AMENDMENT #1 TO THE CONTRACT WITH
RECOVER MEDICAL GROUP P.C. (RES 23-300)

THIS AMENDMENT is executed this March 12, 2024 by and between RECOVER MEDICAL GROUP P.C., hereinafter referred to as "Contractor" and COUNTY OF NEVADA, hereinafter referred to as "County". Said Amendment will amend the prior Agreement between the parties entitled Professional Services Contract, executed on June 27, 2023 per Resolution RES 23-300; and

WHEREAS, the Contractor operates Provision of outpatient rehabilitative treatment services for Medi-Cal beneficiaries for the recovery and treatment of alcohol /drug dependency; and

WHEREAS, the parties desire to amend their Agreement to revise Exhibit "A" Schedule of Services to incorporate the addition of Medication Assisted Treatment (MAT) services for the current contract amount of $142,329 under the current contract term of July 1, 2023 through June 30, 2024.

NOW, THEREFORE, the parties hereto agree as follows:

1. That Amendment #1 shall be effective as of 02/01/2024.
2. That the Schedule of Services, Exhibit "A" is amended to the revised Exhibit "A" attached hereto and incorporated herein.
3. That in all other respects the prior agreement of the parties shall remain in full force and effect except as amended herein.

COUNTY OF NEVADA:

By:_____
Hardy Bullock
Chair of the Board of Supervisors

ATTEST:

By:_____
Clerk of the Board

CONTRACTOR:

By: _____
Recover Medical Group P.C.
120 Birmingham Drive, Ste 240A
Cardiff, CA 92007

EXHIBIT A
SCHEDULE OF SERVICES
RECOVER MEDICAL GROUP P.C.

Recover Medical Group PC, hereinafter referred to as "Contractor", shall provide services related to the treatment of substance use disorders for the County of Nevada, Department of Behavioral Health hereinafter referred to as "County".

Program Overview:

"Contractor", shall provide outpatient treatment services American Society of Addiction Medicine (ASAM) Level 0.5 Early Intervention Services, ASAM Level 1.0 Outpatient Treatment Services, ASAM Level 2.1 Intensive Outpatient Services, and Recovery Services for Medi-Cal Beneficiaries for the recovery and treatment of alcohol/drug dependency for the Nevada County Department of Behavioral Health, hereinafter referred to as "County."

Scope of Work:

A. OUTPATIENT SERVICES:

Early Intervention Services (ASAM Level 0.5)
Early intervention services are covered DMC-ODS services for beneficiaries under the age of 21. Any beneficiary under the age of 21 who is screened and determined to be at risk of developing an SUD may receive any service component covered under the outpatient level of care as early intervention services. Early intervention services are provided under the outpatient treatment modality and must be available as needed based on individual clinical need, even if the beneficiary under age 21 is not participating in the full array of outpatient treatment services. Early intervention services may be delivered in a wide variety of settings, and can be provided in person, by telehealth, or by telephone.

Outpatient Treatment Services (ASAM Level 1) are counseling services provided to beneficiaries (up to 9 hours a week for adults, and less than 6 hours a week for adolescents) when determined by a Medical Director or Licensed Practitioner of the Healing Arts (LPHA) to be medically necessary and in accordance with an individualized client plan. ASAM level 1 Youth treatment services will be provided following the current Youth Treatment Guidelines issued by the Department of Health Care Services (DHCS).

Intensive Outpatient Treatment (IOT) (ASAM Level 2.1) are structured programming services provided to beneficiaries a minimum of nine (9) hours with a maximum of nineteen (19) hours a week for adults, and a minimum of six (6) hours with a maximum of nineteen (19) hours a week for adolescents, when determined by a Medical Director or LPHA to be medically necessary and in accordance with the individual treatment plan.

Services consist of intake, individual and/or group counseling, patient education, family therapy, medication services, collateral services, crisis intervention, treatment planning, and discharge services. ASAM level 2.1 Youth treatment services will be provided following the current Youth Treatment Guidelines issued by the Department of Health Care Services (DHCS).

For group counseling in ODF and IOT, one or more therapists treat two or more clients at the same time with a maximum of 12 in the group, focusing on the needs of the individuals served. At least one participant in the group session must be Drug Medi-Cal (DMC) eligible to claim DMC reimbursement for the group session. (Title 22 §51341.1).

Individual counseling and care coordination services may be provided in person, via telehealth, or via telephone. Group and individual counseling services may be provided in person or via telehealth.

Outpatient and Intensive Outpatient Program Treatment Services:
Services shall include but not necessarily be limited to the following:

- Substance abuse counseling and education;
- Individual, group, and family counseling;
- Sexual and physical abuse counseling that is trauma informed
- Education on HIV/AIDS transmission and access to testing;
- Education on Tuberculosis (TB) and Hepatitis C and access to testing;
- Coordination of ancillary services (i.e. assistance in accessing and completing dental services, social services, community services, educational/vocational training); referral to pertinent community services according to client treatment/discharge plans;
- Substance abuse treatment to include trauma informed approaches
- Sufficient care coordination to ensure that beneficiaries have access to primary medical care, primary pediatric care, gender specific substance abuse recovery and treatment, and other needed services.

Care Coordination: This is a service to assist beneficiaries in accessing needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services. Care coordination can be face-to-face, via telehealth, or over the telephone and shall be consistent with and shall not violate confidentiality of alcohol or drug patients as set forth in 42 Code of Federal Regulations (CFR) Part 2, and California law. The components of care coordination include but are not limited to:

1. Comprehensive assessment and periodic reassessment of individual needs to determine the need for the continuation of care coordination;
2. Transition to a higher or lower level of Substance Use Disorder (SUD) care;
3. Development and periodic revision of a client plan that includes service activities;
4. Communication, coordination, referral, and related activities;
5. Monitoring service delivery to ensure beneficiary access to service and the service delivery system;
6. Monitoring the beneficiary's progress; and
7. Patient advocacy, linkages to physical and mental health care, transportation, and retention in primary care services.

Assessments: Assessments shall be performed face-to-face, by telehealth ("telehealth" throughout this document is defined as synchronous audio and video) or by telephone and performed by an LPHA or registered or certified counselor and may be done in the community or at home. If the assessment of the beneficiary is completed by a registered or certified counselor, then the LPHA shall evaluate that assessment with the counselor and the LPHA shall make the initial diagnosis. The consultation between

the LPHA and the registered or certified counselor can be conducted in person, by video conferencing, or by telephone.

The purpose of assessing a participant is to determine an appropriate current Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnosis of a substance-related disorder, to establish medical necessity, and to arrive at the appropriate level of care. The level of care determines both the number of contacts per week the participant is expected to make during treatment, and the expected level of time that the participant will remain in the program, in addition to the Urine Analysis (UA) testing schedule. Each participant will be assigned to an appropriate group and primary counselor, as determined by the Contractor's Program Director or Assistant Program Director. Each program includes appropriate individual counseling. ASAM level of care data shall be recorded in the client chart and reported to the county for each assessment. The Youth ASAM tool shall be used for Youth (age 13- 17). Medical necessity for an adolescent individual shall be assessed to be at risk of developing a SUD. The adolescent individual shall also meet the ASAM adolescent criteria.

1. Contractor is responsible for verifying participant's Medi-Cal eligibility status. Contractor must obtain prior approval from the County to be reimbursed for individuals with gaps in insurance coverage or out of county Medi-Cal.

2. Services provided shall be in compliance with all state guidelines pertaining to DMC services; such as but not necessarily limited to the following:
    A. Individuals who are DMC eligible are not placed on waiting lists due to budgetary constraints.
    B. Services provided to DMC beneficiaries are equivalent to services provided to non-DMC participants.
    C. No fees are charged to Medi-Cal beneficiaries for access to DMC services or for admission to a DMC treatment program. (Exception- Share of Cost Medi-Cal beneficiaries)
    D. Program complies with participant fair hearings, audit process, and DMC Provider Administrative Appeals.
    E. Termination of participant attending DMC services occurs only when the participant:
        a. Fails to return to the program
        b. Transfers to another program
        c. Meets program discharge criteria

3. Admission criteria & Procedures for Outpatient Drug Treatment, Contractor shall perform all of the following:
    A. Develop and use criteria and procedures for the admission of beneficiaries to treatment.
        - Complete a personal medical and substance abuse history for each beneficiary upon admission to treatment.
        - Complete an assessment of the physical condition of the beneficiary within 30 days of the admission to treatment date. The assessment shall be completed by either a physician, registered nurse practitioner, or physician assistant authorized by state law to perform the prescribed procedures. The physical exam requirements can be met by either:
            - A physical examination of the beneficiary.
            - A review of documentation of the beneficiary's physical examination that has been completed within the last 12 months.
            - If the physician has not reviewed or conducted a physical exam, the provider shall document the goal of obtaining a physical exam on the initial and updated treatment plans until the goal of obtaining a physical exam has been met.

4. Continuing Services for Beneficiaries

A. Continuing services shall be justified as follows:
    1. No sooner than 5 months and no later than 6 months from the beneficiary's admission to treatment date or the date of completion of the most recent justification for continuing services, the counselor shall review the progress and eligibility of the beneficiary to receive treatment services
    2. If the counselor recommends that the beneficiary requires further treatment, the physician or LPHA shall determine the need to continue services based on the following:
        i. Medical necessity of continuing treatment.
        ii. The prognosis.
        iii. The counselor's recommendation for the beneficiary to continue
    3. The Contractor shall discharge the beneficiary if the physician determines there is no medical necessity to continue treatment.

B. RECOVERY SERVICES

Program Overview:

Recovery Services are made available to eligible beneficiaries after they complete their course of treatment. Recovery Services are designed to 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 to clients. Services are available to beneficiaries whether they are triggered, have relapsed, or as a preventative measure to prevent relapse. Recovery Services may be provided by a LPHA, registered, or certified substance use treatment counselor.

Recovery Services shall include:

- **Outpatient Counseling Services**: in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care. (Billed as "Individual Counseling" or "Group Counseling")

- **Recovery Monitoring**: Recovery coaching, monitoring via telephone and internet. (Billed as Recovery Monitoring/Substance Use Assistance)

- **Substance Abuse Assistance**: Peer-to-peer services and relapse prevention. (Billed as Recovery Monitoring/Substance Use Assistance)

- **Education and Job Skills**: Linkages to life skills, employment services, job training, and education services. (Billed as Care coordination)

- **Family Support**: Linkages to childcare, parent education, child development support services, family/marriage education. (Billed as Care Coordination)

- **Support Groups**: Linkages to self-help and support, spiritual and faith- based support. (Billed as Care coordination)

- **Ancillary Services**: Linkages to housing assistance, transportation, care coordination, or individual services coordination. (Billed as Care Coordination)

Additionally, the Contractor shall:

1. Provide Recovery Services to beneficiaries as medically necessary.
2. Provide beneficiaries with access to Recovery Services after completing their course of treatment.
3. Provide Recovery Services either face-to-face, by telephone, or by telehealth, and in any appropriate setting in the community with the beneficiary.

Requirements

A Recovery Services plan is required for all clients in Recovery Services. It is due within 30 days of the day of admission to Recovery Services.

Services should be provided in the context of an individualized client plan that includes specific goals. This may include the plan for ongoing recovery and relapse prevention that was developed during discharge planning when treatment was completed.

Services provided by peers will be allowed after the County submitted a SUD Peer Support Training Plan to DHCS and received approval.

Contractor shall utilize evidence-based practices (EBPs) and curricula throughout the programs, including outpatient services and residential treatment. The practices must have efficacy as referenced in literature and be identified as a best practice at the SAMHSA website (http://www.samhsa.gov).

Overviews of some of these practices are listed below:

Seeking Safety: Seeking Safety is a present-focused treatment for clients with a history of trauma and substance abuse, listed on SAMHSA's National Registry of Evidenced-Based Programs and Practices (NREPP). This modality is delivered by counselors or therapists in group and individual settings and was chosen due to the prevalence of prior trauma (including domestic violence) in our population.

Seeking Safety focuses on coping skills and psycho-education and has five key principles: 1) safety as the overarching goal (helping clients attain safety in their relationships, thinking, behavior, and emotions); 2) integrated treatment of Post-Traumatic Stress Disorder, Substance Use & other addictive behaviors (smoking, excessive spending, gambling, pornography, etc.); 3) a focus on ideals to counteract the loss of ideals in both PTSD and substance use; 4) four content areas: cognitive, behavioral, interpersonal, and case management; and 5) attention to clinician processes (helping clinicians work on counter-transference, self-care, and other issues). Results from trials showed significant improvements in substance use (both alcohol and drug), trauma-related symptoms, suicide risk, suicidal thoughts, social adjustment, family functioning, problem solving, depression, cognitions about substance use, and didactic knowledge related to the treatment.

Motivational Interviewing: Motivational interviewing (MI) is an evidence-based strategy designed to address ambivalence to change. According to SAMHSA's Center for Substance Abuse Treatment, "MI is a client-centered, directive method for enhancing intrinsic motivation to change (by exploring and resolving ambivalence) that has proven effective in helping clients clarify goals and commit to change". MI can also be modified to meet the special circumstances of clients with co-occurring disorders (COD).

Cognitive Behavioral Therapy (CBT): Cognitive-Behavioral Therapy is a form of psychotherapy proven in numerous clinical trials to be effective for a wide variety of disorders. Therapists help clients to

overcome their difficulties by changing their thinking, behavior, and emotional responses. Outcomes include decreases in: Posttraumatic Stress Disorder symptoms, self-blame, problem behaviors, and depression. CPT is a strategy used in group and individual sessions. *Family Team Meetings:* Family Team meetings are modeled on Family Group Decision Making (FGDM), an approach recognized by the California Evidence Based Clearinghouse, that positions the "family group" as leaders in decision-making. FTMs are convened as needed, engaging informal and formal support, including counselors, therapists, social workers, MD's, etc. along with identified social supports (family, friends, clergy etc.). Through this process, the "family group" (the client, their families, their support networks, and community members) is given the opportunity to develop recovery plans. Since the "family group" is involved, the plans have a greater likelihood of being family-centered, reflective of the family group's culture and strengths, and comprehensive.

The intent of these plans is to resolve the issues endangering both clients' and their family members' health and wellbeing. This strengths-based practice is appropriate for mothers in recovery, many of whom have children in the Child Welfare System. The process emphasizes recovery capital by strengthening family support networks, increasing social connections, supporting effective community-based recovery support services, and respecting the client as an asset in her own recovery. This is important, both to increase attractiveness of the service and effectiveness as it fosters strength, self-worth, and capability in the individuals own recovery process.

Interactive Journaling (Change Companies): The Change Companies curricula are designed not only to enable programs to implement leading behavioral-change research, but to do so in a way that is accessible, meaningful and motivational for the program participant. Interactive Journals deliver core behavior-change content combination with targeted questioning designed to engage participants in exploring risks, needs and skill deficits, as well as strengths, resources and solutions to problem behaviors. Clients are provided a set of workbooks (up to 15 if authorized for 90 days) upon entry into the program which are split out for the duration of their program. They retain those completed when they are discharged from the program.

Managing Co-occurring Disorders Curriculum: This twelve-lesson format provides a focal point for specific treatment of adults with co-occurring disorders. The program utilizes 12 workbooks (20-50 pages) to offer a cognitive behavioral approach using reading, journaling, and discussion, all of which are delivered by the group facilitator using motivational interviewing. This also utilizes the Stages of Change to elicit change talk by the client in moving from pre-contemplation to maintenance of the disorders through participation in the program. The twelve core sessions include; 1) Orientation, 2) Responsible Thinking, 3) My Individual Change Plan, 4) Values, 5) Substance Use Disorders, 6) Handling Difficult Emotions, 7) Life skills, 8) Healthy Relationships, 9) Maintaining Positive Change, 10) Mental Health Disorders, 11) Transition, 12) Employment Skills.

Living In Balance Curriculum: Living in Balance is an NREPP recognized, evidence-based psychoeducational treatment program published by Hazelden, supported by the National Institutes of Drug Abuse (NIDA). Living in Balance (LIB): Moving from a Life of Addiction to a Life of Recovery is a manual-based, comprehensive treatment program that emphasizes relapse prevention. LIB consists of a series of 1.5- to 2-hour psychoeducational and experiential training sessions. LIB can be delivered on an individual basis or in group settings with relaxation exercises, role-play exercises, discussions, and workbook exercises. The psychoeducational sessions cover topics such as drug education, relapse prevention, available self-help groups, and sexually transmitted diseases (STDs).

The experientially based or interactive sessions are designed to enhance the client's level of functioning in certain key life areas that are often neglected with prolonged drug use: physical, emotional, and social

well-being, adult education opportunities, vocational development, daily living skills, spirituality/recovery, sexuality, and recreation/leisure. These sessions include a large amount of role-play with time to actively process personal issues and learn how to cope with everyday stressors.

Strengths-Based Care Coordination: Care coordination is identified as a promising practice related to increased access and attractiveness of services, quality of services, especially related to assertive linkages to community resources. Originally developed at the University of Kansas School of Social Welfare to help people with mental illness transition from institutionalized care to independent living *(Rapp and Chamberlain, 1985),* this strengths-based model is based on two primary principles: (1) providing clients support for asserting direct control over their search for resources (2) examining clients' own strengths and assets as the vehicle for resource acquisition.

C. MEDICATION ASSISTED TREATMENT (MAT) SERVICES:

Medication Assisted Treatment

MAT includes FDA-approved medications and biological products to treat AUD, OUD, and any SUD. MAT may be provided in clinical or non-clinical settings and can be delivered as a standalone service or as a service delivered as part of a level of care covered by DMC-ODS Services. The Contractor shall provide MAT to individuals age eighteen (18) or older for which MAT is clinically appropriate. Specifically, the Contractor shall:

1. Provide prescribing and monitoring for MAT for SUD, which is prescribing, ordering, monitoring, and/or managing the medications used for MAT for SUD.
2. Be certified and licensed by the appropriate federal and state agencies to provide chemical maintenance.
3. Conduct comprehensive medical and bio-psychosocial assessments in order to determine individuals' physical and environmental appropriateness for MAT.
4. Assess each individual applicant for the stage of change or readiness for treatment.
5. Provide "Patient Education", which is education for the beneficiary on addiction, treatment, recovery, and associated health risks.
6. Utilize a harm-reduction model which is defined as attempts to keep individuals in treatment even if complete abstinence is not achieved and which allows for incremental decreases in substance use, when total abstinence has been unachievable.
7. Incorporate as staff, peer specialists or other individuals who have experienced living with an addiction disorder and who are in a stable recovery.
8. Refrain from having a zero tolerance policy for any specific classification of medication.
9. Ensure Releases of Information shall be signed by all individuals being prescribed pain medication, other opiates, benzodiazepines or other classifications of medications as appropriate, and routinely consult with other prescribers to ensure maximum individual safety and minimize medication diversion.

Contractor's Performance Standards for all Contract Components:

Contractor shall maintain at all times a trained, skilled staff, which understands and maintains confidentiality of participants and records. Confidentiality of participants is maintained by staff. In-service training shall be provided at least monthly for staff in order to maintain a well-trained staff. Contractor shall maintain qualified staff to provide Drug / Alcohol services.

All programs and facilities shall be in full compliance with applicable county, state, and federal laws, ordinances, rules, certifications and regulations and shall remain in full compliance during the term of this Agreement.

DATAR:

Treatment providers that receive state or federal funding through the County must send DATAR information to the Department of Health Care Services (DHCS) each month. This has information on the program's capacity to provide different types of SUD treatment to clients and how much of the capacity was utilized that month. If the provider has a waiting list for publicly-funded SUD treatment services, DATAR includes summary information about the people on the waiting list. Contractor agrees to comply with this requirement.

Contractor shall also cooperate with County Behavioral Health Department and County Probation Department for collection of any other data of informational reports as may be needed pertaining to services rendered under this Agreement**.**

Contractor agrees to abide by the provisions of Attachment 1 hereto attached and incorporated herein as required of "contractors" and "subcontractors" under the State Department of Health Care Services (DHCS) Standard Agreement Number 14-90076 by and between DHCS and the County.

Drug Medi-Cal Organized Delivery System:

I. TIMELINESS and ASAM data (for Youth and Adult Services)

Contractor will track Timely access data, including date of initial contact, date of first offered appointment and date of scheduled assessment.
Performance Standard:

a. First face-to-face, telephone, or telehealth appointment shall occur no later than 10 business days of initial contact.

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

c. ASAM Level of Care data for initial full assessments and follow up assessment; record ASAM level of care data on the county provided spreadsheet. The Adolescent ASAM screening tool should be used for adolescents.

d. Timely access data and ASAM data will be submitted by the 10th of the month for the prior month.

e. No shows for assessment appointments shall be collected and reported.

f. No show data for ongoing treatment appointments, including individual and group counselling, shall be included in the quarterly report.

II. TREATMENT PERCEPTION SURVEY

Contractor shall participate in the annual Treatment Perception Survey (TPS) as directed by County and DHCS.

a. At least 75% of beneficiaries completing the Treatment Perceptions Surveyreported being satisfied (3.5 out of 5.0) with the location and time of services

II. DELIVERY OF INDIVIDUALIZED AND QUALITY CARE

a. Beneficiary Satisfaction: DMC-ODS Providers (serving adults 18+) shall participate in the annual statewide Treatment Perceptions Survey (administration period to be determined by DHCS). Upon review of Provider-specific results, Contractor shall select a minimum of one quality improvement initiative to implement annually.

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

c. ASAM Level of Care: All beneficiaries participate in an assessment using ASAM dimensions. The assessed and actual level of care (and justification if the levels differ) shall be recorded in the client's medical record. All ASAM LOC assessments that were performed when opening or closing a client to a LOC will be submitted to the county together with the CalOMS opening and closing paperwork.

Performance Standards:

1. At least 80% of beneficiaries will report an overall satisfaction score of at least 3.5 or higher on the Treatment Perceptions Survey
2. At least 80% of beneficiaries completing the Treatment Perceptions Survey reported that they were involved in choosing their own treatment goals (overall score of 3.5+ out of 5.0)
3. Contractor will implement with fidelity at least two approved EBPs
4. 100% of beneficiaries participated in an assessment using ASAM dimensions and are provided with a recommendation regarding ASAM level of care
5. At least 70% of beneficiaries admitted to treatment do so at the ASAM level of care recommended by their ASAM assessment
6. At least 80% of beneficiaries are reassessed within 90 days of the initial assessment

III. TRAINING

Applicable staff are required to participate in the following training:

a. DMC ODS overview and documentation training (annually)

b. Information Privacy and Security (At least annually)

c. ASAM E-modules 1 and 2

All direct treatment staff will complete the ASAM E-modules 1 and 2 upon hire and prior to delivering services. All service providers using the ASAM criteria to determine Level of Care will complete an annual refresher.

d. Cultural Competency (At least annually)

e. All LPHA staff are required to complete a minimum of five (5) hours of continuing education related to addiction medicine each year.

f. All direct treatment staff will attend at least two of the following Evidence-Based Practices (EBPs) each year:

Motivational Interviewing

1) Relapse Prevention
2) Trauma Focused Care
3) Seeking Safety
4) Cognitive Behavioral Therapy
5) Matrix Model

IV. Quarterly Reports

The Quarterly Report, based on the Fiscal Year, are due October 31st for 1st quarter, January 31st for 2nd quarter, May 31st for 3rd quarter and August 30th for 4th quarter. Send quarterly reports to the Program Manager and the Quality Assurance Manager. Quarterly Reports shall include the following information:

- Average length of stay of program participants for each program (ASAM Level 1 average length of stay, ASAM Level 2.1, ASAM Level 3.1, 3.2, 3.5, Recovery Services and Recovery Residences
- No show data for treatment appointments, including individual counseling and group counseling, reporting as a percentage per month; ideally the Contractor will have the ability to review no show data at the staff, client, and program level to utilize for system improvement activities.
- Percentage of unplanned exits for each level of care.
- Number of successful "graduations" for each level of care; at least 80% of clients will show successful completion or satisfactory progress on treatment goals; only clients who have engaged in treatment services for at minimum 10 days from day of episode opening will be included in this measure
- # of clients that are linked to a primary medical care appointment and dental appointment and location of primary care. At least 80% of clients will be linked to at least a preliminary primary care medical and dental appointment if they have not had one within a year. In the latter case Contractor will confirm and document that they are under the care of a doctor and/or dentist
- # of clients with Alcohol Use Disorder as a primary diagnosis linked to MAT
- # of clients with Opioid Use Disorder as a primary diagnosis linked to MAT
- # of Ancillary Services provided to participants
- Number of Youth enrolled in outpatient services

Quarterly Quality Assurance activities report:

- Total number of charts reviewed within 30 days of admin
- Total number of charts reviewed within 90 days of admin

- Percentage of records reviewed meeting medical necessity criteria
- Percentage of assessments in charts reviewed with appropriate staff signature and ASAM LOC
- Percentage of client plans completed on time with all required signatures
- Percentage of progress notes reviewed that had all required elements
- Groups:
- Total number of groups facilitated
- Total number of group progress notes reviewed with corresponding sign-in sheets as verification of attendance
- Percentage of group notes that met attendance documentation requirements
- Staff Trainings:
    - Submit titles of trainings, training dates, and the number of staff in attendance
    - A brief description of the training
    - Specific trainings on culturally specific and supported practices
    - Specific trainings on recovery model, evidence-based practices, and family engagement efforts

The Parties hereby acknowledge and agree that in the event of changes to the Drug Medi-Cal Organized Delivery System which County determines will constitute a material change to rights and obligations set forth in this Agreement, the County has, at its option, the right to re-open and renegotiate this Agreement upon thirty (30) days written notice to Contractor

EXHIBIT B
SCHEDULE OF CHARGES AND PAYMENTS
RECOVER MEDICAL GROUP P.C.

Subject to the satisfactory performance of services required of Contractor pursuant to this contract, and to the terms and conditions as set forth, the County shall pay Contractor a maximum amount not to exceed $142,329 for the period of July 1, 2023 through June 30, 2024. The maximum obligation of this Contract is contingent and dependent upon final approval of State budget and County receipt of anticipated funding to support program expenses.

Direct Service Staff By Discipline	Hourly Rate	Average Productivity
Physicians Assistant	$ 346.71	40%
Nurse Practitioner	$ 492.00	40%
RN	$ 314.01	40%
MD (typically in SUD system of Care)	$ 773.06	50%
Psychologist/Pre-licensed Psychologist	$ 310.91	40%
LPHA/Intern or Waivered LPHA (MFT, LCSW, LPCC)	$ 241.00	50%
Alcohol and Drug Counselor	$ 208.00	50%
Peer Recovery Specialist	$ 190.00	35%

1. CLAIMING
   A. Contractor shall submit to County, for services rendered in the prior month, and in accordance with CPT format requirements, a statement of services rendered to County and costs incurred that includes documentation to support all expenses claimed by the 10th of each month. County shall review the billing and notify the Contractor within fifteen (15) working days if an individual item or group of costs is being questioned. Contractor has the option of delaying the entire claim pending resolution of the cost(s).
   B. Claims shall be complete and accurate and must include all required information regarding the claimed services.
   C. Contractor shall maximize the Federal Financial Participation (FFP) reimbursement by claiming all possible Medi-Cal services and correcting denied services for resubmission in a timely manner as needed.
2. INVOICING
   A. Contractor shall invoice County for services monthly, in arrears, in the format directed by County. Invoices shall be based on claims entered into the County's billing and transactional database system for the prior month.
   B. Invoices shall be provided to County after the close of the month in which services were rendered. Following receipt and provisional approval of a monthly invoice, County shall make payment within 30 days.
   C. Monthly payments for claimed services shall be based on the units of time assigned to each CPT or HCPCS code entered in the County's billing and transactional database multiplied by the service rates in Exhibit B-2.
   D. County's payments to Contractor for performance of claimed services are provisional and subject to adjustment until the completion of all settlement activities. County's adjustments to provisional payments for claimed services shall be based on the terms, conditions, and limitations of this Agreement or the reasons for recoupment set forth in Article 5, Section 6.

E. Contractor shall submit invoices to:

Nevada County Behavioral Health Department
Attn: Fiscal Staff
500 Crown Point Circle, Suite 120
Grass Valley, CA 95945

3. ADDITIONAL FINANCIAL REQUIREMENTS
   A. County has the right to monitor the performance of this Agreement to ensure the accuracy of claims for reimbursement and compliance with all applicable laws and regulations.
   B. Contractor must comply with the False Claims Act employee training and policy requirements set forth in 42 U.S.C. 1396a(a)(68) and as the Secretary of the US DHHS may specify.
   C. Contractor agrees that no part of any federal funds provided under this Agreement shall be used to pay the salary of an individual per fiscal year at a rate in excess of Level 1 of the Executive Schedule at https://www.opm.gov/ (U.S. Office of Personnel Management), as from time to time amended.
   D. Federal Financial Participation is not available for any amount furnished to an Excluded individual or entity, or at the direction of a physician during the period of exclusion when the person providing the service knew or had reason to know of the exclusion, or to an individual or entity when the County failed to suspend payments during an investigation of a credible allegation of fraud (42 U.S.C. § 1396b(i)(2)).
   E. Contractor shall cooperate with the County in the implementation, monitoring and evaluation of the Contract and comply with any and all reporting requirements established by the County. Payment of invoices may be held until Contractor is in compliance with reporting requirements. County shall not be responsible for reimbursement of invoices submitted by Contractor that do not have proper authorizations in place.

4. FINANCIAL AUDIT REPORT REQUIREMENTS FOR PASS-THROUGH ENTITIES
   A. If County determines that Contractor is a "subrecipient" (also known as a "pass-through entity") as defined in 2 C.F.R. § 200 et seq., Contractor represents that it will comply with the applicable cost principles and administrative requirements including claims for payment or reimbursement by County as set forth in 2 C.F.R. § 200 et seq., as may be amended from time to time. Contractor shall observe and comply with all applicable financial audit report requirements and standards.
   B. Financial audit reports must contain a separate schedule that identifies all funds included in the audit that are received from or passed through the County. County programs must be identified by Agreement number, Agreement amount, Agreement period, and the amount expended during the fiscal year by funding source.
   C. Contractor will provide a financial audit report including all attachments to the report and the management letter and corresponding response within six months of the end of the audit year to the Director. The Director is responsible for providing the audit report to the County Auditor.
   D. Contractor must submit any required corrective action plan to the County simultaneously with the audit report or as soon thereafter as it is available. The County shall monitor implementation of the corrective action plan as it pertains to services provided pursuant to this Agreement.

Records to be Maintained

Contractor shall keep and maintain accurate records of all costs incurred and all time expended for work under this contract. Contractor shall contractually require that all of Contractor's Subcontractors performing work called for under this contract also keep and maintain such records, whether kept by

Contractor or any Subcontractor, shall be made available to County or its authorized representative, or officials of the State of California for review or audit during normal business hours, upon reasonable advance notice given by County, its authorized representative, or officials of the State of California. All fiscal records shall be maintained for five years or until all audits and appeals are completed, whichever is later.