AMENDMENT NO. 7
TO
CONTRACT NO. MA-042-20010248
FOR
ADULT RESIDENTIAL DRUG MEDI-CAL SUBSTANCE USE DISORDER TREATMENT SERVICES

This Amendment ("Amendment No. 7") to Contract No. MA-042-20010248 for Adult Residential Drug Medi-Cal Substance Use Disorder Treatment Services is made and entered into on July 1, 2022 ("Effective Date") between Straight Talk Clinic, Inc. ("Contractor"), with a place of business at 3785 South Plaza Drive, Santa Ana, California 92704 and the County of Orange, a political subdivision of the State of California ("County"), through its Health Care Agency, with a place of business at 405 W. 5th St., Ste. 600, Santa Ana, CA 92701. Contractor and County may sometimes be referred to individually as "Party" or collectively as "Parties".

RECITALS

WHEREAS, the Parties executed Contract No. MA-042-20010248 for Adult Residential Drug Medi-Cal Substance Use Disorder Treatment Services, effective July 1, 2019 through June 30, 2022, in an aggregate amount not to exceed $19,480,950, renewable for two additional one-year periods ("Contract"); and

WHEREAS, the Parties executed Amendment No. 1 to amend the Contract, effective August 9, 2019, to modify Exhibit A; and

WHEREAS, the Parties executed Amendment No. 2 to amend the Contract, effective January 24, 2020, to modify a reimbursement rate; and

WHEREAS, the Parties executed Amendment No. 3 to amend the Contract, effective September 1, 2020, to modify various provisions of the Contract; and

WHEREAS, the Parties executed Amendment No. 4 to amend the Contract, effective March 4, 2021, to exercise the 10% cost contingency to increase the Period Two Aggregate Maximum Obligation by $649,365 from $6,493,650 to $7,143,015, for a revised cumulative total aggregate amount not to exceed $20,130,315, and to add Exhibit D (Good Neighbor Policy); and

WHEREAS, the Parties executed Amendment No. 5 to amend the Contract, effective July 1, 2021, to increase the Period Three Aggregate Maximum Obligation by $1,298,730 from $6,493,650 to $7,792,380, for a revised cumulative total aggregate amount not to exceed $21,429,045, and to modify Exhibit A; and

WHEREAS, the Parties executed Amendment No. 6 to amend the Contract, effective October 26, 2021, to modify the addresses where Services are performed; and

WHEREAS, the Parties now desire to enter into this Amendment No. 7 to amend various provisions of the Contract and to renew the Contract for two years for County to continue receiving and Contractor to continue providing the services set forth in the Contract.

NOW THEREFORE, Contractor and County agree to amend the Contract as follows:

1. The Contract is renewed for a term of two (2) years, effective July 1, 2022 through June 30, 2024, in an aggregate amount not to exceed $17,000,000 for this renewal term, for a revised cumulative total aggregate amount not to exceed $38,429,045; on the amended terms and conditions.

2. Page 4, Referenced Contract Provisions, Term provision and Maximum Obligation provision, of the Contract are deleted in their entirety and replaced with the following:

"**Term:** July 1, 2019 through June 30, 2024
Period One means the period from July 1, 2019 through June 30, 2020
Period Two means the period from July 1, 2020 through June 30, 2021
Period Three means the period from July 1, 2021 through June 30, 2022
Period Four means the period from July 1, 2022 through June 30, 2023
Period Five means the period from July 1, 2023 through June 30, 2024

Aggregate Maximum Obligation:

Period One Aggregate Maximum Obligation:	$	6,493,650
Period Two Aggregate Maximum Obligation:		7,143,015
Period Three Aggregate Maximum Obligation:		7,792,380
Period Four Aggregate Maximum Obligation:		8,500,000
Period Five Aggregate Maximum Obligation:		8,500,000
TOTAL AGGREGATE MAXIMUM OBLIGATION:	$	38,429,045"

3. The following table is updated within the Referenced Contract Provisions:

CFDA#	FAIN#	Program/ Service Title	Federal Funding Agency	Federal Award Date	Amount	R&D Award (Y/N)
93.959	T110062-20	SABG	Substance Abuse and Mental Health Services Administration (SAMHSA)	7/1/2021 TO 6/30/2024	$19,276,499 annually	N

4. Paragraph IV. Compliance, subparagraph B. (but not including subparagraphs B.1 through B.7), of the Contract is deleted in its entirety and replaced with the following:

"B. SANCTION SCREENING – CONTRACTOR must screen all Covered Individuals employed or retained to provide services related to this Agreement to ensure that they are not designated as Ineligible Persons, as pursuant to this Agreement. Screening must be conducted against the Social Security Administration's Death Master File at the date of employment. Screening must be conducted monthly against the General Services Administration's Excluded Parties List System or System for Award Management, the Health and Human Services/Office of Inspector General List of Excluded Individuals/Entities, and the California Medi-Cal Suspended and Ineligible Provider List, and/or any other list or system as identified by ADMINISTRATOR."

5. Paragraph IV. Compliance, subparagraph E.6., of the Contract is deleted in its entirety and replaced with the following:

   "6. CONTRACTOR shall meet the HCA Quality Assessment and Performance Improvement Standards established by Authority and Quality Improvement Services (AQIS) and participate in the quality improvement activities developed in the implementation of the DMC-ODS Quality Management Program. CONTRACTOR shall establish an internal Quality Management program and appoint designated Quality Improvement (QI) staff consisting of at least one dedicated QI coordinator/professional to participate in QI activities with ADMINISTRATOR and to ensure service delivery and support program staff implement QI initiatives and requirements appropriately at the program site."

6. Paragraph VII. Cost Report, subparagraph A. (but not including subparagraphs A.1 through A.3), of the Contract is deleted in its entirety and replaced with the following:

   "A. CONTRACTOR shall submit an individual and/or consolidated Cost Report for each Period, or for a portion thereof, to COUNTY no later than forty–five (45) calendar days following the period for which they are prepared or termination of this Agreement. CONTRACTOR shall prepare the individual and/or consolidated Cost Report in accordance with all applicable federal, state and COUNTY requirements, GAAP and the Special Provisions Paragraph of this Agreement. CONTRACTOR shall allocate direct and indirect costs to and between programs, cost centers, services, and funding sources in accordance with such requirements and consistent with prudent business practice, which costs and allocations shall be supported by source documentation maintained by CONTRACTOR, and available at any time to ADMINISTRATOR upon reasonable notice. In the event CONTRACTOR has multiple agreements for mental health services that are administered by HCA, consolidation of the individual Cost Reports into a single consolidated Cost Report may be required, as stipulated by ADMINISTRATOR. CONTRACTOR shall submit the consolidated Cost Report to COUNTY no later than five (5) business days following approval by ADMINISTRATOR of all individual Cost Reports to be incorporated into a consolidated Cost Report."

7. Paragraph XVI. Licenses and Laws, subparagraphs B. and C., of the Contract are deleted in their entirety and replaced with the following:

   "B. CONTRACTOR shall comply with all applicable governmental laws, regulations, and requirements as they exist now or may be hereafter amended or changed. These laws, regulations, and requirements shall include, but not be limited to, the following:
   1. ARRA of 2009.
   2. Trafficking Victims Protection Act of 2000.
   3. CCC §§56 through 56.37, Confidentiality of Medical Information.
   4. CCC §§1798.80 through 1798.84, Customer Records.
   5. CCC §1798.85, Confidentiality of Social Security Numbers.
   6. CCR, Title 9, Rehabilitative and Developmental Services, Division 4; and Title 22 Social Security.
   7. HSC, Divisions 10.5 Alcohol and Drug Programs and 10.6. Drug and Alcohol Abuse Master Plans.
   8. HSC, §§123110 through 123149.5, Patient Access to Health Records.

9. Code of Federal Regulations, Title 42, Public Health.
10. 2 CFR 230, Cost Principles for Nonprofit Organizations.
11. 2 CFR 376, Nonprocurement, Debarment and Suspension.
12. 41 CFR 50, Public Contracts and Property Management.
13. 42 CFR Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records.
14. 42 CFR 54, Charitable choice regulations applicable to states receiving substance abuse prevention and treatment block grants and/or projects for assistance in transition from homelessness grants.
15. 45 CFR 93, New Restrictions on Lobbying.
16. 45 CFR 96.127, Requirements regarding Tuberculosis.
17. 45 CFR 96.132, Additional Agreements.
18. 45 CFR 96.135, Restrictions on Expenditure of Grant.
19. 45 CFR 160, General Administrative Requirements.
20. 45 CFR 162, Administrative Requirements.
21. 45 CFR 164, Security and Privacy.
22. 48 CFR 9.4, Debarment, Suspension, and Ineligibility.
23. 8 USC §1324 et seq., Immigration Reform and Control Act of 1986.
24. 31 USC §1352, Limitation on Use of Appropriated Funds to Influence Certain Federal Contracting and Financial Transactions.
25. 42 USC §§285n through 285o, National Institute on Alcohol Abuse and Alcoholism.
26. 42 USC §§290aa through 290kk-3, Substance Abuse and Mental Health Services Administration.
27. 42 USC §290dd-2, Confidentiality of Records.
28. 42 USC §1320(a), Uniform reporting systems for health services facilities and organizations.
29. 42 USC §§1320d through 1320d-9, Administrative Simplification.
30. 42 USC §12101 et seq., The Americans with Disabilities Act of 1990 as amended.
31. 42 USC §6101 et seq., Age Discrimination Act of 1975.
32. 42 USC §2000d, Civil Rights Act pf 1964.
33. 31 USC 7501 – 7507, as well as its implementing regulations under 2 CFR Part 200, Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards
34. U.S. Department of Health and Human Services, National Institutes of Health (NIH), Grants Policy Statement (10/13).
35. Fact Sheet Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for Co-Occurring Disorders, Mental Health Services Oversight and Accountability Commission, 1/17/08.
36. State of California, Department of Health Care Services (DHCS), Alcohol and/or Other Drug Program Certification Standards, December 2020.
37. CCR Title 22, §§70751(c), 71551(c), 73543(a), 74731(d), 75055(a), 75343(a), and 77143(a).
38. State of California, Department of Health Care Services ASRS Manual.
39. State of California, Department of Health Care Services DPFS Manual.
40. HSC §123145.
41. Title 45 CFR, §164.501; §164.524; §164.526; §164.530(c) and (j).
42. 5 USC §7321 – §7326, Political Activities (Hatch Act)
43. DMC Certification Title 22, California Code of Regulations (CCR).
44. DMC Billing Manual April 2019.
45. Federal Medicare Cost reimbursement principles and cost reporting standards.

46. Orange County Drug Medi-Cal Organized Delivery System Managed Care Plan
47. California Bridge to Health Reform DMC-ODS Waiver, Standard Terms and Conditions, August 2015, and subsequent versions.
48. Title 21, CFR Part 1300, et seq., Title 42, CFR, Part 8.
49. California Code of Regulations (CCR), Title 22, Section 51341.1; 51490.1; 51516.1 and the Drug Medi-Cal Certification Standards for Substance Abuse Clinics.
50. Title 22, CCR, Sections 51341.1, 51490.1, and 51516.1.
51. Standards for Drug Treatment Programs (October 21, 1981).
52. Title 9, CCR, Division 4, Chapter 5, Subchapter 1, Sections 10000, et seq.
53. Title 22, CCR, Division 3, Chapter 3, sections 51000 et. seq.
54. Title 9, CCR, Section 1810.435.
55. Title 9, CCR, Section 1840.105.
56. Title 22, CCR, §51009, Confidentiality of Records.
57. California Welfare and Institutions Code, §14100.2, Medicaid Confidentiality."

8. Paragraph XXII. Notification of Death, subparagraph D. is added to the Contract as follows:

"D. All death reports must be verified by the coroner's office. The information should include date of the death as well as the cause of death."

9. Paragraph XXIII. Patient's Rights, of the Contract is deleted in its entirety and replaced with the following:

"XXIV. BENEFICIARIES' RIGHTS

A. CONTRACTOR shall post the current Drug Medi-Cal Organized Delivery System (DMC-ODS) Grievance and Appeals poster in locations readily available to Clients and staff and have Grievance and Appeal forms in the threshold languages and envelopes readily accessible to Clients to take without having to request it on the unit.

B. In addition to those processes provided by ADMINISTRATOR, CONTRACTOR shall have an internal grievance processes approved by ADMINISTRATOR, to which Client shall have access.

1. CONTRACTOR's grievance processes shall incorporate COUNTY's grievance and/or utilization management guidelines and procedures. Client has the right to utilize either or both grievance process simultaneously in order to resolve their dissatisfaction.

C. The parties agree that Clients have recourse to initiate an expression of dissatisfaction to CONTRACTOR and file a grievance or complaint."

10. Exhibit A, Section I. Common Terms and Definitions, subparagraph A., of the Contract is deleted in its entirety and replaced with the following:

"A. The Parties agree to the following terms and definitions, and to those terms and definitions which, for convenience, are set forth elsewhere in this Agreement.

1. AB109 means services for those Clients deemed eligible by Assembly Bill 109, Public Safety Realignment, under which Client's last offense was non-violent, non-sexual, and non-serious.

2. AB109 Supervision means an offender released from prison to OCPD or sentenced under AB109 and is doing their incarceration in jail instead of prison.

3. ASAM Criteria means a comprehensive set of guidelines for placement, continued

stay and transfer/discharge of Clients with addiction and co-occurring conditions.

4. ART Team means a Health Care Agency team that assesses for treatment, authorizes services and refers for treatment.

5. DHCS-Designated Levels of Care (LOC) means a designation that is issued by DHCS to a residential program based on the services provided at the facility. For the purposes of this Agreement, CONTRACTOR shall provide services in accordance with one of the following DHCS-Designated Levels of Care:

a. 3.1 – Clinically Managed Low-Intensity Residential Services means a twenty-four (24) hour structure with available trained personnel; at least five (5) hours of clinical service/week and preparation for outpatient treatment.

b. 3.3 – Clinically Managed Population-Specific High-Intensity Residential Services means a twenty-four (24) hour structured living environment in combination with high-intensity clinical services for clients with significant cognitive impairment

c. 3.5 – Clinically Managed High-Intensity Residential Services means a twenty-four (24) hour residential care for clients who require a twenty-four (24) hour supportive treatment environment in order to develop sufficient recovery skills to avoid relapse or continued AOD use. It will include at least five (5) hours of clinical service/week.

6. Bed Day means one (1) calendar day during which CONTRACTOR provides services as described in this Exhibit A of the Agreement. If admission and discharge occur on the same day, one (1) Bed Day will be charged.

7. CalOMS means a statewide Client-based data collection and outcomes measurement system as required by the State to effectively manage and improve the provision of alcohol and drug treatment services at the State, COUNTY, and provider levels.

8. Case Management or Care Coordination means services that assist Client to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

9. CESI/CEST mean self-administered survey instruments designed to assess Clients' motivation for change, engagement in treatment, social and peer support, and other psychosocial indicators of progress in recovery.

10. Client means a person who has a substance use disorder, for whom a COUNTY-approved intake and admission for Residential Treatment Services as appropriate have been completed pursuant to this Agreement.

11. Clinical Component means services designed to improve Client's ability to structure and organize tasks of daily living and recovery.

12. Completion means the completion of the Residential Treatment Services program whereby Client has successfully completed goals and objectives documented in Client's treatment plan and no longer has medical necessity for the Residential Level of Care.

13. Co-Occurring means when a person has at least one substance use disorder and one mental health disorder that can be diagnosed independently of each other.

14. DATAR means the DHCS system used to collect data on SUD treatment capacity and waiting lists.

15. EPSDT means the federally mandated Medicaid benefit that entitles full-scope Medi-Cal-covered beneficiaries less than twenty-one (21) years of age to receive any Medicaid service necessary to correct or help to improve a defect, mental illness, or other condition, such as a substance-related disorder, that is discovered during a health screening.

16. Incidental Medical Services means optional services, approved by DHCS to be provided at a licensed adult alcoholism or drug use residential treatment facility by or under the supervision of a LPHA that addresses medical issues associated with either detoxification or substance use.

17. Intake means the initial face-to-face meeting between Client and CONTRACTOR staff in which specific information about Client is gathered including the ability to pay and standard admission forms pursuant to this Agreement.

18. IRIS means a collection of applications and databases that serve the needs of programs within HCA and includes functionality such as registration and scheduling, laboratory information system, invoices and reporting capabilities, compliance with regulatory requirements, electronic medical records and other relevant applications.

19. Linkage means connecting Client to ancillary services such as outpatient and/or residential treatment and supportive services which may include self-help groups, social services, rehabilitation services, vocational services, job training services, or other appropriate services.

20. LPHA means any Physician, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologists, Licensed Clinical Social Worker, Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapists, or Licensed Eligible Practitioners working under the supervision of Licensed Clinicians, working within their scope of practice.

21. MAT Services means the use of Federal Drug Administration-approved medications in combination with behavioral therapies to provide a whole client approach to treating substance use disorders

22. Perinatal means the condition of being pregnant or Postpartum. This condition must be documented to apply billing descriptor of perinatal attached to services.

23. Perinatal Residential Treatment Services means AOD treatment services that are provided to a woman, eighteen (18) years and older, who is pregnant and/or has custody of dependent children up to twelve (12) years of age, in her care; who has a primary problem of substance use disorder, and who demonstrates a need for perinatal substance use disorder residential treatment services. Services are provided in a twenty-four (24) hour residential program. These services are provided in a non-medical, residential setting that has been licensed and certified by DHCS to provide perinatal services. These treatment services are provided to both perinatal and parenting women in accordance with the Perinatal Network Service Guidelines.

24. Postpartum means the 60-day period beginning on the last day of pregnancy, regardless of whether other conditions of eligibility are met. Eligibility shall end on the last day of the calendar month in which the 60th day occurs.

25. Recovery Services means billable services available after Client has completed a course of treatment. Recovery services emphasize Client's central role in managing their health, the use of effective self-management support strategies, and the organization of internal and community resources to provide ongoing self-management support to Clients.

26. Residential Treatment Authorization means the approval that is provided by the HCA ART Team for Client to receive residential services to ensure that Client meets the requirements for the service. Decisions for service authorization are provided by the ART Team for admission with exception determined by CONTRACTOR.

27. RTS means alcohol and other drug treatment services that are provided to Clients at a twenty-four (24) hour residential program. Services are provided in an alcohol and drug free environment and support recovery from alcohol and/or other drug related problems. These services are provided in a non-medical, residential setting that has been licensed and certified by DHCS.

28. Self-Help Meetings means a non-professional, peer participatory meeting formed by people with a common problem or situation offering mutual support to each other towards a goal of healing or recovery.

29. Structured Therapeutic Activities means organized program activities that are designed to meet treatment goals and objectives for increased social responsibility, self-motivation, and integration into the larger community. Such activities would include participation in the social structure of the residential program. It also includes Client's progression, with increasing levels of responsibility and independence through job and other assignments culminating in employment seeking and employment-initiation activities in the community.

30. SUD means a condition in which the use of one or more substances leads to a clinically significant impairment or distress per the DSM-5.

31. Token means the security device which allows an individual user to access IRIS.

32. Unfunded means individuals that are eligible for Medi-Cal but their benefits may not be current for Orange County."

11. Exhibit A, Section II. General Requirements, subparagraphs A. and B., of the Contract are deleted in their entirety and replaced with the following:

"A. MEETINGS – CONTRACTOR's Executive Director or designee shall participate, when requested, in meetings facilitated by ADMINISTRATOR related to the provision of services pursuant to this Agreement.

1. Active participation in regular SUD Quality Improvement (QI) Coordinators' meetings organized by the Authority and Quality Improvement Services (AQIS) Quality Management program is required for at least one dedicated program QI coordinator/professional

B. ALCOHOL AND/OR DRUG SCREENING

1. CONTRACTOR shall have a written policy and procedure statement regarding drug screening that includes random drug and/or alcohol screen at a minimum of one (1) time per month for the first thirty (30) calendar days and two (2) times per month for the remaining term of the agreement for all Clients. This policy shall be approved by ADMINISTRATOR. A Client shall not be denied admittance to treatment for a positive alcohol and/or drug screen at admission if they meet all other criteria for admission. CONTRACTOR shall:

a. Establish procedures that protect against the falsification and/or contamination of any body specimen sample collected for drug screening; and,

b. Assure that all urine specimen collections are observed by same-sex or sex congruent staff; and,

c. Document results of the drug screening in Client's record.

2. In the event CONTRACTOR wishes to utilize a COUNTY-contracted laboratory for drug screening purposes, CONTRACTOR shall collect and label samples from Clients. Such testing shall be provided at COUNTY's expense. For tests not already covered in the COUNTY-contracted laboratory agreement, CONTRACTOR must receive approval from ADMINISTRATOR prior to using COUNTY-contracted laboratory for drug screenings.

3. In the event that any Client receives a drug test result indicating any substance abuse, CONTRACTOR shall formulate and implement a plan of corrective action which shall be documented in Client's record. CONTRACTOR shall notify ADMINISTRATOR within two (2) business days of receipt of such test results via an incident report indicating the corrective action to be taken by Client if Client is allowed to remain in the program."

12. Exhibit A, Section II. General Requirements, subparagraphs N. and O., of the Contract are deleted in their entirety and replaced with the following:

"N. MEDICATION POLICY – CONTRACTOR shall establish a written Medication Policy, which shall be reviewed and approved by ADMINISTRATOR. The policy shall include but not be limited to the securing, handling, and administering of medication(s) prescribed to Client. The policy shall address Medications that are prescribed for substance and mental health disorders. Clients shall be allowed to have Medications during their stay with the program, and/or to have the ability to get refill(s).

O. OPIOID OVERDOSE EMERGENCY TREATMENT – CONTRACTOR shall have available at each program site at minimum two (2) unexpired Naloxone doses for the treatment of known or suspected opioid overdose. At least one (1) staff per shift shall be trained in administering the Naloxone. Naloxone is not a substitute for emergency medical care. CONTRACTOR shall always seek emergency medical assistance in the event of a suspected, potentially life-threatening opioid emergency."

13. Exhibit A, Section III. Payments, subparagraph A., of the Contract is deleted in its entirety and replaced with the following:

"A. BASIS FOR REIMBURSEMENT – As compensation to CONTRACTOR for services provided pursuant to the Agreement, COUNTY shall pay CONTRACTOR monthly in arrears at the following rates of reimbursement; provided, however, the total of all such payments to CONTRACTOR and all other COUNTY contractors for all substance use disorder treatment services for substance users shall not exceed COUNTY's Total Aggregate Maximum Obligation as set forth in the Referenced Contract Provisions of the Agreement; and provided further, that CONTRACTOR's costs are allowable pursuant to applicable COUNTY, federal, and state regulations. Furthermore, if CONTRACTOR is ineligible to provide services due to non-compliance with licensure and/or certification standards of the state, COUNTY or OCPD, ADMINISTRATOR may elect to reduce COUNTY'S Total Aggregate Maximum Obligation proportionate to the length of time that CONTRACTOR is ineligible to provide services. CONTRACTOR shall ensure compliance with all DMC billing and documentation requirements when entering Units of Service into COUNTY IRIS system. ADMINISTRATOR may reduce, withhold or delay any payment associated with non-compliant billing practices. If CAPs are not completed within timeframes as determined by ADMINISTRATOR, payments may be reduced accordingly.

1. For Medi-Cal services provided pursuant to the Agreement, COUNTY shall claim reimbursement to the State Medi-Cal unit on behalf of CONTRACTOR to the extent these services are eligible.

2. Proper DMC certification and enrollment with the Provider Enrollment Division (PED) of DHCS, through the Provider Application and Validation for Enrollment (PAVE) system is required. CONTRACTOR shall submit proof of enrollment for each new rendering provider as required by regulations. Failure to demonstrate provider enrollment within six months of services being rendered shall result in disallowance of those services by pending providers.

3. CONTRACTOR shall submit appropriate Medi-Cal billing to ADMINISTRATOR on a monthly basis. ADMINISTRATOR shall review billing and remit to Accounting for submission to the State Medi-Cal unit.

4. CONTRACTOR shall assume responsibility for any audit disallowances or penalties imposed on COUNTY by the State related to amounts or services claimed by COUNTY on behalf of CONTRACTOR. CONTRACTOR shall reimburse COUNTY for any such disallowances or penalties within thirty (30) calendar days of written notification by

COUNTY.

Mode of Service	Reimbursement Rate					
	PERIOD ONE (7/1/19-1/31/20)	PERIOD ONE (2/1/20-6/30/20)	PERIOD TWO	PERIOD THREE	PERIOD FOUR	PERIOD FIVE
Residential Treatment 3.1 (per bed day)	$119.79	$119.79	$119.79	$119.79	$126.67	$126.67
Residential Treatment 3.5 (per bed day)	N/A	N/A	N/A	N/A	N/A	N/A
Room and Board 3.1 (per bed day)	$47.45	$70.85	$70.85	Actual Cost	Actual Cost	Actual Cost
Room and Board 3.5 (per bed day)	N/A	N/A	N/A	N/A	N/A	N/A
Case Management (per 15 minute increment)	$26.21	$26.21	$26.21	$26.21	$34.30	$34.30
Recovery Services (per 15 minute increment)	$26.17	$26.17	$26.17	$26.17	$34.30	$34.30
Medication Assisted Treatment (per 15 minute increment)	N/A	N/A	N/A	N/A	N/A	N/A

14. Exhibit A, Section V. Reports, subparagraph A.3., of the Contract is deleted in its entirety from the Contract.

15. Exhibit A, Section VI. Services, subparagraph B., of the Contract is deleted in its entirety and replaced with the following:

"B. LENGTH OF STAY - Length of stay is based on medical necessity as determined by a Licensed Practitioner of the Healing Arts. COUNTY is adhering to the state goal of a thirty (30) calendar day average in the residential level of care based on medical necessity. At CONTRACTOR'S discretion, CONTRACTOR may hold Client's bed during a temporary absence. A temporary absence is seven (7) calendar days or less during which Client is absent from the program due to a brief hospitalization for physical or mental health condition including detoxification, family death or emergency, or flash incarceration. A temporary absence bed day hold is not reimbursed by ADMINISTRATOR. Client's readmission does not count as a new treatment episode and will not necessitate a new treatment authorization or CalOMS admission. Documentation timelines must adhere to original admission date."

16. Exhibit A, Section VI. Services, subparagraphs C. and D., of the Contract are deleted in their entirety and replaced with the following:

"C. PERSONS TO BE SERVED – In order to receive services through the DMC-ODS, the Client must be enrolled in Medi-Cal or plan to enroll in Medi-Cal, reside in Orange County, and meet medical necessity criteria, as outlined below.

D. MEDI-CAL ELIGIBILITY - MEDICAL NECESSITY

1. CONTRACTOR must verify the Medi-Cal eligibility determination of potential Clients.

2. ADMINISTRATOR will reimburse up to thirty (30) calendar days of treatment for unfunded Clients with realignment funding while CONTRACTOR assists Client in applying for benefits or transferring Medi-Cal benefits to Orange County. Exceptions to the thirty (30) calendar day maximum must be approved by ADMINISTRATOR. The Heath plan in IRIS will be assigned as "Self Pay". When applying for Medi-Cal, Client shall request that Medi-Cal coverage is retroactively applied to date of admission. If current Medi-Cal is assigned to a different county (not Orange County), Client must initiate transfer within ten (10) calendar days of admission. If county of responsibility is other than Orange County and county of residence in Medical Eligibility Data System is Orange County and Medi-Cal transfer has been initiated, CONTRACTOR shall enter Health plan as "Medi-Cal" in IRIS. These claims will be accepted by the State. If both county of responsibility and county of residence are other than Orange County, Contractor shall assign the Health plan as "Self-Pay". CONTRACTOR shall review Self Pay Health Plan claims from the previous month and recheck eligibility status. If claims dates are covered by Medi-Cal, CONTRACTOR shall update the Health Plan and these claims will be automatically credited and re-dropped by the IRIS system.

3. Medical necessity for an adult [an individual age twenty-one (21) and over] is determined using the following criteria:

a. The individual must have received at least one diagnosis from the DSM for Substance-Related and Addictive Disorders with the exception of Tobacco-Related Disorders and Non-Substance-Related Disorders;

b. The individual must meet the ASAM Criteria definition of medical necessity for services based on the ASAM Criteria.

4. Individuals under age twenty-one (21) are eligible to receive Medicaid services pursuant to the EPSDT mandate. Under the EPSDT mandate, beneficiaries under the age twenty-one (21) are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority. For individuals under 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 a SUD are considered to ameliorate the condition and are thus covered as EPSDT services.

5. Medical necessity for an adolescent individual [an individual under the age of twenty-one (21)] is determined using the following criteria:

a. The adolescent individual must be assessed to be at risk for developing a SUD; and

b. The adolescent individual must meet the ASAM adolescent treatment criteria."

17. Exhibit A, Section VI. Services, subparagraphs E. and F., of the Contract are deleted in their entirety and replaced with the following:

"E. ADMISSIONS

1. CONTRACTOR shall accept any person with Orange County Medi-Cal; and who is physically and mentally able to comply with the program's rules and regulations. Said persons shall include persons with a concurrent diagnosis of mental illness, i.e., those identified as having a co-occurring diagnosis. Persons with co-occurring disorders and others who require prescribed medication shall not be precluded from acceptance or admission solely based on their licit use of prescribed medications.

2. CONTRACTOR shall have policies and procedures in place to screen for

emergency medical conditions and immediately refer beneficiaries to emergency medical care.

3. CONTRACTOR shall have a policy that requires a Client who shows signs of any communicable disease or through medical disclosure during the intake process admits to a health-related problem that would put others at risk, to be cleared medically before services are provided.

4. Admission Policy – CONTRACTOR shall establish and make available to the public a written Admission Policy. ADMINISTRATOR may revise Admission Policy due to funding changes. Admission Policy shall recognize the following specialty populations:

a. pregnant injection drug users.
b. pregnant substance abusers.
c. injection drug users.

5. CONTRACTOR's Admission Policy shall reflect all applicable federal, state, and county regulations. CONTRACTOR shall have the right to refuse admission of a person only in accordance with its written Admission Policy; provided, however, CONTRACTOR complies with the Nondiscrimination provisions of this Agreement.

6. CONTRACTOR shall initiate services within reasonable promptness and shall have a documented system for monitoring and evaluating the quality, appropriateness, and accessibility of care.

F. RESIDENTIAL TREATMENT AUTHORIZATION

1. Beneficiaries will be authorized and referred to CONTRACTOR by the ART Team. Beneficiaries who contact CONTRACTOR directly to request services shall be referred by CONTRACTOR to the ART Team. If Beneficiary is pregnant or an intravenous drug user who meets medical necessity for Residential Treatment, CONTRACTOR may admit to treatment bypassing the ART Team if provider has available bed slot. In this instance, CONTRACTOR must complete a SUD assessment and establish medical necessity for residential level of care. Assessment and authorization request must be submitted to the ART Team for authorization within seventy-two (72) hours of beneficiary admission. CONTRACTOR shall enter data regarding request for service into IRIS access log established by ADMINISTRATOR for these beneficiaries who access provider directly and bypass the ART Team.

2. If it is determined after assessing the beneficiary that the medical necessity criteria, pursuant to DMC-ODS STCs 128 (e), has not been met, then a written Notice of Adverse Benefit Determination shall be issued in accordance with 42 CFR 438.404 and 42 CFR Part 431, subpart E."

18. Exhibit A, Section VI. Services, subparagraph I.4., of the Contract is deleted in its entirety and replaced with the following:

"4. Family Therapy: When clinically appropriate, family members can provide social support to Client, help motivate their loved one to remain in treatment, and receive help and support for their own family recovery as well."

19. Exhibit A, Section VI. Services, subparagraph I.12., of the Contract, the term "Case Management" is deleted and replaced with "Case Management or Care Coordination."

20. Exhibit A, Section VI. Services, subparagraph I.13., of the Contract is deleted in its entirety and replaced with the following:

"13. Medication Assisted Treatment - MAT services may be provided onsite with approval for Incidental Medical Services from DHCS. Medically necessary MAT services must be provided in accordance with an individualized treatment plan determined by a licensed physician or LPHA working within their scope of practice.

a. MAT services must be provided in compliance with Policy and Procedures submitted to DHCS for IMS designation. CONTRACTOR must ensure ability to continue MAT after discharge through linkage to appropriate prescriber. MAT shall include the assessment, treatment planning, ordering, prescribing, administering, and monitoring of all medications for SUDs.

b. CONTRACTOR shall provide administration of buprenorphine, naltrexone (oral and injectable), acamprosate, disulfiram, and vivitrol. Other approved medications in the treatment of SUDs may also be prescribed and administered, as medically necessary.

c. CONTRACTOR must provide care coordination with treatment and ancillary service providers and facilitate transitions between levels of care. Clients may simultaneously participate in MAT services and other ASAM LOCs.

d. CONTRACTOR must participate in ADMINISTRATOR'S Medication Monitoring practices process as a quality assurance measure. Medication Monitoring is to assure the appropriateness of medication prescriptions for Mental Health and Recovery (MHRS) Clients and to establish practices for monitoring the safety and effectiveness of medication practices in MHRS."

21. Exhibit A, Section VI. Services, subparagraph I.16.a.5., of the Contract is deleted in its entirety and replaced with the following:

"5) Referrals and linkages to appropriate resources."

22. Exhibit A, Section VI. Services, subparagraph J., of the Contract, the term "ASAM-Designated" is replaced with the term "DHCS."

23. Exhibit A, Section VI. Services, subparagraphs K.2.c. and d., of the Contract are deleted in their entirety and replaced with the following:

"c. Objective 3: CONTRACTOR shall provide linkage to the next level of care for Clients upon discharge. Twenty percent (20%) of Clients who have discharged will be linked with a lower level of care within seven (7) calendar days, as measured by charge data entered into the IRIS. Linkage rates for Clients who discharge will include all CalOMS standard discharge dispositions. All CalOMS administrative discharge dispositions will be excluded."

24. Exhibit A, Section VII. Staffing, subparagraph B., of the Contract is deleted in its entirety and replaced with the following:

"B. Professional staff shall undergo the HCA credentialing process by the AQIS Managed Care Support Team (MCST) prior to rendering any Medi-Cal covered services.

1. CONTRACTOR shall comply with the requirements of the State's established uniform credentialing and re-credentialing policy that addresses behavioral and substance use disorders, outlined in DHCS Information Notice 18-019.

2. CONTRACTOR shall follow COUNTY's process for credentialing and re-credentialing of network providers and shall ensure that all registered, licensed or certified

staff who deliver Medi-Cal covered services are properly credentialed by COUNTY before delivering any Medi-Cal covered services."

25. Exhibit A, Section VII. Staffing, subparagraphs L.1.e. and f., of the Contract are deleted in their entirety from the Contract.

26. Exhibit A, Section VII. Staffing, subparagraphs M. and N., of the Contract are deleted in their entirety and replaced with the following:

"M. STAFF TRAINING – CONTRACTOR shall develop a written plan for staff training. All Staff training shall be documented and maintained as part of the training plan.

1. All personnel shall be trained or shall have experience which provides knowledge of the skills required in the following areas, as appropriate to the job assigned, and as evidenced by safe and effective job performance:

a. General knowledge of alcohol and/or drug abuse and alcoholism and the principles of recovery;

b. Housekeeping and sanitation principles;

c. Principles of communicable disease prevention and control;

d. Recognition of early signs of illness and the need for professional assistance;

e. Availability of community services and resources;

f. Recognition of individuals under the influence of alcohol and/or drugs; and

g. Principles of nutrition, food preparation and storage, and menu planning.

2. CONTRACTOR shall ensure that within thirty (30) calendar days of hire and on an annual basis, all program staff including administrator, volunteers and interns having direct contact with Clients shall have completed:

a. Annual County Compliance Training; and

b. A minimum of one (1) hour training in cultural competence annually.

3. In addition to the above, CONTRACTOR shall ensure that staff complete training as follows:

a. Professional staff (Licensed Professionals of the Healing Arts), including Medical Directors, shall receive a minimum of five (5) hours of continuing education related to addiction medicine annually.

b. All providers, including volunteers and interns, providing DMC-ODS services are required to be trained and complete at least once prior to providing services, the following two (2) training modules:

i. American Society of Addiction Medicine (ASAM) Multidimensional Assessment (sometimes referred to as ASAM-A or ASAM I).

ii. Assessment to Service Planning and Level of Care (sometimes referred to as ASAM-B or ASAM II).

iii. This requirement applies to all physicians and Medical Directors regardless of their role in the program and may only be waived for physicians/Medical Directors who are Board Certified with an Addiction sub-specialty.

c. All providers and administrators must receive training on DMC-ODS requirements at least annually. These requirements will be contained in the COUNTY-developed Annual Provider Training.

d. DMC-ODS/SUD documentation training within ninety (90) calendar days of hire is mandatory for all clinical staff, all on-site Quality Management staff, and all supervisors; however, compliant documentation is required from the onset of services.

e. Annual training in the two minimum evidence-based practices (EBP) utilized at the program.

f. Motivational Interviewing must be taken at least once and will count as one EBP for the year; Contractor may choose other EBP courses thereafter.

g. Naloxone Administration Training.

h. CPR / first aid Training.

N. PERSONNEL FILES – CONTRACTOR shall maintain personnel files and ensure continued compliance with required credentials and trainings for each staff persons, including management and other administrative positions, subcontractors, and volunteers/interns, both direct and indirect to the Agreement, which shall include, but not be limited to, the following:

1. Application for employment and/or resume;
2. Signed employment confirmation statement/duty statement;
3. Job description;
4. Salary schedule and salary adjustment information;
5. Performance evaluations;
6. Health records/status as required by the provider, AOD Certification or Title 9;
7. Other personnel actions (e.g. commendations, discipline, status change, employment incidents and/or injuries);
8. Training documentation relevant to substance use disorders and treatment;
9. Current registration, certification, intern status, or licensure;
10. Proof of continuing education required by licensing or certifying agency and program; and
11. CONTRACTOR's Code of Conduct and, for registered, certified, and licensed staff, a copy of the certifying/licensing body's code of conduct as well.
12. All personnel files shall be complete and made readily accessible to ADMINISTRATOR for purposes of audits and investigations or any other reason deemed necessary by ADMINISTRATOR."

This Amendment No. 7 modifies the Contract, including all previous amendments, only as expressly set forth herein. Wherever there is a conflict in the terms or conditions between this Amendment No. 7 and the Contract, including all previous amendments, the terms and conditions of this Amendment No. 7 shall prevail. In all other respects, the terms and conditions of the Contract, including all previous amendments, not specifically changed by this Amendment No. 7 remain in full force and effect.

SIGNATURE PAGE FOLLOWS

SIGNATURE PAGE

IN WITNESS WHEREOF, the Parties have executed this Amendment No. 7. If Contractor is a corporation, Contractor shall provide two signatures as follows: 1) the first signature must be either the Chairman of the Board, the President, or any Vice President; 2) the second signature must be either the Secretary, an Assistant Secretary, the Chief Financial Officer, or any Assistant Treasurer. In the alternative, a single corporate signature is acceptable when accompanied by a corporate resolution or by-laws demonstrating the legal authority of the signature to bind the company.

Contractor: Straight Talk Clinic, Inc.

Roberta Cone	Executive Director
Print Name	Title
DocuSigned by: Roberta Cone B70BD94C688D4BF...	4/20/2022
Signature	Date
Print Name	Title
Signature	Date

County of Orange, a political subdivision of the State of California

Purchasing Agent/Designee Authorized Signature:

Print Name	Title
Signature	Date

APPROVED AS TO FORM
Office of the County Counsel
Orange County, California

Brittany McLean	Deputy County Counsel
Print Name	Title
DocuSigned by: Brittany McLean 9713A4061D4343D...	4/20/2022
Signature	Date