NAPA COUNTY AGREEMENT NO. 190292B
AMENDMENT NO. 3

THIS AMENDMENT NO. 3 TO AGREEMENT NO. 190292B is effective as of the 1st day of July, 2024, by and between NAPA COUNTY, a political subdivision of the State of California hereinafter referred to as "COUNTY," and **BAYMARK HEALTH SERVICES dba MEDMARK TREATMENT CENTERS, INC.,** hereinafter referred to as "CONTRACTOR." COUNTY and CONTRACTOR may be referred to below collectively as "Parties" and individually as "Party."

RECITALS

WHEREAS, on or April 23, 2019, COUNTY and CONTRACTOR entered into Napa County Agreement No. 190292B (hereinafter referred to as the "Agreement") for CONTRACTOR to provide methadone, buprenorphine, disulfiram and naloxone treatment services to specifically referred clients of COUNTY's Alcohol and Drug Services programs; and

WHEREAS, on October 1, 2018, the Parties amended the Agreement in order to reimburse CONTRACTOR for services provided prior to the original effective date of April 23, 2019; increase the maximum amount for the term October 1, 2018 through June 30, 2020 for payment of those services with no change to the maximum amount of $94,900 for each subsequent automatic renewal; amend Specific Terms and Conditions 3.4.—Compliance with State ODS Waiver Requirements to add an additional requirement; revise the Compensation section (Exhibit B) to reflect the increase to the maximum amount and to update the invoicing requirements of CONTRACTOR for reimbursement of services; and

WHEREAS, as of July 1, 2023, the Parties amended the Agreement in order to replace Exhibit A with Exhibit A-1 (Scope of Work) and Addendum 1 to Exhibit B with Exhibit B-2 (Compensation) in order to update the Narcotic Treatment Program (NTP) Service rates set by the California Department of Health Care Services (DHCS) and update invoice documentation requirements.

WHEREAS, as of the effective date of this Agreement No. 3, the Parties wish to further amend the Agreement to modify Specific Term and Condition 3.6; replace Exhibit A-1 with Exhibit A-2 (Scope of Work); and Exhibit B-2 with Exhibit B-3 (Compensation) in order to update the Narcotic Treatment Program (NTP) Service rates set by the California Department of Health Care Services (DHCS) and update invoice and cost report language documentation requirements.

TERMS

NOW THEREFORE, for good and valuable consideration, the adequacy and receipt of which are hereby acknowledged, the Parties amend the Agreement as follows:

1. Specific Terms and Conditions 3.6 is modified to read in full as follows:

   COUNTY delegates its authority to the Director of the Health and Human Services Agency to approve future amendments to Exhibits A and B, attached to this Agreement, provided that any such amendment does not materially alter the nature of the services to be provided or increase the maximum compensation available under this Agreement.

2. Exhibit A-1 shall be replaced with "Exhibit A-2" attached hereto and incorporated by reference herein, and all references in the Agreement to Exhibit A-1 shall refer to "Exhibit A-2" as of the effective date of this Amendment No. 3.

3. Exhibit B-2 shall be replaced with "Exhibit B-3" attached hereto and incorporated by reference herein, and all references in the Agreement to Exhibit B-2 shall refer to "Exhibit B-3" as of the effective date of this Amendment No. 3.

4. Except as provided above, the terms and conditions of the Agreement shall remain in full force and in effect as originally approved.

[SIGNATURE PAGE TO FOLLOW]

IN WITNESS WHEREOF, the Parties hereto have executed this Amendment No. 3 of Napa County Agreement No. 190292B as of the date first above written.

MEDMRK TREATMENT CENTERS-FAIRFIELD, INC.

By: _____
BRUCE JARVIE,
Chief Financial Officer

By: _____
PATRICE TRISVAN,
OTP Group President

"CONTRACTOR"

NAPA COUNTY, a political subdivision of the State of California

By: _____
ANNE COTTRELL
Chair of the Board of Supervisors
"COUNTY"

APPROVED AS TO FORM Office of County Counsel By: //s//Jo Ann Iwasaki Parker Deputy C.C. by e-signature Date: June 5, 2024	APPROVED BY THE NAPA COUNTY BOARD OF SUPERVISORS Date: Processed By: _____ Deputy Clerk of the Board	ATTEST: NEHA HOSKINS Clerk of the Board of Supervisors By:_____

EXHIBIT A-2
SCOPE OF WORK

July 1, 2024 through June 30, 2025
(and each subsequent automatic renewal)

I. Narcotics Treatments Program Services

1. BayMark, Inc dba MedMark Treatment Center, Fairfield (CONTRACTOR) shall offer and prescribe medications to patients covered under the DMC-ODS formulary, including methadone, buprenorphine, naltrexone (oral and long-acting injectable), naloxone and disulfiram.
2. CONTRACTOR shall notify COUNTY Alcohol and Drug Program Administrator or designee prior to any admission. CONTRACTOR shall secure and maintain signed beneficiary authorization for Release of Information to coordinate care, verify Napa is the county of residence, and collect the patient's medical/insurance information.
3. CONTRACTOR shall provide NTP Services for COUNTY residents. The services are limited to residents who are eligible for Medi-Cal benefits in Napa County. Treatment services are inclusive of initial physician exam, follow up substance use disorder treatment, follow up medical exams, and required monthly laboratory urinalysis testing. The following services are included in this Agreement:
   a. NTP- Methadone Dosing
   b. NTP - Individual Counseling
   c. NTP- Group Counseling
   d. NTP- Buprenorphine
   e. NTP - Buprenorphine-Naloxone Combo Product
   f. NTP – Naltrexone (oral and long-acting injectable)
   g. NTP - Disulfiram
   h. NTP - Naloxone (2-pack Nasal Spray)
4. CONTRACTOR may provide "courtesy dosing" (defined as replacement narcotic therapy) to visiting beneficiaries approved to receive services on a temporary basis (less than 30 days) in accordance with Title 9, Section 10295. Prior to providing replacement narcotic therapy to a visiting beneficiary, CONTRACTOR must comply with Title 9, Section 10210(d).
5. CONTRACTOR further agrees to comply with all applicable laws and regulations, including Sections 96.126, 96.127, 96.128, 96.131 and 96.132ofthe Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) Reauthorization Act, Public Law 106-310; the State of California Alcohol and/or Other Drug Program Certification Standards (May 1, 2017 version); Title 21, CFR Part 1300, et seq.; Title 42, CFR, Part 8; Drug Medi-Cal Certification Standards for Substance Abuse Clinics; Title 22, CCR, Sections 51341.1, 51490.1, and 51516.1; Title 9, CCR, Division 4, Chapter 4, Subchapter I, Sections 10000, et seq., Title 22, CCR, Division 3, Chapter 3, sections

51000 et. seq. and any and all guidelines promulgated by the State Department of Health Care Services' (DHCS) Substance Use Disorder Services and/or the Napa COUNTY Department of Health and Human Services to serve special populations and groups, as applicable; as well as COUNTY laws, ordinances, regulations and resolutions; and any amendments to the above laws and regulations as may from time to time arise.
CONTRACTOR shall perform all services under this Agreement in a manner in accordance with the standards and obligations of CONTRACTOR's profession.
CONTRACTOR shall devote such time to the performance of services pursuant to this Agreement as may be reasonably necessary for the satisfactoly performance of CONTRACTOR's obligations.
COUNTY shall maintain copies of above-mentioned statutes, regulations, and guidelines for CONTRACTOR's use.

II. Reporting Requirements

A. DMC-ODS requirements regarding Provider Medical Director:
   1. Substance Use Disorder Medical Director.
      a. Written roles and responsibilities and a code of conduct for the Medical Director shall be clearly documented, signed and dated by a provider representative and the physician.
      b. The SUD Medical Director's responsibilities shall, at a minimum, include all of the following:
         i. Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
         ii. Ensure that physicians do not delegate their duties to non-physician personnel.
         iii. Develop and implement written medical policies and standards for the provider.
         iv. Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.
         v. Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.
         vi. Ensure that provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries, and determine services are medically necessary.
         vii. Ensure that provider's physicians are adequately trained to perform other physician duties, as outlined in this section.
         viii. The SUD Medical Director may delegate their responsibilities to a physician consistent with the provider's medical policies and standards; however, the SUD Medical Director shall remain responsible for ensuring all delegated duties are properly performed.

B. DMC-ODS requirements regarding Provider Staff (including Interns):
   1. Written provider code of conduct for employees and volunteers/interns shall be established, signed and dated by staff, filed in personnel file and shall address at least the following:
      a. Use of drugs and/or alcohol.

b. Prohibition of social/business relationship with beneficiaries or their family members for personal gain.
c. Prohibition of sexual contact with beneficiaries.
d. Conflict of interest.
e. Providing services beyond scope.
f. Discrimination against beneficiaries or staff.
g. Verbally, physically, or sexually harassing, threatening or abusing beneficiaries, family members or other staff.
h. Protection of beneficiary confidentiality.
i. Cooperate with complaint investigations.

C. Continuing Education and Continuing Medical Education Reporting Requirement:
1. Physicians shall receive a minimum of five hours of continuing medical education (CME) related to addiction medicine each calendar year.
   a. Provider shall report addiction medicine CMEs accumulated in the previous calendar year on an annual basis by January 15 for licensed medical personnel in their program in the manner prescribed by the County.
2. Professional staff (LPHAs) shall receive a minimum of five hours of continuing education (CEU) related to addiction medicine each calendar year.
   a. Provider shall report addiction medicine CEU's accumulated in the previous calendar year on an annual basis by January 15 for each LPHA in their program in the manner prescribed by the County.

D. Notification of Beneficiary status:
Provision for prompt notification to the COUNTY when it receives information about changes in a beneficiary's circumstances that may affect the beneficiary's eligibility including all the following:
1. Changes in the beneficiary's residence.
2. The death of a beneficiary.

III. Oversight of Legal Requirements

CONTRACTOR shall meet Substance Use Disorder (SUD) treatment service requirements pursuant to all relevant regulations including but not limited to CCR Title 9, Title 42 CFR, the current Intergovernmental Agreement with California Department of Health Care Services (DHCS), the current DMC-ODS contract with DHCS, and all applicable DHCS Behavioral Health Information Notices. The DMC-ODS demonstrates how organized SUD services improves beneficiary health, while decreasing system-wide healthcare costs. Critical elements of the DMC-ODS include:

A. Providing a continuum of care modeled after the American Society of Addiction Medicine (ASAM) Criteria for SUD treatment services;

B. Increasing local control and accountability with greater administrative oversight;

C. Creating utilization controls to improve care and efficient use of resources;

D. Increasing program oversight and integrity;

E. Providing treatment services for the criminal justice population;

F. Expanding the SUD treatment workforce by including Licensed Practitioners of Healing Arts for the assessment of clients and other functions within the scope of their practice;

G. Requiring evidence-based practices (EBPs) in substance abuse treatment, including access to FDA approved medications for the treatment of alcohol and opioid use disorder; and

H. Increasing coordination with other systems of care including primary care and mental health.

IV. Compliance Program, Including Fraud Prevention and Over Payments

A. Contractor shall have in place a compliance program designed to detect and prevent fraud, waste and abuse, as per 42 C.F.R. § 438.608 (a)(1), that must include:

I. Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the Agreement, and all applicable federal and state requirements.

II. A Compliance Office (CO) who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of this Agreement and who reports directly to the CEO and the Board of Directors.

III. A Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under the Agreement.

IV. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the federal and state standards and requirements under the Agreement.

V. Effective lines of communication between the Compliance Officer 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, corrections of such problems promptly and thoroughly to reduce the potential for recurrence, and ongoing compliance with the requirements under the Agreement.

VIII. The requirement for prompt reporting and repayment of any overpayments identified.

B. Contractor must have administrative and management arrangements or procedures designed to detect and prevent fraud, waste and abuse of federal or state health care funding. Contractor must report fraud and abuse information to the County including but not limited to:

I. Any potential fraud, waste, or abuse as per 42 C.F.R. § 438.608(a), (a)(7).

II. All overpayments identified or recovered, specifying the overpayment due to potential fraud as per 42C.F.R. § 438.608(a), (a)(2).

III. Information about change in a client's circumstances that may affect the client's eligibility including changes in the client's residence or the death of the client as per 42 C.F.R. § 438.608(a)(3).

IV. Information about a change in the Contractor's circumstances that may affect the network provider's eligibility to participate in the managed care program, including the termination of this Agreement with the Contractor as per 42 C.F.R. § 438.608 (a)(6).

C. Contractor shall implement written policies that provide detailed information about the False Claims Act ("Act") and other federal and state Laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

D. Contractor shall make prompt referral of any potential fraud, waste or abuse to County or potential fraud directly to the State Medicaid Fraud Control Unit.

E. County may suspend payments to Contractor if DHCS or County determine that there is a credible allegation of fraud in accordance with 42 C.F.R. § 455.23. (42 C.F.R. § 438.608 (a)(8)).

F. Contractor shall report to the County all identified overpayments and reason for the overpayment, including overpayments due to potential fraud. Contractor shall return any overpayments to the County within 60 calendar days after the date on which the overpayment was identified. (42 C.F.R. § 438.608 (a)(2), (c)(3)).

EXHIBIT B-3
COMPENSATION

July 1, 2024 through June 30, 2025
(and each subsequent automatic renewal)

I. Compensation

CONTRACTOR shall be entitled to payment for qualifying services delivered under the Agreement at the applicable current Drug Medi-Cal rates for Narcotic Treatment Programs, as determined pursuant to Welfare & Institution Code Section 14021.51. No changes in the rates shall add a new type of services to those services set forth in Exhibit A of the Agreement. Total reimbursement under this **Agreement may not exceed $94,900.00**.

COUNTY shall accept, and reimburse, a claim from any subcontracted OTP/NTP provider (Referring OTP/NTP) that pays another OTP/NTP for providing courtesy dosing (Dosing OTP/NTP) to a visiting beneficiary. COUNTY shall use the reimbursement rate established in this Agreement.

CONTRACTOR shall invoice the COUNTY for services by the 15th of the month following its provision of any services under this Agreement. CONTRACTOR shall include documentation of individual services by date of service, including client name, address and case number, and the CMS-1500 Claim forms.

Per Federal Regulation, providers must bill all other health coverage (OHC) prior to submitting claims to Napa County for Medi-Cal reimbursement, as Medi-Cal is the payer of last resort.

The OHC insurer is considered the primary insurance and may pay all, part, or none of the cost of services. Any unreimbursed cost may be claimable to Medi-Cal. In place of the 15-day billing period otherwise required by the immediately preceding paragraph, claims where OHC exists shall be submitted to Napa County within 30 days from receipt of the Explanation of Benefits (EOB), or no later than four months from the date of service, whichever occurs first. When submitting claims to Napa County for individuals with OHC, a copy of the OHC EOB or denial shall be attached to the CMS-1500 form unless the claim falls under the next paragraph.

In order to submit claims to Napa County within four months from the date of service, claims must be submitted to any OHC insurer in a timely manner. If no response or EOB is received from the OHC insurer within 90 days from the date of claim submission, CONTRACTOR may presume denial from the OHC and submit their CMS-1500 claim to Napa County. When submitting claims with a presumed denial from the OHC, CONTRACTOR shall attach a letter stating that no response was received from the OHC, include in the letter the name of the OHC, and state the date the claim was submitted to the OHC.

Either party may terminate this Agreement for any reason by giving a (30) calendar day written notice to the other party. Notice of termination shall be by written notice to the other party and be sent by registered mail. CONTRACTOR shall reimburse COUNTY for all overpayments identified by CONTRACTOR, and/or State or Federal oversight agencies as an audit exception.

CONTRACTOR shall make any repayment based on audit exception(s) upon discovery of said exception(s). If reimbursement is required, CONTRACTOR shall reimburse COUNTY within 60 days of identification.

II. Payment Rates

"Uniform Statewide Daily Reimbursement Rate (USDR)" means the rate for NTP services based on a unit of service that is a daily treatment service, developed in accordance with Section 14021.6 of the W&I Code Section, Section 11758.42 of the HSC and Title 9, CCR, commencing with Section 10000 (Document 3G). The following table shows USDR rates:

(*) The NTP Contractor may be reimbursed for up to 200 minutes (20 ten-minute increments) of individual and/or group counseling per calendar month. If a medical necessity determination is made that requires additional NTP counseling beyond 200 minutes per calendar month, NTP Contractors may bill and be reimbursed for additional counseling (in 10 minute increments). Medical justification for the additional counseling must be clearly documented in the patient record. Reimbursement for covered NTP services shall be limited to the lower of the NTP's usual and customary charge to the general public for the same or similar services or the USDR rate.

1. Buprenorphine: Average daily dose of 16 milligrams, sublingual tablets.
2. Disulfiram: Average daily dose between 250 and 500 milligrams.
3. Naloxone: One dose equal to 4 milligrams per 0.1 milliliter.

NTP Service	Period	SFY 2024-25 Rate	
		Non-Perinatal	Perinatal
Methadone	**Daily**	**$19.37**	**$20.87**
Buprenorphine Mono	**Daily**	**$24.60**	**$29.84**
Buprenorphine-Naloxone Combo Tablets	**Daily**	**$24.97**	**$29.00**
Disulfiram	**Daily**	**$8.88**	**$9.16**
Naloxone HCL – 2 pack (Narcan)	**Dispensed as needed**	**$149.22**	**$149.22**

COUNTY shall compensate CONTRACTOR for contract services provided and properly documented, as defined in Table 1 and in Exhibit A. Rates billed for contract services during the contract term shall be based the following:

TABLE 1: RATES PER BILLABLE MINUTE

LPHA (MFT, LCSW, LPCC)/ Intern or Waivered LPHA (MFT, LCSW, LPCC)	**$5.69**
Mental Health Rehab Specialist	**$4.37**
Certified AOD Counselor	**$4.37**
Other Qualified Providers - Other Designated MH Staff that Bill Medi-Cal	**$4.21**

4. A billing unit is defined as one minute of service. Only authorized service activities provided by eligible staff, while providing Medi-Cal eligible services to Napa County Medi-Cal eligible clients, shall qualify for payment. The following requirements apply for claiming of services:
   a. Accurate and precise number of minutes shall be reported and billed properly, by a qualified staff member.
   b. A maximum of 60 units of time may be reported or claimed for any single client during a one-hour period.
   c. Units of time reported or claimed shall not exceed hours worked by eligible staff.
   d. When a single staff member provides eligible service to, or on behalf of, more than one beneficiary at the same time, the staff member's time must be prorated to each beneficiary.
   e. When more than one staff member provides an eligible service to more than one beneficiary at the same time, the time utilized by all those providing the service shall be added together to yield the total claimable services. The total time claimed shall not exceed the actual time utilized for claimable services.
   f. All documentation of services provided to, or on behalf of, more than one beneficiary at the same time, or services provided by multiple staff members to one or more beneficiaries at the same time, must include clear indication of the clinical necessity for the chosen treatment approach.
   g. All documentation of services provided to, or on behalf of, more than one beneficiary at the same time, or services provided by multiple staff members to one or more beneficiaries at the same time, must clearly delineate the total minutes of the direct service and the combined number of clients served.
5. Total contract payments for the term shall not exceed the contract maximum, which is based on an estimate of services that may be performed during the contract period and shall not be considered a guaranteed sum.

III. Clients with Medi-CAL and Other Health Coverage (OHC)

Per Federal Regulation, providers must bill all other health coverage options prior to submitting claims to Napa County for Medi-Cal reimbursement.

The Other Health Care (OHC) insurer is considered the primary insurance and may pay all, part, or none of the cost of services. Any unreimbursed cost may be claimable to Medi-Cal. Claims where OHC exists must be submitted to Napa County within 30 days from receipt of the Explanation of Benefits (EOB), but no later than 5 months from the date of service. When submitting claims to Napa County for individuals with OHC, a copy of the OHC EOB or denial must be attached to the monthly itemized invoice.

In order to submit claims to Napa County within 5 months from the date of service, it is in the best interest of the client and the provider to submit claims to the OHC insurer in a timely manner. If no response or EOB is received from the OHC insurer primary insurance within 90-days from the date of claim submission, the provider may presume denial from the OHC and submit their monthly itemized invoice to Napa County. When submitting claims with a presumed denial from the OHC, attach a letter stating that no response was received from the OHC, include in the letter the name of the OHC and the date the claim was submitted.

IV. Required Submissions

1. Budget: Fifteen days prior to the beginning of the Fiscal Year, CONTRACTOR shall submit an estimated Budget consistent with the Fiscal Year contract maximum. CONTRACTOR shall include estimated FTEs, by standardized classification, and identify those providing Direct Client Care. The COUNTY shall supply a revised Budget Template which correlates to standardized classification fields.

2. Invoices: CONTRACTOR shall invoice the COUNTY for services by the 15th of the month following its provision of any services under this Agreement. CONTRACTOR shall include documentation of individual services by date of service, including client name, address and case number, and the CMS-1500 Claim forms.
   The invoice shall itemize all the following for each billed service:
   i. Client name(s)
   ii. Program name
   iii. Description of service
   iv. Approved staff member who provided service
   v. Identifiable Activity Code
   vi. Must correlate to approved staff member's scope of service, by credential
   vii. Date of service
   viii. Length of service

ix. Rate of service
x. Total amount billed for each service
xi. Invoice shall only include billing for the eligible contract services performed in the manner described herein.

CONTRACTOR shall submit an invoice on agency letterhead with the total amount due for the services along with service month and year to BHInvoices@countyofnapa.org

Validity and accuracy of invoice submission is critical to ensure timely payment of invoices for contracted services. Invoices will be paid within 60 days of receipt of invoices that are valid, accurate, and approved. If COUNTY staff requires any invoice follow-up, clarification, adjustment, or resubmission from CONTRACTOR, the 60-day timeframe for invoice payment resets to the date all outstanding issues are resolved, and the most recently received invoice is confirmed to be valid and accurate.

V. Other Limitations Affecting Payments

CONTRACTOR shall perform services and provide such documentation as required by all applicable State and Federal laws, rules, and regulations, and as described in Exhibit A of this agreement. Other limitations affecting contract payments may include, but are not limited to:

1. CONTRACTOR shall provide such documentation as required by COUNTY at any time in order to substantiate its claims for payment. COUNTY may elect to withhold payment for failure by CONTRACTOR to provide such documentation required by COUNTY.
2. Contractor's services and claims are subject to any audits conducted by COUNTY, the State of California or federal government, or other auditors. Any resulting audit exemption shall be repaid to COUNTY.
3. CONTRACTOR shall make COUNTY whole for disallowances for payment or lost revenues as identified and discovered by the COUNTY that are attributable to Contractor's performance under this Agreement, including, but not limited to, Contractor's insufficient documentation of Medical Necessity or billing errors by CONTRACTOR that preclude COUNTY from claiming the Federal Financial Participation share of Medi-Cal.
4. To the extent CONTRACTOR shall make whole the COUNTY under this Paragraph, COUNTY may elect to withhold any payments for past services, offset against any payments for future services for which CONTRACTOR provides, or demand reimbursement without offset.
5. CONTRACTOR shall pay any penalty or fine assessed against COUNTY arising from CONTRACTOR's failure to comply with all applicable Federal or State Health Care Program Requirements, including, but not limited to any penalties and fines which may be assessed under a Federal or State False Claims Act provision.

Non-compliance with this agreement may lead at any time to withholding of payments and/or a termination of the agreement based on breach of contract.