Stanislaus County Behavioral Health and Recovery Services (BHRS)

Substance Use Disorder Provider Minimum Qualifications

Youth Residential Services Open Enrollment

This open enrollment shall establish qualified Residential Treatment Programs to provide services to youth within Stanislaus County. Stanislaus County BHRS has developed a set of minimum qualifications (MQ) required for Youth Residential Providers. Upon meeting all of the MQ's, a Residential facility may enter into an agreement with Stanislaus County BHRS in order to be reimbursed.

Open Enrollment Point Person: Robert Weston, (209) 525-7411, rweston@stanbhrs.org

Estimated/Proposed Timeline

- August 1, 2022
  - Open Enrollment to be discussed and documents will be provided to parties expressing interest.
- August 3, 2022
  - Open Enrollment documents posted on Stancounty.com/bhrs under Quick links – Youth Residential Services Open Enrollment.
  - Contact any additional vendors that express interest and direct them to StanCounty.com for Open Enrollment Documents
- August 22, 2022
  - Deadline to submit questions to CBHRS@stanbhrs.org
- August 26, 2022
  - Questions & Answers will be posted on StanCounty.com under the Open Enrollment Documents.
- September 26, 2022
  - All required documentation due (business license, budget, insurance requirements acknowledgment, etc.) Can be submitted via email to CBHRS@stanbhrs.org or mailed to Stanislaus County BHRS Contract Services at 800 Scenic Drive, Modesto CA 95350
- Facility walk-throughs will be conducted during October, November, and December.

Minimum Qualifications

- Submit financial reports that include detailed information about Residential facility's financial condition (e.g., audited/unaudited financial statements, as applicable, statement of income and retained earnings, letters of reference, etc.)
- Submit an estimated budget (daily rates, capacity, food, laundry, etc.)
- Submit a copy of the Residential Program Drug Medi-Cal Certification.
- Submit a copy of the Residential Program ASAM or DHCS Level of Care Designation and Department of Social Services License (or pending application)
- Procure and maintain the insurance requirements detailed in Exhibit B "Insurance Requirements for Professional Services"
- Demonstrate the ability to provide Residential Treatment services in accordance with the Scope of Work and the Youth Treatment Guidelines, including, but not limited to:

- Ability to comply with Minimum Quality Drug Treatment Standards (MQDTS)
- Ability to comply with Youth Treatment Guidelines
- Ability to establish and maintain a computer system with:
    - Windows 10 OS (32 bit or 64 bit);
    - Antivirus solution (i.e. Sophos, Norton, McAfee);
    - Firewall (Windows Firewall on);
    - WiFi capability when connecting via wireless Contractor must not use free WiFi spots that do not require a password but rather use their own wireless connection with WPA2 (WiFi Protected Access 2) protocol to establish a secure connection;
    - Parallels Client (to connect to EHR) which is a free software that is provided to the contractor
    - The above computer system will insure Contractor can access the County's Electronic Health Record (EHR) and State Databases for the submission of information required under the terms and conditions of this Agreement, including but not limited to the submission of:
        - Drug Medi-Cal claims;
        - CalOMS (California Outcomes Measurements System) treatment admission, annual updates, and discharge data, including client demographic data;
        - ASAM (American Society of Addiction Medicine) Level of Care data;
        - Initial contact data for each Medi-Cal beneficiary; and
        - DATAR (Drug Alcohol Treatment Access Report) waiting list record.
- Ability to offer culturally competent services including: interpreter services and adequately trained staff.

Selection Procedure

- Once all required documentation is submitted and reviewed by BHRS a site review conducted by a team from BHRS will be scheduled.

All agreements begin upon execution and are subject to renewal each fiscal year. The execution of an agreement does not guarantee any minimum or maximum amount of utilization of services, and may or may not be utilized, at the County's sole discretion.

Today's Date: **XX/XX/XXXX**
Facility Name:
Fiscal Year: **FY22/23**

Number of beds:

Daily rate:

Contract Maximum:

EXHIBIT A

SCOPE OF WORK

Contractor agrees to provide substance use disorder services to eligible beneficiaries of Stanislaus County within the scope of services defined in this contract.

Exhibits included in this Agreement are listed below:

Exhibit A	Scope of Work
Exhibit B	Insurance
Exhibit C	Modality of Covered Service Descriptions
Exhibit D	Department of Health Care Services (DHCS) Drug Medi-Cal Organized Delivery System (DMC-ODS) Requirements
Exhibit E	Substance Abuse Block Grant (SABG) Requirements

These exhibits contain provisions that require strict adherence to various contracting laws and policies. Some provisions herein are conditional and only apply if specified conditions exist.

As a subcontractor under the Agreement(s) between the California Department of Health Care Services (DHCS) and County as the Mental Health Plan (MHP), Contractor shall perform the delegated activities and reporting responsibilities specified in compliance with County's agreement obligations, as applicable. Contractor shall also be required to comply with the requirements stated within the Agreement(s), as it pertains to subcontractors, by this reference incorporated herein. A copy of the Agreement(s) shall be made available to Contractor. Contractor agrees to comply with all applicable Medicaid laws, regulations, including applicable sub-regulatory guidance and contract provisions. If Contractor is found to be non-compliant or inadequate in the provision of services under this agreement, County may terminate the Agreement in alignment with Section 4, Term of the Agreement, or specify other remedies as necessary.

A. PROGRAM SPECIFIC SERVICES

Contractor shall provide American Society of Addiction Medicine ASAM level(s):

1. 3.1 Clinically-Managed Low Intensity Residential Services
2. 3.2 Clinically Managed Residential Withdrawal
3. 3.3 Clinically Managed Medium Intensity Residential Services
4. 3.5 Clinically Managed High-Intensity Residential Services

B. GENERAL PROGRAM REQUIREMENTS

1. Contractor shall provide Drug Medi-Cal substance use disorder treatment services at State certified locations to eligible beneficiaries of Stanislaus County, as identified in this Agreement, including all exhibits.
2. Contractor shall provide services as described in Exhibit C, Stanislaus County, Behavioral Health & Recovery DMC-ODS Modality of Covered Service.
3. Descriptions and comply with Exhibit D, DHCS DMC-ODS Requirements and Exhibit E, SABG Requirements, attached hereto and incorporated by this reference.
4. Contractor shall comply with Drug Medi-Cal and County policies and procedures and Document Guidelines.

5. Contractor shall comply with the Stanislaus County Substance Use Disorder Provider Guidelines, by this reference incorporated herein, made available by County on the BHRS Extranet -> SUD->Provider Guidelines. No formal amendment of this agreement is required for changes to the Provider Guidelines to apply.

6. Youth Residential License Requirements, at this time:
   - DCSS licensing as an STRTP
   - DHCS Licensing & ASAM or DHCS LOC designation
   - DMC certification

7. Contract shall participate in SUD Program Monitoring annually, at minimum, including but not limited, to the follow:

   a. Minimum Quality Drug Treatment Standards (MQDTS) Monitoring tools made available by the County on the Stanislaus County website -> County Services -> BHRS -> Quick Links -> Contract Services -> MQDTS Monitoring
   b. SUD Program Monitoring Instrument is made available by the Stanislaus County website located at www.StanCounty.com -> County Services -> BHRS -> Contract Services -> Quick Links ->SUD Monitoring Tools
   c. Onsite Review
   d. Any deficiencies or areas for improvement identified by County shall be corrected by Contractor via corrective action plans.
   e. Contractor shall comply with BHRS DMC-ODS Practice Guidelines posted on the BHRS Extranet -> SUD -> DMC-ODS Practice Guidelines.

7. Contractor shall establish and maintain, at Contractor's cost, the following computer system:

   a. Windows 10 OS (32 bit or 64 bit);
   b. Antivirus solution (i.e. Sophos, Norton, McAfee);
   c. Firewall (Windows Firewall on);
   d. WiFi capability when connecting via wireless Contractor must not use free;
   e. WiFi spots that do not require a password but rather use their own wireless connection with WPA2 (WiFi Protected Access 2) protocol to establish a secure connection;
   f. Parallels Client (to connect to EHR) which is a free software that is provided to the contractor;
   g. The above computer system will insure Contractor can access the County's Electronic Health Record (EHR) and State Databases for the submission of
   h. information required under the terms and conditions of this Agreement, including but not limited to the submission of:
      - Drug Medi-Cal claims;
      - CalOMS (California Outcomes Measurements System) treatment admission, annual updates, and discharge data, including client demographic data;
      - ASAM (American Society of Addiction Medicine) Level of Care data;
      - Initial contact data for each Medi-Cal beneficiary; and
      - DATAR (Drug Alcohol Treatment Access Report) waiting list record.

8. Contractor shall complete all required data entry in accordance with DMC-ODS Intergovernmental Agreement, County policies and procedures, and BHRS DMCODS Documentation Guidelines posted on the BHRS Extranet.

9. Contractor shall provide agreed upon number of comprehensive SUD assessment slots. Following completion of comprehensive SUD assessment, contractor will assist client in scheduling first service at the appropriate level of care based on ASAM indication and medical necessity.

10. Contractor shall actively participate in the following meetings, committees or collaborations: BHRS Behavioral Health Equity Committee (BHEC), SUD Quality Improvement Council (QIC), SUD Peer Review, SUD Providers meeting (Program coordinators and managers only), and any other meetings, committees or collaborations found appropriate between Contractor and Contract monitor.

C. BILLING AND PAYMENT

1. In consideration of Contractor's provision of services under the terms of this Agreement, the total maximum amount payable for all salaries, benefits and other operating costs shall not exceed $TBD during the term of this Agreement. County shall reimburse Contractor.

2. County shall reimburse Contractor for any undisputed invoices, which County and Contractor agree represent the costs of delivering the services required under the terms of this Agreement for the period covered by the invoice, within 30 days of invoice receipt. Contractor agrees that the monthly invoices represent an estimate of the actual program costs and not a final settlement for the costs of delivering the services under the terms of this Agreement. Contractor shall manage the program operations and program costs to insure the provision of services for the full term of this Agreement.

3. Monthly invoices shall be equal to the monthly program costs for delivering the services required under the terms of this Agreement. Contractor shall provide a monthly expenditure report to accompany the invoice in support of the program costs.

4. Contractor shall submit invoices electronically to abhrs@stanbhrs.org or by mail to the following address:

   Stanislaus County Behavioral Health & Recovery Services (BHRS)
   800 Scenic Drive, Building 4
   Modesto, CA 95350
   Attention: Accounts Payable

5. Contractor is expected to generate a total minimum amount of $TBD in MediCal Federal Financial Participation (FFP) during the term of this Agreement. The Net Cost to BHRS for the provision of services under the terms of this Agreement shall be $TBD, which is calculated by subtracting the FFP of $TBD from the maximum amount of $TBD.

6. FFP revenue projections are based on year to date actual approved and authorized Medi-Cal units of service. Denied, disallowed, and unauthorized units shall be considered as non-contributory towards Contractor's generation of FFP. Contractor shall be liable for any increase in the stated "Net Cost to BHRS" as a result of any denied, disallowed and unauthorized units. Actual and projected FFP revenue shall be monitored regularly by County and Contractor during the term of this Agreement. In the event the FFP revenue projected through the term of this Agreement does not meet the budgeted amount necessary

to support the program expenditures, Contractor shall submit a plan to increase the FFP revenue or reduce the operating costs of delivering the services required in this Agreement. Contractor shall be at risk for shortfalls in FFP revenue and is therefore accountable for submitting/entering services that are eligible for reimbursement into the County Electronic Health Record (EHR).

7. Contractor shall submit a fiscal year-end cost report to County, upon request from County, generally in November following the close of a fiscal year. County shall process a preliminary settlement to the Contractor's actual costs of delivering the services and estimated Medi-Cal units of service produced during the term of this Agreement in approximately January. County and Contractor shall agree that the approved units of services from the County Electronic Health Record and the actual program costs are the actual services and costs used for purposes of this contract and final cost report settlement. After completing its preliminary settlement, County shall notify Contractor if funds are due to the Contractor. If funds are due to County, County shall invoice Contractor and Contractor shall return the overpayment to County. During the multiple phases of the cost report reconciliation and settlement process, FFP revenue loss on any denied, disallowed and unauthorized units resulting in the Contractor exceeding the Net County Cost specified herein in Section D of Exhibit A, as well as any units denied, disallowed and unauthorized as a result of state or federal audits shall be billed to the Contractor. Settlement is limited to the Contract Maximum and is also limited to the Net County Cost after applying the FFP revenue.

D. CULTURAL COMPETENCY

1. Contractor shall ensure that cultural competency is integrated into the provision of services. The terms of this section of the Agreement shall be reviewed during contract monitoring meetings.

2. County will provide the Cultural Competence Plan Requirement (CCPR) and its updates to Contractor when submitted to the California Department of Health Care Services (DHCS).

3. Contractor shall adhere to the provisions of the County CCPR, as submitted and updated, and provide information as required for submitting and updating the CCPR.

4. Contractor shall document evidence that interpreter services are offered and provided for threshold languages at all points of contact. Contractor shall also document the response to the offer of interpreter services.

5. Contractor shall have a representative participate in the County Behavioral Health Equity Committee (BHEC).

6. Contractor shall document its certified bilingual staff, including their title and languages and shall have the documentation readily available. Protocols on how to request interpreters shall be in place and documentation shall be provided.

7. Contractor shall have knowledge of the County's Cultural Competence Program. Contractor shall either adopt the County's Cultural Competence Program or if they maintain their own program, they shall provide evidence that their program aligns with the

County's program and expectations. Evidence shall be provided at annual reviews or at on-going monitoring activities.

8. Cultural Competence training opportunities will be shared by the County. If Contractor develops their own trainings or attends offsite trainings, approval from the County's Training Department shall be documented to ensure that the training meets cultural competence guidelines.
9. Contractor is responsible for tracking all contracted staff's cultural competence trainings and documentation shall be readily available during monitoring visits and at on-going monitoring activities. Documentation should include evidence of monitoring and oversight, including but not limited to attendance tracking, records, sign in sheets, protocols, and action steps for staff that has not met cultural competence requirements as delineated in the County's Cultural Competence Program.

E. TERM

These services shall commence on _____, 2022 to June 30, 2023.

F. DUPLICATE COUNTERPARTS

This Agreement may be executed in counterparts, each of which shall be deemed to be an original, but all of which, taken together, shall constitute one and the same agreement.

EXHIBIT B

Insurance Requirements for Professional Services

Consultant shall procure and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by the Consultant, its agents, representatives, or employees.

MINIMUM SCOPE AND LIMIT OF INSURANCE

Coverage shall be at least as broad as:

1. **Commercial General Liability** (CGL): Insurance Services Office Form CG 00 01 covering CGL on an "occurrence" basis, including products and completed operations, property damage, bodily injury and personal & advertising injury with limits no less than $1,000,000 per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location (ISO CG 25 03 or 25 04) or the general aggregate limit shall be twice the required occurrence limit.
2. **Automobile Liability**: If the Consultant or the Consultant's officers, employees, agents, representatives or subcontractors utilize a motor vehicle in performing any of the work or services under the Agreement Insurance Services Office Form Number CA 0001 covering, Code 1 (any auto), or if Consultant has no owned autos, Code 8 (hired) and 9 (non-owned), with limit no less than $1,000,000 per accident for bodily injury and property damage.
3. **Workers' Compensation** insurance as required by the State of California, with Statutory Limits, and Employer's Liability Insurance with limit of no less than $1,000,000 per accident for bodily injury or disease.
4. **Professional Liability** (Errors and Omissions) Insurance appropriates to the Consultant's profession, with limits not less than $1,000,000 per occurrence or claim, $2,000,000 aggregate.

If the Consultant maintains broader coverage and/or higher limits than the minimums shown above, the County requires and shall be entitled to the broader coverage and/or higher limits maintained by the Consultant. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the County.

Application of Excess Liability Coverage

Consultants may use a combination of primary, and excess insurance policies which provide coverage as broad as ("follow form" over) the underlying primary policies, to satisfy the Required Insurance provisions.

Other Insurance Provisions

The insurance policies are to contain, or be endorsed to contain, the following provisions:

Additional Insured Status

The County, its officers, officials, employees, agents and volunteers are to be covered as additional insureds on the CGL and the Auto policy with respect to liability arising out of work or operations performed by or on behalf of the Consultant including materials, parts, or equipment furnished in connection with such work or operations. General liability and Auto Liability coverage can be provided in the form of an endorsement to the Consultant's insurance (**at least** as broad as ISO Form CG 20 10 11 85 or **both** CG 20 10, CG 20 26, CG 20 33, or CG 20 38; **and** CG 20 37 forms if later revisions used).

Primary Coverage

For any claims related to this contract, the **Consultant's insurance coverage shall be primary** insurance primary coverage **at least** as broad as ISO CG 20 01 04 13 as respects the County, its officers, officials, employees, agents and volunteers. Any insurance or self-insurance maintained by the County, its officers, officials, employees, agents or volunteers shall be excess of the Consultant's insurance and shall not contribute with it.

Reporting: Any failure to comply with reporting provisions of the policies shall not affect coverage provided to the County or its officers, officials, employee's, agents or volunteers.

Notice of Cancellation

Each insurance policy required above shall provide that coverage shall not be canceled, except with notice to the County in accordance with policy terms and conditions.

Waiver of Subrogation

Consultant hereby grants to County a waiver of any right to subrogation (except for Professional Liability) which any insurer of said Consultant may acquire against the County by virtue of the payment of any loss under such insurance. Consultant agrees to obtain any endorsement that may be necessary to affect this waiver of subrogation, but this provision applies regardless of whether or not the County has received a waiver of subrogation endorsement from the insurer.

Self-Insured Retentions

Self-insured retentions must be declared to and approved by the County. The County may require the Consultant to provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention.

Acceptability of Insurers

Insurance is to be placed with California admitted insurers (licensed to do business in California) with a current A.M. Best's rating of no less than A-VII or a Standard & Poor's rating of at least BBB, however, if no California admitted insurance company provides the required insurance, it is acceptable to provide the required insurance through a United States domiciled carrier that meets the required Best's rating and that is listed on the current List of Approved Surplus Line Insurers (LASLI) maintained by the California Department of Insurance.

Claims Made Policies

If any of the required policies provide coverage on a claims-made basis:

1. The Retroactive Date must be shown and must be before the date of the contract or the beginning of contract work.
2. Insurance must be maintained, and evidence of insurance must be provided for **at least** five (5) years after completion of the contract of work.
3. If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a Retroactive Date prior to the contract effective date, the Consultant must purchase "extended reporting" coverage for a minimum of five (5) years after completion of contract work.

Verification of Coverage

Consultant shall furnish the County with a copy of the policy declaration and/or endorsement page(s), original certificates and amendatory endorsements or copies of the applicable policy language effecting coverage required by this clause. All **certificates and endorsements are to be received and approved by the County before work commences**. However, failure to obtain the required documents prior to the work beginning shall not waive the Consultant's obligation to provide them. The County reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time.

Subcontractors

Consultant shall require and verify that all subcontractors maintain insurance meeting all the requirements stated herein, and Consultant shall ensure that County is an additional insured on insurance required from subcontractors.

Special Risks or Circumstances

County reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.

Insurance Limits

The limits of insurance described herein shall not limit the liability of the Consultant and Consultant's officers, employees, agents, representatives or subcontractors. Consultant's obligation to defend, indemnify and hold the County, its officers, officials, employees, agents and volunteers harmless under the provisions of this paragraph is not limited to or restricted by any requirement in the Agreement for Consultant to procure and maintain a policy of insurance.

[SIGNATURES SET FORTH ON THE FOLLOWING PAGE]

_____ Exempt from Auto – I will not utilize a vehicle in the performance of my work with the County.

_____ Exempt from WC – I am exempt from providing workers' compensation coverage as required under section 1861 and 3700 of the California Labor Code.

I acknowledge the insurance requirements listed above.

Print Name: _____ Date:_____

Signature: _____ Date:_____

Vendor Name: _____

For CEO-Risk Management Division use only

Exception: Not Applicable

Approved by CEO for Risk Management: _____ Date: 3/31/2022

MODALITY OF COVERED SERVICE DESCRIPTIONS

Stanislaus County, Behavioral Health & Recovery Services
Drug Medi-Cal Organized Delivery System
Modality of Covered Service Descriptions

Covered services under the Drug Medi-Cal Organized Delivery System (DMC-ODS) shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to beneficiaries under fee-for-service Medicaid, as set forth in 42 CPR 440.230. Contractors shall ensure that the services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished. Contractors may not arbitrarily deny or reduce the amount duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary (IA III.C, Covered Services).

Contractors are required to ensure services are provided timely. For outpatient, intensive outpatient and residential services, the Contractor shall ensure a face-to-face appointment within 10 business days of the initial service request. For OTPs, the Contractor shall ensure a face-to-face appointment within 3 business days of the initial service request. Beneficiaries screened as having an urgent (non-emergency) SUD need will be referred for a face-to-face appointment with within two business days.

Placement in an appropriate level of care must be determined through an assessment based on the American Society of Addiction Medicine (ASAM) criteria and determined by the contractor's Licensed Practitioner of the Healing Arts (LPHA).

DRUG MEDI-CAL SERVICES:

OUTPATIENT SERVICES (ASAM LEVEL 1.0)

Outpatient services consist of up to nine (9) hours per week of medically necessary services for adults and less than six (6) hours per week of services for adolescents.

Outpatient services shall include: counseling and education about addiction-related problems, with specific components including intake, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, treatment planning and discharge services.

Services may be provided in-person, by telephone, or by telehealth in any appropriate setting in the community.

INTENSIVE OUTPATIENT SERVICES (ASAM LEVEL 2.1)

Intensive outpatient involves structured programming provided to beneficiaries as medically necessary for a minimum of nine (9) hours and a maximum of nineteen (19) hours per week for adult perinatal and non-perinatal beneficiaries. Adolescents are provided a minimum of six (6) and a maximum of nineteen (19) hours of service per week.

Intensive outpatient services shall include: intake, individual counseling, group counseling, family therapy, patient education, medication services, collateral services, crisis intervention services, treatment planning and discharge services.

Services may be provided in-person, by telephone, or by telehealth in any appropriate setting in the community.

PERINATAL/NON-PERINATAL RESIDENTIAL SUBSTANCE USE DISORDER TREATMENT SERVICES (EXCLUDING ROOM AND BOARD) (ASAM LEVELS 3.1, 3.3 and 3.5)

Residential services are provided in California Department of Health Care Services (DHCS) licensed residential facilities (Department of Social Services for adolescents) that also have DMC certification and an ASAM designation by DHCS as capable of delivering care consistent with ASAM treatment criteria. The treatment portion of residential services is reimbursable through Drug Medi-Cal.

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

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

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

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

Perinatal beneficiaries shall receive lengths of stay up to the length of the pregnancy and postpartum period (60 days after the pregnancy ends).

The components of Residential Treatment Services shall include intake, individual and group counseling, family therapy, patient education, safeguarding medications, collateral services, crisis intervention services, treatment planning, transportation services and discharge services.

Residential contractor(s) must seek prior authorization for residential services following the established Residential Authorization Request Process, found on the extranet in the in the Provider Guidelines.

CASE MANAGEMENT

Case management services shall focus on coordination of SUD care, integration around primary care especially for beneficiaries with a chronic SUD, and interaction with the criminal justice system. This includes services that assists a beneficiary to access needed medical, educational, social, prevocational, vocational, rehabilitative, or other community services.

Care Coordination and Service Coordination are the services that BHRS has developed to ensure Case Management activities are being provided to beneficiaries. Care & Service Coordination (Case Management) description can be found on the extranet in the in the Provider Guidelines.

Case management services will be provided by contractors once the beneficiary is enrolled in a SUD program. Case management services will be monitored by County during the annual site review.

Case management services may be provided in person, by telephone, or by telehealth with the beneficiary and may be provided anywhere in the community.

Case management shall be consistent with and shall not violate confidentiality of alcohol or drug beneficiaries as set forth in 42 CPR Part 2, and California law.

PHYSICIAN CONSULTATION

Physician Consultation services include DMC physicians' consulting with addiction medicine physicians, addiction psychiatrists or clinical pharmacists. Physician consultation services are designed to assist DMC physicians by allowing them to seek expert advice with regards to designing treatment plans for specific DMC-ODS beneficiaries. Physician consultation services may address medication selection, dosing, side effect management, adherence, drug-drug interactions, or level of care considerations.

BHRS will provide DMC certified contractors with access to one or more American Board of Addiction Medicine-certified physicians or pharmacists in order to facilitate consultations.
Access to physician consultation will only be available to DMC contracted treatment providers.

RECOVERY SERVICES

Recovery Services may be accessed by the beneficiary after completing their course of treatment whether they are triggered, have relapsed or as a preventative measure to prevent relapse. Recovery services emphasize the patient’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 patients. Services are provided as medically necessary.

The components of Recovery Services include:

1. Outpatient counseling services in the form of individual or group counseling to stabilize the beneficiary and then reassess if the beneficiary needs further care.
2. Recovery Monitoring: Recovery coaching, monitoring via telephone and internet.
3. Substance Abuse Services Peer-to-peer assistance. (This service only available currently at Stanislaus Recovery Center.)
4. Education and Job Skills: Linkages to life skills, employment services, job training, and education services.
5. Family Support: Linkages to childcare, parent education, child development support services, family/marriage education.
6. Support Groups: Linkages to self-help and support, spiritual and faith- based support.
7. Ancillary Services: Linkages to housing assistance, transportation, case management, individual services coordination.

Recovery services may be provided face-to-face, by telephone, or by tele health and may be provided anywhere in the community.

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

Contractors that do not opt to make recovery services available must refer beneficiaries to a DMC-ODS program that provides recovery services.

WITHDRAWAL MANAGEMENT (WM-ASAM LEVELS 3.2)

The treatment portion of withdrawal management service is reimbursable through Drug Medi-Cal.

1. Withdrawal Management services shall be determined daily by an LPHAs, as medically necessary, and in accordance with an individualized beneficiary's treatment plan.
2. The components of Withdrawal Management services shall include intake, observation, medication services, care coordination and discharge services.
3. For beneficiaries in Withdrawal Management, case management services to coordinate care with ancillary service providers and facilitate transitions between levels of care will be provided.

OPIOID (NARCOTIC) TREATMENT PROGRAMS (ASAM OTP LEVEL 1.0)

Opioid (Narcotic) Treatment Program (OTPs) shall provide services in Narcotic Treatment Provider licensed facilities. Medically necessary services shall be provided in accordance with an individualized treatment plan determined by a licensed physician and approved and authorized according to the State of California requirements.

OTP components shall include intake, individual and group counseling, patient education, arrangement through health plans of transportation services, if needed, medication services, collateral services, crisis intervention services, treatment planning, medical psychotherapy and discharge services.

OTPs shall provide the beneficiary, at minimum 50 minutes of counseling sessions with a therapist or counselor for up to 200 minutes per calendar month, although additional services may be provided based on medical necessity.

OTPs shall schedule beneficiaries that have been assessed and meet OTP Medical Necessity for their first face-to-face service on the same day as their first dose.

OTPs shall offer and prescribe medications to patients covered under the DMC-ODS formulary including methadone, buprenorphine, naloxone, and disulfiram.

OTPs contractor shall ensure case management services are available to coordinate care with treatment and ancillary service providers and facilitate transitions between levels of care. Beneficiaries may be simultaneously participating in OTP services and other ASAM LOCs.

NON-DMC FUNDED SERVICES:

Room and Board for residential treatment and withdrawal management services is not eligible for reimbursement through DMC. These costs will be covered with other non-DMC funding sources.

Recovery residences will be available by or before April 1, 2021, to DMC and non-DMC eligible beneficiaries who are actively engaged in outpatient SUD treatment or recovery services. The costs of these support services will be covered with other non-DMC funding sources.

FOR THE UNINSURED/UNDER-INSURED (I.E. MEDICARE):

Uninsured/under-insured eligible beneficiaries will have access to the same services as DMC beneficiaries with costs reimbursed through other sources.

EXHIBIT D

DHCS DRUG MEDI-CAL ORGANIZED DELIVERY SYSTEM (DMC-ODS)

1. Provider Selection and Monitoring

1.1 Credentialing and re-credentialing requirements.

1.1.1 Contractor shall follow the state's established uniform credentialing and re-credentialing policy that addresses behavioral and substance use disorders, outlined in DHCS Information Notice 18-019.

1.1.2 Contractor shall follow a documented process for credentialing and re-credentialing of network providers.

1.1.3 Attestation: All providers who deliver covered services must include a signed and dated statement attesting to the following:

1.1.3.1 Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation;
1.1.3.2 A history of loss of license or felony conviction;
1.1.3.3 A history of loss or limitation of privileges or disciplinary activity;
1.1.3.4 A lack of present illegal drug use; and
1.1.3.5 Accuracy and completeness

1.2 Contractor shall receive training on the DMC-ODS requirements, at least annually. County shall report compliance with this section to DHCS annually as part of the DHCS County Monitoring process.

1.3 Contractor shall be trained in the ASAM Criteria prior to providing services. At minimum, providers and staff conducting assessments are required to complete the two e-Training modules entitled "ASAM Multidimensional Assessment" and "From Assessment to Service Planning and Level of Care". A third module entitled, "Introduction to The ASAM Criteria" is recommended for all county and provider staff participating in the Waiver. With assistance from the state, counties will facilitate ASAM provider trainings.

1.4 Residential services shall be provided in DHCS or Department of Social Services (DSS) licensed residential facilities that also have DMC certification and have been designated by DHCS as capable of delivering care consistent with ASAM treatment criteria.

1.5 Contractor shall implement mechanisms to detect both underutilization of services and overutilization of services.

1.6 County shall monitor appropriate and timely intervention of occurrences that raise quality of care concerns. Contractor shall take appropriate follow-up action when such an occurrence is identified. The results of the intervention shall be evaluated by County at least annually.

1.7 County shall conduct performance-monitoring activities throughout Contractor's operations. These activities shall include, but not be limited to, beneficiary and system outcomes, utilization management, utilization review, provider appeals, credentialing and monitoring, resolution of beneficiary grievances and an on-site review at least annually.

1.8 If County identifies deficiencies or areas for improvement, Contractor shall take corrective actions and implement these corrective actions.

2. Scope of Practice

2.1 Professional staff shall be licensed, registered, certified, or recognized under California scope of practice statutes. Professional staff shall provide services within their individual scope of practice and receive supervision required under their scope of practice laws. Licensed Practitioners of the Healing Arts (LPHA) include:

- 2.1.1 Physician
- 2.1.2 Nurse Practitioners
- 2.1.3 Physician Assistants
- 2.1.4 Registered Nurses
- 2.1.5 Registered Pharmacists
- 2.1.6 Licensed Clinical Psychologists
- 2.1.7 Licensed Clinical Social Worker
- 2.1.8 Licensed Professional Clinical Counselor
- 2.1.9 Licensed Marriage and Family Therapists
- 2.1.10 Licensed Eligible Practitioners working under the supervision of Licensed Clinicians

2.2 Non-professional staff shall receive appropriate onsite orientation and training prior to performing assigned duties. A professional and/or administrative staff shall supervise non-professional staff.

2.3 Physicians shall receive a minimum of five hours of continuing medical education related to addiction medicine each year.

2.4 Professional staff (LPHAs) shall receive a minimum of five hours of continuing education related to addiction medicine each year.

2.5 SUD Medical Director responsibilities shall, at a minimum, include all of the following:

- 2.5.1 Ensure that medical care provided by physicians, registered nurse practitioners, and physician assistants meets the applicable standard of care.
- 2.5.2 Ensure that physicians do not delegate their duties to non-physician personnel.

2.5.3 Develop and implement written medical policies and standards for the provider.

2.5.4 Ensure that physicians, registered nurse practitioners, and physician assistants follow the provider's medical policies and standards.

2.5.5 Ensure that the medical decisions made by physicians are not influenced by fiscal considerations.

2.5.6 Ensure that provider's physicians and LPHAs are adequately trained to perform diagnosis of substance use disorders for beneficiaries and determine the medical necessity of treatment for beneficiaries.

2.5.7 Ensure that provider's physicians are adequately trained to perform other physician duties, as outlined in this section.

2.5.8 Develop and implement written medical policies and standards for the provider.

2.5.9 Written Provider code of conduct for employees and volunteers/interns shall be established which addresses at least the following:

- 2.5.9.1 Use of drugs and/or alcohol
- 2.5.9.2 Prohibition of social/business relationship with beneficiaries or their family members for personal gain
- 2.5.9.3 Prohibition of sexual contact with beneficiaries
- 2.5.9.4 Conflict of interest
- 2.5.9.5 Providing services beyond scope
- 2.5.9.6 Discrimination against beneficiaries or staff
- 2.5.9.7 Verbally, physically, or sexually harassing, threatening or abusing beneficiaries, family members or other staff
- 2.5.9.8 Protection of beneficiary confidentiality
- 2.5.9.9 Cooperate with complaint investigations

2.5.10 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.

2.5.11 The SUD Medical Director may delegate his/her 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.

3. Culturally Competent Services

Contractor shall ensure that their policies, procedures, and practices are consistent with the principles outlined and are embedded in the organizational structure, as well as being upheld in day-to-day operations. Translation services shall be available for beneficiaries, as needed.

4. Medication Assisted Treatment

Contractor shall have procedures for linkage/integration for beneficiaries requiring medication assisted treatment. Contractor staff will regularly communicate with physicians of beneficiaries who are prescribed these medications unless the beneficiary refuses to consent to sign a 42 CFR part 2 compliant release of information for this purpose.

5. DMC Claims and Reports

Contractor shall be responsible for verifying the Medi-Cal eligibility of each beneficiary for each month of service prior to billing for DMC services to that beneficiary for that month. Medi-Cal eligibility verification should be performed prior to rendering service, in accordance with and as described in the DHCS DMC Provider Billing Manual. Options for verifying the eligibility of a Medi-Cal beneficiary are described in the Department of Health Care Services DMC Provider Billing Manual.

6. Inspection and Audit of Records and Access to Facilities

The DHCS, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any records or documents of the Contractor, and may, at any time, inspect the premises, physical facilities, and equipment where Medicaid-related activities are conducted. The right to audit under this section exists for 10 years from the final date of the Agreement period or from the date of completion of any audit, whichever is later.

7. Recordkeeping Requirements

The contractor shall retain, as applicable, the following information: beneficiary grievance and appeal records in 42 CFR 438.416, and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610 for a period of no less than 10 years.

8. Coverage and Authorization of Services (42 CFR 438.210)

Contractor shall have in place, and follow, written authorization policies and procedures.

9. Language and Format Requirements

9.1 Pursuant to WIC 14029.91(e)(1), the Contractor shall make interpretation services available free of charge and in a timely manner to each beneficiary. This includes oral interpretation and the use of auxiliary aids (e.g. TTY/TDY and American Sign Language) and services, including qualified interpreters for individuals with disabilities (WIC 14029.91(e)(2)). Oral interpretation requirements apply to all non–English languages, not just those that the Department identifies as prevalent

9.2 For consistency in the information provided to beneficiaries, the Contractor shall use the DHCS developed model beneficiary handbooks and beneficiary notices.

9.3 Beneficiary information may not be provided electronically by Contractor unless all of the following are met:

9.3.1 The format is readily accessible;
9.3.2 The information is placed in a location on the DHCS or Contractor's website that is prominent and readily accessible.

10. Beneficiary Rights and Protections - Grievance and Appeals

10.1 Contractor shall maintain records of grievances and appeals and shall review the information as part of its ongoing monitoring procedures, as well as for updates and revisions to the DHCS quality strategy.

10.2 The record of each grievance or appeal shall contain, at a minimum, all of the following information:

10.2.1 A general description of the reason for the appeal or grievance.
10.2.2 The date received.
10.2.3 The date of each review or, if applicable, review meeting.
10.2.4 Resolution at each level of the appeal or grievance, if applicable.
10.2.5 Date of resolution at each level, if applicable.
10.2.6 Name of the covered person for whom the appeal or grievance was filed.
10.2.7 The record shall be accurately maintained in a manner accessible to DHCS and available upon request to CMS.

11. **Program Integrity – Compliance**

11.1 Contractor, to the extent that subcontractors are delegated responsibility by County for coverage of services and payment of claims under this Agreement, shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse.

11.2 The arrangements or procedures shall include a compliance program that includes, at a minimum, all of the following elements:

11.2.1 Written policies, procedures, and standards of conduct that articulate the organization's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements.
11.2.2 The designation of a Compliance Officer 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 County Behavioral Health Director and the Board of Supervisors.
11.2.3 The establishment of a Regulatory Compliance Committee on the Board of Supervisors and at the senior management level charged with overseeing the organization's compliance program and its compliance with the requirements under this Agreement.
11.2.4 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 this Agreement.
11.2.5 Effective lines of communication between the compliance officer and the organization's employees.
11.2.6 Enforcement of standards through well-publicized disciplinary guidelines.

11.2.7 Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under this Agreement.

11.2.8 Provision for the prompt referral of any potential fraud, waste, or abuse that Contractor identifies.

12. CalOMS-Tx Business Rules and Requirements

12.1 Electronic submission of CalOMS-Tx data shall be submitted by Contractor within 45 days from the end of the last day of the report month.

12.2 Contractor shall comply with data collection and reporting requirements established by the DHCS CalOMS-Tx Data Collection Guide (Document 3J) and all former Department of Alcohol and Drug Programs Bulletins and DHCS Information Notices relevant to CalOMS-Tx data collection and reporting requirements.

12.3 Contractor shall submit CalOMS-Tx admission, discharge, annual update, resubmissions of records containing errors or in need of correction, and "provider no activity" report records in an electronic format approved by DHCS.

12.4 Contractor shall comply with the CalOMS-Tx Data Compliance Standards established by DHCS for reporting data content, data quality, data completeness, reporting frequency, reporting deadlines, and reporting method.

13. Evidence Based Practices

Contractor shall implement at least two of the following Evidence Based Practices (EBP) based on the timeline established in County's implementation plan. The two EBPs are per provider service modality. County will monitor the implementation and regular training of EBPs to staff during reviews. The required EBPs include:

13.1 Motivational Interviewing: A beneficiary-centered, empathic, but directive counseling strategy designed to explore and reduce a person's ambivalence toward treatment. This approach frequently includes other problem solving or solution-focused strategies that build on beneficiaries' past successes.

13.2 Cognitive-Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned.

13.3 Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use treatment.

13.4 Trauma-Informed Treatment: Services shall take into account an understanding of trauma, and place priority on trauma survivors' safety, choice and control.

13.5 Psycho-Education: Psycho-educational groups are designed to educate beneficiaries about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries' lives, to instill self- awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf.

EXHIBIT E

SUBSTANCE ABUSE BLOCK GRANT (SABG) REQUIREMENTS

1. Hatch Act

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

2. No Unlawful Use or Unlawful Use Messages Regarding Drugs

Contractor agrees that information produced through these funds, and which pertains to drugs and alcohol-related programs, shall contain a clearly written statement that there shall be no unlawful use of drugs or alcohol associated with the program. Additionally, no aspect of a drug or alcohol-related program shall include any message on the responsible use, if the use is unlawful, of drugs or alcohol (HSC Section 11999-11999.3). By signing this Agreement, Contractor agrees to these requirements.

3. Counselor Certification

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

4. Debarment and Suspension Certification

Contractor shall not subcontract with or employ any party listed on the government wide exclusions in the System for Award Management (SAM), in accordance with the OMG guidelines at 2 CFR 180 that implement Executive Orders 12549 (3 CFR part Comp. p. 189) and 12689 (3 CFR part 1989., p. 235), “Debarment and Suspension.” SAM exclusions contain the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549.

Contractor is obligated to comply with applicable federal debarment and suspension regulations, in addition to the requirements set forth in 42 CFR Part 1001. If Contractor subcontracts or employs an excluded party, DHCS has the right to withhold payments, disallow costs, or issue a CAP, as appropriate, pursuant to HSC Code 11817.8(h).

5. Restriction on Distribution of Sterile Needles

No SABG funds made available through this Agreement shall be used to carry out any program that includes the distribution of sterile needles or syringes for the hypodermic injection of any illegal drug unless DHCS chooses to implement a demonstration syringe services program for injecting drug uses.

6. Cultural and Linguistic Proficiency

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

7. Tribal Communities and Organizations

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

8. Confidentiality of Substance Use Disorder Patient Records

Performance under the terms of this Agreement is subject to all applicable federal and state laws, regulations, and standards. In accepting DHCS drug and alcohol SABG allocation pursuant to HSC Sections 11814(a) and (b), Contractor shall: (i) establish, and required its subcontractors to establish, written policies and procedures consistent with the control requirements set forth below; (ii) monitor for compliance with the written procedures; and (iii) be accountable for audit exceptions taken by DHCS against the County and its subcontractors for any failure to comply with these requirements:

a. Code of Federal Regulations (CFR), Title 42, Part 2, Confidentiality of Substance Use Disorder Patient Records

b. Federal Law Requirements; Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2, Subparts A-E).

9. Employee Training

All workforce members who assist in the performance of functions or activities on behalf of the Department, or access or disclose Department PHI or PI must complete information privacy and security training, at least annually, at Contractor's expense. Each workforce member who receives information privacy and security training must sign a certification, indicating the member’s name and the date on which the training was completed. These certifications must be retained for a period of six (6) years following termination of this Agreement.

10. Confidentiality Statement

All persons that will be working with Department PHI or PI must sign a confidentiality statement that includes, at a minimum, General Use, Security and Privacy Safeguards, Unacceptable Use, and Enforcement Policies. The statement must be signed by the workforce member prior to access to Department PHI or PI. The statement must be renewed annually. The Contractor shall retain each person’s written confidentiality statement for Department inspection for a period of six (6) years following termination of this Agreement.