**. Pursuant to 42 USC Section 17934(b), if BA knows of a pattern of activity or practice of CE that constitutes a material breach or violation of the CE's obligations under the agreement or Addendum or other arrangement, BA must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, BA must terminate the agreement if feasible, or if termination is not feasible, report the problem to the Secretary of DHHS. BA shall provide written notice to CE of any pattern of activity or practice of CE that BA believes constitutes a material breach or violation of CE's obligations under the agreement or Addendum or other arrangement within five (5) days of discovery and shall meet with CE to discuss and attempt to resolve the problem as one of the reasonable steps to cure the breach or end the violation.

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12. **Audits, Inspection and Enforcement**. Within ten (10) days of a written request by CE, BA and its agents or subcontractors shall allow CE to conduct a reasonable inspection of the facilities, systems, books, records, agreements, information systems, policies, and procedures relating to the use or disclosure of PHI, PI, or PII pursuant to this Addendum for the purpose of determining whether BA has complied with this Addendum; provided, however, that (i) BA and CE shall mutually agree in advance upon the scope, timing, and location of such an inspection; (ii) CE shall protect the confidentiality of all confidential and proprietary information of BA to which CE has access during the course of such inspection; and (iii) CE shall execute a nondisclosure agreement, upon terms mutually agreed upon by the parties, if requested by BA. The fact that CE inspects, or fails to inspect, or has the right to inspect, BA's facilities, systems, books, records, agreements, policies, and procedures does not relieve BA of its responsibility to comply with this Addendum, nor does CE's (i) failure to detect or (ii) detection, but failure to notify BA or require BA's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of CE's enforcement rights under the agreement or Addendum. BA shall notify CE within ten (10) days of learning that BA has become the subject of an audit, compliance review, or complaint investigation by the Office of Civil Rights.

13. **PROVISIONS FOR CE TO INFORM BA OF PRIVACY PRACTICES AND RESTRICTIONS**

A. CE shall notify BA of any limitation(s) in the Notice of Privacy Practices of CE under 45 CFR 164.520, to the extent that such limitation(s) may affect BA's use or disclosure of PHI.

B. CE shall notify BA of any changes in, or revocation of, the permission by an individual to use or disclose his or her PHI, to the extent that such changes may affect BA's use or disclosure of PHI.

C. CE shall notify BA of any restriction on the use or disclosure of PHI that CE has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect BA's use or disclosure of PHI.

14. **TERMINATION**

A. Material Breach. A breach by BA of any provision of this Addendum, as determined by CE, shall constitute a material breach of the agreement and shall provide grounds for immediate termination of the agreement, any provision in the agreement to the contrary notwithstanding. [45 CFR Section 164.504(e)(2)(iii)].

B. Judicial or Administrative Proceedings. CE may terminate the agreement, effective immediately, if (i) BA is named as a defendant in a criminal proceeding for a violation of HIPAA, the HITECH Act, the HIPAA Regulations, or other security or privacy laws or (ii) a finding or stipulation that the BA has violated any standard or requirement of HIPAA, the HITECH Act, the HIPAA Regulations, or other security or privacy laws is made in any administrative or civil proceeding in which BA has been joined.

C. Obligations of BA Upon Termination. Upon termination of this agreement for any reason, BA, with respect to PHI, PI, or PII received from CE, or created, maintained, or received by BA on behalf of CE, shall:

1. Retain only that PHI, PI, or PII which is necessary for BA to continue its proper management and administration or to carry out its legal responsibilities;

2. Return to CE the remaining PHI, PI, or PII that the BA still maintains in any form;

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3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this Section, for as long as BA retains the PHI;

4. Not use or disclose the PHI, PI, or PII retained by BA other than for the purposes for which such PHI, PI, or PII was retained and subject to the same conditions set out in this agreement above which applied prior to termination; and

5. Return to CE or, if agreed to by CE, destroy the PHI, PI, and PII retained by BA when it is no longer needed by BA for its proper management and administration or to carry out its legal responsibilities.

15. INDEMNIFICATION

BA agrees to indemnify, defend, and hold harmless CE and CE's agents, board members, elected and appointed officials and officers, employees, volunteers, and authorized representatives from any and all losses, liabilities, charges, damages, claims, liens, causes of action, awards, judgments, costs, and expenses (including, but not limited to, reasonable attorneys' fees of County Counsel and counsel retained by CE, expert fees, costs of staff time, and investigation costs) of whatever kind or nature, which arise out of or are in any way connected with any negligent act or omission of BA or BA's officers, agents, employees, independent BAs, subcontractor of any tier, or authorized representatives. Without limiting the generality of the foregoing, the same shall include injury or death to any person or persons; damage to any property, regardless of where located, including the property of CE; and any workers' compensation claim or suit arising from or connected with any services performed pursuant to this agreement on behalf of BA by any person or entity.

16. DISCLAIMER

CE makes no warranty or representation that compliance by BA with this Addendum, HIPAA, the HITECH Act, or the HIPAA Regulations will be adequate or satisfactory for BA's own purposes. BA is solely responsible for all decisions made by BA regarding the safeguarding of PHI.

17. CERTIFICATION

To the extent that CE determines that such examination is necessary to comply with CE's legal obligations pursuant to HIPAA relating to certification of its security practices, CE or its authorized agents or contractors, may, at CE's expense, examine BA's facilities, systems, procedures, and records as may be necessary for such agents or contractors to certify to CE the extent to which BA's security safeguards comply with HIPAA, the HITECH Act, the HIPAA Regulations, or this Addendum.

18. AMENDMENT

The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of the agreement or Addendum may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule, and other applicable laws relating to the security or confidentiality of PHI. The parties understand and agree that CE must receive satisfactory written assurance from BA that BA will adequately safeguard all PHI. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Addendum embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule, or other applicable laws. CE may terminate the agreement upon thirty (30) days' written notice in the event (i) BA does not promptly enter into negotiations to amend the agreement or Addendum when requested by CE pursuant to this Section or (ii) BA does not enter into an

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amendment to the agreement or Addendum providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

19. ASSISTANCE IN LITIGATION OR ADMINISTRATIVE PROCEEDINGS

BA shall make itself, and any subcontractors, employees, or agents assisting BA in the performance of its obligations under the agreement or Addendum, available to CE, at no cost to CE, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CE, its directors, officers, or employees based upon a claimed violation of HIPAA, the HITECH Act, The Privacy Rule, the Security Rule, or other laws relating to security and privacy, except where BA or its subcontractor employee or agent is a named adverse party.

20. NO THIRD-PARTY BENEFICIARIES

Nothing expressed or implied in the agreement or Addendum is intended to confer, nor shall anything herein confer, upon any person other than CE, BA, and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

21. EFFECT ON AGREEMENT

Except as specifically required to implement the purposes of this Addendum, or to the extent inconsistent with this Addendum, all other terms of the agreement shall remain in force and effect.

22. INTERPRETATION

The provisions of this Addendum shall prevail over any provisions in the agreement that may conflict or appear inconsistent with any provision in this Addendum. This Addendum and the agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the Privacy Rule, and the Security Rule. The parties agree that any ambiguity in this Addendum shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act, the Privacy Rule, and the Security Rule.

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COMMUNITY SERVICES ORGANIZATION BEHAVIORAL HEALTH PROGRAMS, INC.

OUTPATIENT SUBSTANCE USE TREATMENT SERVICES
RECOVERY INCENTIVES PROGRAM
PENAL CODE 1000 DRUG DIVERSION PROGRAM

EXHIBIT E – PRIVACY AND INFORMATION SECURITY PROVISIONS

This Exhibit is intended to protect the privacy and security of specified Kern Behavioral Health and Recovery Services (County) information that Contractor may access, receive, or transmit under this agreement. County information covered under this Exhibit consists of: (1) Protected Health Information (PHI) as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191; (2) Personal Information (PI) as defined under the California Information Practices Act (CIPA), at California Civil Code Section 1798.3; Personal Information may include data provided to the Department by the Social Security Administration; and (3) Personally Identifiable Information (PII); however, to the extent that data is PHI or ePHI and PI or PII, this Exhibit shall apply.

1. Recitals.

A. In addition to the Privacy and Security Rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which defines Protected Health Information (PHI), County is subject to various other legal and contractual requirements with respect to the personal information (PI) and personally identifiable information (PII) it maintains. These include:

a. The California Information Practices Act of 1977 (California Civil Code §§ 1798 et seq.).

b. The Agreement between the Social Security Administration (SSA) and the Department of Health Care Services (DHCS), known as the Information Exchange Agreement (IEA), which incorporates the Computer Matching and Privacy Protection Act Agreement (CMPPS) between the SSA and the California Health and Human Services Agency.

c. Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2.

d. California Welfare and Institutions Code § 5328 et seq.

B. The terms used in this Exhibit but not otherwise defined, shall have the same meanings as those terms have in the above referenced statute and agreement. Any reference to statutory, regulatory, or contractual language shall be to such language as in effect or as amended.

C. For the purpose of this Exhibit, PHI, PI, and PII all refer to confidential information that must be protected.

2. Definitions.

A. Breach shall have the meaning given to such term under the IEA, CMPPA and under HIPAA, the HITECH Act, and the HIPAA regulations at 45 C.F.R §164.402. It shall include a security incident, intrusion, or unauthorized access, use or disclosure of County PHI, ePHI, PI or PII.

B. Breach of the security of the system shall have the meaning given to such term under the California Information Practices Act, Civil Code section 1798.29(f).

C. CMPPA agreement means the Computer Matching and Privacy Protection Act agreement between the Social Security Administration and the California Health and Human Services Agency (CHHS).

D. Confidential Information: Information that is exempt from disclosure under the provisions of the

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California Public Records Act (Government Code sections 6250-6265) or other applicable state or federal laws.

E. Department PI shall mean Personal Information, accessed in a database maintained by County, received by Contractor from County or acquired or created by Contractor in connection with performing the functions, activities and services specified in this agreement on behalf of County.

F. Notice-triggering Personal Information shall mean the personal information identified in Civil Code section 1798.29 whose unauthorized access may trigger notification requirements under Civil Code section 1798.29. For purposes of this provision, identity shall include, but not be limited to, name, address, email address, identifying number, symbol, or other identifying particular assigned to the individual, such as a finger or voice print, a photograph, or a biometric identifier. Notice-triggering Personal Information includes PI in electronic, paper, or any other medium.

G. Personally Identifiable Information (PII): Any information about an individual which can be used to distinguish or trace an individual's identity, such as name, social security number, date and place of birth, mother's maiden name, and biometric records. This information can be in paper or electronic files and includes, but is not limited to, education records, financial transactions, employment history, criminal records, and medical files.

H. Personal Information (PI): Information that identifies or describes an individual, including, but not limited to, name, social security number, physical description, address, telephone number, education, financial matters, and medical or employment history. It includes statements made by, or attributed to, the individual.

I. Protected Health Information (PHI): Individually identifiable health information that is transmitted or maintained in any form or medium, created or received by a health care provider or health plan, that relates to past, present, and future physical or mental health condition of an individual; provisions of healthcare to an individual; or past, present and future payment for the provision of healthcare to an individual. Health information which is considered subject to the regulations contained in the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) including: name, date of birth, telephone number, names of relatives, names of employers, photographic images, facsimile number, medical record number, finger or voice prints, certificate/license number, social security number, internet (IP) address, web URL, e-mail address, and any device or serial number. "Protected Health Information" includes electronic protected health information.

J. Public Information: Information that is not exempt from disclosure under the provisions of the California Public Records Act (Government Code sections 6250-6265) or other applicable state or federal laws.

K. Required by law means a mandate contained in law that compels an entity to make a use or disclosure of PI or PII that is enforceable in a court of law. This includes, but is not limited to, court orders and court-ordered warrants, subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information, and a civil or an authorized investigative demand. It also includes Medicare conditions of participation with respect to health care providers participating in the program, and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits.

L. Security Incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of PHI, PI, PII or confidential data utilized in complying with this Agreement; or interference with system operations in an information system that processes, maintains or stores P H I , PI, or PII.

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M. Sensitive Information: Information that requires special precautions to protect from unauthorized use, access, disclosure, modification, loss, or deletion. Sensitive information may be either public information or confidential information. It is information that requires a higher than normal assurance of accuracy and completeness. Thus, the key factor for sensitive information is that of integrity. Typically, sensitive information includes records of agency financial transactions and regulatory actions.

3. Contractor and its employees, agents, or subcontractors shall promptly transmit to the County Contract Manager all requests for disclosure of any PHI, PI, or PII not emanating from the person who is the subject of PHI, PI, or PII without a signed Consent for Release of Information.

4. Contractor shall not disclose, except as otherwise specifically permitted by this agreement or authorized by the person who is the subject of PHI, PI, or PII, any PHI, PI, or PII to anyone other than DHCS without prior written authorization from the County Contract Manager, except if disclosure is required by state or federal law.

5. Terms of Agreement

A. Permitted Uses and Disclosures of KernBHRS PHI, PI, and PII by Contractor:

1. Except as otherwise indicated in this Exhibit, Contractor may use or disclose Department PHI, PI, and/or PII only to perform functions, activities, or services for or on behalf of KernBHRS pursuant to the terms of this agreement provided that such use or disclosure would not violate the California Information Practices Act (CIPA) if done by KernBHRS.

2. Contractor shall not directly or indirectly receive remuneration in exchange for County PHI.

B. Responsibilities of Contractor

Contractor agrees:

1. **Nondisclosure.** To protect from unauthorized disclosure any Sensitive or Confidential information. Not to use or disclose KernBHRS PHI, PI, or PII other than in carrying out the Contractor's obligations under this agreement or as permitted or required by applicable state and federal law.

2. **Safeguards.** To implement appropriate and reasonable administrative, technical, and physical safeguards to protect the security, confidentiality, and integrity of KernBHRS PHI, PI, and PII, to protect against anticipated threats or hazards to the security or integrity of KernBHRS PHI, PI, and PII, and to prevent use or disclosure of KernBHRS PHI, PI, or PII other than as provided for by this agreement. Contractor shall develop and maintain a written privacy and information security program that include administrative, technical, and physical safeguards appropriate to the size and complexity of Contractor's operations and the nature and scope of its activities. Contractor will provide KernBHRS with its current policies upon request.

3. **Security.** Contractor shall take any and all steps necessary to ensure the continuous security of all computerized data systems containing PHI, PI, and/or PII, and to protect paper documents containing PHI, PI, and/or PII. These steps shall include, at a minimum:

   i. Complying with all of the data system security precautions listed in Business Associate Agreement Data Security Requirements.

   ii. Providing a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III- Security of Federal Automated Information Systems, which sets forth

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guidelines for automated information systems in federal agencies.

4. **Mitigation of Harmful Effects.** To mitigate, to the extent practicable, any harmful effect that is known to Contractor of a use or disclosure of KernBHRS PHI, PI, or PII by Contractor or its subcontractors in violation of this Exhibit.

5. **Contractor's Agents and Subcontractors.** To impose the same restrictions and conditions set forth in this Exhibit on any subcontractors or other agents with whom Contractor subcontracts any activities under this agreement that involve the disclosure of Department PHI, PI, or PII to the subcontractor.

6. **Availability of Information to County.** To make County PHI, PI, and PII available to County for purposes of oversight, inspection, amendment, and response to requests for records, injunctions, judgments, and orders for production of County PHI, PI, and PII. If Contractor receives County PHI, PI, and/or PII, upon request by County, Contractor shall provide County with a list of all employees, contractors, and agents who have access to County PHI, PI and/or PII, including employees, contractors, and agents of its subcontractors and agents.

7. **Cooperation with County.** With respect to County PHI, PI, and/or PII, to cooperate with and assist County to the extent necessary to ensure County's compliance with the applicable terms of the California Information Practice Act including, but not limited to, accounting of disclosures of County PHI, PI, and/or PII, correction of errors in County PHI, PI, and/or PII, production of County PHI, PI, and/or PII, disclosure of a security breach involving County PHI, PI, and/or PII, and notice of such breach to the affected individual(s).

8. **Confidentiality of Substance Use Disorder and Treatment Records.** Contractor agrees to comply with all confidentiality requirements set forth in Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2. Contractor is aware that civil and/or criminal penalties may be imposed for a violation of these confidentiality requirements.

6. The Contractor shall observe the following requirements:

A. Safeguards. Contractor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, PI, and/or PII, including electronic PHI, PI, and/or PII that it creates, receives, maintains, uses, or transmits on behalf of County. Contractor shall develop and maintain a written information privacy and security program that includes administrative, technical, and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities, including at a minimum the following safeguards:

1) **Personnel Controls**

a. **Employee Training.** All workforce members must complete privacy and information security training through the Relias training system, upon hire and annually thereafter. If Contractor does not have access to Relias, Contractor may utilize the Microsoft Teams training available through the BHRS Privacy & Corporate Compliance Office. Contractor may also utilize their own training platform. Contractor will need to document their staff's training attendance, including maintaining a sign-in sheet, e-sign or certificate, indicating the staff member's name and the date on which the training was completed. These certifications must be retained for a period of ten (10) years following contract termination. Contractor will need to develop an internal tracking mechanism to monitor their staff's attendance. This tracking system shall be available for the County to review at any time, to ensure that this required training is completed. Contractor's Privacy and Information Security training must consist of the following:

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1) HIPAA Privacy and Security regulations (45 CFR Part 160 and 164)

2) California Welfare and Institutions Code § 5328 et seq (required if Contractor provides mental health services)

3) Title 42 Code of Federal Regulations, Chapter I, Subchapter A, Part 2 (required if Contractors provides any substance use services, even if Contractor is a primary mental health provider)

4) Contractor's internal policies and procedures related to sections 1-3 above.

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

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

d. **Background Check.** Before a member of the workforce may access County PHI, PI, and/or PII, a thorough background check of that worker must be conducted, with evaluation of the results to assure that there is no indication that the worker may present a risk to the security or integrity of confidential data or a risk for theft or misuse of confidential data. Contractor shall retain each workforce member's background check documentation for a period of three (3) years following contract termination.

2) **Technical Security Controls**

a. **Workstation/Laptop encryption.** All workstations and laptops that process and/or store County PHI, PI, and/or PII must be encrypted using a FIPS 140-2 certified algorithm which is 128-bit or higher, such as Advanced Encryption Standard (AES). The encryption solution must be full disk unless approved by the County Information Security Officer.

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

c. **Minimum Necessary.** Only the minimum necessary amount of County PHI, PI, and/or PII required to perform necessary business functions may be copied, downloaded, or exported.

d. **Removable media devices.** All electronic files that contain County PHI, PI, and/or PII data must be encrypted when stored on any removable media or portable device (i.e. USB thumb drives, floppies, CD/DVD, Smart Phone, backup tapes etc.). Encryption must be a FIPS 140-2 certified algorithm which is 128-bit or higher, such as AES.

e. **Antivirus software.** All workstations, laptops and other systems that process and/or store County PHI, PI, and/or PII must install and actively use comprehensive anti-virus software solution with automatic updates scheduled at least daily.

f. **Patch Management.** All workstations, laptops and other systems that process and/or store County PHI, PI, and/or PII must have critical security patches applied, with system reboot if

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necessary. There must be a documented patch management process which determines installation timeframe based on risk assessment and vendor recommendations. At a maximum, all applicable patches must be installed within thirty (30) days of vendor release.

g. **User IDs and Password Controls.** All users must be issued a unique username for accessing County PHI, PI, and/or PII. Username must be promptly disabled, deleted, or the password changed upon the transfer or termination of an employee with knowledge of the password, at maximum within twenty four (24) hours. Passwords are not to be shared. Passwords must be at least ten (10) characters and must be a non-dictionary word. Passwords must not be stored in readable format on the computer. Passwords must be changed every ninety (90) days, preferably every sixty (60) days. Passwords must be changed if revealed or compromised. Passwords must be composed of characters from at least three (3) of the following four groups from the standard keyboard:

- Upper case letters (A-Z)
- Lower case letters (a-z)
- Arabic numerals (0-9)
- Non-alphanumeric characters (punctuation symbols)

h. **Data Destruction.** When no longer needed, all County PHI, PI, and/or PII must be wiped using the Gutmann or U.S. Department of Defense (DoD) 5220.22-M (7 Pass) standard, or by degaussing. Media may also be physically destroyed in accordance with NIST Special Publication 800-88. Other methods require prior written permission of the County Information Security Officer.

i. **System Timeout.** The system providing access to County PHI, PI, and/or PII must provide an automatic timeout, requiring re-authentication of the user session after no more than fifteen (15) minutes of inactivity.

j. **Warning Banners.** All systems providing access to County PHI, PI, and/or PII must display a warning banner stating that data is confidential, systems are logged, and system use is for business purposes only by authorized users. User must be directed to log off the system if they do not agree with these requirements.

k. **System Logging.** The system must maintain an automated audit trail which can identify the user or system process which initiates a request for County PHI, PI, and/or PII, or which alters County PHI, PI, and/or PII. The audit trail must be date and time stamped, must log both successful and failed accesses, must be read only, and must be restricted to authorized users. If County PHI, PI, and/or PII is stored in a database, database logging functionality must be enabled. Audit trail data must be archived for at least three (3) years after occurrence. Audit Trail logs must be reviewed for potential violations and/or breaches on a regular basis.

l. **Access Controls.** The system providing access to County PHI, PI, and/or PII must use role-based access controls for all user authentications, enforcing the principle of least privilege.

m. **Transmission Encryption.** All data transmissions of County PHI, PI, and/or PII outside the secure internal network must be encrypted using a FIPS 140-2 certified algorithm which is 128-bit or higher, such as AES. Encryption can be end-to-end at the network level, or the data files containing PHI, PI, or PII can be encrypted. This requirement pertains to any type of PHI, PI, or PII in motion such as website access, file transfer, and E-Mail. Any transmission of unencrypted PHI, PI and/or PII outside of Contractor's secure network, must be reported to the KernBHRS Privacy and Corporate Compliance office. (Contacts are listed at the end of this Exhibit).

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n. **Intrusion Detection.** All systems involved in accessing, holding, transporting, and protecting County PHI, PI, and/or PII that are accessible via the Internet must be protected by a comprehensive intrusion detection and prevention solution.

3) **Business Continuity / Disaster Recovery Controls**

a. **Emergency Mode Operation Plan.** Contractor must establish a documented plan to enable continuation of critical business processes and protection of the security of electronic County PHI, PI, and/or PII in the event of an emergency. Emergency means any circumstance or situation that causes normal computer operations to become unavailable for use in performing the work required under this agreement for more than twenty-four (24) hours.

b. **Data Backup Plan.** Contractor must have established documented procedures to back up County PHI, PI, and/or PII to maintain retrievable exact copies of County PHI, PI, and/or PII. The plan must include a regular schedule for making backups, storing back-ups offsite, an inventory of backup media, and an estimate of the amount of time needed to restore County PHI, PI, and/or PII should it be lost. At a minimum, the schedule must be a weekly full backup and monthly offsite storage of County data.

4) **Paper Document Controls**

a. **Supervision of Data.** County PHI, PI, and/or PII in paper form shall not be left unattended at any time, unless it is locked in a file cabinet, file room, desk, or office. Unattended means that information is not being observed by an employee authorized to access the information. County PHI, PI, and/or PII in paper form shall not be left unattended at any time in vehicles or planes and shall not be checked in baggage on commercial airplanes.

b. **Escorting Visitors.** Visitors to areas where County PHI, PI, and/or PII is contained shall be escorted and County PHI, PI, and/or PII shall be kept out of sight while visitors are in the area.

c. **Confidential Destruction.** County PHI, PI, and/or PII must be disposed of through confidential means, such as cross-cut shredding and pulverizing.

d. **Removal of Data.** County PHI, PI, and/or PII must not be removed from the premises of Contractor except with express written permission of County.

e. **Faxing.** Faxes containing County PHI, PI, and/or PII shall not be left unattended and fax machines shall be in secure areas. Faxes shall contain a confidentiality statement notifying persons receiving faxes in error to destroy them. Fax numbers shall be verified with the intended recipient before sending the fax.

f. **Mailing.** Mailings of County PHI, PI, and/or PII shall be sealed and secured from damage or inappropriate viewing of PHI, PI, or PII to the extent possible. Mailings which include five hundred (500) or more individually identifiable records of County PHI, PI, and/or PII in a single package shall be sent using a tracked mailing method which includes verification of delivery and receipt, unless the prior written permission of County to use another method is obtained.

5) **Audit Controls**

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a. **System Security Review.** All systems processing and/or storing County PHI, PI and/or PII must have at least an annual system risk assessment/security review that provides assurance that administrative, physical, and technical controls are functioning effectively and providing adequate levels of protection. Reviews should include vulnerability scanning tools.

b. **Log Reviews.** All systems processing and/or storing County PHI, PI, and/or PII must have a routine procedure in place to review system logs for unauthorized access.

c. **Change Control.** All systems processing and/or storing County PHI, PI, and/or PII must have a documented change control procedure that ensures separation of duties and protects the confidentiality, integrity, and availability of data.

d. **Receiving and Investigating Privacy Issues.** Contractor shall have a process for staff or individuals to make complaints or report privacy issues. Contractors must document all complaints received and privacy issues investigated, including their disposition. Contractor shall provide to County, documentation of privacy issues investigated, upon request. Additionally, Contractor must submit a quarterly report, utilizing **Exhibit F, Privacy and Compliance Investigation Summary**, to the BHRS Privacy and Corporate Compliance office via email to BHRSPrivacy@KernBHRS.org within thirty (30) calendar days of the end of each fiscal quarter.

B. Security Officer. Contractor shall designate an Information Security Officer to oversee its data security program who will be responsible for carrying out its privacy and security programs and for communicating on security matters with County, under 45 CFR 164.308.

C. Privacy Officer. Contractor shall designate a Privacy official who is responsible for the development and implementation of HIPAA policies and procedures per 45 CFR § 164.530(a)(1)(i). Contractor must designate a contact person or office who is responsible for receiving complaints under 45 CFR § 164.530(a)(1)(ii).

D. Discovery and Notification of Breach. Contractor shall notify County **immediately by telephone call at (661) 868-6868 and email at BHRSPrivacy@KernBHRS.org** upon the discovery of a breach (or suspected breach) of privacy or security of PHI, PI, and/or PII in electronic, paper, spoken or in any other media, if the PHI, PI, and/or PII was not securely transmitted, or is reasonably believed to have been, accessed, acquired by an unauthorized person, or upon the discovery of a suspected privacy or security incident that involves data provided to County by the Social Security Administration or involving County PHI, PI, and/or PII; **or by email within twenty-four (24) hours** of the discovery of any suspected security incident, intrusion, or unauthorized use or disclosure of PHI, PI, and/or PII in violation of this agreement or the Business Associate Agreement, or potential loss of confidential data affecting this agreement. A breach shall be treated as discovered by Contractor as of the first day on which the breach is known, or by exercising reasonable diligence, would have been known, to any person (other than the person committing the breach) who is an employee, officer, or other agent of Contractor.

Notification shall be provided to the KernBHRS Contract Manager, the KernBHRS Privacy & Corporate Office, and the KernBHRS Information Security Officer. If the incident occurs after business hours or on a weekend or holiday and involves electronic PHI, PI, and/or PII, notification shall be provided by calling the KernBHRS Information Security Officer at (661) 203-5397. Alternately, contact the KernBHRS Information Technology Services Division (ITSD) Help Desk at 661-868-6740. Upon discovery of a breach or suspected security incident, intrusion or unauthorized access, use, or disclosure of PHI, PI, and/or PII, Contractor shall take:

1) Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the Contractor's operating environment and information confidentiality and security requirements.

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2) Any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.

E. Investigation of Breach. In the event Contractor's actions or inactions cause a security incident, breach or unauthorized use or disclosure of PHI, PI, and/or PII, Contractor shall immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI, PI, and/or PII and within **forty eight (48)** hours of the discovery, Contractor shall submit an initial Department of Health Care Services (DHCS) "Privacy Incident Report," containing the information marked with an asterisk and all other applicable information listed on the form, to the extent known at that time. Contractor shall use the most current version of this form, which is posted on the DHCS Information website https://www.dhcs.ca.gov/formsandpubs/laws/priv/Documents/Privacy-Incident-Report-PIR.pdf. Submit this report to the KernBHRS Privacy and Corporate Compliance Office via email at BHRSPrivacy@KernBHRS.org.

F. Written Report. Contractor shall provide a final written report of the investigation to the BHRS Privacy & Corporate Compliance Office, via email to BHRSPrivacy@KernBHRS.org within ten (10) working days of the discovery of the breach or unauthorized use or disclosure. The report shall be submitted on the DHCS "Privacy Incident Report" form and shall include an assessment of all known factors relevant to a determination of whether a breach occurred. The report shall also include a full, detailed corrective action plan, including information on measures that were taken to halt and/or contain the improper use or disclosure. If necessary, a Supplemental Report may be used to submit revised or additional information after the completed report is submitted, by submitting the revised or additional information on an updated "Privacy Incident Report" form. BHRS Privacy & Corporate Compliance Office will submit this information to DHCS, who will review and approve the determination of whether a breach occurred and whether individual notification is required. Contractor shall also submit, to the BHRS Privacy & Corporate Compliance Office, an internal incident or investigation report, completed by Contractor.

G. Notification of Individuals. In the event Contractor's actions or inactions cause a breach or unauthorized use or disclosure of PHI, PI, and/or PII, Contractor shall notify individuals of the breach or unauthorized use or disclosure when notification is required under state or federal law, and shall pay any costs of such notifications, as well as any costs associated with the breach.

1) Once DHCS has made a breach determination, Contractor shall draft a (de-identified) proposed breach notification letter, using guidelines provided in the SIMM 5340-C (State of California, California Information Security Office: Requirements to Respond to Incidents Involving a Breach of Personal Information), as instructed, and submit to the BHRS Privacy & Corporate Compliance Office via email at BHRSPrivacy@KernBHRS.org, who will submit the letter to DHCS for approval.

2) When the proposed breach notification letter is approved by DHCS, KernBHRS Privacy Office or designee will notify Contractor, who shall then proceed with mailing the notification letter(s) to the affected beneficiary/beneficiaries without reasonable delay, and in no event later than sixty (60) calendar days following the date of discovery.

3) Contractor shall notify the Department of Health and Human Services (HHS), Office for Civil Rights (OCR) no later than sixty (60) days after the end of the calendar year in which the breach is discovered, for a breach affecting less than five hundred (500) individuals, by visiting the HHS website (https://ocrportal.hhs.gov/ocr/breach/wizard_breach.jsf?faces-redirect=true) and filling out and electronically submitting a breach report form. If the breach affects five hundred (500) or more individuals, the KernBHRS Privacy Office will coordinate next steps with Contractor, including HHS notification.

H. Effect on lower tier transactions. The terms of this Exhibit shall apply to all contracts, subcontracts,

and subawards, regardless of whether they are for the acquisition of services, goods, or commodities. Contractor shall incorporate the contents of this Exhibit into each subcontract or subaward to its agents, subcontractors, or independent consultants.

I. **Contact Information.** To direct communications to the below referenced KernBHRS staff, Contractor shall initiate contact as indicated herein. KernBHRS reserves the right to make changes to the contact information below by giving written notice to Contractor. Said changes shall not require an amendment to this Exhibit or the agreement into which it is incorporated.

Kern Behavioral Health and Recovery Services Contract Manager	**Kern Behavioral Health and Recovery Services Privacy Officer**	**Kern Behavioral Health and Recovery Services Information Security Officer**
Name: Ana Olvera E-Mail: AOlvera@KernBHRS.org Phone: (661) 868-7596 Kern Behavioral Health and Recovery Services P.O. Box 1000 Bakersfield, CA 93302	Privacy & Corporate Compliance Officer Elizabeth Brown Email: Ebrown@KernBHRS.org Direct Line: (661) 868-6821 Kern Behavioral Health and Recovery Services P.O. Box 1000 Bakersfield, CA 93302 Privacy and Corporate Compliance Office Telephone: (661) 868-6868 Email:BHRSPrivacy@KernBHRS.org	Information Security Officer Rachelle Hunt Email: Rhunt@KernBHRS.org Kern Behavioral Health and Recovery Services P.O. Box 1000 Bakersfield, CA 93302 Help Desk Telephone: (661) 868-6740 Email: BHRSHelpDesk@KernBHRS.org

J. **Audits and Inspections.** From time to time, KernBHRS may inspect the facilities, systems, books and records of Contractor to monitor compliance with the safeguards required in this Exhibit. Contractor shall promptly remedy any violation of any provision of this Privacy and Information Security Exhibit. The fact that KernBHRS inspects, or fails to inspect, or has the right to inspect Contractor's facilities, systems, and procedures does not relieve Contractor of its responsibility to comply with this Exhibit.

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COMMUNITY SERVICES ORGANIZATION BEHAVIORAL HEALTH PROGRAMS, INC.

OUTPATIENT SUBSTANCE USE TREATMENT SERVICES
RECOVERY INCENTIVES PROGRAM
PENAL CODE 1000 DRUG DIVERSION PROGRAM

EXHIBIT F - PRIVACY AND COMPLIANCE INVESTIGATION SUMMARY

(NOT REQUIRED FOR INDEPENDENT CONTRACTOR OR CONTRACTED EMPLOYEE)

NOTE: COMPLETED COPY ON FILE WITH PRIVACY AND CORPORATE COMPLIANCE

Contractor must provide this summary to the KernBHRS Privacy and Corporate Compliance office by email @ BHRSPrivacy@KernBHRS.org, within 30 calendar days of the end of each quarter. Please keep in mind that privacy and compliance investigations do not have a negative impact. Investigating privacy and compliance issues and following up on issues/risks identified are a way to show that a Privacy or Compliance Program is effective.

Report for: FY Click or tap here to enter text. ☐Qtr. 1 (July-Sept) ☐ Qtr. 2 (Oct-Dec) ☐ Qtr. 3 (Jan-Mar) ☐Qtr. 4 (Apr-Jun)

Contractor: Click or tap here to enter text.
Contractor Address: Click or tap here to enter text.
Name of Privacy Officer: Click or tap here to enter text.
Phone: Click or tap here to enter text. Email:Click or tap here to enter text.
Name of Compliance Officer: Click or tap here to enter text.
Phone:Click or tap here to enter text. Email:Click or tap here to enter text.
Name of Information Security Officer: Click or tap here to enter text.
Phone:Click or tap here to enter text. Email: Click or tap here to enter text.

Privacy Investigations:

Total investigations this quarter: Click or tap here to enter text.
Attestation: Did you report all investigations to KernBHRS
Yes ☐ No ☐
How many of the total investigations did your agency determine were violations? Click or tap here to enter text.
Select the type and enter the total number of each type of investigation

Type of Investigation	Total	Type of Investigation	Total
Select One:		Select One:	
☐Access to EHR ☐Access to PHI (other than HER ☐Disclosure Of PHI ☐Electronic PHI lost or stolen ☐Misdirected fax/mail ☐Non-electric PHI lost or stolen ☐Security of electronic PHI ☐Social Media related ☐Storage of PHI ☐An unencrypted email containing PHI, PI, or PII		☐Access to EHR ☐Access to PHI (other than HER ☐Disclosure Of PHI ☐Electronic PHI lost or stolen ☐Misdirected fax/mail ☐Non-electric PHI lost or stolen ☐Security of electronic PHI ☐Social Media related ☐Storage of PHI ☐An unencrypted email containing PHI, PI, or PII	

Corporate Compliance Investigations

Total investigations this quarter: Click or tap here to enter text.
Attestation: Did you report all investigations to KernBHRS
Yes ☐ No ☐
How many of the total investigations did your agency determine were violations? Click or tap here to enter text.
Select the type and enter the total number of each type of investigation

Type of Investigation	Total	Type of Investigation	Total
Select One:		Select One:	
☐Code of Ethics Violation ☐Conflict of Interest ☐Inaccurate/Inappropriate Billing ☐Service Delivery Standards ☐Fraud Related to Credentials ☐Doing Business With Excluded Entity or Person ☐Fraud, Waste & Abuse		☐Code of Ethics Violation ☐Conflict of Interest ☐Inaccurate/Inappropriate Billing ☐Service Delivery Standards ☐Fraud Related to Credentials ☐Doing Business With Excluded Entity or Person ☐Fraud, Waste & Abuse	

Signature: Click or tap here to enter text. Title: Click or tap here to enter text.
Name (Please print):Click or tap here to enter text. Date:Click or tap here to enter text.

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COMMUNITY SERVICES ORGANIZATION BEHAVIORAL HEALTH PROGRAMS, INC.

OUTPATIENT SUBSTANCE USE TREATMENT SERVICES
RECOVERY INCENTIVES PROGRAM
PENAL CODE 1000 DRUG DIVERSION PROGRAM

EXHIBIT G - PROGRAM INTEGRITY REQUIREMENTS

1. GENERAL REQUIREMENTS

As a condition for receiving payment under a Medi-Cal managed care program, Contractor shall comply with the provisions of 42 CFR §§ 438.602, 438.608, 438.610, 455.1(a)1, 455.104-455.106, 455.434; Social Security Act §§ 1128, 1156, and 1842(j)(2).

2. COMPLIANCE PROGRAM

Contractor shall have administrative or management arrangements or procedures designed to guard against fraud and abuse. Contractor shall comply with the provisions of 42 CFR 438.608.

A. Option 1: Utilize the KernBHRS Corporate Compliance Program

i. Contractor must designate a Compliance Officer (CO), who reports directly to the CEO and the Board of Directors (BoD) and is charged with overseeing the organization's compliance with requirements under the contract.

ii. Contractor must abide by all tenets of the KernBHRS Corporate Compliance Program.

iii. Contractor must adopt all policies and procedures contained within the KernBHRS Corporate Compliance Program.

iv. All Contractor's workforce members must complete KernBHRS Corporate Compliance and Ethics training, through the Relias training system, upon hire and annually thereafter. Additionally, Contractor must ensure all workforce members are familiarized with the KernBHRS Compliance Program and know where to locate it, as well as providing all workforce members with contact information for the Contractor's Compliance Officer (CO) and training on how to report a compliance issue or concern. Contractor shall track employee trainings, to ensure training is completed at required intervals.

v. Contractor must establish effective lines of communication between the CO and the organization's employees, including routine communication with workforce members regarding pertinent compliance issues.

vi. Contractor must provide enforcement of standards through well-publicized disciplinary guidelines.

vii. Contractor must establish and implement procedures and a system for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential of recurrence, and ongoing compliance with the requirements under the contract. Contractor must submit a quarterly report, utilizing **Exhibit F, "Privacy and Compliance Investigation Summary"**, to the Privacy and Corporate Compliance office via email to BHRSPrivacy@KernBHRS.org within thirty (30) calendar days of the end of each fiscal quarter.

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viii. Contractor's Compliance Officer must report any violation of the KernBHRS Corporate Compliance program, including policies and procedures contained therein, to the KernBHRS Privacy and Corporate Compliance Office via email to BHRSPrivacy@KernBHRS.org. Any allegation of fraud, waste or abuse must be reported promptly.

ix. Contractors utilizing Option 1 must notify the KernBHRS Privacy and Corporate Compliance Office of their decision to utilize the KernBHRS Compliance Program, within thirty (30) days of the executed agreement and annually thereafter for every fiscal year covered under the executed agreement. Additionally, within sixty (60) days of the executed agreement, Contractor must submit supplemental training materials/plans for ensuring all workforce members are familiarized with the KernBHRS Compliance Program and where to locate it, as well as contact information for the Contractor's Compliance Officer and how to report a compliance issue or concern. This information must be submitting utilizing the contact information listed below.

B. Option 2: Contractor shall implement and maintain a Compliance Program that must include, at a minimum, the seven (7) **essential elements** outlined in items i-vii below:

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

ii. **Designation of A Compliance Officer** (CO) who is responsible for developing and implementing policies, procedures, and practices designated to ensure compliance with the requirements of the contract, and who reports directly to the CEO and the Board of Directors (BoD).

iii. **A Regulatory Compliance Committee** (RCC) on the BoD and the senior management level, charged with overseeing the organization's compliance program and its compliance with the requirements under the contract.

iv. **A system for training and education** for the CO, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the contract, including specialized training on Contractor's Compliance Program, including training on the False Claims Act.

Contractor's workforce members must complete Corporate Compliance and Ethics training, through the Relias training system upon hire and annually thereafter. Contractor shall track employee trainings to ensure training is completed at required intervals. In addition to the Relias training, Contractor shall ensure staff receive training on their specific Compliance Program, including contact information for the Contractor's Compliance Officer and training on how to report a compliance issue or concern.

If Contractor does not have access to Relias, Contractor must provide training to all staff that includes specifics on Contractor's Compliance Program, which includes detection and prevention of fraud, waste and abuse, False Claims Act – including rights of employees to be protected as whistleblowers, Contractor's standards of conduct, code of ethics, how to report compliance issues, as well as contact information for Contractor's Compliance Officer. Contractor will need to document their staff's attendance, including maintaining a sign-in sheet, e-sign or certificate, indicating the staff member's name and the date on which the training was completed. These certifications must be retained for a period of ten (10) years following contract termination. Contractor will need to develop an internal tracking mechanism to monitor their staff's attendance. This tracking system shall be available for the County to review at any time, to ensure that this required training is completed.

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v. **Effective lines of communication** between the CO and the organization's employees.

vi. **Enforcement of standards through well-publicized disciplinary guidelines**.

vii. **The establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks**, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the agreement. Contractor shall provide to County, documentation of monitoring and auditing of compliance risk and response, upon request. Contractor must submit via email to BHRSPrivacy@KernBHRS.org, a quarterly report, utilizing **Exhibit F, "Privacy and Compliance Investigation Summary**," to the Privacy and Corporate Compliance office within thirty (30) calendar days of the end of each fiscal quarter. Additionally, Contractor must report any allegation of fraud, waste or abuse promptly.

viii. Contractors utilizing Option 2 must provide to the KernBHRS Privacy and Corporate Compliance Office a copy of Contractor's Compliance Program and training materials utilized to train workforce members within sixty (60) days of the executed agreement and annually thereafter for every fiscal year covered under the executed agreement. The KernBHRS Privacy and Corporate Compliance Office will review the submitted Compliance Program. If it doesn't meet regulatory requirements, as outlined in 42 CFR 438.608 (or doesn't include contact information for Contractor's Compliance and Privacy Officer(s)), it will be returned to the Contractor for corrections. Contractor will have a maximum of thirty (30) calendar days to resubmit the Compliance Program, with corrections completed. Should Contractor not submit the required Compliance Program and training materials within the above timeframes, KernBHRS will not process submitted claim for payment. Any delayed payments will be processed upon receipt of the approved Compliance Program and training materials from Contractor. This information must be submitted utilizing the contact information provided below.

Kern County Behavioral Health and Recovery Services Compliance Officer
Compliance Officer: Elizabeth Brown Telephone: (661) 868-6724 Email: EBrown@KernBHRS.org Privacy and Corporate Compliance Office Telephone: (661) 868-8222 Email: BHRSPrivacy@KernBHRS.org Kern County Behavioral Health and Recovery Services PO Box 1000 Bakersfield, CA 93302

3. EXCLUDED PROVIDERS

Contractor shall not knowingly have a relationship with any individual or entity that is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in any of such programs by any federal agency or by any department, agency or political subdivision of the state. For purposes of this paragraph, "principal" means an officer, director, owner of any portion of the entity, partner, key employee, subcontractor, or other person with primary management or supervisory responsibilities, or a person who has a critical influence or substantive control over Contractor's operations. Contractor shall

be required to submit a Disclosure of Ownership and Control Interest Statement during the initial contracting, re-contracting and/or recredentialing process or upon request by County.

A. Consistent with the requirements of 42 CFR § 438.602(d), Contractor must confirm the identity and determine the exclusion status of all employees and any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee through routine checks of federal and state databases.

i. List of Excluded Individuals/Entities (LEIE), which is maintained by the United States Department of Health and Human Services (HHS), Officer of the Inspector General (OIG), upon hire and monthly thereafter.

ii. Contractor shall submit Exclusion report with claim for payment, as outlined in **"N. Medi-Cal Rate-Based Reimbursement,"** of this agreement.

iii. This list includes entities and individuals who have been suspended from receiving payments for services provided under any provider number to Medi-Cal beneficiaries. If Contractor or subcontractor is listed, this agreement shall terminate consistent with the paragraph entitled, **"IMMEDIATE TERMINATION."** Contractor shall ensure that any excluded individual is immediately prevented from performing services resulting in claims for payment for services, directly or indirectly to a Medicare or Medi-Cal recipient. The excluded individual should also be removed from active duty in any position in which the person's salary or the services rendered or prescribed are paid in whole or in part, by federal health care programs or federal funds until such time the person is removed from the Exclusions lists. Contractor shall maintain records confirming verification of initial and monthly monitoring for a minimum of ten (10) years after the employee's separation from employment. Contractor shall provide affirmation of review to the SOC Administrator monthly, the Quality Improvement Division designee during annual audits and upon request, and shall, as prescribed by Department, report any provider individual, employee or subcontractor provider, appearing on any of these exclusions lists, databases or indices.

iv. The parties mutually represent and warrant to one another that they and their respective representatives are not: (i) currently excluded, debarred, or otherwise ineligible to participate in the federal health care program as defined in 42 U.S.C. section 1320a-7b (f) (the federal health care programs) and/or present on the exclusion database of the Office of the Inspector General ("OIG"); (ii) convicted of a criminal offense related to the provision of health care items or services but have not yet been excluded, debarred, or otherwise declared ineligible to participate in the federal health care programs; or (iii) debarred, suspended, excluded, or disqualified by any federal governmental agency or department or otherwise declared ineligible from receiving federal contracts or federally approved sub-contracts or from receiving federal financial and nonfinancial assistance and benefits.

v. This shall be an on-going representation and warranty during the term of this agreement and a party shall immediately notify the other party of any change in the status of any of the representations and/or warranties set forth in this section. At a minimum, the parties shall verify all current staff against the sources at the frequency identified in Section **35.B**. Any breach of this section shall give the non-breaching party the right to terminate this agreement immediately

vi. If Contractor or subcontractor is identified as an excluded provider, this agreement shall terminate consistent with the guidelines in the paragraph entitled, **"IMMEDIATE TERMINATION."**

B. Contractor must conduct an initial check, prior to hire new staff, of the following databases:

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i. Social Security Administration's Death Master File, which is maintained by the United States Social Security Administration.

ii. National Plan and Provider Enumeration System (NPPES), which is maintained by the Centers for Medicaid and Medicare.

iii. List of Excluded Individuals/Entities (LEIE)

iv. System for Award Management Excluded Parties List System (SAM-EPLS)

v. Department of Health Care Services (DHCS) Medi-Cal Suspended and Ineligible Provider List (S&I List)

C. Contractor must conduct monthly checks of the following databases:

i. List of Excluded Individuals/Entities (LEIE)

ii. System for Award Management Excluded Parties List System (SAM-EPLS)

iii. Department of Health Care Services (DHCS) Medi-Cal Suspended and Ineligible Provider List (S&I List)

Contractor understands that it must comply with the National Provider Identification (NPI) system, and will provide the County NPI numbers for all staff providing direct health care or clinical services. Contractor further agrees to verify the NPI numbers(s) upon hiring staff, and to apply for NPI numbers on new employees within five (5) business days of the hiring date, immediately providing confirmation of NPI application to the Department. Contractor further understands that all services entered in the **KernBHRS electronic health record** will suspend and agrees that electronic billings for services will not be accepted without the inclusion of the NPI number(s). If the NPI number is not received within ninety (90) days after the service, the service will no longer be billable and reimbursable to Contractor. Contractor shall notify the department within twenty-four (24) hours of any change to staff NPI numbers or related information, including the termination of employment of any Contractor staff. NPI numbers are also required for each physical delivery site.

D. Contractor shall submit reports in accordance with KernBHRS Policy 3.1.15 (Screening for Ineligible and Suspended Employees and Entities), providing verification that each database referenced in KernBHRS policy 3.1.15, and this section of this contract, are monitored at the required intervals (upon hire/monthly, depending on the database). Contractor shall not knowingly have a relationship with an individual or entities that are excluded from participating in any Federal health care program per §1128 of the Social Security Act, including:

i. Any individual or entity that has been convicted of a criminal offense related to the delivery of an item or service under Title XVIII or under any state health care program.

ii. Any individual or entity that has been convicted, under federal or state law, of a criminal offense relating to neglect or abuse of patient in connection with the delivery of a health care item or service.

iii. Any individual or entity that has been convicted for a criminal offense consisting of a felony relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct after the enactment of the Health Insurance Portability and Accountability Act of 1996.

iv. Any individual or entity that has been convicted for an offense consisting of a felony relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance

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which occurred after the date of the enactment of the Health Insurance Portability and Accountability Act of 1996.

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

F. In accordance with Section 1903(i) of the Social Security Act, the Contractor is prohibited from making payment:

i. With respect to any amount expended for an item or service that is furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Social Security Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person).

ii. With respect to any amount expended for an item or service that is furnished by an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments.

iii. With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act (ASFRA) of 1997.

G. These lists include entities and individuals who have been suspended from receiving payments for services provided under any provider number to Medi-Cal beneficiaries. If Contractor or subcontractor is listed, this agreement shall terminate consistent with paragraph entitled, **"IMMEDIATE TERMINATION."**

H. Contractor shall ensure that any excluded individual is immediately prevented from performing services resulting in claims for payment for services, directly or indirectly to a Medicare or Medi-Cal recipient. The excluded individual should also be removed from active duty in any position in which the person's salary or the services rendered or prescribed are paid in whole or in part, by federal health care programs or federal funds until such time the person is removed from the Exclusions lists. Contractor shall maintain records confirming verification of initial and monthly monitoring for a minimum of ten (10) years after the employee's separation from employment. Contractor shall provide affirmation of review to the SOC Administrator monthly, the Quality Improvement Division designee during annual audits and upon request, and shall, as prescribed by Department, report any provider individual, employee or subcontractor provider, appearing on any of these exclusions lists, databases or indices. Instructions for monthly submission are found in **"Paragraph 4. Submission of a Claim for Payment,"** of this agreement.

I. The parties mutually represent and warrant to one another that they and their respective representatives are not: (i) currently excluded, debarred, or otherwise ineligible to participate in the federal health care program as defined in 42 U.S.C. section 1320a-7b(f) (the federal health care programs) and/or present on the exclusion database of the Office of the Inspector General ("OIG"), the General Services Administration ("GSA") or the Medi-Cal ineligible list; (ii) convicted of a criminal offense related to the provision of health care items or services but have not yet been excluded, debarred, or otherwise declared ineligible to participate in the federal health care programs; or (iii) debarred, suspended, excluded, or disqualified by any federal governmental agency or department or otherwise declared ineligible from receiving federal contracts or federally approved sub-contracts or from receiving federal financial and nonfinancial assistance and benefits.

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This shall be an ongoing representation and warranty during the term of this agreement, and a party shall immediately notify the other party of any change in the status of any of the representations and/or warranties set forth in this section. At a minimum, the parties shall verify all current staff against the sources at the frequency identified in this Exhibit. Any breach of this section shall give the non-breaching party the right to terminate this agreement immediately.

J. If Contractor or subcontractor is identified as an excluded provider, this agreement shall terminate consistent with the guidelines in the paragraph entitled**, "IMMEDIATE TERMINATION."**

4. SERVICE VERIFICATION

Pursuant to 42 C.F.R. § 438.608(a)(5), Contractor shall implement and maintain arrangements or procedures designed to detect and prevent fraud, waste, and abuse that include provisions to verify, by sampling or other methods, whether services that have been represented to have been delivered, were received by beneficiaries, and the application of such verification processes on a regular basis.

Contractor may follow the County process or shall develop and maintain their own process for Service Verification, based on 42 C.F.R. § 438.608(a)(5), and provide evidence to the KernBHRS Compliance Office by the last business day of each fiscal quarter (September, December, March and June), by encrypted email to BHRSPrivacy@KernBHRS.org.

A. Contractor shall utilize the County's prescribed method of Service Verification for all office-based, billable, face-to-face services.

B. For billable field-based and group services, Contractor may choose one of two options for Service Verification:

i. Contractor may use the County's method of obtaining Service Verification for billable, field-based and group services, **OR**

ii. Contractor may select an alternate method of Service Verification. If Contractor selects an alternate method:

a. This method must be submitted to the KernBHRS Privacy and Corporate Compliance office (BHRSPrivacy@KernBHRS.org) at least thirty (30) days prior to the beginning of an upcoming audit cycle, e.g., proposed Service Verification method must be submitted by September 1, December 1, March 1 and June 1.

b. Contractor will be responsible for maintaining the Service Verification process, monitoring the process meets the County standards, and reporting the data to the KernBHRS Privacy and Corporate Compliance office by encrypted email, to BHRSPrivacy@KernBHRS.org, by the last business day of the fiscal quarter (September, December, March and June).

5. DEFICIT REDUCTION ACT

A. The parties to this agreement are aware of the provisions of Federal Deficit Reduction Act of 2005: Employee Education on False Claims Recovery and certify that they comply with Section 1902(a) of the Social Security Act.

B. Section 6032 of the Deficit Reduction Act requires any entities that receive or make annual payments under the state plan (Medi-Cal in California) of at least five million dollars ($5,000,000) as a condition of receiving such payments to comply with the following requirements:

i. Establish written policies for all employees of the entity, including management and any contractor(s) or agent(s) of the entity. These written policies shall provide detailed information about the following:

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a. The Federal False Claims Act, including administrative remedies for false claims and statements established under title 31, USC, Chapter 38.

b. State laws pertaining to civil or criminal penalties for false claims and statements; whistleblower protections under such laws; and the role of these laws in preventing and detecting fraud, waste and abuse in federal health care programs.

c. Contractor's procedures for detecting and preventing fraud, waste and abuse.

ii. Contractor must provide employee training on the False Claims Act, including the rights of employees to be protected as whistleblowers. Documented evidence of this training is to be provided to County upon request. (This training can be incorporated into Compliance Program training. See 2.B. iv. above).

6. FRAUD REPORTING REQUIREMENTS

A. Contractor shall implement and maintain arrangements or procedures designed to detect and prevent fraud, waste and abuse that include prompt reporting to County about the following:

i. Any potential fraud, waste or abuse. (42 CFR §438.608(a), (a)(7).)

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

iii. Information about changes in a beneficiary's circumstances that may affect the beneficiary's eligibility including changes in the beneficiary's residence or the death of the beneficiary. (42 C.F.R. §438.608(a), (a)(3).)

B. If Contractor identifies an issue or receives notification of a complaint concerning an incident of potential fraud, waste or abuse, in addition to notifying the County within **twenty-four (24) hours,** the Contractor shall conduct an internal investigation to determine the validity of the issue/complaint, and develop and implement corrective action, if needed, notifying the County of the outcome of the investigation.

C. Contractor shall implement and maintain written policies for all employees that provided detailed information about the False Claims Act and other federal and state laws, including information about rights of employees to be protected as whistleblowers. (42 CFR §438.608(a), (a)(6).)

D. County shall suspend payments to Contractor if there is a credible allegation of fraud. (42 CFR §438.608(a), (a)(5).)

7. DISCLOSURES OWNERSHIP CONTROL INTEREST STATEMENT

A. Contractor agrees to furnish County with the names of its officers, owners, stockholders owning more than five percent (5%) of its stock, and major creditors holding more than five percent (5%) of the debt of Contractor. This information shall become public record on file with the U.S. Department of Health and Human Services.

B. Contractor agrees to comply with the requirements set forth in the federal regulations 42 CFR 455.104-455.106 in reference to the Medicare, Medicaid, or Title XX service programs.

C. Contractor agrees to submit to County the completed form attached herein as **Exhibit H, "Disclosure of Ownership and Control Interest Statement"** upon submitting the provider application, during the re-validation of enrollment, and upon request. Any person with a five percent (5%) or more direct or indirect interest in Contractor must include results of fingerprints/criminal background check.

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D. Contractor agrees to notify County and update **"Disclosure of Ownership and Control Interest Statement"** within thirty-five (35) days if a change in ownership occurs.

E. County may terminate the Agreement if any person with a five percent (5%) or greater direct or indirect ownership interest in Contractor does not submit timely and accurate information and cooperate with any screening methods required in 42 CFR 455.416.

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COMMUNITY SERVICES ORGANIZATION BEHAVIORAL HEALTH PROGRAMS, INC.

OUTPATIENT SUBSTANCE USE TREATMENT SERVICES
RECOVERY INCENTIVES PROGRAM
PENAL CODE 1000 DRUG DIVERSION PROGRAM

EXHIBIT H - DISCLOSURE OF OWNERSHIP AND CONTROL INTEREST STATEMENT

NOTE: COMPLETED COPY ON FILE WITH CONTRACT MONITORING TEAM

The federal regulations set forth in 42 CFR 455.101, 455.104, 455.105, 455.106, and 455.434 require providers who are entering into or renewing a provider agreement to disclose to the U.S. Department of Health and Human Services, the state Medicaid agency, and to Managed Care Organizations that contract with the state Medicaid Agency: 1) the identity of all owners with a control interest of five percent **(5%) or greater**, 2) certain business transactions as described in 42 CFR 455.105 and 3) the identity of any excluded individual or entity with an ownership or control interest in the provider, the provider group, or disclosing entity or who is an agent or managing employee of the provider group or entity or who is an agent or managing employee of the provider entity and 4) arrange for fingerprint clearance for criminal background checks and submit proof of clearance along with Disclosure of Ownership and Control Interest Statement documentation. Any changes in ownership during the contract year will require all documentation to be updated. **Please attach a separate sheet if necessary.**

Provider Entity Information
Circle the Type of disclosing entity: **____Individual Member of a Group or Sole Proprietor ____Partnership ____Corporation ____Limited Liability** **____Other (Specify)_____**
Legal Name of individual or entity ("**Provider Entity**"):
DBA Name:
Group Name:
Primary/Main Office Address:
Mailing Address (if different from above)
Practice Address 1:
Practice Address 2:
Federal Tax Identification #:
Medicaid ID#:
National Provider ID (NPI) #:
Provider CAQH #:

***If applicable, add the group, provider or health care professional name and EIN when the Provider Entity is part of a group practice, attach a separate sheet if necessary.**

Section I

Are there any individuals or organizations with an Ownership or Control Interest of 5% or more in the Provider Entity?
___Yes ___No
List the **name, title, address, date of birth (DOB**) and **Social Security Number** (SSN) for **all individuals** having an ownership or control interest in the Provider Entity of 5% or greater. This Should match those listed in the organizational chart. For Owners list the percentage of ownership. Attach additional pages if needed to **identify all parties** with ownership or control interest.
List the name, Tax Identification Number (TIN), business address of each organization, corporation, or entity having an ownership of corporation, or entity having an Ownership or Control Interest of **5% or greater**. (42 CFR 455.104 (b) (1) (ii))

Name/Title	DOB	Address	Address	SSN (if listing an individual) TIN (if listing an entity)	% Interest

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Section II
Are any of the individuals listed in Section I above related to each other? ___**Yes** ___**No** If yes, list the individuals identified and the relationship to each other (spouse, sibling, parent, child). Are any individuals listed in Section I above related to any individuals with an ownership or control interest in any of the subcontractors listed in Section III below? ___**Yes** ___**No** If yes, list their name and relationship. (42 CFR.455.104 (b) (2))

Name of Individual	Relationship

Section III
Does the Provider Entity have a Direct or Indirect Ownership Interest in any Subcontractor 5% or more that another individual or organization also has an Ownership or Controlling Interest? ___**Yes** ___**No** If yes, list the following information for each person with an Ownership or controlling Interest in any Subcontractor in which the Provider Entity has Direct or Indirect Ownership of 5% or more. (42 CFR 455.104)

Name/Title	Address	DOB	SSN or TIN	% Interest

Section IV
Has any person who has an ownership or control interest in the provider entity, or is an agent or managing employee of the Provider Entity ever been convicted of a crime related to that person's involvement in any program under Medicaid, Medicare or Title XX program? ___**Yes** ___**No** (verify through HHS-OIG List of Excluded individuals/Entities (LEIE), General Services Administration (GSA) Excluded Parties List (EPLS), the Medicare Exclusion Database (the MED) databases and any State specific database.) **Any person who has a 5% or more direct or indirect interest must also submit fingerprints and a background check.** **If yes**, please list those persons below. (42 CFR 455.106)

Name/Title	DOB	Address	SSN (if listing an individual) TIN (if listing an entity)

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Section V
Business Transactions: Has the provider Entity had any business transactions with Subcontractors or Wholly Owned Supplier totaling more than $25,000 or 5% or operating expenses in the previous twelve (12) month period? ___**Yes** ___ If yes, list the ownership of Subcontractor with whom the Provider Entity **has had a business transactions total more than $25,000** during the previous twelve 12-month period; **and any Significant Business Transaction between this provider and any wholly owned supplier** exceeding the lesser of $25,000 or 5% operating expense, during the past 5-year period. This information must be provided within 35 days of request. Attach a separate sheet if necessary. (42 CFR 455.104 and 42 CFR 455.105)

Name of supplier/ Subcontractor	Address	Owner	SSN (if listing an individual) TIN (if listing an entity)	Transaction Amount

Section VI
Managing Employees: Does the Provider Entity have any Managing Employees? **Yes No** If yes, for Disclosing Entities, list each member of the Board of Directors, Governing Board, and Managing Employees (general manager, business manager, administrator or director), including the name, date of birth (DOB), Address, Social Security Number (SSN), and percent of interest.

Name/Title	DOB	Address	SSN (if listing an individual)	% Interest

I certify that the information provided herein, is true, accurate and complete.

Any person who has a 5% or more direct or indirect interest must also submit fingerprints and a background check results with the Disclosure of Ownership form.

Additions or revisions to the information above will be submitted immediately upon revision. Additionally, I understand that misleading, inaccurate, or incomplete data may result in a denial of participation. Individuals and Sole Proprietors must sign their own form. An authorized representative may sign for Partnership, Corporation, LLC or Other disclosing entities.

Signature **Title (indicate if authorized Agent)**

Name (please print) **Date**

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COMMUNITY SERVICES ORGANIZATION BEHAVIORAL HEALTH PROGRAMS, INC.

OUTPATIENT SUBSTANCE USE TREATMENT SERVICES
RECOVERY INCENTIVES PROGRAM
PENAL CODE 1000 DRUG DIVERSION PROGRAM

EXHIBIT I - CREDENTIALING AND RE-CREDENTIALING REQUIREMENTS

INTRODUCTION:

A. KernBHRS will establish and conduct a provider Credentialing Program for credentialing and re-credentialing Contractor's network treatment providers. Contractor shall agree to comply with the terms set forth herein.

B. Contractor shall adhere to the California Department of Health Care Services' (DHCS) statewide uniform provider credentialing and re-credentialing requirements, established pursuant to Title 42 of the Code of Federal Regulations, Part 438.214.

C. KernBHRS will ensure that Contractor and its employees, agents, or subcontractors are qualified in accordance with current legal, professional, and technical standards, and are appropriately licensed, registered, waivered, and/or certified.

D. Contractor and its employees, agents, or subcontractors must be in good standing with the Medicaid/Medi-Cal programs. Any provider of Contractor, including contracted organizational providers, provider groups, and individual practitioners, who are excluded from participation in federal health care programs, including Medicare or Medicaid/Medi-Cal, may not participate in any KernBHRS provider network.

E. The uniform credentialing and re-credentialing requirements apply to all licensed, waivered, or registered mental health providers and licensed, registered, or certified Alcohol or Other Drug Counselors, employed by or contracting with KernBHRS to deliver Medi-Cal covered services.

F. Contractor shall observe the following requirements:

1. For all licensed, waivered, registered and/or certified providers, KernBHRS will verify and document the information listed below. The listed requirements are not applicable to all provider types. When applicable to the provider type, the information must be verified by KernBHRS through an auditing process of Contractor's primary source verification efforts or by Contractor's submitting these documents directly to the KernBHRS Credentialing Unit or designee. This will be required unless Contractor can demonstrate the required information has been previously verified by the applicable licensing, certification, and/or registration board.

2. Contractor shall submit the following information for their employees, agents, or subcontractors at the time of hire and at the various timelines listed below to the KernBHRS Credentialing Unit or designee. KernBHRS reserves the right to audit the primary source verification that Contractor reports it is doing for their employees on a quarterly basis. Regardless of whether Contractor submits all information to KernBHRS to credential or Contractor's credentialing process is audited, Contractor must submit all credentialing requirements to KernBHRS Credentialing team or designee at the time of hire of any new employee. Contractor will also notify KernBHRS Credentialing team when an employee separates from their organization to ensure that credentialing/re-credentialing efforts are not continued for separated employees.

I. Primary Source Verification shall be required in the following areas at the time of hire and every three (3) years thereafter unless Contractor can demonstrate the required information has been previously verified by the applicable licensing, certification and/or registration board:

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a. The appropriate license and/or board certification or registration, as required for the particular provider type;

b. Evidence of graduation or completion of any required education, as required for the particular provider type;

c. Proof of completion of any relevant medical residency and/or specialty training, as required for the particular provider type; and

d. Satisfaction of any applicable continuing education requirements, as required for the particular provider type.

II. Additional information shall be required in the following areas from Contractor and its employees, agents, or subcontractors, as applicable, at the time of hire and every three (3) years thereafter

a. Work history;

b. Hospital and clinic privileges in good standing;

c. History of any suspension or curtailment of hospital and clinic privileges;

d. Current Drug Enforcement Administration identification number;

e. National Provider Identifier number;

f. Current malpractice insurance in an adequate amount, as required for the particular provider type;

g. History of liability claims against the provider;

h. Provider information, if any, entered in the National Practitioner Data Bank, when applicable. See https://www.npdb.hrsa.gov/ ;

i. History of sanctions from participating in Medicare and/or Medicaid/Medi-Cal: providers terminated from either Medicare or Medi-Cal, or on the Suspended and Ineligible Provider List, may not participate in the Plan's provider network. This list is available at: http://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp

j. History of sanctions or limitations on the provider's license issued by any state's agencies or licensing boards;

k. Employee Attestation consisting of five (5) required elements:

i. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.

ii. A history of loss of license or felony conviction.

iii. A history of loss or limitation of privileges or disciplinary activity.

iv. A lack of present illegal drug use; and

v. The application's accuracy and completeness

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l. Enrollment in the Provider Application and Validation of Enrollment (PAVE), as applicable to provider type

m. Other sources pertinent to the credentialing or recredentialing process as identified by KernBHRS.

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COMMUNITY SERVICES ORGANIZATION BEHAVIORAL HEALTH PROGRAMS, INC.

OUTPATIENT SUBSTANCE USE TREATMENT SERVICES
RECOVERY INCENTIVES PROGRAM
PENAL CODE 1000 DRUG DIVERSION PROGRAM

EXHIBIT J – ROLES AND RESPONSIBILITIES IN PARTNERSHIP WITH KERN'S MANAGED CARE PLANS

1. Training and Education.

A. Contractor must provide training and orientation for their employees who carry out activities under this agreement. The training courses will be assigned by KernBHRS or the Contract Administrator and include information on agreement requirements contained in this exhibit including, but not limited to, what services are provided or arranged for by the MCP, and the policies and procedures outlined in this exhibit. Contractor must provide this training prior to any such person or entity performing responsibilities under this agreement, as assigned by the contract administrator under the directives of KernBHRS and to all such persons or entities at least annually thereafter.

B. In accordance with the health education standards required by the Medi-Cal Managed Care Contract, Contractor must provide KernBHRS MediCal Members with educational materials related to accessing Covered Services, including for services provided by BHP/DMC-ODS. These materials will be provided to Contractor as directed by DHCS and will include educational materials on how Managed Care Plan (MCP) Covered Services and MHP/DMC-ODS services may be accessed, including during non-business hours.

2. Screening, Assessment, and Referrals.

A. DMC-ODS Screening and Assessment.

1. Contractor must implement and adhere to KernBHRS policy procedures that address how Members must be screened and assessed for MCP Covered Services and DMC-ODS services.

B. DMC-ODS Referrals.

Contractor must implement and adhere to KernBHRS policies and procedures that ensure Members are referred to the appropriate MCP Covered Services and DMC-ODS services.

1. Contractor must refer Members via the referral section of the TOC tool to MCP for Covered Services, as well as any Community Supports services or care management programs for which they may qualify, such as Enhanced Care Management ("ECM") or Complex Case Management ("CCM"). If DMC-ODS contractor is an ECM Provider, DMC-ODS provides ECM services pursuant to that separate agreement between MCP and DMC-ODS for ECM services; this MOU does not govern DMC-ODS's provision of ECM.

2. Contractor must ensure that Members may access services through multiple pathways and Members receive SUD services when Members have co-occurring SMHS and/or NSMHS and SUD needs.

3. Contractor must comply with KernBHRS policy surrounding the process by which a referrals from MCP staff, providers, or a self-referred Member is referred for assessment, as well as provide data upon request indicating such acceptance of the referral to BHP.

3. Care Coordination and Collaboration.

A. DMC-ODS Care Coordination.

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1. Contractor must implement and adhere to KernBHRS policies and procedures for coordinating Members' access to care and services that incorporate all the requirements set forth in this exhibit.

2. Contractor must discuss and address care coordination issues or barriers to care coordination efforts with KernBHRS via the SUD Access Line as outlined in Exhibit A of this agreement".

3. Contractor must implement and adhere to KernBHRS policies and procedures that coordinate Members' care:

i. The requirement for Contractor to refer Members to MCP to be assessed for care coordination and other similar programs and other services for which they may qualify provided by MCP including, but not limited to, ECM, CCM, or Community Supports.

ii. The specific point of contact to act as the liaison and be responsible for initiating, providing, and maintaining ongoing care coordination for all Members under this exhibit and in accordance with coordination of care requirements with the MCP.

iii. A process for how Contractor and MCP will engage in collaborative treatment planning to ensure care is clinically appropriate and non-duplicative and considers the Member's established therapeutic relationships.

iv. A process for coordinating the delivery of Medically Necessary Covered Services with the Member's Primary Care Provider, including without limitation transportation services, home health services, and other Medically Necessary Covered Services for eligible Members.

v. A process for how Contractor and MCP will help to ensure the Member is engaged and participates in their care program and a process for ensuring the Members, caregivers, and providers are engaged in the development of the Member's care.

vi. A process for reviewing and updating a Member's problem list, as clinically indicated; including the circumstances in which updates are required.

vii. A process for how Contractor will engage in collaborative treatment planning and ensure communication among providers, including procedures for exchanges of medical information.

B. DMC-ODS Transitional Care.

1. Contractor must implement and adhere to KernBHRS policies and procedures for the coordination of transitional care services for Members. A "transitional care service" is defined as the transfer of a Member from one setting or level of care to another, including, but not limited to, discharges from hospitals, institutions, and other acute care facilities and skilled nursing facilities to home- or community-based settings, 2 level of care transitions that occur within the facility, or transitions from outpatient therapy to intensive outpatient therapy and vice versa.

2. For Members who are admitted for residential SUD treatment, including, but not limited to, Psychiatric Residential Treatment Facilities where DMC-ODS is the primary payer and the Member is receiving services through Contractor. Contractor is primarily responsible for coordination of the Member upon discharge.

3. Contractor must implement and adhere to KernBHRS policies and procedures for completion of the discharge planning documents as required for Members transitioning to or from MCP or DMC-ODS services;

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4. Clinical Consultation.

A. Contractor must implement and adhere to KernBHRS policies and procedures to provide clinical consultations to MCP regarding a Member's mental illness, including consultation on diagnosis, treatment, and medications.

B. Contractor must implement and adhere to KernBHRS policies and procedures for reviewing and updating a member's problem list, as clinically indicated (e.g., following crisis intervention or hospitalization), including when the care plan or problem list must be updated, and coordinating with Member's ECM or CS service provider.

5. DMC-ODS Clinical Consultation.

A. Contractor must implement and adhere to KernBHRS policies and procedures to ensure that Members have access to clinical consultation, including consultation on medications, as well as clinical navigation support for patients and caregivers.

6. MHP Enhanced Care Management.

A. That Contractor ensures that all members who qualify for Covered Services from their Managed Care plan are referred to these services using the Transition of Care Tool if the patients meet Population of Focus criteria.

B. That Contractor implements a process for avoiding duplication of services for individuals receiving ECM with SMHS Targeted Case Management ("TCM"), Intensive Care Coordination ("ICC"), and/or Full-Service Partnership ("FSP") services as set forth in the CalAIM ECM Policy Guide, as revised or superseded from time to time, and coordination activities.

7. Community Supports.

A. Coordination must be established with applicable Community Supports providers under contract with MCP, including:

1. The identified point of contact, from the Contractor to act as the liaison to oversee initiating, providing, and maintaining ongoing coordination.

2. Identification of the Community Supports covered by MCP.

3. Adhering to KernBHRS procedure for referral via the Transition of Care (TOC) form.

8. DMC-ODS Enhanced Care Management.

A. Delivery of the ECM benefit for individuals who meet ECM Population of Focus definitions (including, but not limited to, the Individuals with Severe Mental Illness and Children Populations of Focus) must be consistent with DHCS guidance regarding ECM, including:

1. That Contractor refers all qualifying members to MCP by utilizing the TOC tool for ECM if the patients meet Population of Focus criteria.

B. Contractor must implement a process for avoiding duplication of services for individuals receiving ECM with DMC-ODS care coordination. Members receiving DMC-ODS care coordination can also be eligible for and receive ECM.

9. Community Supports.

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A. Coordination must be established with applicable Community Supports providers under contract with MCP, including:

1. Identification of the Community Supports covered by MCP and which members qualify for these services.

2. Refer all qualifying members to MCP by utilizing the TOC tool for Members eligible for or receiving Community Supports.

10. DMC-ODS Prescription Drugs.

A. Contractor must implement and adhere to KernBHRS policies and procedures to coordinate prescription drug, laboratory, radiological, and radioisotope service procedures.

11. Quality Improvement.

A. Contractor must develop QI activities specifically for the oversight of the requirements of this agreement, including, without limitation, any applicable performance measures and QI initiatives, including those to prevent duplication of services, as well as reports that track referrals, Member engagement, and service utilization. Such QI activities must include processes to monitor the extent to which Members are able to access mental health services across SMHS and NSMHS, and Covered Service utilization. Contractor must document these QI activities in policies and procedures.

12. Dispute Resolution.

A. Contractor must adhere to KernBHRS procedures regarding disputes with MCP partners.

13. Data Elements.

A. Except where prohibited by law or regulation, contractors must share the minimum necessary data and information to facilitate referrals and coordinate care under this agreement.

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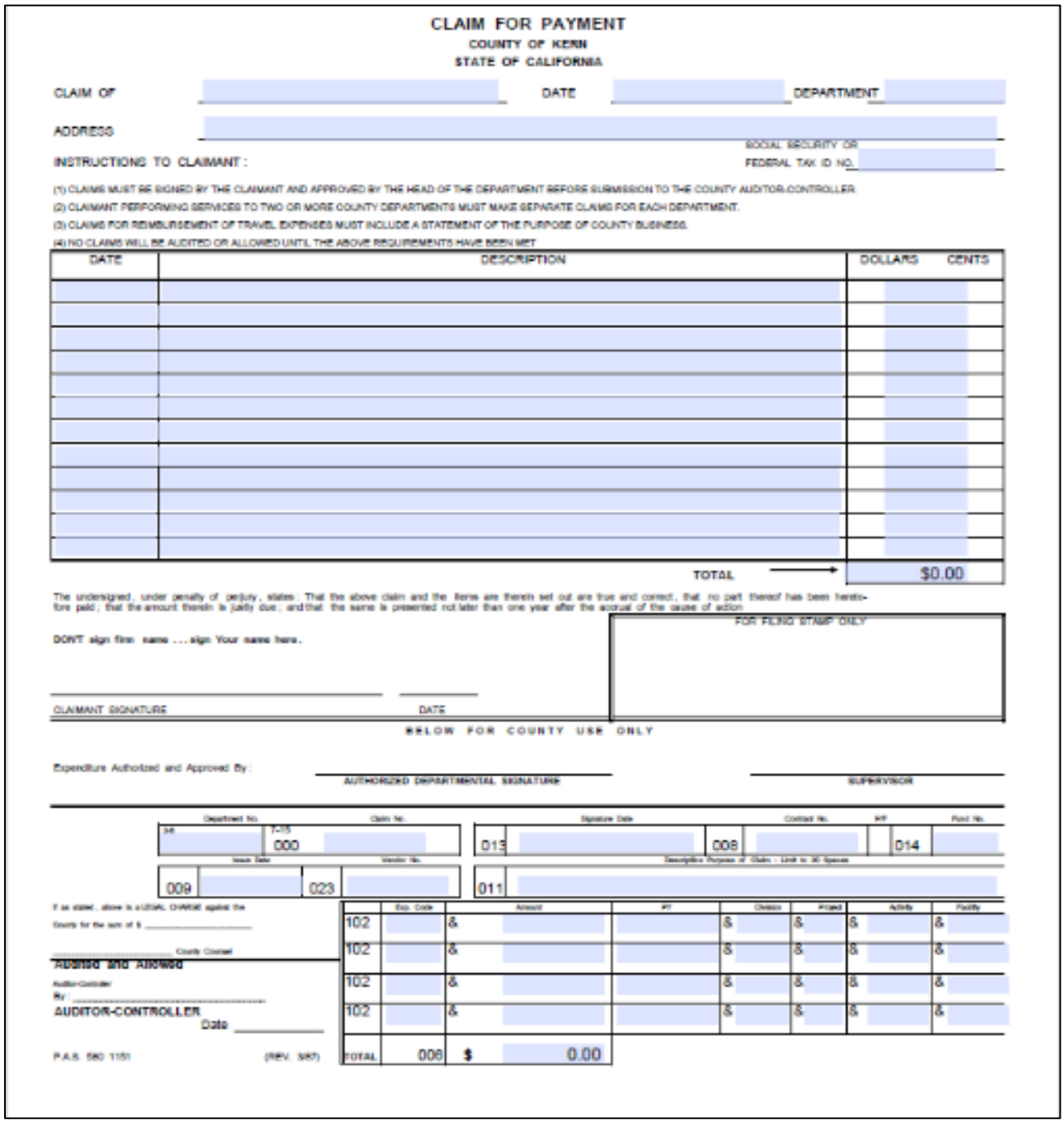
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COMMUNITY SERVICES ORGANIZATION BEHAVIORAL HEALTH PROGRAMS, INC.

OUTPATIENT SUBSTANCE USE TREATMENT SERVICES
RECOVERY INCENTIVES PROGRAM
PENAL CODE 1000 DRUG DIVERSION PROGRAM

EXHIBIT K – CLAIM FOR MEDI-CAL RATE BASED REIMBURSEMENT AGREEMENTS

NOTE: COMPLETED COPY ON FILE WITH FINANCE



CLAIM FOR PAYMENT
COUNTY OF KERN
STATE OF CALIFORNIA

CLAIM OF _____ DATE _____ DEPARTMENT _____

ADDRESS _____

SOCIAL SECURITY OR
INSTRUCTIONS TO CLAIMANT: FEDERAL TAX ID NO. _____

(1) CLAIMS MUST BE SIGNED BY THE CLAIMANT AND APPROVED BY THE HEAD OF THE DEPARTMENT BEFORE SUBMISSION TO THE COUNTY AUDITOR-CONTROLLER.
(2) CLAIMANT PERFORMING SERVICES TO TWO OR MORE COUNTY DEPARTMENTS MUST MAKE SEPARATE CLAIMS FOR EACH DEPARTMENT.
(3) CLAIMS FOR REIMBURSEMENT OF TRAVEL EXPENSES MUST INCLUDE A STATEMENT OF THE PURPOSE OF COUNTY BUSINESS.
(4) NO CLAIMS WILL BE AUDITED OR ALLOWED UNTIL THE ABOVE REQUIREMENTS HAVE BEEN MET.

DATE	DESCRIPTION	DOLLARS	CENTS
	TOTAL →	$0.00	

The undersigned, under penalty of perjury, states: That the above claim and the items are therein set out are true and correct; that no part thereof has been heretofore paid; that the amount therein is justly due; and that the same is presented not later than one year after the accrual of the cause of action.

DON'T sign firm name ... sign Your name here.

FOR FILING STAMP ONLY

_____ _____
CLAIMANT SIGNATURE DATE

BELOW FOR COUNTY USE ONLY

Expenditure Authorized and Approved By: _____ _____
AUTHORIZED DEPARTMENTAL SIGNATURE SUPERVISOR

Department No.	Claim No.	Signature Date	Contract No.	MT	Fund No.
34 T-TS 000		013	008		014

Issue Date	Vendor No.	Descriptive Purpose of Claim - Limit to 30 Spaces
009	023	011

If as stated, above is a LEGAL CHARGE against the County for the sum of $ _____

_____ County Counsel

Audited and Allowed

Auditor-Controller
By: _____
AUDITOR-CONTROLLER
Date _____

P.A.S. 580 1151 (REV. 9/87)

	Exp. Code	Amount	MT	Division	Project	Activity	Facility
102		&		&	&	&	&
102		&		&	&	&	&
102		&		&	&	&	&
102		&		&	&	&	&
TOTAL	006	$ 0.00					

Docusign Envelope ID: D49FA866-8322-81FF-8377-1B59D7915C97

COMMUNITY SERVICES ORGANIZATION BEHAVIORAL HEALTH PROGRAMS, INC.

OUTPATIENT SUBSTANCE USE TREATMENT SERVICES
RECOVERY INCENTIVES PROGRAM
PENAL CODE 1000 DRUG DIVERSION PROGRAM

EXHIBIT K-1– EXAMPLE

CLAIM FOR MEDI-CAL RATE BASED REIMBURSEMENT AGREEMENTS

CLAIM FOR PAYMENT
COUNTY OF KERN
STATE OF CALIFORNIA

CLAIM OF Hope ABC DATE 07/05/2023 DEPARTMENT

ADDRESS ABC 123 STREET

INSTRUCTIONS TO CLAIMANT: SOCIAL SECURITY OR FEDERAL TAX ID NO. 12-123456

(1) CLAIMS MUST BE SIGNED BY THE CLAIMANT AND APPROVED BY THE HEAD OF THE DEPARTMENT BEFORE SUBMISSION TO THE COUNTY AUDITOR-CONTROLLER.
(2) CLAIMANT PERFORMING SERVICES TO TWO OR MORE COUNTY DEPARTMENTS MUST MAKE SEPARATE CLAIMS FOR EACH DEPARTMENT.
(3) CLAIMS FOR REIMBURSEMENT OF TRAVEL EXPENSES MUST INCLUDE A STATEMENT OF THE PURPOSE OF COUNTY BUSINESS.
(4) NO CLAIMS WILL BE AUDITED OR ALLOWED UNTIL THE ABOVE REQUIREMENTS HAVE BEEN MET.

DATE	DESCRIPTION	DOLLARS	CENTS
04/21/2023	Service Code 15/01, CPT(99233), Quantity = (1,401 UOS) x $Y rate per UOS		
	Service Code 15/07, CPT(99233), Quantity = (1,235 UOS) x $Y rate per UOS	ENTER	
	Service Code 15/10, CPT(99233), $Quantity = (1,132 UOS) x $Y rate per UOS	$SUB-	
	Service Code 15/30, CPT(99233), Quantity = (2,253 UOS) x $Y rate per UOS	TOTALS	
	Service Code 15/40, CPT(99233), Quantity = (1,700 UOS) x $Y rate per UOS	BY	
	Service Code 15/57, CPT(99233), Quantity = (0 UOS) x $Y rate per UOS	LINE	
	Service Code 15/58, CPT(99233), Quantity = (577 UOS) x $Y rate per UOS	ITEM	
	Service Code 15/60, CPT(99233), Quantity = (371 UOS) x $Y rate per UOS		
	Service Code 15/66, CPT(99233), Quantity = (0 UOS) x $Y rate per UOS		
	Service Code 15/70, CPT(99233), Quantity = (112 UOS) x $Y rate per UOS		
	Service Code 45/10, CPT(99233), Quantity = (0 UOS) x $Y rate per UOS		
	Activity GSA 9 page 1 of 1		
	TOTAL →	$Total $X.XX	

The undersigned, under penalty of perjury, states: That the above claim and the items are therein set out are true and correct; that no part thereof has been heretofore paid; that the amount therein is justly due; and that the same is presented not later than one year after the accrual of the cause of action.

DON'T sign firm name ... sign Your name here

FOR FILING STAMP ONLY

CLAIMANT SIGNATURE

EXAMPLE

BELOW FOR COUNTY USE ONLY

Expenditure Authorized and Approved By:

AUTHORIZED DEPARTMENTAL SIGNATURE SUPERVISOR

Department No.	Claim No.	Signature Date	Contract No.	FP	Fund No.
Lit	T-15 000	013	006		014
Issue Date	Vendor No.	Descriptive Purpose of Claim - Limit to 30 Spaces			
009	023	011			

If so stated, above is a LEGAL CHARGE against the County for the sum of $ _____

County Counsel

Audited and Allowed
Auditor-Controller
By: _____
AUDITOR-CONTROLLER
Date _____

	Exp. Code	Amount	PY	Division	Project	Activity	Facility
102		&		&	&	&	&
102		&		&	&	&	&
102		&		&	&	&	&
102		&		&	&	&	&
TOTAL	006	$ 0.00					

P.A.S. 980 1101 (REV. 3/97)

Docusign Envelope ID: D49FA866-8322-81FF-8377-1B59D7915C97

[END OF THE AGREEMENT]